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The interface between payment for health service and Karimojong women's health seeking behaviour

Anitta Underlin

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The Interface Between Payment for
Health Services and Karimojong Women's
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1999

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Anitta Underlin

	IFRA
	
No. d'inventaire	IFRA000371
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Co	UG/UND T362.11

A dissertation submitted in partial fulfilment of the requirements for the degree of Masters of Arts in
Sociology of Makerere University. (Faculty of Social Sciences, November 1999).

DECLARATION

I hereby declare that this thesis is my original work and has not been submitted for a degree in any other University.

Anette Lindner

2-12-99

Signature

Date

This thesis has been submitted for examination with my authority as University Supervisor.

A. Mittelburg

2-12-99

Signature

Date

PREMAMBLE

Nadunget is a health unit seven kilometres from Moroto town in Karamoja. The buildings have recently been renovated. There are four rooms and an entrance hall in the main building. One room is used for storage of drugs; another room is equipped with a bed, which is rarely used. Another room is used for injections and for consultations with male patients. The last room is occupied by the In-charge, Anna, who is a nurse. Mothers also occupy this room with their babies. A nursing-aid is employed by the district, but he is usually absent, so Anna is in reality the only staff present in the health unit. In front of the building is a covered terrace where patients and their relatives meet. The only other buildings in the compound include pit-latrines and shower room for the mothers and their children. These were not working at the time of my visit.

Anna was born in the village just behind Nadunget. Anna worked for years in the private Kololo Hospital in Kampala. When the job as In-charge for Nadunget became she “wanted to go home to serve my own people”. She speaks the language, she is an integrated part of the society, and she familiar with cultural beliefs that impact on health seeking behaviour. She knows the practises of traditional health providers and she works closely with the traditional birth attendants in the district. My clear impression is that she is well liked, and respected by both male and female patients. She treats the patients with gentleness and respect and seems to take an interest in every patient she sees.

On the day that I spend in the health unit the majority of the patients were women with their babies and a few elderly women. The women would quietly wait on wooden benches inside the consultation room. Anna was seated in the middle of the room at a table with very basic medical equipment, a few drugs, and health charts. No man would enter that room. My attempt to be a ‘fly on the wall’ was at first a bit difficult, being the only white woman present and not talking Karimojong. Anna explained to the women I was a friend of hers and why I was there. The women sat with their children talking in low voices attending the babies. All the mothers were dressed in the typical Karimojong style with beads and metal decorations and a piece of cloth tied around their body and another cloth in which the baby was tied. The clothes were often old, ragged, and sometimes appeared not to be washed for a long time. Only a few women wore shoes. The babies would wear a little piece of cloth like a little undershirt, but no under wear. The babies would also wear beads and other decorations which I later learned was different kind of amulets.

Women sat patiently waiting for their turn. Anna would normally examine several children at the same time. After the health card for the child was found, the mother would be interviewed about the child’s symptoms and the child would have the temperature taken by placing a thermometer under the arm. I later learned that Anna also would question the mothers about the traditional herbs and other treatment they have tried before coming to the health unit. The reason for asking this was to separate the two types of treatment, as “only one form of treatment should be used at the time”. Being a Karimojong, Anna knew the most of the herbs and situations where used. After examining the baby the drugs would be given to the mother with an explanation of dosage.

Only a few men and young boys came during the day I stayed in Nadunget. Anna would sit so she that saw everybody entering the entrance hall. As soon as a male appeared she would leave the room and go with the male patient into the "injection room." Anna would sometimes come back for drugs to give to the male patient. Injections were sometimes to men. In contrast women and the babies received no injections. None of the women who had patiently waited for hours would complain or question Anna's procedure of serving the males immediately. When I asked Anna about this afterwards she seemed surprised by the question, and replied "this is how it is with us, you know that."

Cost sharing has been introduced by the health unit management committee in Nadunget. The fee is Shs. 300 for a consultation for a child and Shs. 500 for an adult. When women paid they would unpack an old plastic bag appearing somewhere from inside their cloth and carefully unfold rolled dirty and tattered bank notes. All the women would have the exact money - Shs. 300 only- and nothing more in their little plastic bag.

During my stay a mother came with a very sick baby. The mother was accompanied by an older man who I later learned was her father. They both looked exhausted as they had walked a long distance from their village. The baby was taken into the room with the unoccupied bed where Anna tried unsuccessfully for half an hour to save the life of the baby. The dead baby was given back to the mother, who was crying. The baby's grandfather stood a little distance away with tears rolling down the cheeks. Anna explained that the mother had searched for money – the Shs. 300 – for too long. When she finally got the money it was too late and her baby died. I asked about exemptions from payment. Anna explained that no exemption rules are formally approved and all patient have to pay. When I asked about credit for males, Anna looked surprised at me and responded that she had never received such a request from any male. Her clear impression was that males are able to pay, as the household always will find money if a young warrior or an elder male are sick.

This dissertation is about gender, health, and access to health services in a society where women have a status which might be considered of less value. It is a society in which women have less voice in decision making and limited access to resources at the household level. It is a society where the mere payment of Shs. 300 for a consultation of a sick child is a problem.

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Last, but not least, thanks to all the Karimojong women, who gave me their time and who gave voice to the findings presented in this report.

Anitta Underlin, Kampala 30.11.99.

ABSTRACT

This study investigates how payment and payment terms¹ in the formal and in-formal sector affects women's choice of health provider in Karamoja, and why use of in-formal health care providers are the first choice for many Karimojong women. The main objective of the study was to explore the inter-related factors that shape women's health seeking behavior in Karamoja, with particular emphasis on the role that user fees play in the process.

Like women in most parts of the world, Karimojong women have, compared to men, access to a smaller share of critical resources, including resources needed for health care. Access to resources and control over resources in the household impact on the ability to pay for health services and on the choice of health care option. Payment for health services in the formal sector is, in contrast to the in-formal sector, normally characterized by up-front payment without possibilities for exemptions, credit, payment in installments, or payment in kind. Proximity of formal health care facilities with appropriate payment structures does not in itself guarantee that women will use the formal system as the first point of entry into the health care system outside the family. Co-operation between the different categories of health providers are therefore a necessity to ensure provision of affordable basic health care to rural Karimojong women. The traditional gender roles for men and women, which hinder equal access to health care and place responsibility for health care largely on women need to be addressed. Gender Officers in the districts should be actively involved in promotion of equal health for all by arranging sensitization meetings in villages, as poor health status is linked to gender specific roles and to the fact that the discrimination against women in terms of access to resources hinder women's access to health services.

¹ 'Payment terms' refers to the mode of payment required in the formal and informal sector i.e. cash up front before treatment, possibility of credit, exemption, payment in kind and timing of decided payment, which might impact the decision of preferred health care option.

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ABBREVIATIONS

CHW	Community Health Worker.
DDHS	District Director of Health Services.
DHV	District Health Visitor.
FFS	Fees-for-Service.
GOU	Government of Uganda.
HUMC	Health Unit Management Committees
MISR	Makerere University Institute for Social Research.
MOH	Ministry of Health.
MS	Medical Superintendent [in hospital].
NGO	Non-Governmental Organisation.
PHC	Primary Health Care.
PRA	Participatory Rural Appraisal.
TBA	Traditional Birth Attendance.
TYP	Three Year Plan.
UN	United Nations.
WHO	World Health Organisation.

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CHAPTER 1

INTRODUCTION

1.1 Background to the problem.

Uganda once had one of the best health care systems in Africa. With the misrule of Amin between 1971 and 1979 health services collapsed. By 1979 the organised provision of health ceased altogether in many areas. Strategies for improving health were identified in 1982, and a health sector programme funded by donors was implemented.¹ Since then Uganda's health policy has been guided by the Bamako and World Bank approaches, to be described shortly.

Uganda's population in 1999 was about 20.9 million people, of whom 51% are female and 49% are male. The population growth rate is estimated at 2.5%.² In 1991 the life expectancy was 45.7 years for males and 50.5 years for females. Uganda has poor health indicators and heavy burden of disease. Table 1.1 compares some of Uganda's health indicators with those of regional neighbours.

¹ Wiebe and Dodge, (1987:101-112).

² Uganda Demographic and Household Survey, 1995, *in* MOH, (1999c:4)

Table 1.1 Comparative regional health indicators early-mid 1990s .³

Health Indicator	Uganda⁴	Tanzania⁵	Kenya⁶
Life Expectancy (years)	48	51	54
Infant Mortality Rate per 1.000	97	82	67
Probability of death before 5 years	14.3%	12%	10%
Total Fertility Rate	6.9	5.8	5.2
Maternal Mortality Rate per 100.000	506	529	345

Worldwide there are four principal sources of income for the health sector, namely: governments, private cost-sharing, health insurance and external donor support. For a long time in many countries the most important source of health financing was the government. In recent years donor funding and private cost-sharing have become increasingly important in many sub-Saharan African countries, as the government budgetary allocation for health has been limited due to a general deterioration in the national economy and budgetary constraints.⁷ The shift towards private sources of finance has manifested itself in a variety of ways. The most notable change took place in 1980s, with the introduction and increase in user fees for government services.⁸ By 1987 the private contribution to health expenditures as a percentage of total health expenditures in some African countries, including Uganda, was as high as 80%.⁹⁺¹⁰ More recent studies from the World Bank

³ MOH, (1999:5) (c).

⁴ Uganda Demographic and Health Survey of 1995 referred in MOH, (1999c:4).

⁵ Tanzania Demographic & Health Survey, 1996 referred in MOH, (1999c:5).

⁶ Kenya Demographic and Health Survey, 1993 referred in MOH, (1999c:5).

⁷ WHO, (1993 : 11-45).

⁸ Literature concerning user fees in the health sector includes, for example; Nolan & Turbat (1995); WHO (1993); MOH (1993b), Child health and Development Centre(1995).

⁹ The 'officially recognised' private contribution to health services in Uganda only covers service fees but excludes indirect costs such as transport, food and drink and accommodation for family members who care for their patients in hospital.

show a decrease in the percentage of private share of health service related expenditure from 70.6% of the total in 1993-4 to 57.9% in 1996-7. The private contribution of 57.9% is still more than donors and government together contribute.¹¹ In 1998/99 the government and donors only spent the equivalent of USD 3.95 per capita on health in Uganda.¹²

The Bamako Initiative, that was announced during a meeting of African Ministers of Health in 1987, saw user fees as playing an important role in the future provision of health care. The Bamako Initiative focussed on the attainment of universal accessibility to primary health care in Africa through community financing and management. This model operates in a decentralized framework and recommends user financing of primary health care to be budgeted and planned at the community level. Higher levels of health care are not a direct concern in the Bamako model, nor does it promote the use of referral hospitals. Although the Bamako model includes user fees with exemptions for the poor, these will have little application in communities, like most of those in Uganda, where almost everybody is poor.¹³ It has been estimated that in 1998/99, 46% of Uganda's population were living in absolute poverty.¹⁴ If the intentions in the Bamako initiative were followed nearly half of the Ugandan population would qualify for exemption from health user fees.

An alternative model for financing health is 'the standard model'. Here emphasis is on the general role of user fees in social sectors. This model has been of interest to the World Bank. The basic assumption in the 'standard model' is that user charges produce resources and efficiency benefits, while offering protection to the poor through exemption schemes.

¹⁰ WHO, (1993 : 15).

¹¹ Hay, (1998:34).

¹² MOH, (1999b:2).

¹³ Nolan & Turbat, (1995: 1-5).

¹⁴ 1995/96 Monitoring Survey, MOF, Planning and Economic Development referred in MOH, (1999b:1).

The standard model also assumes that fees for curative hospital services should be implemented first and will eventually cover the full cost of providing high-cost hospital care. If 'high' user fees are to be charged at hospital level, some form of insurance will be needed so that the risks of having to pay hospital charges can be shared. The model is a broadly-based model that could be applied to any developing country, although its implementation would have to be tailored to a specific country's political, economic, and social circumstances.¹⁵

Thus, the broader ('standard model') cost-recovery programmes and Bamako-type schemes are different in terms of: what the fees cover; who has control over the revenue raised; how fees for PHC relate to hospital costs; what kind of exemptions are provided to the poor; and how exemptions are implemented. This is not the place for a detailed analysis of these differences between the two models, but the fact that the two models do differ must be kept in mind in discussing issues relating to cost-recovery. It must be emphasized, however, that poverty in Uganda remains high. Poverty is recognized by Government of Uganda to be the main underlying cause of poor health in the country. The Government has embarked on a major Poverty Eradication Programme. One of the components increases support to PHC in order to reduce the high burden of infectious diseases.¹⁶ According to the Burden of Disease Study in Uganda, over 75% of the life years lost due to premature death were due to just ten preventable diseases.¹⁷

The National Health Policy from Ministry of Health spells out the policy reform on private-public mix which is envisaged to take place during the planning period. The reform intends to restructure the relationship between public and private sector, with the aim of increasing the co-operation between the two sectors and increase the access to health care. More specifically the policy has stressed the integration of the previous

¹⁵ Nolan. & Turbat, (1995: 1-5).

¹⁶ MOH, (1999b:1).

¹⁷ MOH, *The Burden of Disease Study in Uganda*, in MOH,(1999)(a). Prenatal and maternal conditions 20.4%, malaria 15.4%, acute lower respiratory tract infections 10.5%, AIDS 9.1% and diarrhoea 8.4% together account for over 60% of the national death burden. Others include tuberculosis, malnutrition, trauma/accidents and measles.

isolated private sector (NGO and private-for-profit as well as traditional healers and midwives) in the national district health care system.¹⁸

The Ministry of Health (MOH) has deployed an operational planning framework. This planning framework initially covered a period of three years – a Three Year Plan (TYP). Five Year Plans will be developed for the period beyond the year 2000.¹⁹ The objectives stated are:

- to consolidate existing services and not to support expansion in terms of new hospitals and health units.
- to reorient health services to primary health care.²⁰

Financial constraints for the Health Sector are addressed in the TYP:²¹

“ The plan frame stresses the financial constraints facing the public Health Sector – because the lack of finance is a critical factor which is undermining the efforts to improve health in Uganda. The plan frame suggests that efforts be made to enhance the contribution of communities to their own health: it also identifies the need to increase contribution of external donors and to improve the efficiency of existing services.”²²

The ‘formal’ (professional) sector is at present the only part of the health sector that qualifies for government finances, despite the fact that it is not the primary source of health care for Uganda’s population.²³ People often use western medicine as ‘last resort’,

¹⁸ Birungi, (1999:47).

¹⁹ At the time of writing (July 1999) a Health Sector Strategy Plan 2000-2005 was ready in draft. The Health Sector Strategy Plan was developed as a collective undertaking of MOH, its development partners and other stakeholders. References are however made to the plan where appropriate and where it differs from the previous TYP although not passed through Parliament.

²⁰ MOH, (1993a:preface:1).

²¹ MOH, (1993a) .

²² MOH, (1993a: preface).

²³ Whyte, (1996:132).

not only due to the cost of the medicine but also because non-formal health provision is an integrated part of the local society where people feel confident in the sense that the non-formal sector is subject to some community control in the sense that informal service providers will be used only when they are trusted and recognised by the community.²⁴

To the best of my knowledge no research has been conducted covering the use of traditional health care providers in Karamoja.²⁵ Research has, however, suggested that the traditional sector is the first point of entry into the health care system outside the family sphere for the overall majority of the Karimojong.²⁶ For particular communities in Moroto District traditional health care providers are the only accessible health care option. The traditional health care sector is often considered as illegal by the professionals, due to the unregulated and unrecognised nature of the sector. However, TBA's have recently been recognised by the formal sector as valuable partners in out-reach health care activities. Health messages can with the TBA's be disseminated to a rural population for whom accessibility to the formal health care system normally would be constrained or not possible.

In Karamoja few households have cash savings to pay for health care. The most commonly reported strategies to obtain cash when immediate funds are needed for health care are the sale of subsistence crops and short-term borrowing. These strategies can be unreliable and loans depend on the presence of someone willing and able to lend out money.²⁷ Gender specific studies suggest that males are more likely than females to use

²⁴ See, for example, Janzen, (1978:193), Kleinman, (1980), Henlander, (1989:25), Underlin, (1999).

²⁵ Karamoja is the name of the district in the Northeast of Uganda. Karimojong is the name of the people. Ocan, (1993: 93) considers the Mathenko, the Pian, the Bokora and the Pokot as Karimojong. Pazzaglia, (1982: 39) and Novelli, (1988: 38) define the Karimojong as 10 different groups Maseniko, Mogos, Kosowa, Bokora, Tome, Masingo, Muno, Peei, Kaleeso and Pian. These 10 groups are sub-groups of the three groups Maseniko, Bokora and Pian. I will use the last definition for Karimojong.

²⁶ Underlin, (1999), Hay, 1998(:16:17), Lane *et al.*, (1995:33), Barton *et al.*, (1999).

²⁷ Underlin, (1997). A pilot study carried out in the summer 1997 at Matany Hospital shortly after user fees were raised in a hospital in Karamoja, found that increased user fees affected women's attendance to the hospital negatively.

the government health system in Uganda.²⁸ Similarly, gender-specific data shows that female-headed-households²⁹ are more likely than male headed-households to be forced to borrow to pay for health care services.^{30+ 31} Like women in many parts of the world, Karimojong women have, compared to men, access to a disproportionately small share of the critical resources, including resources needed for health. Exit interviews with 82 women in three selected health units in Karamoja found that levels and terms for payment of health care impact on women's choice of health care option.³²

This research in this dissertation was conducted in Moroto - one of the two districts in Karamoja. The two communities in this study are Campswahili Chini near Moroto Hospital and Nafam/Naturumuru near Matany Hospital. The locations of the two hospitals are marked on the map of Moroto district on the following page.

²⁸ GOU /Uganda National Council for Children, (1994:96-97).

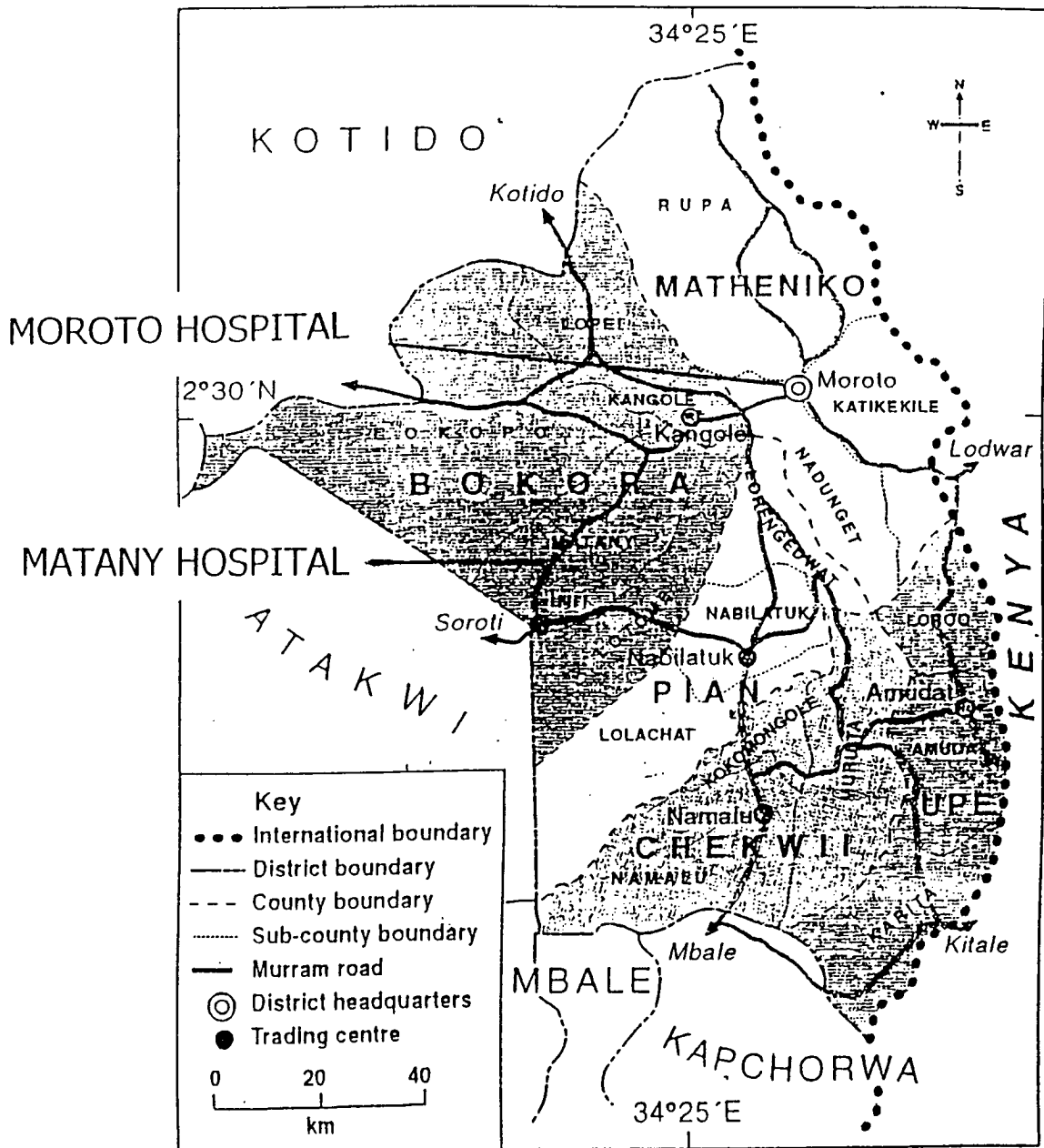
²⁹ The term: "female headed household" is used in this dissertation in the way defined by the respondents themselves. Their definition included: widows, women living alone as husband migrated, husband living with another woman, husband handicapped etc. The group of female-headed-household should therefore not be considered as a homogenous group.

³⁰ GOU /Uganda National Council for Children, (1994:90-94).

³¹ Underlin, (1999:) A study carried out from November 1998 to May 1999 in Amudat Health Centre, Tokora Health Centre and Nadunget Health Unit revealed that payment terms are an especially decisive factor for the women. Few women have savings to use for up-front payments - normally required in the formal sector .

³² Underlin, (1997).

Moroto District



³³ Rwabwoogo, (1997:94).

Compared to the rest of Uganda Karamoja is a disadvantaged region that lags far behind the most of Uganda in terms of social well-being indicators. Table 1.2 shows some of the indicators for wellbeing for Karamoja compared to the national level.

Table 1.2 Social and health indicators for Karamoja.³⁴

	Karamoja	National Level
Infant Mortality Rate Infant deaths in a year per 1000 live births	172	122
Fertility rate	6	7
Female-headed-households ³⁵	>45%	29%
Population within 5km of health unit	8.9%	49%
Primary one enrolment by gender Females as percentage of males	50%	86%
Literacy of adults and adolescents	11%	54%
Female literacy age 10 and above	6%	45%
Children without schooling 6 – 12 years, who have never attended school	93 %	30.4%

Matany Hospital near Moroto town has attempted to adapt its patient fee structure to the culture in Karamoja where women and children have a very low status. The hospital has a stated objective to maintain accessibility to the poorest and most vulnerable members of the society. Generally children pay only a small proportion of the adult consultation fee, while simple treatment to children is offered free. Fees for maternity care are kept low to meet the target that 80% of the patients should be women and children. Matany Hospital had to increase their fees in the summer 1997 as the hospital was running a budget deficit,

³⁴ GOU / Uganda National Council for Children, (1994:17–62). The latest publish figure from MOH estimate the Infant Mortality Rate per 1.000 for Uganda to 97 but as the figure available for Karamoja dates back to the publication from 1994, I will for comparison reason keep the “old” figures.

³⁵ The table on page 46 in GOU/Uganda National Council for Children (1994) is not completely clear in the sense that the percentage of female headed households in the two districts in Karamoja can be read to be between 45-60% or as 60% . I have used >45% . The table shows however, that Karamoja is the area in Uganda with the highest percentage of female headed households.

after adhering to a government policy to increase health workers salaries to ‘a living wage’.³⁶

1.2 Statement of the problem.

The assumption in this study is that the utilisation of the health services is influenced by factors such as:³⁷

- the socio-economic characteristics of the health seeker
- payment of user fees,
- quality of the offered care,
- availability of alternative health services,
- cultural beliefs and perception of disease

A basic argument in the study is that payment structure for health care in combination with the cultural beliefs and perceptions of disease shape the health seeking behaviour for women.

The Government of Uganda has argued that user fees in the health system will create more equal access to services provided in the formal health system. Data from Matany Hospital appears to show the contrary. User fees had a direct negative influence on the attendance of female and child patients in Matany Hospital when they were increased in August 1997.³⁸ My own pilot study found that at rural health units attendance did not

³⁶ St. Kizito Hospital – Matany 1995/96 Hospital Report. St. Kizito Hospital is the formal name of the hospital given by the Catholic Fathers. The hospital is most often referred to as Matany hospital.

³⁷ A variety of studies show these inter-related factors see for example Kleinman, (1980), Nolan and Turbat, (1995), Oestergaard, (1992).

³⁸ User fees at Matany hospital were reduced again later in 1997, due to the decrease in attendance of women and children. Source: Matany Hospital Archive October 1997.

increase after user fees were increased in Matany Hospital.³⁹ This suggests that some of the patients sought treatment outside the formal health system, probably in the non-formal sector where payment terms are more sensitive to the capability of the community and of individuals to pay user fees.⁴⁰

The findings of my pilot study in Matany and my study of three selected health units in Moroto District supported the hypothesis that payment for health care has a direct impact on women's health seeking behavior, partly because women do not control many economic resources in Karamoja.⁴¹ Many Karimojong women must seek consent from a male family member to be able to pay for health services, or they may look for alternative treatment outside the formal health system. Discussions with the Director of District Health Services (DDHS) and 'In-Charges' in health units reveal that health care for men is normally paid for, since men control the necessary resources, but that women and children often found difficulties in paying even a small fee of Shs. 300 (USD 0.21). It was also noted that although cows constitute a major household resource in Karamoja, they are mainly exchanged during marriages and traditional ceremonies. When a male DDHS was asked if men would sell cows to pay for health services, he replied:

“ I wish it was so, but cows are for marriages and traditional services, that is all. If it is a man, he will be paid for as the men control the resources, but for women and children no.”

Karimojong women are, like women everywhere, the primary health providers in their society.⁴² This century the status of Karimojong women has declined relative to that of men for a number of reasons. Ocan has shown that Karimojong women have experienced

³⁹ A study was in Oct.-Dec. 1997 conducted by Matany Hospital at the introduction of increase user fees. The gender broken data from Matany and interviews with officials from Moroto District were used in two pilot studies: “ Equity in access to health services in the changing economic environment in sub-Saharan Africa.” and “ Introduction of user fees in the Health Sector and consequences for disadvantaged groups such as women.” Underlin, (1997).

⁴⁰ Research by Underlin, (1999) at three selected health units revealed that the payment terms which require up-front payment are a constraint to women seeking health care in the formal sector.

⁴¹ Underlin, (1997), Underlin, (1999).

⁴² See, for example, Ostergaard, (1992:131) and Vagnby, *et al.*, (1998:4).

decreasing access to resources in the family household.⁴³ In the traditional Karimojong setting women were responsible for milking and controlling the use of milk. With the change of milk from a product for subsistence to a commodity for sale, the participation of men in its extraction and control has increased greatly. At the same time, the increased risk of raiding and conflicts between groups has resulted in “buffer zones” that deny women access to their fields.⁴⁴ Although Karimojong men have, with the introduction of the plough, been involved in cultivation, women still perform the most labour-intensive processes. Control of the harvest is linked to the husbands or another male relative and women do not have direct access to the resources.⁴⁵

Despite the fact that women can often only gain access to resources through males, studies suggest that more than 45% of households may be female-headed.⁴⁶ This is partly an outcome of the predominance of male deaths in connection with raiding. Traditionally widows became the wives of their husband’s brothers. Today many widows are no longer inherited, as their husbands might not have left cattle and only a few men are able to provide adequately for additional dependants. Women whose husbands die may also be rejected due to fear they may carry the AIDS virus. One common implication for the female-headed family is a reduced capacity to meet the needs of the family.⁴⁷ Although it is difficult to generalise, we know that female-headed households are more likely to suffer from poverty than male-headed households, as there is usually only a single adult to generate income for the family. A large proportion of Uganda’s 19% core poor, who cannot afford adequate food, live in female-headed households.⁴⁸ Another study found that female headed households in general have less funds available for health care than

⁴³ Ocan, (1994:122).

⁴⁴ Lane, (1995:16).

⁴⁵ Ocan, (1994:121).

⁴⁶ GOU/ Uganda National Council for Children, (1994:46) and Lane, (1995:32).

⁴⁷ Lane, (1995:32).

⁴⁸ GOU/ Uganda National Council for Children, (1994: 46 and 61).

male headed households.⁴⁹ Studies have shown that priorities resource allocation differ in female and male-headed households.⁵⁰ For instance, a survey carried out in 1995 in Uganda by the Inter-Ministerial National Task Force on Health Financing, found that female-headed household spent less on health care per illness, were more likely to use market/shops for care, and were more likely than other types of households to borrow to pay for the health care.⁵¹ The utilisation of resources varies from household to household and female-headed-households cannot be considered as a homogenous group. However, studies suggest that many female-headed-household are poorer and have more difficulty in providing the necessary funds for appropriate health care for the family members than male-headed-households.

Most Karimojong women have less access to resources and fewer possibilities to pay for health services than men. It is therefore likely that user fees for health services have a direct impact on the health seeking behaviour of women and children in ways that strengthen the existing inequalities in the Karimojong society. The current study therefore sought to establish how the payment for health services affects the health seeking behaviour of women in Moroto District, including their choice of health care options.

1.3 Scope and purpose of the study.

The study was a cross sectional, exploratory, and descriptive study carried out from October 1998 to August 1999. The geographical area of the study was Moroto District in Karamoja, Uganda. Two communities – Campswahili Chini and Nafam/Naturumuru - in close proximity to the two hospitals in the districts were studied. 109 Karimojong women

⁴⁹ Child Health Development Centre, (1995:22-25).

⁵⁰ World Bank, (1997:5).

⁵¹ Child Health and Development Centre, (1994:13). The female headed households were together with groups of high density households, low-education households, rural households with young children and fishing and pastoralists households identified as vulnerable groups to be specially targeted in monitoring the impact of introduction of user fees.

in the two communities form the core of respondents supplemented by group discussions and interviews with key informants. The major concern is the impact of the introduction of user-fees on the accessibility to health services for Karimojong women and children who, for reasons already stated, must be considered a particularly vulnerable group.

1.4 Objectives.

The study explores the inter-related factors that shape women's health-seeking behaviour in Karamoja, with particular emphasis on the role that user fees play in this process.

Specifically the study:

1. explores Karimojong women's first point of entry into the health care system outside the family sphere system.
2. identifies the contribution of gender relations to the situation in which the Karimojong women has limited access to resources on household level although being the economic provider for payment of health services to their children and themselves.
3. describes the impact of payment structures within the health sector and on Karimojong women's health seeking behaviour.
4. discusses proposals for improving accessibility to health care for vulnerable groups such as women and children within the context of a user paid private/public health care system.

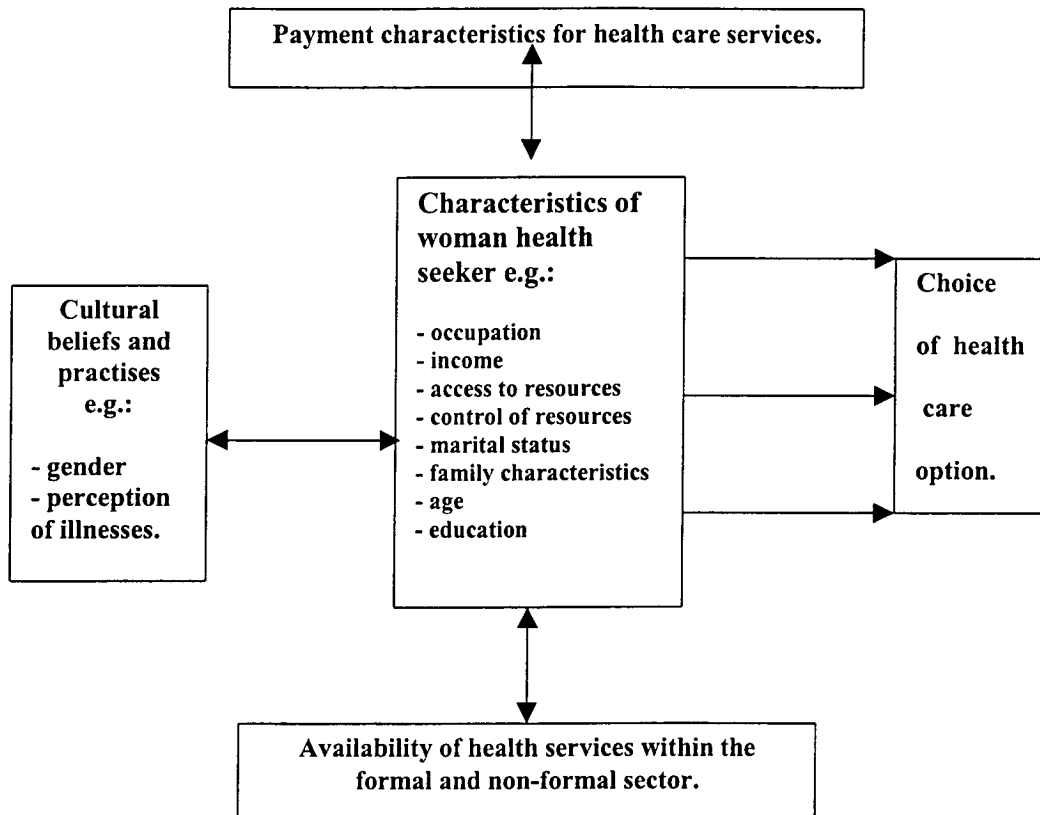
The question to be explored in this dissertation is how type of payment impact on women's health behaviour and the utilisation of the formal health services.⁵²

⁵² Kleinman, (1980) introduced a model of three overlapping sectors in the health care system: the popular, the folk and the professional sector. The model is detailed described in the literature review. GOU/Uganda

1.5 Conceptual framework

The study is conceived within the health-seeking framework illustrated in Figure 1.1.

Figure 1.1: Conceptual framework.



The health care seeker, the “actor”, is at the centre of a decision making process influenced by the payment structure for different types of health services, the availability of health care options, and cultural beliefs and perceptions of disease. The model is actor-oriented in the sense that social actions and interactions by actors or groups can change

National Council for Children, (1994:96) differs between the informal sector, the intermediate sector and the formal sector. The three sectors correspond generally to Kleinman’s although being a more precise description of the situation in the Ugandan health sector. In this study I have chosen to use the terms formal/in-formal / traditional health care systems. The formal system corresponds to professional sector and in-formal/ traditional covers folk sector, popular sector and intermediate sector.

established social institutions.⁵³ The term interface describes the dynamic process by which on-going negotiations and actions by the community members influence and change established institutions and create new institutions as a result of a local defined need. Social reality is as a result of on-going negotiations between mutually involved sets of actors. Actors are considered as capable, active, and reflective individuals who solve problems by choosing between different behavioural options. The actor oriented approach places the actor as the focus of the analysis by acknowledging that large-scale and remote social forces do alter life chances and behaviour of individuals to a certain extent, but also that external intervention are mediated and transformed by individuals and groups affected to fit to the local context.⁵⁴

Arrows in the conceptual framework therefore go in both directions. Payment terms and conditionalities of health services will impact the choice of health care option. The chosen option of health care reflect the availability and willingness of prospective patients to pay. Likewise, cultural beliefs and perception of diseases are dynamic processes, changeable over time. Availability of different types of health care options are influenced by demand, by national health policies, and general 'development' in the area.

1.6 Significance.

Women in Karamoja, as elsewhere, are most often the primary health providers to the family. Women's health seeking behaviour has therefore an impact on the well-being of family members, who need to be healthy to attend schools, to work in the fields, to herd the cattle and so forth.

This study contributes to a better understanding of the factors that influence women's utilisation of health services in Karamoja, with a particular focus on the impact of user fees and the impact of different types of payment systems. It is important to know how

⁵³ For description of Symbolic Interactionism see: Coser, (1977:568-579), Farganis ed.,(1994: 359-375), Bilton *et al.*, (1996: 91-96, 620-631).

⁵⁴ Norman L. *et al.*, (1994: 64-65).

people decide between different health care alternatives, since there are situations in which some alternatives will be more appropriate than others.

Many people view Karamoja as a 'special case' due to its remoteness and history of civil unrest, which has an impact on the health care delivery. Nonetheless, many situations faced by Karimojong women are faced by other women in- and out-side of Uganda. To this extent many of the findings are relevant in other settings also.

CHAPTER 2

LITERATURE REVIEW

This literature review is divided into two parts. The first section discusses Karamoja and the Karimojong. The second part focuses on:

- women's health status and women's access to resources in Karamoja;
- the impact of user fees on utilisation of health services in other settings;
- health seeking behaviour.

2.1 Karamoja and the Karimojong¹

Karamoja is the name of the 24800 square kilometer region that occupies the northeastern corner of Uganda. In the 1991 census Karamoja had a human population of just under 400.000.² Ecologically, Karamoja is different from most of the country, resembling the southern part of Sudan and Turkana in northwestern Kenya. Rainfall is unreliable in terms of timing and in spatial distribution. Annual rainfall totals range from 500 mm to 1000 mm, with variations from year to year and from place to place. Thorny bushes, woodland, and patches of grassland characterize the vegetation in Karamoja. Karamoja can be subdivided into three ecological categories running from east to west, with the west endowed with better prospects. Because of seasonal variations in weather and resource potential, the three zones have been interrelated through social activity in order to ensure sustainable use of resources. Pastures are broadly divided into short and long grass plains, and their respective qualities determine much of the pastoral migratory pattern.³

¹ For a detailed description of the ecology and development efforts in Karamoja see Wabwire, (1993:28-49).

² The 1991 census is considered by many in Karamoja as unreliable as the census was conducted in the dry season, when many men were grazing cattle outside of Karamoja.

³ Lane, (1995:4).

Traditionally male Karimojong are cattle herders. Although pastoralism is difficult in much of Karamoja, the Karimojong have been able to organize their activities in such a way as to exploit the resources offered by the land without impoverishing it. The essence of this method is the rotation of pastures, - known as transhumance.⁴

The Karimojong are Plains Nilotes. Other Plains Nilotes include the Samburu, Masaai, Turkana and Jie. Cultivation of crops (mainly sorghum) by women plays an important role in the Karimojong pastoral economy. The Karimojong have permanent settlements in which most of the family stay throughout the year, while male herders move out with their animals in ‘cattle camps’, sometimes a hundred kilometers or more from home. Crop cultivation takes place in the plains near the settlements, producing important additional sources of food.⁵

The traditional social organization includes the political system, which is based upon power exercised collectively by elders who have passed through the initiation rites for male Karimojong known as the “*asapan*”.

The traditional age-set structure of men is illustrated below:

1	2	3	4
Boys	Warriors (Labour)	Elders (Authority)	Grandparents (Retired)

The elders in the Assemblies discuss matters of importance for the Karimojong. Matters discussed in the Assemblies normally include: raids, disputes among individuals, cases of theft or of adultery, inheritances etc. Decisions are taken on the basis of the arguments contributed by each person. Non-initiated males must remain outside the semi-circle of the Assembly, but have the right to participate in the discussion. Women and children are

⁴Ocan, (1992b:4-5) distinguishes transhumance from nomadism as nomadism involves movements from place to place with whole families, and thus no permanent claim on land or territory. Transhumance involves movement with livestock according to seasons, in a regular pattern repeated from one year to the next.

⁵ Ocan, (1994:100).

not allowed into Assemblies.⁶ Recent studies in Karamoja by Ocan shows that criteria attaining authority are often no longer social age but economic ability. There are many elderly people who are now unable to be members of the elders council because of impoverishment.⁷

In 1988 Novelli, a priest who lived among the Karimojong for twenty years, described the traditional Karimojong society as a democratic and egalitarian society.

“ This democratic and egalitarian system offers a strange contrast with that of neighboring peoples, which are structured among more or less hierarchical lines.”⁸

Ocan challenged Novelli’s opinion and suggested that many anthropologists:

“failed to see that not all warriors wielded equal power nor equal benefits. They ignored the social stratification of the society and paid attention to the natural strata. They equally ignored the fact that not all elders in their councils were equal. Those who despite being elders continued to command the youth to war or foretold the fortunes ahead and, above all possessed more cattle gained prominence.”⁹

Novelli believes that raiding has now degenerated to such a degree that it cannot longer be distinguished from pure banditry.¹⁰ Contrary to popular belief, cattle raiding was not a common occurrence in Karamoja before the middle of this century.¹¹ Raiding has created a new class of leaders, the warlords, who accumulate their wealth and status through cattle raids, and robbery of travelers on highways. Villages and cattle camps are burned,

⁶ Novelli, (1988:44-48).

⁷ Ocan, (1992a:39) .

⁸ Novelli (1988:46-47).

⁹ Ocan, (1994:109).

¹⁰ Novelli, (1988:154).

¹¹ Ocan, (1992b) .

and killing is done for its own sake. Rape of women and young girls, unknown earlier, has become a usual feature of raiding.

Raiding and demographic pressures led to a decline in the ratio of people to cattle in Karamoja from 1:3 in 1931 to 1:1 in 1980.¹² The number of people owning large herds in Karamoja is growing smaller while those owning few or no cattle is growing larger. Families without cattle risk a less nutritious diet as they have no immediate access to milk, blood and milk, which is an important part of the staple diet. Lack of cattle impact on gender relations. Male family members may migrate in search for work and leave the female family members to provide for the family.

The lives of Karimojong women differ from those of men economically and socially. Men live a life that is mostly nomadic and their diet reflects this fact. Men's diet is mostly made up of meat, blood, and milk. Although men are increasingly participating in the agricultural sector, male participation does not mean that men perform the same tasks as women. Notably, only males use ploughs. Labour-intensive and time consuming tasks remain feminine tasks, leaving the women to bear the heaviest burdens in agriculture.¹³ Lane (1995), Ocan (1994) and Okwera (1994) demonstrated that during the last 10 years Karimojong women's access to resources has diminished due to men's increasing control of the yields of livestock and agriculture and the increased insecurity due to cattle raiding. Ocan suggests that where a product gets transformed from subsistence to a product for extraction of resources males take over the control.

Women are responsible for all important daily chores around the '*manyatta*'¹⁴: Women build houses, look after the children, grow vegetables, prepare food and collect firewood. Women's diet is composed mostly of products from the fields including maize, sorghum,

¹² Mamdani *et al.*, (1992:18) refer to figures by which the total numbers of cattle in 1930 was 192.000 compared to 308.000 in 1980. In the same period the human population in Karamoja has increased from 65.000 in 1931 to 350.086 in 1980, which as a consequence will mean a decrease in the ratio of cattle per person.

¹³ Ocan, (1994:118-122).

¹⁴ Compound containing a number of huts. The manyatta is normally housing one extended family. Each family unit consists of one male with one or several wives. Friends can also stay semi-permanently in the compound.

various greens, and chickens. Women bring products from the fields to the men while they herd their animals, including ground meal, beer, and tobacco.¹⁵ The diet for women and men can be considered well balanced in 'good' times, but women and children will be the first to suffer when there is not sufficient food for everybody. Traditional food taboos prevent women and children from eating protein-rich food such as chicken, eggs and goat meat, which means women are even more reliant on milk, blood and meat from the cattle.

The family of the future husband pays bride price for the Karimojong woman in a system which has been described by some people as an economic transaction, in which the woman is treated in a way similar to an object bought in the market. However, Novelli argued that the Karimojong bride wealth payments and marriage should be seen as a social system of alliances, sealed through the transfer of livestock to the family of the bride, to safeguard individuals. Novelli also argued that polygamy seen in this social perspective loses some of its negative connotations. By increasing and strengthening the network of alliances with clans, the family group will gain greater social and economic security. Children are perceived as a guarantee of prosperity. Girls will secure the family wealth in form of bride wealth and the sons will generate income as warriors bringing cattle home to the family. It must be stressed that this contributes to the subordination of Karimojong women. For example a divorce would mean that the family should deliver the bride wealth back to the husband's family.¹⁶ For this reason considerable pressure is usually exercised by the women's family for her to remain in the marriage – even in case of serious and prolonged ill-treatment of the wife.¹⁷

A woman achieves a new status when she is married and from that moment, she is no longer called girl (*apese*), but woman (*aburu*). Adultery rarely happens and traditionally

¹⁵ Novelli, (1988:61-65), Ocan, (1992b:30) mentions also security constraints as a contributing factor for malnutrition, as the in-security means that the warriors will keep all the cattle with them, and not, as earlier, leave a few cattle behind to feed women and children.

¹⁶ Interviews with several key informants June 1999.

¹⁷ Novelli, (1993), Lane, (1995). Confirmed by interviews with key informants June 1999.

was considered one of the gravest offences that a Karimojong could commit. In the traditional society an adulterous male would be lynched. Now an adulterous male is more likely to be required to make a payment to the offended husband, corresponding to a new marriage (at least sixty heads of cattle). An adulterous woman can be repudiated by her husband, in which case her father must return the bride wealth and cattle of the marriage. If the woman is not repudiated she must undergo a special 'cleaning' ceremony performed by her parents.

Women constitute more than half the population in Karamoja, but are largely absent from public and private decision making. Government policy to increase women's participation in Local Councils has yet to have a significant impact. Vagnby found that Karimojong women are socialised to feel it is the role of men to take decisions, and that despite being members of Health Unit Management Committees (HUMC) women frequently do not show up.¹⁸ This is one of the reasons why concerns of women and the inability of some women to pay the user fees are rarely raised at the HUMC, or, if raised, they are discussed and decided upon by the male members of HUMC's. During a management meeting for the Health Unit in Nadunget Sub-county in Moroto District no woman was present in the Health Unit Management Committee, in spite of women being members of the committee. One elder replied when asked if a woman could chair the HUMC :

"Women can also lead, provided there is a man to guide."¹⁹

Wamai and Barton also found that Karimojong women and children lack a meaningful voice in domestic and community affairs. Gender roles affect women's and girl's freedom of movement and participation in associations. It is the expectation that married women stay at home in charge of the domestic work, which prevent their active participation in community and political activities.²⁰

¹⁸ Vagnby, (1998:14).

¹⁹ Vagnby, (1998:14).

²⁰ Wamai and Barton, (1994:81).

This section has reviewed literature concerned with Karimojong women's lack equal access to resources on household level and how Karimojong women's participation in the decision making process both on family level and in the public sphere is hindered by the traditional gender roles. The next section reviews literature concerned with gender impacts on accessibility to health care for women and their dependants.

2.2 Women's health status and women's access to resources in Karamoja.

Ostergaard has shown that gender, health, and development are related in a dynamic triad.²¹ Without a certain level of economic and social development a population cannot be provided with basic health care, and without a healthy population, development of the society will not take place. Ostergaard adds to this chicken and egg dilemma a third dimension, which is always present - gender. She raises the following questions:

“ Can a nation give birth to healthy babies without healthy mothers?”

“Will the suckling survive without sufficient mothers' milk?”

“Will the family gain enough energy from its meagre resources if the food-providing female is not able to produce sufficient provisions and practise good nutrition?”

“Will the growth in population stop exploding if females have no knowledge about and no access to family planning measures?”²²

Clearly, the cultural and socio-economic context within which women live has a bearing on their health. Ugandan women are trapped within a web of traditional values that assign a very high value to martial status and childbearing, and almost no status to anything else women do.

“ The health status, as well as the social status, of Ugandan women is of particular concern.

²¹ Ostergaard, (1994: 110).

²² Ostergaard, (1994: 110-113).

The low status that the traditions assign to them, their lack of voice in decision-making as well as in formulation of politics, further impede their chances to stay healthy and productive.”²³

Women usually marry at an early age in Uganda despite the legal minimum age of marriage of 18 years.²⁴ Less than 2% of women never marry. Early marriage and high fertility impact on women’s lives in many ways including health, education and material well-being. The majority of mothers – 43% - produce their first child whilst between 15 to 17 years of age. The fertility rate of 7.1 is among the highest in Africa.²⁵ A baseline study for Moroto conducted in 1999 found that of the mothers who had delivered within the last 12 months, 11.2% had lost their child.²⁶

Women’s resistance to disease is often lower compared to their male counter-parts due to the strain of repeated childbearing and breast-feeding, combined with poor nutrition and long hours of hard work. Many women are most of the time in poor health due to the high prevalence of anemia, malaria, AIDS and other sexually transmitted diseases. A survey in four districts in Uganda showed that the morbidity rate of rural women was alarmingly high and that 76% of women reported being sick in the two weeks prior to the interview.²⁷ The latest draft of the Health Sector Strategic Plan recognised that:

“... the different health needs and priorities of women and men have not been identified and addressed by the health system. Thus, development of health sector policies and programmes have not responded to gender concerns, showing little appreciation of the way in which inequality impact on health of the population.”²⁸

²³ Kirumira *et al.*, (1993).

²⁴GOU/Uganda National Council for Children, (1994:119) In Uganda 44% of women marry between the age of 15-17 years and 23% of girls marry under 15 years.

²⁵GOU/Uganda National Council for Children, (1994:22).

²⁶ Barton *et al.*,(1999).

²⁷ Kirumira *et al.*, (1993:13). The four districts included covered Gulu in the Northern region, Mbale from Eastern region, Mbarara from Western region and Entebbe representing the central region.

²⁸ MOH, (1999b:2).

Many barriers hinder women's access to health facilities. This is especially true of poor women, who form the vast majority of the population of women. Long distances, poor communication, cost of transportation and insecurity may all discourage women from travelling to health centers. The loss of a day's work in the field and the absence of the mother from unattended children and necessary household duties are also obstacles.²⁹ Food production must often take priority over health care to ensure the survival of many rather than take time just to care for one. Gender roles further act as a barrier for equal access to health services, as the women has to get the consent from their male counterpart before going to a health clinic.³⁰ An other obstacle women face in gaining access the appropriate health care is shortages of drug supplies in many health facilities. Women are often given prescriptions and have to buy their medicines on the private market, at prices well beyond the reach of the most women.³¹

Karamoja has as many as 37.800 female-headed households, partly due to male deaths in connection with raiding and the change in social situations by which widows are no longer automatically are 'taken over' by the dead husbands brother. Another group of female-headed households are these, where the male breadwinner has migrated in search for work leaving the families behind to produce for themselves.³² These households with normally only one adult, adopt a number of strategies for survival. One of these strategies may be to reduce expenditures on health.³³

Lack of resources impact on the health seeking behavior. A study from Kenya concerning equity in provision of health care to the poorest part of the population had as major findings:

²⁹ See, for example, Lane *et al.*, (1995:23).

³⁰ Wamai and Barton, (1994: 81).

³¹ Ostergaard, (1992:131).

³² Ocan, (1994: 128) and Lane, (1995:32).

³³ Hay, (1998:14).

- 60% of those who sought an alternative to using government health facility did so due to costs or dissatisfaction with the service or both.
- 95% of the poor households indicated that they knew of someone who recently had not sought care because inability to pay.³⁴

Similar findings have been reported in a survey in Uganda which identified female-headed households as particularly vulnerable, and found that the female-headed household were more likely to borrow to pay for health services than other types of households and that female-headed households spent less on health care per illness than other households.³⁵

This section has reviewed literature relevant to the issue of how limited access to resources at the household level impacts the health seeking behaviour for the Karimojong women and their dependants. The next section in this literature review focuses on Government of Uganda's overall strategy for implementation of cost-sharing in the formal health sector, including the protective measure envisaged for the poorest part of the population.

2.3 User fees.

As stated in Chapter One Uganda's health policy concerning cost-sharing is influenced by the Bamako initiative and the World Bank financing model. The Government of Uganda has committed itself to shift from costly curative services to more cost-effective preventive services.³⁶ Although the Ugandan population already contributes significantly to payment of health services, the government has stated its desire to increase further individual and community contributions to payment of health services. The latest draft of the Health Sector Strategic Plan for the year 2000/1 – 2004/5 states:

³⁴ Newbrander *et al.*, (1995:v).

³⁵ Child Health and Development Centre, (1995:13).

³⁶ See : MOH, (1993b), (1993a),(1997a) .

“ Government will ensure that such schemes do not unduly discriminate against the poor and vulnerable groups, distort the demand for care, or the provision of health care.”³⁷

There is no precise description of how the Government will ensure that the poor and vulnerable have access to health facilities, as it is increasingly the responsibility of the Districts to put such measures in place. It is not clear how implementation of a new health strategic plan will differ from the present situation, where no mechanism in reality is in place for ensuring equal access to health facilities. Moroto District has not implemented the guidelines concerning cost-sharing recommended by MOH in 1997. No overall district policy concerning implementation of user fees has been decided upon in the district. District guidelines defining groups to be considered for exemption are non-existent in the district. Research suggests that groups likely to get exemption in Uganda at present are military, police and health workers including family and relatives.³⁸

Exit interviews with patients at three different formal health facilities in Moroto District have suggested that treatment in the non-formal sector is not always cheaper than in the formal sector. A significant difference observed is that whereas money is the only acceptable form of payment in the formal sector, payments in kinds such as a chicken, beer, food etc. are acceptable in the in-formal sector and that extended credit facilities also exist. This difference in payment terms sometimes wrongly leads to the conclusion that traditional treatment is cheaper than professional treatment. However, a value for the kind ‘paid’ for traditional treatment needs to be set. A chicken is for example equivalent to Shs. 2500. If this value is compared to the cash payment required for treatment in a formal health facility it is not always possible to argue and document that traditional health care providers demand less payment for their services than what is required in the formal sector.³⁹

³⁷ MOH, (1999c:52).

³⁸ Underlin, (1999).

³⁹ Underlin, (1999).

Because Karamoja belongs to one of the most disadvantaged regions in Uganda, tax revenue is very meager, so funds available on local level to improve the quality of the health care system are extremely limited. It is possible that decentralisation might reinforce the already existing resource inequalities. Delegated funds from central level may decrease leaving District responsible for raising supplementary funds for essential health services.⁴⁰

The focus of this section has been the overall health strategy and aspects of the policy for cost-sharing within the health sector. The next section investigates how payment and payment structures impact the utilisation of available health care options.

2.4 Health seeking behaviour.

People choose their health service provider on basis of factors such as cost, on quality of services offered, and the level of service they believe is appropriate to their needs. In rural areas this depends, importantly, on the proximity of the provider, because of transport and time.⁴¹ The interface between payment for health services and health seeking behaviour is a dynamic process where the availability of different categories of health care providers impacts the choice of the health care seeker. The health seekers choice and the demand for a particular health care option impact the payment conditions of health care facilities e.g. only a few private practitioners or clinics are available around Matany Hospital in contrast to Moroto town. New health care facilities might open, as have been the situation with private health care providers, if the demand is there and existing health care facilities might adjust their service or/and payment to the ability and willingness to pay by the patients. The market of health care providers is not static but dynamic adapting to the demand and competition.

⁴⁰ Hay, (1998:14).

⁴¹ Hay, (1998:18).

Kleinman's model of the popular, folk and professional sector is applicable in analysing the different health care options in Uganda to-day. Kleinman describes three overlapping sectors in the health care system: the popular, the folk and the professional sector.⁴²

The popular sector, which is self-treatment, herbs and medical treatment, is individual, family, or community based, and is characterised by the absence of payment for the treatment. In Uganda, the popular sector would include self-treatment and family care using herbal remedies and all sets of pharmaceuticals obtained without prescription from pharmacies, drugstores, peddlers, vendors, relatives, friends and neighbours. And it is this sector the majority of the population uses. Kinuka *et al.* noted that 90% of the rural population in Uganda administered drugs in their homes.⁴³ Similarly, findings of the Community Drug Use Project undertaken by MISR in three districts: Arua, Tororo and Mabarara, showed that 72.5% of the households are self-medicated.⁴⁴ Based upon a two week of recall illness episodes one national study found that people used government facilities for only 21% of all illness episodes.⁴⁵

The folk sector includes herbalists, bone-setters, ritual specialists, diviners, and fortune tellers. The folk sector is a non-bureaucratic, non-licensed specialised sector subject to general community control. In relation to the provision and distribution of pharmaceuticals, providers with no formal training practice. Sale of pharmaceuticals is observed in markets, open stalls, on shop verandas and in taxi parks.⁴⁶ Payment varies as some traditional health providers only demand payment if cured, while others require payment in all case although prices and conditions are sometimes negotiable.⁴⁷

⁴² Kleinman, (1980:3-70).

⁴³ Kinuka *et al.*, (1985) in Birungi, (1999:41).

⁴⁴ Birungi, (1999:41).

⁴⁵ GOU/Uganda National Council for Children, (1994:96).

⁴⁶ Birungi, (1999:42).

⁴⁷ Vagnby *et al.*, (1998:10) and Helander, (1989:25).

The professional health sector consists of legally recognised, institutionally organised licensed health providers in which biomedicine dominates, and payment is required often in advance.⁴⁸ Whyte observes that the professional sector in Uganda has been transformed by two processes: structural adjustment and indigenisation.⁴⁹ Whyte argues that the effect of these changes has been a ‘democratisation of health’ in the sense that the responsibility of health is shifted from professionals to community members. A weak professional sector has facilitated the growth of the popular sector and the privatisation of medicine, which has made some medicines more easily accessible to lay people for self treatment.

Janzen found in Zaire “a unique pattern of integration with all therapy systems required in meeting expectations of complete care”.⁵⁰ He believed that people would sometimes use western medicine as the last resort due to the cost of the medicine, but also because of the feeling that western medicine is not effective for many diseases such as mental illnesses. Another issue was peoples fear of the hospital and the fear of dying there, away from their village. Janzen concluded that folk treatment is preferred by many people in Zaire as there are shared values between the native doctor, the client or/and the traditional healer, who also would be able to suggest acceptable explanations for the reason of the disease. Janzen’s study highlighted the inter-related factors that contribute to the final choice of health providers, and found that the cost of western treatment is a barrier for some people. My study agreed with Janzen’s findings. In Karamoja the folk sector is often the preferred health care option due to shared values and proximity.⁵¹

With the emerging wage earning class and the individual accumulation of wealth in Karamoja, traditional mutual support mechanisms have broken down. People are striving to survive and there is no surplus, hence people are unwillingly to help. Not surprisingly,

⁴⁸ Kleinman, (1980:3-70).

⁴⁹ Whyte, (1992), referred to in Birungi, (1999:43). Indigenisation is the process of transformation which western professional medicines undergo once introduced into non-western societies. The result is a re-shaping of the professional clinical care.

⁵⁰ Janzen, (1978:193).

⁵¹ Hay, (1998:16-17).

the inability to meet demands has its greatest impact on the poorest families. Adults can be forced to adopt survival strategies that may in turn affect women and children and risking their health by denying them access to health services.⁵² A poor household may decide to use the available economic resources on food, clothing and other necessities for the benefit of several family members instead of taking a sick child for treatment.

Traditionally, Karimojong have their local healers/doctors/ old women, who are consulted whenever there is a health need. Unlike the government health facilities, where user charges must be paid before treatment, traditional medicine and services in Africa are usually paid after the patient recovers.⁵³ Helander found in his study of traditional medicine in Somalia, that for most traditional forms of treatment the price is set according to whom the patient is. A poor family will thus be expected to pay much less than a wealthy one. Similarly, in Karamoja there are rarely demands for instant payment. Rather, most traditional healers are prepared to accept payments that have been postponed until the family is in better circumstances, such as after harvest.⁵⁴ These findings seem to be applicable as well in other parts of Uganda.⁵⁵

Birungi reported that many people consider private health care outside government institutions in most cases to be 'good'.⁵⁶ Uganda data shows that there is an appropriation of expert knowledge among lay persons concerning pharmaceuticals. Members of local communities are considered experts in treating local diseases. Birungi states that in almost every neighbourhood in the rural communities there are home providers who specialise in treatment of malaria. Health services which law makers consider illegal and criminal are appreciated by the local community and might be the only possibility for health care.

⁵² Lane *et al.*, (1995:33).

⁵³ Vagnby *et al.*, (1998:4).

⁵⁴ Helander, (1989:25).

⁵⁵ Barton *et al.*, (1999).

⁵⁶ Birungi, (1999:47).

Cultural beliefs and traditional values often play a significant role in the choice of health care provider. Payment for the service also plays an important role , especially for the Karimojong women, who, for reasons already discussed, often do not have the same access to resources as men. Although Karimojong women must be considered disadvantaged compared to men in relation to access to resources, differences among the category of women must be acknowledged. For example, the options available to individual women in their health seeking behaviour vary with her life cycle and her marital status. A young woman with several children to provide food and health care for may discover other difficulties in obtaining appropriate health care for herself and her dependants than an older woman left with no or few children.

CHAPTER 3

METHODOLOGY.

3.1 Research design

The study is a descriptive, exploratory study carried out over the period November 1998 to July 1999.¹ The study investigated the utilisation of health facilities in the formal and in-formal sector and the reasons behind women's health-seeking behaviour, including women's use of non-professional health services. The implementation of the study was in two phases: an explorative phase and the evaluation phase.

3.2 The setting

The study was conducted in Moroto District. Moroto District was created in 1976. The district is vast, covering 14,250 square km's. The total population according to the 1991 census is 174,417.² The real figure was probably about 30,000 higher, because migrating groups were not included. Moroto District is divided into 5 counties, one municipality, 20 sub-counties and 85 parishes. The district infrastructure is poor. Power supply is erratic. The only telephone connection for the whole district is located in the post office. Roads are dirt or gravel.

Moroto District was purposely chosen because of the presence of a government hospital, health units and an NGO hospital, and because a pilot study was conducted by the researcher in this district in 1997, followed by a study in 1999 of three selected health facilities in Moroto District.

¹ Hardon, *et al.*, (1994: 123-141).

² Danida, (1995:28-29).

Moroto District has 2 hospitals (one government hospital and one NGO hospital), 3 health centers, 13 sub-dispensaries, 1 clinic, 3 mobile clinics and 1 aid post.³ To the best of my knowledge no published information is available about the widely used non-formal health sector in this district.

The study was carried out in two selected locations in Moroto District, in catchment areas of the government owned Moroto Hospital and the private, not-for-profit, Matany Hospital. The catchment area for Moroto Hospital is Moroto Municipality, Campswahili Parish, community Campswahili Chini while the catchment area for Matany Hospital is Bokora county, Irimi sub-county, Tepeth parish, community Nafam/Naturumuru.

In general health facilities in Karamoja are short of qualified staff. Most of the staff are non-Karimojong. Nursing aids, often without education, and possibly a nurse or a nurse-midwife, manage a typical sub-dispensary. At the time of writing (July 1999), salaries for many non-qualified but established staff in formal governmental health facilities had not been paid for a very long time.⁴ The way that these employees survive is through combination of user fees, lunch allowance, and payment for out-reach activities. Health workers also engage in non-health related activities such as petty trade and small scale agriculture to gain a supplementary income.

With the exception of Matany Hospital, which is mainly financed by the Catholic Church, and some NGO health centers, all health units need rehabilitation. These health facilities have not been maintained for many years and civil strife has left many looted and dilapidated. Matany Hospital (244 beds), is possibly one of the best-run hospitals in Uganda. The hospital and its nurse training school are of considerable importance to Moroto district, as the school has a dedication to educate Karimojong. In contrast, Moroto

³ Danida, (1995).

⁴Vagnby, (1998:8) "salaries to non-qualified but established staff (in particular nursing aides that are the most common in not the only health staff in rural health units) have in general not been paid in Karamoja for the last 5 years or so.

Hospital (128 beds) is in a particularly bad state of repair, although the Italian Government is financing rehabilitation.

Moroto District has since 1990 trained TBAs.⁵ Initially the training was provided by the Church of Uganda. Since 1995 the district itself has conducted both training and refresher courses for the TBAs. The immediate objective is to train three TBAs per parish. The DHV emphasized the importance of the co-operation with the TBAs in matters of reproductive health and early childhood illnesses. Matany Hospital has for years co-operated with the TBAs whereas no co-operation at present exists between Moroto Hospital and the TBAs.⁶

Infant mortality is significantly higher in Karamoja than for the rest of Uganda (Table 3.1). There is more prevalence of traumas in Karamoja than in most of the country due to violence, especially gun wounds. Tuberculosis and meningitis are also more prevalent here than in many other parts of Uganda. The high prevalence of TB and meningitis can be partly explained by the patterns of nutrition and the climatic environment of Karamoja. Tuberculosis is often found in areas where people have a high consumption of raw milk. The high prevalence of meningitis is associated with the 'meningitis belt' – found in a climatic zone stretching over Africa.⁷ Elephantiasis is also present in Moroto District, especially around Namulu.⁸

⁵ Interview with key informant, District Health Visitor (DHV) June 1999.

⁶ Interview with key informant June 1999.

⁷ Lankinen *et al.*, (1994:266).

⁸ Barton *et al.*, (1999).

Table 3.1 Basic health indicators for Moroto District and Uganda:⁹

Indicator	Moroto District	All Uganda
Population growth rate	-0.7%	2.5%
Female literacy	6%	45%
Male literacy	18%	65%
Infant mortality	172/1.000	122/1.000
Under-five mortality rate	245/1.000	203/1.000
Population doctor ratio	31.783 : 1	24.700 : 1
Population/hospital bed	917	646
Latrine coverage	6.3%	47%
Rural Water Coverage	23.6%	26.5%

3.3 Methods of data collection.

Data for the study was collected using a combination of qualitative and quantitative methods. The research instruments were of six types, namely: quantitative structured interviews, secondary sources, qualitative in-depth interviews, interviews with key informants, group discussions, and a consensus panel.¹⁰

⁹ GOU / Uganda National Council for Children, (1994: 64-72).

¹⁰ Bernard, (1994: 171-178) The consensus model is a test of your data where you let knowledgeable informants discuss and answer questions within a defined domain, in this case health seeking behaviour within the framework of cost sharing for health services. Invited to 'my' consensus panel were In-Charges of health facilities in Moroto District, NGO representatives, District officials and politicians , key informants and my research assistants.

3.3.1 Quantitative methods.

Quantitative data was collected using personal interviews conducted on basis of structured questionnaires (Appendix 1). The questionnaire for household surveys included open-ended questions. The purpose was to generate specific quantitative information about:

- health seeking behaviour;
- access to resources in the households .

The questionnaires were administered by three trained research assistants. Each interview lasted 40 minutes. The interviews were conducted in the respondent's home. Only women were interviewed as this research focuses on the 'voices' and experiences of women.

For each of the selected communities data were collected within a period of two weeks. The number of women responding to specific questions varied. This is due to the nature of the questions, which are a combination of structured interviews and sometimes having multiple responses. Variations are also associated with non-responses in some instances. Secondary data were reviewed in form of reports, and existing records at district level including HMIS.¹¹

Quantitative data was edited, coded, and tabulated. The findings were presented and discussed with a consensus panel in Moroto District consisting of key informants and other individuals with a particular interest in the study.

¹¹ HMIS is GOU's Health Management Information System by which all health facilities in the formal sector on a monthly basis report health data to the district. The district authorities will compile all the data into a comprehensive report to be submitted quarterly to MOH.

3.3.2 Sampling frame.

The study was carried out in two communities: Campswahili Chini and Nafam/Naturumuru. The communities are representative of an urban and rural health care setting. Campswahili Chini is an urban area in the centre of Moroto town representing a lower strata of Moroto town. According to district authorities this area is typically inhabited by migrants from the rural area, who have been unsuccessful in creating a living for themselves and/or their families in their villages. The community has a high percentage of female headed households engaged in in-formal activities.

Nafam/Naturumuru is located in Tepeth parish, Iriiri sub-county. It is a rural setting with the people engaged in cattle herding and subsistence farming which is the main occupation for the women. Both areas have easy access to hospital facilities and other health facilities both within the formal and in-formal sectors.

The selection of study communities in Moroto was done on basis of the “30-Cluster” sampling methodology (WHO) in combination with random sampling techniques.¹² The 30 cluster sampling methodology is a simple method of selecting representative sample from a large population. Initially, 30 field sample sites representing Moroto district were selected by simple random sampling.¹³ Out of these 30 field sample sites two field sample sites Campswahili Chini and Nafam/Naturumuru - were purposively selected due to the proximity to the two hospitals in Moroto District. Campswahili Chini is situated in Moroto hospital catchment area, while Nafam/Naturumuru is in the catchment area of Matany hospital.¹⁴

Altogether, the quantitative study covered 109 households: 54 in Campswahili Chini and 55 from Nafam/Naturumuru. See table 3.2. The selection of households in Campswahili

¹² Barton, (1998:44-49).

¹³ The selection was done in connection with a base line study for Moroto, Kotido and Kitgum District by Creative Research Centre in Kampala conducted on behalf of Danida, HSSP in the period May-June 1999.

¹⁴ Campswahili Chini is also referred to as Moroto catchment area and Nafam/Naturumuru is referred to as Matany catchment area.

Chini was done on basis of the household list. The list was obtained from the district authority. We used the last digit on a currency note to select the first household on the list.¹⁵ The selection of households in Nafam/Naturumuru was done differently as no household list was available. The first household was randomly selected from the centre of the village by spinning a bottle on even ground. The selection of the first household was directed by the pointing of the bottle.¹⁶ Once the first household was selected the second household was the one nearest to the first. The next nearest household is the one whose front door is closest to the front door just visited.

Table 3.2 Sampling frame.

Location	Total population	Total Females	Target sample	Actual sample
Campswahili Chini	833	443	50	54
Nafam/Naturumuru	439	231	50	55
Total	1272	674	100	109

3.3.3 Qualitative data collection.

Qualitative data was generated through a number of methods:

- Reviewing reports and district records.
- Discussions with mothers.
- Key informant interviews.
- Focus group discussion and consensus panel.

¹⁵ Barton, (1998:47).

¹⁶ Barton, (1998:47).

In-depth discussions were held with several key informants in the district. These included the following:

LCV Chairman	Anthropologist Prof. Sandra Gray,
DMO Moroto District	Dr. Giovanni Dall'Ogilio CUAMM Moroto
Medical Superintendent Matany Hospital	Women in Development Officer, Moroto
CUAMM/Danida advisor to DMO	District Health Visitor, Moroto District
Medical Superintendent Moroto Hospital	Secretary of Health, Moroto Local Council.
Secretary of Finance, Moroto Council	In-charge, Nadunget Health Centre ¹⁷

The major issues discussed with the key informants were accessibility to health care for Karimojong women, the influence payment of user fees have on the health seeking behaviour, and the control and access to resources at household level.

Group discussions with 20 trained TBAs and with women were held. The TBA group discussion was organised, although not initially planned, as it became apparent that the TBAs are major health providers, not only for maternal care but also care providers for children at the village level. The role of TBAs as health providers for small children is important, as the orthodox understanding of the role of TBAs is in connection with deliveries only. The network of established TBAs could therefore be considered as an entrance for improvement of health for children in rural areas not normally visited by ordinary out-reach activities. Individual interviews and discussions with mothers at health facilities took place and replaced one of the two planned group discussions with women.

The group discussions were conducted by the researcher assisted by a translator. The discussions stimulated responses and thoughts we had not come across in the structured interviews as well as findings from the individual interviews and interviews with key informants were confirmed. Group discussions were guided by a check list of themes that

¹⁷ The majority of the respondents in this research are the Karimojong women – the mothers, the TBA's, the female politicians, the female staff in the health facilities, the female district officers -. Key informants, however included also non-Karimojong females and males.

Table 3.4 shows that 26 (23.9%) respondents out of 109 live in a female headed household. This is lower than the average (over 45%) that has been reported for Karamoja.²⁰

Table 3.4 Head of family by sex.

Status	Frequency n=109	Percentage
Female head of family	26	23.9%
Male head of family	83	76.1%

More than half of the - 15 (57.7%) of the 26 - female headed households rated themselves as belonging to the poorest section of the society. In contrast only 38 women (45.8%) in the 83 male headed households rated themselves as poor (Table 3.5).

Table 3.5 Profile of wealth status of family by gender.

Rating of household. Head of family.	Wealthiest category	Middle category	Poorest category
Male headed household n=83	1 (1.2%)	44 (53.3%)	38 (45.8%)
Female headed households. n=26	2 (7.7%)	9 (34.6%)	15 (57.7%)
Total n=108	3 (2.8%)	53 (48.6%)	53 (48.6%)

The reasons given by the respondents for why a female head a household are:

²⁰GOU/Uganda Council for Children, (1994:46).

- Husband died.
- I am a widow.
- Married to a civil servant, who is employed far away.
- The husband is lame.

It is very unusual for a woman never to marry or to divorce, so most female headed households are households in which the woman is a widow or where the husband works far away, or where the husband is handicapped.

One woman said:²¹

“ Actually a divorce is nearly unthinkable in this culture, because marriage is highly valued. Women would rather stay in marriage and suffer than to have a divorce due to how society looks at single ladies.”

104 (94.5%) respondents out of 109 were married or had been married. Of the 82 women living in an active marriage 43 (52.4%) were in monogamous families, and 39 (47.6%) were in polygamous families. The majority of the women 66 (60.6%) out of 109 were in the age group 15 - 35 years. The average family size was 4-6 members . The majority (90.7%) of respondents were born in Karamoja. Two-thirds of the women stated that they have never attended school. Only 11 (10.2%) respondents had attended secondary schools and only 1 respondent out of 108 had a post-secondary education.

3.5 Data analysis

Quantitative data was checked for uniformity, accuracy, consistency and comprehensibility, and coded and tabulated for analysis using Epi-Info and SPSS. The qualitative data was coded and analysed using AskSam. Frequency runs and cross tabulations from the descriptive data for selected variables of the study were produced.

²¹ Interview with Gender Officer, Moroto June 1999.

Explanatory socio-economic variables such as age, marital status, level of education, income and dependant variables such as payment for health services were the focus of the analysis of utilisation of health services.

Qualitative data were analysed continuously during data collection. The interviews were analysed and themes identified. The major themes include: views about payment for health services and the impacts they have on health seeking behaviour, women's access to resources, and how they generate funds for payment of health services, usage of formal and non-formal system and alternatives.

CHAPTER 4

KARIMOJONG WOMEN'S UTILISATION OF THE HEALTH CARE SYSTEM.

4.1 Access to health care.

This chapter describes the different types of health care providers in the two communities - Campswahili Chini and Nafam/Naturumuru - selected for this study, and the utilisation by women of the available health care providers.

The two communities are both in close proximity to the two hospitals in Moroto District, and all the respondents were living within an radius of 5 km to the nearest health facility.¹ People in need of treatment usually walked to the health facility, so no cost was incurred for transport. However, when referral to Matany Hospital was required people had to arrange and pay for transport. The average cost of transporting a sick person from Moroto to Matany Hospital was about Shs. 80.000 (USD 60).² Because this is a figure which is beyond the reach of most people, many people who ought to obtain specialist services do not.

Table 4.1 shows that all the respondents were within the reach of a formal health provider. In addition to government facilities, households have access to private clinics, drug shops and pharmacies. However, the situation in Matany catchment area is different as only 4 (7.3%) respondents out of 55 would confirm accessibility to private clinics and only 7 (12.7%) respondents out of 55 would indicate accessibility to drug shops. In both areas

¹ A 1994 survey by the GOU/Uganda National Council for Children, (1994:40), showed that accessibility to health facilities is limited and that only an estimated 8.9% of the population in Karamoja to live within 5 km. radius to a health facility. During my own pilot study Underlin, (1999:25), some informants suggested that while it is correct that health facilities are scattered they reflect the settlement pattern and that accessibility is therefore much better than usually portrayed.

² Group discussion with TBA's and interviews with Medical Superintendent (MS) Moroto Hospital and with MS Matany Hospital, June 1999.

most respondents - 92 out of 109 – reported having access to traditional healers and herbalists.

Table 4.1 Availability of health care providers.

Health care providers	Formal health unit within 5km.	Access to private clinics.	Access to drug shops and pharmacies.	Access to traditional healers and herbalists.
Moroto catchment area. n=54	54 (100%)	41 (75.9%)	39 (72.2%)	43 (79.6%)
Matany catchment area. n=55	55 (100%)	4 (7.3%)	7 (12.7%)	49 (89.1%)
Total n=109	109 (100%)	45 (41.3%)	46 (42.2%)	92 (84.4%)

Based upon a two week recall of illness episodes, the study found that mothers actually used the formal health care system much less commonly than their reports of either nearest or preferred providers would suggest.³ When asked about the preferred health care option 99 (90.8%) respondents out of 109 indicated that they would prefer to use the formal health care system. The quite high preference for formal health care option has to be seen in the light of the locality of the communities. It does not mean that the mothers actually went to the formal health care system as their responses initially could suggest. A mother may prefer to go to the formal health unit but, due to lack of cash she may use the nearest health provider: the herbalist, with whom she can arrange to pay on a later stage and for which service she do not need to consider transport. The difference between people's perception (nearest), desires (preferred), and behaviours (actual) are very notable and important in assessing demand, utilisation and access to health care.⁴

³ See table 4.3 and 4.6 for recall of child's last illness episode and mother's last illness episode.

⁴ See also GOU/Uganda National Council for Children, (1994:95-97).

The actual utilisation pattern of health care providers in connection with child's last illness episode and mother's last illness episode show limited utilisation of formal health facility despite the fact that the two research communities had very good access to the formal health care system. A significant number of households 36 (37.5%)⁵ respondents used the in-formal system for treatment of child's last illness while 44(48.4%)⁶ mothers reported the use of in-formal system for treatment of last illness episode.

Mothers were asked for their preferred health care option – where would they go for treatment - in the event that they or their children became sick during the next two weeks. The preferred option was cross checked with actual caregiver selected in connection with last illness episode – recall episodes for the women and/or their child - and a higher utilisation of non-formal health care providers or was found than the preferred health care option pointed to. These findings point to the fact that a preferred health care option is not always used. The difference might be due to a combination of funding for the particular health care option, lack of availability of health care option, or beliefs that guide mothers to seek care in the informal sector for particular illnesses.

This section has shown that the majority of the respondents lived in close proximity of a formal health care facility and had access to traditional healers and herbalists. The urban area near Moroto Hospital had further access to private health care providers, pharmacies and drug shops in contrast to the rural area around Matany Hospital. The next section will present the actual utilisation of health care provider in connection with child last illness episode.

⁵ See Table 4.3

⁶ See Table 4.6

4.2 Health seeking behaviour during child's last illness.

Three-quarters of the households reported that they had a sick child within the last month. Half of these had a sick child within the last 2 weeks. The main illnesses affecting children are malaria, fever, diarrhoea, and chest pain (including pneumonia). The illness pattern matches the leading illness conditions with malaria included in the “top five causes of morbidity for children”.⁷ Malaria is followed by diarrhoea, pneumonia, measles and anaemia.

Table 4.2 Illnesses among children during the previous two weeks.

Illness frequency	Frequency	Percentage
Illness	n=133*	
Malaria	33	24.6%
Fever	28	21.0%
Chest pain	28	21.0%
Diarrhoea	23	17.3%
Other	21	15.8%

* Note: Some of the children experienced more than one illness.

The majority (91.9%) of the mothers sought treatment for their children, but 8 mothers did not seek treatment outside the family sphere. There are a difference between the urban area – Moroto – and the rural area – Matany . 7 respondents out of 53 did not go for treatment in Matany. In contrast, only 1 respondent out of 46 did not go for treatment with her sick child in Moroto. Some of the mothers who did not seek treatment for their child explained that lack of funds for payment of health care was the reason.

When asked which type of treatment the mothers tried as the first option in connection with their child's last illness episode, a third of the mothers approached the non-formal

⁷ GOU / Uganda National Council for Children, (1994:87).

sector before going to the formal sector (Table 4.3). Two thirds approached the formal sector as first option outside the family sphere, even though the two communities are in near proximity to formal health care facilities. Besides cost and methods of payment the preferred treatment option also depends on factors such as type of illness and whether treatment has been sought earlier.

The use of formal health facilities appears to be higher than in many other part of Uganda. One report found that government health facilities were used in only for 21% situations of all illness episodes.⁸ The seemingly high figure in my study may be due to the close proximity of formal health care facilities.

Table 4.3 Utilisation of health care options for child's last illness.

Health provider	Family, friends, neighbours.	Traditional health provider.	Private clinics, drug shops.	Formal health care system.
Moroto n=47	1 (2.1%)	5 (10.6%)	13 (27.7%)	28 (59.6%)
Matany n=49	5 (10.2%)	5 (10.2%)	7 (14.3%)	32 (65.5%)
Total n=96	6 (6.3%)	10 (10.4%)	20 (20.8%)	60 (62.5%)

Table 4.3 shows a difference in health seeking pattern between the urban Moroto and the rural Matany. More women in Matany area would try to cure their illnesses at home or with help from the traditional system, while in Moroto area more women would try to cure their child's illness with help of drugs from private clinics or from drug shops. This might be explained by the limited accessibility of private clinic and drug shops around Matany. More than half of the women went to the formal system for treatment in

⁸ GOU/ Uganda National Council for Children, (1994:96-97).

connection with child's last illness. The utilisation of traditional health care provider was the same in the two locations. The findings correspond with the general health seeking pattern for Uganda where isolated communities and rural villages have a higher percentage utilisation of non-formal health providers.⁹

There is quite a variation with regard to what the mothers paid for the treatment of their child's last illness episode. Over half of the mothers - 51 (53.7%) out of 95 respondents paid - between Shs. 1001-5000 for the treatment of child's last illness episode.

Differences between Moroto and Matany can be observed as health care provision is slightly more expensive around Matany than in Moroto (Table 4.4).

Table 4.4 Payment in connection with child's last illness in different locations.

Payment.	0-300 Shs.	301-1000 Shs.	1001-5000 Shs.	Over 5000 Shs.
Moroto Hospital n=47	10 (21.3%)	16 (34.0%)	18 (38.3%)	3 (6.4%)
Matany Hospital n=48	11 (22.9%)	2 (4.2%)	33 (68.8%)	2 (4.2%)
Total n=95	21 (22.1%)	18 (18.9%)	51 (53.7%)	5 (5.3%)

The DDHS explained that the difference in fee structure has historical roots, as Matany, in common with other missionary hospitals, has demanded payment for service for a long period. Moroto Hospital only introduced cost-sharing as recommended by MOH in 1998/99.

This section revealed roughly that two third of mothers who sought treatment, would seek treatment in the formal sector in connection with child last illness while one third would seek treatment in the non-formal sector. 8 mothers out of 96 respondents did not seek

⁹ GOU/ Uganda National Council for Children, (1994:97).

treatment for their child. The amount paid for the treatment varied slightly between Matany and Moroto. More than half of the mothers seeking treatment at Moroto Hospital paid less than 1000 Shs., whereas the majority of mothers seeking treatment at Matany Hospital paid between Shs. 1000 and 5000. The next section will describe the health care provider used in connection with mother's last illness and the related costs.

4.3 Health seeking behaviour during women's last illness.

Half of the women 53.5% reported that they had been sick within the last month. The main illnesses affecting these women were chest pain, malaria, fever, and diarrhoea (Table 4.5).

Table 4.5 Illnesses among women during the previous month.

Illness frequency	Frequency	Percentage
Illness	N=89	
Chest pain/cough	25	28.1%
Malaria	23	25.8%
Fever	14	15.7%
Diarrhoea	14	15.7%
Other	13	14.6%

The majority of women went for treatment - 79 out of 98 -, but 19 women did not go for treatment. There are difference between the urban area, Moroto, and the rural area, Matany . 7 (15.2%) respondents out of 46 did not go for treatment in Moroto in contrast to 12 (23.1%) respondents out of 52 did not seek treatment herself in Matany location. A higher percentage of the mothers did not go for treatment 19 (19.4%) out of 98 compared to children not getting treatment where 8 (8.1%) respondents out of 98 said that they did not take their sick child for treatment.

Less than half of the women 48.4% tried the non-formal sector as a first resort, even though the two communities are in close proximity to formal health care facilities. This is a higher percentage utilisation of non-formal health care providers than found in connection with child's last illness, where one third would use non-formal health care providers. The responses in this study point to a higher use of formal health care for children than for women. Mothers would explain lack of funds as one reason for not seeking health care outside the family sphere, another explanation might be linked to the particular type of illness i.e. for children measles, which is considered curable only by isolating the child in darkness with no food and water until the skin eruption/rash have disappeared.

Table 4.6 Utilisation of health care options for women's own illnesses.

Health provider	Family, friends, neighbours.	Traditional health provider.	Private clinics, drug shops.	Formal health care system.
Moroto n=44	3 (6.8%)	3 (6.8%)	14 (31.8%)	24 (54.5%)
Matany n=47	8 (17.0%)	6 (12.8%)	10 (21.3%)	23 (48.9%)
Total n=91	11 (12.1%)	9 (9.9%)	24 (26.4%)	47 (51.6%)

Table 4.6 shows a difference in health seeking pattern between the urban Moroto and the rural Matany. More women in Matany area would try to cure their illnesses in the family, or with help of the traditional system than in Moroto area. More women in Moroto area would try to treat themselves using drugs from private clinics or from drug shops, which might be explained by the limited availability of private clinic and drug shops around Matany.

36 out of 84 women paid between Shs. 1001-5000 for the treatment of their last illness episode (Table 4.7). The payment is in generally higher than for the care given in

connection with child's last illness, which might be explained by the different payment scales for children and adults. Again a difference between Moroto and Matany can be observed. It seems – as with child's last illness - that the health care provision is slightly more expensive around Matany than in Moroto.

Table 4.7 Payment in connection with women's last illness in different locations.

Payment.	0-300 Shs.	301-1000 Shs.	1001-5000 Shs.	Over 5000 Shs.
Moroto Hospital n=42	5 (11.9%)	7 (16.7%)	21 (50.0%)	9 (21.4%)
Matany Hospital n=42	8 (19.0%)	6 (14.3%)	15 (35.7%)	13 (31.0%)
Total n=84	13 (15.5%)	13 (15.5%)	36 (42.9%)	22 (26.2%)

This section focussed on the health providers chosen during the mothers last illness episode, and the payment for the service. Women were less likely to seek care for themselves in case of illness than if their child was sick. Women seeking health care outside the home were also more likely to opt for non-formal health care providers than was the case for their sick children. The next section considers possible explanations why women sometimes prefer the non-formal system when seeking treatment for themselves.

4.4 Preference for non-formal health care.

Earlier studies in Karamoja have revealed that for the majority of Karimojong, the utilisation of non-formal health care providers as a first option outside the family sphere is a common feature.¹⁰ The Gender Officer in Moroto felt that:¹¹

“ People believe highly in the treatment of traditional healers, but it is also poverty. Now, with cost sharing, people have to pay and the health unit might be far away. There is a strong belief that western medicine is harmful for pregnant women. So it is better to go for traditional medicine, the western medicine is taken as a last resort.”

I asked the In-charge at Nadunget Health Unit if the patients would use traditional medicine at the same time as western medicine:¹²

“ I tell them not to mix. They should only use one type of medicine at the time so it can give effect. Sometimes I have to keep patients here until the treatment is over. The mothers will normally tell me which herbs have been tried with the child. I know the herbs and know how they work. This is common knowledge between the women, at least some of them.”

In view of these comments it is surprising that in my study only 21 out of 109 women (19.2%) answered that they would prefer to seek advice from the traditional health care system. It might however be due to the close proximity of formal health care facilities to the two communities in the study. Several informants pointed out that traditional health care providers are used for particular illnesses such as ‘evil eye’, even though formal health provision is present. Furthermore, traditional health care providers are frequently used in situations where cash is not available.

About one-fifth of the women said they would seek treatment from private clinics, drug stores and friends. Many respondents mentioned more than one health care provider as

¹⁰ Vagnby, (1998), Hay, (1998) and GOU/Uganda National Council for Children, (1994).

¹¹ Key informant interview June 1999.

¹² Interview with key informant June 1999.

preferred health care option. Respondents explained how women would most often first try to cure their illness at home in the family sphere. And if this failed might next seek assistance in the informal health care system. Only if these measures did not work the patient might be taken to the formal health care system for treatment. Alternatively the health seeking pattern could point to options of several and complementary health care as not only one option is tried. Women explained that herbs may be used at the same time as western medicine.

When respondents were asked to explain their choice of non-formal health provider, responses included:

- My choice of health provider are traditional healers, herbalists and hospitals in that order.
- Traditional healers is my choice preference because I always succeed with them.
- When I tried to treat within the family, I thought the child would heal. When it did not I took it to the traditional healer because the scabies could have been worsened by the evil eye.
- Traditional healers and herbalist have good herbs.
- I felt it was the “evil eye” which causes the fever and only traditional healers can remove that.
- That sickness cannot be managed by a formal health provider.
- I had no money for other treatment.
- I prefer traditional healers and herbalists because they are cheap and work well. They are really handy.

Other general reasons given were that the traditional healers and herbalist are known, near, cheap and trust-worthy.

Participants in the consensus panel in Moroto recommended extended co-operation between the formal and in-formal health care providers. Specific suggestions included:

- We should train traditional healers and be trained our-selves in their practices to gain appropriate knowledge about each-others area of knowledge and promote co-operation.
- Research should be conducted into the efficiency of herbs and correct dosages should be identified.

- An association for the traditional healers should be formed, to have a formal body to work together with.
- Traditional health care providers should be co-opted into the total health care system for the district.
- Manyatta workers should be trained for each village as an extension service.¹³

TBAs are normally considered to be part of the traditional sector, even though they are the link between the formal and informal health service providers in the district and in sub-counties. TBA's are often the only available health care providers available for the women to provide reproductive care and treatment of children. The District Health Visitor was asked about possibilities for greater co-operation between the formal and informal health care system.¹⁴

Researcher: "From your point of view, would it be possible to train or integrate the traditional health providers and herbalists into a comprehensive health care system?"

DHV: "The TBA's are free with us, they show us their drugs and tell us how the drugs help. But the traditional healers are not so free and honest to show you. The traditional healers will also charge even if it does not help, whereas the TBA's will try and help. If it works, people know how to appreciate that. The traditional healer will charge you a chicken, a goat or even a cow for their treatment. You need to be very tactful to deal with them."

Researcher: "Karimojong women have told me that it is common knowledge which herbs can cure which illnesses. Is it also your experiences that women know which herbs to use?"

DHV: "Yes, but the problem with them is that if the herbalists know they have failed they will never tell the patient, and they will keep on trying. We are working very hard with the TBA's to make them realise when they fail and cannot cure the mother, they have to refer her immediately in order to save lives. But sometimes it is hard and with the traditional healers and herbalists it might be very difficult."

¹³ Manyatta workers or Community health workers as they are also called are members of a community trained in provision of basic health care in villages.

¹⁴ Interview with key informant June 1999.

I also asked the Medical Superintendent (MS) in Moroto Hospital about the co-operation between the hospital and TBAs in the districts, and the prospects for future involvement of community workers as to extend health care to a larger part of the population in Karamoja.¹⁵

Researcher: “How does your hospital co-operate with the TBA’s to ensure expecting mothers at risk get transferred to the hospital?”

MS: “Unfortunately until 1998 the hospital was not involved with the community. It is only recently we have started community work. Until now we have no co-operation with the TBA’s. That might explain why mothers come so late. But we try to set up a structure for co-operation between the community and the hospital.”

Both of these informants underlined the importance of cooperation between the formal and informal system, as the utilisation of the traditional health care system is extensive in Karamoja.¹⁶ For most women the informal health care system is the first point of entry into the health care system outside the family sphere whereas the formal health care system by the majority of the Karimojong is considered as the last resort.¹⁷ The figures in my study for use of formal health facilities are higher than in other studies due to the proximity of the two hospitals.

Helander suggested in his study in Somalia, that the factors in health seeking behaviour are more varied than only the question of payment.¹⁸ He found – as in my own study – that the cost between the formal health care system and the in-formal sector are not so different. Helander suggested that a critical factor in the choice of health care provider was whether the provider is known to the patient or family. The social context of decision making does not only involve family. Advice given by neighbours, friends and so forth

¹⁵ Interview with key informant June 1999.

¹⁶ Hay, (1998:16-17), Underlin, (1999:37), Barton *et al.*, (1999), table 4.3 & 4.6.

¹⁷ Qualitative interviews with the key respondents in the study and Danida, (1998c:4) and (1998c:8).

¹⁸ Helander, (1989:23).

also plays an important role in shaping the individual's health seeking behaviour. Helander shares his suggestion with Janzen who in his study from Zaire suggests, that the shared values between the traditional health care provider, who is known by the community and the ability of the traditional health provider to give understandable and acceptable explanations sometimes make people prefer the folk sector.¹⁹

This chapter explored some of the reasons for the use of non-formal health providers. Lack of funds for payment of health service impact together with other factors such as local traditions, cultural beliefs and proximity of non-formal health providers, on the decision making process of the choice of actual health care provider. The next chapter will focus on how the resources needed for payment of health care is obtained by women.

¹⁹ Janzen, (1978:193).

CHAPTER 5

WOMEN'S ACCESS TO RESOURCES AND THE IMPACT ON HEALTH SEEKING BEHAVIOUR

Access to resources can be interpreted in different ways. These resources include access to support networks, access to knowledge, and access to economic resources. This study focuses on access to economic resources to pay for health care, but acknowledges that access to other resources impact on the health seeking behaviour. This chapter will focus on the resources available to Karimojong women to pay for health care for sick children and themselves.

5.1 Women's source of cash for care of sick children.

Sixty percent of the women in my sample earned their income by brewing, selling fire wood, selling food, carrying water, and from similar activities (Table 5.1). In Moroto half of the respondents stated that their husbands gave them money to obtain health care for the children. Only 5 of the 44 respondents in Matany said they could obtain money from their husbands for this purpose (Table 5.1). This difference between Moroto and Matany is significant. It might illustrate, how in an urban area under external influence, some traditional gender roles are challenged so health care for children also become an issue for the father of the child.

Table 5.1 Sources of cash for health care for child's illnesses.

Location	Moroto area.	Matany area.	Total
Source of cash.	n=44	n=44	n=88
Brewing, selling fire wood, selling food, carrying water	19 (43.2%)	34 (77.3%)	53 (60.2%)
Money from husband or sons	23 (52.3%)	5 (11.4%)	28 (31.8%)
Other i.e. assistance from neighbour or church.	2 (4.5%)	5 (11.4%)	7 (8.0%)

These findings correspond with the general data for Uganda in which source of cash covering health expenses are identified.¹ According to one GOU survey 65.2% of the cash utilised for payment of health services originates from activities linked to women's income generating activities.²

Key informants were asked why so many Karimojong fathers do not believe that they have a shared responsibility for their health of the children. The Gender Officer explained:³

" I feel there is a need for a lot of sensitisation⁴ so that both parents will take responsibilities for the children. The division of the work is that men tend to look after cattle. But cattle are not reared for commercial use, so the activities for the men are less income generating. It is the activities of the women, which bring money to the family. The entire welfare and development of the family rest with the mother. The mothers are paying for the health and education of their children."

¹ GOU/Uganda National Council for Children, (1994:91).

² GOU/Uganda National Council for Children,(1994:91). Sale of subsistence, sale of cash crops, labour and home production total to 65.2%.

³ Interview with key informant June 1999.

⁴ The gender officer explained on a later occasion that sensitisation is directed at both men and women.

I also discussed the issue with Anna. Anna was educated on Matany Hospital and worked until recently in Kololo Private Hospital in Kampala. When the post as In-Charge for Nadunget Health Unit became vacant she “wanted to return to her people.”⁵

Researcher: “Women generate money for themselves for own treatment and treatment of the children. How is it that Karimojong men do not feel a responsibility for keeping their children healthy?”

In-charge: “I do not really know, but you find they do that. Maybe it is something planted in their mind. Men believe that women should take care of the household and the children, and it is their work to take care of the cows, sitting under a tree relaxing. Men do not mind how the women get the food or pay for health services.”

Researcher: “ But we know that the men want their children to be healthy, so it is difficult to understand this reluctance to pay even a little. How can it be?”

In-charge: “I do not know if you saw yourself the woman who just lost her child. Her father was with her and tears were rolling down from his eyes, so he does care. But it might also have something to do with the fact that men do not come near when a woman is delivering, only women visit. Only when the child starts crawling the man will get interested. They have no contact with the children in a very early age.”

Researcher: “Delivery and the responsibility for the baby will be considered as the sole responsibility of the woman?”

In-charge: “ Yes, a man will never come near where the woman has delivered.”

It is important to note that men are excluded from the early stages of the child’s life and that the division of labour in the Karimojong society points to the mother as the sole caretaker of her own health as well as for the children. Women have few sanctions they can use to force a man to contribute to health. However, women are a diverse group and might have more or less influence depending of the stage they are in their life cycle. For

⁵ Interview with key informant June 1999, see Preamble.

example, a newly married women with small children might be more dependent on the husband than an older women with “own” garden, assisted by co-wives. A woman married to a husband without cattle has a different life than a woman married to a big cattle owner.

5.2 Women’s source of cash to pay for their own treatment.

When I asked how the women obtained the money to pay for their own health care, almost half said that they earned the money themselves by brewing, selling fire wood, selling food, carrying water. In Moroto more than half of the respondents revealed that the husbands gave them money to pay for treatment for their own illness in contrast to Matany where only 11 respondents out of 37 said they got money from their husbands for this purpose. Differences in educational levels of the wives might explain a part of the observed difference.⁶ It would seem from these figures that some husbands are more willing to contribute towards the cost of treating their wives than their children.

Table 5.2 Sources of cash for health care for women’s own illnesses.

Location	Moroto area.	Matany area.	Total
Source of cash.	n=36	n=37	n=73
Brewing, selling fire wood, selling food, carrying water	14 (38.9%)	21 (56.8%)	35 (47.9%)
Money from husband or relatives.	21 (58.3%)	11 (29.7%)	32 (43.8%)
Other.	1 (2.8%)	5 (13.5%)	6 (8.2%)

⁶ Half of the respondents in Moroto said they had no schooling, whereas 80% in Matany said that they have never been to school.

Karimojong women, like many other women in Uganda, are normally the primary health care providers in their families. Health care is seen as an extension of the domestic gender roles of women. However, the Gender Officer in Moroto drew the attention on the fact that responsibilities for health in the family sometimes clash with other domestic responsibilities.⁷

“ This is an area [(health)] of conflict. Women are supposed to take care of the sick, the elderly and the children for at the same time do household chores like collection of fire wood, construction of houses, gardening etc. They would go for treatment very late when the children are sick. In most cases they actually go there too late.”

This observation was supported by the In-charge of Nadunget health unit:⁸

“ Here in Karamoja the health of the child is a woman’s task, she must look for food and money to take the children to hospital. This is a very painful thing. The man comes in very late to accept to sell a chicken. The woman must first try to sell charcoal, or the woman has to find her way around doing petty work to clean a compound. The man is there to see a very healthy child, but when the child is sick it is the task of the woman. They are having it really rough.”

5.3 Access to resources at the household level.

The women in this survey were asked who decides which health care options should be used. There were three possible answers : male, female and jointly. The answer ‘shared’ can cover different scenarios and does not always mean equal participation in the decision process. Issues such as type of illness, age of the woman, and whether a male is normally resident in household affect women’s participation in the decision making process.

⁷ Interview with key informant June 1999.

⁸ Interview with key informant in June 1999.

Table 5.3 Male and female participation in health decisions.

Who decides in your family which type of health service to be used?	Moroto N=54	Matany N=54	Total
Male only.	5 (9.3%)	24 (44.4%)	29 (26.9%)
Female only.	10 (18.5%)	19 (35.2%)	29 (26.9%)
Shared male and female.	39 (72.2%)	11 (20.4%)	50 (46.3%)

In Karamoja men would generally have the greatest influence on the choice of health care option to be sought. For example, a former women representative in the Local Council described herself as married although her husband left her for another women many years ago. The husband visits her infrequently, but she has just given birth to her 13th child. This woman is solely responsible person for her family. However, the father of the children is often still consulted in questions relating to the domestic issues and sometimes overturns decisions his wife has made in his absence. The Gender Officer said:⁹

Gender Officer: “ There is nothing as a woman going to a health unit before consulting a man. The man has to know what you are doing and where you are going. In most cases the man will not accept unless it is very serious.”

Although women are expected to pay for the treatment most cannot make decisions on their own about where to go for health care and at which time. Only 29 (26.9%) of the women indicated an ability to make independent decision on health care options.

One of my informants was a Karimojong women, who lost her husband 12 years ago during a road robbery. She is well educated, but has since the accident lived alone with

⁹ Interview with key informant June 1999.

her three sons in Moroto. She earns her own living and has all her children in boarding school. She described the pressure family members put on her to remarry, as a single women without a man in the household is suspect in Karamoja. Her ability to resist this pressure might be partly due to her educational level and fact that she has a well-paid job. She spends nearly all the weekends in her parents' village, and is active in the community. For example, has she recently bought spares for a pump so the village could get the pump working again. She explains, that acceptance of her type of life is appearing very slowly even within the elders in her society. However, she described especially the first years of her widowhood as being tough because she was always pressed by the family to marry again.

Table 5.4 Control of resources at the household level.

Who controls resources in your family?	Moroto N=53	Matany n=55	Total
Male	24 (45.3%)	16 (29.1%)	40 (37.0%)
Female	21 (39.6%)	10 (18.2%)	31 (28.7%)
Jointly male and female.	8 (15.1%)	29 (52.7%)	37 (34.3%)

Responses to the questions about the control of resources in the households vary according to location (Table 5.4). In the urban setting under half of women (45.3%) pointed to the male as the decision maker in the household. In rural Matany the majority (52.7%) pointed to both the male and the female as jointly controlling resources. Ocan suggests that the traditional gender roles by which the women in rural areas are responsible for milking, gardening, brewing are followed by a higher status and bigger saying than where external influence transform traditional gender roles.¹⁰ For example has

¹⁰ Ocan, (1994a:39-44).

introduction of the plough attracted males to farming, which traditional has been an activity for the women. Men gain control over an traditional female activity reducing female influence and reducing women's saying in farming activities. I asked the Gender Officer about control of resources at the household level:¹¹

Researcher: "Women have some income generating possibilities. But the income that women earn. Where does it go?"

The Gender Officer: " There is a problem here. The woman will normally provide food for the whole family and the elders. The woman is normally the only one earning money for the household. If there is something left, the man must know. Normally men control the money women get."

Researcher: "Is it normally a man who decide how to use the money?"

The Gender Officer: "Yes. Even if she is for example selling fire wood, she will be followed by a man."

In many other part of Uganda women have strategies for keeping at least some of their income secret from men. It might also be possible that some Karimojong women would try to keep a part of this income secret, but the women in the study and key informants made it clear that it was not a common occurrence.

A surprising large number of women (78.5%) felt that men and women had equal access to health care facilities.(Table 5.5). However, one third responded in Moroto that they felt that there was a difference in the accessibility for men and women. A comparison of Table 5.4 and Table 5.5 suggests that women feel that a lesser degree of equality in access to health services in urban setting where the male influence on the control of resources in the household is relatively higher.

¹¹ Interview with key informant June 1999.

Table 5.5 Female / male equity of access to health care.

Does men and women/children have the same health care options?	Yes	No	Total
Moroto area. n= 52	33 (63.5%)	19 (36.5%)	52 (48.6%)
Matany area. n=55	51 (92.7%)	4 (7.3%)	55 (51.4%)
Total n=107	84 (78.5%)	23 (21.5%)	107

Women were asked to explain why there would be a difference in access to health care. Many women referred to poverty as an important factor. Only a few explicitly identified gender as an issue:

- The treatment is not the same. Big people are treated better than children.
- Because men, women and children do not suffer from the same diseases.
- The poor do not get any treatment because they have no money to pay for treatment.
- Only those who have money get treated.
- People with large families and no money get no treatment.
- Distance and lack of finances restrict access to health care.
- Most of us are poor and we do not have access to health facilities.
- Some have totally nothing to pay for treatment and resort to traditional healers.
- Some people are poor. Orphans and the aged are normally forgotten.

Women in the household survey and the participants in the consensus panel were asked to suggest ways in which accessibility to appropriate health care could be improved for women and children. Responses included:

- Giving the women first priority because they are more sensitive to illnesses than men.
- Women and children should be seen as a source of the future, because for a reproductive mother and child to die is to cut off the continuation of the reproduction.
- By reducing the payment of certain drugs to enable children and the elderly to get treated.

- Lower prices and provision of transport in case of referral.
- There should be free ante-natal care and delivery service for the women.

This chapter has shown how lack of funds hinders access to appropriate treatment. The chapter also shows how access to economic resources on household level is constrained for the Karimojong women, despite the fact that women are expected to take care of the health in the family. Males dominate the decision making process about appropriate health care. Few women are able decide themselves which care they judge most appropriate.

CHAPTER 6

THE INFLUENCE OF PAYMENT STRUCTURES ON KARIMOJONG WOMEN'S HEALTH SEEKING BEHAVIOUR.

A basic argument in this study is that payment structures for health care in combination with cultural beliefs and perceptions shape the health seeking behaviour. The previous chapters identified the types of health care is available in Karamoja and how women's access to resources impact on the health seeking behaviour. This chapter focuses on characteristics of payment systems for health care in the formal and non-formal health care system.

6.1 Cost sharing in the formal health system.

Matany Hospital is a mission, not-for-profit hospital, which for a long period has had cost sharing. Matany hospital had to increase the user fees in 1997 in an effort to pay a "living wage" to its health workers. The increase in user fees lead to a decrease of more than 50% in out-patient attendance. User fees were reduced again 3 months later. Moroto Hospital is a governmental hospital, which only introduced cost sharing in 1998 following the guidelines from MOH for cost sharing in hospitals and health centres. Moroto District has not issued its own guidelines or a standard price list for health facilities in the district. It is the Health Unit Management Committees or the Board of Directors in hospitals that decides the payment scale.

Virtually all respondents in my study (105 respondents out of 107) confirmed that there is cost sharing in their nearest formal health facility. However, the fee structure in Moroto Hospital and in Matany Hospital differ. Matany Hospital has different payment scales for women, children, and men. Maternal health care and treatment of children are either given for free or is at little cost to make the services available to as many women as possible. Moroto Hospital has introduced a consultation fee which is the same for all patients at

present. The Medical Superintendent informed me that once patients get used to paying for services in the governmental hospital, fees might be increased to generate revenue for the hospital.

Up-front payment in cash is required at both Moroto and Matany hospitals. Exemptions are only given for treatment of TB, leprosy, guinea worm and other highly communicable diseases and for children's immunisation. Over eighty percent of women believed that no exemption was possible at the hospitals. Ninety-five percent of the women believed that credit facilities do not exist and ninety percent of women felt payments in instalments was not acceptable.(Table 6.2) No major differences were observed on these matters in two study communities. However, 13 (23.6%) respondents reported that payment in kind was possible at Matany Hospital. This is important for some women who have access to crops such as sorghum, as cash is difficult to access for these women.

Table 6.1 Payment terms in formal health facilities.

Location.	Moroto area.	Matany area.
Payment mechanism.		
No to exemption possibilities.	44 out of 54 (81.5%)	44 out of 55 (80.0%)
No to credit facilities.	49 out of 54 (90.7%)	52 out of 54 (98.1%)
No instalment payment possible.	45 out of 54 (83.3%)	53 out of 55 (96.4%)
Yes to payment in kind.	0 out of 54 (0%)	13 out of 55 (23.6%)

Ninety-five percent of the women said they paid between 301 and 5000 Shs. for their most recent consultation(Table 6.1) Over eighty percent of women paid between 301 and 1000 Shs. for a consultation at Moroto hospital, whereas over ninety percent of women using Matany hospital said they paid between Shs. 1001 and 5000 for their last

consultation. Five women said they did not pay for their last consultation. In some cases this was due the nature of the illness, because of family relationship to staff at the hospital, or being married to a military person. In none of the situations were exemption given due to the poverty of the person. The difference in payment might also reflect difference in the quality of health care. Matany Hospital has been described as one of the best hospitals in East Africa and has the ability to deliver a more sophisticated health care than Moroto Hospital.

Table 6.2 Fee paid during most recent hospital consultation.

Payment.	0-300 Shs.	301-1000 Shs.	1001-5000 Shs.	Over 5000 Shs.
Moroto Hospital	3 (5.8%)	43 (82.7%)	6 (11.5%)	0 (0%)
Matany Hospital	0 (0%)	2 (3.6%)	51 (92.7%)	2 (3.6%)
Total n=107	3 (2.8%)	45 (42.1%)	57 (53.3%)	2 (1.9%)

The pervious paragraphs and tables have focussed on payment of health services in the formal health care sector. Treatment in the non-formal or traditional sector also has a cost, but different payment terms than those in the formal health care sector. Ninety-five percent of respondents believed that payment was always required for health services outside the formal sector. The respondents also revealed that possibilities for payment in kind, in instalments and credit are present in the in-formal sector. This is confirmed by interviews with key informants, who highlighted that more flexible payment terms in the in-formal sector might explain why women initially seek advice in the traditional sector. Several key informants explained how the exact payment in the non-formal sector depend upon the relation between the health care provider and the patient and upon the patient's status in the community. Assistance from a TBA in connection with delivery of a child

would normally cost a chicken, valued at approximately Shs. 2500. If, however, the women is very poor she might give a piece of soap, which has a value of about Shs. 250. When I asked how the traditional health care provider would know who can afford what amount, the answer was that everybody in a community knows who is poor and who is rich. Sometimes these payments can be delayed until after harvest or when the person is able to pay for the service. I asked if people would always pay these debts. Women said yes, because people would need to use the service another time and they could not afford to have outstanding payments blocking needed treatment.

Nearly half of the respondents in my study (48 out of 109) stated that they had been in a situation where they were unable to pay for health care service for themselves or their children. Two-thirds of the people who had been in a situation where they could not pay for the required health service came from an urban setting the Moroto catchment area. When asked how they coped with this problem, women responded:

- I went to relatives and friends to beg.
- I went to the traditional healer.
- I stayed at home.
- I tried to sell some brew to get money.
- I bought cheap drugs from the drug shop.
- I gave up and tried local treatment.
- I drank herbals all the time.
- There was nothing I could do. God forgave me.
- Went to a traditional healer. Meanwhile I looked for money for the hospital.
- I stayed without treatment.
- I prayed to God.

In summary, some women stayed at home without treatment. Another group of women sought assistance in the non-formal sector. Finally, some women continued their search for money from relatives or by own income generation activities to raise funds. Most of the women would use complementary health care services such as traditional healer or herbalists, if prevented due to lack of funds from the formal health care sector. The women's strategy is to combine available resources with the type of health care they could

afford. These quotes seem to confirm that the preferred care in this case the formal health care was sometimes replaced by another type of care – the actual care – due to lack of funding for immediate payment normally required in the formal sector.

The lack of ability to pay user fees is also confirmed through discussion held with the Medical Superintendent (MS) at Moroto Hospital:¹

Researcher: “What is your impression on women’s ability to pay. Do you have women coming who cannot pay?”

MS: “ Yes, but we can give credit. Cost sharing is a quite new feature for the hospital. The fee for a delivery is right now fixed at Shs. 2000 (USD 1.4 June 1999). In the future when people have got used to the fees, fees for complicated deliveries may go up.”

Researcher: “What type of credit do you have?”

MS: “ We don’t ask for the money first. The service is given and then we ask for the money. Credit facilities we want to organise, but for the moment we do not have that service. In many cases the mothers know the fees and pay.”

The Medical Superintendent identified two important factors. Firstly, the fees structure is new both for the hospital administration but also for the patients. Both need time to become used to the new structure. Once fully implemented, fees might be increased. Secondly, the Medical Superintendent explained which credit facilities are available and stated as mentioned elsewhere in the interview that no women have been refused treatment due to lack of funds. The Medical Superintendent stated, that expecting mothers know about the user fees, and that this might mean that some mothers are staying away due to lack of funds. The reality is that no formal credit facility exists. However, women can informally pay in instalments if they do not have all the cash to pay immediately, especially in connection with deliveries. Such informal arrangements have the disadvantage, that they cannot be considered as a right for the woman, but depend upon a

¹ Interview with key informant June 1999.

woman's ability to explain her situation and get accepted for treatment in the hospital by the hospital staff without previous payment.

The In-charge in Nadunget Health Unit commneted: ²

Researcher: "For you and me Shs. 300 and Shs. 500 seems very low. It might seem strange that the women cannot afford that little. How can it be?"

In-charge: "It is because men give the whole responsibility to the women[to provide appropriate health care for the child.]. Even if they have cows they will not sell to pay for a child. I recently had a mother with a girl with measles. When she came her the eyes were nearly closed. The girl risked going blind if she did not get ointment. I told the mother to go to Moroto Hospital because we did not have the drug. She told me she had no money. I know the family and they have cows, so I asked her: "Can't you sell a cow and take care of the child?" She told me that it is not easy to sell a cow when a child is sick. I even went to the father to the child and he told me he had no cow to sell for the child. It was really sad. Finally I gave the mother funds from here so she could go and buy ointment for the child. It is very sad, but men are not taking responsibilities."

The In-charge in Nadunget mentioned several situations where children have died as a result of delayed treatment due to the time it took the mother to look for the funds.³

Researcher: "I am interested in how payment affects women's health seeking behaviour. What does it mean that women have to pay for treatment. Does it mean that some women are not coming here?"

In-charge: "I think some of them do not come because they have to pay."

Researcher: "If one could imagine another payment structure with free treatment for women and children, would more come?"

In-charge: "Yes, like the one I had where the child just died. She said she has been looking for money to come and that she had been staying too long in the village to look for the money. Some will ask for credit."

²Interview with the In-charge Nadunget Health Unit June 1999.

³ Interview with key informant June 1999.

Researcher: “What is the practise here. Do you give credit?”

In-charge: “ If they come and I see the child is sick and they do not have money I give credit and they come with the money later.”

Researcher: “Can you, as an In-charge, decide to give credit, even though HUMC tells you to get money from everybody?”

In-charge: “I can decide, but I am new. I had my first meeting with HUMC last week. I explained that I give some credit. Some of them [HUMC] did understand.

The interview highlights how the power to decide credit remains with the HUMC. The Government of Uganda requires that 30% of the members of the HUMC must be women. In reality, these women seldom appear, and when present they often say very little. Protection mechanisms for women and children can be difficult to implement in an environment dominated by male members who do not face the same problems and responsibilities for the health in the family as the women.

The respondents in my study and the participants in the consensus panel were requested to propose how accessibility to appropriate health care in the formal system could be improved for women and children.

- Free medicine should be provided.
- Women should pay less as an priority.
- We do not have access to money so women and children should get free treatment.
- I feel nursing mothers and old women and children should be given free services in governmental health units.
- Charges in hospital or clinics should be reduced.
- There should be credit facilities for women and children.
- Village women should be trained to form income generating activities to pay for health care.
- Management Committees should identify women for exemption of payment.
- Health Units should be the ones deciding upon appropriate fees applicable to the local conditions.

The majority of the quotes refers to the need for either free treatment or reduced fees for treatment of children and women, due to their limited access to economic resources. Some women requested formal exemption and credit facilities, as well as the idea of a shared insurance system in form of village income generation activities for women. The issue of payment structures needs to be addressed to improve women's accessibility to formal health care facilities.

This section has described how payment for health care services differs with the type of health facility. Nearly half of the women in the study had been in a situation where they could not pay for health care in the formal sector and they explained which alternative type of health care they would seek. Lack of funds prevents some women from using formal health care facilities. Suggestions made to improve accessibility for women to appropriate health care the answers all related to the issue of charges and lack of funds. Two parallel strategies can be chosen by the district: Firstly extending exemption based upon criteria's relating to illness i.e. all expecting mothers should get free treatment, all children under 3 years free treatment and similar exact type of condition or illness. Secondly the district could request HUMC to identify patients who are unable to pay and therefore qualify for exemption on basis of socio-economic conditions.

The next section focuses on payment in the non-formal sector, including herbalist, traditional health care providers and TBAs.

6.2 Payment for services in the non-formal health care system.

The non-formal sector is characterised by its non-regulated and non-licensed nature. It is difficult to compare payment in formal and informal sector due to differences in payment structures and payment terms. Many of the women in my study said they did not pay for service in the non-formal system. In practice this meant they usually were not required to pay in cash but in kind in the form of food, beer or a chicken. Clearly it would not be possible for everyone to choose to pay in kind since the traditional health providers need cash themselves also. However, other possibilities for the traditional health care providers

to obtain cash exist as shown in the example below. In situations where TBAs provide services within the formal sector they get paid in cash. However, cash is in the big parts of the Karimojong society still rare although that varies with urban rural setting. When I asked why TBA's did not provide basic medicine as malaria pills, paludrine and similar I got the same answer from both TBA's and key informants. The TBAs do not have money to purchase these drugs and keep them in stock and the mothers have no funds to pay for these. Women told me that services provided directly to the woman from TBAs are normally paid in kind. Services provided within the formal health care system and where the hospital is involved are often paid in cash.

I asked the District Health Visitor how much Traditional Birth Attendance's (TBA's) charge for their services.⁴

DHV: "A normal delivery is a chicken or so, but if it is a difficult delivery they get a bit more. The TBA's are really appreciated and respected. When mothers come for pre-natal control [in the hospital] we charge the mothers Shs. 300 and then we give Shs. 100 of this amount to the TBA for tobacco as an appreciation. Out of cost sharing they get Shs. 100 to motivate them."

Researcher: "So it is not as in the formal system where we have a fixed scale for payment? I understand that it is also up to the relationship between the mother and the TBA how much is charged?"

DHV: "Yes it is like that."

Researcher: "Will a poor woman pay less than a wealthy one?"

DHV: "I think so, but people in the village they know. If she is very poor, she gives something as a piece of soap because a chicken here is around Shs. 2500-3000, whereas a piece of soap is Shs. 250. Normally the women can afford that."

Some women will benefit from this situation more than others, and the quality of treatment might also vary according to the ability of the women to pay. However, the

⁴ Interview with key informant June 1999.

traditional health care provider depends upon the acknowledgement and respect by the local community and is controlled by its members. Compared to the formal system the non-formal system has an established credit facility and different payment scales exists, which seemingly benefit poor women without guaranteeing equality. The findings in my study corresponds to Helander's study of medicine in Somalia where he found that for most traditional forms of treatment the price is set according to the patient's status.⁵ Thus a poor family will be expected to pay less than a wealthy one.

If we try to compare payment in the formal health care sector with payment in the non-formal sector a child delivery could be an example. Deliveries in Moroto Hospital costs Shs. 2000. Compared to the payment structure mentioned above, the formal health sector is not more expensive, since a TBA would normally charge a chicken worth Shs. 2500 for the same service. However, payment structures in the formal health care system create barriers to access to provision of appropriate health care for some women who need the service as payment in the formal sector is normally required immediately and often before treatment. Exemption or credit facilities do not exist and fees are not gauged according to the ability of the payee in contrast to the non-formal sector, which has credit facilities, possibility for payment in kind and different payment scales depending on the economic status of the payee.

I asked the In-charge at Nadunget if it would possible to have different payment scales for men and women, and how that would be received in the community.⁶

Researcher: " You have no differences in payment of user fees between men and women?"

In-charge: "No."

Researcher: " Now you have a different scale for children. Imagine you had a different payment scale for men and women in which women pay less than men. Would that be accepted?"

⁵ Helander, (1989:25).

⁶ Interview with key informant June 1999.

In-charge: “ I think there would be no problem if the community was told.”

Researcher: “Do men have the same difficulties with paying as women have?”

In-charge: “ I have never had any men who had problems paying. I have only given credit to women with small children.”

The issue of different payment scales for men, women and children was discussed with key informants and during the consensus panel. For women this is an acceptable solution. Some men had difficulties accepting this proposal despite recognising women’s lesser ability to pay for the health services. Another suggestion could be to exempt special conditions – illnesses and preventive health care – from payment to compensate for the different payment abilities men and women have in Karamoja.

Many women felt that an advantage of the in-formal system is that immediate payment is not usually demanded. Unlike the government health facilities where fees are paid before treatment, traditional medical practitioners usually require payment after the patient recovers and credit can be given to for example after harvest if deemed needed by the health provider.⁷ Women suggested that the request for payment upon health care provision in the formal health care system sometimes delays and may often prevent women from using the formal health care system. Data obtained from PRA revealed that most community members had a negative attitude towards cost sharing schemes. In their opinion, cost sharing could result in deaths of patients since patients would only go to the formal health system when the patient is very badly off.⁸

This chapter compared payment for health services in the formal and non-formal sector. Both sectors require payment but payment terms differ. This influences the use of health care facilities by women. If more women are to be attracted to the formal health care sector, or if women are to be given a realistic choice between the different types of health

⁷ Vagnby *et al.*, (1998:4).

⁸ Danida, (1998c:8).

care options, alternative strategies for payment for service in the formal sector seem necessary. The present payment system prevent some women from optimal use of available formal health care facilities.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS.

7.1 Conclusions.

This study has shown that in Karamoja women's health seeking behaviour is influenced by a number of contextual factors: the socio-economic characteristics of the health seeker, payment of user fees, quality of the offered care, availability of alternative health services, cultural beliefs and perception of disease. A basic argument in this study is that payment structures for health care in combination with cultural beliefs and perceptions of disease shape the health seeking behaviour for women. The actor oriented approach adopted in this study places the actor as the focus of the analysis. This approach acknowledges that large-scale and remote social forces do alter life chances and behaviour of individuals to a certain extent, but that external intervention are mediated and transformed by individuals and groups affected to fit to the local context.

I have used a contextual model of on-going negotiations between mutually involved set of actors. I acknowledge the diversity amongst the women including ways that their health needs, their resources, and their options vary during the life cycle. The preferred health care option is based upon the interface, which is created between consumers and providers and influenced by the socio-economic setting of Karamoja. Karimojong are considered as capable, active and reflective individuals who attempt to solve their health problems in the most appropriate way between the different available health care options.

The health seeking pattern reflected in this study is widely influenced by a range of health care options especially within the formal health sector, which is quite unique in the sense that the two communities in focus of this study have easy access to formal health facilities in form of hospitals and health units.¹ Accessibility to the traditional sector is also confirmed by the respondents in both communities. However, the two communities vary

¹ Easy access to formal health care facility is used as the two studied communities lived within a 5 km. radius to the health care facility and all of the respondents could reach the facility by foot.

concerning availability of private health care providers such as drug shops and private clinics. These are mainly found in the urban setting around Moroto. Only a few health care providers in this sector are available around Matany. Therefore the range of health care providers is limited in Matany compared to Moroto.

The findings show that although many women lived in close proximity to formal health care facilities a third of the respondents used the non-formal health care providers in connection with child's last illness episode.² In connection with own most recent illness, more than half of the women used the non-formal system.³ Proximity to formal health service facilities and appropriate payment terms for services rendered to women and children in itself does not guarantee formal health care provision to all, since other factors such as cultural beliefs and perceptions and access to resources to pay for the health care shape the health seeking behaviour. At present a major extension of formal health care services is not realistic in Uganda. Utilisation of the non-formal or traditional sector is the only realistic option for many people in Uganda and it is important to clarify in which situations the traditional sector is useful. It is likewise important to clarify in which situations the formal health care service is needed and try to cater for this as much as possible. However, it is not realistic to expect that exemption rules or credit facilities will ensure the poorest and weakest part of the population equal accessibility to formal health care provision. Alternative and complementary solutions such as extended co-operation with the already existing traditional health care providers need to be found to ensure a minimum health care provision.

The overall majority of the women interviewed for this study generate the income for payment of health services for themselves and for their children.⁴ The decision making process related to expenditures at household level is however dominated by males. Many

² See Table 4.3.

³ See Table 4.6.

⁴ See Table 5.1 & Table 5.2.

women cannot decide for themselves when and where to go for health care.⁵ One fifth of the women did not think that men and women had equal access to health care provision because women do not have as much access to or control over resources as men.⁶

Payment for health services in the formal health sector is normally 'up-front payment' without possibilities for credit, payment in instalments or payment in kind or exemption.⁷ Only few defined illnesses or relationships to exempted groups waive the user fee. The user fees vary from urban to rural setting, but cannot be considered the only barrier to the formal health care system, as non-formal health care providers require payment as well. Nonetheless, payment structures in the formal health care system create barriers to access of appropriate health care for women and children. Exemption or credit facilities do not exist in reality unless linked to a particular illness and fees are not gauged according to the ability of the payee.⁸

The reality in Uganda to-day is that the first entry into the health care system outside the family sphere for the overall majority of the Ugandans is the in-formal health care system. For the rural communities increased use of traditional health providers is proven. Payment structures influence the final choice of health care option for the women. Lack of control over resources sometimes force women to the non-formal sector in which payment terms are more flexible and more user-friendly in the sense that credit facilities, payment in instalments or in kind exists. The payment structure in the formal health care sector act as a barrier for some women to access needed health care. A more 'user friendly' payment structure is needed to secure women equal accessibility to formal health care provision.

⁵ See Table 5.3.

⁶ See Table 5.5.

⁷ See Table 6.1.

⁸ The Bamako initiative and the World Bank initiative both emphasise the need for protective measures for the poorest part of the population to ensure equal access to the health facility. However, although GOU has disseminated guidelines concerning user fees, the districts are in charge of implementation of exemption rules. No exemption rules on basis of the socio-economic status of the payee are implemented in Moroto according to DDHS.

Many communities in Karamoja depend to a large degree on the traditional health care system for provision of health care. All communities have a functional health care system consisting of traditional health care providers. It is relevant to focus on the possibilities for a further extension of health services to be delivered through the traditional health care system as to provide health services to a larger population. An important step has already been taken to train and include TBA's in provision of health care in connection with reproduction and early childhood illnesses to rural communities. Inclusion of other groups of traditional health care providers in the complementary health care service for Karamoja seem a logical solution, as the economic situation in Uganda will not permit an intensive extension of already existing formal health services.

7.2 Recommendations.

1. Statistics, interviews with women in Karamoja and with key informants show that the health status of the Karimojong women and their children is a matter for concern. Special priority for health measures to reduce the maternal and infant mortality rates should be given. Re-call interviews with mothers show a very high prevalence of illnesses for children and for the women themselves. Health policy and strategy on central level in MOH should target and prioritise efforts to reduce maternal and infant mortality rates. The study shows that the woman is the responsible person for health in the family and men are only to a lesser degree concerned with health. The majority of the fathers showed little or no interest in paying for health care for their wives and for their children. The traditional gender roles for men and women which hinder equal access to health care and place the sole responsibility for health care on the woman can be addressed. Gender Officers in the districts should be actively involved in promotion of equal health for all by arranging sensitisation meetings in villages as poor health status is directly linked to gender specific roles and to the fact that discrimination against women in terms of access to resources hinder women's access to health services.
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2. Most women do not have the same access to or control over money as men in Karamoja. Women are at the same time expected by the men to be the main providers of funds for payment of health care for their children and for themselves. The Government should consider the possibility that women should pay for health care on a reduced scale compared to men as well as special payment scales for children should be maintained and introduced where they are not already applied. Special vulnerable categories of women – widows, women in female headed households, handicapped women, women living in poor families – should be identified by the Health Unit Management Committees in the health facilities and should be exempted from payment. Fees for services should be revised with consideration given to the burden of diseases for women and children. Credit facilities should be available so no-one is denied treatment in case of illness due to in-ability to payment at the time they are ill. The HUMC could administer the credit and exemption scheme under supervision of the DDHS as HUMC already to-day is responsible for the administration of user-fees. The district should envisage a payment structure in the formal health sector, which consider the daily circumstances that the Karimojong women face, including their limited access to and control over resources at household level. The payment structure needs to consider the difficulties Karimojong women encounter in providing the required up-front-payment for health services.
3. For the majority of rural poor people, the informal sector or the traditional health care system is the first point of entry into the health care system outside the family sphere. A realistic improvement of the health care system for the weakest part of the population therefore needs to strengthen co-operation with the informal sector in order to ensure accessibility to appropriate health care for all. Recognised bodies of traditional health care providers should be established so co-operation between the two sectors could be extended. Associations for herbalists, for traditional healers and for similar groups should be encouraged. Successful association has been created for the TBA's who after initial training are linked to the nearest formal health care facility, which provides a possibility for refresher training and delivery of health messages. The advantage for the TBA's of such a system is provision by the health

facility of basic tolls to carry out their work. Government of Uganda will not be able to allocate sufficient funds to expand the formal health care system to all part of Uganda within the near future. Health care delivery needs therefore to build upon the already established health care system in the informal sector which is present, known and respected in all localities. Reciprocal co-operation between the different categories of health providers are therefore a necessity to ensure provision of basic health care to the rural poor to which group the Karimojong women belong.

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Appendix 1.

Household Survey Instrument

Sample size n=100

Questionnaire identity number Date of the interview

Name of the interviewer Household Head : Female
Male

Name of respondent's village Sub-county

I would like to speak to the mother or caretaker of the children in this household.

Introduction: My name is I am from Makerere University, Department of Sociology or
My name is I am research assistant on a study from Makerere University, Department of
Sociology. We would like to learn from women in the community about the health situation in your village.
We would like to know where you normally go for treatment when you are sick. We will not ask you for
your name and the information that you give us will not be related back to you. The research team has
secured the permission from LC authorities to talk to the community members. We would like you to talk
with us. Is that all right? (*If busy try to arrange for a call back, if refusal, do not coerce, proceed on*).

Can you please tell me about the health facilities near your village.

1. How far away is your village from the formal (governmental or mission health facility) you would use?
0-5 km
5-20 km
over 20 km
2. If you or your family get sick how long time does it take to get to that health facility?
0-1 hour
2-5 hours
more than 5 hours
3. Which transport means do you use?

4. How much do you have to pay for transport?
5. Is there payment of user fees in the health facility?
1. Yes
 2. No
6. Has there always been payment of user fees?
1. Yes
 2. No
 3. Don't know
7. How much do you pay for a consultation?
- 0 Shs. , please explain why
- | | |
|--------------|----------------|
| 0-300 Shs. | 1000-5000 Shs. |
| 300-999 Shs. | Over 5000 Shs. |
8. Does everybody pay the same?
1. yes
 2. no
 3. Don't know
9. Are you able to pay?
1. Yes
 2. No
10. Can you get exemption?
1. Yes
 2. No
 3. Don't know
- Why/ why not?
11. Do you get credit?
1. Yes
 2. No
 3. Don't know

47. Have you been in a situation where you or your child could not get treatment because you could not pay for it?

1. Yes
2. No

48. If yes, what did you do instead?

49. How could we in your opinion ensure that women and children would get access to appropriate health care, when they are sick?

50. Does the men and the women/children have the same accessibility to get treatment when they are sick?

1. Yes
2. No

Please explain your answer.

Now about yourself:

51. What is your marital status?
1. Never married.....
 2. Married as the only wife.....
 3. Polygamous marriage.....
 4. Separated/divorced
 5. Widowed

- 52.. How old are you ?
- under 15
- 15-35 years
- over 35 years

53. What is the highest level of education that you attained?

1. None
2. Primary
3. Secondary
4. Diploma/ certificate/ university

54. Are you born in Karamoja?

1. yes
2. no

55. How many members belong to your household?

- 1-3 members
- 4-6 members
- 7-10 members
- more than 10 members

56. Do you work outside your home?

57. How would you describe the household in relation to the other families in the village?

1. Wealthiest
2. Middle range
3. Poor

- Where do you get the best treatment compared to the payment for health service?
- Does all pay the same for the same treatment?
- Why/why not, please explain.

RESOURCES:

- Who in a family will normally decide and control the resources – money, milk for sale, yields from the fields and other products that your household may have for sale?
- When you need money for health treatment of your children or yourself how do you get the money?
- Have you been in a situation where you could not get treatment because you could not pay for it?
- If yes, what did you do instead?
- Who usually decides in your household which health service is to be used?
- Have any of the men who live in your house hold been in a situation where he could not get treatment due to lack of resources?
- Can you suggest any reasons for this difference in access to health care between male and female members of you household.
- Do you think your family gets adequate health care

Appendix 3

Work plan.

TASKS	ACTIVITIES	PERSONEL	DURATION
1. Preparatory activities	<ol style="list-style-type: none"> 1. Assemble documentation 2. Desk Appraisal 3. Write-up 	Researcher	July 1998 – October 1998
2. Presentation of proposal	<ol style="list-style-type: none"> 1. Finalisation and presentation of proposal 	Researcher	Presentation 13.10.98 Finalisation 01.11.98.
3. Field Work	<ol style="list-style-type: none"> 1. Introduction Moroto District 2. Interviews with 50 women 3. Interviews with key-informants 4. Group discussions 5. Secondary sources, assembling data 6. Consensus panel 	Researcher & Translator / Research assistant	Feb. 1999 April – June '99. July 1999
4. Data Analysis	<ol style="list-style-type: none"> 1. Analysis of structured interviews 2. Analysis of in-depth interviews with key-informants 3. Themes from group discussions to be analysed 4. Findings to be discussed with consensus panel 5. Secondary sources to be analysed 	Researcher	May – Oct. 1999
5. Finalisation of dissertation	<ol style="list-style-type: none"> 1. Consolidating data 2. Assemble documentation 3. Write –up 4. Finalisation of dissertation 	Researcher	May – Oct. 1999 Nov. 1999