ReBUILD Consortium

RESEARCH BRIEF

ReBUILDing Health Systems Beyond Health Facilities

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Introduction:

The Health Care System refers to the organization of people, institution and resources to meet the health care needs of populations. It refers to the totality of how health care is organized and provided. Yet post conflict health system development in northern Uganda continues to emphasise health facility reconstruction, much more than access to and use. The end of war in northern Uganda paved way for relative peace and the eventual return of IDPs to their former homes. To enable the north catch up, the Government of Uganda (GoU) adopted the Peace, Recovery and Development Plan (PRDP), the blue print for the post conflict reconstruction in the north. With respect to health services provision, the strategic objective of the PRDP was to reduce morbidity and mortality from major causes of ill health and decrease disparity therein, through a strategy of constructing more health facilities to increase the percentage of the population living within five kilometers to the nearest health facility, improved service delivery and public health education (GoU 2007). In addition, several non-state providers emerged to compliment government provision.

This research, undertaken under the DFID funded ReBUILD Consortium, sought to study changes in trends in accessing household health care by the poorest households. This policy brief analyses how the poor navigated the post conflict health care terrain and what the government/district leadership was doing to enable the poor access health care. It highlights that reconstructing health care systems requires more than building health care facilities.

Study Area:

The study was done in four villages of Gulu district (see Map) selected to represent the rural and urban mix. These were Agung and Omel villages from Unyama and Paicho parishes respectively, to represent rural Gulu and Keyi B and Wii Layibi villages from Bardege and Layibi parishes respectively to represent urban Gulu. Gulu was selected because being a post conflict urban area, it had a semblance of a health care market, which would enable the researchers assess household health care decision making in a plethora of health care providers.

Study Methods:

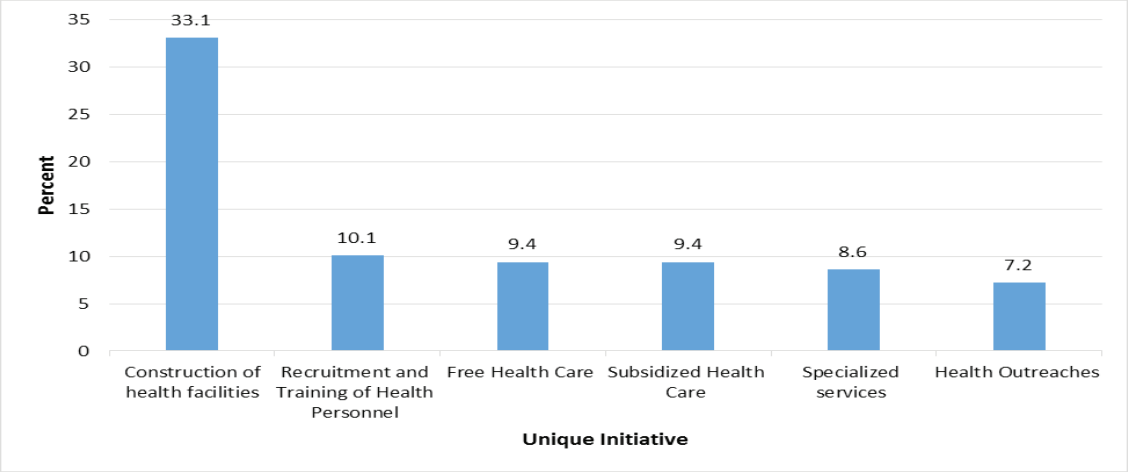
- 410 randomly selected households were subjected to survey to assess proxy poverty indicators. Data analysis was done using STATA; The data from the quantitative survey, a poverty proxy survey, was used to select the poorest of the poor households to subject to life history interviewing. Wealth index for the data was computed using the principal component analysis method and five quintiles were obtained.
- 47 life history interviews with household heads of the poorest households identified by the mini household survey were conducted in the four villages.
- 16 key informant interviews were conducted with health providers and opinion leaders, purposively selected.
- Qualitative data was analysed using Atlas ti and Excel software packages. Within excel, percent mentions of a particular choice were used to assess the trends in health provider preferences over time.

Key Findings:

The Health system over-emphasises health facility reconstruction

Post conflict health reconstruction continues to focus on infrastructure development rather than improving direct access to health care. Even as a policy of prioritizing free and equal access to health care, this was often equated to the construction of health facilities as Figure 1 below shows:

Fig. 1: Unique Strategies to Enable the Poor Access Health Care



Source: Life Histories

However, challenges to access were dire, especially for the poor, the majority of who were women.

Gender, Age and Widowhood Key Determinants of Poverty

From the mini household survey, gender, age and being widowed were the key proxy determinants of being poor. Female household heads who were older and widows were more likely to be poorer than married women or male household heads. Female household heads were more likely to be subsistence farmers, without animals, unemployed and without a wage as Table 1 below shows:

Table 1: Economic Empowerment by Gender

Employment	Female (n=138)	Male(n=272)	P-value
	% (95%CI)	% (95%CI)	
Farmer/Peasant	61.6 [19.5,91.4]	57 [20.8,87.0]	0.183
Civil Servant	3.6 [0.6,18.8]	8.5 [2.6,24.3]	
Business	14.5 [2.6,51.4]	8.1 [2.8,21.4]	
Politician	--	1.5 [0.5,4.3]	
Casual Laborer	4.3 [0.6,24.0]	3.7 [0.9,14.0]	
Unemployed	4.3 [1.8,10.2]	2.9 [0.4,18.9]	
Others	11.6 [5.5,22.7]	18.4 [5.2,48.0]	
Salaried Employment			
No Wage	80.9 [65.1,90.6]	64.6 [35.3,85.9]	
Earn a wage	19.1 [9.4,34.9]	35.4 [14.1,64.7]	0.011

Source: Primary Data from the Mini Household Survey

Government Health Facilities most Preferred by the Poor

Despite the frequent drug stock outs and few health care workers, government health facilities were the most preferred over the three time periods, with their preference being highest before and after the war because 1) most health care facilities found in the community were government owned and 2) the high cost of accessing health care after the war. Many poor people had such impoverished livelihoods that they could not afford health care from fee paying facilities that had established in Gulu after the war.

Cost the Main Reason for Choice of Health Care Facility

Cost was the major factor in determining the choice of health provider. This choice was either direct (actual cost of care) or indirect (in form of transport, perceived quality of care or illness severity). Hence, illnesses perceived to be less severe were taken to the government health centres and drug shops, while more severe conditions were taken straight to fee paying facilities, often far off in town, attracting higher transport costs. This was because by the time they sought care, survival was key and free health care was no longer an option.

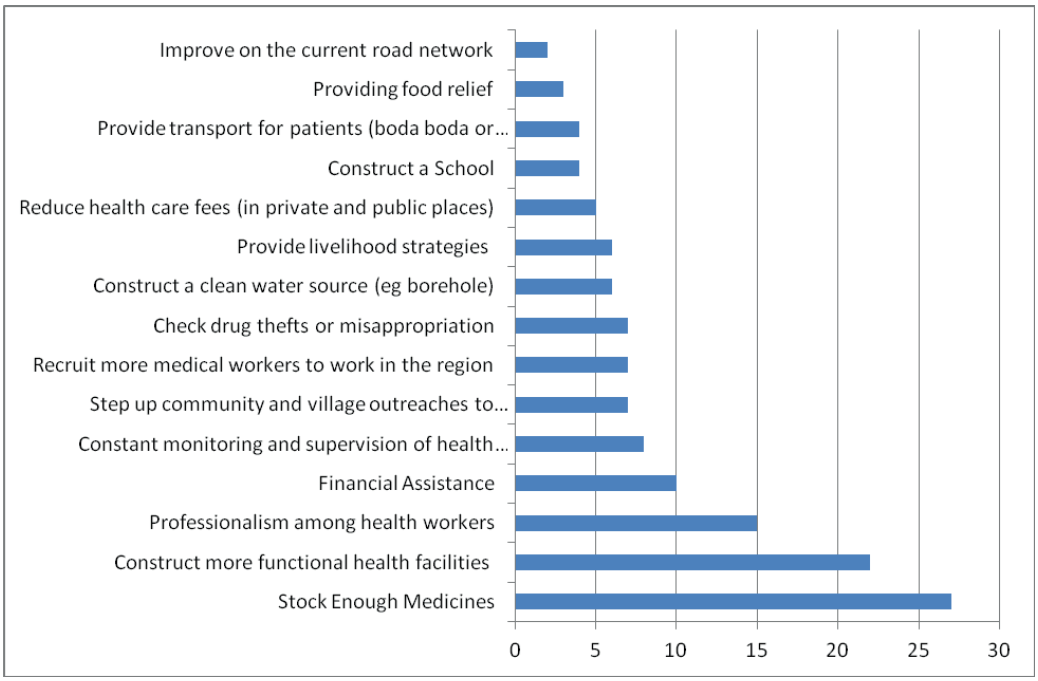
The Poor Engage in Catastrophic Expenditures to Pay for Household Health Care

The most prominent strategies to raise money for health care were selling foodstuffs, selling animals, relying on relatives to pay, borrowing and casual labour. With most animals depleted by the war, foodstuffs (relief or own grown) remained the main source of raising money, which increased food insecurity and caused more illness. Money earned from casual labour was minimal, requiring relatives to help or the head to borrow money. All these implied that health care could not be sought promptly.

People Preferred More Holistic Development

As a result, people asked for more comprehensive social development, not just construction of health facilities. They requested that health facilities be stocked with medicines, and staffed with competent health care professionals, in addition to clean water sources, primary schools, iimproved livelihoods, transport services and improved road network as Figure 2 below shows.

Fig. 2: Community's Recommendations for Improving Health Care



KEY LESSONS:

1. Health care system goes beyond the provision of health services, to the organization and provision of services.

2. While construction of health facilities is key for post conflict health reconstruction, the health facilities should be well stocked with medicines and with appropriate medical staff

3. To improve health care utilization, the secondary challenges to health access need to be addressed.

4. Due to impoverishment, post conflict populations do not have the financial resources to engage the privatized health care market. Hence, government needs to continue providing affordable health care services.

5. Post conflict health reconstruction needs to prioritise the improvement of livelihoods and social development to enable people pay for health care.