

NOT BY MONEY ALONE: THE HEALTH POVERTY TRAP IN RURAL UGANDA

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Résumé

Le présent article analyse le « piège de la pauvreté santé » des ménages ruraux en Ouganda. Cette approche va au-delà des aspects strictement financiers et médicaux. La notion est abordée dans le cadre des besoins minimaux de santé du ménage et dans celui de la productivité de celui-ci, qui dépendent de facteurs sociaux, culturels et économiques intérieurs au ménage. Il s'agit d'un premier pas qui permet d'identifier, sur base de la littérature existante, la nature et les causes sous-jacentes de la pauvreté persistante en Ouganda. En effet, malgré une croissance économique élevée, une partie importante de la population rurale ne bénéficie pas d'une vie saine. Des variables et des relations non économiques à l'intérieur des ménages influencent de façon durable tant la demande de soins de santé que la productivité de leurs membres. Ces faits ont été insuffisamment pris en compte dans les politiques appliquées en matière de santé. Cet article montre que des changements dans les facteurs socio-économiques et culturels caractérisant les ménages pourraient offrir une voie de sortie du « piège de la pauvreté santé » dans l'Ouganda rural.

1. INTRODUCTION

Poverty as a concept has a number of definitions and most of them tend to focus on the monetary and income characteristics of poor people rather than the non-monetary ones that keep people trapped in poverty conditions. The 1950's unidirectional focus on economic growth assumes that poor countries especially in Sub-Saharan Africa are trapped in poverty, which requires increased aid and investment as a way out². The recent increase in the awareness and interest in the multidimensional nature of poverty is a departure from the exclusive consideration of income and poverty line measures of households as homogenous units of analysis and decision-making.

In this article we will discuss the elaboration of an approach to break out of a health poverty trap for low-income populations in Uganda, using a framework of minimum health improvement, socioeconomic progress and tailored by socio-cultural factors which influence intra-household relationships. Our focus will be on the impact of these relationships between household members such as spouses, on health problems. This will be mainly based on a re-reading of the existing literature on health and poverty issues of Uganda, complemented with findings of other research. A concise overview of recent research on intra-household differentiation and corresponding indicators will be given in section 5.

¹ This article benefitted from comments made during the 2008 New Delhi Human Development and Capabilities Conference and of various workshops at Mbarara University of Science and Technology with social scientists, economists and health practitioners. We also thank John Moore and Gad Ruzaaza for their input to a pilot study and two anonymous referees for useful comments.

² EASTERLY, W., "Reliving the '50s: "The Big Push, Poverty Traps and Takeoffs in Economic Development", Working Paper, No. 65, Washington, DC, Center for Global Development, 2005.

An extended examination of the poor does include consumption shortfalls of a predetermined basic minimum level of needs, socio-economic, political and structural constraints and human deprivations, which make a rationale for multidimensional poverty assessment.³ However, for policy practice the monetary approach mostly retains its dominance in descriptions and alleviation tools of poverty, both nationally and internationally.⁴ This is frequently the case for studies on poverty dynamics⁵. Without underestimating the weight of economics, we should consider also the non-economic aspects of deprivation in the broadest sense⁶.

According to Maltzahn and Durrheim, poverty dimensions could include: life expectancy, caloric intake, height and weight, formal education, literacy, health, access to public goods, housing, employment, environmental conditions and income⁷. By definition poor people have fewer resources and may be forced to sell what assets they have, including land and livestock, or borrow at a high price to deal with an immediate crisis caused by health problems. Despite these explanations, the causal relations in poverty trends continue to be complex; health as a poverty dimension continues to have cross cutting effects that restrict productive capacity, as well as other direct and indirect costs such as time spent on taking care of the sick and expenditure on treatment.⁸

A small sample study showed that 56% of the Ugandans were unable to pay the costs of ill health, which included direct medical costs and expenditure on transport to reach a health facility.⁹ They had to sell assets or borrow money. While ill health and poverty are mutually reinforcing and can generate a

³ TSUI, K., "Multidimensional poverty indices" *Social Choice and Welfare*, Vol. 19, 2000, pp. 69-93; BARRETT, C., CARTER, R., LITTLE, D., "Understanding and reducing persistent poverty in Africa: introduction to a special issue", *Journal of Development Studies*, Vol. 42, No. 2, 2006, pp. 167-177.

⁴ RUGGERI, L., SAITH, R., STEWART, F., "Does it matter that we do not agree on the definition of poverty? A comparison of four approaches", *Oxford Development Studies*, Vol. 31, No. 3, 2003, pp. 243-274; ABUKA, C., ANTINCI-EGO, A., OKELLO, P., "Determinants of poverty vulnerability in Uganda", *IIS Discussion Paper* no. 203, 2007.

⁵ ADDISON, T., HULME, D., KANBUR, R., *Poverty Dynamics: Measurement and understanding from an Interdisciplinary Perspective*, BWPI Working Paper, No. 19, Manchester, Brooks World Poverty Institute, 2008.

⁶ WOOLCOCK, M., *Toward an Economic Sociology of Chronic Poverty: Enhancing the Rigor and Relevance of Social Theory*, CPRC Working Paper, No. 104, Manchester, Brooks World Poverty Institute 2007. SHEPHARD, A., *Understanding and explaining chronic poverty. An evolving framework for Phase III of CPRC's research*, CPRC Working Paper, No. 80, London, Overseas Development Institute, 2007.

⁷ MALTZAHN, R. von, DURRHEIM, K., "Is poverty multidimensional? A comparison of income and asset based measures in five southern African countries", *Social Indicators Research* 10, 2007.

⁸ WAGSTAFF, A., BUSTREO, F., BRYCE, J., CLEASON, M., WHO-WORLD BANK CHILD HEALTH AND POVERTY WORKING GROUP, "Child Health: Reaching the Poor", *American Journal of Public Health*, Vol. 94, No. 5, 2004, pp. 726-36.

⁹ DEKKER, M., WILMS, A., "Health insurance and other risk-coping strategies in Uganda. The case of Microcare Insurance Ltd.", *World Development*, Vol. 38, No. 3, 2010, p. 372.

vicious circle of deterioration and suffering, studies are often concentrated on how poverty is bad for health.¹⁰ Many explanations on the relationship between health and poverty at a micro level are represented by the uni-directional reasoning on how reduced-out-of-pocket costs for health services can drive families into poor health situations.¹¹ However, the experience in many low income countries suggest that ill health is not only a manifestation of poverty, but also a cause and key human development indicator.¹²

A health poverty trap will be used as an indication of how poor health conditions and poverty reinforce each other, making it difficult for poor population groups with health problems to break out of this trap. This can also be seen as the persistence of insufficient economic productivity of individuals, households and the entire community, due to continued poor health conditions. About one fifth of Uganda's mainly rural population still lives under conditions of chronic poverty, despite high economic growth rates and successful poverty reduction strategies. In this study we have taken the situation of the Mbarara district in the South-Western region as indicative for rural Uganda.

The arguments will be unfolded in the following sections. After this introduction we discuss in section 2 the poverty dynamics in Uganda showing its multidimensional nature. The persistence of health poverty traps is presented in section 3 in relation with the conventional direct and indirect costs of illness and other factors that keep people trapped in ill health and poverty. Section 4 gives a discussion of national and communal socioeconomic factors that affect the household and individual health outcomes. A framework of the effects of intra-household relations and orientation of possible way-outs of the health poverty trap are presented in section 5. The health policies are discussed in section 6 to show the limited attention given to non-monetary intra-household factors that trap people in poverty. The conclusive remarks of section 7 emphasize the need to integrate monetary and non-monetary instruments at the household level for effective health promotion and poverty reduction interventions.

2. MULTIDIMENSIONAL POVERTY DYNAMICS

The 1999 Uganda participatory poverty assessment project (UPPAP) reports that the poor are mainly internally displaced persons in areas of conflict, civil war and HIV/AIDS orphaned children, marginalized groups in

¹⁰ KAWACHI, I., KENNEDY, P., "Socioeconomic determinants of health. Health and social cohesion: why care about income inequality?", *BMJ*, Vol. 314, No. 1037, 1997.

¹¹ WHITEHEAD, M., DAHLGREN, G., EVANS, T., "Equity and health sector reforms: can the developing countries escape a medical poverty trap?", *The Lancet*, Vol. 358, No. 9284, 2001, pp. 833-836.

¹² KANBUR, R., MUKHERJEE, D., "Premature Mortality and Poverty Measurement", Working Papers of the Institute for Social and Economic Research, University of Essex, 2003; ZHANG, J., ZHANG, J., "The effects of life expectancy on fertility, saving, schooling and economic growth: Theory and Evidence", *Scandinavian Journal of Economics*, Vol. 107, No. 1, 2005, pp. 45-66.

official decision making processes, unemployed, elderly, disabled persons, and people in remote rural areas. The common poverty pattern seems to be of a structural nature and the persisting concentration in the northern region of the country is shown as a consequence of long standing conflicts. In the period 1992-2000 the North showed the highest rates of poverty that has staggered between 60-70% and chronic poverty of 39%, which apparently confirms the earlier qualification.¹³

Further insights by poverty analysts on Uganda give a more dynamic picture where groups of people or households have been escaping from and falling into poverty. For the North almost a fifth of the population had been moving out of and a quarter moving into poverty in the referred period as shown in table 1. Studies and policies on Uganda's poverty dynamics show important clues about the relationships between health and poverty: Krishna and colleagues associate descent into poverty for Central and Western Uganda mostly (66.6%) as a result of disease, which include the decline of household material circumstances due to ill health, the related costs and death of the household income earner.¹⁴

Other factors mentioned are social and behavioural factors including family size, marriage expenses, alcoholism and inactivity. Multiple income sources, employment, access to land, start-up capital, higher education and intra-household behaviour were reported to have significant influence on the ability to escape poverty. From Table 1 it will be clear that poverty and especially chronic poverty is very much concentrated in rural areas and not only in the remote ones.

¹³ LAWSON D., McKAY, A., OKIDI, J., "Poverty Persistence and Transitions in Uganda: A Combined Qualitative and Quantitative Analysis", *Journal of Development Studies*, Vol. 42, No. 7, 2006, pp. 1225-51; OKIDI, J., MUGAMBE, G., *An Overview of Chronic Poverty and Development Policy in Uganda*, CPRC Working Paper, No. 11, 2002.

¹⁴ KRISHNA, A., LUMONYA, D., MARKIEWICZ, M., MUGUNYA, F., KAFUKO, A., WEGOYE, J., "Escaping poverty and becoming poor in 36 villages of central and western Uganda", *The Journal of Development Studies*, Vol. 42, No. 2, 2006, pp. 346-370.

Table 1. Poverty dynamics Uganda (1992/1999 panel data)

LOCATION	POVERTY STATUS (%)				TOTAL
	CHRONIC	MOVING OUT	MOVING IN	NEVER POOR	
National	18.9	29.6	10.3	40.9	100
Rural	20.5	30.7	11.1	37.6	100
Central	13.8	29.7	8.5	47.8	100
East	16.4	36.8	10.4	36.2	100
West	16.2	27.2	8.7	47.6	100
North	38.9	18.1	22.9	20.1	100
Central-West *	20.4	24.0	15.0	40.6	100
Agriculture **	23.3	63.2		13.5	100

Source: LAWSON *et al.*, *op. cit.*; KRISHNA *et al.*, *op. cit.*; WORLD BANK, *op. cit.*, 2005.

Notes: * 36 villages, 25 years; ** agricultural self-employed, 1992-1996 (moving out and in together is 63,2%).

It should be mentioned that poverty has been frequently identified by the lack of income to meet the basic needs of a household, consumption expenditure per adult, per capita consumption and the requirements of cash crop farming.¹⁵ Additional variables are unemployment, insecurity due to the more than 20 years rebellion in the North, lack of basic education, health care and infrastructure.¹⁶ The increased GDP growth and decline of poverty in the western region is attributed to high investments in agricultural services, rural feeder roads and rural education, which increased agricultural productivity, within a stable political environment¹⁷. In 2005/2006 consumption expenditure increased even more in rural than urban areas, which could be attributed to the growth of cash crops and live stocks.¹⁸ Nevertheless, most of the population still consumes less than the basic needs level. There seems to be no significant difference by gender of the household head, neither by consumption and income, nor by health indicators.¹⁹ Female headed households with non-farm incomes like remittances appear to be better off, but could be more

¹⁵ OKIDI, J. A., McKAY, A., "Poverty Dynamics in Uganda: 1992 to 2000", CPRC Working Paper, No. 27, Chronic Poverty Research Centre, 2003.

¹⁶ DEININGER, K., OKIDI, J., "Growth and Poverty Reduction in Uganda, 1999-2000: Panel Data Evidence", *Development Policy Review*, Vol. 21, No. 4, 2003, pp. 481-509.

¹⁷ FAN, Sh., ZHANG, X., "Public Expenditure, Growth and Poverty Reduction in Rural Uganda", *African Development Review*, Vol. 20, No. 3, 2008, pp. 466-496; FAN, Sh., "Investment for Agricultural Productivity: Comments on ADNV Paper", Washington, International Food Policy Research Institute, 2009.

¹⁸ UGANDA BUREAU OF STATISTICS, *Uganda Demographic and Health Survey*, Kampala / Calverton MD, UBOS / ORC Macro, 2006.

¹⁹ APPLETON, S., "Women-headed households and household welfare: An empirical deconstruction for Uganda", *World Development*, Vol. 24, No. 12, 1996, pp. 1811-1827.

affected by falling incomes. Despite the importance of health, government spending in this category had no significant impact on agricultural growth and poverty reduction.²⁰ A large share was spent on HIV/AIDS containment, while health investment effects are only measurable in the long run. The Ugandan results are quite different from an international study of the effects of a health indicator as the adult survival rate on GDP growth in low-income countries. Factors as nutrition, infection diseases, health infrastructure, smoking prevalence and premature deaths may be integrated in this indicator for poor countries. Not only were the health effects positive, but also was the magnitude more than three times higher than that of the investment/GDP ratio.²¹ Recent micro studies of Central and Western Uganda indicated poor health and high health related expenses in 71% of the cases as principal reason for descent into poverty. For escaping poverty in this region, 54% pointed at income diversification by improved agricultural yields, access to land and appearance of informal and formal jobs²².

From a multidimensional perspective, Amartya Sen relates poverty to the absence or lack of key capabilities to function in society.²³ This may include poor social relations, personal integrity, health, environment, intellectual stimulation and other capabilities²⁴. Therefore, Bastiaensen and others were inspired to define the poor as “those human beings who for one reason or another almost systematically end up at the losing end of multiple bargains”.²⁵ Another important challenge is that chronic poverty, which traps individuals and households in severe multidimensional deprivation for a prolonged period of more than five years, is of an enduring nature and often transmitted across generations.²⁶ It will be argued that the intra-household relations of its members may be important for the movement out of and into poverty in rural Uganda.

3. A HEALTH POVERTY TRAP

We describe a ‘poverty trap’ as a vicious circle that continuously runs through unfavourable household socioeconomic and cultural characteristics; such as food insecurity and poor nutrition, poor hygiene, problematic habits that may translate in ill health and low household productive capacity. Poverty

²⁰ FAN, Sh., ZHANG, X., *op. cit.*

²¹ BHARGAVA, A., JAMINSON, D., LAU, L., MURRAY C., “Modelling the effects of health on economic growth”, *Journal of Health Economics*, Vol. 20, 2001, pp. 423-440.

²² KRISHNA *et al.*, *op. cit.*; KRISHNA, A., “For reducing poverty faster: target reasons before people”, *World Development*, Vol. 35, No. 22, 2007, pp. 1947-1960.

²³ SEN, A., *Economic Progress and Health*. New York, Oxford University Press, 2001.

²⁴ NUSSBAUM, M., “Capabilities as Fundamental Entitlement: Sen and Social Justice”, *Feminist Economics*, Vol. 9, No. 2-3, 2003, pp. 33-59.

²⁵ BASTIAENSEN, J., DE HERDT, T., D’EXELLE, B., “Poverty reduction as a local institutional process”, *World Development*, Vol. 33, No. 6, 2005, pp. 979-993.

²⁶ GREEN, M., *Thinking through chronic poverty and destitution: theorising social relations and social ordering*, School of Social Sciences, University of Manchester, 2007; LWANGA-NTALE, C., “A Social Protection agenda for Uganda’s Poorest of the Poor”, Chronic Poverty Research Centre, Uganda, Policy Brief, No. 2, 2006.

traps are persistent in Africa, especially in Sub-Saharan countries and have been attributed to low-productive agriculture, small markets and high transport costs, slow technology diffusion, but also to considerable health problems.²⁷ The 'health poverty trap' has been explained as a state of being trapped into low productive capacity and income deprivation due to ill health conditions and the costs that come forth²⁸. A similar concept is the poverty nutrition trap in rural India, which appears to be related to the incapacity to operate in labour markets.²⁹ In the case of Uganda the common ill health conditions are often due to preventable diseases such as malaria, malnutrition, diarrhoea, unskilled delivery attendance, tuberculosis and HIV/AIDS, which account for over 75% of the lost years by premature deaths³⁰. While the conventional 'health poverty traps' are deduced from the costs and time lost when ill, this article focuses on intra-household social and economic characteristics that keep people trapped in ill health. Individuals', households' and the entire community's low productive capacity may also be due to poor health conditions related to household's and community's beliefs and attitudes that determine family decision making. Community acceptance of age and gender rules may be very important for household decision-making. For Ugandan households only a fifth of the wives make sole decisions on their own health care and four in every ten have their husbands decide. 30% of married women are not paid for their work compared to 13% of men.³¹ These conditions keep women in a state of not being in charge of their health and economic production. Power relations that are at the root of gender inequality affect the vulnerability to ill health and are socially imposed restrictions on women's access to health care.³² An estimation of the magnitude of the health poverty trap is not easy for Uganda and could be based on the proportion of chronically poor households of table 1. For rural areas this figure amounts to 20% at least. When we use the percentages of the poor with sickness in the month before the survey of Deininger and Okidi, one gets a national average health poverty trap of between 10-14% of the population as a first approximation³³.

While macro indicators like education, level of income and location (rural or urban) may provide explanations for access to health care and

²⁷ SACHS, J., *The End of Poverty: How can we make it happen in our lifetime*, New York, Penguin Books, 2005.

²⁸ ACCORSI, S., FABIANI M., NATTIBI, B., CORRADO, B., IRISO, R., AYELLA, E., PIDO, B., ONEK, P., OGWANG, M., DECLICH, D., "The disease profile of poverty: morbidity and mortality in northern Uganda in the context of war, population displacement and HIV/AIDS", *Transactions of the Royal Society of Tropical Medicine and Hygiene*, Vol. 99, No. 3, 2005, pp. 226-233.

²⁹ JHA, R., "Caloric and micronutrient deprivation and poverty nutrition transept in rural India", *World Development*, Vol. 37, No. 5, 2009, pp. 982-991.

³⁰ MINISTRY OF FINANCE, PLANNING AND ECONOMIC DEVELOPMENT, *Uganda. Poverty Eradication Action Plan (2004/5-2007/8)*, Kampala, 2004.

³¹ UGANDA BUREAU OF STATISTICS, *op. cit.*

³² BRAUNHOLTZ-SPEIGHT, T., HARPER, C., JONES. N., "Progressive social change – women's empowerment", Policy Brief No. 12, Chronic Poverty Research Centre, 2008.

³³ DEININGER, K., OKIDI, J., *op. cit.*

measures of the multidimensional nature of poverty, much of what is written about the relationship often implicitly assume the causal direction as from wealth to health.³⁴ Therefore the possibility that either at the individual or population level there can be a causal link running from health to wealth should be considered explicitly. When the causality runs both sides, a mutually reinforcing virtuous cycle out of poverty could be generated. This view is not new, it was a central part of the public health care agenda, more than 20 years ago, which emphasizes measures that deal with the underlying causes of ill health and promote community actions for effective health policy, service provision and utilization of health services by the targeted populations³⁵. In many cases primary health care has been assumed to be a prerogative for economic growth. Sen argues that while plenty of evidence show that income and health move together, the connection is weakened by two major influences: how the income generated by economic growth is used to expand public services adequately and reduce the burden of poverty and when an economy is poor, how health improvements are achieved through using the available resources in a socially productive way.³⁶ Examples are given by countries with higher GDP per capita which are not necessarily better off in terms of HDI (Human Development Index based on longevity, education and standard of living); as may be observed for the year 2007 by the cases of Saudi Arabia with purchasing power corrected GDP per capita of US\$ 22,935 and HDI 0,843, compared to Uruguay (US\$ 11,216 and HDI 0,865) and Costa Rica (US\$ 10,842 and HDI 0,854).³⁷

The historical verification of the appearance of virtuous cycles is that several of the great takeoffs were supported by important breakthroughs in public health, disease control and improved nutrition intake. Examples are the rapid growth of Britain during the industrial revolution and of Japan in the 20th century; the development of the US south in the early 20th century; and the dynamic development of Southern Europe and East Asia in the beginning of 1950s and 60s. The global declines in mortality that have been observed over the past 200 years have been importantly boosted by increased availability of calories in diet and advances in public health and medical technologies in Europe.³⁸ The available empirical (macro) studies on Latin America as a whole and for the individual countries, show that health plays an important long-term role in economic growth. In a cross section of 147 countries it was demonstrated that good health has a sizable effect through productivity on GDP

³⁴ KANBUR, R., MUKHERJEE, D., 2003, *op. cit.*

³⁵ VAN DER GEEST, S., SPECKMANN, J., STREEFLAND, P., "Primary health care in a multi-level perspective: towards a research agenda", *Social Science & Medicine*, Vol. 30, No. 9, 1990, pp. 1025-34.

³⁶ SEN, A., 2001, *op. cit.*

³⁷ www.undp.org. For the latest HDI, the new method of calculus and its limitations, see RAVALLION, M., *Troubling tradeoffs in the Human Development Index*, Policy Research Working Paper, No. 5484, World Bank, 2010.

³⁸ FOGEL, R., "Health, Nutrition, and Economic Growth", *Economic Development and Cultural Change*, 2004, Vol. 52, No. 3, pp. 643-658.

growth³⁹. A one-year improvement in life expectancy contributes to an output increase of 4%. Therefore in the following section of the paper we try to explain the discrepancy between health outcomes and wealth creation in Uganda by identifying the relevant socioeconomic and cultural factors at community and national levels as a first step towards assessing their effects in a framework with intra-household relations.

4. THE LINKAGE BETWEEN HEALTH AND WEALTH

Many explanations and theories on the relationship between health and poverty present a uni-dimensional reasoning, such as how limited spending for public and private health care services drive families into poverty, and increase the poverty of those who are already poor – a situation which Whitehead and her colleagues have called a “medical poverty trap”.⁴⁰ Other studies focused on the impact of user fees on poor household incomes, which directly affect their health care seeking behaviour.

As part of the reforms of the health system, Uganda abolished user fees for first level government facilities in March 2001, which improved the access to health care considerably. The sick households who reported not to have utilised health services decreased from about 50% in 1999 to 35% in 2002.⁴¹ The question has remained whether poor household’s failure to pay for health services in the past was the only factor that had sustained ill health, reduced productive capacity and led to persistent impoverishment.⁴² When ill health hurts the main earner in poor families, it has severe implications for economically dependant family members and particularly children. The magnitude of this situation is illustrated by national household surveys and participatory poverty alleviation studies. However, a study of Bangladesh shows the hidden costs of free maternity care to include food, transport and social position since free services are left for uneducated and poor women⁴³. In Uganda the use of free maternity services is plagued by problems of quality, lack of access, privacy and shortage of medical supplies.⁴⁴ Stock-outs at local health units and behaviour problems of health workers because of loss of

³⁹ BLOOM, D. E., CANNING, D., SEVILLA, J., “The effect of health on economic growth: a production function approach”, *World Development*, Vol. 32, No. 1, 2004, pp. 1-13.

⁴⁰ WHITEHEAD, M. *et. al.*, *op. cit.*

⁴¹ DEININGER, K., MPUGA, P., *Economic and welfare impact of abolition of health user fees: Evidence from Uganda*, World Bank Policy Research Working Paper, No. 3276, 2004.

⁴² XU, K., EVANS, B., KADAMA, D., NABYONGA, J., OGWANG, P., NABUKHONZO, P., AGUILAR, A., “Understanding the impact of eliminating user fees: Utilization and catastrophic health expenditures in Uganda”, *Social Science & Medicine*, No. 62, 2006, pp. 866-876.

⁴³ NAHAR, S., COSTELLO, A., “Research report. The hidden cost of ‘free’ maternity care in Dhakar, Bangladesh”, *Health Policy and Planning*, Vol. 13, No. 4, 1998, pp. 417-422.

⁴⁴ TASHOBYA, K., McPAKE, B., NABYONGA, J., YATES, R., “Health Sector reforms and increasing access to health services by the poor: what role has the abolition of user fees played in Uganda?”, in TASHOBYA, K., SSENGOOBA, F., OLIVEIRA, V. (eds.), *Health Systems Reforms in Uganda: Processes and Outputs*, Health Systems Development Programme, London School of Hygiene and Tropical Medicine, 2006.

income and increasing work loads are other noted disadvantages. The 1999 Uganda Participatory Assessment Poverty Report highlights that for most poor people issues such as the death of the family earner, number of children, access to land and credit will limit access to health care and overall poverty reduction opportunities. Land and health seem to be key assets associated to chronic poverty⁴⁵. The 2006 Uganda Demographic Health Survey (UDHS) mentions the gendered unequal distribution of household chores and farm labour. While poor families' social cultural characteristics tend to draw some attention, it is still of a limited nature. The combination of poverty and ill health may make the situation much more complex. Without considering additional factors that make family members more vulnerable in the absence of the main family earner, the circle of reducing poverty at the household level remains incomplete.

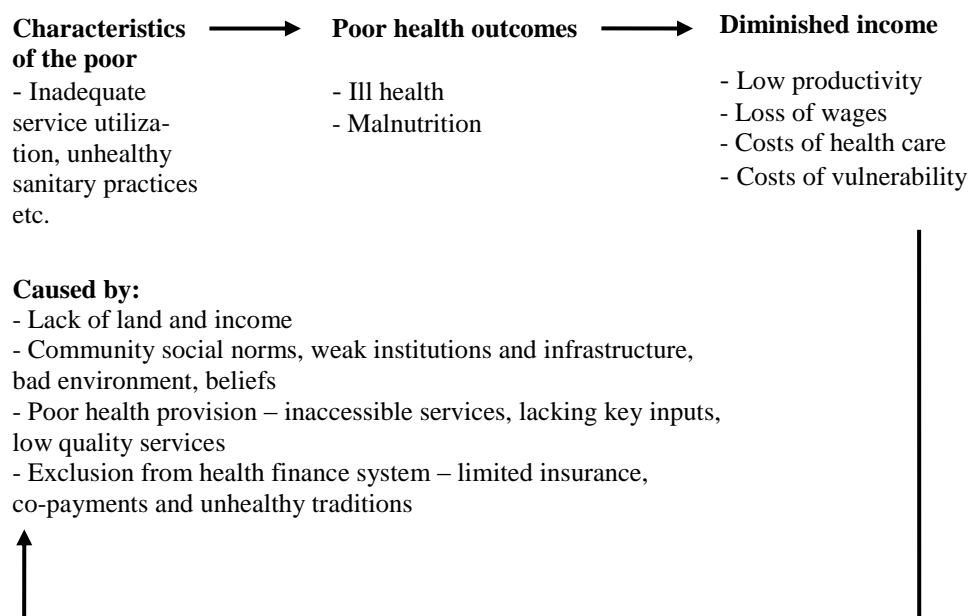
Although non-monetary factors like social norms regarding the gendered distribution of family responsibilities tend to be mentioned in most health promotion and poverty reduction strategies, we conclude from the literature that they are hardly operationalised.⁴⁶

Revision of the 2005/2006 UDHS report on the gender gap in time spent on care labour activities at the household level gives interesting facts. Whereby males spend eight hours of the day on economic activities and one hour on care activities such as fetching water, their female counterparts spend nine hours on economic activities such as digging and six hours on care and other household activities. Studies on the household sexual division of labour have called this 'the double burden of women', as they are both caregivers and income generators. For about 70% of the households husbands decide on the family purchases and in 60% on women's movements.⁴⁷

⁴⁵ HICKEY, S., "The politics of staying poor: exploring the political space for poverty reduction in Uganda", *World Development*, Vol. 33, No. 6, 2005, pp. 995-1009.

⁴⁶ SEGAL, L., "The importance of patient empowerment in health system reform", *Health Policy*, Vol. 44, No. 1, 1998, pp. 31-44; JENKINS, M. W., SCOTT, B., "Behavioral indicators of household decision making and demand for sanitation and potential gains from social marketing in Ghana", *Social Science & Medicine*, Vol. 64, No. 12, 2007, pp. 2427-42.

⁴⁷ UGANDA BUREAU OF STATISTICS, *op. cit.*

Figure 1. Ill-health and poverty linkages of a health poverty trap

To some scholars these non-monetary aspects keep women in positions of not being in charge of their lives and disempowered in terms of decision-making.⁴⁸ The vicious cycle of health and poverty of figure 1 adopted from Wagstaff's assessment of poverty and health inequalities, focuses on the underlying factors at the community and policy levels of a health poverty trap, while households are considered as homogenous entities.⁴⁹

To explain the underlying causes of chronic poverty and health inequalities at the community level, this framework might need to include intra-household factors that limit the possibility to escape from the trap of ill health and poverty⁵⁰. The WHO 2001 report on macroeconomics and health indicates that the main components of ill health in low-income countries continue to include HIV/AIDS, malaria, tuberculosis, childhood infectious diseases, maternal and prenatal problems, micronutrient deficiencies and

⁴⁸ LANGSTEN, R., SALEM, M., "Two approaches to measuring women's work in Developing Countries: A comparison of survey data from Egypt", *Population and Development Review*, Vol. 34, No. 2, 2008, pp. 283-305.

⁴⁹ WAGSTAFF, A., "Poverty and health sector inequalities", *Bulletin of the World Health Organisation*, Vol. 80, No. 2, 2002, pp. 97-105.

⁵⁰ GRANT, U., "Health and Poverty Linkages: Perspectives of the chronically poor", Background Paper for the Chronic Poverty Report, No. 2008-9, Manchester, Chronic Poverty Research Centre, 2005.

tobacco related illnesses⁵¹. When services to control these illnesses are provided in conjunction with programmes that influence the underlying socio-economic and cultural factors of the demand for health services, impoverished families could not only enjoy longer and healthier lives, but also be more productive and less poor. The linkages of positive health outcomes and poverty reduction are clear and much better understood than when it comes to the underlying components of health improvement determinants.⁵² These components include what this paper has formulated as the household social and cultural factors. It is with this background that we have come up with the following conceptual framework that particularly focuses on the role of the non-monetary factors at the intra-household level that may help to move out of poverty.

5. A FRAMEWORK FOR MOVING OUT OF HOUSEHOLD ILL HEALTH AND POVERTY

To improve health outcomes and productivity of most rural poor households, one needs to understand the socio-economic and cultural dynamics at the household level that influence health services demand practices and productivity. This section explains a framework for moving out of poor health and low productivity by extending the discussion on monetary and medical poverty traps with three assumptions:

- a. Household productive capacity depends on intra-household family dynamics, which are influenced by social cultural factors such as the gendered distribution of family responsibilities, spousal relations, social hierarchy and other intra-household relationships and decision-making.
- b. Changes of attitudes towards socially stigmatized preventive health strategies like the use of contraceptives, household hygiene, skilled birth attendance, immunisation, use of bed nets and child nutrition may lead to improvement of maternal and child health.
- c. The factors mentioned in point a and the attitudes in point b may affect the demand for health services and their increased utilisation may improve maternal and child health which has an equivalent effect on household productivity as access to land, credits, education etc.

These factors and attitudes may affect the allocation of resources and the distribution of bargaining power, which show a considerable differentiation

⁵¹ SACHS, J. D., “*Macroeconomics and health: Investing in health for economic development*,” Report of the Commission on Macroeconomics and Health, World Health Organization, 2001; ENSOR, T., COOPER, S., “Overcoming barriers to health service access: influencing the demand side”, *Health Policy and Planning*, Vol. 19, No. 2, 2004, pp. 69-79.

⁵² ENSOR, T., COOPER, S., *op. cit.*

among members of the household as is demonstrated in a number of international studies⁵³.

A cross section of poor countries demonstrated that intra-household inequality of wellbeing accounts for between half and two-thirds of total health inequality as measured by BMI or body mass index.⁵⁴ With improving living standards, this inequality even increases.

Figure 2 is an illustration of the aggregate impact of changing social cultural situations on household health through improved demand for preventive health services and the simultaneous effects on household wealth creation and productive capacity. The intra-household dynamics may be part of a vicious circle as in figure 1, but may also initiate a virtuous cycle out of a health poverty trap. The effects of changes in intra-household relations may give the needed push out of the trap in addition to the impact of community and national efforts on moving out of poverty and poor health. The argument goes in the same line as studies by Bloom and colleagues, where under critical conditions, improvement in health could lead to higher productivity and lower population growth.⁵⁵ They also ascertain that for hot landlocked countries as Uganda it is hard to break out of a low level poverty trap.

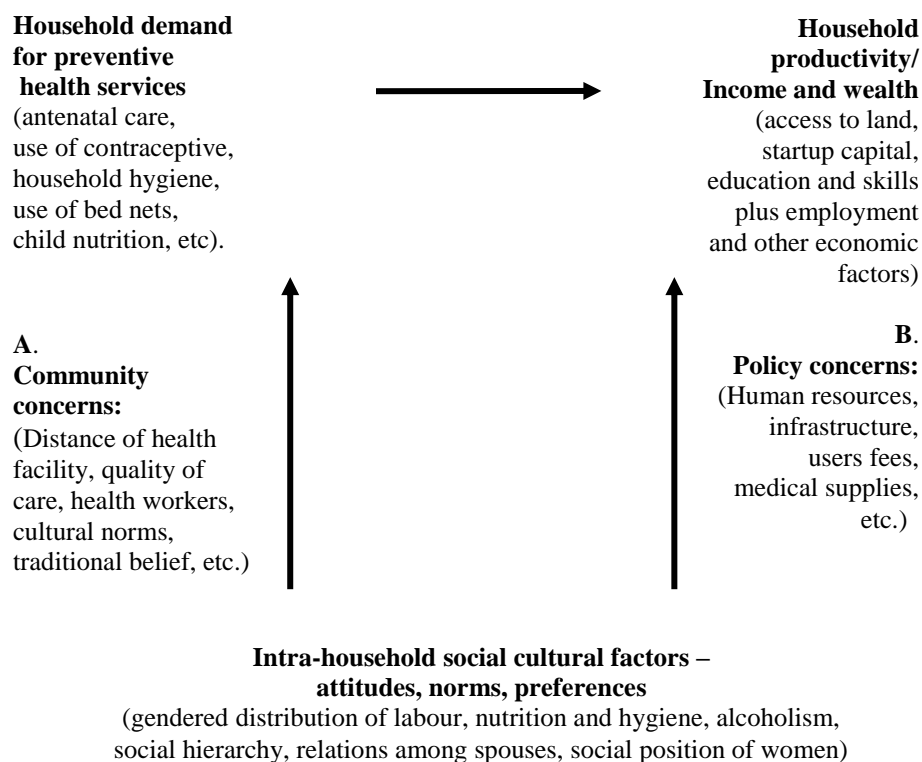
⁵³ LANCASTER, G., MAITRA, P., RAY R., "Endogenous intra-household balance of power and its impact on expenditure patterns: evidence from India", *Economica*, Vol. 73, No. 291, 2006, pp. 435-460.

CUESTA, J., "The distributive consequences of machismo: a simulation analysis of intra-household discrimination", *Journal of International Development*, No. 18, 2006, pp. 1065-1080; FLETSCHEMER, D., "Rural women's access to credit: market imperfections and intra-household dynamics", *World Development*, Vol. 37, No. 3, 2008, pp. 618-631; ASHRAF, N., "Spousal control and intra-household decision-making: an experimental study in the Philippines", *American Economic Review*, Vol. 99, No. 4, 2009, pp. 1245-1277; BIRD, K., *Chronic poverty and understanding intra-household differentiation*, CPRC Working Paper, No. 13, Chronic Poverty Research Centre, 2003.

⁵⁴ SAHN, D. E., YOUNGER, S. D., "Measuring intra-household health inequality: explorations using the body mass index", *Health Economics*, Vol. 18, No. S1, 2009, pp. 13-36.

⁵⁵ BLOOM, D. E. *et al.*, *op. cit.*; BLOOM, D. E., CANNING D., SEVILLA, J., "Geography and poverty traps", *Journal of Economic Growth*, Vol. 8, 2003, pp. 355-378.

Figure 2. A framework illustrating the interplay between the different factors and levels: possible ways out of the trap



During a pilot study that was presented in 2007, a number of underlying intra-household causes for ill health and low productivity in local communities in Mbarara were identified. These included unequal gendered distribution of family labour, alcoholism, poor nutrition and hygiene, social hierarchy, intra-household relations among spouses, lack of women participation and exclusion in general.⁵⁶

Some of these or similar factors appeared in other Uganda studies; such as the gender division of labour, relationship to household head (polygamy, child adoption, poor relative), birth order of children, age and disability.⁵⁷ Women's participation in labour markets and employment is strongly affected

⁵⁶ NYAKATO, V., RUZAAZA, G., MOORE, J., "Defining the role of social relations in promoting rural health and progress", Poster presentation, Kampala, The Network:TUFH Conference, September 2007.

⁵⁷ BOLT, V., BIRD, K., *The intra-household disadvantages framework: a framework for the analysis of intra-household difference and inequality*, CPRC Working Paper, No. 32, Manchester, Chronic Poverty Research Centre, 2003.

by ill health and its duration.⁵⁸ The very high ranking of Uganda in world alcohol consumption is also reported as affecting the health differentiation among family members.⁵⁹ All these factors link together in a complex web and have commonalities that may have caused a vicious cycle of low productivity and stagnant maternal and child health indicators in rural communities in Mbarara, South-Western Uganda.

However, there is lack of research evidence on how these factors should be operationalised for rural health improvement and poverty reduction. From case studies of Uganda and India, Bolt and Bird concluded that there is a 'lack of comprehensive research tools' for the analysis of intra-household social differentiation.⁶⁰ There is need to find out the causal relationships or mechanisms between these factors and health variables, levels of income or growth. Other studies have found that the intra-household structure and relationships influence the decisions to attend healthcare facilities by its members.⁶¹ Influencing factors such as ignorance of health service products, cultural reluctance to use public facilities and inclination to minimising household costs, seem to be largely neglected⁶². The intra-household distribution of bargaining power and related access to resources, have important impacts on both health satisfaction and wellbeing. Cooperative and non-cooperative household decision models are extensively discussed in a number of studies⁶³. Modelling and application cases from around the world are given by these. Examples are the study of negative effects of gender discrimination on expenditure, nutrition and human capital in Chile⁶⁴, the impact of the spread of bargaining power between spouses on expenditure in India⁶⁵, the effects of the allocation of resources on health satisfaction in poor families in Mexico⁶⁶, gendered access to rural credit resources in Paraguay⁶⁷ and the impact of spousal control on financial choices in the Philippines.⁶⁸ In a

⁵⁸ BRIDGES, S., LAWSON, D., "A gender-based investigation into the determinants of labour market outcomes: Evidence from Uganda", *Journal of African Economies*, Vol. 10, No. 107, 2008, pp. 1-35.

⁵⁹ LWANGA-NTALE, C., "Drinking into deeper poverty. The new frontier for chronic poverty in Uganda", Kampala, Chronic Poverty Research Centre, Policy Brief no. 1/2007.

⁶⁰ BOLT, V., BIRD, K., *op. cit.*

⁶¹ ALABA, O. A., KOCH, S. F., "Household structure, social protection and health seeking behaviour in South Africa", 1st Annual Conference: Charlotte Manyaxwe Collaboration in Research and Capacity Building in Economics of Social Protection, University of Pretoria, 2007. LINDELOW, M., "Health as a family matter: Do intra-household education externalities matter for maternal and child health?", *Journal of Development Studies*, Vol. 44, No. 4, 2008, pp. 562-85.

⁶² ENSOR, T., COOPER, S., *op. cit.*

⁶³ BIRD, K., *op. cit.*

⁶⁴ CUESTA, J., 2006, *op. cit.*

⁶⁵ LANCASTER, G. *et al.*, 2006, *op. cit.*

⁶⁶ ROJAS, M., "Intra-household arrangements and health satisfaction, Evidence from Mexico", *Research Paper* No. 2008/57, Facultad Latinoamericana de Ciencias Sociales, Sede Mexico

⁶⁷ FLETSCHNER, D., 2008, *op. cit.*

⁶⁸ ASHRAF, N., 2009, *op. cit.*

nutshell, the spread of bargaining power between spouses plays an important role for the possible escape from or descent of households into poverty.

6. UGANDA'S POLICIES

Countries with healthy populations and a good policy environment tend to grow faster. For Uganda this correlation operates through a number of channels including the effects of improved health on demography, education, labour market and investment⁶⁹. Nevertheless, there are still great disparities of health satisfaction to be considered. The burdens of disease in most low-income regions in sub-Saharan Africa still stands as a severe barrier to economic growth. Health improvement must be addressed centrally and locally in any comprehensive development strategy. Reducing poverty in Uganda has been registering forward and backward movements, where income poverty fell drastically in the 1990s from 56% in 1992 to 44% of the population in 1997 and more recently the 2000 household survey reported a further decline to 35%. However, after this year the proportion of the people living below the poverty line rose again to 38% in 2003⁷⁰

At the present the national poverty reduction priorities are health (public health care), education, rural feeder roads and safe and clean water⁷¹. The policies and priorities for health improvement and poverty reduction are focused on streamlining poor prioritization, inadequate investment in critical inputs, piecemeal implementation and poor coordination of technical interventions that result in hindrance to achievement of national service coverage and health outcome targets⁷². However, evaluations show that rural government health investments have the lowest benefit-cost ratio for Uganda and each of its four regions⁷³. This ratio is only for the case of health investments even lower than one, except for the Central region. Health investments have also by far the smallest number of reduced poor per million UGS compared to agricultural R&D, feeder roads and education.

Mbarara district health structures and policies are in line with the national policy framework and the overall objective of bringing services near to the people through a decentralised system. The district health infrastructure has

⁶⁹ LAWSON, D., "Determinants of ill health in Uganda – Is it just the wealthy that are more healthy?", Centre for research in economic development and international trade, CREDIT Working Paper, No. 04/09, University of Nottingham, 2004.

⁷⁰ UGANDA BUREAU OF STATISTICS, *op. cit.*; BYARUHANGA, C., "Poverty reduction and public sector reform in Uganda: the roles of institutions in the past experience and challenges for the way forward. 'Integrating structural and budget reforms for a better performing public sector'", London, Adam Smith Institute, 2002; MINISTRY OF FINANCE, *op. cit.*

⁷¹ WOODHOUSE, P., "Local Identities of Poverty: poverty narratives in decentralized government and the role of poverty research in Uganda", GPRG Working Paper, No. 13, Oxford, Global Poverty Research Group, 2005.

⁷² SABIK, M., LINDSAY, R., LIE, K., "Priority setting in health care: Lessons from the experiences of eight countries" *International Journal for Equity in Health*, Vol. 7, No. 4, 2008.

⁷³ FAN, Sh., ZHANG, X., *op. cit.*

expanded and currently it offers a number of services which are categorized as (i) curative/ clinical services, (ii) preventive services (school health, environmental health and sanitation, child immunizations, growth monitoring, HIV counselling, prevention of STI/HIV, epidemics and disaster prevention, nutrition, adolescent counselling), (iii) maternal and child health (maternity services, antenatal care, intermittent presumptive treatment, infant feeding, family planning and prevention of mother to child transmission), (iv) surveillance for special diseases, (v) health education and promotion and (vi) in-patient services and rehabilitation services. The local health department also carries out outreach services and support and management functions.

Mbarara has 53 functioning health units, of which a majority are operated by the local government and others by private or non-governmental organizations. They include four hospitals, four sub county health centres level IV which are planned to offer obstetric care, in-patient services and minor surgeries, 13 level III health centres which offers out-patient care services and in-patient for normal delivery and 29 centres at level II to offer out-patient care.

While education, water and sanitation are important, household (maternal and child) health status have remained both a necessary condition and a prerequisite for development.⁷⁴ In Uganda ill health continues to be named as a cause of poverty more than others⁷⁵. For nearly two-thirds of the households in the Central and Western regions of Uganda who descended into poverty over the past 25 years this was primarily due to ill health and health related costs.⁷⁶

In spite of the significance of health for Uganda's economic development, improvement still remains a challenge. In the 1995/96 the burden of disease (BOD) study using the discounted life years (DLYs) measure found that three quarters of all DLYs of the country are due to preventable diseases with five of them accounting for approximately 60% of the total burden⁷⁷. In our study area of rural Mbarara, only four diseases share 90% of the burden; malaria accounts for 53.2%, respiratory tract infections 22.7%, AIDS/HIV 10% and urinary track infections 5.1%.⁷⁸ In general, the 1990's registered poor health indicators, such as the decrease of all vaccination rates of children below

⁷⁴ WORLD BANK, "Improving health outcomes for the poor in Uganda", Human Development Sector, Africa Region 2005.

⁷⁵ YATES, R., TASHOBYA, C. K., OLIVEIRA, V., McPAKE, B., SSENGOOBA, F., MURINDWA, G., LOCHORO, P., BATARINGAYA, J., NAZERALI, H., OMASWA, F., "The Ugandan health system reforms: miracle or mirage", in TASHOBYA *et al.*, *op. cit.*

⁷⁶ KRISHNA, A. *et al.*, "For reducing poverty faster...", *op. cit.*

⁷⁷ Prenatal and maternity related conditions 20.4%, malaria 15.4%, acute lower respiratory tract infections 10.5%, AIDS 9.1%, diarrhoea 8.4%. JEPPSON, A., OKUONZI, S. A., OSTERGREN, P.-O., HAGSTORM, B., "Using burden of disease/cost effectiveness as an instrument for district health planning: experience from Uganda", *Health Policy*, Vol. 70, No. 3, 2004, pp. 261-270.

⁷⁸ DISTRICT RECORDS OFFICE, "Mbarara District burden of disease", Mbarara, District Records Office, 2008.

five.⁷⁹ This situation prompted the government of Uganda and development partners to embark on improving health systems performance⁸⁰. As a result a process of preparing a National Health Policy and a Health Sector Strategic Plan was initiated.

The plans focus on reducing child and maternal mortality, including the provision of emergency obstetrics care closer to rural women and further development of prevention, treatment services for malaria and HIV/AIDS and the respective utilizations of financial resources for the sector.⁸¹ According to the 2010 Human Development Report, Uganda has one of the world highest maternal and child mortality rates: 550/10000 and infant and under five mortality rates at 85 and 135 per 1000 live births respectively.⁸² The most important contributor to these high rates seems to be a combination of poverty and insufficient health practices as unskilled birth attendance, child malnutrition and poor hygiene⁸³. Child and maternal mortality rates remain higher in rural than in urban areas. For example the 2006 UDHS reports the total child mortality rate discrepancy of 68 for urban and 88 for rural areas per 1000 live births⁸⁴. The changes are operationalized in the health sector strategic plans 2000/1, 2004/5, 2009/10 and the Poverty Eradication Plan (PEAP) with the overall objective of delivering the Uganda Minimum Health Care Package (UMHCP) to all households⁸⁵. The UMHCP is categorized in preventive, curative, clinical and population based health services. The use of preventive services - immunization, antenatal and delivery cares, contraceptive services, voluntary counselling and testing for HIV/AIDS improved after the abolition of user fees in March 2001. However, utilization is still low among rural dwellers and poor socioeconomic groups⁸⁶.

The package targets the most common diseases using cost effective interventions designed to shift spending towards areas of greatest effectiveness. These include: increasing resource allocation for primary health care, abolition of users' fees in public facilities, expansion of rural lower health facilities, provision of subsidies for the private not for profit subsector, introduction of

⁷⁹ ANDERSON, E., "Growth incidence analysis for non-income welfare indicators: evidence from Ghana and Uganda", Background paper for the Chronic Poverty Report 2008-09, Manchester, Chronic Poverty Research Centre, 2008.

⁸⁰ YATES, R. *et al.*, *op. cit.*

⁸¹ BYARUHANGA, C., *op. cit.*

⁸² www.undp.org.

⁸³ SSENGOOBA, F., NEEMA, S., MBONYE, A., SENTUBWE, O., ONAMA, V., "Maternal Health Review Uganda", Kampala, Makerere University Institute of Public Health, Health Systems Development Programme, 2004.

⁸⁴ UGANDA BUREAU OF STATISTICS, *op. cit.*

⁸⁵ MUHWEZI, J., "Health Policy Statement 2005/2006", Ministry of Health, The Republic of Uganda, 2005.

⁸⁶ DEININGER, K., MPUGA, P., *op. cit.*, p. 18.

health subdistrict structure, recruitment of qualified health workers and increase in the volume of essential drugs purchased for health centres⁸⁷.

The challenge remains that infant and maternal mortality rates have internationally remained highest for Uganda and did not improve in the period of the 2000s⁸⁸. According to the 2006 UDHS, women start antenatal care relatively late. Only 47% of women had 4 or more antenatal care visits with the first one at 5.5 months. Delivery at health facility only rose from 37% in 2000/01 to 42% in 2006. In this year almost 50% of the deliveries are by traditional birth attendants and relatives and 10% without any assistance. Hardly 46% of children aged between 12 to 13 months are fully immunised⁸⁹. Much of the discussions about health improvement, inequality and poverty reduction still lack localized research and examples to understand the dynamics that may improve the situation. A methodological framework as outlined in figure 2 is needed with a complete identification of the main mechanisms that may lead to vicious or virtuous health-wealth cycles. While local health policies and core interventions could be seen as an attempt to deal with factors that may affect the demand for health care by the most disadvantaged rural poor, the factors embedded in the household, especially the social and cultural ones, are rarely dealt with. Nevertheless, the household is still the primary unit of health promotion and production and concentrating on national and community levels alone does not result in a functioning health system that balances inadequacies in the demand and supply of health services. For these reasons, we have discussed an initial framework on socio-economic and cultural factors, which could enhance the demand and utilisation of health services that may improve rural households' health and productivity.

7. CONCLUDING REMARKS

The persistence of a health poverty trap for one out of every ten rural households in Uganda or more, depends on economic and non-economic national, community and intra-household variables and relationships. In this paper we have concentrated on the non-economic ones, paying special attention to intra-household relationships, which in rural Uganda also may relate to socially stigmatized health practices. Present research and policies are very much oriented towards the improvement of the supply of health services. However, the household remains the primary unit of health promotion and production in most rural communities and therefore effective research on the

⁸⁷ PARKHURST, J. O., PENN-KEKANA, L., BLAAUW, D., BALABANOVA, D., DANISHEVSKI, K., RHAMAN, S. A., ONAMA, V., SSENGOOBA, F., "Health systems factors influencing maternal health services: a four-country comparison", *Health Policy*, No. 73, 2005, pp. 127-138; GWATKIN, D. R., "10 best resources on health equity", *Health Policy and Planning*, No. 22, 2007, pp. 348-51.

⁸⁸ OKUONZI, S. A., "Learning from failed health reform in Uganda", *BMJ*, Vol. 329, No. 7475, 2004, p. 1173-75.

⁸⁹ UGANDA BUREAU OF STATISTICS, *op. cit.*

effects of social and cultural factors on health demand has to be drawn at the household level. Many studies about Uganda and other countries have made clear that households are not homogenous and show considerable differentiation in decision-making of the members. Policies and strategies to influence intra-household norms and value changes are more than needed and should be explicitly considered in poverty reduction and health promotion agendas of rural communities.

Poverty reduction and health promotion interventions, in the socio-cultural sphere should focus on long-term results. The elimination of underlying barriers related to the gendered division of labour and the social hierarchy at the household level, could improve maternal and child health and may become the breakthrough of a health poverty trap. Poor nutrition and hygiene, alcoholism, relations between spouses and exclusions are additional barriers identified and have appeared in studies of Uganda and other developing countries. Partly due to the predominance of income measures at the national and community levels, poverty reduction interventions are constrained by expectations to produce short-term results. However, only a long-term socioeconomic and cultural perspective on pro-poor health policies is realistic to reach a higher sustainable level of welfare for the poorest rural groups. Only then will the poor and marginalized be able to take responsibility for their lives and contribute actively to interventions that are effective in improving their livelihoods.

Another conclusion is that a breakthrough of the health poverty trap by non-monetary intra-household measures should not be seen as an alternative, but as rather a complementary effort to monetary interventions at community and national levels. Non-monetary factors will help in analysing poverty reduction interventions, which have been constrained by micro level social and cultural barriers. To define, measure and investigate the non-monetary determinants of escaping poverty by most rural populations require the identification of variables and relationships that are associated with social elements of poverty. The present article attempts to contribute to this need and the raised questions are hoped to be addressed by ongoing research in this area.

Mbarara/Tilburg, April 2011