Equity in Maternal Health Care Services in post-conflict Northern and non-conflict East-Central Uganda: A Comparative Mixed Methods Multi-case study

Authors – Andrew Alyao-Ocero, Tim Martineau, Freddie Ssengoobba, Sally Theobald Theme C. Health equity and rights

Background

Weak health systems in fragile states constrain global progress on the MDGs. Uganda won't achieve the 5th MDG by 2015. Uganda's Northern Region that emerged from a 23 year civil war in 2006 is recognised as a major contributor to the country's poor performance in maternal health. Evidence indicates that there is poor utilisation of maternal health care (MHC) services by people resettling home from internally displaced people's camps. Financial and technical input by the Ugandan Government and its Donors into Northern Uganda has not yet led to health or social welfare improvements.

Methods

A study using a mixed-method, multi-case approach is just starting, comparing the benefit incidence of MHC funded by government and its developmental partners for women of differing socioeconomic status in the post-conflict region and in a non-conflict region (East Central Uganda), during the immediate post-conflict period 2006-2011. The influence of stakeholders in maternal health policy and governance will be evaluated.

Therefore the Benefit incidence for any selected group j from a selected frame, e.g. the poorest 20% women, the women that delivered more than four times, women below 18 years,

$$x_j = \sum_{i=1}^{3} E_{ij} \frac{S_i}{E_i} \equiv \sum_{i=1}^{3} \frac{E_{ij}}{E_i} \cdot S_i$$

Where,

- X_j is the value of the total value of health care subsidy imputed to a selected group j,
- i represents the health care level. When i = 1 it denotes health centre III level, 2 denotes health centre IV and 3 denotes district hospital.
- E_{ij} represents the numbers of women of reproductive age from the selected group j at health centre level i.
- E_i represents the total number of women of reproductive age across the group or catchment population. S_i/E_i represents the unit subsidy.

Results

Benefit incidence is a function of MHC utilisation and its cost at service delivery level. Uganda demographic and health surveys for 2006 and 2011 will determine utilisation rates of MHC amongst women of varying socioeconomic status in the two regions. Costing studies for health facilities under the tiered decentralised health care system and Health Management Information System secondary data for that period will determine the MHC costs at various levels of care. Benefit incidence and determination of variables associated with disparities in utilisation of publicly funded maternal health will be analysed using concentration indices, Lorenz concentration curves and multiple regression analysis. Analysis of interviews and meetings held with MHC policy stakeholders will develop understandings of governance, implementation at regional, district and community levels.

Conclusion

The study findings will inform national and donor health policy on the rebuilding of equitable health systems for disrupted populations.