ReBUILD Consortium

RESEARCH BRIEF

A STRONG PUBLIC HEALTH SECTOR KEY FOR HEALTH SYSTEM RESILIENCE IN GULU DISTRICT, NORTHERN UGANDA

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Post Conflict situations pose unique challenges, ranging from poor and dependent populations to the total lack of health care facilities and workers. A strong public sector is key for delivering equitable, quality service, in order to enable resilient and responsive health systems, in post conflict situations. With the end of the war in northern Uganda, a health care market, comprising several state and non-state providers emerged. While the Government of Uganda (GoU) adopted the Peace, Recovery and Development Plan (PRDP) for northern Uganda, to among other things reduce morbidity and mortality by expanding access to health care, many private and private not for profit health care facilities also emerged. This saw several initiatives established to help people access health care including: constructing a health centre per parish; constructing of private health facilities; providing community health insurance; providing advanced diagnostic health care; subsidies for vulnerable groups; hotlines and ambulance services. How this has improved people's access to health care is still not clear.

This research, undertaken under the DFID funded ReBUILD Consortium, sought to study how households were coping with health care needs in the post conflict health care system being rebuilt, in relation to the past scenarios before and during the war. This particular brief looks at the particular choices people made over the three time periods.

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 an emerging health care market.

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.

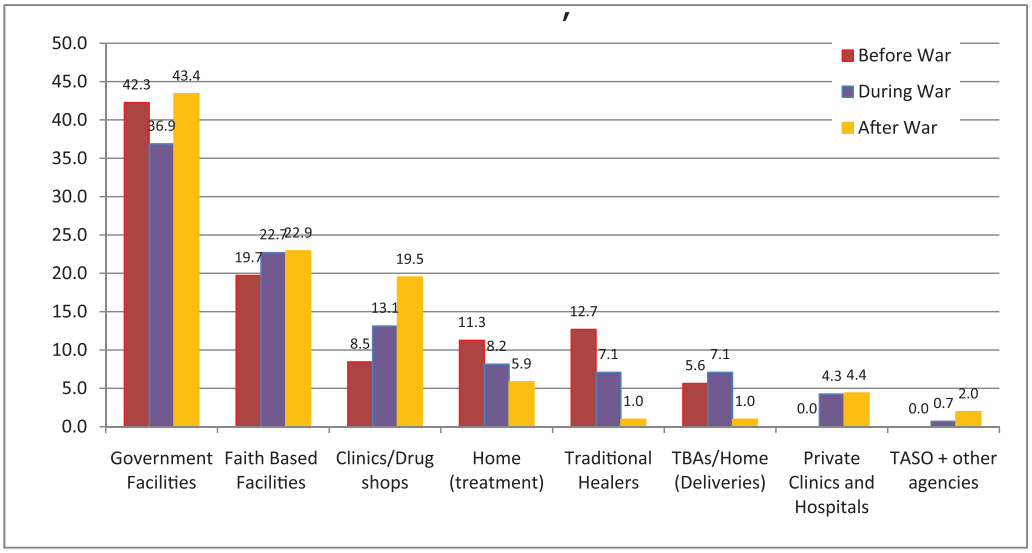
- Qualitative data was analysed using Atlas ti and Excel software packages. Within excel, percent mentions of a particular choice were used to assess the trends in health provider preferences over time.

KEY FINDINGS:

Government Health Facilities Largest Providers of Health Care

1. The government facilities were the most preferred health care providers over the three time periods, but especially after the war, because: 1) only government health care facilities existed in many rural areas; 2) the post war populations were too poor and dependent to seek paid health care and 3) private health care facilities were largely in urban areas.

Figure 1: Choice of Health Care Provider Before, During and After the War



Source: Life Histories

Faith Based Health Facilities Second Largest Providers of Health Care

2. Faith based facilities, operated by different missions, especially St. Mary's Hospital Lacor, were the second most predominant recourse for health care because the missions' charitable policy of providing the services to the poorest of the poor, ensured that they continued providing good quality care at subsidized cost, or free care for vulnerable groups such as women and children and the elderly.

> *"Lacor was preferred because Lacor is a mission hospital and they have very good services and they really try to help people who need help. Lacor at that time had a very good reputation as the hospital that saves life." (Male Household Head, 48 Years)*

Moreover, being a hospital, Lacor had the medicines, health professionals and equipment to conduct higher level health care which is lacking in other facilities.

Declining Traditional Medicine

3. s on alternative health care or non-facility based health care was clearly on the decline. The massacre of traditional healers and the provision of free health services closer to the people in the camps during the war exposed many to appreciate professional health care, causing them to abandon traditional medicine in preference for professional health care from health facilities. They only resorted to non-formal medicine when there were no other options.

Slow Development of Private Health Care in Gulu

4. Private health care comprised clinics, drug shops and specialised diagnostic facilities such as Gulu Independent Hospital. While lack of medicines and diagnostics in government health centres forced others to go to these clinics and drug shops, many found them, especially diagnostic facilities to be very expensive. Few people would consider them a first recourse for health care seeking. Moreover, most of these were located in the urban areas and not in the rural areas.

Advent of Specialised Health Care

5. The presence of organizations such as The AIDS Support Organization (TASO) were also a recent phenomenon, owing to HIV and AIDS being a new health challenge. But their presence also signifies the trend in the verticalisation of health care programming which started in the late 1980s in Uganda. As such, TASO served only those who had HIV.

Cost the Main Reason for Choice of Health Care Facility

6. Cost was a major factor in determining the choice of health provider (See Table 2). This choice was either direct (actual cost of care) or indirect (in form of transport, perceived quality of care or illness severity).

> *"I have been referred to Gulu Hospital but I have not yet gone. I will go on Monday because that is when I expect to get money. Though the services are free, I need money for paying 'boda'[motor bike transport]. I need two thousand (2,000/=) shillings to reach town. That means I need four thousand (4,000/=) shilling for to and fro." (Female Household Head, 65 Years)*

Conditions perceived to be less severe were taken to government health centres and drug shops, while illnesses perceived to be more severe were taken straight to far off fee paying facilities where the health care was perceived to be of better quality. This was because by the time they sought care, they needed good quality health care which was not provided in public health facilities.

KEY LESSONS:

1. Government the major provider of health care in post conflict Gulu district, given the limited private investment in health, all located in urban areas.
2. Given the insufficiency of the private sector in health, Government needs to continue providing health care for those in post conflict Gulu. It should not abdicate its role to the private sector.
3. Cost (direct and indirect) a major challenge to health care access from all facilities, public or private.
4. Targeting of free health care for the special groups (such as expectant mothers and infants) a good practice which should continue
5. Government facilities need to be revamped to provide quality services, to make the free health care really worth seeking.
6. Faith based facilities offering subsidized health care need to be given incentives to compliment government in providing health care to rural communities.