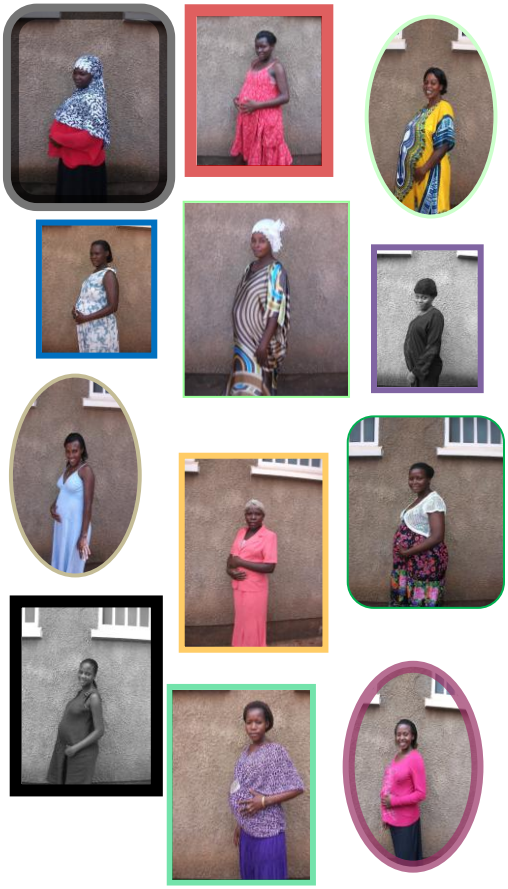
It's about mothers

A qualitative study on the utilization of maternal care at Kawempe Health Centre- Kampala.

A study by Sabrina Verheul



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Abstract

This qualitative study is focused on understanding the why, what, when and how of maternal care utilization at Kawempe Health Centre (KHC), one of the biggest governmental run health centers in Kampala, Uganda. KHC lies in Kawempe division, one of Kampala's five divisions and probably also the poorest. KHC was chosen with the help of The Liverpool-Mulago Partnership for Women's and Children's Health (LMP), an organization that tries to reduce the high maternal mortality rate in Uganda by providing governmental run health centres such as KHC with necessary equipment, skills and expertise. KHC is one of the governmental run health centers supported by LMP that has to cope with many problems ranging from unmotivated staff to lack of medicine, equipment and an ambulance. Yet, maternal deaths cannot solely be reduced by providing health centers with the necessary means- a better understanding of the personal situation of users of maternal care is also needed to provide care that fits the expectations and needs of its users. Therefore, this study tries to explain which factors are of influence on the utilization of maternal care.

The focus lies on local women that are pregnant and make use of antenatal care and women that have just given birth and make use of postnatal care at KHC. By letting 40 women tell their story, a better insight into the way in which utilization of maternal care is being shaped, has been provided. Central to the interviews are the socioeconomic and cultural background of the women; the accessibility and quality of care and the perceptions of these women on the care provided to them. These three topics are drawn from the *Access model* of Peters et al.(2008) which has functioned as an analytical model to study the different components of health-seeking behavior of local women at KHC. Therefore, other actors have also been drawn into this study. As the situation at KHC is poor, staff members have also been interviewed and incorporated to understand their side of the story. Their perceptions and opinions on the problems surrounding the provision of maternal care help to put the stories of the users in perspective. Further, community leaders and experts in the field of (maternal) care and health have also been interviewed to put the way in which maternal care at KHC is used and provided in a broader perspective.

Word of thanks

There are many people that need to be thanked as without them this study would not have turned out the way it has. Unfortunately, there is not enough space to address them all. Therefore, I would like to give a big thanks to all those people that have helped me before, during and after my internship. Yet, there are some that deserve special attention.

First, it would not have been possible to write this thesis without the kindness and generosity of Professor Louise Ackers of Liverpool University and co-founder of the LMP. Without her help, support and guidance it was possible to work at KHC and experience what it is like to live in a developing country for a period of fifteen weeks. Thank you Louise, for giving me this opportunity to grow as a researcher and making me part of something bigger. Then, a special thanks goes out to my Dutch supervisor Dr. Maggi Leung of Utrecht University. The critical supervision she has given me has led me to produce a Master thesis I am proud of. Her guidance and support during my time in Uganda have helped me to stay sharp and focused, but also made me aware to enjoy the moment. Thank you Maggi, for having faith in me to shape this study in the way I thought was best.

Without those 40 women that opened up and told me their stories, this thesis would not have been here today. Even after hours of waiting at the antenatal clinic these women still were willing to participate in this study. Their lives, the circumstances they are living in, but most of all their visible will power to carry on and raise a baby in often difficult circumstances, will stay with me for the rest of my life. These women have helped to understand and possibly improve the situation at KHC. Also, the staff members of KHC that participated in this study deserve a special thanks. Even when they had little time, because of the high working load, they were willing to tell me their perceptions on the situation at KHC. This is a real asset to this study.

Further, conducting interviews with local women would have not been possible without the help of my research assistant Vivien Mugenyi. Her personal touch, ability to make the women feel at ease, positive attitude and ongoing drive have helped me to obtain results in a way I would otherwise would not have. Thank you, Vivien, for this. Also, I would like to thank my family for supporting me and letting me travel to the other side of the world to study something I have become passionate about. A special thanks goes to my parents for always supporting me as you taught me that my best is always good enough. Last but certainly not least, I would like to thank my boyfriend for his faith, advice and understanding during these ten months of intensive study.

A global (maternal) health crisis

This study is written in a time of crisis and as we are all aware now, a crisis can take many forms. Ever since 2008 daily news reports about the global housing crisis, banks going bankrupt and countries becoming more and more financially unstable, hence the global economical crisis. Then, there is also an environmental crisis in which the world is becoming more and more aware of the fact that natural sources are ending. These are quite 'visible' crises. Yet, there is also another crisis going one. One that gets less attention, but maybe it has the biggest impact on our well-being. For years now in both developed and developing countries a health care crisis is going on. A crisis that can be divided into many 'sub-crises', with many causes and consequences, but that cannot be tackled so easily, especially in developing countries. This study puts one of these health care crises in the spotlight, but first it is necessary to set out the severity of this global health care crisis.

Failing health care systems

The access to health services and the ability to obtain high quality care seems to become more and more difficult. The United States is a good example of this. One of the richest countries in the world is not able to provide its people with health insurances. The results: millions of Americans that are not able to see a doctor or get medicine as they simply cannot afford to do so and health care providers such as hospitals that lack the capacity to cater to the ill and injured. Quite worrisome as more Americans are dealing with 21st century health problems such as obesity (Colvin, 2012). In Europe things are not any better. In Greece, a country that is declared bankrupt, hospitals and pharmacies are lacking medicine as they do not have the money to pay for them (EuropaNu, 2012). In The Netherlands, insurance companies want to close more than half of the hospitals to lower costs for patients. According to the hospitals, this will only decrease the accessibility and quality of care (NRC Handelsblad, 2012). In Romania, still one of the poorest countries of Europe and the country with the lowest government expenditure on health care, more than 5000 doctors since 2007 have left the country to work in countries where they are paid more (BBC News, 2010). There are many more examples of failing health care systems across developed countries and they certainly deserve attention. Still, when supposedly rich and developed countries have these kinds of problems, how will the situation be in less privileged and developed countries? The answer: it is worse.

Some 30 years ago The Alma-Ata Declaration stated that health for all would contribute to a better quality of life and to global peace and security (WHO, 2010). Unfortunately, 'for all' became 'for some' as throughout the developing world, health care systems have been in crises for years now. It is a whole list of things that are

going wrong. Especially, public health care services (run by the government) and other public services in developing countries in general are often too expensive, making them inaccessible for the poor. Then, they also lack required technical quality and the responsiveness to cater to the needs of patients (WHO, 2004). Further, specialized staff such as doctors and midwives is moving away from governmental health care providers and out of the developing world as payment and working conditions are often much better overseas. Especially, in remote rural areas, specialized staff seems to move out and the ones that are there often lack appropriate working ethics such as punctuality and commitment (WHO, 2004). Bad working conditions are being formed by lack of the right equipments, medicine and high demand. This together leads to health care workers not being able to treat patients in an ethical way: there is often a big social distance between the client and provider (WHO, 2004). In other words: health facilities in developing countries can be characterized as inaccessible, of low quality, hence unattractive.

So, to have a health problem in a developing country, keeping in mind that one has to deal with all of these difficult circumstances, makes the use of health services unattractive. Therefore, people in need of medical care in developing countries choose not to make use at all of these public health services or turn to private ones instead (WHO, 2004). This is worrisome, as being poor and being ill often go hand in hand in these countries (Peters et al., 2008). When people turn to private health care providers they may get quality, but will go home with less money to feed their children. Then, if one failed to save up and is not able to go to a private medical clinic and public ones are too far away and of low quality, such common and curable diseases as malaria can be fatal. So, we cannot speak of 'universal access to health care', especially as most of the world's population has little to no access. In this way, failing health services in developing countries are decreasing the chances for these people to develop themselves further as development requires a healthy population. Yet, one of the biggest hurdles for these countries to tackle in order to develop further, is to provide accessible and quality care to those that deliver new life to this world.

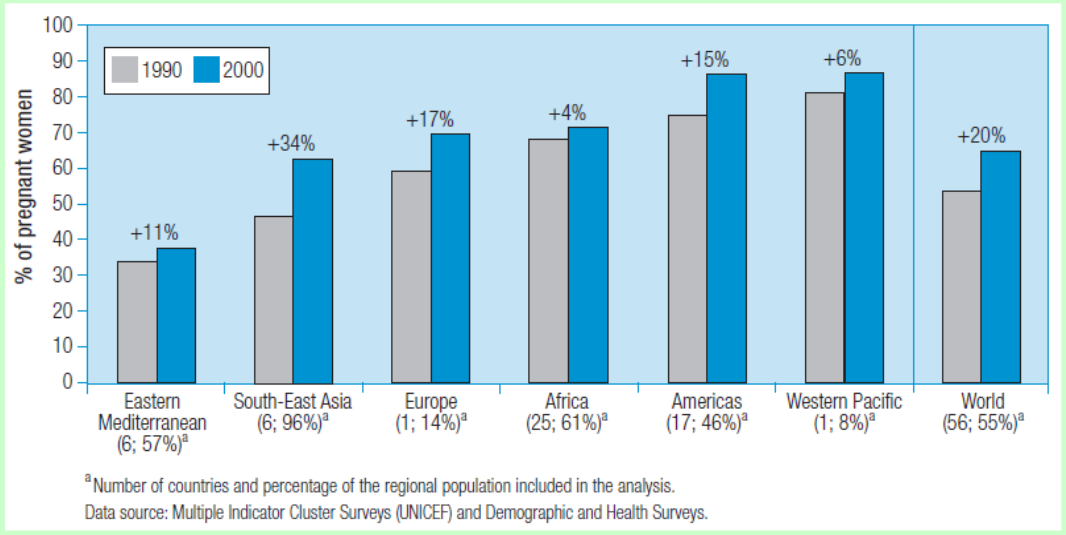
The crisis of mothers in developing countries

The number of mothers that do not survive the delivery of their child is immense in developing countries. Globally, it is estimated that every year more than 500,000 women do not survive their pregnancy, delivery or the 24-hours after giving birth. Almost all of these deaths (99 per cent) occur in developing countries (UNICEF, 2011). For Sub-Sahara Africa this means that 1 in 16 women die in pregnancy or childbirth (Filippi et al., 2006). In these countries being pregnant mostly does not equal happiness and joy, but can be seen as one of the most dangerous times in a woman's life.

For a pregnant woman to have a pregnancy without complications and to safely deliver her child to this world, it is necessary she is in good health during her

pregnancy, childbirth and the postpartum period (UNICEF, 2011). One of the ways to avoid complications is to make regular use of antenatal care. By obtaining regular antenatal care, four or more check-ups during the nine months of pregnancy, a woman gets to know how her health is and that of her unborn child. These check-ups prepare the woman on how to take care of herself during pregnancy and after delivery. Also, in developing countries it is also an opportunity to get tested for HIV/AIDS, being immunized, receiving treatment for malaria and obtaining important vitamins she would otherwise not be able to get due to a lack of the right nutrition. Further, it is also a way to be guided through the whole process of pregnancy by being consulted on family planning, diet guidelines and having someone to listen to fears and anxieties (WHO, 2011[a]). In this way, antenatal care is an important tool to decrease the chances of maternal deaths as 1 out of 4 maternal deaths occurs during pregnancy, making regular check-ups necessary to detect symptoms such as anemia, sepsis and high blood pressure early on in the pregnancy. Fortunately, between the year 1990 and 2000 a global increase was witnessed in the use of antenatal care (Figure I).

Figure I: World coverage of antenatal care for the period 1990-2000.



WHO, 2005, p.42.

Although already more than a decade old, Figure I makes clear that Africa had the lowest increase and today it is still one of the parts of the world with the highest maternal mortality rate (WHO, 2012). For example, in Uganda every day sixteen women die whilst giving birth to new life (UBOS, 2010/11). This is an unimaginable high number and much of its causes are not clear. Yet, keeping in mind that health care systems are often failing, it is not that difficult to figure out why these women are dying.

Most of the public facilities in Uganda that provide maternal care, that is care during the pregnancy, when in labour, during the delivery and after the delivery are either absent, inaccessible or of low quality. In other words: they are overcrowded, understaffed, underequipped and often underskilled. It is quite imaginable that this leads to women in for example Uganda not making use of maternal care. Instead they turn to expensive private clinics or to so called Traditional Birth Attendants (TBAs). These TBAs are usually village women that are specialized in the use of local herbs without any professional background in midwifery or nursing and that rely on their often long experience in delivering babies in the traditional way. For many women in developing countries, these TBAs are often more accessible than the public clinics and more affordable than the private ones. Also, TBAs are appreciated as they often speak the same (cultural) language and provide care that also includes kindness and affection- something most public clinics fail to provide. Although these TBAs are 'skilled', many 'easy to fix' problems that occur during childbirth can become life threatening as these self-acclaimed midwives often do not have the required expertise or means to treat the patient. This often leads to women bleeding to death or having lifelong health problems afterwards. A skilled attendant is therefore absolutely necessary to prevent this.

> *"On the service coverage side, the proportion of births attended by a skilled health worker can be as low as 10% in some countries, for example, while it is close to 100% for countries with the lowest rates of maternal mortality. Within countries, similar variations exist. Rich women generally obtain similar levels of coverage, wherever they live, but the poor miss out. Women in the richest 20% of the population are up to 20 times more likely to have a birth attended by a skilled health worker than a poor woman. Closing this coverage gap between rich and poor in 49 low-income countries would save the lives of more than 700 000 women between now and 2015"* (WHO, 2010).

So, the solution to high maternal mortality rates and bad maternal health throughout the developing world is quite easy then: provide women with access to reproductive health care that is supplied with equipment, medicine and skilled attendants and also offers quality care (UNDP, 2012 & O'Donnell, 2007). Yet, such improvements seem easy, but keeping in mind that they need to be implemented in countries that are often both politically and financially unstable makes that these countries cannot improve on their own. Fortunately, the severity of the problem is universally recognized and several programs have been created to reduce maternal mortality rates and improve the provision and utilization of maternal care. Millennium Development Goal 5 "improving maternal health by improving the accessibility and quality of maternal care in developing countries in order to reduce the number of maternal deaths in developing countries by three quarters in the year 2015, is a good example of this (UNDP, 2012). Yet, this universal attempt is still a long way from reaching its goal, especially in Sub-Sahara Africa. It is being more and more recognized that fragile and fragmented health systems in developing countries

are hampering the provision of care to those in need (Travis et al., 2004). Especially in Sub-Sahara Africa progress in the field of maternal health is slow due to a low overall economic growth, failing institutions and impoverished infrastructure (IMF, 2011). Without improving this, providing adequate care to pregnant women, both the economic and social development of this part of the world is likely to hamper. The same is true for Uganda.

Figure II: MDG 5.

Source: UNDP, 2012.

Inefficient and poorly functioning health systems such as the maternal health care system seem to hamper the development process. According to the work of Filippi et al. (2006) the death of a mother or a mother with bad health during or after her pregnancy has a great impact on her own well-being and that of her family: *"Good maternal health is crucial for the welfare of the whole household, especially children who are dependent on their mothers to provide food, care and emotional support. The death or chronic ill-health of a mother increases the probability of death and poor growth and development of her children"* (Filippi et al., 2006, pp. 1535-1536). The death of a mother is not only an emotional loss, in the end it also contributes to the overall poverty of a country.

Listening to the users of maternal care

When even a global initiative seems to be failing in tackling maternal mortality, what else can be done to improve the situation? Well, the answer is quite simple: start at the bottom, incorporate the local and listen to the women that make use of maternal care. 'One-size-fits-all' approaches such as the MDGs seem to miss their point and contradict with the instable and weak societies in developing countries. Instead, it should be understood that developed and developing countries both have their problems with the provision and utilization of health care, but circumstances are often very different. By only focusing on one side, making sure that health facilities have all the right tools and staff to provide accessible and quality maternal care, a big mistake is made. To make sure women actually start using these facilities, it is necessary to listen to their experiences, needs and wants to provide maternal care that fits the expectations. Only in this way will improvements on the provider side of maternal care lead to higher coverage use of those who are in need of it. This is exactly the point of this study, namely to focus on one particular provider of maternal care in a country that has one of the highest maternal mortality rates in the world, Uganda. By listening to what users of maternal care have to say about the accessibility and quality, but also to take consideration of their socioeconomic and cultural background, this study puts the local central. At the same time it has tried to incorporate the difficult context of the maternal care provider. In this way, both

users and providers of maternal care are treated at the same level to contribute to a better understanding of not only utilization of maternal care, but also of possible underlying causes of maternal mortality. Although small in scope, this study hopes to contribute to reversing the situation: from one in which pregnancy is related to death, to one in which pregnancy equals joy and happiness.

Content

Abbreviations

As	Accessibility, Acceptability, Accountability Affordability, Availability & Alternativity
EUR	Euro
WHO	World Health Organization
KHC	Kawempe Health Centre
LMP	Liverpool-Mulago Partnership for Women's and Children's Health
TBA	Traditional Birth Attendant
UBOS	Ugandan Bureau of Statistics
UGX	Ugandan shilling
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNHCO	Uganda National Health Users'/ Consumers' Organization
USD	American dollar

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1 Introduction

"*Mother dies in labour as midwife takes bed rest*"- This is an headline from an Ugandan news article telling the story of a 24-year old woman that dies while she is in labour. The midwife that was supposed to help her had gone to bed to rest and did not want to wake up to take care of her patient. The midwife explained that she was tired, because of the high workload at the public health centre she was working (Sunday Monitor, 2012). The headline summarizes the current situation of maternal care and health in Uganda in a nutshell, namely that pregnant women have a high risk of not surviving their pregnancy, labour, delivery or the 24-hours after the delivery, mainly because the accessibility and quality of maternal care providers are in poor condition.

Stories such as of the 24-year old woman are sadly more the rule than the exception in Uganda and it are mostly governmental run health facilities that are the actors in such stories. With a maternal mortality ratio of 435 deaths per 100,000 live births, meaning every day 16 women in Uganda do not survive their pregnancy, labour, delivery or the 24-hours after delivery, it would be expected that the government would do everything to reverse this dangerous situation. Especially, as the death of a mother does not only have emotional consequences- it also adds to the underdevelopment of the country as women in developing countries are essential factors in both economic and social development.

Although global initiatives such as the MDGs offer support to developing countries such as Uganda to reduce the maternal mortality ratio, active involvement of the government is needed to reverse the situation from one in which pregnancy is related to death, to one in which women will have no fear to give birth to new life. Yet, the opposite is occurring as recently the Ugandan government cut its annual budget for the health care sector from nine to seven percent creating a situation in which public run health centers are not receiving enough medicine and equipment (UBOS, 2010/11). Such budget cuts mean health care workers such as midwives and nurses receive lower monthly payments, creating an atmosphere that makes these essential maternal care workers less motivated. As another news article reported:

> *"The majority of mothers in Uganda – 59%- deliver their babies from their homes or clinics, which provide unskilled care. For some of these women, it is not because they do not know about midwives, they just feel safer having their babies close to home. During surveys many women have accused midwives of being rude to them and that's why they prefer going to traditional birth attendants"* (New Vision, April 2012).

The low pay and high demand contribute to rude behavior of health workers, increasing the chances of pregnant women to deliver in an unsafe environment. Then, having unmotivated staff is one thing, but not being able to attract more staff is another. It seems that Uganda lacks around 2,000 health workers, mainly because the government is failing to promote the sector. This, together with an high fertility

rate adds up to the chances of pregnant women not being able to be attained by a skilled attendant. Overall, the current situation of the health care system can best be described as a dangerous chain of circumstances that, without any changes, will only lead to more maternal deaths.

In the western world, being pregnant for most women is a time that is associated with joy and happiness, not with a fear to not be able to receive adequate care or in a worst case scenario, death. That there are women in this world for who it is quite 'normal' to have lost a pregnant mother, sister or friend, because she was not able to have access to quality care, is something that needs to change. Yet, it must be understood that such a problem cannot solely be solved by supplying governmental run health centers in Uganda with the right means. Although this will increase the accessibility of maternal care, it does not automatically mean staff will behave differently, but most important: it does not automatically mean pregnant women will make use of the health centre.

The high maternal mortality number is far more complex than merely the lack of adequate health care providers- it is something that is also related to the users of maternal care, women themselves. It is also about whether pregnant women find it necessary that they make use of maternal care having regular check-ups is part of this. Then, a health care provider may think it provides maternal care that can easily be reached; is affordable and has staff that treats every patient in a just way- the users may think the opposite. Further, it has also to do with what pregnant women ought normal- maybe in their families it is normal to deliver from the home with the help of a traditional birth attendant (TBA) or to use local herbs to treat certain pregnancy related ailments. It is not only about provision, but more so about utilization. Therefore, to make sure that less women die during their pregnancy, when in labour or after the delivery in Uganda, it is time and necessary to take consideration of both the providers' and users' side of the story.

Within academic studies and literature on the utilization and provision of (maternal)care much is said about the interaction between users and providers of (maternal) care. While some only focus on what providers are offering, others look at barriers on the users' side of care or a combination of both (see Ensor & Cooper, 2004; Obrist et al., 2007, Peters et al.2008) and Thaddeus & Main, 1994). Yet, when it comes to studies on maternal care focused Uganda in particular and then especially in relation to public health facilities, there is much undiscovered ground as these (Ugandan) studies mainly focus on socioeconomic factors such as age and education (see Kyomuhendo, 2003 and Birungi et al., 2009). Therefore, it is not only time to change to situation of maternal health in Uganda, but also to change the way in which this situation is being studied. This is what this study wants to establish.

The aim of this study is to contribute to a better understanding of the current situation of maternal health and care in Uganda by focusing on the utilization of maternal care and the way it is provided. Of course, this is quite a broad and difficult topic as there are many maternal health care providers and users within the country. As it are mostly governmental run health facilities that seem to be failing in providing accessible and quality maternal care, it is useful to zoom in on one of those facilities. In particular, it is useful to see how certain facilities operate in an area with high and ever increasing population, hence an urban area. This is especially relevant for the increasing population in Uganda and its capital city Kampala. As in many developing countries the capital city seems to be the place for all development to take place, hence the capital city of Uganda, Kampala offers the 'ideal' circumstances to study the utilization and provision of maternal care. Such an urban area is expected to have a more modern way of providing care, hence sets the 'example' for less developed regions in the country. Yet, within Kampala there are numerous health care facilities, making it difficult to choose the 'right' one. Fortunately, The Liverpool Mulago Partnership for Women's and Children's Health (LMP) is an organization that tries to help governmental run health centers that offer maternal care throughout the country by providing these health centers with the necessary internal infrastructure, expertise and skills.

The connections of LMP have enabled this study to focus on one of the health centers it supports, namely Kawempe Health Centre (KHC)- a health centre situated in Kawempe division, one of Kampala's five divisions. Although problems are various, from lack of electricity and ambulance to unmotivated staff, it is one of the biggest governmental run health centers of Kampala, catering to more than 130,000 patients in 2011 of which almost 12,000 first time maternal care visitors. As LMP mainly focuses on practical improvements by studying basic determinants such as the number of beds and medicine available at KHC, a more substantive and behavioral approach is required to get more in-depth insights into the problems of the health centre and its use by pregnant women. This to get a better understanding of the underlying reasons of maternal mortality.

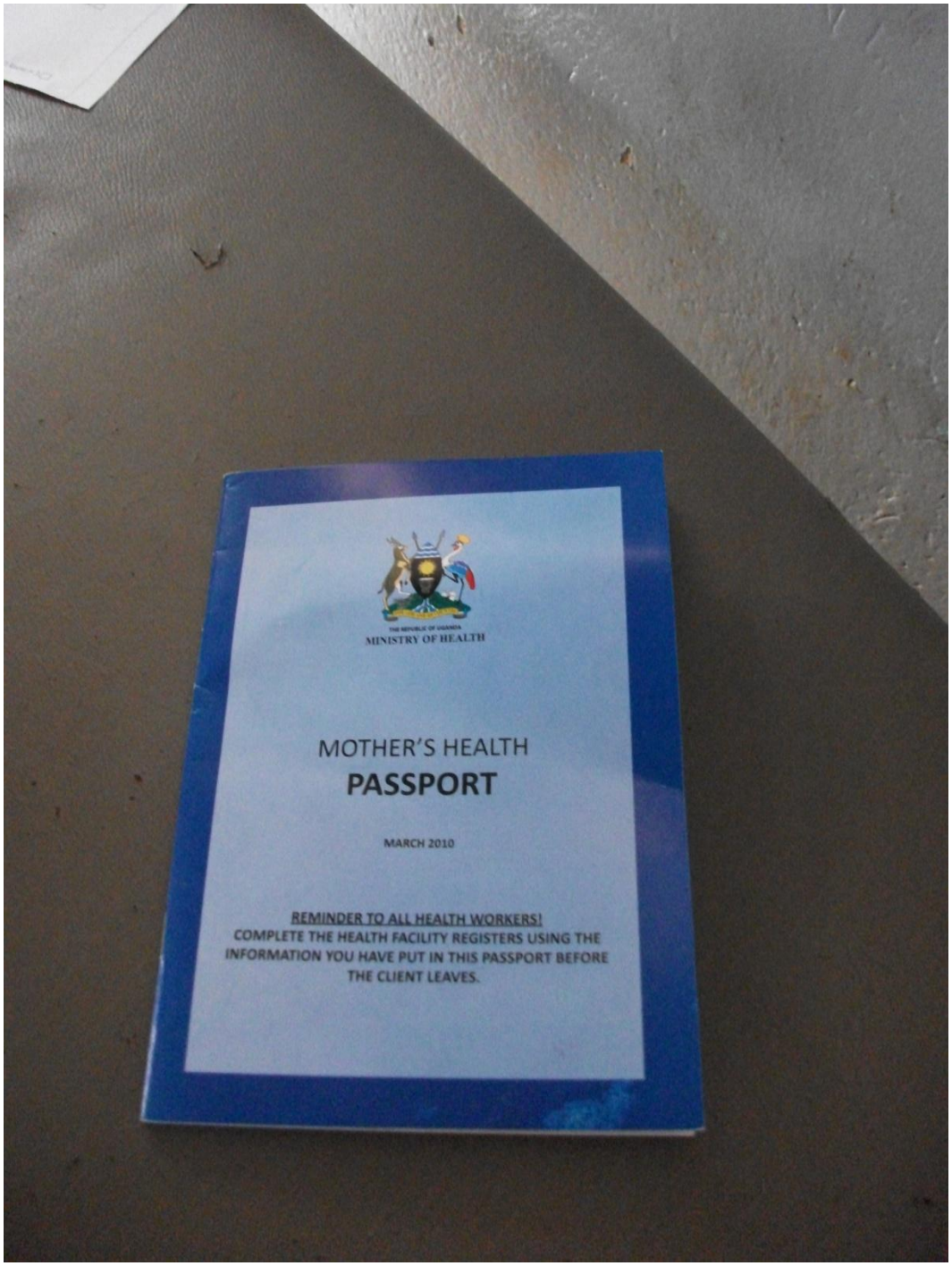
To create more awareness on the different factors that play a role in the utilization and provision of maternal care at KHC, it is important to incorporate those people that are affected most by poor circumstances at the health centre, namely the main beneficiaries of maternal care, women themselves. By providing users of maternal care with an opportunity to share what drives them to make use of maternal care at KHC and what they think about its accessibility and quality, it will become possible to see how what is needed, interacts with what is provided. Therefore, a qualitative approach is used in which the women are able to share their stories that are connected to the story of the provider, KHC. The following research question is thought to capture the aim of this study in the best possible way:

In which way can the utilization of maternal care at Kawempe Health Center by local women be explained and how do these women perceive the care they are receiving?

The first part of the question incorporates the interactive relationship between users and providers of maternal care at KHC as it is thought that there are various factors to influence utilization. The second part concentrates more on what the women themselves think about the accessibility and quality of care. The question will be answered by incorporating important elements from the *Access model* of Peters et al.(2008)- a model that helps to explain the behavior of people in need of care by focusing on both external and internal factors (Chapter 3). The model puts accessibility and quality of care central as they are thought to shape the interaction between users and providers of care- a 'perfect' model to study the utilization and situation of KHC. Also, other academic concepts important when studying the utilization of (maternal) care will be drawn to this study to broaden and enhance the main model. For example, the different dimensions of *accessibility*, the five As together with the difficult to grasp content of *quality* deserve more attention to create a study that fits the situation.

How the situation at KHC and the utilization of maternal care by local women has been studied will become clear in the next nine chapters. The order of the chapters and their content has been chosen wisely and is thought to tell the story of the local women and providers in a clear and understandable manner. The next chapter, Chapter 2, will set out the national context of maternal care and health. Then, Chapter 3 will elaborate on important academic concepts by drawing on important literature in the field of (maternal) health care provision and the behavior of health care users. This chapter will stress the importance of *accessibility* and *quality* in full length. The most important academic concepts have been used to formulate three sub-questions. These questions and other important steps taken in the research process have been set out in the methodological chapter, Chapter 4. Chapter 5 will zoom in on the situation of Kawempe division and KHC. The content of these four chapters together have been used to generate results that will answer the main research question- Chapter 6, 7 and 8 give an overview of the most important results drawn from the interviews conducted with both users and providers of maternal care at KHC. These results will be connected to theory in Chapter 9, were an answer to the main research question is provided. The last chapter, Chapter 10, will elaborate on the relevance of this study to society and the academic world which in turn will lead to providing recommendations to others that want to study maternal care utilization in Uganda or in other developing countries.

[2] A national maternal care crisis



2.1 Introduction

Uganda or 'The Pearl Of Africa' is a landlocked country in the eastern part of Africa and covers an area of almost 242,000 square kilometers giving home to more than 32 million people (Figure 2.1). 1,6 million of these people live in the capital city of Kampala which is divided into nine political regions (UBOS, 2011). The country received its nickname as the equator lies astride the country making it relatively greener and more fertile than its neighboring countries.

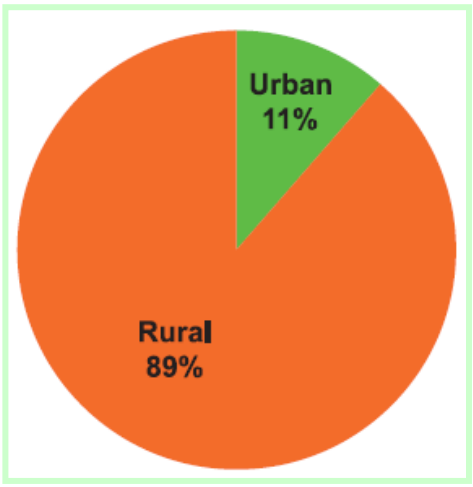
Figure 2.1.A: Map of Uganda divided in nine districts.

Source: UBOS, 2011.

The favourable climate not only explains the distribution of Uganda's population, as 85 percent of the population lives in rural areas. The grounds of Uganda are not the only things that are extremely fertile: its population also seems to be. Where the total population of Uganda in 1999/2000 stood at 21.4 million inhabitants this number has risen to 30.7 million in 2009/2010 (UBOS 2009/2010). Today, the Ugandan woman is expected to have an average of 6.7 children and as expected women that live in rural areas give birth to more children than their urban counterparts (Figure 2.1.B). The pace in which Uganda's population is growing has

resulted in an extremely youthful population in which almost 60 percent of the population is under the age eighteen years (UBOS, 2009/2010).

Figure 2.1.B: Relative division of the number of deliveries divided by rural and urban areas in Uganda.



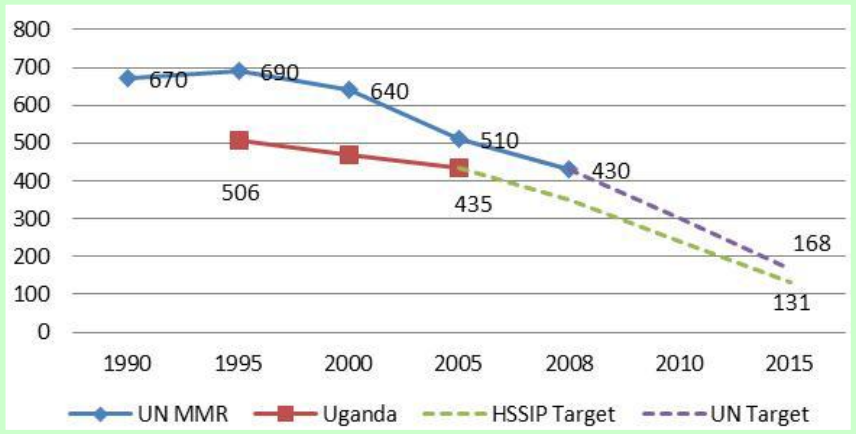
Source: WHO, 2007.

Yet, such population growth goes hand in hand with increasing poverty. Today, almost a quarter of Uganda's population, almost 7.5 million Ugandans are living below the national average of 110,000 UGX (490 USD or 370 EUR) per month (UNICEF, 2012). The high number of people living in poverty in Uganda is visible in a relatively high number of people that is still not capable of reading and writing (more than 25 percent); a relatively low life-expectancy at birth, namely 54 years of age (in comparison: life-expectancy at birth in The Netherlands stands at 81 years of age) and high numbers of HIV/AIDS and malaria (UNICEF, 2012). Also, it seems that the gap between Uganda's rich and its poor has increased over the last couple of years (UBOS, 2009/2010). In summary: Uganda is a developing country that needs accessible and quality care to make sure its growing population can contribute to economic and social development. Unfortunately, the health care system seems to be failing.

2.2 A high maternal death number

To turn back to the high fertility rate, a health system that provides accessible and quality care would be expected. Unfortunately, Uganda is the 'perfect' example of a country with a serious health care crisis, especially in the field of maternal care. With an average of 435 mothers dying per 100,000 live births, the country has one of the highest and most worrisome maternal mortality rates in the world (UBOS, 2010/11). In comparison, the maternal mortality ratio of a developed country such as The Netherlands stands at 9 per 100,000 live births and the global average stands at 280 per 100,000 live births (WHO, 2011[b]). For the country to reach the target of MDG 5 the maternal mortality ratio needs to be reduced to131 per 100,000 live births in 2015: a goal that the country is unlikely to meet (Figure 2.2).

Figure 2.2: Health facility-based maternal deaths between 2009/10 and 2010/11.



Source: UBOS, 2010/11, pp.10-11.

Reasons for the country to have such a high maternal mortality rate are numerous and can be traced back to overall failing government support. With an annual government expenditure of nine percent, hospitals and health facilities are struggling every day to cater to their patients. According to WHO (2004) standards, there need to be 23 health workers per 10,000 inhabitants: Uganda has 15 health workers per 10,000 inhabitants. Low wages and challenging work conditions are the result of low coverage of public health sector positions. The health workers that are there, often do not have the right mentality: showing up late or not at all, are problems that are decreasing public confidence in health care workers and the system (UBOS, 2010/11). The challenging work conditions are related to health care workers not being able to examine patients with the right equipment as these are often not available or broken and medicines are often out of stock. For the year 2010/11 57 percent of the health facilities in Uganda did not have enough regular prescribed drugs in stock such as aspirins (UBOS, 2010/11). In many ways the Ugandan health system is neither capable nor attractive to make use of. In this light, many maternal care providers are not able to cater to the many women that are pregnant today and even to those that will become pregnant in the future.

Already, numbers are dropping. Where in the year 2009/10 47 percent of all pregnant women attended four antenatal visits, a year later this number had dropped to 32 percent. Yet, for the same period more women delivered in the presence of a skilled attendant, namely 47 percent of all births. This can be related to the promotion of maternal care utilization of the Ugandan government. In comparison *all* births in The Netherlands are assisted by skilled attendants (WHO, 2011). Especially, pregnant women in rural areas are more likely to deliver without the help of a skilled attendant than their urban counterparts. This is not surprising when looking at the number of women per midwife, as in general there is one

midwife for more than 7000 women (AHSPR, 2010/11). Still, it remains unclear whether dropping numbers in antenatal coverage or the relatively low number of women making use of a skilled attendant are directly linked to failing health system or are a combination of the failing health care systems on the one hand and personal preferences of women on the other. This study assumes that it is a combination of both. The focus on KHC will help to 'test' this assumption. Although this study is only focused on the situation at one health centre, it hopes to set the 'example' for others on how to look at maternal care utilization and provision in general.

2.3 Conclusion

The high number of maternal deaths in Uganda is a consequence of both the way in which maternal care is provided and the level of awareness present in Ugandan society. The fact that high fertility rates go hand in hand with poverty and failing health systems leads to dangerous situations. Not being able to cater to a high demand, because of lack of funding leads to women not only seeking care somewhere else or not at all, but also means deprived working conditions for health care workers. The economic situation of Uganda requires more and better public health facilities, yet it is also about knowing what drives women to make use or not of maternal care. Only then, will it be possible to increase the number of women delivering with the help of a skilled attendant and receiving four antenatal check-ups. Only with the help of adequate theoretical 'tools' will it be possible to get a broader understanding and severity of the situation.

Therefore, the next chapter will incorporate important ideas and model(s) that help to put the situation of maternal care in perspective. By zooming in on important academic concepts within the field of (maternal) health care provision and the behavior of users of this health care, it will become possible to create a tailor-made study that fits the situation.

[3] Theoretical framework

3.1 Introduction- A health-seeking behavior study

This is not the first study that tries to explain and understand maternal care use in Uganda as maternal mortality rates are high and improvements need to be made to reverse this ongoing crisis. Yet, most of these studies on Uganda tend to only focus on socioeconomic and cultural factors such as education and age (Tann et al., 2007; Kyomuhendo, 2003 and Birungi et al., 2009). Although such general and basic factors can help to explain maternal care use, making them the centre of attention will provide a one-sided picture of maternal care utilization. To understand maternal care utilization in Uganda (and other developing countries) a range of contextual factors is required that do not only belong to the users of care (Say & Raine, 2007, p.812). Making use of maternal care has to do with behavior- why, when, what and how are central questions that are asked when studying such behavior. Therefore, this study can be put within the field of health-seeking behavior studies.

According to the work of Obrist et al. (2007) on different approaches to study utilization of health care, these health-seeking behavior studies put the individual central: "*Health-seeking studies provide a deeper understanding of why, when, and how individuals, social groups, and communities seek access to health care services, and investigate interactions between lay persons and professionals*"(Obrist et al., 2007, p. 1584). The utilization of maternal care and the forming of perceptions about this care are products of health-seeking behavior on the side of health care users- they are individual processes. This is the opposite to the why, when and how that occur on the side of providers of care- they belong to the field of health service studies.

By not focusing on processes that occur and shape the provider's side of maternal care this study has taken an important step. For too long policy makers, governments, development organizations and research have put the supply side of care in the spotlight as improvements on the side of health care providers were thought to better and increase utilization rates (Obrist et al., 2007). This emphasizing of the supply side of care has not worked out in most of the developing world as health systems interact with other (often) weak systems in a country such as the economic and political system. Internal and external crises such as corruption have led governments being incapable to provide adequate and competent (public) health services (Standing, 2004, p.9). There have been several 'solutions' to increase the access and quality of health services in developing countries. For example, privatization of health care was thought to increase access, quality and utilization, yet high user fees led to fewer accessible health facilities as many people in developing countries are too poor to pay for them (WHO, 2010). Such an 'easy to fix' approach misses the point of what health care provision is about as it fails to cater to users in a way that fits within their context. For many decades users and providers were treated as two separate entities that did not interact in anyway. Up

to the 1990s governments, policy makers, development organizations and researchers in the field of public service delivery were mainly focused on understanding and improving public services in developing countries from above- the focus on the supply side only. It was believed that improvements of the supply side of (health) services would automatically mean more people would make use of them (Standing, 2004). Such an unidirectional approach led to fewer people using public health services as they became less *accessible* (WHO, 2004).

As providers of care did not take notice of the context of their users, their problems, needs and wants, demand for services decreased creating not only more people that did not treat their illness, but also forced them to turn to other more expensive alternatives- lower demand for services led to already poor people having to pay for their health, leading to more poverty (Peter et al., 2008). The HIV/ AIDS crisis that especially struck developing countries at the end of the '80s and throughout the '90s up to today, created a whole new awareness on the provision of health services- different people in different situations require tailor made approaches (Nelson, 2007 & Huisman, 2011). It became clear that access to health services is being determined by both the people that use it and the providers. A shift took place where a better understanding of both the demand and supply sides of care would have to go hand in hand. To contribute to such an understanding it is necessary to look at multiple factors- the next sections of this chapter will touch upon some of the most important ones.

By labeling this study as a 'health-seeking behavior' one, it has been possible to draw upon a wide range of literature that helps to look at the situation at KHC and its users in a critical way and also provides enough tools to analyze the situation in a way that suits the subject. Yet, it cannot be said that existing health-seeking behavior studies are based on up-to-date theories and models. Even, no all ruling theory exists within the field (Hausman-Muela et al., 2003). Yet, this does not mean that these models and theories are stagnant as variations on older models are often made. For example, The Health Care Utilization Model of Andersen & Newman (1973) that explained the use of biomedical health services by looking at three influencing factors (predisposing, enabling and need) has many variations and extensions and is still being used to explain utilization of for example prenatal health care (Habibov & Fan, 2008). Also, for a model to be 'old' does not necessary mean it is not useful and the ability of health-seeking behavior models to be used in different ways and situations is only a prove of their flexibility. Still, this study is about maternal health in a developing country. Therefore, it is a logical step to use a model that is relevant to explain utilization of care in the developing world as there are often different circumstances involved.

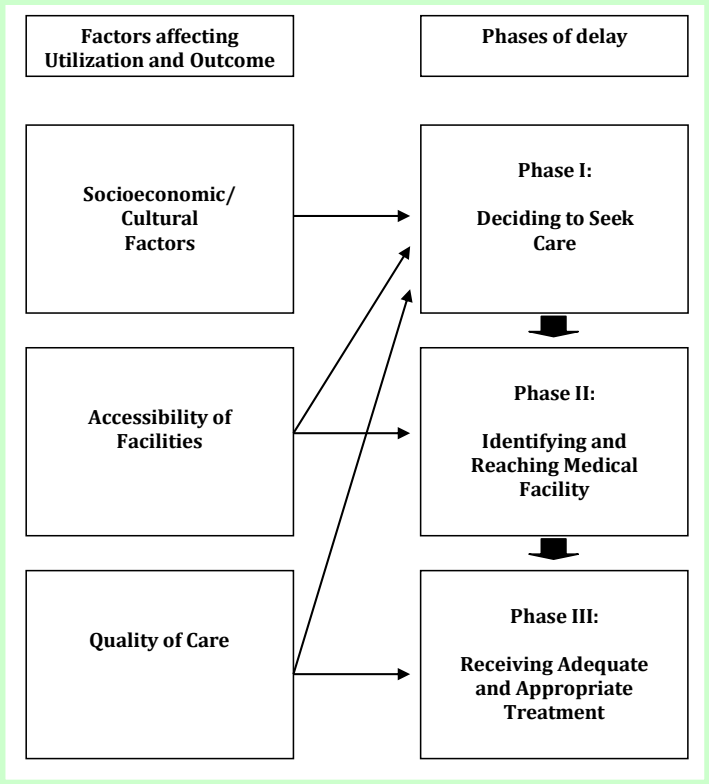
3.2 Choosing the right model

Choosing the right model or theory is never easy, especially when it comes to analyzing the behavior of users of health care as different factors and circumstances are often involved, making it a complex process. This study also went through this process in which different academic concepts and models were touched upon to create a study that incorporates the most relevant and useful thoughts and concepts to study the subject. In order to understand the final design of this theoretical framework it is necessary to start at the basis, namely with a model that helps to explain the utilization of maternal care. As will become clear in this section, some steps have been taken that led to the final model, namely the *Access model* of Peters et al. (2008).

3.2.1 Three delays model

Initially, a model was chosen that puts maternal mortality central, namely the *Three delays model* (Thaddeus & Maine, 1994). Although the model is already 20 years old, many of today's literature on maternal care and health still see it as one of the most clear analytical models in the field (see Hunt & Bueno de Mesquita, 2005 and Rosenstein, Romero & Ramos, 2008). Its clarity can be attributed to the fact that it's creators have put often studied and relevant concepts on maternal care and health in one model. Thaddeus & Maine (1994) decided that there are three influencing factors in the process of seeking and making use of maternal care, namely *Socioeconomic and Cultural* factors; *Accessibility of facilities* and *Quality of care*. The *Socioeconomic and Cultural factors* consist of both basic demographic characteristics such as age and more cultural ones such as the way in which women value their own health. The *Accessibility of facilities* has to do with factors such as the geographical location of the facility and the availability staff and medicine and the *Quality of care* is being determined by the way in which users and providers of maternal care interact with each other (Thaddeus & Maine, 1994, pp. 1092-1104). These three factors then are of influence on three phases of health seeking and utilization behavior on the side of both users and providers of maternal care in which any delay in the process is seen as a pertinent factor of maternal mortality (Thaddeus & Maine, 1994). All of the concepts used in the model interact with each other and help to explain the different obstacles pregnant women in developing countries are facing when using and receiving immediate obstetric care (Figure 3.2.1).

Figure 3.2.1: The three delays model.



Source: Thaddeus & Maine, 1994.

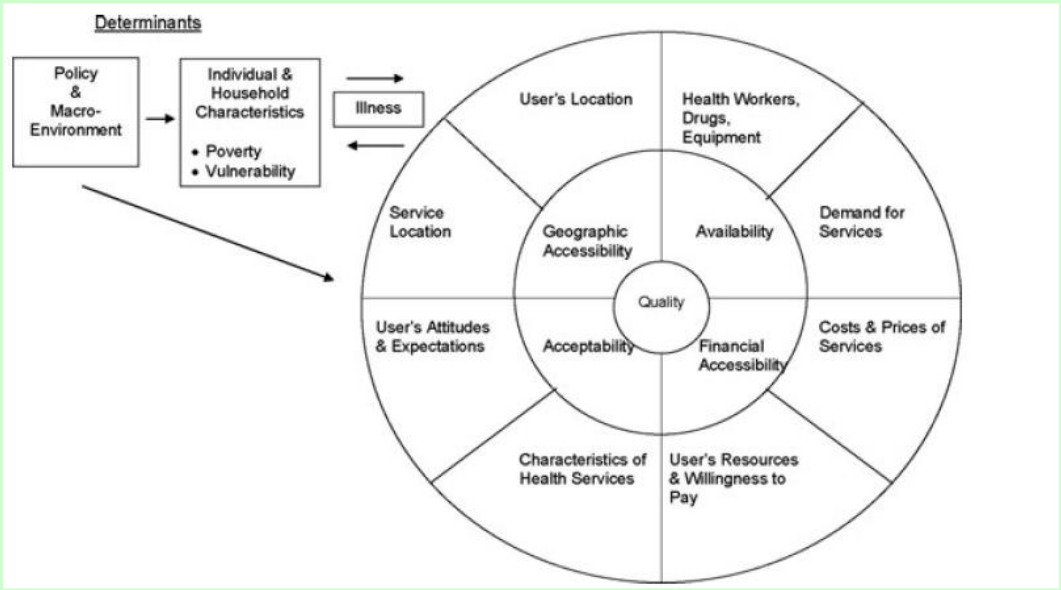
The *Three delays model* is an example of the shift that has taken place over the last two decades within the field of health care utilization studies. It is not only what providers have to offer or what users need and want- it is about these two working together. Therefore, the different components and relations that are set out by Thaddeus & Maine in 1994, today can still help to explain the utilization and perceptions of maternal care among local women from Kawempe division. Yet, it is believed that there are more 'modern' models that can help to explain the utilization of maternal care at KHC in a more elaborative way as the focus of the *Three delays model* solely lies on immediate obstetric care and the different phases of delay. Still, the model has provided this study with three main analytical factors that can be used in different situations. In this way, the model has made it easier to explore other academic studies on the subject and has led to a shift towards a model that also incorporates more external factors to the utilization of maternal care, namely the *Access model* (Peters et al., 2008).

3.2.2 The Access model

The *Access model* designed by Peters et al. (2008) is thought to best capture the process of utilization of care. Just as the *Three delays model* (1994), the *Access model*

explains utilization as a process influenced by different factors (Figure 3.2.2). Yet, it has managed to be more elaborative on the content of such factors as it looks at the macro (government), meso (health care providers) and micro (users) level of health care utilization. In other words: Making a road to a health facility (macro) is only useful when understanding why it is that people (micro) make use of the facility, if they really think the road is needed and whether the road is in good shape (meso). The model makes clear that such a process is influenced by many different factors.

Figure 3.2.2: The Access model.



Source: Peters et al., 2008.

The main claim of the model is that poverty and access to health services go hand in hand and are being determined by both the individual context and the context of the providers of health. Although this study does not focus on factors that explain the poverty of the users of maternal care at KHC, the *Access model* is highly relevant as it is a model focused on developing countries and areas such as Kawempe division. As can be seen (Figure 3.2.2) the model is also built around three main determinants, namely *Policy & Macro environment* (more global initiatives and policies); *Individual & Household Characteristics* and *Illness*. In general, it is thought that more global and national policies are of influence on whether an individual is poor or not, which leads to fewer or more people being ill, which in turn is being determined by the different components of access in the big circle that are both determined by users and providers of care (nature of policies). The prominent place of accessibility and quality of care is something that needs to be considered when studying the utilization of care. Peters et al. (2008) seem to expect that these two elements are critical in the utilization of care. Therefore, as the *Access model* is in line with the 'new' focus of incorporating both providers and users to explain the utilization of care, it is worthwhile building upon its ideas by applying the model to the situation at KHC.

3.3 Access and Accessibility

When looking again at Figure 3.2.2 it becomes clear that its creators have put the accessibility and the quality of the providers central. Access is thought to exist of four dimensions, namely *Geographical accessibility*; *Availability*; *Financial Accessibility* and *Acceptability*. *Quality* is central as it is believed that this is an important component of each of the four As and is ultimately seen as the technical ability of the health care provider to affects people's health (Peters et al., 2008). More on quality will be elaborated on in the next section of this chapter. Before turning to the four As it is first necessary to understand that there is a difference between *access* and *accessibility* and the relevance of these two concepts when studying the utilization of maternal care at KHC by local women.

3.3.1 Definition & Barriers

First, it must be made clear that *access* and *accessibility* are two different things. In its essence, the difference between the two concepts has to do with ability. Although relatively old, Frenk (1992) in his work on the concept and measurement of accessibility, makes clear that access is something belonging to the user while accessibility is determined by the providers of care: *"[…] access is the ability of a person to utilize health care given a need and/or desire to obtain it, while accessibility is really the degree to which a person needing and seeking care actually receives care"* (Frenk, 1992). A more recent explanation provided by Mshinda et al. (2007) supports this difference, as access is seen as something that has to do with the willingness and ability of the user- the provider of care can influence this ability (Mshinda et al., 2007, p. 4). To *have* access and to *be* accessible are two different things. Peters et al. (2008) summarized this difference with his model by stating that access is the level in which the needs of patients are realized by the providers (Peters et al.,2008, p.162). These definitions assume that utilization of care is part of access- when making use, people actually have succeeded to access the provider. Yet, the situation of maternal mortality in Uganda suggests a different story- one in which utilization is being surrounded with problems and barriers.

The two definitions indirectly explain why sometimes women fail to make use of maternal care as there are two sides that influence their use. According to the work of O'Donnell (2007) on the access of health care in developing countries, not having access to health care providers has two sides to it: *"There are two sides to the access problem. On the demand side individuals may not utilize services from which they could benefit. On the supply side good quality, effective health care may not be offered. The two are related"* (O'Donnell, 2007, p.2820). These two sides become visible in the *Access model* as users are being influenced by their own personal context such as their location, expectations and resources and the context of the providers such as

location and costs(Figure 3.2.2). When both sides are not in balance with each other, barriers to the utilization of care will arise.

According to the work of Standing (2004) on different demand side approaches and frameworks, it all has to do with inputs on the level of both demand and supply: *"[…] 'supply side' refers to service delivery inputs such as human resources and supplies provided on the basis of formal sectoral planning by technical planners and managers. 'Demand side' refers to the behavior and inputs of the recipients or intended recipients of these efforts: individuals, households and communities"* (Standing, 2004, p.6). The barriers there exist on both the side of users of maternal care and the providers at KHC need to be understood to understand the overall accessibility and quality of maternal care at KHC. The work of Ensor & Cooper (2004)on different barriers present on both demand and supply side of care, provided an overview of the different barriers that might exist (Table 3.3.1).

Table 3.3.1: The different components of the demand and supply side with examples of possible barriers. Source: Ensor & Cooper, 2004, p.70.

	Example of barrier
Demand side 1) Information on health care choices/ providers 2) Education	Lack of knowledge of providers Low ability to assimilate health choices and negotiate access to appropriate providers
3) Indirect consumer costs • distance cost • opportunity cost	Long and slow travel to facilities Need for patient to stop working for long periods in order to seek care
4) Household preferences 5) Community and cultural preferences, attitudes and norms	Asymmetric control over household resources Reluctance to seek health care for women outside home; community resistance to using modern medical care to assist with pregnancy
6) Price and availability of substitute products and services	Patients seek treatment through providers that are inappropriate for their condition such as drug sellers
Demand and supply interaction Direct price service of a given level of quality (including informal payment) Quantity rationing	High cost of services Large unofficial payments to staff Long waits to see medical staff
Supply side 1) Input prices and input availability • Wages and quality of staff • Price and quality of drugs and other consumables	Absenteeism, staff not attracted to the area Scarcity of supplies, weak cold chain
2) Technology	Inability to treat disease with given technology
3) Management/ staff efficiency	Poor quality of management training, lack of management systems

The barriers described in Table 3.3.1 make clear that there is a whole range of barriers that all are linked to each other. For example, the lack of information that exists on the scale of the individual can be related to lack of information distributed

on the scale of the provider. For this reason, by incorporating some of these barriers to this study, it is possible to create a broader understanding of the different factors that play a role in the utilization of care. Still, it is also valuable to see how users of maternal care perceive the possible barriers of KHC itself and how staff members at KHC think about barriers present at the health centre. The four different dimensions used in the *Access model* (Figure 3.2.2) are useful tools to study the possible barriers on the side of KHC as they touch upon important fields of access in which barriers can exist.

3.3.2 The As

The model of Peters et al. (Fig 3.2.2) already demonstrated that there are four dimensions to *access*. This is also called '*The model of the four As*' (Hausman-Muela, 2003, p.14). By dividing access into different dimensions it becomes possible to measure the level of access of both users and providers of maternal care. Therefore, it is useful to look at different variations of the four As to decide which combination is best to use in this study.

First, the four dimensions used in the *Access model* as defined by Peters et al. (2008)

1) *Geographical accessibility* – the physical distance or travel time from service delivery point to the user.
2) *Availability* – having the right type of care available to those who need it, such as hours of operation and waiting times that meet demands of those who would use care, as well as having the appropriate types of service provider and materials.
3) *Financial accessibility*- the relationship between the price of service (in part affected by their costs) and the willingness and ability of users to pay for those services, as well as be protected from the economic consequences of health costs.
4) *Acceptability*- the match between how responsive health service providers are to the social and cultural expectations of individual users and communities (Peters et al., 2008, pp. 165-166).

The way in which the four As are defined again stress the multidirectional side of utilization of care as all four As incorporate both an user and a provider side of the story. Yet, these four are not fixed. As Table 3.3.2 shows, a fifth A can also be added.

Table 3.3.2: Overview of the five As.

Dimension	Questions
Availability: The existing health services and goods meet clients needs	What types of services exist? Which organization offers these services? Is there enough skilled personnel? Do the offered products and services correspond with the needs of poor people? Do the supplies to cover demand?
Accessibility: The location of supply is in line with the location of the clients	What is the geographical distance between the services and the homes of the intended users? By what means of transport can they be reached? How much time does it take?
Affordability: The process of services fit the clients' income and ability to pay	What are the direct costs of the services and the products delivered through the services? What are the indirect costs in terms of transportation, lost time and income, bribes, and other "unofficial" charges?
Adequacy: The organization of health care meets the clients' expectations	How are the services organized? Does the organizational set up meet the patients' expectations? Do the opening hours match with the schedules of the clients, for instance the daily work schedule of small-scale farmers? Are the facilities clean and well kept?
Acceptability: The characteristics of providers match with those of the clients	Do the information, explanation, and treatment provided take local illness concepts and social values into account? Do the patients feel welcome and cared for? Do the patients trust in the competence and personality of the health care providers?

Source: Obrist et al., 2007, p. 308.

Within 'access literature' the concept of *alternativity* is also considered possible as a component of access. This is quite imaginable as low accessibility of a facility will lead people to turn to other health care providers. The influence of alternative health care providers on the utilization of a particular facility has already been studied and is highly relevant to incorporate (see Akin & Hutchinson, 1999; Mshinda et al., 2007 and Parkhurst & Ssengooba, 2009). It is also extremely relevant and applicable to the situation at KHC – it is the only health centre IV within Kawempe division and alternatives are either private clinics or TBAs. Chapter 8 will elaborate more on these alternatives.

Although the five As that have been selected make access and therefore utilization of maternal care at KHC more measurable, they will not provide the answer to who is responsible for such negative interactions. For example, users might perceive the availability of medicine as inadequate which indeed is being caused by low stock, but what explains this low stock and what are the consequences for the user? In other words: who is accountable? This is a question that is becoming more and more asked in relation to service delivery such as maternal care, hence *accountability* is becoming more and more part of the access problem (Huisman, 2011& WHO, 2004).

In the western world it is normal to go to a hospital or general practitioner and find an 'idea box' or 'suggestion box' in which users of care can share their feelings,

experiences and ideas on the care they are receiving with the managers of such health facilities. The idea is that users can anonymously share their opinions and complaints in order for health care providers to improve their services. Whether such boxes are being used to their fullest potential is never clear, but then in developed countries there are numerous of other ways for users of care, or any other public service, to actively participate in managing and improving health care. According to Standing (2004) such mechanisms are all about 'voice' and 'responsiveness' in which the former refers to a range of measures on side of the users of care such as complaints and participating in decision making to improve the way care is provided. On the other hand responsiveness lies in the hands of the providers of care- it is about what these providers do with the complaints of the users (Standing, 2004, p.18). This voice-responsiveness mechanism is an example of the sixth A - *accountability*: users of care hold providers of care accountable for their actions and these providers change their services in a way that benefit both the accessibility and quality of care. The work of Brinkerhoff (2003) on accountability and health systems provides a relevant definition of the sixth A: *"The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/ or actions"* (Brinkerhoff, 2004, p. 372). By adding accountability, a broader and better understanding of access to and use of health care will become visible. This is thought needed in developing countries, especially as poor service delivery is often the result of corruption, rent seeking and bad governance and has made public services being unresponsive to the needs of users (Standing, 2004, p.17). If there is no one that holds (health) service providers accountable for their missteps, such services will never improve and be able to cater to its users in the best possible way, hence accountability helps to explain the accessibility and quality of maternal care and indirectly, utilization.

Although accountability is becoming more popular to incorporate when studying health systems as it is a valuable way to study the responsiveness of health care providers, it is not something that can be actively incorporated in this study. It is a difficult and controversial concept to measure, especially in an environment as KHC that is governmental run. Yet, by observations and the results that will be obtained from the other five dimensions it will be possible to 'measure' the *accountability* of KHC. Also, by incorporating *accountability* the other five dimensions and the quality of maternal care at KHC will be put into perspective. In this way, an extensive As model has been made that will help capture the factors that play a role in the utilization of maternal care at KHC.

3.4 Quality of care

The *Access model* has put quality at the core of the circle. This has been done as it is believed that quality is an important component of access which is related to the technical ability of health care providers to affect the health of users (Figure 3.2.2). Yet, the description provided by Peters et al. (2008) is thought to be too one-sided- it only looks at the ability of the provider. In fact, *quality* of care is a complex concept that cannot easily be grasped.

3.4.1 Definition

Within maternal care studies there are a number of viewpoints and trends on what maternal care should encompass. Where in the 1990s and beginning of 2000s antenatal care was seen as key in overcoming maternal mortality, the last decade the focus shifted from antenatal to neonatal and postpartum to a combination of all three plus postnatal care (Bloom, Lippeveld & Wypij, 1999; Carolli, Rooney & Villar, 2001 and Filippi et al., 2006). Still, which type of care or combination has the highest positive outcome is prone to changes and therefore different strategies are often used (Campbell & Graham, 2006). Therefore, the type of maternal care that is being offered by health providers does not say anything about the quality. Of course, to overcome maternal mortality it is better to offer more types of care then only a few. Also, the work of Donnay (2000) on the different approaches to reduce maternal mortality makes clear that maternal care is not only about what is being offered but is a combination of multiple factors derived from both access and quality:

> *"Women friendly services: are available, accessible, affordable, located as close as possible to where the women live, open at convenient hours, reasonable priced; provide care with the highest possible technical standards, including infrastructure, infection control, written protocols and supplies and equipment; ensures the satisfaction of both users and providers through support and motivation of suppliers and client involvement in decision-making process, and providers responsiveness to clients cultural norms and needs; and respects women's rights to information, choice, safety, privacy and dignity"* (Donnay, 2000, p.96).

Of course, any health care provider should live up to such guidelines as they make quality quite measurable. Still, maternal mortality rates would not be this high and coverage use of follow up antenatal check up this low in Uganda when all of the requirements were in place. What makes maternal care 'quality maternal care' is difficult to define- its definition lies in the hands of the users.

Although put in the middle of the *Access model*, Peters et al. (2008) do not provide a sufficient definition of quality, only that it determines the overall access of care (Peters et al., 2008, p.162). What quality actually entails and how it is measured does not become clear. Fortunately, the work of Harteloh (2003) on the definition of quality, explains why the *Access model* does not provide in definition of this

concepts: "*Quality doesn't exist as such. Quality the thing, is the capacity of an object with its properties to achieve a goal. The more completely the goal is achieved, the higher we will judge the quality. Quality is not the property (the metaphysical quality) or the object or the goal.[…] Quality is an abstract entity. We cannot refer to it as we refer to a table or a chair. Quality is constructed in an interaction between possibilities realized on the one hand and a normative frame of reference on the other*" (Harteloh, 2003, p.261). The way someone perceives the quality of care is dependent on the way the user and provider of care interact with each other. This interaction is dependent on the context of both: when the context of the user is in line with the possibilities of the provider than care will be perceived positively by the user and vice versa. Therefore, true quality of care lies not in the type of care that is provided, but more in the way care is applied to a particular patient in a particular situation (Harteloh, 2003, p.261). In this way, the perceptions of users on care, how they think care should be provided to them, are of influence on the utilization of care. This relates to the already mentioned need: care is of high quality when the needs of users are satisfied in the way they expected, hence the users of care determine whether a provider of maternal care offers 'quality maternal care'. This in turn explains the central role of quality within Figure 3.2.2. Quality of care is being defined and includes all aspects of accessibility and is pivotal in understanding the utilization of maternal care. Therefore, studying maternal utilization at KHC without incorporating the concept of quality is undesirable- its inclusion is necessary to provide an overall understanding of maternal care utilization at KHC.

3.4.2 The role of perceptions

There are several definers or determinants that can influence perceptions of users on quality of care. When user and provider do not speak the same language and information cannot be distributed in an understandable way, this can lead to negative perceptions about the quality and accessibility of care. Quality of care is about perceptions: what one user might perceive as positive behavior of the provider another will perceive as negative. This role of perceptions on the quality of maternal care has been demonstrated in the work of Say & Raine (2007) on the importance of context in maternal health care:

> *"[..] interactions between factors at the level of the individual and those associated with supply or organization of health care were often crucial. Women in Tajikistan preferred to deliver at home because although medical settings were accessible and free of charge, women perceived these settings to be of very low quality and unsafe. Midwives advice on where to deliver was ignored by Jamaican women, who perceived the midwives to be too authoritarian. Women in rural Guatemala were less likely to deliver in medical settings because of the lack of social support provided by health care*

professionals compared with traditional midwives.[…]" (Say & Raine, 2007,p.816).

This makes clear that in developing countries interaction between users and providers of maternal care do not always run smoothly. This is often being caused by a lack of trust. Therefore, to make quality of maternal care at KHC more concrete, the interaction between user and provider in relation to trust needs to be studied side by side with quality.

3.4.3 The role of Trust & Context

Quality of care cannot be incorporated without touching the role of *trust*. That trust is something that is important in any kind of relationship is something that has been studied by many social scientists (Hawe & Shiell, 2000). For anybody to share personal issues is something that requires a somehow private and trustworthy environment. When linking this back to the access and utilization of care it is important that users feel at ease to share their problems. Therefore, it is important to incorporate trust into this study as it will tell a lot about the quality of maternal care at KHC.

An explanation of the importance of incorporating trust in health-seeking studies is being provided by the work of Thiede (2005) on information sharing and access to health care. According to Thiede the accessibility of health care is something that depends per person and the way individuals proceed information: *"As there is a whole set of aspects defining access to health care that is inherent in the individual, such as knowledge about health and health services, perceptions and preferences, part of the challenge depends on the exchange of information between the health system and the individual"* (Thiede, 2005, p.1452). In this way, the accessibility of care is not only something that can be explained from a supply side point of view, but is more seen as the level in which supply and demand sides understand and cohere with each other. In order for coherence to be established Thiede sees it as the task of the supply side to interact with the demand side in a way that fits the context: *"What is more, health services need to be such that they are not only medically secure but also culturally secure, i.e. they do not just fulfill the proper criteria of medical quality but they also incorporate expectations towards the health system that people have on the grounds of their culture"* (Thiede, 2005, p.1453). The demand and supply side need to speak the same language to have a positive outcome. Without connectedness between both sides Thiede believes that trust cannot be established. The higher the level of overlap between the reality of the provider and that of the receiver, the higher the level of trust will be (Thiede, 2005). By creating (mutual) trust between user and provider any possible barriers to the utilization of care will decrease, hence accessibility and quality will increase. To change this and bring more coherence and trust to the foreground Thiede stresses to importance of a participatory approach in which the demand side of care gets to have a voice in the hope that the supply side will comply more with the context of the receiver of care

(Thiede, 2005). This, at the same time, stresses the importance of adding a sixth 'A' to the access debate.

Of course, trust is not the sole determinant of quality. Even, no actual interaction between user and provider has to take place for users to have perceptions on the quality of care being offered. The social environment plays an important role in creating positive or negative perceptions about care and the eventual health-seeking behavior (Mackian, Bedri & Lovel,2004, p.142). Everyone that has ever made use of a particular health care provider has shared his or her experiences and perceptions with others. In this way without ever having used a particular health facility, (possible) users will be able to form their perceptions. The social connectedness the users of care have with others, be they family, friends or others can influence their health seeking behavior both negatively and positively Yet, such social relationships are understudied within health-seeking behavior studies as the focus often solely lies on the individual context (Mackian, Bedri & Lovel, 2004, p.142). Still, it is quite understandable that such individual context is being influenced by others and therefore, it is relevant to incorporate the social environment of users of maternal care.

3.5 Socioeconomic & Cultural factors

Within the *Access model* more socioeconomic and cultural factors are mentioned, yet not explicitly. Yet, Peters et al. (2008) make clear that these factors have something to do with the individual circumstances of the users. A more prominent role is given to socioeconomic and cultural factors in the *Three delays model* (Figure 3.2.1). Its creators believe that both demographic characteristics such as age and education and more cultural determinants such as the way in which women treat their own health are of influence on the utilization of maternal care (Thaddeus & Maine, 1994). Many other studies that focus on maternal care utilization or related topics have studied these contextual factors in length and depth (for example Celik & Hotchkiss, 2000 and Say & Raine, 2007). Many of these scientists believe that by focusing on the socioeconomic and cultural background of maternal care users the use or non-use of this care can be explained (Celik & Hotchkiss, 2000,pp.1797-1806). There are many contextual factors that play a role in the utilization of care and maternal care in particular: *"[…],factors related to place of residence and socioeconomic status may account for variations in use of maternal health care. These factors include women's age, ethnicity, education, religion, culture, clinical need for care and decision-making power. The costs, location and quality of health services are also important. These factors interact in different ways to determine use of health care"* (Say & Raine, 2007, p.812). This makes clear that although less visible in the *Access model* (Peters et al., 2008) these individual contextual factors are indeed useful and important when studying the utilization of maternal care. By

incorporating factors such as age and treatment of the personal health, a better understanding of the women that make use of maternal care can be provided. In this way, taking consideration of one's background will put utilization behavior in perspective.

3.6 Incorporating the concepts

Now that is clear which general ideas, assumptions and model are thought to be useful in studying the utilization of maternal care at KHC, it is necessary to provide an overview of their importance to this study. The *Access model* has highlighted the importance of *access to health care* and the central role *quality* plays in this. The different dimensions used by Peters et al. (2008), but also variations to these dimensions as used by Obrist et al. (2007) will help to measure both the accessibility and quality of maternal care at KHC. Still, as Harteloh (2003) has made clear quality as such is a difficult to measure concept. Yet, the explanation provided makes clear that much of quality is defined by the users of care, hence maternal care user at KHC. The way in which the context of the women and the staff of KHC is in line with each other is thought to define quality making it a relevant concept to incorporate.

Yet, as Thiede (2005) and Say & Raine (2007) have made clear, trust and perceptions form a part of this context. Therefore, these two concepts need to be incorporated as they form part of the way in which the users of maternal care at KHC experience the quality of the health centre. Further, the context of users of maternal care, their socioeconomic and cultural background is thought to play a role in the utilization of maternal care (for example Celik & Hotchkiss, 2000; Say & Raine, 2007). Therefore, it is also necessary to incorporate these factors into this study, especially since the *Access model* does not provide an extensive overview of such factors. Especially, the role of the social environment on the utilization of maternal care at KHC by local women needs to play a role, as this is an understudied topic within health-seeking behavior studies, but not in the least unimportant. By including the social environment it will become possible to see whether the utilization of maternal care is influenced in any way.

Further, the overall quality and accessibility of maternal care at KHC can be 'measured' by incorporating *accountability*: why is it that certain things go wrong at the health centre and who can be held accountable? As Brinkerhoff (2003) demonstrated, this is an important dimension of accessibility that deserves attention, be it less extensive. The situation at the health centre and it being a governmental health facility will make it a difficult task to hold anybody accountable. Still, it can function as a tool to put other (negative) results in perspective. Overall, the studied academic concepts can be seen as the foundation of this study- they help to analyze the situation at KHC in a way that fits within the local and academic context.

3.8 Conclusion

The presented academic concepts have all been selected for their contribution to the field of health-seeking behavior studies or health care utilization in specific. They have shown to be quite flexible as they are multisided and can also be applied to explain the utilization of maternal care. Especially the *Access model* of Peters et al. (2008) provides a valuable framework to analyze the situation at KHC. Although some of the used literature is a little dated, this does not undermine the results of this study as it is believed that such embedded literature rather leads to a more solid and reliable results.

Before it is time to put the academic concepts in practice, it is first necessary to understand the situation to which they will be applied. Therefore the next chapter will put the spotlight on the field of the research, namely Kawempe division and KHC.

[4] A local maternal care crisis

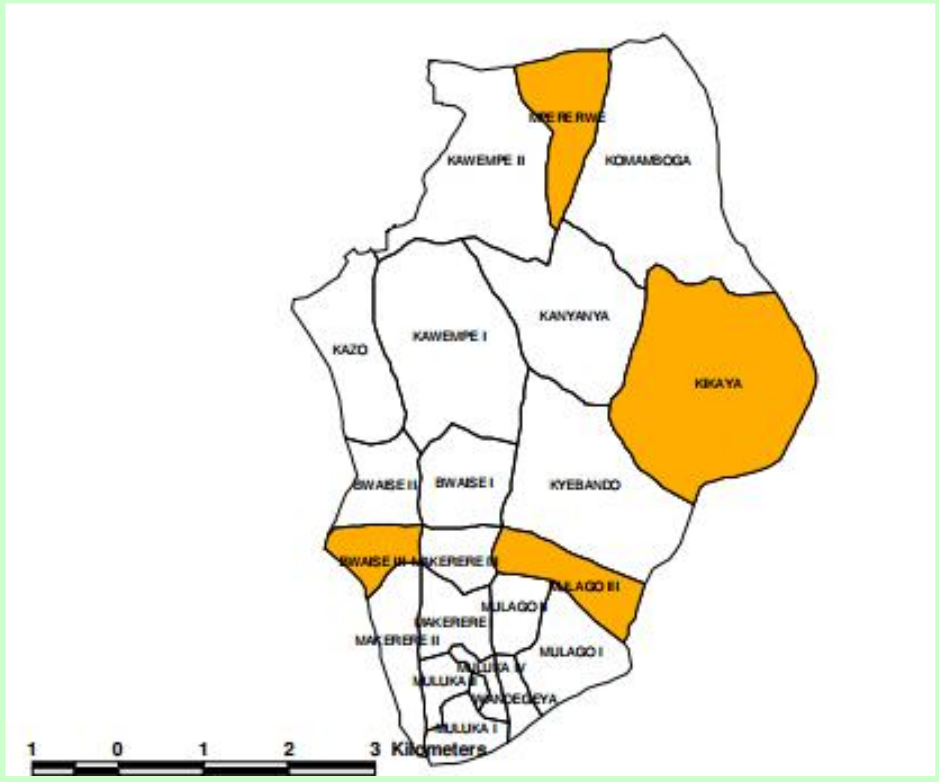
4.1 Introduction

Now that is clear what the national situation of maternal care and health of Uganda looks like and which academic concepts will be used to get a better understanding of maternal care utilization at KHC, it is time to zoom in more on the main actor in this study, KHC itself. By focusing on the local context it becomes clear in what kind of environment the health centre is situated, the people it serves and the problems surrounding it. This, to make clear that the day to day provision of maternal care and its utilization do not run smoothly. At the end of this chapter it will be clear that for both local mothers and the people that provide maternal care, Kawempe and KHC pose many challenges.

4.2 Kawempe division

Kawempe division is one of the five divisions to make up the capital city of Kampala. It covers an area of 32.45 km^2, divided into 19 districts, giving home to almost 300,000 inhabitants (Figure 4.2). Many of the people that live in Kawempe division have their origin in the northern part of Uganda as they fled from this part of the country during political instabilities between the period from 1981 to 1986.

Figure 4 .2: Map Kawempe division divided in nineteen districts. Source: Shuaib & Nyakaana, 2005.



The immense increase of people living in the division has led to a number of problems, such as lack of appropriate housing and public services. Further, Uganda also has to deal with an increasing (youthful) population: something that is also the case for Kawempe division. Almost 46 percent of the population is under eighteen years of age and more than 40 percent is between the ages of 10 to 24 years. In part, this can be related to religious believes as Islam and Catholicism dominate the division, but also to widespread practices of polygamy and high unemployment rates.

> *"The practicing of polygamy in Kawempe is normal, this also contributes to a lot of women that are being abandoned by their spouses. These men mainly jump off and leave the responsibilities to the mothers"* (Community leader).

Also, lack of schools and health services contribute to problems related to high youthful population numbers(City Council of Kampala, 2010-2011/2012-2013,p.54).Yet, most of the inhabitants in the division seem to have access to safe drinking water within a radius of one kilometre from their homes and almost 95 percent of all inhabitants has access to a health facility within a radius of five kilometres (City Council of Kampala, 2010-2011/2012-2013, p.56). Still, most of these health facilities are privately run and are therefore often too expensive for the people of Kawempe as it is one of the poorest divisions of Kampala.

> *"In Kawempe there are not sufficient public services to serve all the people. Many people go to witch doctors and take local medicine to cure themselves as it is often believed that illness has a spiritual cause and meaning. Also, there are a lot of private clinics that charge patients too much and are therefore too expensive for most people. In order for Kawempe to improve as a whole the district should get more public services in the field of health and education"* (Community leader).

Agriculture and livestock form the main sources of income, but there is also a large part of Kawempe its population that makes a living through informal activities such as selling little eatables, carpentry and the manufacturing of wooden furniture near their homes. Still, only 52 percent of the total working population in the division has a paid job of which only eighteen percent is being occupied by the female population (City Council of Kampala, 2010-2011/2012-2013).

Women are clearly represented in the division as they make up more than half of the population. Yet, this does not mean women are better off. A large number of women in Kawempe division is highly illiterate, unemployed and often single mother engaged in informal businesses. This is being caused by the tough environment in which these women live. The women of Kawempe generally have a low health status due to low levels of education, low levels of contraceptive use, and poorer economic status and gender inequalities at the household level. A high number of domestic violence is also part of daily life for many women in the division. When it comes to their health, women tend to be health care givers instead

of takers as the health of their children and other family members often comes first (City Council of Kampala, 2010-2011/2012-2013). Then, being an uneducated, unemployed, pregnant and (young) woman in Kawempe division that has to take care of other family members often leads to women not taking good care of themselves. The lack of public health facilities in the division makes using maternal care even more difficult. Making use of alternatives such as expensive private clinics or TBAs are for many women ways to obtain care. Such use does not need to taken place as Kawempe division is home to one of the biggest governmental run health centres of Kampala, namely KHC. Therefore, it is necessary to look at the situation of KHC to understand its use and non-use by local women.

4.3 KHC

KHC is the biggest health centre IV in Kampala which means that it plays a key role within Uganda's health system. As a health centre IV, KHC has the capacity to provide basic promotive, preventive and curative services such as emergency surgeries; obstetric services; to supervise and support planning and implementation of the lower health units (UBOS, 2010/11). A health centre IV such as KHC caters to people on a rather local level as it is a step below the district hospital (Figure 4.3). For a health centre IV to provide in such services, a couple of factors need to be present: infrastructure and equipment need to be present and appropriate to use, just as qualified staff qualified and an interest in maintaining and improving the functionality of the health centre through active management (UBOS, 2010/11). When all in place, health centre IVs such as KHC are critical players in the functionality and provision of health services in Uganda. Yet, this is often not the case as many health centre IVs throughout the country are facing problems related to understaffing and efficiency. Health care workers are not willing to work at health centre IVs as payments are often low and bed occupancy is often either too high or too low. Then, record keeping is often unstructured or irregular which leads to inadequate and incomplete data on for example maternal mortality rates (UBOS, 2010/11, p. 19). Such problems lead to

Figure 4.3: Photo of the different health care levels of the Ugandan health care system. Source: Author's own, 2012.

dropping coverage rates and lower quality for example antenatal check-ups obtained. The different problems that health centre IVs are dealing with in Uganda are remarkably clear at KHC.

When looking at the biggest health centre IV in Kampala, KHC seems to be putting on the burden of being the only health centre IV within the division. It has too little resources available to attend to all its patients in an adequate way. The number of patients is growing by the year and does not increase in a slow pace- between 2010 and 2011 the total number of patients for KHC as a whole increased from more than 98,000 to over 130,000 patients. A big part of this increase can be attributed to the growing number of women making use of maternal care at KHC. During the period from 2009 to 2011 the number of maternal care admissions, women that come for the first time at the health centre, increased substantially (Table 4.3).

Table 4.3.A: Overview of maternal care use at KHC.

	2009	2010	2011
Admission	5,435	5,488	6,473
Deliveries	4,396	4,312	5,285
Live births	4,332	4,291	5,262
Still births	50	46	39
Maternal deaths	0	1	0

Also, the number of deliveries at the health centre increased which is in line with the national trend. Further, the health centre does well in relation to maternal deaths (Table 4.3.A). Yet, whether these figures are adequate is not clear as record keeping often happens in a rather unstructured way. To come back to first time visitors, women that come for their first antenatal check-up, numbers increased during the last three years. Fortunately, these first time visits are also increasingly being followed up by more check-ups as also the number for fourth time antenatal visits increased (Table 4.3.B). Still, the numbers of the second and third check-ups are much lower and therefore do not say anything about the total number of women completing all four check-ups. Also, the number of women that come back for postnatal care, taking vitamins and immunization of their babies, is on the rise- from around 2,900 in 2010 to over 4,000 users in 2011. Again, there is no information on whether these postnatal care users only come for one or both of the consultations.

Table 4.3.B: Overview of antenatal care attendance at KHC for the years 2009, 2010 and 2011.

	2009	2010	2011
Antenatal 1st visit	11,094	11,173	11,968
Antenatal 4th visit	10,891	11,497	13,189

Although it is a good thing that pregnant women and mothers increasingly seem to make use of maternal care services offered at KHC, this also leads to problems. Especially, when putting this increase in relation to the availability of staff, medicine and equipment. In total, KHC has about 60 employees of which the majority works for the maternity clinic. Still, 60 employees and over 130,000 patients each year

indicates that there are not enough staff members to cater to all these users. Then, tight budgets to supply the health centre with enough drugs, equipment and a reasonable salary for the staff, leads to situations in which staff members become unmotivated.

> *"The payment is very bad. We entered into a system in which we are still given salaries of when one kilogram of sugar was still cheap. No, the sugar is expensive, but we still have the same salary. The demand is very high for what we are getting paid"* (Nurse KHC).

This together with a failing internal infrastructure in which running drinking water and electricity are often lacking; the availability of only one public toilet and old buildings that do not provide the necessary space and privacy to house all users, all seem to contribute to staff members not living up to their ethical working codes and user unfriendly services.

4.4 Conclusion

It seems that Kawempe division has problems that are typical for urban areas in developing countries. The growing population and the relatively young age of mothers is the 'perfect' ingredient for an increase in the number of women making use of maternal care at KHC. Yet, lack of efficient support of the government has led to a health centre that is not able to cater to all these people, creating an environment in which it is quite 'attractive' to search for more expensive and dangerous alternatives. This in turn, increases the chances of maternal mortality and also adds to the number of women having to struggle in an economically. The situation at KHC almost screams for attention, especially when it comes to understanding why women still decide to make use of the maternal care there.

As it is critical to have a method that captures the influencing factors of the utilization in the best possible way, but also has the capacity to focus on the overall situation, the next chapter will set out the methodological steps that have been taken.

[5] Methodology

5.1 Introduction

When it comes to building a health centre or any building, its structure and sustainability all depend on the right tools and equipment. Without them or with the wrong ones, the health centre would collapse or be highly unstable. The same is true when doing research: without the right research methods it will be difficult to find an adequate answer to the research question and the whole purpose of the research will be lost. Yet, choosing the right method is a process that is highly dependent on the focus and field of the study. The same is true for this study as the eventual research method, qualitative in-depth interviewing, has replaced a more quantitative structured questionnaire. Further, now that the context of this study is clear and the theoretical basis has been set out, it is now time to formulate the sub-questions that are part of the mean research questions. Also, doing research in a developing country poses a number of issues that need to be considered, especially ethical ones. Therefore, this chapter will set out the different components of the research and the steps that have been taken along the way.

5.2 Sub-questions

Now that the overall situation of maternal health in Uganda has become clear; the characteristics of both Kawempe division and KHC have been set out and the most important academic concepts have been incorporated in this study, it is time to formulate sub-questions that incorporate both context and theoretical concepts. This, to provide adequate answers to the main research question. The sub-questions each have been divided into several sensitizing topics drawn from the context and literature.

5.2.1 Sub-question 1

How can the socioeconomic and cultural background of local women help to understand the utilization of maternal care at KHC?

This question has been based on the situation of women within Kawempe division where most women do not have any economic activity and are uneducated. Also, the *Access model* (Peters et al., 2008) makes clear that there are individual determinants, characteristics of the users, which help to explain the utilization of care. These characteristics are thought to explain the utilization of maternal care at KHC. Further, the previous chapter made clear that the role of the social environment also can play a role in the utilization of maternal care, hence sociocultural characteristics. Therefore, this sub-question is divided into the following two topics.

1. General demographic characteristics
2. Specific sociocultural characteristics

5.2.2 Sub-question 2

What are the main reasons for local women to make use of maternal care at KHC?

Why do women make use of maternal care in the first place? This is a simple question, yet based on context and theory. The national context has showed that maternal mortality rates in Uganda are high and that women at KHC not always make use of its facilities to the fullest. By zooming in on different topics (below), a better understanding of the process to make use of maternal care at KHC will become visible.

1. General reason to make use of antenatal care
2. Number of check-ups
3. Delaying
4. Choosing for KHC
5. Delivery at KHC
6. Perception on received antenatal care
7. Things that are missing, needed or wanted at KHC

5.2.3 Sub-question 3

How do the accessibility and quality of KHC help to explain the utilization of maternal care by local women?

As the *Access model* (Peters et al., 2008) mainly focuses on the accessibility and quality of care, the main part of this study revolves around just those two concepts. The way in which local women perceive the maternal care they are receiving is thought to be essential in explaining the utilization at KHC. The utilization is explained by the five As plus accountability. Also, the perceptions of the women would provide a one-sided story. Therefore, incorporating the perceptions of the staff members on the same As is important to put the utilization by the women in perspective. This question consists of six topics.

1. Alternativity
2. Accessibility
3. Affordability
4. Availability
5. Acceptability
6. Accountability

Although already mentioned in the previous chapters, the topics or concepts used in the main research question and the three sub-questions need to be defined in a way that fits this study. Therefore the next section will provide an overview of these topics transformed to more measurable concepts.

5.3 Operationalization

Although making topics from the context and literature 'measurable' is more a characteristics of quantitative studies, it is necessary to set out how a certain concepts discussed in the theoretical framework are defined in a way that fits this study. This, to contribute to a better understanding of the results set out in the next three chapters. Most of the definitions provided, are a combination of definitions set out in the previous chapter, while others maintain their original definition.

5.3.1 Defining concepts of maternal care

There are a number of concepts that are related to and form part of the concept of maternal care- they are within the field of maternal health and care studies. For each of the concepts a definition is provided that is in line with the aim of this study.

To start with maternal health. According to WHO ***maternal health*** refers to: *"the health of women during pregnancy, childbirth and the postpartum period"* (WHO, 2012). This definition highlight that maternal health can be divided into three phases. Two of those phases are actively incorporated in this study, namely the antenatal and postnatal period. In the light of this study, the ***antenatal period*** is the phase in which women are pregnant and make use of antenatal check-ups at KHC. On the other hand, the ***postnatal period*** is a phase in which women have recently given birth at KHC and make use of the postnatal clinic at KHC. The ***antenatal care*** at KHC consists out of consultation, check-ups of the womb and overall health, blood testing, treatment of malaria and other diseases, weighing and the receiving of medicine and vitamins. The ***postnatal care*** at KHC consists out two consultations in which mostly the baby receives immunization and is weighed- the mother does not receive any specific type of care. Yet, these ***postnatal care women*** are women from Kawempe division that have made use of all maternal care facilities at KHC, whilst most ***antenatal care women*** are women from Kawempe division that only have made use of antenatal care at KHC. In this way ***maternal care*** can be defined as the care women receive during their pregnancy, when in labour, delivery and after the delivery. Maternal care is provided to women to overcome and decrease the chances of ***maternal deaths*** which by WHO is defined as follows: *"The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes"* (WHO, 2012). This definition makes clear that maternal death can have many causes, but that these causes can be foreseen and treated. Then, ***maternal mortality*** is defined as: *"The number of maternal deaths during a certain period time per 100 000 live births during the same time-period"* (WHO, 2005).

5.3.2 Defining concepts part of the utilization of maternal care

From more specific related maternal care concepts, it is time to define more 'general' concepts used in relation to the utilization of maternal care. As the *Access model* (Figure 3.2.2) makes clear, the access to and the quality of care is important in explaining the utilization. In turn as the literature has showed, there are several concepts that influence the access and quality of maternal care at KHC.
First, to define ***access to maternal care*** the original definition provided by Peters et al. (2008) can be incorporated. For local women to have access to maternal care, means they have a need to make use of maternal care and that this need is being realized by the providers of maternal care. This access can be 'measured' by five dimensions plus a sixth one. Their definitions are based on both the *Access model* (Figure 3.3.2) and Table 3.3.2 (Obrist et al., 2007).

Acceptability is the level in which the context of the local women are in line with the context of the providers of maternal care at KHC, hence which behavior both think is appropriate. This behavior is being determined by several aspects such as the interaction between the women and the staff of KHC, the attitude of the staff towards the women and vice versa, the level of ***trust*** there exist between the women and the providers measured by whether the users think the information they receive is acceptable and the way this information is shared. Also, the waiting time and the available privacy form part of the acceptability of maternal care at KHC in which the available ***privacy*** is measured by how the women perceive the available space at the antenatal clinic. Then, the ***Accessibility*** of KHC can be defined as to how the women perceive the geographical location and the transport time in minutes from their homes to the health centre. Although KHC offers free services, there are also some costs involved such as transportation costs and additional items that need to be bought. Therefore, the ***Affordability*** of maternal care at KHC can be defined as the costs women have when making use of KHC. Also, as the literature makes the utilization of maternal care at KHC can be explained by lack of health care providers within the division. In this way, ***Alternativity*** can be defined as the presence of other health care facilities that offer maternal care, private, public and TBAs, as well as the knowledge the women have on these alternatives. The fifth A that needs to be defined is ***Availability*** which in the light of this study can be defined both as the actual number of available staff, medicine and equipments at KHC and the perceived availability by the women. Although ***Accountability*** is not something that has been actually measured, it will help to put the other five dimensions in perspective. The definition provided by Brinkerhoff (2003) covers the load of the subject, namely that accountability has to do with the obligation of KHC to answer questions regarding the situation at KHC, the behavior and actions of its staff to the users of maternal care. In other words: accountability helps to hold someone responsible for possible negative perceptions on the utilization of maternal care at KHC and the work load of its staff.

Besides access and its dimensions, quality is an element of all of the dimensions (Peters et al., 2008). It has to do with how the context of users and providers is in line with each other and then mostly how users perceive the way in which care is being provided. Yet, how quality is defined differs per user, hence it is a difficult to measure concept Still, when talking about contexts, the definition of ***Acceptability*** comes closest in defining quality. Yet, the total of results provided by the local women will make clear how quality of maternal care at KHC is rated as such. This makes clear that it is about ***perceptions*** which are the personal believes of the users as to how care should be and is actually provided. These perceptions are based on the socioeconomic and cultural context of the users of maternal care at KHC. Socioeconomic and cultural factors are thought to play a role in the utilization of maternal care. Therefore ***socioeconomic factors*** are more basis demographic factors such as age, religion, education and economical activities. ***Sociocultural factors*** are for example the way the women treat their own health, positively or negatively; whether the 'maternal care' behavior of the ***social environment***, friends and family, of the users plays a role in their utilization of maternal care at KHC and whether the women are supported by their social environment to make use of maternal care.

5.4 Methods used

To answer the main research question and the different sub-questions a method needed to be chosen that would lead to valuable results and at the same time take consideration of the participants. Although at the start of the research a more quantitative approach, a structured questionnaire, was thought to benefit the results, a shift took place after conducting seven test-interviews with antenatal care users. The initial method turned out to provide useful (structured)information, but remained on the surface of the subject as it disabled obtaining in-depth information. To fully understand the contexts of both users and providers, a qualitative approach was chosen that made it possible to let the users and providers tell their personal side of the story. The use of qualitative methods will enable to paint a picture of the lives of the participants and to observe and participate in day to day life (Boeije,'t Hart & Hox, 2009). Therefore, in-depth interviewing was chosen as the main research method.

5.4.1 Semi-structured interview

A semi-structured interview was designed in which five main topics drawn from the context and literature are central, namely 1) *Socioeconomic & Cultural background*, 2) *Pregnancy information*, 3) *Antenatal care information*, 4) *Decision-making process& Restrictions* and 5) *Perceptions on the accessibility and quality of maternal care at KHC*. These five main topics where divided into numerous smaller topics to get the most out of the interview (Appendix 1). Further, to not get an one-side story

of the situation at KHC, staff members were also interviewed with the help a semi-structured topic list. Although much shorter, this topic list consisted out of topics related to what the staff members thought were problems of the health centre; what they thought about the interaction with the users of maternal care and their working conditions (Appendix 2). Then, to put the pros and cons of the health centre in perspective, several in-depth interviews with experts of the community and within the field of (maternal) health care in Uganda were conducted (Appendix 3 & 4). These interviews were less structured and more based on the results obtained from the interviews with local women and staff members. All of the interviews have been transcribed, coded by hand and put into Excel sheets to make analysis more efficient.

5.4.2 Observing & Participating

Another component of the research was actively observing and participating in day to day activities at KHC. Especially during the first four to five weeks small conversations with patients and staff members, but also with locals outside of the health centre, formed part of the research. This approach has helped to gain more trust with both users and providers at KHC and has put the situation at KHC in perspective. For example, a visit was brought to Katooke, one of the districts within Kawempe division. By observing daily life there and talking with one of the community leaders, it became clear why KHC has so many patients as all districts within the division, small or big, make use of KHC. Also, this visit made clear that the area in which KHC is situated is one of the more developed areas within the division as Katooke district has no tarmac roads or public health facilities.

5.4.3 Local women- Selecting, Place & Time

As the study is centered around the situation at KHC, selecting participants for the research was not that difficult. Still, choosing the right target group was more of a challenge. At first, the aim was to incorporate only antenatal care users into this study as these pregnant women are supposed to regularly visit the health centre during their pregnancy, hence they have a variety of experiences. Yet, after the first 10 interviews it became clear that most of these women only had experiences with the antenatal clinic at KHC- they did not have knowledge on the other types of maternal care that are provided at KHC. Therefore, another group of users needed to be chosen- a group that had made use of all the types of maternal care at KHC already. This group was found in postnatal care users, women that already had given birth at KHC and at the moment of the interviews were taking their babies for immunization at KHC. This led to an extension of the research in which in total 30 antenatal care users were interviewed together with ten postnatal care users. Such numbers are not fixed, but it turned out that a saturation of the data was taking place after 25 interviews of antenatal care users. Due to time it was only possible to interview ten postnatal care users. Still, this difference in participants is not a limitation to the validity of the research as this study is too small to be

representative for maternal care users in Kawempe division or Uganda as a whole. Yet, by incorporating two different groups to this study, a more extensive data base was created that provides a good reflection of the situation at KHC. Also, most of the results will be discussed as a total, hence antenatal care and postnatal care participants are treated equally- no comparisons have been made.

Over a period of four weeks consisting out of eight interview rounds the 40 users of maternal care weere interviewed. The interviews started in the morning, when the antenatal and postnatal clinic opened and lasted until early afternoon. Each interview lasted on average 30 to 40 minutes and took place in an open tent behind the HIV-clinic at KHC. This place was private enough for the women to not feel threatened by the presence of staff and other users. The attending nurses at both the antenatal and postnatal clinic were informed about the research by the research assistant. Then, the research assistant would inform the women about the research; the content of the interview; its duration and issues related to confidentiality and consent as all of the interviews were recorded (Appendix 5). The main task of the research assistant were to approach the women in a way that made them feel comfortable enough to open up and to create a fluid conversation in which the main topics where addressed and translated. After the interview, each participant was handed a little incentive, a second-hand night gown or an herbal soap, as a way of showing appreciation for participating in the research. Beforehand the women did not know a little incentive would be handed out. This to not jeopardize the integrity of the research.

5.4.4 Staff members- Selecting, Place & Time

Although equally important for the research, the interviewing of the staff members at KHC was less structured and 'formal' then the interviewing of local women. This is related to the working conditions of the staff members- enrolled nurses, midwives and the head nurse were all extremely busy and had little to no time to participate. Therefore, only nine interviews were conducted. Most of them took place during short breaks and lasted for ten minutes on average. As the interviews took place at the health centre, most of the participants did not feel comfortable with using a voice recorder. Although these participants were informed about their rights and confidentiality issues, most of them did not agree on using a voice recorder. The fact that the interviews took place at the health centre in an environment where everybody could hear any possible negative perceptions, is a reason for this. Therefore, notes were taken to give these participants a 'safer' feeling in relation to confidentiality issues.

5.4.4 Experts- Selecting, Place & Time

The interviews with community leaders and experts in the field of (maternal) health care in Uganda required a different approach. For most of the interviews that were conducted with community leaders much was arranged by the first research assistant, a local of Kawempe and volunteer at KHC. His connections helped to arrange several interviews with for example a local medical officer. Most of these 'community interviews' took place on the street and were not formal in nature. Usually, such an interview took around fifteen minutes in which participants were asked about their opinions on life in Kawempe division and what their knowledge and experiences with. The interviews with experts in the field of (maternal) health care in Uganda were more formal and required longer preparation time. The experts formed part of non-governmental organizations where they specialized in (maternal) care provision. These organization were found during random walks through Kampala. Then, making an appointment was often difficult due to busy time schedules. In the end, four experts participated in the research. Most of these interviews took place at the office of the experts and lasted between 30 to 60 minutes. Although all of the interviews provided relevant information, not all have been incorporated into this study as some interviews were less specific in relation to the main research question.

5.5 Ethical considerations

When doing research it is always important to respect the people that are helping to deliver results, hence participants need to be treated in a just way. Yet, when doing research in a developing country as Uganda and especially in an area such as Kawempe division, there are some ethical considerations that need to be taken into account. First, being a western researcher in an area with little to no interaction with western people, makes it difficult to gain trust of the local population. Especially, to interact with users of (maternal) care at KHC in the beginning was difficult, because of the language. Therefore, the aim was to make users and providers of KHC and other locals aware that the research would not take advantage of the situation. This has been done by actively participating in day to day activities and by random talks with users and staff members. Also, obtaining knowledge outside of the health centre made it easier to connect to users and providers at KHC as they became aware that a mutual understanding about the situation in Kawempe division existed.

5.6 Strengths & Weaknesses

Although the best possible method for the field of study has been chosen and all of the participants have been treated in the best possible way, there are always strengths and weaknesses that need to be considered as they help to put the results in the next chapters into perspective.

5.6.1 A deeper understanding

The strength of this study is at the same time its weakness, namely being a qualitative study. By using a qualitative method the local women, the users of maternal care, have been put central. Their lives and experiences have provided this study with valuable and relevant data to answer the main research question. At the same time, such an approach made it possible to 'connect' with the users in way that made them feel at ease and confident enough to share their stories. This method has made this study more 'human' and enables to give the results a 'face'. Further, this study is not one-sided as it also incorporates view-point from staff members and others, hence fits within the ongoing trend of looking at the interaction between users and providers instead of focusing on only one of them. This has led to a study that by no means chooses sides- it shows that to understand the utilization of maternal care both the story of users and providers needs to be told. Then, the duration of the research, fifteen weeks in total, enabled to actively engage in day to day activities at the health centre which has contributed to its reliability and validity- the results have been put in perspective with 'outside information' of community leaders and other experts. Overall, the main strength of this research is that it has aimed to be a listing ear for both users and providers of maternal care at KHC which has led to an all encompassing framework to study the utilization of maternal care in developing countries in general. The study has made clear that to understand and improve utilization of maternal care and indirectly maternal mortality, a 'one-size-fits-all approach is less relevant.

5.6.2 No generalization

On the other hand, choosing a qualitative method also has its weaknesses. By using a quantitative approach in the form of a structured questionnaire a broader scope of results could have been obtained making this study more representative. For now, the qualitative results that will be discussed in the next chapter, cannot be used to make any generalizations as to the utilization of maternal care at KHC in general or for maternal care users in Uganda as a whole- the results only are applicable to the situation of those that participated. This also means no generalizations can be made in relation to underlying causes of maternal mortality in Uganda or other developing countries. Further, only local women that make use of maternal care at KHC have been incorporated in the study. Therefore, the reasons why others do not make use of the services provided at the health centre are not clear, hence the results might be too 'positive'. There were will be numerous reasons not to make use of the health centre, yet these are not incorporated. In this way, the results on mainly the reasons and perceptions on accessibility and quality of KHC are rather one-sided. It was chosen to only focus on those women that make use of maternal care at KHC, because it was believed more results could be gained from this. The access to data

on local women that do not make use of KHC is limited to non-existent, hence there was no reference or starting point. Further, it was believed that a more random approach to collect these women would not work out, as there would be more limitations to participate such as daily activities. In this light, only approaching women at the health centre was much more convenient and turned out to be successful.

5.6.3 Language

Maybe one of the biggest weaknesses or better limitations of the research is the language barrier that existed between researcher and the local women. Although the research assistant spoke English fluently, the participants did not. Beforehand the questions and topics from the topic list were discussed with the research assistant. This to make clear which direction the conversation needed to take in order to obtain results that were in line with the research questions. Although the research assistant understood the questions, not having the ability to check with the participants themselves led to uncertainty as to whether the questions were asked in the right way. Also, sometimes participants became emotional during the interview which led to uncomfortable situations in which the research assistant was able to give comfort but as a researcher it was more difficult to participate.

5.6.4 Interviews with staff

Another weakness of the study is that it failed to have extensive interviews with staff members. More could have been done to make the staff members aware of their role in the research. For now, only short interviews were conducted that although delivered quite some valuable insights, do not equal up to the number of local women that were interviewed. It is believed that longer interviews with the staff or focus groups would have benefited the research more. Yet, taken in consideration that work load is high at the health centre such longer interviews might have turned out negatively as other work obligations on the side of the staff members would have hampered the interview.

In short, conducting research in a developing country in general and at a health centre such as KHC in specific, brings with it risks and limitations that have not always led to the best possible outcomes. A different attitude towards these risks and limitations beforehand would have benefitted the outcomes more. Still, only by participating and observing such risks and limitations become visible, hence doing research is a learning processes that needs to have its ups and downs to deliver a study that is considerate of them all.

5.7 Conclusion

Overall, the research has gone through many stages and has taken many steps to have a methodological framework that would best capture the objectives of the study. In the end, taking consideration of the environment and the people that are

central to the study and contemplating which method or question was best, has increased the quality of this study.

Now, it is time to see how the theoretical concepts and methods have worked out in practice. Therefore, the next three chapters will provide an overview of the most important results that have contributed to a better understanding of the utilization of maternal care at KHC.

[6] Socioeconomic & Cultural background

6.1 Introduction

This chapter and the following two set out the results that have been obtained. As 40 women participated in this study it is not possible to address all of them. Therefore, throughout the next three chapters the stories of several participants will have a more prominent place. Their stories are thought to reflect the general lives and opinions of the 40 participants and are valuable in answering sub-question 1.

6.2 The role of socioeconomic factors

As said Kawempe division is an area with a relatively youthful population in which people have no to little education, where unemployment is high and where women start at an early age with having children. Such individual characteristics are mentioned in the Access model (Figure 3.2.2) and they are thought to determine the access and utilization of maternal care. Therefore, all of the participants were asked several questions about their socioeconomic background ranging from their age to their education.

6.2.1 Young, uneducated and financially dependent

Chapter 4 made clear that life in Kawempe division is not the easiest. To be pregnant in such an environment is even more difficult, not in the least because of the lack of skilled health facilities. With the right means such as a proper education and money, it would not be that difficult to live a more comfortable life in which a child could be safely born and raised and in which pregnant women and mothers would not have to worry about 'unnecessary' things. Of course, the situation in Kawempe division does not resemble such an utopia (Box 6.2.1).

Box 6.2.1: The story of a seventeen year old woman six months pregnant of her first child.

Ok, I am 17 years of age. I am a Muslim and I am a Mwuganda. I live in Kalerwe, which is in Kawempe division. And when I am planning to come here, I wake up, I prepare myself, I take tea and I walk. It takes me 45 minutes to reach this place from Kalerwe to here.

This is my first pregnancy. I stopped in Secondary 2 and it was because of money. My parents did not have enough money that is why I stopped. I stay with my mother, but I have a boyfriend but I am not married. No I do not stay with my husband, but my husband is very tough that even sometimes I am asking for money to come to the clinic, he does not want to give me the money. He takes long to understand what I want, so he is really tough.

Our economical status is not all that good, because my mom just makes mats for sale. So it is not all that – **Participant 12**.

Most of the participants were relatively young to give birth to their first child or to be a mother already as the majority of the women were between seventeen and twenty years of age. There were also some older women (the oldest was 39 years of age) that already had four or more children. These women usually raise their children without the help of a husband or spouse- raising children is more a female 'business' in Kawempe division. The fact that polygamy is a common practice within the division, for many of the women means that they cannot count on the support of the men that impregnated them- these are usually older men that already have two or three wives and impregnate young women such as participant 12 to show their 'status'. Just as participant 12 these women are left with all the responsibilities- they have no support whatsoever during their pregnancy, delivery or when raising their children. The fact that such responsibilities often go hand in hand with money only increases the complexity of being a pregnant woman in Kawempe.

A lack of money for most of the women can be traced back to their lack of education. Participant 12 still lives with her mother- she does not have enough money to live on her own and is dependent on what her 'husband' is willing to give her. She has not been able to finish her education- there was only one participant that finished both her primary and secondary education and also received a college diploma. One woman out of 40 that has been able to obtain knowledge by going to school- the others simply did not have enough money to finish their education. Yet, becoming pregnant while still in school is also a reason for some of the women to drop out of school.

> *"Because I just got pregnant when I was in Secondary 3"* (Participant 32).

Becoming pregnant at such an early age without having finished an education leads to few of the women being able to obtain a paid job- most of the women were bounded to the house were they take care of their children and the household. Such circumstances create a situation in which it is difficult to obtain enough money to provide in such basic things as food, clothes and especially health care. The women that are economically active usually have a small business in selling little eatables.

> *"I am a business woman [...] I am self-employed. I sell tomatoes, onions and spices at the market"* (Participant 33).

Not having enough money, knowledge and support can lead to a situation in which the women become reluctant in obtaining care, especially when even reaching the health centre becomes difficult. Having to walk for more than 45 minutes, whilst being six months pregnant, because of lack of money for transportation costs increases the chances of participant 12 to stop coming to the health centre. Yet, the fact that she came to the health centre is a sign that she is not being put off by such financial barriers. In general, it took the participants between 15 and 30 minutes to reach the health centre using public transport- all of the women lived within the division. This indicates that even with a poor economic status, most of the women

are willing to pay to reach the health centre. There were even some women that had to walk for 60 minutes- this clearly indicates that the women had a need to obtain maternal care and that this need could only be satisfied by KHC.

6.2 The role of the sociocultural background

Besides the socioeconomic characteristics, the sociocultural background of the women is also worthwhile considering. Already, the role of support has been briefly mentioned. As responsibilities of raising children often lie solely in the hands of the women, it has been necessary to look at some other components of the cultural background of the participants. This has led to some important insights into the utilization of maternal care. The women were asked several personal questions about common practices in their families in relation to taking care of women's health and the utilization of maternal care.

6.3.1 Respecting one's health

Clearly, in an environment such as Kawempe division where every day it is difficult to obtain enough means to make a living, it is understandable that the women would have other things on their minds then thinking about their own health or take care of themselves. This is the case for most women in developing countries as women are usually only care givers instead of care takers. It is important to understand how the women treat their own health and whether they have 'role models' within their families to understand their utilization of maternal care at KHC.

Box 6.3.1: The story of an eighteen year old woman that had just given birth to her first child.

> *They really respect pregnant people. For example, myself when I was pregnant my mother was very far, but my auntie took good care of me. When we came here, they told me I was supposed to go to Mulago and my auntie went with me. So they really take care about us. And for myself I do not do a lot of work, so I take my rest.*
>
> *No my people at home give birth from the hospital, especially my auntie where I stayed with. She used to give birth from here, but that has not influenced me at all, because I know when you are pregnant you are supposed to go for check-ups*– **Participant 34**.

For a pregnant woman it is important that she obtains the required four antenatal check-ups and overall is aware of the fact that she has to take good care of herself. While daily life by most of the women was described as difficult, the story of participant 34 makes clear that she takes care of herself by taking enough rest. She also mentions that she knows that she has is supposed to go for check-ups when being pregnant, because that is the best option. Most of the participants had the same awareness about their own health. Taking care of oneself was generally

defined by the women as taking rest and not working too hard. Further, most of the women came from families were it is common to deliver at a health centre or a hospital- there were only a few women that said that within the family it was normal to deliver from the home. These were usually women that had family in rural areas.

> *"The ones in town like me, we always go to the clinics and the hospitals, some relatives in the villages, they just give birth from there. They cannot come to town"* (Participants 3).
>
> *"I remember the women always coming to my grandmother to give birth"* (Participants 28).

Being an urban woman means having access to more public health facilities than family members that live in more rural areas. Still, the behavior of family members could have functioned as an example for the women. Yet, most of the women were not influenced by the common behavior in their families. As participant 34 makes clear, when you are pregnant you are supposed to get yourself checked, hence what others do or say does not matter. In general, the women were aware of the benefits of obtaining maternal care at a professional (governmental) health facility and most of them saw it as their obligation to take good care of themselves. Yet, this does not mean that more traditional alternatives were not used. Some of the women used a combination of traditional and modern care- the use of local herbs to ease their wombs or create relief when in labour are examples of this. This is a sign of the role of culture in the utilization of care as some of the women do not solely rely on modern health care-it is within their tradition to also use herbs. Whether this stems from the fact that KHC does not comply more with the cultural context of the women or that the women do not want to rely solely on traditional health care, remains unclear.

6.4 Discussion

Although no causal relationships have been tested in relation to the socioeconomic and sociocultural characteristics of the women and their use of maternal care at KHC, the factors that have been discussed in this chapter have helped to create a general understanding of the utilization of maternal care at KHC. In relation to the prominent role of socioeconomic and cultural factors in the *Three delays model* (Figure 3.2.1) and *Access model* (Figure 3.2.2), it can be concluded that demographic characteristics such as the economic situation and the location of the women within the division provide an explanation for their use of maternal care at KHC. Such characteristics help to understand the context of the women (Say & Raine, 2007). In this way, studying utilization of maternal care cannot be done without knowledge about the 'basic' background as it helps to put other results in perspective.

Further, the *Access model* states that a certain need to obtain care has to be present for people to make use of care (Peters et al., 2008). The women that were

interviewed almost all made use of maternal care, because they wanted to know about their health status- there existed a need. Respecting one's health and having awareness about the risks that are involved with pregnancy help to explain utilization of maternal care at KHC. Further, the assumption of Mackian, Bedri & Lovel (2004) that the social environment plays a role in health-seeking behavior of people, in the case of the 40 women, is partly true. Although family members of the women commonly gave birth at skilled health facilities, most of the women said not to be influenced by this, because they were aware of their own responsibilities. Yet, having support from the social environment such as participant 34 makes clear that the social environment plays a small role in explaining the utilization of maternal care at KHC as it is likely that without social support some of the women would have not made use of maternal care at all.

In short: socioeconomic and sociocultural characteristics such as the economic situation, the location of the women, the way the women treat their own health and a need to know about one's health whilst being pregnant, indeed help to understand the utilization of maternal care at KHC by these women. In this way, the results discussed in this chapter have provided an answer to sub-question 1.

Now that the background of the women is clear, the next chapter will elaborate on the nature of the maternal care use in general and at KHC in specific.

[7] Reasons for maternal care utilization

7.1 Introduction

As the previous chapter showed, the women had a certain need to make use of maternal care at KHC. Yet, this need can take many forms and will be triggered by different factors such as the presence of accessible and quality health facilities. Therefore, both antenatal care and postnatal care participants were asked several questions that would help to explain their use of maternal care in general, but most of all why they decided to do so at KHC. In this way, this chapter will revolve around sub-question 2.

7.2 Antenatal care in general

As the previous chapter showed, most of the women were aware of the fact that making use of antenatal care at a (public) health facility would benefit their health and that of their unborn children. Still, such awareness does not automatically have to be the main reason for the women to make use of antenatal care or become visible in their behavior. Therefore, all of the women were asked why they made use of antenatal care and how many check-ups they (already) obtained.

7.2.1 Knowledge about health status

Antenatal care is seen as a powerful tool to overcome maternal deaths. Yet, to make it effective, women should start early and return on a regular basis. As the previous chapter made clear the women are aware that they are more vulnerable when they are pregnant and need to take good care of themselves. Yet, knowing and acting are two different things and unfortunately the awareness that most of the women had, did not result in action.

Box 7.2.1: The story of a 22 year old woman 8,5 months pregnant of her first child.

I decided with my husband to start coming, but even my parents were telling me…they were telling me to start and take drugs from the antenatal clinic. We wanted to know how the baby is and even myself to know how I am, so we decided to start coming when I was five months and today is my first check-up. I decided at five months, because I did not got anything disturbing me. So I was fine that is why I took some little time before coming- **Participant 9**.

Wanting to know how the baby is and making sure one's own health is in good shape, is something positive and another explanation for maternal care utilization. Yet, the story of participant 9 makes clear that maternal deaths are not only being caused by poor facilities as the general awareness indeed remains 'general'. Not acting on time- starting with antenatal check-ups on time can have a negative impact on the pregnancy and delivery as possible ailments such as anemia are treated to late or not all. Unfortunately, participant 9 was not the only one to delay

her first-check-up. In fact, the majority of the women started after the fourth month of pregnancy and often the actual utilization was much later than the moment of decision- participant 9 decided on five months, but obtained her first antenatal check-up when she was already 8.5 months pregnant. Reason for such delays is that most of the women felt fine as they had no 'visible' ailments. The ones that did have some pains here and there did not pay sufficient attention to them. In this way, being pregnant is just part of daily life and does not need special attention. A very wrong thought that is being caused by a lack of deeper understanding and knowledge of how taking care of oneself when pregnant should look like. According to one of the experts in the field of (maternal) health care in Uganda, creating awareness is most important.

> *"There is something missing between what women know they should do and what women actually do. Between these two lies empowerment: when women know what their rights and responsibilities are they will be capable of acting like it"* (Executive Director UNHCO).

KHC is aware of the power of educating the women within the division and as a health centre IV has an obligation to actively contribute to this awareness.

> *"Yet there are village health teams which go into the communities to sensitize women benefits of making use of the health center. These teams tell the women that they should go for antenatal check-ups at least 4 times and that it is safer for time to give birth at the health centre"* (Obstetrician KHC).

Although raising awareness is an important step, the health centre has to create an environment to which women are eager to return. Yet, the general situation at KHC is one in which lack of space and staff increases the waiting time. This together with a lack of facilities such as running drinking water and availability of a proper cafeteria make it less attractive to return for a second, third or fourth check-up. Most of the women that delayed and failed to obtain the required four check-ups said they were put off by the first visit in which some had to wait for more than seven hours. Therefore, utilization of maternal care has to be made more efficient.

Besides sensitizations of KHC, the influence of others is also worthwhile considering to explain the utilization of maternal care at KHC. Participant 9 makes clear that she was 'pressurized' by her parents and husband to start making use of antenatal care, because this is what they felt was best for her. Such social pressure needs to be considered and taken serious as it helps to explain why some women eventually make use of maternal care while others do not- having someone to tell you that you should make use of maternal care, because that will benefit your health and that of your baby can also create awareness. Fortunately, all of the women that participated had some sort of awareness that made them make use of maternal care, but what was their particular reason to come to KHC? That there is more to it than just being on the safer side, will become clear in the next section.

7.3 Choosing for KHC

As said in the previous chapter, most of the women come from within the division, hence making use of KHC could have something to do with its geographical location. Then, within the division there is only one governmental run health centre IV the women can make use of- there is a lack of alternatives. Further, the stories of others might have triggered these women to start coming to KHC. Which of these reasons is the most prominent will become clear in the next paragraphs.

7.3.1 Location and Care

A health centre such as KHC has quite a strong position with the overall hierarchy of different health care providers as it not only offers free services, but these services also cover the different aspects of maternal care such as malaria treatment and HIV-testing. Further, KHC also has special teams that help to raise more awareness within the community on the utilization of maternal care. Such services are often not offered by TBAs or private clinics. On the other hand, being a governmental run health centre means funding is often low which leads to inefficient services as demonstrated in the previous section and Chapter 4. Therefore, choosing for KHC is not that straightforward as it supposed to be. Still, the women are all positive about maternal care at KHC and this has several reasons.

Box 7.3.1: The story of a 20 year old woman six months pregnant of her second child.

Ok, it is like Kawempe Health Center is the biggest hospital around Kawempe and Mulago hospital is very far, so I decided to come. I also came here for antenatal check-ups of my girl. I heard everyone talking…they would say that they really care here, especially for pregnant women, so that they care. That has really encouraged me to come. It were my neighbours who told me about it.

I think the care that I am getting…I am still studying, maybe it will be different next time. For now, they are still caring. There is nothing missing here at the clinic. I am going to give birth here, because I got my antenatal here– **Participant 21**.

First of all, KHC has a strategic geographical location as it lies in the centre of the division in the district Kawempe I (see Figure 4.1). Having such a strategic location makes it rather accessible for women from all districts. The fact that the national referral hospital Mulago is difficult to reach from the division as traffic is often chaotic makes it understandable that the women choose for KHC. Especially, when it is time to give birth the women felt safer to deliver at KHC- Mulago is thought to be more congested and chaotic which for many women decreases its accessibility and quality. Yet, when something goes wrong during the delivery or when in labour, there is no ambulance to transport the women to the main referral hospital. This again leads to dangerous situations, as women often get stuck in traffic when in

labour. One of the participant shared a rather sad story in which a woman died on her way from KHC to the main referral hospital, because she was not able to reach the latter facility fast enough. Still, most of the antenatal women were quite positive about delivering at KHC. This is mainly being caused by the fact that most of the women perceived the maternal care at KHC as positive. What they perceive as positive will be discussed in the next chapter. Having experience with how care is provided and being familiar with the staff makes it attractive for most of the women to deliver at KHC.

Again, KHC complies with the need that exists among the local women: providing maternal care that can be easily reached and that is provided in way that fits the context of its users. The statements of the women make clear that KHC and its users interact in a positive way. Yet, there are still some negative sides on the side of KHC that can cause negative publicity, hence decrease utilization.

> *"Actually on Friday I brought my friend to give birth from here, but two people they share one bed after delivery and you find that every condition around it is so scarring and worrying. So I get scared and worried about it"*
> (Participant 24).

The high demand that exists within the division among women to obtain maternal care and deliver at the free health centre means lower accessibility and quality. Having to share a bed with another woman just after the delivery is something that is unbeneficial for maternal care utilization. As Donnay (2000) made clear in Chapter 3, women need quality care that offers privacy and treats them with respect- something that cannot be said of the situation described above. Some of the women felt they were being forced to deliver at KHC, because they could not afford private clinics- if they had the money they would most certainly not deliver at KHC. Again, it is their socioeconomic background that 'forces' the women to make use of a governmental run hospital.

Being the only health centre IV in the division with a favourable geographical location can create a rather 'untouchable' position in which negative practices might be thought to be part of the deal- it is all or nothing in this case. Yet, without KHC it is likely that most of the women would not make use of maternal care at all. Still, there is more to accessibility and quality than only a strategic geographical location.

7.4 Discussion

The results in this chapter are a good example of the way the women interact with the provider, KHC. Although Chapter 6 made clear that the women had a need to know about their health and were aware of their responsibilities, this awareness stays rather 'flat'. That the women do not obtain regular check-ups or start late has to do with low levels of awareness-raising on the side of KHC. Especially, the *Three delays model* (Figure 3.2.1) stresses the importance of interacting sides in which the

providers side of care play an important role in providing users with essential knowledge (Thaddeus & Main, 1994). It turns out, that KHC fails in this as there are too many barriers to do so, namely internal problems that hamper the health center to live up to one of its main objectives, being a promotive health centre. These also is in line with the assumption of Peters et al. (2008) that the macro environment plays a role in the utilization of care- unless the government does not invest more in KHC it will be difficult for the health centre to create more awareness within the division. In this way, maternal care use will remain rather fluctuating. Still, the women have showed to make use of maternal care, because of the care provided there. This is a positive sign, especially keeping in mind that the health centre has many problems.

In short: the local women that have been interviewed make use of KHC, because of its favourable geographic location; the care that is being offered and the need to know about one's health status. Further, it is also clear why there might be women that do not make use of KHC as awareness-raising by the centre itself is not as it should be. This together with negative publicity on for example the situation at the labour ward described by one of the participants can create a situation in which coverage use decreases. In this way, sub-question 2 has been answered.

The next chapter will zoom in more on the problems surrounding the health centre by putting the accessibility and quality central. The way in which both users and providers perceive this accessibility and quality is vital in understanding the utilization of maternal care at KHC and the interaction between these two groups.

[8] Accessibility & Quality of maternal care

8.1 Introduction

Already the different perceptions on the accessibility and quality of maternal care at KHC have been touched upon briefly. As these two concepts are the centre of attention in the Access model (Figure 3.3.2) and are thought to tell a lot about the utilization of maternal care and interaction between local women and care providers at KHC, these two concepts will be the centre of discussion in this chapter. The perceptions of both users and providers will be elaborated on and together will provide an answer to sub-question 3.

8.2 Users & Providers on the 5 As

That KHC is not only being 'rated' by its location, but also by other dimensions of the five As will become clear below. It takes more than only having a strategic location to be used by local women- it is also about attitude of the staff, the availability medicine and the presence of alternatives. The order in which the As is discussed is chosen wisely as it explains the different perceptions of the women in an understandable manner.

8.2.1 Alternativity

The presence of alternatives within Kawempe division, be they other public health centers, TBAs or private clinics is the first indicator that helps to explain the utilization of maternal care at KHC- without alternatives it is logical that women come to KHC or do not obtain any care at all. As became clear in Chapter 6, some of the women interviewed used both traditional and modern health care. The reasons for this can be various. It is quite understandable that health care workers employed at private clinics work harder and with less bad attitude because they get paid more. Also, it is quite understandable that TBAs have more time to listen to their 'patients'. According to one of the experts in the field of (maternal) health care in Uganda, many women are being 'lured' in by the sweet smiles of TBAs and their ability to make women feel at ease.

> *"The TBA promotes herself and acts like she can offer the whole package: psychological support, a smile and nice attitude and knowledge on health. TBAs market themselves as offering the whole package of customer care. They work on the sentiment of the people and they market themselves. Yet, often the marketing is better than the product itself"* (Executive Director UNHCO).

TBAs and private clinics offer something that KHC is often unable to give, namely time for each patient- patients are treated as individuals instead of numbers. Yet, a sweet smile is not enough as these alternatives often offer unskilled care- self acclaimed nurses and midwifes without any diplomas creating dangerous situations

for both mother and child. The fact that care is being provided against high rates presumes that they offer quality. When driving through the different parts of Kawempe division it becomes visible that private clinics are numerous increasing the chances of women making use of them.

Box 8.2.1: Fragment for the interview with participant 34.

Yes, they are there, but just because me I do not have interest in knowing what happens in those clinics. I always prefer to go in big hospitals- **Participant 34**.

There were only two women that did not know about the existence of alternative health care providers within the division. The others had clear opinions about these TBAs and private clinics in which some clearly were aware of the risks while others, if they had the money, would prefer to make use of the alternatives

> *"One thing I know about those other clinics is that they really take care of the patient. So they know you are going to give them money, so they really care. That is what I know about other clinics"* (Participant 8).

It is quite dangerous that some of the women really think that by paying for health care they will receive higher quality of care. Yet, the fact that KHC is unable to pay enough attention to each user makes the alternatives more attractive. Even staff members state that sometimes there is just not enough time for each patient.

> *"People that go somewhere else want extra care, care that we not always are able to give, since it is so busy. So we cannot provide in this extra care"* (Enrolled nurse KHC).

Fortunately, all of the women that were interviewed choose to make use of KHC, not only for its location, but more so because they knew it is safer than the alternatives. In this way, the high costs and risks of the alternatives help to explain the utilization of maternal care at KHC.

8.2.2 Accessibility

There are a number of aspects that have been studied to get a better idea of how the women perceive the accessibility of maternal care at KHC such as the location, the transport distance time in minutes and the opening hours. As the location has already been discussed a couple of times, it does not need extensive elaboration. Most of the participants described the location of KHC as near to their homes and convenient within the division. Its location alongside the main (tarmac) road and the wide range of public transport available in front of the health centre contribute to this. To some of the staff members, KHC its strength is its location.

Box 8.2.2: Fragment from the interview with participant 9 .

The location is ok of the health centre and the distance is ok…it is near as I have told you before. It is near because I use a boda boda to come to the health centre. The timing is not long, it is short…around 30 minutes. The timing is not bad and the opening hour is just ok– **Participant 9**.

Further, the opening hours of the health centre also play role in the accessibility as a health centre that has inconvenient opening hours obviously is less accessible. KHC is open 24/7, but the antenatal and postnatal clinics usually starts their day between 09.00 and 10.00am until 16.00pm in the afternoon. All of the participants expressed themselves positive about the opening hours- they fit within the daily activities of the women, making it easier to obtain maternal care at all times of the day. This is a way to trigger women to come back on a regular basis and make in-between visits in times of sudden emergencies more likely.

8.2.3 Affordability

The staff members of KHC see its affordability as one of the reasons for high numbers of patients coming to the health centre every day, especially since the government of Uganda tries to stimulate pregnant women to make use of these free services.

> *"Well, it is a government facility, so services are free[..]. Also, there is political influence. Politicians tell the people that the services are free here"* (Head nurse KHC).

The *Access model* makes clear that the access of health care providers is partly influenced by policy and the macro-environment, hence politics. When politics influences the behavior of maternal care users by promoting the use of governmental run facilities such as KHC, it is expected that such facilities offer all the necessary services and are indeed for free. Still, when asking the women about any involved costs, it turns out that making use of maternal care at KHC is not without any costs. Important in this, are transportation costs and costs pregnant women have to make when delivering at KHC.

When it comes to transportation costs no clear cut answer can be given as these costs are depend on the distance users have to travel, the budget they have for travelling and price negotiation between public transport drivers and users . Also, a large number of women did not have to spend any money on transportation costs as they walked to the health centre. Therefore, the costs the women had to make within the health centre are much more worthwhile studying.

First, some of the women mentioned to have bought medicine outside of KHC. The staff acknowledges this as one of the obstetricians mentioned that the health centre does not get enough funding to stock the health centre with regular medicine such as aspirins (Obstetrician KHC, 2012). Such unforeseen costs can form a barrier for women to better their health, as these women already have tight budgets that often do not allow them to spend money on such crucial medicine.

> *"To my disappointment they told me there is no medicine again and this is not the first time"* (Participant 34).

In this way, relatively harmless health conditions such as flue cannot be cured and become a possible threat to the lives of both mother and child and a possible barrier to making use of maternal care at KHC again. Still, it seems to be by chance that some of the women had to buy medicine on more than one occasion. Therefore, nothing can be said in relation to having to buy medicine and not making use of maternal care at KHC again. What is much more worthwhile considering when looking at costs users have to make at KHC, is a list of items pregnant women need to bring with them at time of delivery (Table 8.2.3).

Table 8.2.3: List of required items for pregnant women at KHC.

Hospital	Mother	Child
Jilk	Panties (6)	Suit case
Gloves (2 pairs)	Bed sheets (2)	Baby shawl
Cotton wool (2 rolls)	Sanitary towels	Clothes
Basin and bucket (1)	Towel	Nappies (1 dozen)
Bed sheets (2)	Detol liquid soap	Baby basin and soap dish
Mackintosh sheets (2)	Half slip and brassier (2)	Baby coat
	Washing soap (2)	Bed sheets (2 pairs)
	Washing detergent (1 sachet)	Baby soap
	Jilk	Powder
	Bucket	Oil
	Emergency money (50,000 UGX)	Baby comb
		Towel
		Pegs
		Pampers (2 packets)
		Feeding bottle
		Baby wipes

Though it is quite logical to bring some clothes and baby utilities, it is unimaginable, especially in the western world that pregnant women have to purchase their own equipments and utilities such as gloves for the nurses. This does not comply with the policy and promotion of the government to offer free services at KHC. Especially, the emergency money, which is being used to transport women to the referral hospital in the city centre in case of emergencies, often forms a burden on the budget of women as 50,000 UGX (around 16 EUR or 12 USD) is a lot of money for most of them. When asked whether the women were already preparing for their babies in relation to buying clothes and other necessary items, a lot of the women

said that they were still trying to shave up money or already bought some of the items and were now trying to collect the other items.

> *" I have not, because I have not got money to prepare for my baby"* (Participant 25).

In this light, the policy of the Ugandan government is contradicting itself. On the one hand it wants to decrease maternal mortality rates by stimulating pregnant women to make use of maternal care at governmental run facilities, while on the other hand the annual government expenditure on health has decreased in the last two years and disables facilities at KHC to provide accessible and quality care. Still, in relation to private clinics KHC is much more affordable as such private clinics also charge for check-ups and distributions of medicine. Therefore, making use of KHC will remain more attractive than other clinics in the area. KHC seems to succeed in offering free services that are most vital and explains its use by the women.

8.2.4 Availability

In line with the list of required items as the health centre has not enough money to provide every woman with such utilities, lack of funding also creates shortages in staff, medicine and equipments. When even a vital instrument such as an ultrasound scan is not available and even an ambulance is missing, making use of KHC becomes less and less attractive. The way in which the women perceive such low availability is essential in understanding the accessibility and quality of maternal care at KHC.

Box 8.2.4: Fragment from the interview with participant 12.

When I come… the staff is ok down there where we always sit (Note: antenatal clinic)…they are just enough. Except with the equipments I think the first time when they took our blood…we got some problems. It took one day before receiving our results, because the equipments had a problem. So I do not know whether they are enough. And with the medicine they always give us, except the first time I came I had to buy some of the medicine. The other two times they have given me for free the medicine. So I have not bought any medicine then- **Participant 12**.

Much of the availability of the staff was measured by the women with the number of women having to be attended to. While some of the women were quite positive about this, because they came on a 'quite' day, other were less optimistic. Still, as long as the women were attended by a staff member, it seemed they coped with low numbers of staff and long waiting times.

> *"The number of staff depending on the many people we are we need more, but the ones there they work"* (Participant 23).

Although it is positive that the women did not leave the health centre before being attended, it is not an ideal situation, not in the least for the staff members themselves. On an average day the small waiting room of the antenatal clinic could be packed with over 80 women and only three to four nurses to take care of them. This often creates a situation in which midwifes and nurses become tired and unmotivated which decreases their approachability and the quality of care. At the same time, it is also quite understandable that staff members fall out of their role as health care workers- lack of the right equipments and medicine is not only frustrating for the users, but also affects the providers.

Working in a health centre with little to no running drinking water or electricity, shortages of drugs and equipments and protective clothing makes working conditions very difficult. Even essential items for a health centre IV such as an ambulance are not available.

> *"There is no ambulance that is a very serious problem. Also, the health center is understaffed and drugs are often out of stock"* (Health counselor KHC).

Not having enough equipment is one problem, but the ones that are there are often failing to work- this can be related to a lack of electricity and a failing generator. Some of the women said to be send home without having had essential indicators of maternal mortality such as their blood pressure checked. Only the lack of certain equipments was perceived negatively by most of the women. On the other hand, staff members are all negative on the availability of staff, medicine and equipments.

Relating shortages of medicine and equipments to a low pay, little appreciation by superiors and a high demand makes it difficult to keep staff members, motivate them or to attract new health workers, hence the availability of staff at KHC cannot be guaranteed. Yet, it seems that such negative conditions for now do not have a profound influence on the use of maternal care at KHC. Again, this needs to be related to a lack of similar facilities within the division- users seem to put up with the conditions at KHC as free alternatives are lacking. Such an attitude is positive for reducing maternal mortality rates, but conditions at the health centre need to change in order to cater to more women in a more efficient way.

8.2.5 Acceptability

As said the working conditions in which nurses and midwifes have to cater to a growing number of maternal care users can lead to a negative attitude. Such attitudes are thought to decrease the level of acceptability- users will have certain expectations as to how care should be provided to them, while the providers are in a bad mood and do not live up to the expectation. As the problems at KHC are serious, understanding the way in which care is provided to the women helps to explain maternal care utilization at KHC.

Box 8.2.5: Fragment from the interview with participant 21.

The interaction with the staff…it is not bad, it is really good when you tell them the pain you have they listen to you…they answer when you ask. So I trust in the information they give me about my pregnancy, because I believe they know what they are doing. So I really trust them.

The waiting room…it is really small it is not enough. You do not have privacy. The hygiene is not the expected hygiene, but at least for the waiting time…I think it is not a big deal. It is a little bit fine as long as you come early, it may be very ok. So there is no big problem- **Participant 21**.

There are several things that become clear from the story of participant 12. First, she perceives the interaction as positive. Second, she has trust in what is being told by the nurses and midwifes and third the waiting room is too small, hence there is lack of privacy. These three components make up the acceptability of maternal care at KHC.

The level of trust present between user and provider of maternal care is important. With the presence of trust women will have a feeling that they can share their worries and problems with a nurse or midwife- without this trust, women might go home without having checked potential threats to their health. To create such a trust relationship providers need to live up to the expectations of the users- comforting words and understandable information are part of this. Yet, the women that were interviewed almost all based the trust they had on the level of education of the attending staff- they are the ones with an education so it is logical to have trust in them.

> *"The information they give us..we trust it, because it is the one that is educated and has knowledge about my pregnancy, so I believe in any information they give me about me and my child"* (Participant 7).

In this way, the relationship between the women and the staff members is one in which a clear hierarchy is present. This need not be perceived as something negative, as every person that goes to the doctor trusts the doctor for his or hers expertise. Actually, the fact that these women put real meaning to what the staff is telling them, their expertise, indirectly makes clear that alternative health care providers lack such capacities. Also, providing a listening ear and sharing information in the best possible and ethical right manner complies to what most of the women were expecting, hence the context of the providers fits with that of the user. Such ability of the staff members of KHC to even make the women feel at ease to open up in circumstances that not always allow them to, is an important positive factor of the accessibility and quality of maternal care at KHC.

In relation to trust, privacy is an important element for the women to open up to the nurses and midwife. Yet, KHC lacks sufficient space as the waiting, check-up room and labour ward are not built for the high demand. Women are often crammed next to each other for hours in a small semi-open waiting room and midwifes usually check three women at the same time in the same room. In this check-up room the door is always open, there is no curtain to cover the only window and three thin and too short curtains separate the three check-up tables.

> *"When we go for the room of check-up, there are three beds and you find someone is a bit sick, so you cannot open up, because your neighbor will hear you. In there is no privacy, you cannot open up. There is no privacy, no inner space around there"* (Participant 22).

In relation to maternal mortality, lack of personal space and privacy can be dangerous as women can go home with serious health problems merely because there is no space to open up. Then, lack of space also leads to unhealthy circumstances. On many days during the research the antenatal clinic was overloaded with women. Often, highly pregnant women had to stand for hours, because there was not enough space to sit. This led to almost all of the participants expressing themselves negatively about the available space, especially on the waiting room of the antenatal clinic.

> *"It is not enough, because if you sit there you are suffocating, it is too hot. As a pregnant woman like this, we need fresh air. It is too small, it deprives our privacy"* (Participant 14).

Most of the women would like to enlarge the waiting room to make it more acceptable. For now, such privacy depriving practices are not only harmful health wise, but also can have a negative influence on the utilization of maternal care especially on first time visitors. It is not attractive to make use of the antenatal clinic for a second, third or fourth time, when you have experienced a long waiting time in a small waiting room with too many women and a nurse that, because of the workload, is no longer able to treat you in a respectful way. Such negative perceptions might be the cause for the difference between the number of first and fourth time antenatal visitors, hence improvements are needed.

Although most of the women were quite positive about the interaction with the staff, there were also those with bad experiences.

> *"Sometimes we do not understand the information, especially in the books. They do not explain to us, except sometimes they help us. Some that are very nice, when you ask them something they explain very well. They talk a lot with each other. Some are rough and tough. They are very rude when you ask them something"* (Participant 2).

A bad attitude towards the women can by no means be justified- at all times a health care provider needs to treat his or her patients in a righteous way, especially when it involves pregnant women. The consequences of such bad behavior can have a far reaching impact- women can decide to stop coming for check-ups or turn to more dangerous alternatives. Again, the working conditions help to put this behavior into perspective.

As has been mentioned a couple of times, staff members at KHC have to work under a lot of pressure. It is not only users that sometimes experience unacceptable behavior- it is also staff members that have to deal with it.

> *"I do not want to be humiliated by patients, because of the work load they do so. People do not want to wait and therefore treat me badly. The work load is too much. I leave very late, sometimes I start at 08.00 am and I leave at 07.00 pm without being paid overtime. The earning is little, about 400,000 UGX (Note: about 130 Euro or around 100 USD) and I get no payment for lunch and transport. The patients abuse us and call us names. We do not have gloves, people vomit and we do not have anything to clean it with. We have no cotton wool, not enough drugs to treat patients.[…] We give privacy, but it is difficult, because there are many patients"* (Enrolled nurse KHC).

Everything at KHC is related to each other. The bad pay of staff members and high demand may make these essential health care workers sometimes behave rudely to their patients, but at the same time the high demand causes for long waiting times in a too small room that leads to users treating the providers badly. In a way, not getting paid for the amount of work one does can also be seen as rude and unacceptable behavior. It seems that staff member at KHC need to be stimulated more. Whether this is through financial means, more acknowledgements or a combination of both remains unclear. What is clear, is that as long as the situation at KHC does not change there will not be any more motivated health care workers to cater to the increasing number of women that need care so badly, hence utilization of maternal care at KHC cannot be seen separate from the working conditions of its staff members.

8.2.6 Accountability

Much of the problems and negative perceptions on the way care is provided at KHC have a cause and as has become visible, much of these causes are related to the policy of the government. As the Ugandan government only spends seven percent of its annual budget on health care, it is quite imaginable that an health centre IV as KHC that relies on government funding does not receive the required means to provide care in a just way. Yet, who holds the government accountable? From the many interviews with users of maternal care, but also by talking to the staff, it has

become clear that both users and providers at KHC do not have a place where they can share their (negative) experiences and ideas as to improve the situation. Although, there are regular staff meetings at KHC, it remains unclear whether staff members truly get a chance to actively participate in adjustments and improvements at the health centre. According to one of the experts in the field of (maternal) health care in Uganda, health care workers in Uganda are not involved in the development of their work place.

> *"Often, the staff of the health centers are not informed on issues that concern the health centre and themselves. They are not informed about changes and the development of the health centre"* (Executive Director UNHCO).

Further, much of the negative behavior of some of the staff members described by the women, can be attributed to a lack of supervision.

> *"Within the health centers there is no supervision and feedback mechanism. So there are no sanctions when staff acts badly or rewards when staff acts positively. Basically, every staff member is on its own"* (Executive Director UNHCO).

Without any pat on the back for good behavior or sanction for bad behavior, it will be difficult to keep staff members at KHC motivated and focused. Overall, the problems surrounding the health centre such as lack of staff, medicine, equipments, a small waiting room, lack of privacy and rude behavior of the staff, are being caused by a lack of accountability.

8.3 Quality

Although difficult to measure, the overall quality of KHC as perceived by the women that participated in this study can be defined now. The answers on the five As and the sixth A have made clear that overall the women are satisfied with the way in which maternal care is being provided to them. In particular, the level of acceptability is a good indicator of the way in which the women perceive the quality, as this involved the interaction of the context of both user and provider (Harteloh, 2003). It seems that most of the women find that the way in which care is being provided to them is in line with their own context, be they their expectations, norms and values. Much of what KHC offers, a good location, free services for the most essential types of maternal care, creating of trust and availability of skilled attendants, is contributing to the quality of the health centre. Yet, as section 8.2.6 has made clear, to increase the overall quality of the health centre, it also has to pay more attention to its staff members and mechanisms that enable both staff and users to become actively involved in the process of providing care in a just way, hence quality is not only about what is provided and how, but also about what is being done to keep this quality high enough. Still, quality remains a rather difficult to grasp concept- while some of the women did not have any negative feelings

towards the way care is provided at KHC, others were more pessimistic. How maternal care should look like is still object to individual preferences.

8.4 Discussion

When linking the discussed results to the *Access model*, it is clear why Peters et al.(2008) have put accessibility and quality in the centre of the model- these two concepts have told a lot about the way in which maternal care is being provided and perceived, hence help to explain the utilization of maternal care at KHC by the local women that were interviewed. A 'fit' of contexts is necessary to establish a positive result (Thiede, 2005). Overall, it has become clear that despite the poor circumstances at the health centre, most of the women were quite positive about the accessibility and quality of care. This indicates that the interaction that takes place between these women and the health care workers of KHC is one that fits their contexts. Expectations and attitudes of both users and providers shape the accessibility and quality of care (Peters et al., 2008). KHC in the case of the 40 women has succeeded to live up to these expectations by providing care that fits within the reference framework of the women.

Yet, taking in consideration that there is a lack of alternatives within the division, helps to put the results in perspective. Whether the women have excepted the situation at the health centre or care is really provided in a just and adequate way, remains unclear. This is an indication that quality as such cannot be measured (Harteloh, 2003). Still, KHC caters to a high demand in a way that other health care facilities cannot and in this way offers quality maternal care. Yet, the way in which the women perceive the level of trust between themselves and the staff, rather positive, indicates that the health centre tries to work with what it has got and that is educated, skilled and experienced staff that tries to do its best. Although Peters et al. (2008) see quality as the true definer of access and utilization, it remains a rather organic concept that does not need to be put on a pedestal as there are many other concepts that have helped to define the interaction between the women and KHC.

Further, the five dimensions of access that have been central are put in perspective by the sixth dimension of accountability. For the health center to increase its accessibility and quality it needs to have a mechanism in which both users and providers can raise their voice (Standing, 2004). It has become clear this voice is still lacking at the health centre. Staff members clearly stated to not receive enough acknowledgment and users do have a place or person to complain to in case of bad behavior of the staff. There is no responsiveness as to who can be held accountable for the problems of the health centre. Yet, as it is government run, the government of Uganda can be appointed as the sole determinant of lack of equipment, an ambulance, medicine, staff, beds and a small waiting room at the antenatal clinic.

The assumption of the *Access model* (Figure 3.2.2) that the macro environment plays a role on the access of care in this case is true. Without a change of policy the situation at the health centre will only deteriorate. It is vital that the government takes responsibility for its faults in order to makes sure maternal mortality rates at KHC do not increase. In this way, incorporating a sixth A has turned out to benefit the results and the scope of this study.

To answer sub-question 3, the five dimensions used have helped to explain the utilization of maternal care at KHC. Its geographical accessibility, the lack of alternatives, the overall affordability and high levels of acceptability experienced by the 40 women help to understand why it is that women make use of maternal care at KHC. Although relatively difficult to measure, KHC tries its best to offer quality maternal care- the fact that there are no similar facilities within the division make it easy to choose for KHC. It is a good thing that the 40 women that participated turned to KHC- without such a skilled health facilities (pregnant) women in Uganda would be much worse off.

[9] Conclusion

The first pages of this study talked about a maternal care crisis in developing countries that is causing thousands of women each year to not survive their pregnancy, delivery or the 24-hours after delivery. They also included the role of health care providers in this increasing number of maternal deaths and the 'contribution' of the women themselves in this tragic development. This study has functioned as an example by providing two sides of the same story. On the one hand we have the difficult situation in which health care providers such as KHC have to deliver maternal care. On the other, we have the users themselves, women that are in need of care. In the case of KHC there is no one to blame. Yet, the government does not seem to realize that not investing in its own health centers creates a situation where women have less choices: either they are forced to make use of health care providers that are too expensive and underskilled or to free health centers that lack the right tools and attitude. If this situation continues, women in Kawempe division will in the end not make use of maternal care at all. A choice between development and underdevelopment- life and death. This is not in line with the behavior of both government and users of maternal care as use of maternal care at governmental run health facilities is being promoted and the high demand there is to make use of such facilities.

This is connected to the main research question of this study that tries to address how the utilization of maternal health care at a governmental run health centre by local women can be explained and how such women perceive the care they are receiving. To start with the most obvious factor, the women all had a certain need to make use of maternal care at KHC. They were aware of the fact that to be pregnant involves certain risks and those risks that can best be reduced by making use of a governmental health centre that is equipped with the right staff and offers a wide range of maternal care services. This awareness is partially raised by the government itself that promotes maternal care use at public facilities on the radio. Although such promotion is a good thing, health centers such as KHC cannot cope with the high demand this follows the promotion just because the government does not invest enough in the health centre. This leads to lack of equipment, medicine, beds and congested waiting rooms and labour wards. A deterioration of the accessibility and quality would be the result. Yet, the 40 women that were interviewed remained positive about these two vital concepts.

It seems that what KHC is doing, it is doing in a way that fits with what the women were expecting. The fact that KHC is the only health centre IV within the division and 'good' alternatives as Mulago Hospital are too congested and relatively far away, makes using maternal care at KHC the best possible solution. The socioeconomic background of the women seems to have played a role in their utilization as these women are not capable of paying large amounts of money for check-ups at private clinics and also know about the risks of being treated by a TBA. Such awareness is also being initiated by the social environment of the women as use of a public facilities is often preferred above such more dangerous alternatives. Fortunately,

KHC itself tries to promote the benefits of its services within the division- more means are needed to make this more effective. Again, more governmental support is required.

Then, the health centre, in the eyes of the 40 women, is capable of interacting with its users in a rather acceptable way. Having trust in the skills of the staff members that provides a listing ear to the problems of the women adds to this acceptability. In this case, bad attitudes of staff members are somehow justified by bad working conditions. A high work load, bad pay and not having enough means to treat patients in an adequate way help to explain why some of the women were treated badly. Still, staff members at KHC should have the capacity to put such working conditions aside- they should have a passion to treat those in need of care no matter what the conditions are. A lack of supervision enables these bad work ethics to carry on- a mechanism is needed that rewards good behavior and punishes those that behave badly.

The first visit to KHC was one in which it became clear that public health centers in Uganda are much different from the average western hospital or clinic. Clearly, the health centre was by no means a fully equipped, white painted and sterile environment where patients are waiting to be treated in a nicely air-conditioned room. Rather, the health centre was covered in red dust, had one semi-open waiting room where pregnant women were sitting in the sun on wooden benches and one public toilet to ease more than 130,000 patients a year. Not ideal circumstances to bring new life to this world. Yet, over the course of the research and because of the interviews with the women, it became clear that KHC is vital in making sure that the maternal mortality rate of Uganda does not increase. It offers accessible and qualitative good care to an ever increasing population of pregnant women that need maternal care so badly. Whether this care fits the western standards in any way is not important.

What is important, is that KHC tries to cope with what it has and does so in a right way. This explains why women are making use of KHC and why they are rather optimistic: without the health centre their chances of not surviving their pregnancy would only increase. From a developmental perspective, health centre IVs such as KHC are essential in reversing the situation- when better equipped these health centers have the ability to make sure every women obtains antenatal care, delivers with the help of a skilled attendant and gets the necessary postnatal care. This will create an environment in which being pregnant is no longer associated with death, creating a situation in which Uganda has taken another step towards more development. In the end, it is about every woman having the opportunity to experience what it is like to be a mother.

[10] Relevance & Recommendations

In a way, although rather small in scope, this study has helped to clarify the situation of maternal care use in Uganda. It has showed that maternal deaths can only be understood and prevented when both users and providers of this care are incorporated in studies and policies. Therefore, the way maternal care utilization has been studied is an addition to the already existing literature on maternal care utilization. By making use of a model that incorporates different perspectives, the *Access model*, a wide spectrum of factors has been studied, disabling a one-sided focus. In this way, this study can be seen as an example for others that want to study (maternal) care utilization as it is important to pay attention to the context of both users and providers. By letting the women that participated tell their story, this study has showed that it is important to listen to what users have to say. An outsider might never want to make use of KHC, because of the rather deprived conditions. The women have made clear that they are really glad to make use of KHC, even with the problems it has. Also listening to the providers of care has offered these nurses, midwives and health counselors an opportunity to vent their opinions and experiences. Hopefully, the stories of those that participated will help to create better policies that are in line with what local women from the division need and what providers are really capable to offer.

Still, to think that this study is groundbreaking and will change the situation at KHC and of maternal mortality in Uganda overnight is a rather unrealistic thought. The results have showed that the problems of both the women and KHC can be traced back to the policy of the government. It is not only about investing more in the health centre, but also about creating awareness among the female population and stimulating women's empowerment within the division. It is necessary that the Ugandan government informs both women and men about the risks that are involved with pregnancy and that having a child is not only the concern of the woman. Especially in Kawempe division such promotion will help to ease the situation of many (young) women. Then, it is also necessary in the future to incorporate governmental perspectives and to open up the debate about accessibility and quality of maternal care at governmental run health centers. Further, to really reduce maternal mortality in Uganda it is necessary to combine both qualitative and quantitative methods to widen the scope and to cover more health centers and users. Only in this way will it be possible to have substantial results that help to understand why it is that some women make use of maternal care at a governmental facility while other do not at all. In the end this will help to put maternal mortality in a wider context- it is not only about failing health care systems, but more so about an interaction between those systems and the women that are in need of maternal care.

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Appendix 1

Topic list users maternal care at Kawempe Health Centre

1. Personal information

Can you tell me something about yourself?

- Age
- Religion
- Tribe
- Place of residence
- Time in Kawempe (how long)
- Opinion Kawempe life (how do you view Kawempe as a place to live)
- Level of connectedness to Kawempe
- Influence connectedness on use/non-use KHC
- Highest obtained education
- Job/ Daily activities
- Marital status
- State of relationship
- Children
- Household composition- with who do you live?
- Valuation of women's health in her household and/ or family
- Valuation health by respondent herself
- Opinion on personal economical status

2. Pregnancy information

Can you tell me something about your pregnancy?

- Months pregnant
- Number of pregnancies (miscarriages)
- Development other pregnancies (complications)
- Expected
- Her health status + health status of baby
- State of mind (how do you feel to be pregnant)
- State of mind other family members (how does husband, other people feel)
- Any fears related to pregnancy and/ or delivery?
- General treatment of pregnant women in her household and/ or family?
- Personal treatment now pregnant
- Common place of delivery in her family (TBA, private, public, other)
- Influenced by common way of delivery
- Preparation for delivery and baby

3. Individual decision-making process

Who made the decision to get antenatal care and where there any limitations/ restrictions that influenced this decision?

- Main decision-maker to get antenatal care
- Feeling about decision if someone else made the decision
- Restrictions (husband, economical, supply side, personal, health, other)
- General perception on antenatal care in family, friends, others..
- General use of antenatal care by family, friends, others
- Influence of general perception and use on own decision

4. Antenatal care information
Can you tell me something about the antenatal care you are receiving?

- Reason for getting antenatal care
- When in pregnancy decided
- Reason delay
- Reason for choosing Kawempe Health Centre
- Previous knowledge on Kawempe Health Centre and how did you obtained this knowledge
- Way in which this knowledge complies to reality/ your experience
- Thoughts about antenatal care provided to her
- Give birth at Kawempe Health Centre or not- why not?
- Recommend antenatal clinic at Kawempe Health Centre to others
- Anything missing at antenatal clinic that you need and/ or want
- Number of check-ups

5. Perception on accessibility and quality of antenatal clinic at Kawempe Health Centre
What do you think of the antenatal clinic at Kawempe Health Center?

1. **Perception on accessibility:**
    - Location
    - Transport distance time in minutes- long or short
    - Means of transport
    - Opening hours
    - Accompanied by anyone and why
2. **Perception on availability:**
    - Number of staff
    - Number of medicine
    - Number equipment
    - Range of care offered (like HIV-test, malaria treatment, vitamins, check-ups, family planning etc.)
3. **Perception on affordability**:
    - Prices of possible medicine and equipment they had to buy
    - Costs of transportation
4. Other costs, like accompanying people-
5. **Perception on acceptability:**
    - Interaction with staff: attitude of staff, provision of information/ understandable, level of trust, preferences of particular staff (male or female- why)
    - Waiting room; enough space, privacy
    - Waiting time: long or short

    - Overall hygiene-
    - View on quality of care offered (like HIV-test, malaria treatment, vitamins, check-ups, family planning etc.)
6. **Perception on alternativity:**
    - Knowledge on other antenatal clinics
7. **Personal perception on antenatal care:**
    - Personal perception on provision of maternal care (accessibility and quality)
8. **Finalizing question part 5:**
   Which of the discussed topics influenced your perception on the accessibility and quality of care you are receiving the most and why?

- Question and comments?

- If any of the mentioned topics seems to be a barrier- ask whether this topic is a barrier to come back/ make use of the antenatal clinic at KHC.

Appendix 2

Topic list staff members Kawempe Health Centre

1. Function
Can you tell me what it is you do at Kawempe Health Center?
-Main tasks
- For how long
- Education
- Reason for doing this work
- Likes/ dislikes

2. Kawempe Health Centre
Can you tell me about how it is to work at Kawempe Health Center?

- General problems
- Specific problems he/ she deals with on daily basis
- Health issues of patients
- The interaction between him/ her and patients- communication: respect and trust or not?
- Interaction between other staff members
- Reason for patients to come to the health centre
- Reason why patients bypass the health centre
- How the management is: payment, way treated, extra trainings, being respected
- Needs of him/ her to do work better/ like work more
- Strong points of health centre
- Weak points of health centre
- Fields of improvements

Appendix 3

Topic list community leaders Kawempe division

1. Function
What is your function?

- Main tasks
- For how long
- How chosen

2. Information on Kawempe
What do you think about Kawempe?

- Way of living
- Socioeconomical status
- Culture
- Access to public services
- Gender differences- inequalities
- Fields of improvements

3. Information on Kawempe Health Centre
Who do you know about Kawempe Health Center?

- Number of patients
- Shortages etc.
- Improvements
- Importance for community
- Other clinics in Kawempe

Appendix 4

Topic list experts in (maternal) health and care in Uganda

1. Function
Can you tell me something about the organization and what it is you do?

- Main task of the organization
- Goals of organization
- Target group
- Areas in which it operates
- Working methods
- Accomplishments so far
- Main tasks of him/ her

2. Maternal health
Can you tell me something about the main health issues present in Uganda/ Kampala/ maybe Kawempe?

- General status of health In Uganda
- Main issues
- Main problems
- Main complaints
- Relation between staff and patients
- Monitoring
- Gender issues
- Maternal health: Antenatal issues+ postnatal issues

Appendix 5

Consent/ information form

Master International Development Studies Utrecht University, The Netherlands
The Liverpool Mulago Partnership for Women's and Children's Health (LMP), United Kingdom
Consent form

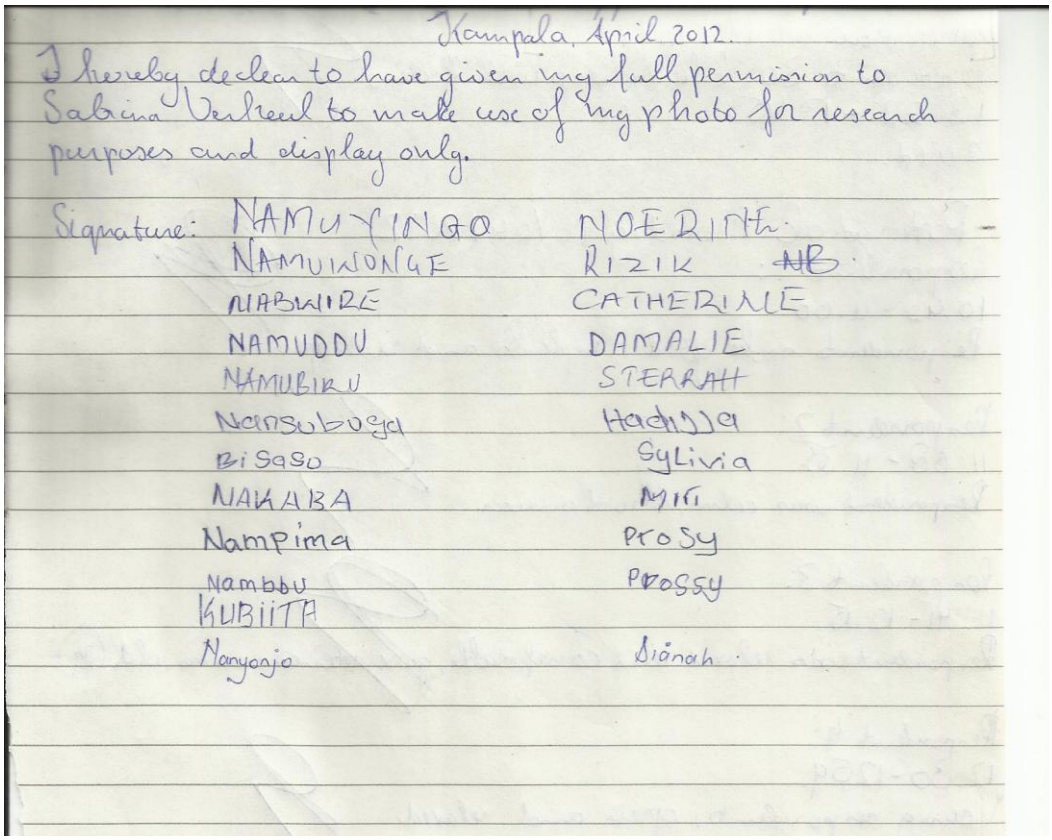
Introduction
Uganda has one of the highest maternal mortality ratio's in the world. Per 100,000 live birth 435 women die. In order to get more insights into the causes of this high number, the Liverpool Mulago Partnership for Women's and Children's Health (LMP) is trying to analyze and improve the situation of maternal health in Uganda. In order to do so LMP tries to work together with different partners. This master study is an example of one of those relationships. As part of the master program International Development Studies of Utrecht University The Netherlands this study tries to get more insights into the factors that play a role in the decision to make use of maternal care at a Kawempe Health Centre among local women and the way in which these women perceive the accessibility and quality of care they are receiving at Kawempe Health Centre.

Target group
The target group of this study are women that make use of antenatal and postnatal care. Also, interviewing of the staff of Kawempe Health Centre and Ugandan health organization, and nongovernmental organizations are being incorporated in the study.

Interview
The in-depth interview will take approximately 30 minutes and will be recorded on a voice-recorder. The information will be transcribed and will be treated as strictly confidential. All respondents are treated as anonymous. Therefore, respondents will not have to fear any consequences for their position as patients at Kawempe Health Centre. Also, the information that is being obtained through the in-depth interviews will only be used for the master study and the goals of LMP.

Appendix 6

Approval for photos cover



Kampala, April 2012.

I hereby declare to have given my full permission to Sabrina Verkeul to make use of my photo for research purposes and display only.

Signature:		
	NAMUYINGO	NOERITH.
	NAMUWONGE	RIZIK ~~NB~~.
	NIABWIRE	CATHERINE
	NAMUDDU	DAMALIE
	NAMUBIRU	STERRAH
	Nansubuga	Hadijja
	Bisaso	Sylivia
	NAKABA	Miri
	Nampima	Prosy
	Nambbu	Prossy
	KUBIITA	
	Nanyonjo	Sianah.