

La santé des femmes vivant en région rurale en Ouganda : problèmes, mécanismes d'adaptation et recommandations

William Rutakumwa et Naomi Krogman

Basée sur 63 entrevues semi-structurées, cette étude fait état des problèmes de santé et des mécanismes d'adaptation des femmes vivant en région rurale dans le centre de l'Ouganda et présente des recommandations concernant les services de santé. Les infections transmissibles sexuellement, en particulier la syphilis, les douleurs abdominales, les lésions génitales et la tension mentale comptent parmi les problèmes les plus souvent cités. Les répondantes ont relevé plusieurs obstacles à l'accès aux soins de santé, dont l'inaccessibilité des services de santé, le manque de temps et d'argent et l'obligation d'obtenir la permission des hommes pour sortir de la maison. Face à ces problèmes, elles font appel à différentes stratégies d'adaptation : ignorer le problème; se soigner elles-mêmes; faire appel aux herbes médicinales et à la médecine traditionnelle; recourir en cachette aux services de planification familiale. Parmi les besoins relevés par les répondantes, soulignons la présence de laboratoires médicaux de services de planification familiale, de services prénatals, de protection de la maternité et gynécologiques et de services de consultation en matière de santé. Les auteurs formulent des recommandations concernant l'éducation sur la santé s'adressant aux deux sexes, en particulier aux hommes en ce qui concerne la planification familiale.

Mots clés : santé des femmes vivant en région rurale, mécanismes d'adaptation, médecine traditionnelle, accès aux soins de santé, Ouganda

Women's Health in Rural Uganda: Problems, Coping Strategies, and Recommendations for Change

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This study draws upon 63 semi-structured interviews with rural women in central Uganda to elicit women's health problems, coping mechanisms, and recommendations for improved health services. The health problems most commonly reported by the women were sexually transmitted diseases, especially syphilis, abdominal pain, genital sores, and mental stress. Women indicated several barriers to obtaining health care, such as inaccessibility to health-care facilities, lack of time and money, and dependence on men for permission to leave the home. In response, they had devised several coping strategies for addressing their health problems, including ignoring the problem, self-care/medication, use of herbal/traditional medicine, and secret use of family planning services. The women indicated a need for medical laboratory services; family planning services; antenatal, maternity, and gynaecological services; and health counselling. They recommended health education for both genders, particularly for men regarding family planning.

Keywords: Health of rural African women, coping strategies, traditional medicine, access to health care, Uganda, developing country, gender

Introduction

While the study of gender and health and community-based health care have been receiving attention since the 1970s, few studies have critically addressed women's health-care needs, coping strategies, and recommendations for change in rural Uganda (Uganda Bureau of Statistics [UBS] & ORC Macro, 2001). Limited access to health care in rural areas (UBS & ORC Macro) and a 3.3% natural population growth rate in Uganda (UBS, 2005) make it all the more important that the limited health services that are provided be suited to and effective for the rural population. Numerous studies report that rural women in Africa are underserved by health services (Okojie, 1994) and use other strategies to attend to their health-care needs (Whyte, 2001). This article provides (a) a general overview of the reported health problems and need for health services among women at two study sites in a rural district of central Uganda, (b) women's coping strategies at these sites in the absence of accessible and affordable health care, and (c) strategies to improve service delivery and women's health in rural Uganda.

The first author (WR), a Ugandan, had worked with rural women in Uganda for 4 years prior to undertaking this study. The inspiration for the study was his experience working with rural Ugandan women on income-generation projects and woodlot programs while employed by the Environment Conservation and Community Development Organisation and hearing women express their health-care needs in casual conversation. He also had contact with people working with the study population; this enabled the investigators to gain easy access to and acceptance by the study population.

Literature Review

In the early 1970s “Uganda enjoyed a level of health services far superior to many other developing countries” (Scheyer & Dunlop, 1985, pp. 28–29). Free health services were provided by the government in hospitals, health centres, dispensaries, sub-dispensaries, maternity centres, and first-aid posts. Complementary services were provided by Catholic and Protestant medical bureaus as well as by private practitioners. However, a history of political instability in Uganda served to reverse this situation. The health-care infrastructure was destroyed (Dodge & Wiebe, 1985; Neema, 1999) and the government’s health-care expenditures dwindled due to increased military spending. The mid-1980s saw a deterioration of services in developing countries (Golladay, 1984; Neema), and Uganda was no exception.

Because of the unequal access to services, Ugandan rural women were hit hard by the situation. Common health issues among these women include early childbearing and close birth spacing (Okojie, 1994) and high fertility (United Nations Development Programme [UNDP], 1997; World Health Organization [WHO], 1999). Yet in the period 1990 to 1996 only 38% of births in Uganda were attended by trained health personnel and the maternal mortality rate in 1990 was 1,200 per 100,000 live births (UNDP, 1997), which is high by international standards (Okojie). Family planning services were poorly designed (Dixon-Mueller, 1994) and inadequate (Okojie), which likely contributed to the average annual population growth rate of 3.3% between 1991 and 2002 (UBS, 2005). A number of researchers have reported a high rate of sexually transmitted diseases (STDs), including AIDS (MacMillan & Ndegwa, 1996; Okojie; Turshen, 1991), while cervical and breast cancers have been at the top of all cancers that affect women in developing countries (Okojie). Women have also reportedly experienced nutritional morbidity (Okojie; Poostchi, 1986; Raikes, 1989) and physical stress (Raikes; Smyke, 1991; Turshen). Violence against women has also resulted in poor health (Gerbert et al., 1996; Smyke). In a study published in 1991, 46% of

women interviewed in Uganda's capital city, Kampala, reported having been abused by their spouses (Heise, Alanagh, Watts, & Zwi, 1994). In general, rural health services have not addressed the key health problems that women are likely to face (Muecke, 1996). The ministry of health has attempted to improve family planning and maternity services by training rural health-care providers to use its *Procedure Manual for Family Planning and Maternal Health Service Delivery* (Ministry of Health & Program for International Training in Health, 1995), but the availability and use of this manual have not been monitored.

Research on women's health has tended to concentrate on women's reproductive functions to the detriment of their productive functions (AbouZahr, Vlassoff, & Kumar, 1996; Eide & Steady, 1980). Moreover, women's health research rarely focuses on aspects other than family planning (AbouZahr et al.). With regard to service provision, the norm worldwide is to provide health care without taking gender into account, yet health care is experienced differently by women and men (Muecke, 1996). When those who design women's health services are insensitive to gender issues in rural health, those services either are not sought by or are inaccessible to women (Muecke).

We define rural areas as those where agricultural activities are the main source of income and where residents are at least 30 kilometres from a major urban centre. The health-care experiences of rural women are very different from those of urban women (Magadi & Curtis, 2003; McCray, 2004). Good health-care facilities are difficult to access as they are usually distant and involve travel costs (Sengooba, 2004). Travel time and costs are a particular hindrance for rural African women, whose workload has increased in the wake of the HIV/AIDS pandemic because they have taken on the responsibility of caring for sick and dying relatives (Collins & Rau, 2000). Additionally, the women's caregiving time detracts from their time for income generation, making it harder for them to afford travel costs.

In order to provide services that are relevant to women's health-care needs, one must first ask the question: What are women's health problems and needs? Since this question has traditionally been addressed to providers rather than recipients of health care, a study of recipients' perceptions is timely. A holistic approach can result in a better understanding of women's health and in the development of health-care policies that are more effective in addressing women's health-care needs. This study sought to narrow the research gaps by redirecting research attention from health-care providers to recipients, in this case rural women.

The study elicited the women's perspectives on their own health problems and how they addressed them, as well as their recommendations

for improving services to suit their health needs. Recent health research has focused on the social determinants of health or on contextual factors, such as the physical environment, social support, social and economic class, education, employment opportunities, and control over one's life choices, as key influences in individuals' health outcomes (Dixon & Welch, 2000; House, 2001; Marmot & Wilkinson, 1999; Ross, 2002; Wilken & Furlong, 2002; Wilkinson, 2000, 2005). Many of these factors can be studied using conventional statistics. For variables such as income, education, and income disparity, however, sociocultural factors are better understood using qualitative approaches with individuals who can describe their personal context as it relates to their overall health. The need for this research is all the more dire in rural Africa, where health outcomes are poorer than in most other parts of the world and life chances are heavily mediated through one's gender (Holmes, 2002; UNFPA, 2000) and cultural belief systems (Annan-Yao, undated; Holmes; Izugbara & Ukwai, 2004).

The Study

Setting

Uganda is located in the eastern part of Africa. It shares borders with Sudan in the north, Tanzania in the south, the Democratic Republic of Congo in the west, and Kenya in the east. Its population in 2002, according to the census, was 24.7 million, of whom 12.6 million were female and 12.1 million male. The majority of the population, 88%, lived in rural areas (UBS, 2004). Of the 5.1 million households in the country, 3.5 million depended mainly on subsistence farming and 1.18 million were headed by females (UBS, 2005). The same census report reveals female and male literacy rates of 61% and 76%, respectively (UBS, 2005). The per capita GDP for 2001 was US\$1,490 (UNDP, 2003).

At the time of data collection (1999), our two study sites, Kasokwe and Kasana, were in the same district, Mukono District in central Uganda, with an area of 14,242 square kilometres.¹ The two communities are similar in size and in composition of livelihoods, but Kasokwe is more ethnically diverse. Kasokwe comprises the Baganda, Banyankore, and Rwandese tribes, whereas Kasana comprises mostly the Baganda tribe. Also, Kasokwe includes fishing as part of its economic activities, along with the crop and livestock production that is prevalent in both communities. Luganda is the major dialect of the Bantu language at the

¹ At the time of the study, in 1999, before a new district was carved out of it, Mukono District had six counties: Bbale, Buikwe, Buvuma Island, Nakifuma, Ntenjeru, and Mukono (Rwabwogo, 1998). In the year 2000, one of the data-collection sites, Kasokwe, became part of the new district of Kayunga (UBS, 2002).

Kasokwe study site, as evidenced by the fact that it was preferred by all of the interviewees.

Mukono District lies between 1,158 and 1,219 metres above sea level. It usually experiences high temperatures and heavy rains in April/May and October/November. The participants in the study reported abnormally dry conditions in the late 1990s, with a negative impact on agricultural production. About 9% of the total area of Mukono District, 123,820 hectares, is covered by forest.

Agriculture is the main economic activity. Food crops include cassava, sweet potatoes, beans, maize, finger millet, ground nuts, soy beans, bananas, sorghum, simsim, cowpeas, pigeon peas, and yams. Cash crops include cotton, coffee, sugar-cane, and tea. Fruits and vegetables grown include tomatoes, onions, pineapples, vanilla, passion fruit, and cabbage. Dairy farming is also carried out, with an estimated 81,294 head of cattle in the district. According to WR's personal observations, the majority of women are involved in agricultural activities.

In addition to agricultural pursuits, the people of Kasokwe engage in fishing on Lake Victoria. There is also some industrial activity in the district, such as the processing of coffee, sugar, and tea. Manufacturing companies include Nyanza Textile Industries, Lugazi Sugar Works, and Nile Breweries. Other industrial activities include grain milling, furniture making, metal works, and animal feed manufacturing. We were unable to access information on gender distribution in formal and informal labour.

At the time of data collection, Mukono District had four hospitals, located in Kawolo, Nagalama, Nkokonjeru, and Kayunga. The Kayunga hospital was the largest. According to the study participants, the Nagalama and Kayunga hospitals were relatively accessible to the population at the two sites. Other health facilities included health centres, dispensaries, clinics, and first-aid posts. Much of the district's road network consists of unpaved roads and rural communities are not adequately served by public transportation. This situation contributes to the lack of access to health-care facilities. Mukona District is typical of rural Uganda in that agriculture is the main economic activity and access to health care is minimal.

Design

We used a qualitative research design to identify rural women's health problems, coping strategies, and recommendations for change. Given that the literature in this area is weak and it would be premature to develop categories of health problems, coping strategies, and recommendations for close-ended survey questions, our goal was to interview a random sample of rural women at two sites until we reached saturation of the response categories.

The study comprised 63 semi-structured interviews conducted at two central Ugandan study sites in January–April 1999. We used mostly open-ended questions, to elicit broader reflection on the context in which women experience health-care needs (Murphy & Dingwall, 2003; Ulin, Robinson, & Toley, 2005) (see Figure 1). This article summarizes the responses to key open-ended questions about health-care needs and the unexpected findings with regard to the women’s coping strategies in the face of inadequate health services.

Figure 1 Interview Guiding Questions

1. What are the general issues/problems, if any, that trouble you in your daily life?
2. What are the health problems you usually experience in your daily life?
3. Have you always sought health care when you have a health problem? If not, what are those health problems for which you have sought prompt health care?
4. What are those health problems for which you usually do not seek (prompt) health care? Why do you not (promptly) seek health care in these cases?
5. How far are the nearest health services from your home? Are you able to obtain health care during the hours the health-care facility is open? How long do you generally wait to visit a health-care provider? What might prevent you from using the health services in your area when you feel you really should seek medical attention?
6. Were you satisfied with your last visit to a health-care clinic? Did the health-care provider request that you return for follow-up on the health problem for which the visit was made? Were you satisfied with the treatment and advice of the health-care provider? If medication was recommended, were you able to obtain the medication?
7. In general, do you have a preference for female or male health-care providers? Are there specific health problems for which you prefer specifically a female or male health-care provider?
8. Do you practise family planning? If no, why? If yes, what type of services do you get from the FP clinic (including counselling)?
Were you asked by the provider:
 - (a) if you have had a recent delivery or abortion?
 - (b) if you have had over four pregnancies?
 - (c) if you are 35 years of age?
 - (d) if you are under 20 years of age (regardless of marital status)?

- (e) if you have any medical conditions likely to endanger the mother's life during pregnancy, childbirth, and immediately after — e.g., diabetes or heart disease?
 - (f) if you have HIV and/or AIDS?
 - (g) if you have had children within a birth interval of less than two years?
 - (h) if you have had a bad obstetric history that is likely to recur with future pregnancies, such as postpartum hemorrhage or preeclampsia?
9. Have you ever suffered from an STD? If yes, which was that? Were you tested/diagnosed? If you had treatment, did you go for post-test? If you did not go for a check-up, how did you establish the type of STD?
 10. Have you heard about cancers of the breast and cervix? If yes, have you ever taken tests for any of the above cancers? If yes, where? If no, why?
 11. Have you ever been physically assaulted by your spouse? If yes, how often?
 12. Do you have Community Health Workers in this area? If yes, what do they do? Are you satisfied with what they are doing? What would you like them to do?
 13. Reflecting on your past experiences with the health services in your village/area, what are your recommendations for improving the services that are available to you? What changes would you like to see?

Sampling

By working with the local council, WR was able to obtain a list of all the women in each village. We are confident that the lists were complete given that local councils normally maintain lists of all residents in their area of jurisdiction. By law, local councils must include a member who represents the interests of the women in the community. Because of her frequent contact with the local women, this representative is aware of the demographic distribution of the women in her village. WR selected the participants randomly from a basket of numbers corresponding to the names on the council's list. The selected women were subsequently asked by the local council representative and WR to participate in a semi-structured interview. To be included in the sample, the women had to be at least 15 years of age and to have accessed local health services for themselves or a family member. In rural areas, young women of 15 are considered mature enough to assume adult responsibilities, including responsibility for their own health. Most 15-year-old females are married or are

single mothers. Young women still living under parental control (unmarried and living at home) were excluded from the study. We suspect that some women in the community did not have access to health services due to physical inaccessibility. The interviews revealed that over 80% of women at the study sites either had no formal education or were primary school (Grades 1 to 7) dropouts. Of the sample, 92% reported being in a spousal relationship, but several of these women said that their spouses were usually away in search of jobs in urban areas. Only a few participants reported being single or widowed. Given 100% agreement to participate in the study, our sample was without replacement. Out of a total of 63 women, 32 were from Kasana and 31 from Kasokwe.

Data Collection

Permission to contact the women was obtained from the local council, which delegated the women's representative on the council to help WR contact those women who had been randomly selected. The pair paid a brief visit to each woman at her home to give her the project information sheet. Most women chose to have the information sheet read to them, which was followed by WR's asking the woman to take part in the study. If the woman indicated interest, WR set up a time for one of the female research assistants to visit for an interview. The researcher explained that his university required him to obtain consent for the interview and that the woman would be asked to sign a consent form. In two cases the woman indicated that she was willing to be interviewed but did not want to sign the consent form. The university human ethics board approved verbal consent in the absence of written consent.

The interviews were conducted by Ugandan female research assistants, fluent in Luganda, college educated, and experienced in social science research. WR held a 2-hour training session with the assistants before the start of data collection. The training entailed a review of ethical issues, with an emphasis on the need for participants' informed consent and their right to withdraw from the study at any time. The training also addressed the assistants' interviewing skills, stressing the importance of tag-and-probe questions. This was reinforced in the field by WR's regular checks on the audiotapes to assess the interviewers' skills in active listening and in posing appropriate tag-and-probe questions. WR's fluency in Luganda enabled him to fully understand the audio-taped dialogue between interviewer and participant, thereby minimizing data loss. At the end of each interview, the participant was paid a small amount of money as compensation for taking time away from her usual chores.

Another source of data was field notes. These included thick description of observations in the community regarding the conditions of health-care delivery, such as the health services available, their quality, and the adequacy and quality of staffing. Field notes also included observations of communication among community residents and reminders to WR to follow up with research assistants on particular matters. While in the field, WR also wrote memos regarding the observations and responses he was noting in the interviews. Memoing also entailed posing tentative reflective questions in a journal format and addressing them in subsequent observations and interviews.

Given the cultural constraints imposed on rural women, the participants were asked to choose the location for the interview. This enabled them to share their experiences with minimum inhibition. All of the interviews were audiotaped and most lasted approximately 45 minutes. Interviewing continued until WR found repeated themes throughout the interviews, suggesting saturation of responses.

Data Analysis

We used the constant comparative method of analysis described by Lincoln and Guba (1995) to develop descriptive categories. The central categories arising from this analysis were: (1) context, conditions, and strategies related to the women's lives; (2) the women's health experiences; (3) the women's experiences with health services; and (4) the women's recommendations for change. Coding was an iterative process during which data from the field were constantly compared to emerging categories. For instance, a statement such as "I need family planning services but do not have the money to visit² the clinic regularly as required by the service providers" was coded in "use of family planning services" as a category. Within each category, or unit of information composed of events, happenings, or instances (Strauss & Corbin, 1990), we identified several "properties" — attributes or characteristics pertaining to a category (Creswell, 1998). Thus, after examining the above statement, we identified three properties: need for family planning services, lack of money, and physical inaccessibility.

The data were closely examined and compared for similarities and differences. The emerging themes determined the information to be sought in the subsequent interviews. After the initial coding process, we carried out axial coding, whereby emerging themes were coded under central categories such as the women's (a) health experiences, (b) expe-

² Several respondents referred to not having the money "to visit" a clinic; they meant not having the money to travel to the clinic, inferring physical distance or, in our coding scheme, physical inaccessibility to the clinic.

riences with health services, and (c) recommendations for changes to the health-care delivery system. Thus, a category such as “use of family planning services” identified during the open coding stage was subsumed as one of the various categories under the new category “experiences with health services.”

Trustworthiness

Sandelowski’s (1986) categorization of trustworthiness includes truth value (credibility), applicability (fittingness), consistency (auditability), and neutrality (confirmability). These categories were considered useful for this study. Credibility was enhanced by the trust that local council members demonstrated to WR in the field, WR’s ability to speak the local language, and WR’s quality checks on the audiotaped interviews, as described above. Fittingness was ensured through the selection of participants who were in an appropriate social location to assess and describe the health services available to Ugandan rural women. Auditability was ensured through comparison of the audiotapes with the written notes of the field assistants to assess the consistency with which they reported participant responses. Confirmability was enhanced through use of the constant comparative method to follow up on unexpected emerging themes (such as the women’s reporting stress as a health issue), and also through a concerted effort by the two principal investigators to share their findings with other experts in the field of international women’s health and to conduct “member checks” with local health-care providers to assess the persuasiveness of our findings. For example, during data collection, after preliminary analysis of the first set of interviews WR presented our preliminary findings to local health-care providers at a government-sponsored workshop on women’s health in rural Uganda. As a result of attending the workshop, WR became more sensitized to the complexities of women’s health, in particular issues around workload and stress, prompting us to explore and probe this topic a bit more in the interviews. Our sharing of findings with decision-makers in the Ugandan ministry of health served to assure us that the conditions in Mukono District were similar to those in other rural regions and permitted discussion of the services that were locally available to the women in a broader, national context.

Limitations

A few select limitations of the study warrant mention. The method of employing research assistants to conduct the interviews could have jeopardized the quality of data collected. In spite of the rigorous training of the assistants, it is possible that the interviews would have been more exhaustive had they been conducted by the principal investigators.

However, this weakness was mitigated by WR's regular perusal of the interview notes and comparison of these with the corresponding recordings. This enabled timely discovery of any issues requiring further probing and discussion with the assistants on how to improve their interviewing skills.

With regard to generalizability, Uganda has more than 50 districts and it is possible that women in the different districts have unique health problems and health-care experiences. However, Mukono District's poor socio-economic and health conditions, as well as its inadequate distribution of health services, are common across all rural districts in the country. Thus, we suspect that the findings can be generalized to some extent to all districts in Uganda.

Results

Perceived Health Problems

The participants reported a range of health problems. In this article we summarize those that they considered important. Syphilis was the most frequently reported problem. Almost one in every two participants reported that they were suffering from this disease or had suffered from it and were not sure whether they had completely recovered given their lack of access to laboratory testing. Second on the list was abdominal pain, which was reported by approximately one in every four participants. This was followed by genital itching or sores, which was reported by approximately one in every five. Thus, the top three health problems were all related to reproductive health.

Other frequently reported ailments were malaria/fever, headache, respiratory problems, recurrent body weakness, heart problems, and gonorrhoea. In addition, participants reported cervical pain and breast lumps, often symptomatic of cervical or breast cancer. At the bottom of the list were ear conditions, asthma, and kidney problems. Besides those health problems reported directly by the participants, we were able to infer others based on their accounts. One such problem was mental stress. The prevalence of this problem appeared to be significant, as indicated by the frequency with which women alluded to it:

My husband does not care for me at all. I take care of all the children's [needs]... I'm so disgusted with childbearing... That is why I decided to go for family planning. Besides, I have to walk a long distance to collect water, there is no money to buy food...I have no peace with my husband and myself.

Our understanding of this woman's comment with respect to "no peace with my husband" was that she was resentful of her disproportionate

workload and her husband's lack of responsibility regarding household labour and use of birth control.

Services that were reported as most needed by the women included medical laboratory services; family planning; antenatal, maternity, and gynaecological services; and health counselling. The women also wanted to have health education for both genders, particularly for men with regard to family planning. Such services have traditionally focused on women and have been disproportionately concentrated in urban parts of Africa where there is relatively easy access to radio, television, and other media.

Coping Strategies

Given the inaccessibility of health services, rural women have developed coping strategies to address their health problems. Our data suggest that these coping strategies are inadequate, as the participants reported a wide range of ailments. Their coping strategies included ignoring the sickness, self-medication, use of herbal/traditional medicine, and secret use of family planning services.

The women tended to ignore their sickness because they lacked both the support of their husbands and the time needed to address the problem. Many women reported that they felt they were expected to seek permission from their husbands to obtain health care, which is consistent with the cultural expectation that husbands know the whereabouts of their family. Some women also reported that their husbands resented the cost of health care for chronic problems such as abdominal pain. Participants additionally reported that they ignored illness because of a lack of money and the distance of health services from their homes. Many said that they often ignored their ailments in the hope that they would go away on their own. The women added that usually they were forced to seek health care when the condition became serious:

Most times when we are sick we leave the disease to heal by itself through natural ways. Because of the money limitation, I never seek health care until I become extremely sick.

I do not go promptly for health care, because sometimes I think the sickness will go away on its own.

When I develop a health problem, I take about a year before reporting it to a health-care centre, as I have to look for money.

Self-care/medication was another common strategy. The women reported that they frequently self-diagnosed their ailments, sometimes with the help of their spouse, and purchased a drug that they deemed appropriate given their budget. Self-medication was carried out even in

cases where the women suspected STDs or had a complicated problem such as a kidney ailment. They also reported taking Panadol, a painkiller, for a host of health conditions associated with pain:

I suffered from persistent joint pains until my husband bought me medicine for syphilis. Now I'm better.

I usually do self-medication. For example, I have a kidney problem and whenever I feel the pain I buy my own drugs from a drugstore.

Given that some of the symptoms the women experienced were common to a number of health problems, there appears to be a high probability of wrong diagnosis, and thus ineffective treatment when women self-medicate.

The participants indicated that they generally preferred modern medicine for the treatment of health problems. However, when modern medicine appeared to be ineffective, or when the cost was too high, they turned to traditional medicine, and sometimes found this more effective. While some studies have found increased use of the services of traditional healers, the participants in this study did not seek these services but, rather, resorted to their own herbal concoctions to treat their ailments — an illustration of the active role that women play in their own health care. Women reported that they learned how to mix the herbal concoctions from their mother or from an elderly female member of their extended family. A typical example is what is locally known as *amalagala*, a product of crushed sweet-potato leaves mixed with water. This mixture is administered to pregnant women, who bathe in it or sit on it to lessen the risk of requiring a Caesarean section or of vaginal tearing during delivery. The women did not discuss trial and error for this concoction but unanimously reported confidence in its efficacy. Traditional medicine was reported to be used for treating birth complications, pediatric problems, and heart conditions. The views conveyed in the following statements were echoed by several women:

During pregnancy I used to have pain in my abdomen. The medication I was given at the clinic did not help and the problem persisted. I had to resort to traditional medicine, which helped.

Before I stopped producing children, I used to spend sleepless nights trying to comfort my sick babies. This happened to all of my four children. I took them to various hospitals and their health problems persisted. I then resorted to the use of traditional medicine, which helped greatly.

Some participants reported using family planning services secretly because their spouses were strongly opposed to the practice. Several women argued that they already had many children and felt physically

and emotionally weak. The physical weakness was related to workload, particularly around water collection, planting and tilling crops, and food processing and preparation. The emotional weakness refers to the stress of uncertainty, particularly with regard to having enough food for all of the children in times of drought and enough cash to cover the essentials, such as health care when a family member is ill. While men's opposition to their wives' use of family planning services is largely a function of culture, it is exacerbated by several factors, notably the lack of reproductive health education, especially in rural areas. The women suggested that they rarely discussed family planning with their spouses and that it is traditionally the man's role to decide how many children a couple will have. Under these circumstances, women indicated secret use of family planning services:

We are on family planning programs secretly because our spouses won't allow us... Sometimes they [husbands] tell us that the Bible does not sanction the practice...but we seriously need the service.

I joined the family planning program without my husband's knowledge because at one time I delivered twice in a year and I was feeling weak.

Secret use of family planning services by rural women may be considered a remarkable development in light of the fact that Ugandan rural women have traditionally favoured having many children as sources of future labour and security. This change in attitude could be an indicator of the perceived heavy toll of high fertility on women, as illustrated by the following comment:

I wanted to join the family planning program but my husband refused to let me... I now have eight children... I have a painful abdomen. I think it is my uterus.

Recommendations for Change

Based on their experiences, the participants made a number of recommendations for improving their local health services. The women recommended that the ministry of health set up health-education programs, emphasizing that these should be targeted mainly at rural communities. They added that the focus should be on issues of particular concern to women, such as family planning, breast and cervical cancers, and other aspects of reproductive health. The women recommended that family planning education be targeted at rural men since men are a barrier to women's ability to more carefully control when to have children and how many children to have. The following view was echoed by several participants:

Family planning education should be mainly for men, because they are the ones who stop their wives from using the services.

In addition, some women recommended that confidential family planning services be offered in order to serve women whose actions are restricted by their husbands. They also recommended that rural health-care centres be well equipped and be staffed by well-trained resident health-care providers who are available 24 hours a day. They pointed to the need for laboratory and X ray facilities and suggested that required drugs be made available so that women do not have to purchase them on the open market. The participants recommended that health services for women, such as antenatal and maternity services, be extended to rural areas. They also recommended the deployment of more midwives to rural areas. The women proposed that traditional birth attendants undergo more training so that they will be able to carry out minor surgical procedures such as suturing, since birthing often takes place outside of health-care institutions. "I got torn during delivery at home but was never stitched up," said one participant, "and this really bothers me."

In view of the fact that some participants were not aware of the presence of community health workers in their area, the women recommended more deployment and training of community health workers, and more outreach by these workers, in order to reach all women in need of assistance. Most of the participants said they preferred female over male health-care providers because female providers have a better understanding of women's problems, especially with regard to reproductive health.

Discussion and Conclusion

When women in rural Uganda require health care they encounter barriers, such as inaccessibility to health-care facilities, lack of time and money, and dependence on men. They have devised several strategies for coping with a particular health concern, including ignoring it, self-care/medication, use of herbal/traditional medicine, and secret use of family planning services.

However, these coping strategies have not been successful. Women in rural Uganda still report high levels of morbidity. Self-medication has always entailed the risk of wrong diagnosis and treatment, especially in the case of rural women who are in need of health education. The magnitude of this risk is conveyed by Whyte's (2001) finding that 63% of households in eastern Uganda and 83% of those in western Uganda owned a needle and syringe for home use, suggesting that self-medication is commonplace across the country. Indeed wrong diagnosis and treatment may explain the recurrence of syphilis, and possibly the exac-

erbatation of symptoms, as reported by the participants in this study. Even with correct diagnosis, self-medication may lead to under- or overdosing, as the participants lacked the training necessary to determine the right doses for treating their medical conditions. Indeed earlier studies (McCombie, 1996) have reported that underdosing is a common result of self-medication.

The present findings are also consistent with those of other studies conducted in Mukono District in central Uganda (Nakamate et al., 2003) and Kabarole District in western Uganda (Langlois, 2005). In these two studies, respondents were generally found to prefer modern medicine to traditional medicine. However, several respondents in our study reported using traditional methods when they could not afford modern medicine or when they believed it was ineffective. Although herbal or traditional medicine is used widely and is known to be effective in treating a variety of ailments, ranging from malaria (Asase, Oteng-Yeboah, Odamtten, & Simmonds, 2005) to skin disorders (Tadeg, Mohammed, Asres, & Gebre-Mariam, 2005), it may not be effective for more complicated health problems such as STDs or kidney disease. Several women in our study reported going to a health-care facility for diagnosis and treatment but continuing to experience the problem even after repeated visits and treatment. These experiences served to reduce the women's confidence in local health-care providers. Personnel in local facilities need more advanced training in order to diagnose and treat STDs, abdominal pain, genital sores, and mental stress.

The women who secretly accessed family planning services usually bought contraceptive pills at a drugstore without consulting family planning professionals. While they could obtain a prescription for birth control pills at family planning clinics, many women preferred to buy them over-the-counter at a drugstore. Women who obtained birth control pills at a drugstore faced less chance of being seen at a clinic and thus being associated with birth control. In addition, shopping at a drugstore was generally more convenient. In fact, many drugs that are prescription-only in North America are exported to Africa and are readily available over-the-counter in Uganda. Occasionally this situation is detrimental to the woman's health because the birth control pill is inappropriate. For example, researchers have reported that, for some women, use of contraceptive pills and injectable hormonal methods can have negative effects such as menstrual irregularities (Chapman & Gordon, 1999; Khefili, 1997) or infertility (Chapman & Gordon).

The women's recommendations for improved services, including well-equipped and well-staffed rural health centres, health education, and family planning education for rural men, would go a long way towards

addressing the problems and concerns of rural women. These recommendations, especially those concerning staffing, should be considered in the context of current human resource capacity. A World Health Organization report gives a figure of 19 nurses and 14 midwives per 100,000 people in Uganda (WHO, 2001). The shortage of doctors is corroborated by the findings of a 2004 study by Kinengyere (undated), which reports a doctor-to-patient ratio in Uganda of 1:10,000 in urban areas and 1:50,000 in rural areas. The shortage of health-care workers has been a function of poor remuneration, as a significant number of available professionals are reportedly not in active service (Kanyesigye, 2003). The successful implementation of the recommendations of our participants rests partly on the Uganda government's efforts to make the health profession attractive by offering adequate remuneration.

Nurses play a pivotal role in rural health-care facilities in Uganda. Matsiko and Kiwanuka (2003) report that registered nurses and midwives, respectively, are the most common local supervisors of rural health centres in Uganda. Yet the numbers of these health-care workers fall short of required staffing levels. For example, in a study of the treatment of women with obstetric fistula in 23 hospitals around the country, Karugaba (2003) found that the average nurse was expected to care for 70 or more patients, which had a negative effect on the both the quality and the quantity of care provided.

It is our view that the types of interventions recommended by the participants in this study cannot be effective unless they are carefully designed to focus on the problems and concerns of rural women. A carefully designed health education program, for instance, would entail a study of women's coping strategies, as this would inform the health education curriculum for the rural population. Preliminary studies to plan the design of health education programs could identify factors leading to drug resistance associated with self-medication. Future studies could examine the effectiveness of various forms of home remedies and traditional medicine on the key health problems faced by the women and how these interact with access to health services and formal medicine.

We propose that gender-sensitive policy interventions be based not only on the recommendations of rural women but also on their daily coping strategies. More broadly, given that rural women have been shown to play an active rather than passive role in addressing their own health needs, we favour policies that promote and nurture this sense of power and personal responsibility. Such policies would build on rather than disregard the women's indigenous knowledge, paving the way for women to become active participants in the policy interventions that affect them.

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