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Widowhood and barriers to seeking health care in Uganda

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Widowhood and Barriers to Seeking Health Care in Uganda

Nyasha Tirivayi[1]

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Abstract

Objectives

This study examined whether widowhood was associated with experiencing barriers to seeking health care in Uganda

Methods

Data from 8674 women aged between 15 and 49 years in the 2011 Uganda Demographic Health Survey, were analysed using multivariable logistic regression models.

Results

Compared to other women, widows were more likely to identify getting money for treatment and not wanting to visit health facilities alone as barriers. The odds for encountering barriers were higher for poor and uneducated widows and to some extent for non-poor widows and those with a basic education.

Conclusions

Widows are at greater risk of experiencing barriers to health care seeking than other women and may require special consideration in poor countries.

Keywords
Health care seeking; widowhood; barriers; access to health care; Uganda

JEL Classification: I14, I30

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Introduction

Past research has established that widowhood may change health behaviours, lead to poor physical and mental health, and is associated with a higher risk of mortality than other marital states (Elwert and Christakis 2008; Galatzer-Levy and Bonnano 2012; Manzoli et al. 2007; Shor et al. 2012; Wood et al.2007). Furthermore, there are indications that marital bereavement adversely affects access to and use of health care through loss of health insurance and spousal informal care, and higher costs of hospital visits and lengthened hospital stays (Iwashyna and Christakis 2003). However, the literature on the association between widowhood and health is dominated by studies from the developed world (Agrawal and Keshri 2014).

In developing countries, there is a large literature on the barriers and facilitators of health seeking and health care access by households. Studies generally show that the key drivers of health seeking include: poverty, distance to health facilities, cultural beliefs, women's education and empowerment, health care service availability and quality, household size and disease patterns (Amin et al.2010; Katung 2001; Navaneetham and Dharmalingham 2002; Shaikh and Hatcher 2005; Singh et al.2013). In addition, it has also been established that women's health seeking behaviours affect child health and mortality (Uchudi 2001). However, little is known about how widows fare in resource limited settings like sub-Saharan Africa. This study addresses this knowledge gap by examining the association between female widowhood and barriers to seeking health care in Uganda. This study's focus on the health care seeking of widows is particularly important since they constitute a significant segment of society in HIV/AIDS afflicted countries such as Uganda.

Methods

Data source

Publicly available data from the 2011 Uganda Demographic Health Survey (DHS) were used for the analyses (ICF 2014). Since the DHS obtains individual social, demographic and economic data solely from women and men aged between 15 and 49 years, this study only focused on women in this age group. The analytical sample comprised 8674 women, of whom 319 were widows.

Measures

There were four outcome measures. The first three are based on the responses to a question asking women whether or not the following problems were a significant barrier to seeking medical care when they were sick: i) not wanting to go alone, ii) getting money for treatment, and iii) distance to health facility. These three measures were binary variables (coded as 1-a problem, 0-not a problem). The fourth measure was created to denote whether respondents encountered any of these three problems in seeking medical care (1-yes, 0-no).

Analysis

Descriptive statistics were used to summarize the characteristics of widowed and non-widowed women. The study used multivariable logistic regression models to estimate the odds ratios for encountering barriers in accessing health care among women in the sample. Regression models were adjusted for age, education, poverty level, household size, household composition, location and region. The primary independent variable was widowhood. Additional logistic regression models were used to assess the relationship between widowhood and barriers to seeking health care among five sub-populations of women: poor, non-poor, uneducated, primary educated, and

post-primary educated. To account for the complex sampling design, all the analyses were weighted and conducted using the procedures for analysing complex sample survey data in Stata version 13.

Results

Sample characteristics

Widows were 3.8 per cent of the weighted sample (Table 1). Widowed women were more likely to be poor (50.4 per cent) compared to non-widowed women (35.1 per cent). A higher proportion of widows had no education (27 per cent) compared to non-widows (12.3 per cent). About 87.3 per cent of widows resided in rural areas compared to about 80 per cent of non-widows. On average, widows were older (39.4 years) than non-widows (27.5 years) and had slightly smaller households. Both widowed and non-widowed women had nearly similar numbers of children under the age of 5 years (about 1 child)

Table 1. Characteristics of the weighted sample of widowed and won-widowed women

Characteristic	Widow (n = 319)	Non-Widow (n = 8355)	*P value*[b]
per cent			
Total	3.8	96.2	
Education			< .0001
None	27	12.3	
Primary	60.4	59.4	
Secondary	11.2	22.9	
Tertiary	1.4	5.4	
Poor[a]	50.4	35.1	
Location			< .001
Urban	12.2	20	
Rural	87.3	80	
Mean			
Age	39.4	27.5	<0.001
Household size	5.4	6.3	<0.001
Number of children under 5 years	1.1	1.4	<0.001

Notes. Data obtained from 2011 Uganda DHS. Percentages and means have been weighted to account for complex design and are therefore population based. [a]Poor status variable denotes the lowest two quintiles of the DHS household asset wealth index. [b]Pearson χ^2 test for proportions and t-test for means.

Barriers to seeking health care

Table 2 shows that widowed women were more likely to identify "getting money for treatment" (odds ratio (OR) =2.2; 95 per cent confidence interval (CI) [1.6, 3.1], p<0.001) and "not wanting to go alone" (OR =1.5 [1.1, 2.0], p<0.05) as barriers to seeking medical care. Overall, widows were 70 per cent more likely to have experienced a barrier to seeking health care than other women (OR=1.7 [1.2, 2.5], p<0.01). Compared to other women, widows were not significantly more likely to report "distance to health facility" as a barrier (OR =1.7 [0.7, 1.4], p<0.01). Among poor (OR=2.2 [1.0, 4.1], p<0.05) and uneducated women (OR=1.7 [1.0, 2.9], p<0.05), widows were more likely to significantly experience a barrier to seeking health care. Widowhood was to some extent associated with experiencing a barrier to seeking health care among non-poor (OR=1.5 [0.9, 2.4], p<0.10) and primary educated women, (OR=1.9 [1.0, 3.8], p<0.10)

Table 2. Adjusted odds ratios of the association between widowhood and experiencing barriers to seeking health care when sick.

Barriers to seeking health care	Widowhood (OR)	95% CI	*N*
Getting money for treatment	2.2****	[1.6,3.1]	8662
Distance to health facility	1.0	[0.7,1.4]	8662
Not wanting to go alone	1.5**	[1.1,2.0]	8661
Ever experienced any barrier	1.7***	[1.2,2.5]	8662
Sub-populations- (ever experienced any barrier)			
Poor	2.2**	[1.0,4.1]	3185
Non-poor	1.5*	[0.9,2.4]	5475
No education	1.7**	[1.0,2.9]	3922
Primary education	1.9*	[1.0,3.8]	2731
Post primary education[c]	0.2	[0.02,1.5]	693

Notes: Data obtained from 2011 Uganda DHS. * p < 0.10, ** p < 0.05, *** p < 0.01, **** p < 0.001. CI = confidence interval; OR = odds ratio. [c] Post primary education refers to secondary and tertiary education.

Regression models were adjusted for age, education, poverty, household size, household composition, location and region. Regressions account for complex sample design.

DISCUSSION

The results show that widows are more likely to experience problems in seeking health care than other women. Widows were more likely to identify paying for treatment and an aversion to visiting health facilities alone as barriers. These results suggest that widows may be more economically and psychologically vulnerable than other women. Generally, the odds for experiencing a barrier to seeking health care were higher for poor and uneducated widows and to some extent for non-poor widows and those with a basic education. Therefore, wealth and basic education may not completely eliminate a widow's challenges in health care seeking.

The findings are consistent with previous research on widowhood and its negative correlation with access to health care in developed countries. A few studies have also begun to assess the effects of widowhood on socio-economic outcomes. They show that female widows in Africa are poorly nourished and deprived of asset inheritance and access to land (Chapoto et al.2011; Peterman 2012; van de Walle et al.2013). In light of these findings and the results of this study, the emerging consensus from research is that widowhood reduces welfare. Widows appear to be more vulnerable than other women and may require health and economic policy consideration in poor countries.

Still, it is important to note that this study demonstrates that widows still encounter health care costs that are high enough to discourage them from seeking health care despite the government of Uganda's abolition of user fees at public health facilities in 2001. Studies from Uganda have shown that despite the elimination of user fees, the lack of supplies and medicines and the

subsequent poor service delivery at public health facilities, leads Ugandan patients to purchase from private sources, thereby incurring high out of pocket expenses (Basaza et al. 2010, Nabyonga et al. 2011). Hence, user fee eliminations implemented in weak health systems may not eliminate financial barriers to care seeking by extremely vulnerable populations like widows. Furthermore, the aversion by widows to visit health facilities alone may reflect an emotional/psychological vulnerability, probably heightened by the link between widowhood and HIV/AIDS in Uganda. In this context, programmes which provide social and psychological support to widows could encourage health care seeking.

This study had a number of limitations which can be addressed by future research. The data were cross sectional hence it was not possible to determine causality and track outcomes over time. The DHS did not have information on the duration of widowhood and HIV status. DHS's age restriction for individual data (15-49 years) meant that the study could not assess older widows, who may have a greater morbidity burden than younger widows (Agrawal and Keshri 2014). Since, previous studies have established a causal impact between the lack of social relationships and health (House et al.1988), future research could also explore whether social isolation and the lack of kinship networks deter widows from visiting health facilities alone. Future research could also determine the impact of widows losing their asset inheritance on health care expenditures and health seeking behaviours.

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