UGANDA BUREAU OF STATISTICS

HEALTH SECTOR

Gender Statistics Profile

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Health Sector

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Preface

The Management of the Uganda Bureau of Statistics (UBOS) is pleased to present the maiden Gender Statistics Profile for the Health Sector. This report attempts to highlight the existing gender differentials and presents a contemporary overview of gender development issues and concerns in the sector. Gender Profiling for Statistics is part of the various efforts to increase availability of gender responsive data to inform policy and decision making.

The Profile was based on a desk review and in-depth analysis of the Uganda National Household Survey (UNHS) 2009/10 and relevant administrative data from the Ministry of Health. The exercise provided an opportunity for key players to gain practical skills and experience in data presentation. The main objectives of the exercise were to:

1. Establish the level of awareness of gender issues and concerns within the ministry.
2. Generate gender responsive indicators for the Health Sector.
3. Repackage information to enhance availability and use of gender statistics by various stakeholders; and
4. Build skills of the Gender Focal Persons (GFP) to generate gender responsive statistics.

The United Nations Fund for Population Activities (UNFPA) and UN WOMEN are appreciated for providing financial support towards the profiling exercise while the facilitators, reviewers and authors appreciated for the technical contribution.

This document is intended to expand the knowledge base of gender statistics and to inform decision making and policy development in the sector.

Ben Paul Mungyereza

Executive Director

Acknowledgements

The Management and Technical Staff of the Ministry of Health are appreciated for their valuable contribution towards the production of this Gender Statistics Profile for the Sector. These included Ms Carol Kyozira (Principal Bio-Statistician) and Mr Allan Nsubuga (Statistician).

The effort and commitment of the core team that conceptualised, authored, reviewed, and coordinated the entire process cannot be underestimated. The respective teams included Ms Norah Madaya (Director, Statistical Coordination Services), Ms Grace Bulenzi-Gulere (Principal Officer, Statistical Coordination Services), Ms Rose Nalwadda (Gender Advisor), Ms Pamela Nabukhonzo Kakande (Senior Statistician, Social Statistics), Mr Robert Makombe (Statistician) and Mr Allan Nsubuga (Statistician).

The contribution of Mr Steven Mugarura (Gender Statistics Specialist) and Dr David Baguma, Ph.D. towards consolidation of the document is also appreciated. Mr Alfred Geresom Musamali (Senior Officer – Editing) did the final proofreading, for which we are most grateful. The Statisticians, Ms Sharon Apio and Ms Rosette Navugga are recognised for the support services throughout the exercise.

Finally, the UNFPA and UN WOMEN, our development partners, are appreciated for providing the opportunity and support to deliver this assignment.

Without such concerted efforts the exercise would not have yielded a valuable document to contribute to the knowledge base of the diverse material on gender issues and concerns.

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Acronyms

CPR	Contraceptive Prevalence Rate
DHO	District Health Officer
DHIS	District Health Management Information System
DSIP	Development Strategy and Investment Plan 2010/11 – 2014/15
GDD	Gender Disaggregated Data
HMIS	Health Management Information System
HSSIP	Health Sector Strategy Investment Plan
IAEG	Inter Agency on Gender Statistics
ICPD	International Conference on Population and Development
IMR	Infant Mortality Rate
IRC	International Research Centre
JILOS	Justice, Law and Order Sector while the districts include Gulu,
JPGEWE	Joint Programme on Gender Equality and Women's Empowerment
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MFPED	Ministry of Finance, Planning and Economic Development
MGLSD	Ministry of Gender, Labour and Social Development
NMR	Neonatal Mortality Rate
NDP	National Development Plan
NGP	National Gender Policy
NPA	National Planning Authority
NSS	National Statistical System
OBT	Output Budgeting Tool
OPM	Office of the Prime Minister
PEAP	Poverty Eradication Action Plan

TB	Tuberculosis
UBOS	Uganda Bureau of Statistics
UGP	Uganda Gender Policy
UN	United Nations
UNCED	UN Conference on Environment and Development
UN-JGEWE	UN Joint Programme on Gender Equality and Women Empowerment
UPHC	Uganda Population and Housing Census

Executive Summary

Development of the Gender Statistics Profiles is anchored in the Beijing Platform for Action, which underscores the need for gender analysis as one of the critical starting point for Gender Mainstreaming. The main objectives of compiling the Gender Statistics Profile were to establish the level of awareness of gender issues and concerns within the Ministry; Generate gender responsive indicators for the sector; Repackage information to enhance availability and use of gender statistics by various stakeholders and Build skills of the Gender Focal Persons to generate gender responsive statistics. The profile provides a contemporary overview of gender and development concerns; as well as gender differentials in access, participation and use of services in the sectors.

The Gender Statistics Profile for the Health Sector was based on a desk review of relevant literature and in-depth analysis of the Uganda National Household Survey (UNHS) and Uganda Demographic and Health Survey (UDHS) and relevant administrative data from the Ministry of Health.

Delivery of the Uganda National Minimum Health Care Package is central to implementation of the Health Sector Strategic Investment Plan (HSSIP) and the attainment of the sector goals and objectives. The exercise revealed that the Ministry mainstreams gender in its programmes, which is consistent with the overall goal for the Health Sector during HSSIP 2010/11 – 2014/15: "To attain a good standard of health for all people in Uganda in order to promote a healthy and productive life".

The report gives a gender analysis with respect to access, participation and use of the services in the Health Sector. It highlights the following:

i. Gender differentials that exist across all indicators including access to extension services.
ii. Existence of data gaps for both the administrative and household based survey data.
iii. National and global recommendations and conclusions on the status of gender equality in the sector; and
iv. The Possible Action Plan and Next Steps to be undertaken for improving availability of data for gender analysis for the Health Sector.

CHAPTER ONE INTRODUCTION

1.0 Background

The focus on gender for national policy analysis, programme formulation and development has not been adequately supported by gender responsive statistics. Gender Statistics is about identifying, producing, disseminating, and analysing statistics to understand how gender issues affect individuals and society. Gender differences and how they affect the economic and social development of society are also displayed. This cross-cutting dimension of statistics is compiled, analysed and presented by sex, reflecting gender issues in society. Inadequate skills to analyse, interpret and package data are the major factors constraining the availability and use of gender statistics. Development of Gender Statistics Profiles was intended to improve data presentation and impart skills of interpretation and use of Gender Statistics for policy, planning, budgeting and programme implementation by Sectors and Local Governments.

The process was supported by the United Nations Fund for Population Activities (UNFPA) under the UN Joint Programme on Gender Equality and Women Empowerment (UNJP-GEWE). One of the main outcomes was to strengthen government capacity for gender responsive planning, budgeting and programme management. The Uganda Bureau of Statistics (UBOS) was supported to contribute to this outcome by ensuring that the National Statistical System (NSS); collects, analyses and disseminates reliable and up-to-date Gender Disaggregated Data (GDD). Gender Statistics Profiles were compiled for the seven priority sectors under the UNJP-GEWE programme to increase availability and use of gender responsive data. The sectors include Agriculture, Education, Health, Water and Sanitation, Energy, Justice, Law and Order Sector and Local Government.

This Profile was based on a desk review of relevant literature, in-depth analysis of the Uganda National Household Survey (UNHS) and Uganda Demographic and Health Survey (UDHS) and relevant administrative data from the Ministry of Health (MoH).

This Profile provides a contemporary overview of gender and development concern; as well as gender differentials in access to and use of health services.

1.1 Purpose and Objectives

The main objectives of compiling the Gender Statistics Profile were to:

1. Establish the level of awareness of gender issues and concerns within the ministry.
2. Generate gender responsive indicators for the Health Sector.
3. Repackage information to enhance availability and use of gender statistics by various stakeholders; and
4. Build skills of the Gender Focal Persons (GFP) to generate gender responsive statistics.

1.2 Justification

The development of the Profile is anchored in the Beijing Platform for Action (BPfA), which underscores the need for gender analysis as one of the critical starting points for Gender Mainstreaming. Gender Statistics play an important role in revealing gender perspectives that are relevant to policy and programme processes. One of the main constraints faced by the Government in development planning, monitoring and evaluation is the absence of updated gender-responsive data. The data and information collected are dispersed to selected institutions but not widely disseminated. The development of this Gender Statistics Profile relates to the general importance of statistics and presents a unique requirement to promote the availability of gender responsive statistics. Most of the national statistical reports tend to provide aggregate indicators without detailing specificities addressed to gender requirements for development initiatives.

The Gender Profile provides a twofold benefit. To begin with, the sector is given an opportunity to analyse gender issues constraining development in the different socio-economic areas within its mandate and jurisdiction based on the relevant literature. Secondly, it provides one document as a source of gender-related information on energy. This is expected to contribute to Gender Mainstreaming for planning, budgeting and programme implementation processes. The UNJPGE indicator shows an increase in the relative budget expenditure on specific strategies and activities, but the benefits to women and girls tend to be marginalised within the sector. The profile will also to inform the setting of targets and guide the allocation of resources for gender-related activities. This Gender Statistics Profile will contribute to the knowledge and database on gender issues in the sector. It will further enhance technical staff basic knowledge and capacity to incorporate gender dimensions in the plans, budgets and monitoring and evaluation processes. Variations in the concepts and definitions[1] for gender statistics is another constraint affecting availability, comparability and effective use of the statistics. The process of developing the Profile provides information and experience exchange among sectors.

1.3 Approach

The Gender Profiling exercise emphasised improvement in data presentation to cater for the various needs of data users. A desk review and documentation of relevant literature on the Health Sector was carried out. This was followed by an in-depth analysis of data on health extracted from the UNHS and UDHS. This was complemented with an analysis of the administrative data compiled by MoH. Extracts were also derived on the level of gender awareness; status of gender statistics; capacity gaps; and recommendations from Focus Group Discussions constituted in MoH for the exercise. The exercise was designed to provide practical skills and experience of statisticians responsible for surveys and those responsible for

[1] Concepts are terms and names of variables used in statistics and statistics production. The definitions guide the users in interpreting the statistics: what kinds of data are included in the statistics, which phenomena they do describe. A single term can have more than one definition, as the same concept may cover different meanings in different statistics (e.g. turnover, retention).

generating administrative data; and GFP in gender analysis. Experimental learning methodologies were adopted for executing some of the tasks including:

i. Identification and documentation of factors influencing gender inequalities in access and utilisation of resources in the Health Sector.
ii. Establishment of the quality of gender-related data generated through the available survey reports and administrative data in the sector.
iii. Analysis of the existing data and establishment of the patterns and trends of gender issues and concerns addressed.
iv. Identification of gender data gaps in the survey reports and administrative data.
v. Development of the sector action plan and further steps for advancing gender statistics within the sector.

The interaction among sectors during the compilation of the Profiles also facilitated harmonisation of the metadata for indicators generated by different sectors on similar issues. The forum provided stakeholders an opportunity to develop a roadmap for addressing data gaps. Overall, the profiling exercise greatly influenced the methodology and approach adopted in development of this Profile.

CHAPTER TWO MANDATE

2.0 Overview

This chapter presents the mandate of the Health Sector for national development as expressed in the National Development Plan (NDP) 2010/11 to 2014/15 as well as the Health Sector Strategic and Investment Plan (HSSIP) 2010/11 – 2014/15.

The NDP 2010/11 – 2014/15, is the overarching national policy and strategic framework governing the development of Health Sector in Uganda. The NDP is being implemented through a Sector-wide Approach to Planning (SWAP), which addresses the Health Sector as a whole in planning and management, resource mobilisation and allocation.

2.1 Role and main functions of the Ministry

Uganda developed a HSSIP for the period 2010/11 – 2014/15 "To attain a good standard of health for all people in Uganda and promote a healthy and productive life". To achieve this goal, the Health Sector focuses on achieving universal coverage with quality health, and health related services through addressing the following strategic objectives:

1. Scale up critical interventions for health and health related services, with emphasis on vulnerable populations.
2. Improve the levels and equity in access and demand to defined services needed for health.
3. Accelerate quality and safety improvements for health and health services through implementation of identified interventions.
4. Improve resource management and ensure efficient and effective service delivery in the sector.

5. Strengthen stewardship of the health agenda supporting the MoH activities.

CHAPTER THREE GENDER ENVIRONMENT

3.0 Background

The guiding principle of the National Health Policy and the HSSP is achieving a gender-sensitive and responsive national health delivery system and attempting to strengthen mainstreaming gender in planning and implementation all health programs. There are several programmes in the Health Sector that are geared towards mainstreaming gender.

Gender-based violence is one of the elements in the cluster on prevention and control of non-communicable diseases/conditions with the main objective as prevention of morbidity and mortality due to gender based violence.

3.1 Institutional Framework

Human rights and Gender Mainstreaming is an element of the maternal and child health cluster that aims at preventing morbidity and mortality linked to human rights violations and gender inequalities. The core indicators therefore are as follows:

i. An integrated strategy to address Sex Gender Based Violence (SGBV) in the Health Sector developed and disseminated.
ii. Health service provision for survivors of rape scaled up in all district hospitals and of Health Center IIIs.
iii. PEP Kits available in all district hospitals and 50 percent of HC IIIs.
iv. Health workers trained in clinical management of survivors of rape increased to 25% by 2015.

The Human Rights and Gender Team did not have an action plan for 2010 / 2011. Only recently did the MoH designate any Gender Desk Officer and the following are the achievements attributed to this:

i. Development of an action plan for mainstreaming Human Rights and Gender.
ii. Development of a trainers' manual for mainstreaming human rights and gender concerns in health programmes.
iii. Several trainings on Sexual and Gender Based Violence (SGBV).
iv. Several inter-sectoral meetings with stakeholders from Ministries of Gender, Labour and Social Development (MGLSD), Internal Affairs (MoIA) and Justice and Constitutional Affairs (MoJCA) to streamline issues related to filling in of the Police Form 3 in case of rape. There have been major positive achievements with clinical officers and midwives now being recognised as eligible health workers to fill the form and testify in court. The Police Form has now been separated into the PFA for General Assault and PF3B for Victims of Sexual Violence. Pictograms have been introduced and mandatory testing of HIV for offenders of sexual violence.

- Development and dissemination of an integrated strategy to address SGBV in the Health Sector.
- Training of 60 health workers in management of survivors of SGBV in Yumbe and Oyam.
- Training of health workers in SGBV Management.
- Development and dissemination of the Information Package for prevention of SGBV for Community leaders .
- Development of Supervision and Monitoring Guidelines for SGBV.

The MoH has taken strides in Gender Mainstreaming in the FY 2011/12 as evidenced in some of the main achievements:

i. Finalised a national human rights and Gender Mainstreaming trainer's manual for health professionals, community workers, leaders and policy makers.

ii. Conducted consultative visits to 5 regions (Moroto, Lira, Mbarara, Gulu, and Mas aka) with support from MGLSD/UNFPA.
iii. Developed implementation guidelines for both private and public GBV safety centr es in those 5 regions with support from MGLSD/UNFPA.
iv. Health workers trained in Management of survivors of Rape.
v. 5 Hospitals have been oriented and supported to serve as one stop centres for Management of SGBV (Gulu, Lira, Moroto, Mbarara and Masaka).
vi. Contributed to the production of the annual Uganda Human Rights Report 2011 c hapter on health.
vii. Held a sensitisation meeting for Senior Management on the HHR/G.
viii. The mother child health passport, a mother held record of health events, services acces sed and education messages was developed and officially launched by the Presid ent of Uganda and introduced in 8 out of the planned 15 districts.
ix. Accessibility to appropriate and gender sensitive nutrition information and knowled ge increased.

The MoH has made deliberate efforts to streamline health and gender by establishing a gender desk and assigned officers (from the Planning Division and Reproductive Health Division). Implementation of some activities has commenced. Further implementation of the action plan will continue in the next financial years.

In the light of all these achievements, it is important to note that the HMIS source documents i.e. the registers, distribution lists etc. used in the collection of primary client information at the facilities and in the community have age and gender columns which enable transcription of gender information into the HMIS reports such as the monthly, quarterly and annual reports that have selected data variables disaggregated by age & sex, hence making the gender

environment in the Health Sector good enough for promoting further gender analysis thus the ability to inform policy decisions from a gender perspective.

CHAPTER FOUR GENDER ANALYSIS

4.0 Introduction

This chapter deals with gender analysis in terms of access, participation and use of the services in the Health Sector.

Studies have shown that gender plays an important role in health care seeking behaviour. In most cases married women may not make decisions on their own regarding how resources in the home should be spent. The UDHS 2011 shows that about half of the women mainly decide by themselves how their earnings are to be spent, 32 percent report that they make the decision jointly with their spouse, while 13 percent report that the decisions are mainly made by the husband or partner. There are variations in the proportion of women who make independent decisions about their earnings ranging from 24 percent in Eastern region to 79 percent in Kampala. This shows that women in urban areas are more likely to make independent decisions compared to those in rural areas.

Decision making is an important determinant of health care seeking behaviour, especially in contexts where decisions are made by men. This may delay seeking appropriate health care. Existing social relations of gender that structure women as providers of reproductive labour also affect the girls who are socialised as apprentices of their mothers so that they can play similar roles in future.

4.1 Access, Participation and Use

4.1.1 Health facility Coverage

Health care access in Uganda is through Government, Private Not for Profit and Private for Profit health facilities. There are 5,229 such health facilities across the country, of which 5,029 are said to be functional at the time of the 2012 Health Infrastructure Readiness Assessment exercise. The table below shows the distribution of health facilities by level and ownership.

Table 4.1: Distribution of health facilities by level and ownership

Health Facility	2010				2012			
Level	GOVT	PNFP	PFP	Total	GOVT	PNFP	PFP	Total
Hospital	65	57	9	131	64	65	23	152
Health Centre IV	165	12	1	178	170	15	8	193
Health Centre III	847	243	26	1116	937	272	70	1279
Health Centre II	1578	489	958	3025	1696	522	1387	3605
Total	**2655**	**801**	**994**	**4450**	**2867**	**874**	**1488**	**5229**

Source: Ministry of Health (HMIS) 2012

4.1.2 Health Services Coverage

There are eight health service coverage indicators used to measure the sector's progress towards NDP, out of the total twenty six core indicators identified by the MoH to monitor progress in implementation of the HSSIP 2010/11 – 2014/15. The table summarises the performance in the First Year of the NDP and the HSSIP 2010 – 2014/15 for the NDP indicators.

Table 4.2: Performance against the 8 NDP indicators for the HSSIP 2010/11 -2014/15 Period

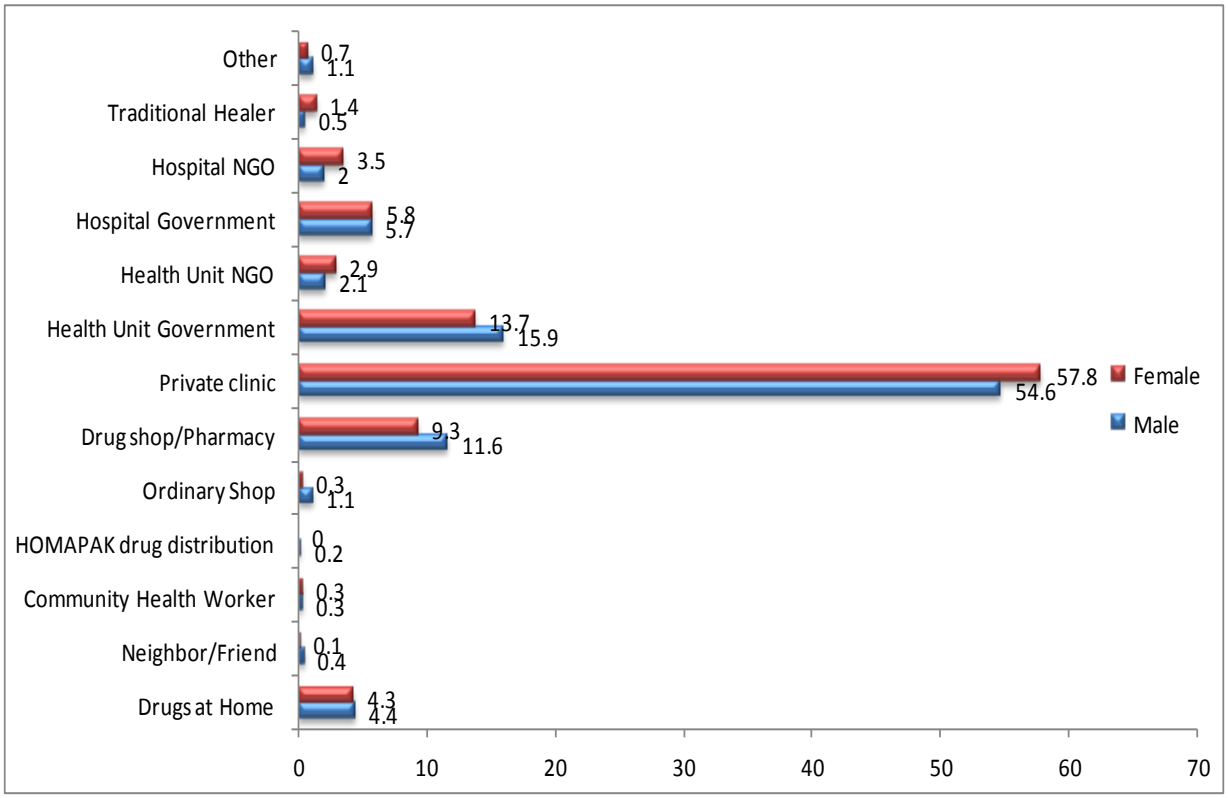
Indicator	Baseline, (year) 2009/10	NDP Target	Annualised HSSIP Target 2010/2011	Achievement 2010/2011
Percent of pregnant women attending 4 ANC sessions	47	60	50	48
Percent of deliveries in health facilities	33	35	40	57
Percent of children under one year immunised with 3rd dose Pentavalent vaccine (m/f)	76	90	80	Males-72; Females-71
Percent of one year old children immunised against measles (m/f)				58
Percent of U5 children with weight /age below lower line (wasting) (m/f)	16	15	15	Males-15; Females-13
Percent of pregnant women who have completed IPT2				27
Contraceptive Prevalence Rate (CPR)	33	34	34	30
Percent of health facilities without stock outs of any of the six tracer medicines in the previous 6 months	21	28	50	
Percent of approved posts filled by trained health workers	56	56	80	
Percent Annual reduction in absenteeism rate	46	28	20	

Ministry of Health (HSSIP 2010/11 – 2014/15)

4.1.3 Place of healthcare access

The UNHS data also shows that 4.3 percent of female headed household carry out self-medication in their homes and 1.36 percent seek medical care from traditional healers. This raises the potential risk of incorrect self-diagnosis, delays in seeking medical advice when needed, infrequent but adverse reactions, dangerous drug interactions, incorrect manner of administration, incorrect dosage, incorrect choice of therapy, masking of a severe disease as well as risk of dependence and abuse of drugs.

Figure 4.1: Percentage distribution of place of access to health care by sex of householdhead



Source: UNHS 2009/10

4.1.4 Healthcare Cost

Health care access by the household involves costs in form of consultancy and transport. In one way or the other this may hinder some sections of the population from accessing adequate medical treatment, especially the vulnerable groups such as women and orphans. According to the UNHS 2009/10 survey data, the average cost of consultancy for female headed households was about 13,760 Uganda shillings and for male headed households it was 15,430 Uganda shillings. The cost of transport to access medication was about 1,825 Uganda shillings for female headed households and about 2,129 Uganda shillings for male headed households. Other costs involved a token of thank you or outright demand by other staff at a health facility.

Over all, the average distance to a health facility is 4.4 km as revealed by UNHS data. However the majority of female headed households lived within a radius of 2.8 km from a health facility. Their male counter parts had an average of 3.0km from a health facility. From the table below, over 95 percent of households spent 50,000Ushs and less to get medical attention.

Table 4.3: Percentage distribution of transport costs in Uganda shillings by household head

Cost of transport	Household head		
	Male	Female	Total
0 – 50,000	95.52	95.1	95.41
51,000 – 100,000	2.56	2.41	2.52
110,000 – 150,000	0.48	1.00	0.61

Source: UNHS 2009/10

4.1.5 Disease Burden

As mothers, daughters, wives and leaders of households, women often steer the health care choices of families and, accordingly, this Profiling looks at the number of households headed by females and also the population of females in reference to health care access. The table below

shows the distribution of households who reported that a member of the household had suffered an illness or injury in the past six months inclusive of the thirty days prior to the survey. Thirty percent of female headed households said they had a person who had suffered an illness or injury.

Table 4.4: Disease Burden by sex of household head

Suffered an Illness or Injury in 6 past months including 30 days to survey	Sex of Household Head			Sex of Household head (%)		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
Yes	3,554	1,539	5,093	69.8	30.2	100.0
No	1,113	569	1,682	66.2	33.8	100.0
Total	**4,667**	**2,108**	**6,775**	**68.9**	**31.1**	**100.0**

Source: UNHS 2009/10

4.1.6 Reason for not consulting during illness

About 30 percent of households headed by females reported that they could not seek medical attention because the illness was mild as compared to 41 percent of male headed households. About 36 percent of female headed households said that the available health facilities in the area were somewhat costly for them. The table below shows the percent distribution of households by reason of not consulting and household headship.

Table 4.5 Percentage distribution of reason for not consulting during illness by sex of household head

Reason for not consulting during illness	Household Head		
	Male	**Female**	**Total**
Illness mild	40.95	29.74	37.7
Facility too far	4.51	14.08	7.28
Hard to get to facility	5.13	2.09	4.25
Available facilities are costly	29.25	36.14	31.25
No qualified staff present	0.51	1.33	0.75
Too busy / long waiting	1.97	3.92	2.53
Facility is inaccessible	0.64	0	0.46
Facility is destroyed	0.4	0	0.29
Drugs not available	3.5	1.61	2.95
Other	13.14	11.09	12.55
Total	**100**	**100**	**100**

Source: UNHS 2009/10

4.2 Health Impact Indicators

Five impact indicators are used to assess the analysis of impact of health service delivery. They are identified by the HSSP to measure access, participation and use of health care services. Four of these, measure the distribution of health across different life cohorts and include Maternal Mortality Ratio (MMR), Neonatal Mortality Rate (NMR), Infant Mortality Rate (IMR), and Under Five Mortality Rate. Three of the impact indicators (Maternal Mortality Ratio, Infant Mortality Rate, and Under five Mortality Rate) are monitored among the MDG targets. The UDHS 2011 reveals that childhood mortality is generally higher among the male child compared to the females, as shown in the table.

Table 4.6: Health Impact Indicators

Indicator	2011 UDHS value		
Maternal Mortality Ratio (2004 - 2011)	438 per 100,000 live births		
	Male	**Female**	**Total**
Neonatal Mortality Rate (2001 - 11)	34 per 1,000 live male births	27 per 1,000 live female births	34 per 1,000 live births
Infant Mortality Rate (2001 - 11)	70 per 1,000 live male births	59 per 1,000 live female births	77 per 1,000 live births
Under 5 mortality rate (2001 - 11)	114 per 1,000 live male births	98 per 1,000 live female births	125 per 1,000 live births

Source: UDHS 2011

4.2.1 Morbidity

The UNHS 2009/10, the UDHS 2011 and administrative data sources from health facilities show that malaria is the leading cause of disease burden among households. According to those sources, 36.4 percent of households reported being ill with malaria thirty days preceeding the survey. Of these, 37 percent were female headed households and 36.1 percent were male headed. The table shows the percentage distribution of households by cause of disease burden and house hold headship.

Table 4.7: Percentage distribution of major symptoms of illness or injury by household head

Major symptoms of the illness or injury	Household headship (%)			Major symptoms of the illness or injury	Household headship (%)		
	Male	Female	Total		Male	Female	Total
Diarrhoea	1.54	2.64	1.82	Mental disorder	0.25	0.15	0.23
Weight loss	0.10	0.00	0.08	Abdominal pain	4.28	2.67	3.87
Fever	8.37	6.26	7.83	Sore throat	0.36	0.22	0.32
Malaria	36.12	37.03	36.36	Difficulty breathing	0.33	0.94	0.48
Skin rash	1.00	1.01	1.00	Burn	0.15	0.55	0.25
Weakness	2.76	3.53	2.95	Fracture	0.36	0.62	0.43
Severe headache	5.85	6.9	6.12	Wound	1.54	2.38	1.75
Fainting	0.10	0.00	0.07	Child birth related	0.00	1. 48	1.48
Chills (feeling hot)	2.33	1.93	2.23	Other	18.51	16.43	17.98
Vomiting	0.80	1.13	0.88	**Total**	**100**	**100**	**100**
Cough	14.54	14.48	14.52				
Pain on passing urine	0.12	0.00	0.12				
Genital sores	0.09	0.14	0.10				

Source: UNHS 2009/10

4.2.2 Non Communicable Diseases

The World Health Organisation (WHO) points out that about 42, 300 females of low income died of Non Communicable Diseases (NCDs) in Uganda in 2008 and the total mortality was 684.9 females per 100,000 persons. The UNHS 2009/10 shows that 3.2 percent of female headed households reported having a person suffering from high blood pressure. The WHO report indicated that cardiovascular diseases and diabetes accounted for 383.7 female deaths per 100,000 persons.

Table 4.8: Prevalence of NCDs by household head

	Household head		
Currently suffering from NCDs	**Male**	**Female**	**Total**
None of them	92.22	94.41	92.83
A	0.43	0.13	0.35
AB	0.37	0.3	0.35
ABC	0.11	0.11	0.11
B	4.55	3.18	4.17
BC	0.39	0.42	0.4
BZ	0.04	0.02	0.03
C	1.79	1.42	1.69
Y	0.1	0	0.08
Total	**100**	**100**	**100**

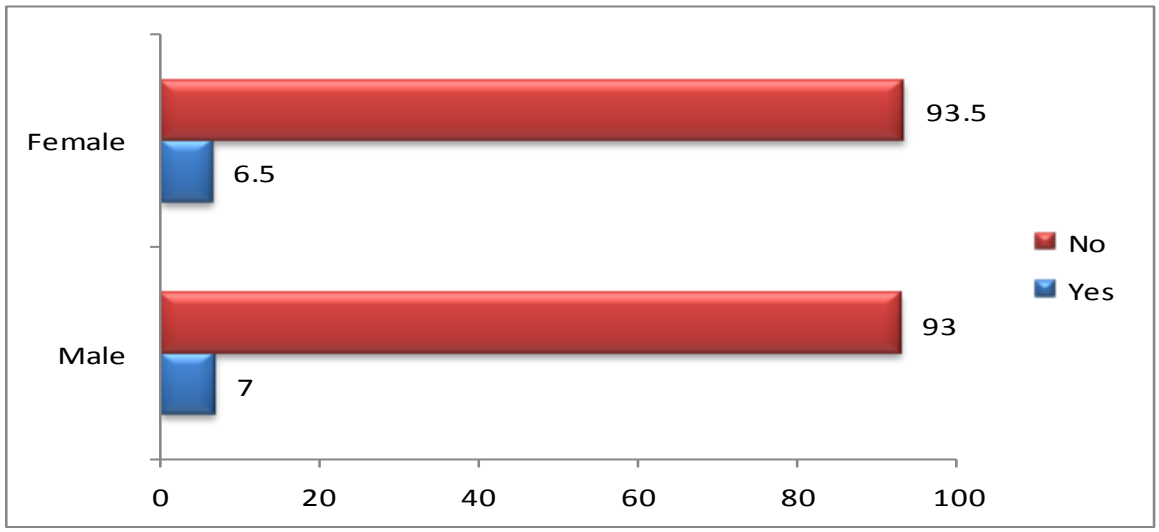
Source: UNHS 2009/10 *Where: Diabetes = A; High blood pressure = B; Heart disease =C; None of them = Z*

4.2.3 Tobacco Use

UNHS 2009/10 data shows that about 6.5 percent of female headed households are reported to be using tobacco and its products. This is close to the national average of 6.8 percent of the population using tobacco.

UNHS data further shows that eight percent of persons 10 years and above are using/have used tobacco products. More males (13%) than females (4%) reported that they currently use or used tobacco in the past. The proportion of males (31%) in the age category of 45 years and above that use tobacco doubles that of females (15%) in the same age group.

Figure 4.2: Percentage distribution of tobacco use by sex of household head



Source: UNHS 2009/10

4.2.4 Malaria Control

According to the UNHS 2009/10 survey 30.5 percent of households said they owned a mosquito net that had been soaked in any repellant. About 32.4 percent of female headed households said they owned such type of mosquito nets. The table shows the percentage distribution of households by use of a mosquito net ever soaked in any repellant and household headship.

Table 4.9: Percentage distribution of mosquito net ever soaked in any repellant by household head

	Household Head		
Mosquito net ever been soaked in any repellant	**Male**	**Female**	**Total**
Yes	29.88	32.37	30.54
No	65.76	63.95	65.28
Not sure	4.36	3.68	4.18

UNHS 2009/10

4.2.5 HIV/AIDS-related Knowledge, Attitudes, and Behavior

The UDHS 2011 showed that more females than males were tested in the last 12 months and received their results. The males were 31 percent while the females were 42 percent.

4.3 Maternal Health Care

Ninety-five percent of mothers received antenatal care from a skilled provider and 3.8 percent received no antenatal at all for their first birth according to UDHS 2011. The Percent of those who received no antenatal increases with birth order to 5.8 percent at a 6th child and above. The findings show that 48 percent of pregnant women made four or more antenatal care visits during their entire pregnancy. Urban women (57 percent) are more likely to have had four or more antenatal visits than rural women (46 percent). Only 21 percent of women made their first antenatal care visit before the fourth month of pregnancy. The median duration of pregnancy at the first antenatal care visit was 5.1 months (5.0 months in urban areas and 5.2 months in rural areas). Notable however is the percent of women who are not seeking any antenatal all; the UDHS 2011 report reveals that 4.3 percent of pregnant women did not seek any antennal with the rural area posting 4.6 percent and urban 2.4 percent.

The Maternal Mortality Ratio (MMR) is 438 birth attended by skilled health personnel (58 percent). Contraceptive prevalence rate is at 30 percent meanwhile the unmet need for family planning is 34 percent and adolescent birth rate is 134.5 percent.

4.4 Child Health

According to 2011 UDHS, 52 percent of children age 12-23 months had received all antigens (according to a vaccination card or the mother's report). The percentage of children who have received no vaccinations at all by age 12 months has remained constant at 3.7 percent country wide over the past four years. It's 4.4 percent among female children and three percent for male children. At the time of the survey, 6 percent of children age 48-59 months had not

received any vaccinations compared with 6 percent of children age 12-23 months. Among children who had received all basic vaccinations by age 12 months, there is a slight increase, from 38 percent of children age 48-59 months to 40 percent of children age 12-23 months within the same period. All this shows some improvement in vaccination coverage in recent years, there is a danger that mothers who continue to give birth in their life span see less value for vaccinating a new born baby as increasing numbers of new children are born. In other words, a child born earlier to a woman with many children is more likely to be vaccinated than the new one yet to be born. The table below shows the percentage distribution of children aged 12-23 months, antigen type and sex.

Table 4.10: Percentage distribution of children aged 12-23 months, antigen type and sex.

	Vaccine	Male	Female	Total
	BCG	94.1	93.3	93.7
	DPT1	94.3	92.0	93.1
	DPT2	87.9	83.3	85.4
DPT	**DPT3**	72.0	71.0	71.5
	Polio-0	67.8	66.6	67.1
	Polio-1	94.2	92.5	93.3
	Polio-2	84.4	82.5	83.4
POLIO	**Polio-3**	63.9	62.1	62.9
	Measles	74.8	76.6	75.8
	All Antigens	51.6	51.7	51.6
	No Vaccination	3.0	4.4	3.7

Source: 2011 UDHS

4.5 Other Health Determinants

The findings of the 2011 UDHS show some differences in the nutrition indicators among boys and girls. The indicators are poorer among the boys compared to the girls.

Table 4.11: Percentage distribution of nutrition indicators by sex

Indicator	Male	Female
U5 children with height /age below lower line (stunting)	• 37%	• 30%
U5 children with weight /age below lower line (wasting)	• 15%	• 13%

Source: 2011 UDHS

Table 4.12: Percentage distribution of children under five years who slept under a mosquito net by sex of household head

Children under 5 slept under a mosquito net last night	Household head		
	Male	**Female**	**Total**
no	20.06	23.85	21
all children	49.86	44.77	48.6
some children	11.47	8.13	10.65
no net in household	18.61	23.25	19.76
Total	**100**	**100**	**100**

Source: 2011 UDHS

4.6 Disability Prevalence in Uganda

Disability is defined as permanent and substantial functional limitation of daily life activities caused by physical, mental or sensory impairment and environmental barriers resulting in limited participations. Disability is analyzed based on the six UN broad categories of difficulty. The categories are in Seeing, Hearing, Walking or climbing steps, remembering or concentrating, Self-care (washing) and Communicating. In Uganda, there is a policy in place with the object of promoting equal opportunities for enhanced empowerment, participation and protection of rights of PWDs irrespective of gender, age and type of disability. The Policy guides and informs the planning process, resource allocation, implementation, monitoring and evaluation of activities with respect to PWDs concerns at all levels.

According to the Uganda Population and Housing Census Report (2002), four out of every 25 persons in Uganda had disabilities. The prevalence rate in 2002 was higher than the 11 percent obtained from the 1991 Census. The prevalence of disability increased with age from two percent among children aged less than 18 years to as high as 18 percent among the elderly. The prevalence was not evenly distributed throughout the country, though. In the central region, it increased from 1.0 to 3.1 percent, Eastern region from 1.2 to 3.6 percent, Western region from 0.9 to 2.9 percent and Northern region from 1.9 to 4.4 percent.

The UNHS 2009/10 data shows that 6.7 percent of the female population had some difficulty in seeing, 2.4 percent in hearing, 4.8 percent in walking or climbing steps and 2.7 percent in concentrating or remembering. The least difficulties noted among females were in self-care (washing) and communication at 0.51 and 0.76 percent respectively. The 2011 UDHS puts the disability rate at 9 percent countrywide. The tables show percentage distribution of population by disability status, disability category and sex.

Table 4.13a: Percentage distribution of population by disability status, disability category and sex

Disability Status	difficulty seeing			difficulty hearing		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
No - no difficulty	92.37	92.08	92.28	97.01	97.32	97.1
Yes - some difficulty	6.16	6.65	6.31	2.59	2.4	2.54
Yes - a lot of difficulty	1.41	1.15	1.33	0.38	0.16	0.32
Cannot see at all	0.05	0.05	0.05	0.01	0.11	0.04
Don't Know	0.01	0.07	0.03	0	0.01	0
Total	100	100	100	100	100	100

Source: UNHS 2009/10

Table 4.13b: Percentage distribution of population by disability status, disability category and sex

Disability status	difficulty walking or climbing steps			difficulty remembering or concentrating		
	Male	Female	Total	Male	Female	Total
No - no difficulty	94.8	93.67	94.46	96.26	96.5	96.33
Yes - some difficulty	3.67	4.81	4.01	2.91	2.72	2.86
Yes - a lot of difficulty	1.47	1.29	1.41	0.76	0.64	0.72
Cannot walk at all	0.06	0.18	0.1	0.07	0.09	0.08
Don't Know	0	0.05	0.01	0	0.05	0.01
Total	100	100	100	100	100	100

Source: UNHS 2009/10

Table 4.13c: Percentage distribution of population by disability status, disability category and sex

Disability Status	difficulty with self-care (washing)			difficulty communicating		
	Male	Female	Total	Male	Female	Total
No - no difficulty	97.35	97.4	97.37	98.74	98.78	98.75
Yes - some difficulty	1.36	0.51	1.1	0.74	0.76	0.75
Yes - a lot of difficulty	0.53	0.97	0.66	0.41	0.39	0.4
Cannot care for self	0.76	1.11	0.87	0.11	0.07	0.1
Don't Know	0	0.01	0	0	0.01	0
Total	100	100	100	100	100	100

Source: UNHS 2009/10

4.6.1 Disability and Healthcare (Effects of disability)

All Persons with Disabilities (PWDs) have the same general health care needs as everyone else. Therefore, the PWDs need access to main stream healthcare services. Article 25 of the UN convention on the rights of PWDs (CRPD) reinforces the right of PWDs to attain the highest standard of healthcare, without discrimination (WHO). The challenge PWDs face in accessing healthcare is physical barriers such as uneven access to buildings (hospitals, health centres), inaccessible medical equipment, poor signage, narrow doorways, internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to health care facilities. Particular case is women with mobility difficulties are often unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand; besides there is a problem of inadequate skills on the side of health providers to meet the health care needs of PWDs, high cost of healthcare makes it worse given these people are not working or if they are then low paying jobs.

A critical look at UNHS 2009/10 data shows that 16 percent of the female sampled population had difficulties in doing work both at home and work place as a result of disability all the time, 49.5 percent of women sometimes had difficulty doing work at home and work place, 12.2 percent at school. The table shows the percentage distribution of population by effect of disability, location and sex.

Table 4.16a: Percentage distribution of population by effect of disability, location and sex

Effect of Disability	At Home			At Work		
status	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Yes, all the time	13.11	15.68	13.88	12.73	15.93	13.68
Yes, sometimes	55.66	49.47	53.8	50.34	49	49.94
No	28.82	32.68	29.98	24.2	25.77	24.67
NA (e.g. too young)	2.41	2.16	2.33	12.73	9.3	11.71
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: UNHS 2009/10

Table 4.16b: Percentage distribution of population by effect of disability, location and sex

Effect of Disability status	At School		
	Male	**Female**	**Total**
Yes, all the time	3.68	3.38	3.59
Yes, sometimes	12.2	12.17	12.19
No	16.44	18.71	17.13
NA (e.g. too young)	67.67	65.74	67.08
Total	100	100	100

Source: UNHS 2009/10

CHAPTER FIVE DATA QUALITY AND GAPS

This chapter presents issues related to data quality and gaps for both the administrative and household based survey data.

5.1 Gender Statistics Production

At the health facility level, data is collected using HMIS source documents which include Registers, Stock Cards and Distribution Lists, to mention but a few. These HMIS source documents are uniform across the country for purposes of harmonisation and comparability.

To cater for gender aspects, a column for sex is included in the HMIS source documents. That is to say that registers and patient cards, as well as other characteristics, such as history of illness and previous prescription of medicine.

The data obtained is tallied, aggregated and recorded in HMIS periodic reports that can be weekly, monthly, quarterly and annual. The HMIS periodic reports are engendered so as to capture all the information as transcribed from the source documents. This fosters analysis and dissemination of Gender Disaggregated Data hence improving availability of Health Sector Gender Statistics.

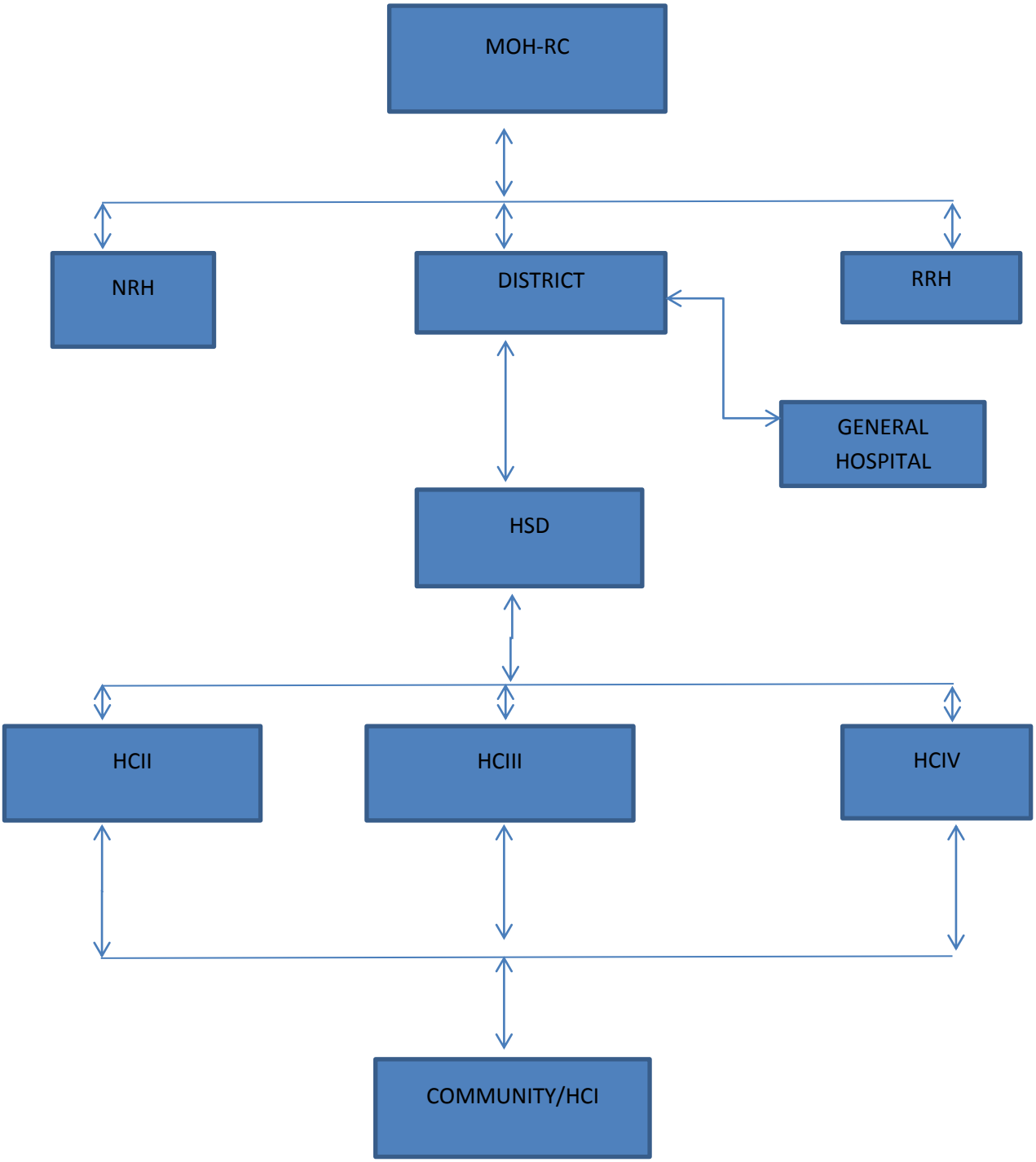
With regard to the key parameters of participation as far as collection of the Health Management Information System (HMIS) data is concerned, different people who include VHT, Health facility in charges, MRAs, District Biostatisticians / HMIS FPs, DHOs are involved.

5.2 Data Sources

The Health Management Information System (HMIS) is the main source of information for the Health Sector. Other key sources of information include the HSSIP 2010/11 – 2014/15, the MoH Ministerial Policy Statement (MPS) 2010/11, MoH activity plan 2010/11, FY 2010/11 quarterly sector performance review reports, MoH programmes and other central level

institutions reports, MoH submissions from the Output Budgeting Tool (OBT) to the Ministry of Finance, Planning and Economic Development (MFPED), Previous AHSPR for the FY 2006/07, 2008/09 and 2009/10, The HIV/AIDS Epidemiological Surveillance report 2010, Medicines availability study 2010, Malaria Indicator Survey 2010, UDHS reports, Millennium Development Goal Report for Uganda 2010.

Figure 5.1: HMIS Data Flow



5.2.1 Flow of data

Data is collected from the community by the VHT who submit to their respective Health Centres in their service areas. The data is aggregated at this level by the health facility in charge or medical records assistant who then submits it to the Health sub-district within the specified timeline.

The health sub-district HMIS focal person compiles and aggregates all the data within the sub-district and submits to the district headquarters. It is at the district headquarters that the District Health Officer (DHO) and district biostatistician compiles data submitted by all the health sub-districts within the district and submits it to the DG/ACHS-RC at the MoH through the DHIS2.

It is important to note that general hospitals, regional referral hospitals and national Referral hospitals submit their data directly to MoH through DHIS2 and a copy to the district.

5.3 Gender Statistics and Capacity Needs

The success of a programme is dependent on human resources. There exist a small number of trained data managers at the Ministry of Health to process the huge volumes of data generated from the districts and be able to produce outputs timely. The districts, health sub districts and health centres also lack trained data managers and records assistants. This is made worse in hard to reach district in remote areas of the country.

The tools for capturing inpatient data disseminated to all districts, the response in terms of reporting is minimal. The factors contributing to this are the little sensitisation given to the clinicians in the health facilities on the importance of reporting inpatient data. The form appears big as it requires data on admissions and deaths for about 70 different diseases and conditions, and computation of some indicators (for example, number of patient days, average bed occupancy, etc.) on a monthly basis.

Although data analysis practice has taken root in most of the health facilities, graphs of disease trends and key indicator levels are regularly plotted and displayed in many health facilities. There is, however, little evidence to show how this data is utilised, especially at the district, health sub district and health facility levels.

Electronic data management and reporting is still lacking. There is the challenge of acquiring the necessary financial resources to upgrade computer units in the districts and purchase new ones, install the appropriate data management software, train users, and ensure connectivity to the electronic network.

Other sources of health data are Censuses DHS, UNHS, UMIS, UAIS reports, notable though is the frequency of carrying out the surveys. Censuses are carried out every ten years which sometimes renders such data irrelevant due to time lag and also the object of conducting it. The rest of these reports are done every five years but do not normally cover the whole country due to either instability or limited resource or both.

The gender health profiling is new in the context of development and skills availability in the bureau and the country. The UDHS, UMIS AND UAIS are surveys based on households so the reporting is based at that level and may not adequately address the women's health at individual level. Therefore, the analysis is done based on household headship leaving out comparisons at individual level.

CHAPTER SIX CONCLUSIONS AND RECOMMENDATIONS

This chapter presents possible conclusions and recommendations on the status of gender statistics and Gender Mainstreaming in the Health Sector.

6.0 Conclusions

Place of health care access: The UNHS data also shows that 4.3 percent of female headed households carry out self-medication in their homes while 1.36 percent seek medical care from traditional healers. This raises a potential risk of incorrect self-diagnosis, delays in seeking medical advice when needed, infrequent but adverse reactions, dangerous drug interactions, incorrect manner of administration, incorrect dosage, incorrect choice of therapy, masking of a severe disease as well as risk of dependence and abuse of drugs.

Health care cost: Over all, the average distance to a health facility is 4.4 km as revealed by UNHS data. However, majority of female headed households lived within radii of 2.8 km from a health facility while their male counter parts had an average of 3.0km from a health facility. Overall, more than 95 percent of the households spent 50,000Ushs or less to obtain medical attention.

Morbidity: Malaria is the leading cause of disease burden among households. According to the sources considered for the analysis, 36.4 percent of households reported being ill with malaria during the thirty days preceding the survey. Of these, 37 percent were female headed households in comparison with 36.1 percent male headed.

Tobacco Use: Data showed that about 6.5 percent of female headed households were reported to be using tobacco and its products. This is close to the national average of 6.8 percent of the population using tobacco. The data further showed that eight (8) percent of the persons 10 years and above were using/have used tobacco products. More males (13%) than females (4%) reported that they currently use or used tobacco in the past. The proportion of males

(31%) in the age category of 45 years and above that use tobacco doubles that of females (15%) in the same age group.

Malaria Control: Findings showed that 30.5 percent of households said they owned a mosquito net that had been soaked in any repellant. Of these, about 32 percent were female headed households compared to 30 percent male headed households.

In conclusion, in order to increase the understanding and identification of gender health gaps, there should be a consistent system of data collection on this subject targeting household women in the whole country and also lower the age limit to filter in more females.

6.1 Recommendations

i. There is need for every district to recruit a Bio statistician to manage health statistics.

ii. Health Centre II staff should be sensitised about the value of timely remittance of unit data.

iii. The Health Centre IIs should be equipped with computer hardware and software to ensure better data management ease work for the staff working with data.

iv. Special consideration should be given to the introduction of modern communication equipment at data capture points to ease communication with the districts and the Ministry of Health.

v. Specific gender health surveys should be conducted every 5 years.

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