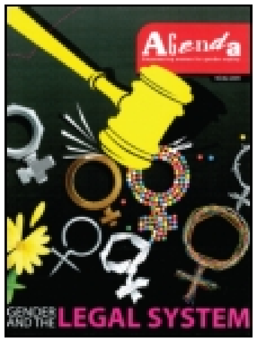

Agenda

ISSN: 1013-0950 (Print) 2158-978X (Online) Journal homepage: https://www.tandfonline.com/loi/ragn20

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To cite this article: Sarah N Ssali Master of Arts Degree in Women and Gender Studies (2006) Revisiting choice: gender, culture and privatised health care in Uganda, Agenda, 20:68, 42-53, DOI: 10.1080/10130950.2006.9674721

To link to this article: https://doi.org/10.1080/10130950.2006.9674721

Published online: 27 Apr 2011.

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Revisiting choice: gender, culture and privatised health care in Uganda

Sarah N Ssali

abstract

Neo-liberal reformers of health care assume that accessing health care in a privatised health care system is a matter of choice. However, choices are mediated through an array of social relationships, which are in turn determined by culture. Culture, in many settings, is often the blueprint for social relations, determining appropriate masculine and feminine roles and identities. Simply introducing user fees to expand health care options is not enough to change the gender roles and identities pertaining to health care access and provision. Using gender roles and identities in the context of user fees, this focus highlights the extent to which health care processes are gendered. It demonstrates that culture interacts with, mediates and even modifies what would appear as a market process of 'free' choice of health care. It shows that, while women are able to identify openings within culture, which they can use to further their own agenda, culture is also capable of permeating new policies and strategies to the disadvantage of women.

keywords

gender, gender roles, masculinity, femininity, culture, household, household headship, choice, health, health user fees

Introduction

Over the past two decades, user fees have become a prominent mechanism for health sector reform in many developing countries. Promoted by the World Bank, user fees were intended to stimulate market allocation of health care (De Ferranti, 1985). User fees, De Ferranti argued, would attract private investment in health care by stimulating market forces in health care provision, thereby stimulating growth in health services. Such growth would provide users with a choice of health care services. In Uganda, user fees were introduced in 1992 despite parliamentary disapproval (Okuonzi and Macrae, 1995). Although they were officially abolished in 2001 during the heat of presidential elections, free health care in Uganda is still elusive; patients still meet the cost of basics such as medicines.

Within the World Bank discourse relating to user fees, access to health care has been treated as a matter of choice. Even where household health care is discussed, it is assumed that households are capable of exercising choice as individuals. But within the household, health care access and provision is not a matter of choices determined by forces of demand and supply. It is a gendered process, with roles such as caring for the sick and who can play the sick role clearly stipulated. Often, these roles are enacted along the socially acceptable identities of masculinity and femininity. Investigating women's experiences of user fees should consider the socially accepted roles of health care provisioning and how these interact with the appropriate masculine and feminine roles in society.

Sweetman (2001) observes that a gender analysis of development/social policy should focus on the cultural basis of difference between

women and men, and consider how this shapes their experiences. This observation is pertinent, given that gender relations arise largely from culture. Culture has been defined in different ways by different authors. Despite the differences, there is a general tendency to consider culture as patterns and designs for living in society or ecological communities (Keesing and Strathern, 1998). This implies that culture is responsible for providing the initial knowledge used in primary socialisation. More significantly, culture determines appropriate male and female behaviour in given contexts. The masculine and feminine roles and identities that arise from culture determine the different experiences of males and females of privatised health care.

This does not mean that everything pertaining to health care provision is culturally determined, leaving no room for individual action and resistance. Like culture, gender roles are often modified by those who seek alternative ways of meeting their roles. Women are not totally helpless and unable to determine choices that benefit them. In fact, Giddens argues that even those who seem to lack options also have choices (Haralambos and Holborn, 2000). This means that even in culturally determined roles such as health care provision, women can still act in ways that serve their interests.

Focusing on women's role in determining household health care in a context of user fees, this *focus* highlights the resilient nature of culture, which is capable of mediating and modifying a potentially standard market process of free choice of health care. It discusses household gender relations with regard to health care provision, focusing on the roles of health care provision and of paying for health care. Whereas providing health care is a women's role, paying for it is a man's role, each with its own valuation attached. What happens if a woman has to assume both roles? How is she perceived and valued? What strategies do women employ to instil a sense of responsibility among men and with what consequences? How are these strategies valued?

Decisions on these questions are all undertaken within a cultural framework. I demonstrate that women are not silent victims of culture, but are able to identify openings within culture that they can use to further their own agenda as women.

The research on which this article is based was undertaken in Mukono District of Uganda over a period of 13 months, from 2000-2001. The situation has not changed much since then. Free healthcare remains elusive and the cultural norms governing household health care decision-making still prevail. The study employed qualitative research methodology, with grounded theory as the research design.

Gender roles

Gender roles refer to the expected duties and responsibilities, rights, and privileges of men and women/boys and girls that are dictated by cultural factors. Gender roles differ from sex roles (Kimmel, 2000) in that they are shaped by society: influenced by religion, economy, cultural attitudes, and political system. They are learnt through the process of socialisation and vary from one culture to another. Similarly, the identities that arise from these roles – masculinity and femininity – vary across cultures and time periods. The relationship between roles and identities is symbiotic. While gender roles construct the appropriate masculine and feminine identities, these in turn communicate to males and females how they should act – what role they should play in their capacity as males and females.

Even those who seem to lack options also have choices

The introduction of user fees in Uganda was an opportunity to modify the masculine and feminine roles regarding health care provision. The fees should have seen male involvement in health care provision increase, as they would be the ones paying for it. However, even when they did get involved, they were cautious not to assume the caring role. The reverse was true for women, who were careful not to assume the paying role. Health care provision became an

extension of existing forms of hegemonic masculinity and femininity[1]. Changes ushered in by user fees risked reinforcing these identities.

Caring for the sick as feminine

Three categories of gender roles in household health care provision can be identified: caring, paying for health and selecting the health care facility. Each category is accompanied by clear roles and identities. Health care, whether consisting of treatment to alleviate illness, or caring for a patient in hospital, were women's roles. These roles included identifying and diagnosing illnesses, determining the health care options to be undertaken, seeking and administering treatment accessed from drug shops or other health care facilities, and caring for the sick. It was regarded as an extension of health maintenance activities, such as nutrition and household hygiene, which were perceived as an extension of women's reproductive roles. Men got involved only when the illness was severe or required more expensive treatment.

Health care provision became an extension of existing forms of hegemonic masculinity and femininity

> *Women are the ones who stay at home with the children. Hence, it is their responsibility to see if a child is unwell and to take such a child to hospital. Men are rarely in their homes, in most cases we [men] return home late. Our children rarely see us, because they are usually asleep by the time we return. So the mother is the one to take the child to hospital.* (Male Focus Group Discussions (FGD) participant, 28 years)

> *A woman must care for all the people in the household. She must also know who is ill and what they are suffering from. She should know whether they have bathed, eaten food or not and why. That is the woman's responsibility in the home: to care for the household members and see what state they are in.* (Female FGD participant, 65 years)

Although men's absence was the common excuse for their limited involvement in caring, it was a role they were less likely to assume even if they had been available. Men downplayed any other significant contributions by women, such as paying for health care (see table), by associating this with women's role of caring rather than with paying for health care.

Paying for health care as masculine

Men's involvement in health care provision was restricted. They were supposed to 'supervise' their wives' health care practices, pay for health care, provide 'wisdom' and construct good structures. Given their long absences from home, however, their supervisory role was more theoretical than practical. They depended on their wives for information.

Paying for health care was the most prominent form of males' involvement in health care provision. Paying was constructed as masculine; as an extension of men's role of household provisioning:

> *Paying for health care is the responsibility of the household head – the man. He pays for himself, his wife and the children.* (Female FGD participant, 58 years)

> *It is natural that a man must look after his home. It is hereditary. Historically, it is men who have always fended for their households and headed them. So even if a man is poor and has no money, it is a rule that he must find the money to pay for health care. "Tezibula mukwaate" 2, a man must find money for his household.* (Male FGD participant, 28 years)

These statements indicate that men's responsibility for paying for health care was derived from their role as household heads; it was not separate from household provisioning. It was assumed to be natural and a sign of their 'independence'.

The table shows the person responsible for paying for health care for specific illness episodes observed during the study:

Table: Paying for health care by household type

Responsibility for payment	Household headship (n = 106) (%)	
	Male	Female
Male	62.95	3.55
Female	15.85	55.13
Any spouse	3.73	-
Both	9.15	-
Other	5.63	25.05
N/A	6.77	20.6

In male-headed households, men are primarily responsible for paying for health care. The reverse is true in female-headed households. Brydon (1989) notes that the concept 'household head' or 'headship' is problematic, especially since it assumes that household decision-making is vested in one key person, usually a male, who makes the decisions for and on behalf of other household members. However, household management and decision-making is not always that centralised. Observing women's increasing role in household management, whether as married or unmarried women, Brydon distinguishes between *de facto* headship (the everyday management of the household) and *de jure* headship (that associated with the legal and jural terms of the society). *De jure* female household headship arises when the male partner is permanently absent (due to separation or death) and the woman is legally single, divorced or widowed, while *de facto* female headship arises when the male partner is temporarily absent.

In the research setting, the obvious household heads were males, implying that those headed by females deviated from the norm:

> *Male superiority is God-given. It is no use questioning it. Any woman who questions it has no business being married. If she is my wife, I just 'fire' her.* (Male FGD participant, 28 years)

> *Women are the legs and men are the heads. The head is on top and the legs are at the bottom. So if you know your position, it is no use trying to challenge it.* (Female FGD participant, 60 years)

This association of household headship with masculinity arose from the fact that in traditional Buganda, constructing the house in which household members would reside was a role undertaken by a man who intended to get married. Culture empowered men with the resources such as land and other economic resources to enable males to perform this role. The head of the household was automatically the man who was responsible for its existence by constructing the house and by marrying a woman or women and establishing the family. His headship was derived from culture, and was therefore unchallenged. 'Household headship', therefore, could not be reduced to the production or management of household resources (Brydon, 1989; Moser, 1993). Neither could it be reduced to one's role in household decision-making (Kandiyoti, 1998; Kabeer, 1994). This was one reason *de jure* female-headed households, and households comprising single males were considered 'deviant'. Although such households had the residential site, they lacked the marriage and family aspect required to complete the 'ideal household'.[3]

When women paid for health care

Although paying for health care was a masculine role, there were several deviations from the norm. Men's payment was usually indirect, since they rarely accompanied the sick to health care facilities. Ideally, men were supposed to provide their wives with money for use in a case of emergency. As the table shows, however, cases where women had to pay for health care in male-headed households were not uncommon. Female payment in male-headed households was often undertaken by the female spouse for her own or her children's treatment, while male payment in female-headed households was often by the sons of the female head, for their mother's, siblings' or their own children's treatment. These exceptions suggest that household heads were not the only ones who paid for health care. The significant number of female spouses paying in male-headed households indicates that the male head's role to pay for health care was not as obligatory as indicated by male FGD participants.

The head of the household was automatically the man

The circumstances under which women paid for health care in male-headed households varied. The most common was male absence. Men's presence was significant for providing women with the money directly or borrowing it if they lacked it. Given that money for health care was raised when the need arose and the critical nature of some illnesses, men's absence implied that women sometimes had to make health care choices without their spouses' financial assistance.

A woman would also pay for health care when her spouse was unwilling to pay, as the case below illustrates.

This case was considered to be extreme by various community members, male and female alike, who claimed that although her spouse may have lacked the money, he, as the household head, should have borrowed it. Others said that with illness, money should always be found. After all, it is cheaper to treat the sick than meet their funeral expenses. However, unwillingness to pay appeared to be not uncommon.

The main reason advanced for men's unwillingness to pay was not taking illness, especially women's illness, seriously. Being

Miriam was a 23-year-old mother of two children, employed as a farm labourer. Her 26-year-old spouse worked as a motorbike transport operator during the day, and as a security guard in the night. One Saturday, her four-year-old son swallowed a coin, which he was supposed to have bought his aunt some vegetable fat with. Although Miriam's spouse was around, he refused to give her money to take the child to the dispensary, or even transport them to the facility. He was not even concerned about caring for their other two-year-old child who had to be left with a neighbour. He continued playing cards with his friends, claiming that whoever sent his son to the shops was responsible and would have to meet the medical bills. Miriam had to walk with her child the 2.75 kilometres to the government dispensary. On reaching it, they were told he needed an X-ray, a service the dispensary lacked; they were referred to Kawolo hospital, located 10 kilometres away, the nearest facility with an X-ray machine. Since she did not have enough money, she walked back home to try and convince her husband to contribute, but he refused and it was only after the intervention of his friends that he parted with some money. However, he still refused to transport them to hospital, and they had to walk the 2.75 kilometres to the roadside, before getting a taxi to Kawolo hospital.

labelled ill is crucial for accessing health care, as well as being allowed to play the sick role (Helman, 1998). Being a patient or *omulwade*,[4] was socially constructed and often characterised by gender divisions. Children were the most obvious patients; they got immediate attention when they fell ill for fear of a drastic change in condition. After children came men. For a woman to be labelled ill, she had to fail to light a fire, while a man had to fail to go to town to work. With the majority of men employed as wage earners or petty traders, they rarely took time off for fear of losing the day's earnings. Nonetheless, I did find men who had failed to report for work because they were unwell. However, I never found a woman who had failed to farm or perform her domestic tasks because of ill health, even when some reported feeling unwell. For even if illness 'excused' women from farming it did not 'excuse' them from domestic work and childcare.

> *Men fall sick in their own way. They may decide to lie down or roll over. It is all up to them. After all, who is going to ask them for food? However, you [the woman] have got the responsibility of looking after them, cooking for them and the children, washing for them, everything is waiting for you.* (Female FGD participant, 58 years)

> *We know that women are more sickly than men. However, even if you [the woman] are sick, you cannot "choose" to be sick because you have got to cook the food and fetch the water. If you choose to fall sick, who is going to do these tasks? You have to carry on with your work even if feeling ill. You walk and work with your illness. Have you not heard of the saying that women do not fall sick?* (Female FGD participant, 60 years)

These statements portray a functionalist perspective of femininity, which denies women an opportunity to be sick. Together with other phrases such as *'Omukazi talwaala nga musajja'* ('a woman does not fall sick as a man does'), they caution women not to 'rush' to assume the sick role, as their work will remain undone. The sick role could be assumed by men and children, but not by women.

Another reason given for men's refusal to pay was financial constraint. Given the limited employment opportunities and the income levels of the majority of men, this seemed a viable explanation. However, others, especially young female participants, were less inclined to accept that their spouses failed to pay for health care due to lack of money, because men never failed to drink alcohol or to eat a good lunch at work. Men denied any connection between their consumption, especially of alcohol, and household income. Besides, they argued, alcohol and meeting with their male friends at the pub were basic necessities, which enabled them to cope with the challenges of life. But the argument that alcohol consumption and household income were unrelated was less convincing in view of the overwhelming evidence linking the two (Elson, 1992; Kanji, 1995). Although alcohol was cheap and sometimes bought by friends, the cumulative effect of daily consumption and the reciprocal nature of having to 'sponsor' others, was likely to have an effect on household income. Contradictions between the way men and women perceived the relationship between alcohol consumption and household income were exacerbated by the fact that incomes were never pooled, and that budgeting was rarely undertaken jointly.

Women's illness was not taken seriously

Avoiding the inconveniences of caring for the sick was another reason women gave for paying for their children's, and sometimes for their own health. Earlier, I observed that women's payment never included the man's health care costs, although such an eventuality was never ruled out. Women paid for their children's health care to avoid the inconvenience accompanying the children's illness. Even if it was acknowledged that children belonged to their fathers, the consequences of illness impacted on

the mother more than on the father.

> *If the child is sick, it is your responsibility because it is you who will sit up the whole night attending to the patient while he [the father] snores.* (Female FGD participant, 24 years)

A similar inconvenience was the discomfort women experienced as a result of their own illness. Where such discomfort was not anticipated, as was the case with men's health care, women did not contribute financially to their health care. In all the interviews and the FGDs, no woman confessed to having paid for her husband's health care. Despite all female respondents stating that their spouses must pay for their health care, none agreed to the suggestion that women should also contribute towards their spouses' health care, although the possibility of doing so when the illness became critical could not be ruled out. According to one elderly respondent, by then 'the two [husband and wife] will have become one', indicating the consequences of men's critical illness on women – the demand for care.

Few men were willing to acknowledge that their wives pay for their health care

The common reason women gave for not paying for their spouses' health care was the fact that the spouse's absence from their homes made it difficult for their wives to know when they fell ill. Some women even suggested men rarely fell ill or, if they ever did, they took treatment from wherever they spent the day without informing their wives. This indicates that, for men, the household was seldom the locus of their health care activities. It resonates with Moser's (1993) and Kandiyoti's (1998) caution against treating the household as the locus of people's lives.

There were three further reasons why women did not contribute to their husbands' health care costs. Several women considered their spouses to have more money than they had; some argued that paying for their spouses was likely to be a waste of money as many men feared injections and tablets; and, most importantly, because of the likely implication of undermining their husbands' masculinity:

> *Why should I pay for him? Huh...You must be courageous to escort him to the facility and find out that he has no money. Even if you escorted him, you may never know what he has in his pocket. How can you suggest paying for him? To be on the safe side, you carry your money, and if there is a requirement he cannot fulfil on his own, then you can suggest contributing, but that too is rare. Otherwise suggesting paying for him? You will be courting trouble.* (Female FGD participant, 35 years)

Few men were willing to acknowledge that their wives pay for their health care, fearing it would be an indication by the wife that her spouse has failed as a household head, which men considered very humiliating. Although some men equated it to a wife paying for the children's or her own health care, men rarely witnessed this, hence, they could ignore it. Alternatively, a man could claim that she paid because he was absent. Besides, there was no way others would know that it was the wife, and not the husband, who paid for the children's or her health care, given that culture prohibited women from making such disclosures. The man could claim to be the one meeting the household's financial requirements, including health care. Being paid for by one's wife was difficult for a man to ignore. According to male participants, that would be the beginning of being dominated by one's wife.

Paying for antenatal and obstetric care as masculine

Although antenatal and obstetric care are forms of health care, paying for them is considered separately, as it reveals a feature of masculinity (man the impregnator) that differs from the one so far discussed (man the provider).[5] Whereas paying for general health care was negotiable,

paying for childbirth was not. In all the FGDs, the consensus was that paying for antenatal care and childbirth was a man's role. All focus group participants denied knowledge of any case in the village where a woman had paid for her own antenatal or obstetric care. The main reason given for the man's responsibility for antenatal and obstetric care was his 'ownership' of the pregnancy and of the child:

> *Considering that, in our culture, children belong to the man, he has the overall responsibility for that child. The woman's responsibility ends with biological reproduction. However much women may claim, a child belongs to the man. Even if a woman divorced and took the child with her for 10 years, a time will come when that child will be returned where it belongs. I think that is why even if a woman had money, she would still insist that her spouse meets the cost of child delivery.* (Male FGD participant, 28 years)

Of course, women's responsibility towards children did not end with childbirth. From my observations, women were very responsible for their children, including caring and financial contributions towards the children's clothing, education and health care. Nonetheless, the statement highlights the cultural basis for male responsibility for obstetric health costs, namely 'man the impregnator'. Paying for antenatal and obstetric care was the way the man established paternity over the child. Women also enforced it as a way of getting the man to acknowledge responsibility for the child, especially where the child was born out of marriage. This was a role both women and men were keen to uphold.

A second reason why women, especially relatively wealthy women, insisted that their spouses meet the costs of their obstetric health care was because their husbands often reneged on their domestic financial obligations to their wealthier wives. Interviews with midwives revealed that for many of the wealthy women, paying for childbirth was the only contribution towards health care that their spouses ever made. Also, it was the only opportunity these women had to get the men to repay some of their money spent on domestic consumption. Women in this category were reported to inflate obstetric costs much more than women in the relatively deprived category.

Men also claimed they paid for antenatal and obstetric healthcare because they considered it to be fairly predictable. In all the focus groups, the consensus was that from conception to childbirth lasted nine months, giving the man ample time to save the money required for delivery. A man who failed to do so was considered grossly irresponsible and regarded as a failure:

> *Given the long duration of pregnancy, the man must be responsible enough to plan for the delivery, be it in a public or private facility. When a woman conceives, the man responsible must begin to plan for childbirth. If the family has been consuming two kilogrammes of meat per week, this may require reducing to one kilogramme, so as to save for the delivery.* (Female FGD participant, 26 years)

Paying for antenatal care was the way the man established paternity

> *Childbirth is predictable, unlike malaria. Malaria is usually abrupt. Sometimes you can spend the whole year without falling sick. How can you keep money for that long? With pregnancy, you are sure you will deliver. So you save appropriately.* (Female FGD participant, 62 years)

Given the high risks associated with pregnancy, many people do not consider miscarriages and premature labour in their plans, as it was feared to be courting bad luck. This is not to suggest that the two did not occur.

Men were willing to save for childbirth but not for other illnesses, because they associated it with several risks. Specifically, most husbands

feared losing their wives in childbirth. With the maternal mortality rate of Mukono District at 500 deaths per 100 000 live births (Mukono District Council, 1999), this was not a remote possibility. This fear was probably the reason why pregnancy and childbirth were a viable income earning strategy for women, given that husbands were more concerned about saving the lives of the mother and child, than with how much was being spent. It could also explain why all mothers preferred to deliver from private facilities, which were more expensive than the government facility, despite failure to use similar facilities for treating general illnesses.

Another reason childbirth was saved for was that, although it was fairly predictable, it was not certain whether a woman would deliver normally, or by caesarean section. Either way, the costs of delivery were much higher than the cost of treating routine ailments. A normal delivery cost Ush 10 000 (US$ 6.67) at the government dispensary and Ush 15 000-25 000 (US$ 10-16.67) at the private domicilliaries. A caesarean section cost between Ush 100 000-200 000 (US$ 66.67-133.33) in either government or private hospitals. All these costs were astronomical compared to the treatment costs of malaria or a cough, which ranged from Ush 200 (US$ 0.13) at the drug shop, Ush 1 500 (US$ 1.00) at the government dispensary, and up to Ush 6 000 (US$ 4.00) at the most expensive private clinic. Given the high costs of childbirth, many men started saving for the delivery well before the expected date. Some even gave the women the money well in advance to avoid the temptation of diverting it to their personal needs and to ensure that she was not stranded in case of an emergency during his absence. Even if a man was to borrow money to pay for childbirth, it was unlikely that he could be lent that entire amount, considering the limited incomes earned by the majority.

Pregnancy and childbirth were a viable income earning strategy for women

Refunding women's money: obligation or investment?

In my fieldwork, I also observed that many women were keen to have the money they spent on health care refunded. Women demanded a refund either directly or by claiming that they had borrowed money from a friend to take a sick child to hospital:

> *If health care requires treatment and his money is not enough, I may suggest contributing mine. However, when he gets his money, he must refund mine, which he usually does.* (Female FGD participant, 23 years)

> *A woman with some income generating activities will never wait for you when a child is ill. She will take it for treatment, but when you return, she ensures that she gets her money back. She will ask you for it all the time until you pay it back.* (Male FGD participant, 25 years)

Women were keen on getting their money back in order to replace their savings spent on health care, to generate some income from their spouses, or to remind men that paying for health care was their responsibility, and to fine them for ignoring women's illnesses:

> *Even if you are not in agreement, you [the woman] can pay because you cannot wait till you die because he is the one supposed to pay. How can you accept to die? I would not accept that, but would go to the facility for treatment, and even if I was charged Ush 1 000 (US$ 0.67), I would claim from him Ush 5 000 (US$ 3.33). I would ensure that I make a difference off him, and if he asks me for the receipt, I would tell him I misplaced it.* (Female FGD participant, 58 years)

> *If you pay for health care, it is the man's responsibility to refund your money. If he refuses, there is nothing to do but to excuse him. However, this also means that*

> *whenever a child falls ill, it will always be your responsibility to pay for health care.* (Female FGD participant, 24 years)

Although women paid for health care, it was a role they were less inclined to 'usurp' from men. The refund was meant to reinforce men's responsibility, failing in which they could be punished with inflated health care costs. Refunding women's money was considered responsible male behaviour, but it was likely to reinforce rigid gender roles in health care provision, and obscure women's contributions to health care – financial or otherwise. Nonetheless, refunding women's money largely depended on the man. Failing to replace women's money signified that providing health care remained a female obligation, although men may contribute to it financially. When women borrowed money to pay for health care, they risked having to pay the debt without their spouse's help, which further undermined their savings and their potential to seek health care promptly in the future. The implied risk to future health care access was the main reason some men refunded their wives' money, as an assurance that health care would be accessed despite their absence. Similarly, it was for such an eventuality that women insisted on having their own money.

Choosing a health care facility

Even if they were working, because they were responsible for child-care, women often decided which health care facility to use. Together with male absenteeism and the risks associated with not seeking health care, this should have enhanced women's relative autonomy in selecting the health facility.

However, this autonomy was undermined by women's limited incomes. With men as the basic providers of household income, their role in selecting a health facility remained prominent. The key factors that determined whether the man participated in choosing the health facility were the wife's lack of money; when a patient did not recover; preference for certain providers; and established clientele. Included within all these factors was the issue of who paid for health care. In fact, some women preferred their spouse to choose the facility because men often accompanied their choices with the money to pay.

In the FGDs, situations where the man selected the facility were uncommon. Generally a man provided the woman with money and let her select the facility she preferred. Most women preferred this, as it allowed them to seek health care from facilities where they had 'connections'. However, this had disadvantages: unlike men who chose the facility, men who allowed their wives to choose did not often provide them with enough cash to exercise that freedom. Maria, a 28-year-old woman married to a 66-year-old market vendor, said:

> *What he gives you is what you go with. After all, another man would choose not to give you any money. Often he gives me only Ush 1 500 (US$ 1.00), which is just enough for one day's treatment (chloroquin tablets and one injection instead of three) from the dispensary. If you have got to go back for referral, you have to "devise your own wisdom". Otherwise, you get inadequate treatment. ... Sometimes, I have had to use my own money, even if he does not reimburse me. By then, my choice is between having a sick child and sticking to my money.*

Autonomy was undermined by women's limited incomes

This case re-emphasises health care provision as a female obligation, one that women have to meet with limited resources. Although the women were free to decide autonomously, without the cash to do so, their choices were indirectly determined by the amount of money provided by the spouse.

Cultural transformation?

This *focus* has demonstrated the changing but resilient nature of culture. Changes in health care provision, such as the introduction of user fees, were both an opportunity to modify the gender

relations of health care provision and an instrument for reinforcing gendered health care provision. Since providing household income was a masculine role, the demand for the fee should have seen men playing a more significant role in determining health care choices. However, this was not likely to be the case. Health care provision remained a feminine role, one which men could choose to help with or not. For women, regardless of financial constraint, such a choice was not available. They had to play their roles with whatever resources they had. The only exception was paying for pregnancy and childbirth, an obligation men were keen to meet. Women, too, were eager to enforce this as a male role.

Women's strategies to recover their money spent on health care reveal their ability to identify openings within culture to get men involved in health care provision. Far from using such strategies to challenge their disadvantaged position in health care provision, women used them to reinforce the gender relations in health care provision, and consequently other stereotypes and inequalities in household gender relations. Although having men pay rescued their meagre savings, it was also likely to reinforce the stereotype of 'man the provider' which is commonly used to deny women opportunities to access economic resources and gainful employment, which would make them financially independent. Kandiyoti (1998) would consider such strategies as providing temporary relief within the unequal gender system, without tackling gender inequality. Tackling gender inequality in all its different manifestations is vital if women are to benefit from new policies such as privatised health care. Considering the centrality of masculine and feminine identities and their attendant roles, exploring ways of modifying these identities for gender equality is a strategy worth pursuing.

Notes

1. Hegemonic masculinity (or femininity), according to Haralambos and Holborn (2000) and Kimmel (2000) refer to the dominant forms of masculinity applicable in a given context. This is not to suggest that other forms of masculinity (and for that matter femininity) do not exist.
2. *Tezibula Mukwaate* is a Luganda idiom denoting that a man can never fail to raise money for his household. *Omukwaate* is a person who has been arrested and fined, hence he or she must pay the fine. If the *omukwaate* lacks the money, he or she should devise means to raise it, such as borrowing or fundraising. As a household head, a man's position is similar to that of an *omukwaate.* He must devise means of meeting his financial obligations to the household, more so in case of illness, otherwise the patient might die.
3. In Luganda, the language of the Baganda people, which was the dominant language spoken in the research setting, the household was referred to as *enyumba,* a term denoting both the residential unit – house and the household. The 'ideal' *enyumba* comprised a man, his wife or wives and sometimes, extended family members. Every *enyumba* had its own *mutwe* or head, who was usually the adult male owner of the house, and the land on which it was constructed.
4. Luganda for a person who has qualified to be allowed to play the sick role, no matter the condition of illness.
5. 'Man the Impregnator' and 'Man the Provider' are two of the three features of masculinity advanced by Gilmore David (cited in Haralambos and Holborn, 2000). Similar views of masculinity existed in the research setting. Among other things, the feature man the impregnator involves males being expected to impregnate women. This view assumes only males perform an active role in reproduction (courting, marrying and impregnating women) and assumes women play a passive role – one of simply receiving the sperm and giving birth to the 'man's child'. Hence, men should own the children and go on to provide for them.

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