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Barriers and coping strategies with the uptake of MCH/ANC-linked services in a selected health facility catchment area in Uganda

Findings of a Rapid Qualitative Assessment

January 2015



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ACRONYMS

ANC	Antenatal Care
ARV	Antiretroviral Therapy
CHC	Communication for Healthy Communities
DOT	Directly Observed Treatment
eMTCT	Elimination of Mother to Child Transmission
HCT	HIV Counseling and Testing
HF	Health Facility
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interviews
IP	Implementing Partner
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment of Malaria in Pregnancy
ITN	Insecticide-Treated Net
LQA	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MIS	Malaria Indicator Survey
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
USG	United States Government
USAID	United States Agency for International Development
UDHS	Uganda Demographic and Health Survey
UAIS	Uganda AIDS Indicator Survey
VHT	Village Health Team

SUMMARY

Background

Uganda government and development partners continue to provide maternal and child health/antenatal care (MCH/ANC) services and products. However, utilization is low and continues to be affected by environmental, social and technical barriers. This paper reports the findings of a rapid qualitative assessment in March 2014 to document specific barriers to MCH services and focused antenatal care packages, and to more closely examine the role they play in the process of health and care-seeking decisions and behaviors among males and females, aged 18-49 years in Sironko District, located in eastern Uganda.

Methods

A cross-sectional qualitative design was deployed among male and female participants, aged 18-49 years, in selected areas of Sironko District. Focus group discussions explored barriers regarding uptake of MCH services (i.e., a focused ANC package that included elimination of mother-to-child transmission of HIV (eMTCT), prevention of malaria in pregnancy, and a health facility delivery). In-depth interviews (IDI) explored characteristics and motivations for successful uptake of MCH services. Analytical review and interpretation of the data was iterative and informed by the socio-ecological model.

Results

One hundred and seven (107) men and women participated in the study. Participants demonstrated knowledge of the critical issues in MCH, including benefits of ANC, eMTCT, intermittent preventive treatment of malaria in pregnancy (IPTp), bednet use, and health facility delivery. The data indicated a lack of distinction between feeling healthy versus the role of ANC in helping to avert common pregnancy complications.

Five categories of women emerged from the data with regard to MCH uptake behaviors and underlying factors. ANC uptake was driven by factors that included: 1) family tradition that is either pro-traditional birth attendant (TBA) or pro-health facility, 2) spousal support, 3) women's sense of beauty, dress, and appearance, 4) financial implications, and 5) perceived provider conduct and health service efficiency. Women with a previous non-problem pregnancy and/or delivery, who may have had a bad experience at health facilities perceived provider neglect and were more likely to deliver at home. Participants also suggested that in recent years, fear of positive HIV test results may keep "weak-hearted" women from attending ANC because they "would worry and die quickly."

Financial implications were perceived in two ways: 1) some couples avoided ANC and health facility delivery because of service costs, and 2) other couples, especially male partners, perceived ANC and health facility delivery as essential for averting avoidable

costs that may arise from pregnancy complications. IPTp did not appear to bar women from attending ANC, but women reported general dislike for the taste of anti-malarials.

Adopters of recommended MCH behaviors were mainly motivated by 1) the desire to protect their unborn child, 2) strong spousal support, and 3) established relations with health services and up-to-date health information. Their motivations reinforced birth preparedness, including putting money aside for ANC and maternity and the male partner tracking the ANC calendar to support the spouse in keeping ANC appointments.

Opportunities for social and behavior change communication

It is important to communicate the broad benefits of ANC including that the service minimizes—but does not necessarily eliminate—the probability of complications during pregnancy and/or at delivery. To increase motivation, social and behavior change communication (SBCC) efforts should incentivize ANC attendance by communicating the immediate and accruing outcomes for either spouse.

To reinforce ability to act, SBCC efforts, particularly through health worker interpersonal communication (IPC) should help couples take small steps to prepare for birth, for instance, shared spousal responsibilities in carefully tracking the woman's due date, keeping aside money for costs such as transport and maternity fees, and addressing aesthetic needs such as buying appropriate maternity garments for both mother-to-be and baby. Provider IPC skills are needed to improve client-provider sessions, and especially to manage personal biases and improve trust.

Regarding eMTCT, providers will need special IPC skills to facilitate spousal dialogue and initiate disclosure of HIV status, so as to offset fear of HIV positive test results and the general suspicion regarding potential lack of confidentiality among providers. In relation to IPTp, spousal support plays an important role in encouraging women's adherence and identifying small doable actions to ease perceived discomforts linked with the effects of anti-malarials.

At the norms level, TBAs remain trusted and readily accessible as a first line of care by pregnant women and their families. SBCC and public health programs may benefit from identifying champions among TBAs, who can link women with the health care system.

1. INTRODUCTION

In order to reduce maternal and child morbidity and mortality, the Government of Uganda and implementing partners have stepped up efforts to provide MCH services to secure up to four ANC visits, HIV counseling and testing (HCT) and eMTCT, health facility (HF) deliveries, and prompt and effective management of childhood illnesses such as diarrhea. However, increased public awareness and availability of MCH services has not been replicated in behavioral uptake in Uganda according to information from several surveys (UBOS 2009, UDHS 2011, UAIS 2011). While ANC attendance appears high on an initial look, this attendance data is limited to first visit, which may occur later in pregnancy, with adverse implications for eMTCT outcomes and maternal and child welfare. Also, while an estimated 94% of pregnant women attending ANC received eMTCT services, uptake of eMTCT services *after* delivery remains low and many unrecorded births continue to take place outside health care facilities (UDHS 2011, STAR-E LQAS 2013). With regard to prevention of malaria in pregnancy, since 2002 health facilities in Uganda have provided IPTp (plus ITNs) as part of the focused antenatal care package. However, uptake of malaria preventive interventions such as IPTp services and net use during pregnancy remain low, estimated at 24.5% and 44% respectively (UBOS 2009).

Studies of patterns of antenatal care and skilled assisted delivery in sub-Saharan Africa indicate that regardless of age, men and women often resort to customary beliefs and tend to avoid antenatal care by skilled health providers. One reason for objection relates to the nature of health services, i.e., providers are male in many cases, and ANC service exposes a woman's private parts to that health care provider, who is not her husband (Kasolo et al. 2000). It is also common in sub-Saharan Africa that men and mothers-in-law make fundamental decisions regarding health care for women during pregnancy, and whether, when, and where to seek care. This is attributable to paternalistic traditions that endorse men as being in control of most of a family's resources (Kasolo et al. 2000; Bawah et al. 1999).

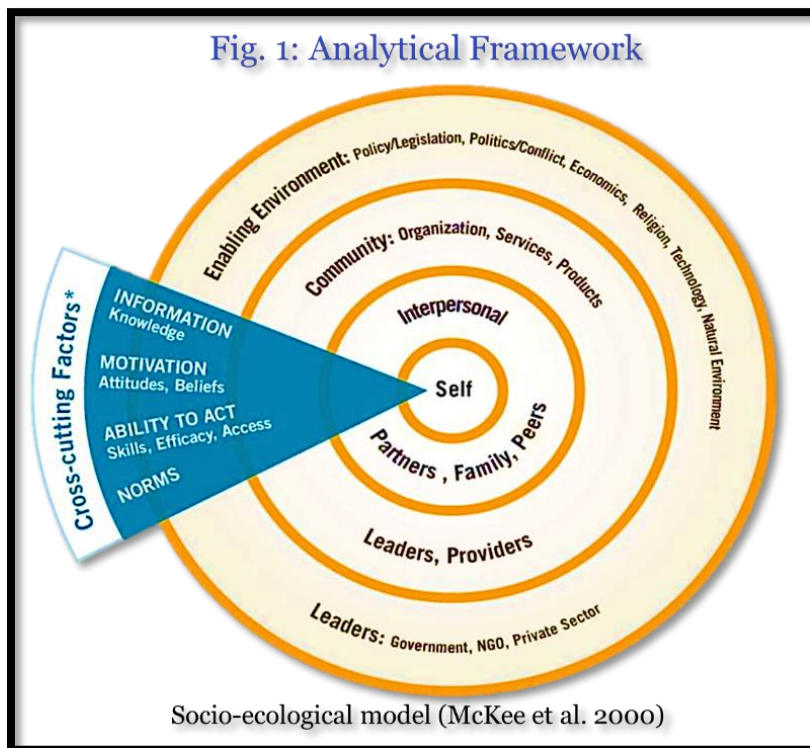
Actual use of nets has been widely documented to be significantly lower than net ownership rates in vulnerable populations (Korenromp et al. 2003, Macintyre et al. 2006, Afolabi et al. 2009, Baume et al. 2009, Deribew et al. 2012). A review of 22 published studies examining attitudes and barriers to bednet use in sub-Saharan Africa shows that reasons for non-use of nets coalesce around three major issues: environmental, social, and technical (Pulford et al. 2011). Environmental factors include heat discomfort and perceived absence of mosquitoes. Social factors include household sleeping arrangements. Technical factors include practical issues ranging from lack of skills or room/space to hang nets.

This paper reports the findings of a rapid qualitative assessment, carried out in March 2014, to document specific barriers to MCH services/interventions in the focused antenatal care package and to more closely examine the role these barriers play in the

process of health and care seeking decisions and behaviors among males and female, aged 18-49 years, in Sironko District.

2. CONCEPTUAL AND ANALYTICAL FRAMEWORK

The research questions, study guides, and analytical review and interpretation of the data were guided by the Socio-ecological model (Fig. 1), which also provided the analytical framework as well as CHC's theory of change (Annex 1). We targeted identification of drivers of barriers to uptake of healthy behaviors and services MCH/Malaria (ANC/ IPTp/ eMTCT, ITNs, and case management of childhood illness), with particular attention to the characteristics of adopters of desired behaviors/services.



3. SPECIFIC OBJECTIVES

The specific objectives were:

1. To document barriers (technical/social/gender, fears, misconceptions/ misinformation, perceived side effects), and perceived benefit effects of the specific health behaviors/products/services,
2. To examine characteristics, decision-making factors, coping strategies, and processes among current adopters of desired behaviors/products/services.¹

4. QUESTION DOMAINS

Important questions that have potential to inform SBCC intervention efforts specific to MCH services under the focused antenatal care package, and that the research sought to address included:

1. What are people's intentions with regard to the desired behaviors/products/services?

¹ Objective two was set on the premise that while there may be real barriers that inhibit the adoption of desired behaviors and/or services, some individuals and families in these very communities are successful adopters of preventive behaviors and services. In-depth interviews with adopters thus sought to identify the factors that facilitate successful uptake of behaviors and use of health products and services.

2. What are the barriers (known from personal experience and/or perceived)?
3. What are the underlying factors and drivers of any fears/barriers?
4. What gender and social norms issues reinforce the barriers?
5. What are the characteristics of current adopters?
 - a. How do current adopters of desired behaviors/products/services overcome obstacles/opposition/fears?
 - b. What do they perceive as the desirable characteristics that motivate them to adhere to the behavior/product/service they have adopted?
 - c. How do the specific interventions fit within their life style?

5. DESIGN AND METHODS

5.1. Overview

The exploratory assessment deployed focus group discussions (FGDs) and in-depth interviews (IDIs). Specifically, FGDs were used to explore normative behaviors outlined in question domains 1-4, (Objective 1) while IDIs assessed coping strategies of adopters outlined in question domain 5 (Objective 2). The assessment was initiated by conducting FGDs and using FGD participant demographic information to facilitate snow-ball sampling for in-depth interviews.

5.2. Study population and recruitment

The assessments on behaviors specific to MCH/malaria (ANC, IPTp, case management, and ITN use) were conducted among catchment populations living in a 5 km radius of health services supported by USG implementing partners.[♦] The study population was composed of males and females; pregnant women, mothers or caregivers of children <5 years, men and women of reproductive age (18-49 years).

Participants identified from FGD demographic profiling sheets to be adopters were approached and asked whether they would be interested in participating further in IDIs. Snow-balling technique was used to ask these initial respondents to direct the study team to adopters (outside of their immediate families) that are known to them. Appropriately briefed community mobilizers assisted in identifying and recruiting participants from around catchment areas of health services.

5.3. Data collection

Three experienced interviewers—two female and one male—collected data for 14 days in late March and early April 2014. One of the interviewers was a supervisor who also conducted interviews. Data collection was initiated through FGDs to facilitate initial

[♦] To minimize reports of accessibility barriers and to focus the study to the research questions (i.e., non-access related barriers), areas supported by USG IPs and assumed to have readily accessible services were prioritized.

recruitment of IDI participants. Thereafter, FGDs and IDI were conducted concurrently. The sample was flexible.

Participants were recruited continuously, until whichever came first, either a desired number of participants was reached or the point of saturation was reached, i.e., no new insights were generated.

5.4. Data analysis

Data was analyzed using flexible, interactive processes involving a search for patterns, and concepts that help explain the patterns. The transcripts for FGDs and IDIs were reviewed to identify similar phrases, relationships between variables, patterns, common themes, and distinct differences, to identify common themes, to create conceptual clusters, and to identify outlying information. A code book was developed from key themes and patterns identified. Data was coded using qualitative software that enabled the cross-classification and retrieval of transcripts and segments of text by theme. The themes and interpretations were reviewed, discrepancies and contradictions analyzed, and supporting evidence and counter-evidence related to each interpretation systematically searched for.

5.5. Ethical considerations

This assessment included slightly greater than minimal risk to participants. All study staff completed training in human subjects' protection. Also, as condom use and sexual behaviors are very personal and some people may not want to talk openly about them, strategies for getting information without causing offense were emphasized. During field work, all interviewers followed standard international research ethics requirements for protection of human subjects. All study participants were informed at recruitment point about project goals and their right to refuse being interviewed, to interrupt the conversation at any time, and to withdraw any given information during or after the interview. Oral informed consent was obtained from each participant. In accordance with the July 2014 Uganda National Council for Science and Technology (UNCST) guidelines (UNCST 2014), participants were given a flat rate cash token in appreciation of their participation in the interviews.

5.6. Limitation of the study

This qualitative assessment was conducted within purposively selected sites areas among men and women in a catchment area of a health facility supported by USG IPs. While the findings and their interpretation and use must take cognizance of this context, they are in concurrence with existing literature in Uganda and meta-analysis in the sub-Saharan African region.

6. RESULTS

6.1. Socio-demographic characteristics of participants

Four FGDs were conducted with women and three with men. In-depth interviews were conducted with 16 women and 14 men. Table 1 presents the demographic characteristics of the 107 male and female participants, aged primarily between 20-49 years. Over half of participants were female; most participants had between 8-11 years in education and more than 70% were peasant farmers.

Table 1: Participants' characteristics	n=107
Sex	
female	60
male	47
Age in years	
18-19	4
20-29	34
30-39	33
40-49	32
Education in years	
1-7	45
8-11	39
12-13	9
Occupation	
Peasant Farmer	70
Private Employment	33
Public Servant	4

6.2. MCH knowledge among men and women

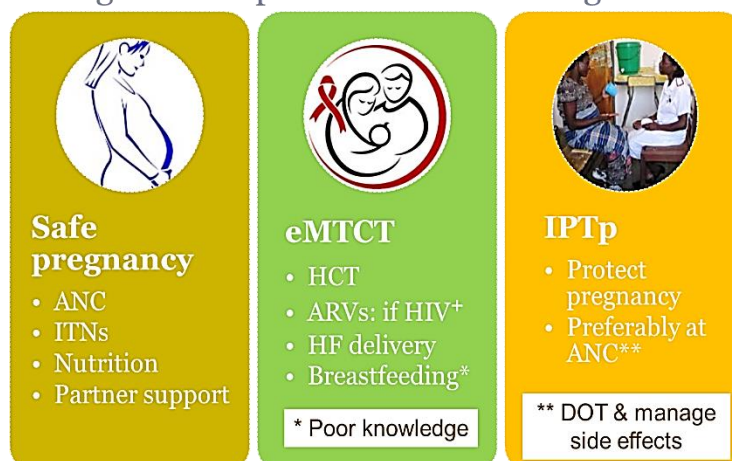
Women and men demonstrated knowledge of the critical issues in MCH (Fig. 2). These include actions required to assure a safe pregnancy such as ANC attendance, sleeping under ITNs to prevent malaria in pregnancy, and good nutrition during pregnancy. They also reflected an understanding of what eMTCT and IPTp involve, plus their important roles in assuring a safe pregnancy and delivery of a healthy baby.

"...when labor comes, the HIV positive mother is not allowed to give birth from home...she must go to a health centre. The health worker should not allow the mother's blood to mix with that of the baby....so that the child does not contract the disease. Male participant, FGD

They also reported a general community support for HIV testing during pregnancy[‡], noting that those who refused to test were mainly reacting to their own personal fears.[♦]

"In most cases all people [in the community] support that pregnant women be tested for HIV....So in most cases men always encourage their women to test for HIV...They think that pregnant women testing for HIV is ok." Female participant, FGD.

Fig. 2: Participants' MCH Knowledge



[‡] Concurs with Mumtaz et al., 2013: <http://dx.doi.org/10.4172/2167-0420.1000121>

[♦] Concurs with Pool et al., 2001: <http://www.academia.edu/197454/>

While breastfeeding was mentioned in discussions about essential baby care, there was confusion about recommended practice for mothers living with HIV. Participants universally noted that breastfeeding was an important part of baby care. They were also universally not very sure about whether a mother living with HIV should breastfeed exclusively, and for how long. Some reported that an HIV-positive mother should breastfeed, but only for three months. Others reported that the mother should not breastfeed at all.

“What we have heard is that if the mother is HIV positive...after giving birth the mother should not breastfeed that baby.” Female participant, FGD

Referring to IPTp as important medication, male and female participants were unanimous that it should at best be administered at the health facility[♣]; that the provider should directly observe that the woman swallows it, and assist the woman to manage any side effects.

“...the health worker should ensure that a pregnant woman swallows the tablet before the health worker as they do for tablets for worms so that by the time she leaves the health facility she has already taken the medicine at the health facility.” Male participant, FGD

“Health workers should ensure that the anti-malaria is given and the woman takes... it in the presence of a health worker... so that in case of any problem or immediate side effect, the health worker can address the problem there and then.” Female participant, FGD

6.3. Categories of ANC service uptake behaviors

The data highlighted at least five categories of women delineated by their uptake of MCH services, particularly ANC and its related package of services including eMTCT, IPTp, and delivering a baby at a health facility (Table 2). Women who have had a successful delivery before (whether home-based or at a health facility) fell into one of the first four categories. They are:

1. Prefers home deliveries,
2. Always delivers at a health facility,
3. Motivated to deliver at a health facility, but barred by inadequate spousal support and the subsequent limited access to finances to cover transport costs and other service costs at ANC/maternity, and
4. Motivated to deliver at a health facility, but barred by relations (real or perceived) with health providers at the nearest health facility.

[♣] Concurs with a review of health service gaps in IPTp uptake: Thiam et al., 2013: <http://www.malariajournal.com/content/12/1/353#B11>

The fifth category encompasses women in their first pregnancy (or first time carrying a pregnancy to full term), hence highly likely to attend ANC and deliver at a health facility, particularly if married[♦]. However, depending on several factors highlighted in column 5 (Table 2), they could fall into any of the first four categories. Uptake of IPTp and HCT (eMTCT services) is assumed to be highly dependent on the provider's initiative to facilitate initiation and completion.

Participants observed that in the case of a pregnancy out of wedlock, it was especially common for women—even if living with their male partners—to shun ANC for fear of social ridicule for being pregnant, yet not 'properly' married. Young girls under the care of parents also tend to hide their pregnancies and may only go for ANC and services such as HCT/eMTCT when the pregnancy is in advanced stages and cannot be hidden.

"...young girls who get pregnant while still at school... such girls first of all cannot tell their parents the responsible man for the pregnancy. That is a reason enough not to go for HIV testing... because they will not even have the courage of going for ANC. They always live in hiding..." Female participant, FGD

In-depth insight into the findings highlighted in Table 2 are presented thereafter in the following order: ANC services, eMTCT, health facility delivery, mother and new born care.

[♦] Concurs with Birungi, 2013 <http://hdl.handle.net/10570/2786>

TABLE 2: CATEGORIES OF MCH UPTAKE BEHAVIORS: ANC (+ HCT/EMTCT), MALARIA IN PREGNANCY, HF DELIVERY

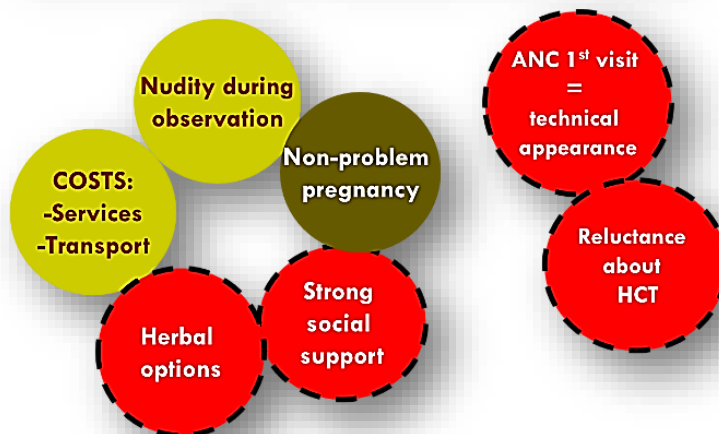
Has had successful deliveries				First pregnancy/mother
WOMAN 1	WOMAN 2	WOMAN 3	WOMAN 4	WOMAN 5
<p>Prefers home deliveries (only 1st delivery at HF)</p> <ul style="list-style-type: none"> Cares about health of fetus but believes traditional options the best Attends ANC 1st visit as surety in case of complications later in pregnancy <p><u>ANC fears</u></p> <ul style="list-style-type: none"> Feeling sick/ abdominal pains after health workers 'squeeze' the abdomen Baring nudity (<i>many women feel dirty down there. TBA only feels with her hands...not looking at the vagina</i>) <p><u>IPTp:</u></p> <ul style="list-style-type: none"> medicine causes dizziness medicine tastes bad, causes nausea <p><u>ITNs</u></p> <ul style="list-style-type: none"> May or may not use depending on <ul style="list-style-type: none"> Feeling of suffocation Hot or cool nights/season <p><u>HF delivery</u></p> <ul style="list-style-type: none"> No food – will starve in maternity No nice maternity/night dress – will feel dirty among other women, High bills with inflexible payment arrangement (TBA offers friendly rates and payment plan) 	<p>All deliveries at HF</p> <ul style="list-style-type: none"> Cares about health of the fetus and believes medical care the best <p><u>ANC:</u></p> <ul style="list-style-type: none"> Family tradition to attend ANC/ HF delivery <u>OR</u> witnessed complications during home-births (<i>especially prior to pregnancy</i>) Attends all ANC visits Returns to ANC if any problem arises Spousal support – financial, psychological Has strategies to overcome service barriers e.g. <i>if nurse unfriendly...change health center or ignore rudeness of nurses. Primarily motivated to protect unborn child.</i> <p><u>IPTp</u></p> <ul style="list-style-type: none"> Bad taste/nausea not important—the health of the unborn child is paramount. Informed about IPTp and may demand for it if provider not offering <p><u>ITNs</u></p> <ul style="list-style-type: none"> Knows to wash/air new ITNs before use in order not to be choked by the chemical <p><u>HF delivery</u></p> <ul style="list-style-type: none"> Preparedness is important to her (<i>ANC helps to project the delivery date better</i>) Gets immediate baby care advise and initial immunizations Gets chance to rest before baby care 	<p>Decisions shaped by spousal support (mainly financial)</p> <p><u>ANC:</u></p> <ul style="list-style-type: none"> Endeavors to attend ANC and all requirements First visit may be timely or late depending on financial support May not complete ANC coverage if unable to attend one of the scheduled follow-on visits – (<i>fear of being reproached by nurse</i>) <p><u>IPTp</u></p> <ul style="list-style-type: none"> Endeavors to complete IPTp if can attain full ANC coverage <p><u>ITNs</u></p> <ul style="list-style-type: none"> May or may not use depending on <ul style="list-style-type: none"> Feeling of suffocation Hot or cool nights/season <p><u>HF delivery</u></p> <ul style="list-style-type: none"> Factors linked to ANC coverage: <ul style="list-style-type: none"> If ANC coverage attained, then highly likely to deliver at HF. If ANC incomplete, then highly likely will deliver at home (<i>fear of reproach by nurse over ANC</i>) Birth preparedness – often unprepared for birth (<i>These ones found delivering on the way to HF</i>) 	<p>Decisions shaped by established relationships with health service</p> <ul style="list-style-type: none"> Somewhat similar to woman 3. Motivated, but the barriers link directly to the relationship with health providers. 	<p>This is a new experience. Most likely to attend ANC and deliver at the HF*.</p> <p>Often takes all necessary care dependent on the following</p> <ul style="list-style-type: none"> Financial support for bus fare and health service fees Family tradition for pregnancy care (home vs medical care) Assumed that if attending ANC will complete IPTp, so this component depends on provider initiative, or if the woman is aware, her own initiative to get the medication.

* Concurs with UDHS 2001, 2006, 2011; Mbonye et al., 2006.

6.4. Overview of factors affecting ANC service uptake

Fig. 3 below summarizes participants' perceptions of factors inhibiting ANC attendance. A non-problem pregnancy (no sickness during pregnancy, or successful previous births) was most cited as a key factor in poor ANC attendance and decisions for home deliveries.[^] This practice was exacerbated by matriarchs, especially the woman's mother, who meticulously followed supplied herbal alternatives for pregnant women. Apparently, women influenced by such social support were less likely to reach out to the health service during pregnancy and/or delivery. Instead, they may deliberately make at least one ANC visit (a technical appearance) as a form of insurance, i.e., to enable admission to the health facility in case complications arose late in the pregnancy or during a home-based delivery.

Fig. 3: Key themes in barriers to ANC uptake



It was also suggested, widely by both men and women despite the suggestion of generalized

Box 1: Barriers, in Context	
Social norms	<i>"such women [who deliver at home]...even if the daughter marries far from home she would rather call her in the last 3 months to stay with her..."</i> <small>Female, FGD</small>
ANC 1st visit	<i>"When some women visit the ANC and the nurse finds everything is good, she will say to herself...I will only go back if I have a problem..."</i> <small>Male, FGD</small> <i>"...some women visit ANC once without intending to go back...it is her ticket for delivering at HF if problems arise..."</i> <small>Female, FGD</small>

community support for HIV testing during pregnancy, that reluctance to make an ANC visit in recent years may be driven by fear of the routine HIV counseling and testing for all pregnant women.[¥] This fear was apparently driven by concerns about negative social consequences such as stigma against persons living with HIV, and potential for marital break-up.

[^] Concurs with Bbaale, 2011: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3562912/>

[¥] Some difference with Mumtaz et al., 2013: <http://dx.doi.org/10.4172/2167-0420.1000121>

The fear of being nude was linked to a perception by some women (self-stigma) that they are too dirty and feared being ridiculed by health workers. This was mentioned in men's focus groups, with some men adding that spouses needed to teach their wives how to be clean especially during pregnancy.

User fees, including registration and costs for small supplies for delivery such as clinical gloves, were also mentioned as key barriers. There were suggestions that health workers were making clients pay for services that the government provides for free.

6.4.1. Barriers linked to zero ANC attendance – woman 1

6.4.1.1. Lack of distinction between feeling healthy and common pregnancy complications

Women who are pro-home delivery reportedly made mockery of women who consistently attend ANC and still end up being referred for caesarean delivery. This misconception may entrench perceptions that ANC services do not increase chances of a safe pregnancy and/or delivery, and that ANC and health facility delivery is not necessary for some women.

“Some women mock those who faithfully go for ANC and end up going to the referral hospital in Mbale for C-section after failing to give birth normally....so such people say for them with their local herbs they do not go for C-section, they give birth normally. They often say: “even if I do not go to the health centre for antenatal, I have my local herbs to take and I will deliver well.”
Female participant, FGD

“There are women who assume that they are healthy, so such women see no need to deliver from a health centre...she looks at herself and says: I have not had any health problems ever since I got pregnant, so why should go to deliver from a health center.” Male participant, FGD

6.4.1.2. Social issues and appearances

As shown in Table 2, women with the highest inclination for home-based pregnancy care and delivery are barred by:

1. A family tradition that is pro-herbal remedies and TBA care – woman 1 mainly,
2. Fear of long duration of hunger (especially if there is nobody to bring food on long ANC queues or during maternity care) – woman 1 mainly, and
3. Embarrassment of presenting at ANC and/or maternity if one does not have proper maternity dresses, pants, and baby stuff – woman 1 mainly.

Participants reported that some women and their families traditionally rely on herbs and TBAs and see no value in attending ANC.

“Such women also pass [this] mentality to their daughters who grow up and also give birth to children from home. This is because they have been instructed by their mothers who may be

TBAs in the village...Even if the daughter is married far away from home, she would rather call her in last three months [of pregnancy] to stay with her.... Male participant, FGD

With regard to manner of dress:

Even if a woman wants to go [to ANC or maternity], she may not have appropriate clothing to put on and that alone makes her feel bad and end up not going at all. Female participant, FGD

"Imagine going to a health centre and when the cloth you are putting on is bad, actually rags and yet all your friends are putting nice maternity dresses. Immediately you arrive at the health centre all people turn and look at you because of the ugly clothes. ...she goes home and never returns." Female participant, FGD

With regard to long queues and hunger:

"...men of the house [spouses] have neglected our women and that also makes some women fail to go for ANC... if you happen to go together, you support each other. For instance, if a woman is seated in a line [is on the queue] to wait for her turn to see the midwife, the man can go to look for a soda and something to eat." Male participant, FGD

6.4.1.3. Making at least one ANC visit as a strategic action

Women who are pro home pregnancy care and/or home deliveries apparently make a calculated decision for at least one ANC visit during the early stages of pregnancy purposefully to obtain an ANC card and a *Mama Kit*. An ANC card could be used as evidence that they have ever attended ANC, in case of a last minute decision to deliver at a health facility, for instance, in the event of problems in later stages of pregnancy, and/or early signs of complications during labor at home.

"Some women go once because they want to get a card and book a place in case they need to go back to give birth. Her main aim to have the baby delivered at home; and only go to the health centre if she develops complications." Female participant, FGD

"Some women go for ANC just in case they get issues during delivery time...when a woman goes to deliver and has never gone for ANC before, the midwives don't attend to her...so some women go for ANC to book their place for delivery especially if it warrants [complications arise in advanced pregnancy] that she has to deliver from a health centre." Female participant, FGD

6.4.1.4. Fear of routine HIV testing

Some women were apparently wary of a positive HIV test result and decided to skip ANC altogether.

"Some women fear that if found HIV positive, she will be laughed at...and others fear that once tested HIV positive, they will get worries which may kill them very fast." Female participant, FGD

It was reported that some men who have been with several partners may even discourage their wives from attending ANC[‡]:

“If you go, those health workers will pronounce you HIV positive.” Female, FGD

If the woman insists on testing and returns with results showing she is positive, the husband may make an excuse to abandon/divorce her.♦

6.4.1.5. Religious prohibitions

Some religious sects do not allow their followers to seek health services including ANC. Participants singled out some Evangelism sects as culprits. One participant said that: *“those members of Evangelism regard number 666 as given by the devil, so their fear is they do not want to go for school or health services in case they get to be given that number. That is why you get that when women who belong to that sect get pregnant they do not go to health facilities.”*

6.4.2. Barriers linked to partial ANC attendance – woman 3 and 4

6.4.2.1. Factors linked to routine STI/HCT services during pregnancy

The factors linked to HIV testing during antenatal care include: 1) fear of a potentially HIV positive test result, 2) fears about safety of testing and potential for accidental infection with HIV, and 3) perceptions that the couple are mutually faithful, hence no need to test.

- STI/HIV stigma

It was reportedly common for women who test HIV positive not to return for antenatal services because of fear of other women knowing her HIV status; often gauged from being known to have been referred to the ARV clinic, and leaving the clinic with a lot of medication.

“Imagine yourself now, as healthy as you look, for a person to go around the village saying: ...you see you may think that she is healthy...she is not...she is on ARVs... So others fear to test because they can easily become the talk of the day if found HIV positive.” Female participant, FGD

Also, any woman testing positive for an STD is often asked by the health workers to return with the husband for appropriate spousal counselling, testing, and treatment. Since it is common that many men refuse to come for services, affected women get discouraged and fail to return to the clinic. Some women reportedly do not know how to handle disclosure of a positive STI or HIV test to their spouses and subsequently decide not to return for antenatal services since they would not be able to explain why their spouse has not accompanied them as directed at the previous visit.

[‡] Concurs with Byamugisha et al., 2010: <http://www.reproductive-health-journal.com/content/7/1/12>

[♦] Concurs with Pool et al., 2001: <http://www.academia.edu/197454/>

“What I know is that some women become lazy to go back to the health centre for ANC after they are told to go with their spouses especially when found with syphilis or HIV.” Female participant, FGD

- *ANC service safety concerns*

Other couples avoid going for HIV testing due to fears of potential for accidental or intentional HIV infection as a result of health worker carelessness or malicious intentions. This may result in failure to attend ANC altogether.

“...there are some pregnant women who do not want to go for HIV testing because they believe that a health worker can easily use the same needle for injecting many people so such women fear that they can easily contract HIV in such a manner. Others think some health workers are HIV positive and those could easily decide to inject patients with their virus.” Male participant, FGD

- *Perceived mutual fidelity of a couple*

Some women, referred to during interviews as faithful to their husband, reportedly thought their spouses were equally mutually faithful. These women did not perceive a need to test for HIV during pregnancy on the assumption that they were, after all, HIV negative. If the health worker insisted, they may opt to drop out of further antenatal care.

“...there are some women who do not test for HIV because they are very faithful [her husband is her only sexual partner]. So such women find it very difficult to test for HIV. They assume they are HIV negative.” Male participant, FGD

6.4.2.2. *Perceived health service efficiency*

Health facility factors highlighted among barriers to antenatal care included: 1) health worker attitude, 2) delays at the health centre, 3) scarcity of ‘nearby’ health facilities, and 4) stock out of ‘important’ medication such as IPTp drugs.

- *Health worker attitude*

Participants said health workers serve pregnant women on the basis of their perceived level of education and economic/social status—gauged by a woman’s ability to speak English and her type of clothing, respectively. Those who are deemed educated and wealthy are given priority.

Female participants reported that it was common for health workers to perceive a woman who appeared senior in age (reportedly 35+ years) and may have ever given birth to be experienced in pregnancy and delivery. Either, they would get ridiculed by health staff during ANC attendance or receive minimal assistance during delivery.

“Why at this age do you go on to have children? You will even give birth to your own intestines.” Female participant, FGD

“And when they see a woman of my age here, they just say that one can manage to deliver normally.” Female participant, FGD

Such experience may make a woman fear to complete ANC visits or deem it useless to seek health facility delivery services in the future (if they do complete ANC and deliver at a health facility).

- *Service delays*

Participants also cited delays, which they perceived to be due to understaffing, as reason for not returning for ANC. It is possible for a woman to go to the health facility at 8:00 am and leave at 1:00 pm. Sometimes staff are in meetings and the pregnant women end up waiting for even longer. This discourages some women from returning for ANC services, especially if they do not have a family member accompanying them to support them through queues.

“...a person who might have gone to the health facility at eight in the morning leaves the facility at one pm while very weak with hunger.” Male participant, FGD

- *Whose definition of ‘nearby’ health antenatal/maternity facilities?*

Other women may lack means of transport to ANC, especially if the health facility is far from their home. This type of support gap is a key barrier for woman 3 and 4 (Table 2) who are otherwise motivated to attend ANC and/or deliver at a health facility.

Another thing is that most men when a woman asks them for transport facilitation to the health centre, they will pretend that they do not have any money for that... And moreover the distance may be long from home to the health centre, so that makes some women fail to go for ANC.” Male participant, FGD

Thus, sometimes a couple may console themselves that all will be well based on the outcomes of previous visits when they lack finances to enable the woman to complete the required four ANC visits.

“One may have money for transport on the first and second ANC visit but then on the third visit money may not be there and the man [spouse] might try to get [transport money] but things do not work out so in such a case both the wife and husband may tell each other that all will be well without completing the routine ANC visits.” Male Participant, FGD

- *Drug stock-outs*

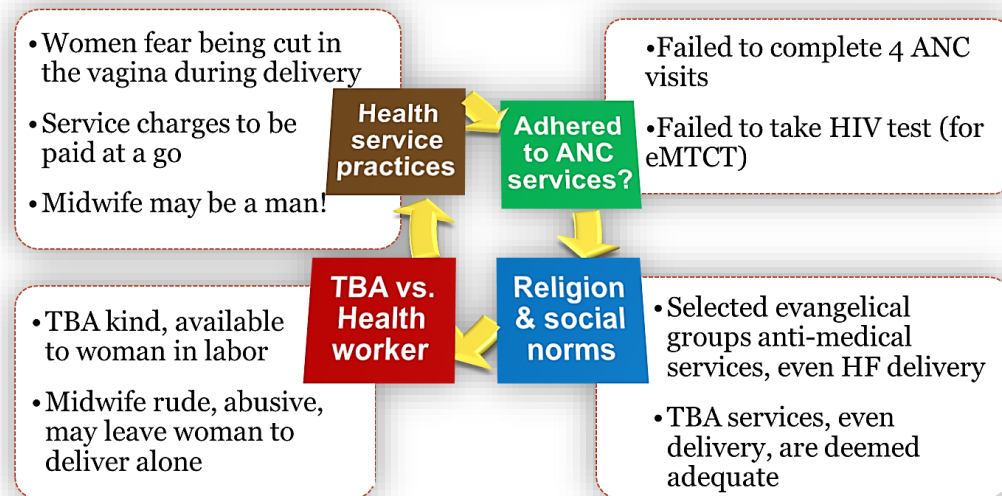
There was a suggestion that, in most cases, the health facility did not have drugs. So health workers only prescribe a drug, e.g., SP for IPTp and the pregnant woman has to buy it from a drug shop. This makes some women think that the health workers have not been of much help, hence they do not return.

“...another reason why women do not go for ANC is that there are no drugs to be given to them. When a prescription is given they are told to go and buy the medication from a drug shop.” Male participant, FGD

6.4.3. Barriers to delivering at health facilities

In addition to factors linked to whether a woman completed ANC visits and important services such as HCT (for eMTCT), participants cited other factors they associated with low uptake of health facility delivery services. The key emerging themes are summarized in Fig. 4 below.

Fig.4: Key themes in barriers to HF delivery services



6.4.3.1. Factors associated with the nature of health services

The nature of health services was perceived to create barriers to antenatal care and/or health facility delivery. Factors cited included 1) understaffing of midwives, 2) service charges, 3) male nurses/ midwives, and 4) episiotomy.

- *Understaffing*

It was noted that client load in maternity services outweighed available service staff, hence the common occurrence that women felt neglected and perceived midwife support to be rather minimal.^Ψ

“Another issue is that the midwives we have are few to manage the number of women delivering at the health center...So there are time many women come at the same time wanting to deliver” Female participant, IDI

- *Service charges and other costs*

^Ψ Concurs with Rujumba et al., 2013: <http://www.biomedcentral.com/1472-6963/13/189>

Participants noted that health facility delivery came with several charges: transport costs for taking the woman to the facility and for bringing her food while she is on maternity care, and maternity service charges. Depending on the “season” (family financial situation at different times) a woman is due for delivery, she may or may not make it to the health facility, even if she commonly delivers at a health service.

“Another thing is that some women get pregnant in the wrong season when there is a lot of poverty, when there is financial hardship... yet the health centre may be very far. She may fail to get transport to the health centre because you as a man cannot afford the transport money to take her...” Male participant, FGD

“Some women say they would love to deliver at a health facility, but then the problem is money to pay at the facility. Some do not have money to pay in at the health facility.... Mama Kit at UGX 10,000 and an immunisation card at UGX 2,000. So you can see why ...it is because of money element.” Female participant, FGD

Also, linked with the financial limitations, participants highlighted the effect of the absence of a birth preparedness plan; women miscalculating their dates, intending to deliver at a preferred health service far from home. Such women more often ended up giving birth on their way to the maternity.

“There are some mothers who deliver from home, because they miscalculate the month in which they conceived... so such things bring about confusion for some mothers...they deliver at the time they least expected and from home against their wish.” Female participants, FGD.

- **Male midwives!**

Some respondents, especially female, reported that they did not like the idea of male health workers helping them to deliver. They narrated a story of a woman who gave birth to her first child in a health facility with the assistance of a male health worker. She has never sought health facility delivery services since, and has safely delivered five more children at home.

“She did not like that, so from that day she never went back again to deliver from a health centre. Recently she gave birth to sixth baby from home,” Female participant, FGD.

- **Episiotomy**

Some women were reported to fear being cut (during episiotomy) to allow the baby come out easily, a practice they associate with health facilities. A male participant said: *“...some women fear to be cut down there to allow the baby to come out easily.”*

6.4.3.2. Social definition of “appropriate care”

- **TBA services deemed adequate**

Participants suggested a widespread perception that giving birth at a health facility is a luxury and was not common until three years ago. In fact, people who seek health facility delivery services were reportedly considered to be cowards.

“Women generally do not want to go to the health centre for antenatal and delivery because they trust the services of TBAs or women who give them herbs to drink. We always hear such women say; even if I do not go to the health centre for antenatal, I have my local herbs to take and I will deliver well.” Female participant, IDI

6.4.3.3. Observed provider attitudes

- **Abusive midwives**

Participants reported that women often have to give midwives money (personal gifts referred to by midwives as ‘our little sisters’) in order to be handled well during labor and childbirth. It was reportedly common for women who fail to bring this gift to be mistreated.

“...Did I send you to open your legs for...? Put up your legs up to your shoulder the way you did for...! [Slaps accompanying verbal abuse]... When I saw that happening, I made up my mind never to give birth from a health facility.” Female participant, FGD

“Those TBAs, by the way...are very loving. They know how to talk to patients, they care for them, they show sympathy... they are polite to the women.” Female participant, IDI

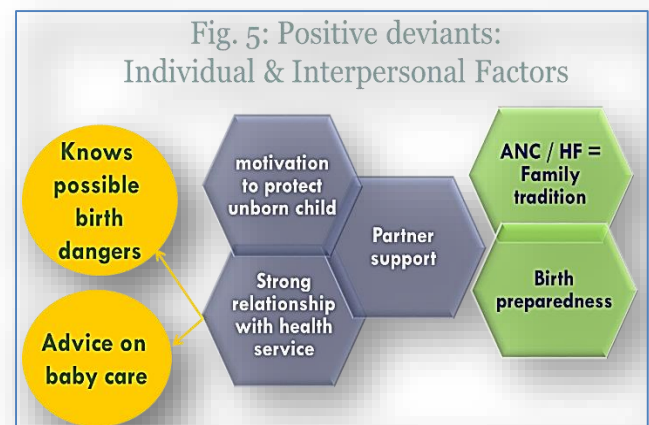
6.4.4. Motivations and coping strategies among adopters of MCH services

Box 2: ANC Adopters, in Context	
Safe birth	“...my important issue is the child in the womb... the baby can be in position during pregnancy. When time to deliver comes, things can change... that the placenta has refused...that she is over bleeding...” Female, FGD
Partner support	“...for ANC services, I have to know the days for visiting. At times she might forget and I have to advise her. I have to check her appointment book and prepare [money] early enough for her next visit” Male, FGD

Fig. 5 and Box 2 highlight key characteristics of adopters of MCH services, including uptake of ANC and related services such as eMTCT and IPTp. They were mainly motivated by the desire to protect their child, and spousal support. Their motivations were reinforced by family tradition to take up ANC services, and desire for birth preparedness, hence their maintenance of strong relationships with the health service for informed opinion and decision-making.

6.4.4.1. Desire to protect unborn child

Women and men who were pro-ANC service and HF delivery were primarily motivated by the need to assure health of the child in the womb, and a safe delivery. They admitted that nurses may be rude, due to very high client loads. In any case, these women and men were so motivated that they instituted coping strategies such as changing health centres or simply ignoring the rudeness of the staff.



“The first time I visited antenatal there was a very very rude nurse...and it was my first time. She even made me change to go to another health centre...I went to Budadiri...they were so caring there. So what I tell other pregnant women; do not just sit at home. If you go somewhere and a nurse is not taking care of you, please do as I did [seek antenatal care at another health centre] to protect my child.” Female participant, IDI

6.4.4.2. Spousal support and commitment

The key motivation to protect the unborn child was enhanced by partner support, including the spouses working together to ensure seamless ANC visits. Spousal cooperation was perceived important for the following reasons:

1. So that the male spouse is prepared in advance to provide for related financial support
2. So that the female spouse has family support for reminding her of the next ANC visit

Certain benefits were also perceived to accrue from consistent ANC attendance. For men, antenatal care was an insurance against avoidable complications with the pregnancy or delivery of the baby, and subsequently, avoidance of undue financial costs and emotional strain that may come with such emergencies. In fact, in the interviews men came out strongly as the ones who would recommend and follow up on ANC.

“Most women go for ANC because their husbands demand they do so [chorus agreement], but if a man chooses not tell her not to go, she will not go.” Male participant, FGD

6.4.4.3. Family tradition and birth preparedness

The reinforcing factors for ANC attendance and delivery at the health facility were cited as family tradition and birth preparedness. Family tradition meant that regardless of the attitude of a health worker, a woman who was clear on why she must deliver at a health facility would not be deterred. She may even travel to a different health facility if possible.

Regular antenatal service visits were deemed as a core component of preparing for birth because it facilitated knowledge of the condition of the pregnancy. The very act of attending ANC itself translated into a woman having a better idea of her due date, hence less likely to be caught unawares and give birth at home or on the way to maternity.

6.4.4.4. Strong relationship with health service

Because of their motivations above, women and men maintained linkages with the health service in order to always make an informed opinion, for instance, to know and prepare for possible complications during pregnancy and/or birth. They also received advice on baby care.

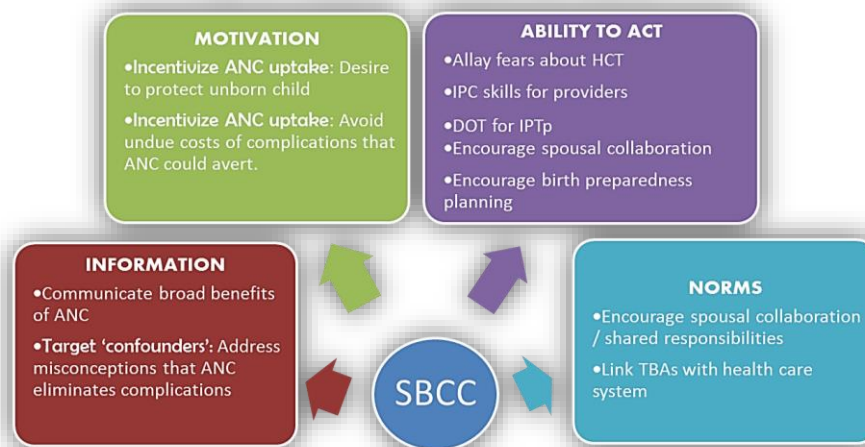
“...you just persevere the bad treatment of staff...because at the hospital... while the nurse may be rude, when you deliver from there they take all possible means to protect your life. You may deliver and over bleed, and they will do everything, even refer you to another hospital if they

cannot manage. But the TBA, if you over bleed she will leave you...there is nothing she can do, and you will die there..." Female participant, FGD

7. OPPORTUNITIES FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

Opportunities for SBCC are presented below using the perspective of the socio-ecological model (Fig. 6) and the four cross-cutting levels including information, motivation, ability to act, and perceived social norms.

Fig. 6: Opportunities for SBCC



Information

Communicate the broad benefits of ANC including that the service minimizes—not necessarily eliminates—probability of complications during pregnancy and/or at delivery.

Motivation

It is important to communicate the immediate and accruing outcomes of ANC in a manner that incentivizes ANC attendance. Adopters among the women had immense desire to protect the well-being of their unborn child, while men additionally considered the financial relief that comes with a safe pregnancy, safe delivery, and increased chances of a healthier child.

Ability to act

Overall ANC attendance. Perceived subsequent gains (see motivation) reinforced men's support for their spouses to attend ANC regularly, the more reason to incentivize ANC service promotion. Birth preparedness should be among key SBCC messages. Notably, motivated clients (see motivation) took proactive measures to prepare for birth including carefully tracking the woman's due date, keeping aside money for costs such as transport and maternity fees, and addressing aesthetic needs such as buying appropriate maternity garments for both mother-to-be and baby. Provider IPC skills are needed to improve client-provider sessions, and especially to manage personal biases about barriers that women may face with ANC uptake.

HCT/eMTCT uptake. SBCC efforts are needed to specifically target fear of HIV positive test results, plus the general suspicion regarding potential lack of confidentiality of providers. Almost 14 years since the first feasibility assessment studies (Pool et al. 2001), fears of a potentially positive test result remain high and a key barrier to HIV testing, even among pregnant women. These fears are driven by concerns about social stigma and domestic conflict. Providers may need special IPC skills to facilitate spousal dialogue and how to initiate disclosure of HIV status.

IPTp uptake. The gap appears to be in the current approach to dispensing the anti-malarial to pregnant women. Directly observed treatment (DOT) has worked well in IPTp uptake. SBCC programs should explore barriers to DOT, and discuss options for enhancing uptake when IPTp is administered without provider support. Spousal support may come in handy to encourage women's adherence and identification of small doable actions to ease perceived discomforts linked with the effects of the anti-malarial.

Norms

While there may be concerns about working with TBAs, it is important to recognize that TBAs remain trusted and readily accessible as a first line of care by pregnant women and their families. SBCC and public health programs may benefit from identifying champions among TBAs who can link with women with the health care system.

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Annex 1: CONCEPTUAL FRAMEWORK FOR CHC Theory of Change

