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**A qualitative study of barriers to access and use of pre-paid postnatal care services among mothers under the reproductive health voucher system in rural Uganda**

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## **Abstract**

**Background:** The first six weeks following a delivery is a critical period for the mother and the newborn. Despite removing out-of-pocket fees at a postnatal care access point in some parts of Uganda, few mothers utilize pre-paid services. Data from a health facility providing pre-paid postnatal care services in rural Eastern Uganda, revealed that only 17.9% of the mothers came back for postnatal care despite the services being free. This study therefore sought to explore and gain a deeper understanding of the barriers contributing to the low turn-up of voucher registered women from using pre-paid postnatal care services.

**Methods:** A qualitative study design was applied, and 10 in-depth interviews with mothers under the pre-paid postnatal care voucher system were conducted in the district of Luuka, Eastern Uganda in January 2018. Data were analyzed through qualitative manifest and latent content analysis.

**Results:** Four themes were developed through the analysis: *a wanting healthcare system* theme revolved around the narrow perceptions about postnatal care services and previous unpleasant experiences of health facilities. *Fighting to meet social expectations* emerged from experiences of how gender roles for women and social norms in communities negatively affected mothers' ability to utilize postnatal care services. *Leaning on cultural customs and religious beliefs* described traditional treatment options and values that were obstacles to seeking health facility-based care. *Suffering with ineffective communication* talks about receiving sketchy information and corruption rumors.

**Conclusion:** Insufficient information and understanding of postnatal care services was a major barrier to utilization of services. Many health workers in the maternal and child health section did not speak the local language well. This suggests a possibility that health messages were not being understood by mothers. Service providers should utilize services like antenatal care to provide accurate information and build options for receiving feedback as regards their health services.

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## **1. Introduction**

Postnatal care is one of the most important services to prevent maternal and infant mortality and morbidity. The first six weeks following a delivery is a critical period for the mother and the newborn. The majority of the deaths of mothers and their infants occur within the first month after giving birth, of which close to 50% of the maternal deaths happen within the first 24 hours <sup>(1,2)</sup> and 66% within the first week <sup>(2)</sup>. Of the 2.8 million newborns who died in 2013 within the first month of their life, one million died on the first day <sup>(2)</sup>. The three major complications that account for three quarters of the maternal deaths are severe bleeding (hemorrhage), infections, and complications after delivery. All of these occur during the postnatal period <sup>(3)</sup>. Postpartum haemorrhage which accounts for two thirds of haemorrhage related maternal deaths and Sepsis which account for 10.7% of maternal deaths both occur after childbirth <sup>(3, 4)</sup>. The lack of access and/or use of postnatal care services clearly contribute to the global public health challenge of maternal morbidity and mortality. Sub-Saharan Africa and south Asia account for the most neonatal deaths and more than 80% occur in small babies and many of these deaths can be prevented with basic newborn care <sup>(1)</sup>. Postnatal care can also increase the chances of detecting long term complications such as stunting and loss of human capital. Care provided for small and newborns could prevent nearly 600,000 newborn deaths by 2025 and addressing family planning unmet needs could lead to 47% reduction in child deaths <sup>(1)</sup>. Postnatal preventive care such as breastfeeding support, cord and thermal care and community approaches like home visits are crucial packages of care that save lives.

### ***1.1 Background***

According to the most recent Uganda Demographic and Health Survey of 2016, a significant proportion of maternal and neonatal deaths in Uganda occur during the first two days after giving birth <sup>(5)</sup>. Although 97% of pregnant women attend at least one antenatal care service and 74% of live births are delivered by a skilled provider, Uganda still has one of the highest maternal mortality rates in the world at 336 deaths per 100,000 live births <sup>(5, 6)</sup>. This figure is far higher than the average 239 deaths per 100,000 live births for low-income countries that contribute to 99% of the world's maternal deaths and most of the deaths occur in rural areas <sup>(6)</sup>.

In an effort to reduce the maternal mortality rate in Uganda, there are high impact interventions run by local and international development partners in collaboration with the government. One of them is the Uganda Reproductive Health Voucher Project run by MarieStopes Uganda and the Ministry of Health with funding from the Swedish International

Development Agency (Sida), the World Bank and the United Nations Population Fund (UNFPA) aimed at providing safe antenatal, delivery and postnatal care services to poor pregnant women <sup>(7, 8)</sup>. The main objective of the voucher scheme is to increase access to skilled care among women living in rural and disadvantaged areas during pregnancy and delivery. It covers 12 districts in the Southwestern parts of Uganda and 13 districts in the East and Central parts of Uganda. The scheme finances the demand side by using vouchers to reduce out-of-pocket fees for deliveries among women in these areas. Pregnant mothers buy voucher cards at 4,000 UGX (\$1.2) from Village Health Team (VHT) members working within their areas of residence. In return, these pregnant mothers get a package of services consisting of four antenatal visits, safe delivery, one postnatal visit, family planning, management of pregnancy related conditions and complications, including caesarean section and emergency transport <sup>(8, 9)</sup>.

There are several studies conducted in other countries about barriers to mothers' access to, and use of, postnatal care services <sup>(10, 11, 12, 13)</sup>. The studies focused on experiences of using postnatal care services among mothers as well as barriers to utilization of postnatal care. In rural Indonesia, inadequate knowledge and skills about postnatal care and inter-generational norms and myths were among the hindrances to mothers' utilization of the services <sup>(11)</sup>. A study conducted in Central and Southwestern regions of Uganda explored the knowledge, attitudes and barriers to utilizing postnatal care services. It recruited community and local leaders, service providers and community members to participate in their study. The main barriers reported were misconceptions about the importance of postnatal care, poor facilities, poor supply of drug stock, distance to the service center and health workers attitudes towards clients <sup>(10)</sup>. However, the study largely presents findings from opinions of individuals who are not the actual users of postnatal care service. Secondly, obstacles were mainly health facility based and out of control of actual users. In another study conducted to ascertain the level and predictors of postnatal care use in Eastern Uganda, formal employment and awareness of postnatal care schedules were significantly associated with utilization of the services <sup>(14)</sup>. There is limited knowledge and understanding about obstacles to access and use of postnatal care that are pre-paid and within reach.

Despite the fact that postnatal care is free of charge for all mothers who are registered for the Uganda Reproductive Health Voucher Project and secured a voucher card, few mothers tend to come back for postnatal care services after giving birth. The previous year's records from

Suubi Health Center, one of the project service providers in Eastern Uganda, indicate that of the 744 pregnant women who registered and received antenatal care services from the facility, 31.3% delivered at the facility and a meager 17.9% came back for postnatal care services <sup>(15)</sup>. Against this background the current study sought to explore barriers to utilization of pre-paid postnatal care services in Luuka District, Eastern Uganda.

### ***1.2 Aim of the study***

The aim of the study was to explore and gain a deeper understanding of the barriers contributing to the low turn-up of voucher-registered women who sought postnatal care services within six weeks after childbirth in Luuka District, Uganda. A voucher-registered woman in this study was defined as any pregnant woman who registered and secured a Uganda Reproductive Health Voucher Project card that enabled her to access pre-paid antenatal, childbirth and postnatal care services.

The specific aims of the study were the following:

1. To explore perceptions and understanding of postnatal care services among newly-become mothers with voucher cards in rural Luuka District
2. To identify and understand socio-cultural barriers that affected newly become mothers' access and use of postnatal care services in rural Luuka District
3. To explore health facility-based barriers to utilization of postnatal care services as experienced by newly-become mothers with voucher cards in rural Luuka District

Whereas this study is conducted as a requirement for the Master's degree in Public Health of Lund University, the author intends to present the findings to the health department of Luuka District local government and MarieStopes Uganda, a non-government organization, to support their evidence-informed decision-making processes regarding maternal and child healthcare in the country.

## **2. Theoretical Model**

The conceptualization of pre-paid postnatal care utilization is based majorly on Andersen's 1995 model of healthcare utilization which demonstrates the factors that lead to health service use <sup>(16)</sup>. The model takes into account the contextual and individual determinants of health care usage. It provides that health service usage including physician visits is determined by predisposing factors, enabling factors and need <sup>(16, 17)</sup>. The Andersen's model of 1995 and later versions have been extensively used in studying the use of health services <sup>(18)</sup>. Basing on

the model, this study focused on how predisposing factors like age and health beliefs influence the likelihood of seeking care or not. Enabling factors include family support and an individual's community. And lastly, need talks about one's perceived and the actual need for a health service. Therefore, the circumstances and environment under which an individual access health care.

### **3. Methods**

#### ***3.1 Study population and setting***

The study was conducted in Luuka District in Eastern Uganda. The district is bordered by districts of Iganga to the Southeast, Kamuli to the Northwest, Buyende to the North, Kaliro to the Northeast, Mayuge to the South and Jinja to the Southwest. According to the Uganda National Census of 2014, Luuka had a population of 238,020 people of which about 60% were below the age of 18 years and about 48% were of childbearing age <sup>(19)</sup>. The national census also revealed that thirty percent of the population 18 years and above are illiterate. Seven percent of the female children married before the age of 18, and 11.2% of children between 12-17 years (excluding those who were pregnant) have previously given birth. Luuka is one of the most heavily populous areas in rural Uganda with a population density of 366 persons per square kilometer as compared to 173 persons per square kilometer at a country level. Suubi Health Center, a private not for profit health facility located in the Southern part of the district, is one of the health facilities implementing the Uganda Reproductive Health Voucher project. It serves a catchment area of 58 villages from Luuka, Iganga and Jinja Districts. The study focused on Luuka district because its catchment area met all the inclusion criteria and sampling described below.

#### ***3.2 Study design***

The main interest of the study was to gain a deeper understanding of the barriers from utilizing pre-paid postnatal care services among mothers with voucher cards, as perceived by mothers themselves. To gain access to the perceptions and experiences of the mothers, a qualitative study method was employed, which gathers and puts the lived experiences and reality of the participants in the center and as a starting point <sup>(20)</sup>. Whereas quantitative methods take the ideas of the researcher as a departure point and test a hypothesis against reality, qualitative methods take informants' perspectives as the point of departure through an act of interpretation <sup>(20)</sup>. A qualitative research design was chosen for this study to pursue a holistic approach so as to interpret the different parts of the study within the overall context.

Based on the assumption that the relationship between the researcher and participants is interactive and inseparable, the author conducted in-depth interviews using open-ended questions <sup>(20, 21)</sup>. The author chose to analyze the data using a qualitative content analysis as described by Granheim and Lundman <sup>(22)</sup>.

### ***3.2 Selection criteria and sampling of participants***

Data for the study were collected during 2 weeks in January 2018. To be included in the study, the mother needed to be 18 years and above and have a voucher card; given birth at a health facility that offered voucher card services; living within a distance of five kilometers from the health facility; and had not come back to the health facility for postnatal care services. Due to resource constraints related to time available for the interviews and the inability to travel to the participants' different locations, convenience sampling was used aiming at recruiting 10-15 mothers who lived within a reasonable distance from the health center (e.g. five kilometers). From Suubi Health Center monthly records, a total of 18 mothers met the inclusion criteria and were contacted by the health facility staff. An information letter containing details of the study had previously been given to the administration of the health facility. The letter was not directly given to potential participants because some could not read; instead one of the staff at the health facility read the letter aloud over the phone. After explaining the purpose of the study to the participants, 14 participants were willing to participate in the study, however, three of them could not be reached on the day of interview. One interview was nullified after discovering during the interview that the participant did not meet all the inclusion criteria. Thus, the total number of study participants was 10.

### ***3.3 Data collection***

A secure and quiet place at the health facility premises was identified for carrying out the interviews. Before the onset of each interview, the interviewer introduced himself, read and explained the details of the consent form, and asked for a verbal consent from the participant to take part and be audio recorded during the interview. Verbal consent was preferred since some participants could neither read nor write. Data were obtained through interviewing study participants using an in-depth interview guide, consisting of thematic open-ended questions. The interview guide was pre-tested by conducting two mock interviews with village health team members and minor changes were made. During the interview process, the interviewer supplemented the interview guide with follow-up questions, paraphrasing and/or short silence breaks to further the discussion, or probe the study participant's comments. Supplementary



interview notes were taken after the interviews to capture impressions and observations. At the end of each interview, audio files from the recorder were backed up on a personal computer before being deleted from the recording device.

### ***3.4 Data handling and analysis***

The device containing audio recordings was kept in a secure place and the audio files that were transferred to the personal computer were protected with a password. The interviews were conducted in Lusoga, a local language spoken by the study participants and the interviewer, who is also a native speaker. Audio data were uploaded and transcribed verbatim to English using oTranscribe online software <sup>(23)</sup>. This program was considered safe, as the transcribing process is done locally on the personal computer, which means that the audio files and transcripts never leave the computer. It is thereby not possible for others to access the data. Every time after transcribing an audio file, the document containing the data was saved on an external hard drive and both the audio and document on oTranscribe were deleted and erased from the history panel. The audio files and data documents will be deleted from the audio recorder and from the external hard drive upon completion of the Master's thesis course.

A manifest and latent content analysis of qualitative data as described as described by Graneheim and Lundman were employed <sup>(22)</sup>. The analysis of text by directly describing the visible and obvious components is referred to as *manifest content*. On a deeper level however, interpretation of the underlying meaning of the text is referred to as *latent content* <sup>(18, 24)</sup>. Each interview was handled as a unit of analysis and data were condensed by removing all unnecessary words and repetitions. Each unit of analysis was then read through several times to get a sense of it as a whole. Words and/or sentences that contained aspects related to each other regarding content and context were merged together to form meaning units. The meaning units were then summarized, deleting redundant and unnecessary words while preserving the core meaning of the text to form condensed meaning units. These were then assigned codes and labels. Moving from meaning units to codes was a back and forth process of abstraction that kept the whole context of the interview in mind. Examples of meaning units, condensed meaning units and codes are illustrated in appendix II. Subcategories and categories were formed through sorting and clustering codes basing on their similarities and differences. At this stage, the author was able to interpret the underlying meanings of 11

categories at a latent level to form four themes. An example illustrating a step-wise data analysis from codes to themes is shown in Appendix III.

### ***3.5 Ethical Consideration***

Lund University students do not require approval from an Ethical Approval Committee. However, the study adhered to the Helsinki Declaration <sup>(25)</sup>. In Uganda, university students conducting non-clinical trials are not required to seek approval from an ethical committee board. However, the author sought permission to collect data from the health centers from Luuka District Health Officer through the District Chief Administrative Officer to ensure that the study was locally supported. In Appendix IV is a letter of introduction from the supervisor, which was countersigned by the District Health Officer allowing the author to proceed with data collection. The author was in close contact with the health facility administration before, during and after data collection. The signed letter from the district health office was also presented to the health facility administration.

All mothers recruited to participate in the study when 18 years and above and no harm was expected to happen to them. A quiet and secure place within the health facility premises was prepared before the beginning of any interview session. Two chairs of the same height facing each other were prepared before hand and the interview leaned a bit forward in such a posture to create a comfortable talking environment. This was also aimed at mitigating potential power relations between the interviewer and study participant. Prior to any interview session, the introduction letter was read aloud to study participants specifying that participating in the study was voluntary and there were no any financial or other forms of gains from participating. However, transportation was covered by the author to prevent participants from incurring a cost as a result of the study. Participants' verbal consent was sought and to ensure anonymity, each interview was assigned an interview code.

## 4. Results

A total of 10 interviews were conducted. The participants ranged from 18 to 37 years and as shown in Table 1 in Appendix I, the number of children increased with higher age. No participant was engaged in any form of formal work and mothers were mainly staying at home, cultivating their land. From the analysis of the data collected, four themes emerged related to barriers to utilization of postnatal care services. The themes were derived from eleven categories, as shown in Appendix IV. Quotes have been used to provide clarity to how the categories were created and to ensure that participants' voices were represented in the analysis.

The findings are presented below: themes are in bold and italicized, categories in bold and quotes italicized, respectively.

### *4.1 A wanting healthcare system*

This theme described the healthcare system where participants lived. The healthcare set up was wanting in such a way that mothers were not informed of the medical procedures they would go through. Furthermore, instead of packaging postnatal care services as one coherent form of service, the set up fragmented postnatal care into independent components, such as family planning or immunization. Generally, such services were thought of as utilized by the general public whether one was in the postnatal period or not. More so, the existing alternatives of non-voucher public health facilities were worse in offering pre-paid postnatal services. The theme, thus, highlights mothers' perceptions, experiences and understanding of postnatal care services. It was derived from abstracting the underlying meanings of the following three categories: i) narrow perception and understanding of the postnatal services offered, ii) distasteful experiences with mothers' previous encounters with antenatal and delivery services and iii) lack of basic needs for patients and caretakers at the health facility.

The category of having a **narrow perception and understanding** of postnatal care services emerged from participants' limited views on specific types of services that existed, and how important it was for them to seek such services. The most reoccurring perception was that postnatal care services were useful but often participants could not specify in what way. '*Such services help in some way. They help. When I fall sick I can come and get treatment*' (Participant 5). Others simply stated that they were uncertain of what meaning postnatal care services had to them. '*I don't know them [postnatal services you get when using the voucher card]*' (Participant 2). Furthermore, others instead asked the interviewer questions such as

*'Suppose I get any illness, do I get treatment on this card when I come back?'* (Participant 3). This illustrated that mothers did not fully understand how the voucher card issued by the health care set-up worked, who it covered and for how long.

It was commonly mentioned that the services enabled participants to get “treated” when they were sick, having pain or ache. The usefulness was expressed in different kind of ways as illustrated by the statements below:

*'Postnatal care services are useful because they treat you when you are sick and you get well. When you are feeling sick, you come and they check it up. I only come to the health center when I am sick.'* (Participant 1)

*'The importance of postnatal care services is that when you get an “omusudha”, you come to the health center and get treatment. Your baby too, if it is sick.'* (Participant 2)

“*Omusudha*” was mentioned often by mothers. The word can mean either an illness such as malaria and flu, a symptom such as fever, or just the state of feeling sick. These were the main ailments that were thought to be addressed by postnatal care services.

Immunization was often mentioned as part of the services mothers could get within six weeks after giving birth.

*'I now know about services you get after giving birth but immediately after child birth, I didn't know about it. They [midwives] just discharged us and told us to just bring the baby back for immunization'* (Participant 8).

This suggests that mothers were aware of immunization not as part of the postnatal care service package but as part of the mainstream immunization services for children under five years. The only other service given within six weeks after childbirth, family planning, was rarely mentioned. More so, participants' expressions seemed not to reflect that family planning was a kind of service that could bring mothers to a licensed health facility.

*'You can't leave your home going to the health center if you are not sick. May be those going for 'obupiso'. But still, those people go to these smaller "clinics" [unauthorized with unqualified service providers]' (Participant 9).*

Knowledge and understanding, especially of these two important postnatal care services were limited. Family planning and immunization were thus not directly linked to being part of postnatal care package of services.

The category **distasteful experience** refers to previous, negative, encounters with the healthcare system. Participants shared their unpleasant and bad experiences when they accessed other pre-paid maternal and child health services, such as antenatal care and delivery services which might have deterred them from coming back for postnatal care services.

*'These days, checking you regarding childbirth is not the usual way and it did not used to be that way. Nowadays health workers insert their arm into your "womanhood". It damages us [women giving birth] and it took me much longer to heal.'* (Participant 1)

*"Kimalanga kyatukosa"*(participant 4), means it turns to be harming in English, was another mother's expression of how it feels when midwives support them in childbirth, and subsequent vaginal examinations, which portrayed participants' perceived harm from using healthcare services.

Mothers were encouraged to use, or initiate, the unpopular family planning services. However, side effects made some women *'not always feel well, with so much headache, lots of heat all over the body or too cold'* (Participant 9). Family planning services were not preferred by women because it made their bodies unrecognizable; they felt heavily crumbled and unable to work for a long time in their gardens after a visit. The experience of the side effects from previous use of family planning methods thus discouraged mothers from returning for postnatal care since it is a large part of postnatal services offered.

Besides health facility providing pre-paid postnatal care services, participants often talked about, and referred to, public health establishments. They expressed dissatisfaction and

mentioned the difficulties they experienced when trying to access services from public health facilities.

*'You go to Busiro [public health center] many times without getting polio vaccination. The vaccines can be there but staffs just keep ignoring you. You get tired of waiting and go home without getting anything, yet the medicine was there. You get back home and people ask if they immunized the child. And you are like, "there isn't anything". I just got tired for nothing. Will I ever bother going back there next time? I will not go back there.'* (Participant 1)

Participants also shared their unpleasant experience and frustration with alternative public health facilities, which offered pre-paid services, including postnatal care such as immunization. Some did not go to those health centers because the conditions and health workers were not considered appropriate.

Many lower level health facilities in rural areas are isolated, as these are located in relatively remote settings. It was a similar case in this study area and mothers shared their experience of **basic needs not being met at the health facility**. In some instances, postnatal care services were scheduled on specific days in a week, and the health facility usually got a high patient turn-up. This caused long queues and longer waiting times, especially for voucher card services. Basic needs such as food and snacks, water and other soft drinks were important but were not readily accessible at the health facility. Some participants said that *'there are usually very, very many people'* (Participant 8) and *'only one woman selling food by the roadside is not enough'* (Participant 5)

*'That day, that woman [roadside cook] had made obundazi [few and small sized baked sweet bread] and obutyere [small quantities of rice] and all got finished in the morning.'* (Participant 8)

Some days mothers could wait long in the queue until it was getting dark. It meant that mothers with newborns were only able to utilize services at a cost of starving through the day.

#### ***4.2 Fighting to meet social expectations***

Social expectations refer to internalized norms and gender roles perceived by a society of what women and men should do. This theme describes the mothers' responsibilities in a home as generally acceptable by the society, navigating through being in charge of their own transport means and what defines a strong woman in "their" battle of childbirth and care. The three categories thus elucidate the struggles amongst mothers in their postnatal period in pursuit of meeting expectations from their husbands and the society around them.

**"Working like a donkey"** was a category that illustrated mothers' struggles as housewives with daily household chores, such as feeding children, making meals, grazing animals, digging in the gardens, cleaning and washing among others.

*'I usually wake up early. Today I prepared breakfast and lunch for children, fetched feeds for the animals and then I walked and came.'* (Participant 5)

*'Sometimes they [family] don't find it important to take you the mother to the hospital. Because you do household chores looking okay and have no need to go back to the health center.'* (Participant 2)

Participants admitted to *'just leaving their small children at home alone'* (Participant 9) when they had to go somewhere. Some participants who were teens and had children before turning 18 years mentioned that their husbands *'worked from far and barely came back home once a month'* (Participant 6). Seemingly, it was women's responsibility to take care of the children and the accounts of participants suggested that there were clear gender roles in these communities. Such daily household chores as expected of them not only took a lot of time but also made women too tired to fulfill other responsibilities, including utilizing health services, unless there was a critical condition. Men, for example, were the breadwinners and were expected to fend for, and provide resources to, their families. They are meant to provide money for transport, healthcare bills and meals for mothers and their children to access health services. One of the participants expressed discontent that the health facility had come too close to them and they would get less money from their partners.

*'Our husbands used to give us some money to eat and get something while in Bukanga [distant public health facility]. You could eat this and that but there where Nadhomi [co-founder of health facility] put the hospital, aaah [you don't get any money]'* (Participant 8).

Women in this study too expected to get money for transport and lunch from their husbands to go for health services. However, women not only used the money to buy nice food but also saved some to meet a few of their other personal needs. Consequently, the health facility coming closer and offering pre-paid services meant less money for women from their husbands.

There were a number of circumstances under which mothers found themselves **hurdling with being in-charge of own transport**. Much as the distance seemed short, participants got tired of walking four kilometers every time they were going to the health facility. One woman expressed that she could have gotten to the venue much earlier but got delays on the way:

*The bodaboda [motorcycle taxi] guy left me on the road side with my baby and went to Busiro [3km from the community] to find a mechanic. I waited alone for a long time and they showed up like 2 hours later. (Participant 9)*

For a distance that takes about thirty minutes to walk, the mother had to wait for two hours for the motorcycle man to come back and drive her to the health facility. The difficulties in finding transport means, and the struggles with the poor road network, were not the only challenges faced by mothers when moving back and forth to the health facility. Even those who possessed a motorcycle in their households were not in charge, or did not own the vehicles. One of the interview sessions was shortly interrupted by a participant's husband ten minutes into the interview, *'He wants his motorcycle, he needs to go somewhere'* (Participant 8). It was common that both women and men heavily contributed to the family resources but women barely owned property, including transport means in a household. They were expected to ask for permission and it was up to the man to decide.

The interviews revealed that mothers were **swallowing pain to portray womanhood**. In this context, womanhood referred to the qualities or characteristics considered to be inherent parts of being a woman. Much as men had their responsibilities too in the community, women considered giving birth and child related care to be a sole responsibility of the mother, and it was often regarded as a women's *"thing"*.



*'I came here on a motorcycle at 1am, with my sister. My husband followed later. There was a funeral at home and when I gave birth, I called him and he came around 6am.'* (Participant 1).

Women needed to show that they were strong and could handle the pain and post delivery related health challenges by not too often visiting the health facility. They also thought that the post delivery complications would get better with time.

*'You need to keep pressing the area around your birth canal with warm water, everyday. You need to show that you are strong.'* (Participant 8)

*They [midwives] asked me to bring back the babies after 3 days. As for me, I was still bleeding but I was going to be okay.'* (Participant 1)

Thus, perceptions of womanhood, rooted in cultural and traditional norms, were barriers to utilization of postnatal care services.

#### **4.3 Leaning on cultural customs and religious beliefs**

As the participants reflected on faith and passed-on knowledge in relation to postnatal care services, cultural and traditional standards of behavior emerged as a significant factor for how mothers' judgment about postnatal care services was made. Such standards of behavior provided mothers with alternatives and options for handling their postnatal care needs as opposed to health facility based care. As described in the following section, some of these values and beliefs acted as barriers to using postnatal care services.

Some participants were aware of what they were supposed to do as regards to accessing postnatal care services but **traditions influencing treatment options** were common. One mother confessed that she had made a mistake of not coming back for postnatal care services even when the health workers had asked her to do so on a specific date.

*'The baby was still having an umbilical cord. In the clan I got married into, they say you don't take the baby across the road if they still have an umbilical cord.'*  
(Participant 2)

Such traditions prolonged the period for seeking postnatal care and the mother or the newborn ended up missing vital services, for example vaccinations. More so, other traditions offered passed-on knowledge about traditional treatment options. These ranged from using different herbs like “*olubirizi*” which treats fever and headache through smearing the herbs on the body to make water-based solutions used to treat conditions of ill-health during the postnatal period.

*‘After giving birth and the woman gets “eikanga” [faint], people lay her on a mat. They soak the husband’s underpants in water. Then they squeeze water from the underpants and mix it with paraffin and then give the woman this to drink. It helps her to come back from the fainting.’ (Participant 10)*

Such treatment options could be related to when mothers talked about the elders’ perceptions of strong and self-healing bodies. Their elders could tell them that they grew up without swallowing a single tablet or visiting a health facility. Participants added that the elders also expressed their disappointment in the young generation who never feel well unless they take some kind of tablet, e.g., *‘They [elders] say we are frequenting health facilities every now and then. That we cannot get well without tablets [medicine]’* (Participant 6).

Some participants brought up a diverse discussion regarding cultural values and traditions. They said that these were modern times and that cultural values were no longer followed – not even naming their children after their great-grandparents. Instead religion emerged as an important aspect and participants expressed a shift from traditional ways to placing their babies in the hands of God.

*‘You need to take the child before God. It needs Him to place his hand, and it will grow.’ (Participant 4)*

#### ***4.4 Suffering from ineffective communication***

The fourth theme emerged from two categories, one describing rumors that the voucher services in fact were not free, and the other communication gaps between service providers and users, which contributed to that mothers failed to get a comprehensive understanding of the post-natal services provided at the health centers.

The accounts revealed that **discouraging corruptions rumors** about the health facility existed in the community, and how these rumors turned into barriers for returning for postnatal care services. Participants reported that gossip flourished in the community that the health facility actually charged user fees for the supposedly free services.

*‘While being discharged, the midwife stressed that I needed to come back for free postnatal care. I did not come back because when you ask people who go there within the six weeks, they say that you will be asked for money. Yet, they said the services were free of charge.’ (Participant 7)*

In a wider context, a second category of **receiving mixed messages** regarding pre-paid postnatal care services emerged from the health workers sometimes asking mothers to come to the health center for postnatal care but specific services to be received were not explained to women. This led to misunderstandings about which services they had the right to receive and having to come back to the health facility basing on unknown reasons and being less or misinformed about the services.

*‘No one ever told me about this service. And there is no way I can come to the health center unless when I am sick. Perhaps, “akapiso”[vaccination], that I can bring my child to the health center.’ (Participant 5)*

*‘If I come with a valid voucher card, I will still receive treatment for free but I don’t know if the card covers my baby too.’ (Participant 4)*

Some mothers were thus not informed at all about the postnatal care package and others did not know if the services covered both the mother and the baby. It also seemed unclear regarding the period during which one could get pre-paid postnatal care services:

*‘That is the problem. Because they tell us that after giving birth, the child gets free treatment until they are six months. After then, you can come with money for treatment.’ (Participant 1)*

*'I still have my card. They [health workers] told me that I should come back if I have any illness. They said I should bring back the child for the next six months for free treatment. I will start paying for the treatment after six months.'* (Participant 3)

As stated in the two accounts above, it appeared to be a confusion among women about the extent of the pre-paid postnatal services since women believed that the period covered six months and not the actual six weeks. Pregnant women and community members were meant to get information regarding existing postnatal care services from health workers while being discharged as well as from their village health team members. The Village Health Teams are the first line of health service access points. However, participants felt that the information received from these teams was of limited, or no, use.

*'Village Health Team members in our community are useless. They too don't know about postnatal care services. And when you ask them, they tell you to go in big hospitals somewhere.'* (Participant 9)

The above findings show that even if there were pre-paid postnatal services within reach, rumors of corruption, not knowing what the service included, who they covered and for how long, remained as significant obstacles to use the services. Suffering from ineffective communication, thus, emerged as a critical health facility-based barrier to utilization of pre-paid postnatal care services.

## **5. Discussion**

In an effort to address the high maternal mortality rate in Uganda, a voucher system was implemented in several districts in Uganda including Luuka District. Such interventions that address immediate barriers to service use, for example financial resources and emergency transportation, are poised with long-term sustainability aspects. However, an important challenge which this study focuses on, is the fact that the design of such interventions seem to not address the underlying determinants of access and use of health services such as postnatal care. The discussion is guided by Andersen's 1995 model of healthcare utilization, which too takes into account the contextual and environmental determinants of health services utilization <sup>(16)</sup>. Results from this study show that at an individual level, there were narrow perceptions and poor understanding of postnatal care services among mothers. This finding

suggests inadequacies and gaps within the health care system set-up in the region that hinder mothers from learning about, and engaging with, postnatal care services. This analysis was supported by another theme from the results that highlighted ineffective communication between service providers and their corresponding recipients. Mothers often received mixed and/or unclear messages from service providers about postnatal care schedules and services offered under the voucher cards. On a broader society level, daily hard work and struggles to maintain their position as women, demonstrated how mothers fought to meet society's expectations of gender roles. Some of the mothers considered passed-on knowledge and experiences from elders during their postnatal period, and leaned on cultural values and beliefs to fill the need for healthcare.

### ***5.1 A wanting healthcare system***

Much as most maternal and infant deaths occur during the days and weeks following childbirth, postnatal period remains as the most neglected period in the provision of maternal and child health services <sup>(26)</sup>. Basic routines both in public and private health facilities and other health service access points in Uganda do commonly not adhere to medical standards of practice <sup>(27)</sup>. Results from this study revealed that mothers perceived postnatal care services to be mainly for treatment when one had an illness and they could not come to the health facility if they were not sick. However, the World Health Organization's (WHO) which Uganda subscribes to stipulates guidelines whose primary audience is health professionals including those in resource limited settings. All mothers and newborns should have postnatal contacts within the first 24 hours, on day three, between one and two weeks after birth, and six weeks from the day they were discharged from the health facility whether sick or not <sup>(2)</sup>. The mother and her family should be encouraged by service providers to identify danger signs in newborns such as stopping breast feeding, severe chest in-drawing, fast breathing, fever and convulsions <sup>(2, 26)</sup>. These are among the 12 recommendations guiding postnatal care, and some of these should be discussed with the mother to motivate her to come back for postnatal care. Including this kind of information in the discharge after delivery procedure will provide an opportunity for mothers to be more informed about postnatal care services.

In addition, there would be less need to go to health facilities if mothers opt for traditional treatment of signs and symptoms such as treating fever with herbs. In cases of potential underlying life-threatening conditions like sepsis which cause fever too, treating signs and symptoms would not only prevent proper management and disease prognosis but would potentially make the condition worse in the long run.

Negative experiences of the healthcare system in this study mainly referred to being asked to initiate the less popular family planning services and discontent with the public healthcare system. Family planning is rather a less popular service in Uganda due to a number of reasons. A case study conducted in Western Uganda stated that misconceptions and fear of side effects were the two major reasons for the low use of family planning services <sup>(28)</sup>. Similar findings are described in this study where participants reported side effects such as excessive body heat, headaches and lack of energy to go about one's day. Myths and misconceptions about family planning such as IUD piercing the penis during sexual intercourse, implants piercing the heart, contraceptives causing cancer, uterine fibroids, absence of menstruation among others have been reported in other studies conducted in Uganda <sup>(29 - 30)</sup>. One of the two specific services mentioned by participants that could be accessed during postnatal care services was family planning. Mothers could possibly shy away from postnatal care to avoid having to deal with discussions of family planning.

Several studies about barriers to utilization of postnatal care also found that being unaware and less knowledgeable about postnatal care was a significant barrier <sup>(10 - 13)</sup>. Probandari et al., (2017) interviewed mothers and family members in rural Indonesia about the knowledge and awareness of postnatal care, and they revealed that the awareness was lacking and was a barrier to utilization of postnatal care. Furthermore, the informants in that study expressed that they were bleeding for weeks and did not know if that was normal or not. Another study conducted in Nigeria demonstrated that insufficient awareness and knowledge about postnatal care services were statistically associated to low postnatal care check-ups <sup>(13)</sup>. These findings are similar to this study's finding that mothers' narrow perceptions and understanding of postnatal care services were barriers to utilization.

## ***5.2 Fighting to meet social expectations***

The fight to meet social expectations of being a woman as regards childbirth and care is reported in several other countries. A study conducted in West African countries reported that childbirth was marked a "woman's battle" <sup>(31)</sup>. This conceptualization of women's role is similar to findings from this study where childbirth and care was regarded as "a woman's thing". Furthermore in regards to social expectations, mothers working like donkeys with minimal social support was an expression that described the difficult circumstances under which mothers must endure while using postnatal care services. Heavy household workload

and husbands not financially supporting them emerged as important reasons for not using postnatal care services even if they were free. Andersen's model <sup>(16, 17)</sup> describes social support such as actual amount of emotional and informational support through social network as an enabling variable to utilizing healthcare.

Similar findings have been reported in other studies. In Uganda, a study revealed that high workload was a key problem that mothers in Uganda faced when seeking maternal and health care services <sup>(32)</sup>. The qualitative study focused on the root causes of lack of access and utilization of maternal health services, it vividly brought out the role of gender and power dynamics in households. Social norms designate and form unwritten rules of roles for women and men. For example, child birth and care is the responsibility of the mother whereas household finances and security are for men. As regards to healthcare, men are expected to work and look for money to support their families, including paying for healthcare related bills. As indicated in the findings, mothers were discouraged from seeking postnatal care from a near-by health facility because husbands would not give them money. Such conceptualization of women's gender roles leaves mothers with less financial and social support needed access and use postnatal services. This puts the mother and her newborn at risk of maternal related complications including death.

Findings from this study and other studies as analyzed above put mothers in challenging positions within society. This analysis coincides with the individual predisposing characteristics described in the Andersen's model <sup>(16, 17)</sup>. It elaborates that the status of a person in their community is determined by many social factors and that such social status influences a person's ability to cope with prevailing problems and command resource to solve them. Therefore, when the society expects mothers to work tirelessly and limiting their contribution to society to childbirth and home care, it diminishes their status and ability to use resources to solve problems including utilizing health services.

### ***5.3 Leaning on cultural customs and religious beliefs***

The study noted that in certain circumstances, commonly reported barriers such as at-the-counter service fees, distance and transport means, and health workers' attitudes were not the most significant obstacles to utilizing postnatal care. Mothers instead relied on the wisdom and knowledge that they amassed from their ancestors, including the traditional treatment options. Much as the correct information and needed health facilities are in place, there are

powerful traditions that influenced participants' healthcare seeking behavior, including access and use of postnatal care services. For example, this study found out that mothers were keeping the baby in the house for the initial couple of weeks because they were not allowed to cross or be on the road in an effort to keep the baby safe. A similar result was reported in a study in Indonesia where the women's reason for not taking the baby far from their house in rural Indonesia was to prevent the mother and her baby from unforeseen hazard <sup>(11)</sup>. This not only prevents the baby from receiving vital health interventions such as immunization, growth monitoring and routine medical check-ups, but keeps the mother at home unable to receive postnatal care too.

Results from this study described that caretakers can make a whole new form of treatment made from water squeezed from the husband's underpants mixed with paraffin. The solution alone is not only unfit for human consumption but it is also not advisable to give a fainting person liquids. It was found that practices of traditional treatment options were also found in other studies. In a study conducted in Indonesia, women used different alternative treatment options including mixing contents of pharmaceutical pills together with vegetables oil for treating episiotomy wounds <sup>(11)</sup>. In Ethiopia, a study found out that ointment and butter is smeared on cord of the newborn to prevent pain and "wind from going into the baby" <sup>(33)</sup>. Such treatment options suggest rationale and perceptions for continued local postnatal care.

#### ***5.4 Suffering from ineffective communication***

Uganda is one of the few Sub-Saharan African countries that has removed user fees for patients at the point of contact with health facilities in order to address financial barriers related to accessing primary health care. Nevertheless, the financing of the health care system by the government keeps dwindling. The National Health Accounts survey showed that Uganda spends less than one US dollar on each citizen's healthcare per month which is much lower than the international minimum threshold <sup>(34)</sup>. The same survey also revealed that the government financed a meager 17% of the national budget for health. Usually, essential supplies and medicines are lacking and users of maternal healthcare shy away from public health facilities <sup>(29)</sup>. Media has frequently reported on the Ugandan public healthcare system suffering from health workers' strikes due to poor pay but corruption, which creates inefficiencies, discrimination, mistrust and unfairness in extending the service to the public <sup>(36-39)</sup>. Although not common, corruption in form of overcharging patients than the usual price is reported in some private health facilities <sup>(40)</sup>. Corruption has been reported at MarieStopes



Uganda - the implementing agency for pre-paid postnatal care services in the study area. The top leadership of the organization has been sued to courts of law for using funds meant to cover maternal and child health care for their personal gains <sup>(39)</sup>. If true, there would be a likelihood that service providers of the voucher system are not re-imbursed for the cost of running pre-paid postnatal services which forces them to charge fees at the counter. However, there are hardly no studies found that have documented how perceptions and attitudes of healthcare are affected by embezzlement.

At the point of access for pre-paid services, voucher cardholders are meant to be aware of, and able to access, antenatal, intranatal and postnatal care services with no over-the-counter fees. Findings from the current study reveal that there were corruption rumors regarding the supposedly free postnatal services amongst participants, which affected their perceptions about using the services. Whether such rumors get a platform to be aired out and addressed by the health facilities that offer postnatal services under the voucher system, remain unanswered. There are some non-profit organizations and health facilities in Uganda funded by external financial resources which offer pre-paid health services. However, there are hardly any studies regarding the impact of soliciting bribes by health workers among on access and use of healthcare.

Voucher Service Providers contracted by MarieStopes Uganda offer a package of maternal health services, including postnatal care services, to mothers who are poor and in hard-to-reach areas. Records from Suubi Health Center regarding the voucher services indicated that mothers are retained at the health facility for at least one day to receive postnatal care <sup>(41)</sup>. Mothers are also requested to come back on the third day and at six weeks post delivery for postnatal care. In general, the voucher scheme allows mothers free healthcare up to six weeks after delivery. However, the findings revealed a lack of consistency regarding how women had understood the information given, as some believed the timeframe for pre-paid services was six months. Others had been told to return if they fell sick. However, this was both insufficient and inaccurate information given by health workers since it did not include services such as family planning, immunization, measurement for vital statistics such as the baby's weight, height, arm circumference to monitor its grow rate. Such services are the reason for scheduling health facility visits for postnatal care whether one is sick or not. The analysis above could suggest that there is a gap in information packaging and effective communication between the service providers and mothers who are the consumers of the

services. However, it could also be that mothers did not understand the instructions and information given. This could be due to several reasons such as health workers using a difficult language or that mothers were given the information in circumstances when it was difficult to take it in.

It is also important to that findings from notes taken through observation revealed that almost none of the medical staff working with postnatal care fluently spoke the local language. It is therefore possible that information received by mothers during their discharge after child birth may have fallen short of the clear message that these mothers needed to know.

### ***5.5 Methodological considerations***

The methodological reflections in relation to this study are based on two aspects: axiological assumptions and trustworthiness. Lincoln and Guba (1985) discuss axiological assumption and how it brings forth the role of values in research <sup>(20, 42)</sup>. On one hand, the author was born and raised from the same region as the study area and understands that society and its people's way of life. On the other hand, the author is a public health specialist with a clear understanding of antenatal, intranatal and postnatal health services. The study was therefore conducted putting into consideration the expectations, pre-understandings and biases of the researcher as regards to barriers to utilization of postnatal services <sup>(20)</sup>. Trustworthiness of the study results was ensured by following through with the study aim and methodology, applicability of results, consistency of the research findings and neutrality of the researcher are discussed in the form of *Credibility*, *Confirmability*, *Dependability* and *Transferability* criteria <sup>(20)</sup>.

*Credibility* focuses on the researcher's ability to grasp study participants' multiple realities. This was ensured by studying a population where the author is a native. The danger of being native and unable to separate own experience from that of participants was addressed by taking reflective notes during the interviews as well as engaging in peer review and debriefing. Reflective notes for example helped with identifying areas the interviewer needed to do better for the next interviews. Regarding debriefing, two public health specialists, one from Uganda, another from Sweden and most significantly the research supervisor, were presented with preliminary results for feedback. Questions and comments such "*Is that what the mother said?*" (debrief person I) helped the analysis to stick to the manifest content as described by the study participants. "*So needing to remain strong is a barrier to utilization of*

*services because it is expected that you will handle the pain without seeking care?”* (Debriefing person II) helped the author think more on a latent content level the interpretations of data. Therefore, such questions and comments from a debrief widened the authors thoughts on several aspects that could not make sense to both a study area setting and other settings outside Uganda. Finally, the participants included in the study were recruited from different villages surrounding the health facility.

*Confirmability* refers to the neutrality of the data and making sure it is unbiased. To ensure confirmability, in-depth interviews using semi-structured interview guides were audio recorded and transcribed verbatim. Moreover, the reflective notes that were taken during the interviews were instrumental in order to elucidate the researcher’s own thoughts, reflections and preconceptions. These notes were also helpful for putting the interviews into context during the analytical stage.

*Dependability* means that the researcher should be able to account for the changing conditions of a study since qualitative research continuously changes due to the nature of its emergent design. Dependability was ensured by thoroughly describing the research methods used in such a way that other researcher are able to follow the decision paths and make their own judgment.

*Transferability* addresses the question of how applicable the findings from a qualitative study are to other settings and contexts. This study described the research context in detail in the methods sections so that results could be applicable to other settings in Sub-Saharan Africa due to similar structures in the healthcare system. Readers who are familiar with this study context and a lot other contexts can thus make an informed choice of the transferability of these study findings.

### ***5.6 Strengths and Limitations***

Prior to onset of any interview session, the interviewer took time to engage study participants in talks about very familiar things in the community such as what they liked most about their community or how the climatic seasons were affecting farmers. These prolonged engagements built a better connection and trust to freely share between the interviewer and study participants as regards questions in the interview guide. In addition, the interviewer listened to audio recordings at the end of each day and this gave the interviewer an

opportunity to spot follow up questions that would be interesting to ask to widen the discussion on particular questions in the interview guide.

Much as the author is a native speaker of the local language, some Lusoga words and phrases were not easily interpreted. For example “*Okulwarilawano*” literally means “falling sick from here” or “contracting an illness and/or infection from here”. The implication is that there could have been risks of misinterpretations of certain words or phrases if the author did not fully grasp the context. In efforts to mitigate this risk, the author used supplementary notes in consultation with the resource persons from the community to make an interpretation of such phrases basing on the context of the question and topic. This was helpful in a few occasions where the interviewer did not ask for clarity on what participants meant during transcription. Using this approach, the author concluded that “*okulwalirawano*” meant that the health center is where the mother usually gets her health services from.

It was however noted that conducting key informants interviews with midwives at the health facility could have given an even deeper input and insight in the study. Their perspectives on the topic would have brought in different angles to the discussions, enhanced triangulation and credibility of the results. Due to resource constraints, such interviews were not included in the study. Furthermore, some recruited participants even after prior scheduling of appointments and follow up calls, did not show up for the interviews. This disrupted schedules and reschedules which reduced the overall amount of time for data collection. Some study participants were not whole-heartedly willing to open up and share their experiences.

## **6. Conclusion and implications for health service providers**

This study identified insufficient information and understanding of postnatal care services as a major barrier to utilization of postnatal services. The revelation that majority of the health workers in the department of maternal and child health do not speak the local language well, it is highly possible that health messages are not being understood by mothers. This relates to how the structure of health care system is organized as talked about in Andersen’s model. The model highlights that is important to put into account how a healthcare institution or delivery system is organized to make it easy for its use including office hours, location of service, outreach and education programs etc. It is therefore important for the health facility to devise means of ensuring that postnatal care schedules, what it does and how it works is explicitly communicated and/or written down for mothers especially before being discharged. Another recommendation for the health facility is that they should take the opportunity to talk to

women's partners when they escort their women for antenatal care and childbirth about the social and financial support needed. They should highlight how the socio-cultural barriers taking forms of what a woman is perceived to be and do (bear pain, support not needed etc.) and their impacts to the health of a mother and the newborn baby with their husbands. Since postnatal care services are pre-paid, midwives can also explore the alternatives of scheduling home visits to offer postnatal care.

Rumors of corruption for pre-paid health services should be given attention to build trust in the community. Creating a favorable platform for back-and-forth communication between the health facility administrators and pre-paid service consumers is recommended. Health facilities can also post printed messages on their premises, specifying services that do not require on the counter payments. This would not only help address corruption rumors but other voucher system based bottlenecks that barrier access and use of maternal health services. Finally, health facilities can utilize the existing stakeholder platforms and opportunities such as community outreach for antenatal care and immunization to highlight traditions and customs that influence and negatively impact health and health seeking behaviors.

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## 8. Appendices

### Appendix I: Table showing participants' age and number of children

Participant	Age	Number of children
1	37	7
2	19	2
3	30	5
4	31	7
5	24	3
6	18	1
7	21	3
8	30	6
9	24	2
10	22	2

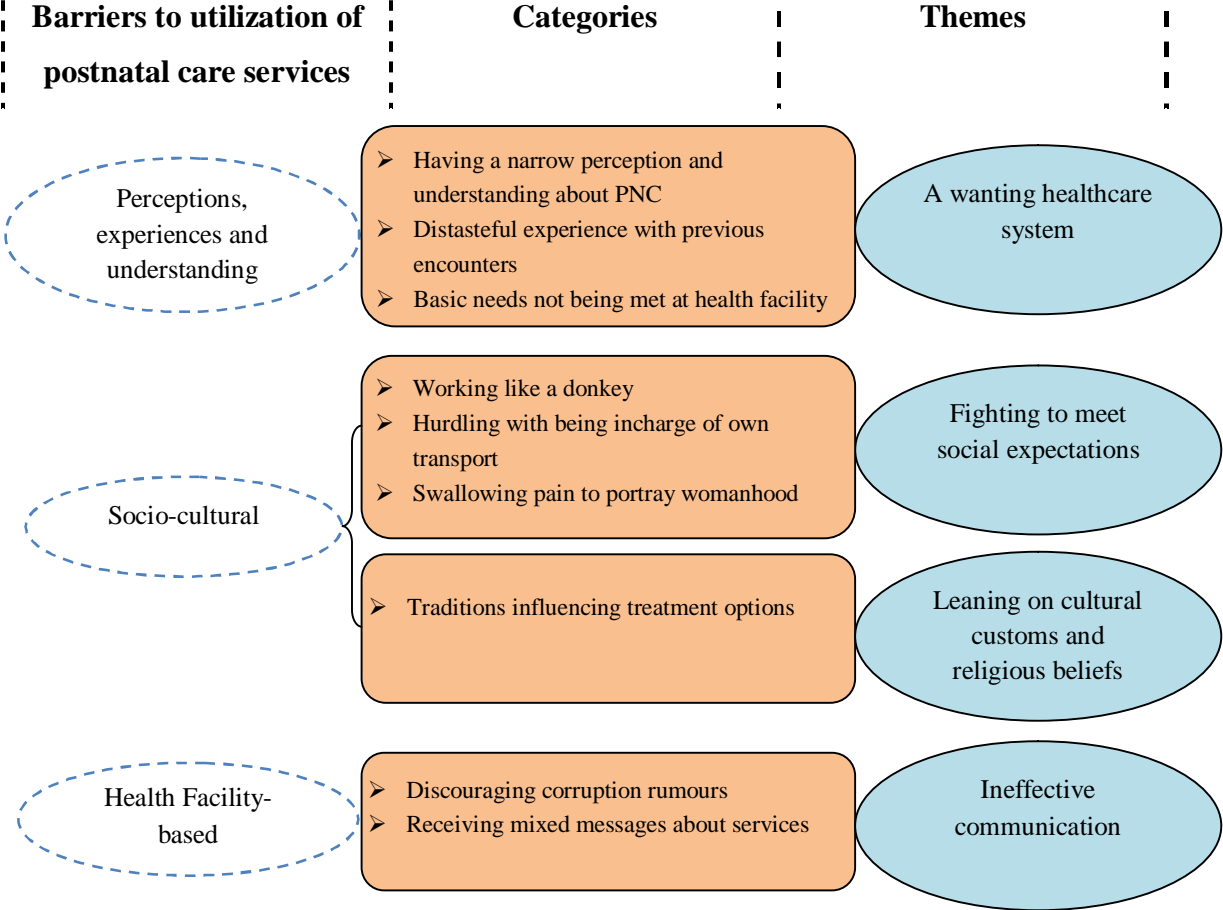
**Appendix II: Illustration of meaning units, condensed meaning units and codes**

<b>Meaning units</b>	<b>Condensed meaning units</b>	<b>Codes</b>
<p>PNC services are important because when you get sick, they treat and you get well. That is the importance. I only come to the health centre when I am sick.</p>	<p>PNC services are important. They treat when you get sick and you get well. I only come to health centre when I am sick</p>	<p>PNC services being important Getting treated when sick Coming to health centre only when sick</p>
<p>After giving birth, health workers insert their arm into womanhood that they are checking you up. It hurts. It takes so much longer to get healed. It takes longer to get back.</p>	<p>Health workers inserting hand into womanhood after giving birth. It did not used to be like that when checking you. It takes much longer to get healed and get back.</p>	<p>Inserting hand into womanhood Checking-up not usual way Taking longer to heal</p>

**Appendix III: Examples of codes, sub-categories, categories and themes**

Theme		A wanting healthcare system				
Categories	Having a narrow perception and understanding about PNC		Distasteful experience with previous encounters		Basic needs not being met at health facility	
<b>Sub-categories</b>	PNC important only for treatment;	PNC for accessing immunization and family planning;	Hurting methods of examination;	Encouraging family planning (side effects)	Inadequate food and water options at facility premises;	Buying water for cleaning, washing
<b>Codes</b>	PNC services are important Getting treated when sick Treating stomach aches and <i>omusudha</i> Getting services like polio Being already sick after delivery Baby had no problem I don't know Not been told about PNC Baby never fell sick, never came back	Providing vaccinations Coming back only when it is ' <i>polio</i> ' (vaccine) Other health centers have no vaccinations No other services apart from family planning	Getting damages during check-ups Speaking ill about inserting hand Check-up not the usual way Taking longer to heal	Told to come back for a ' <i>ring</i> ' ( <i>family planning</i> ) Asked to initiate method of choice ( <i>family planning</i> ) Suggesting family planning on discharge, I was not ready Much headache, burning body when using family planning Heat on body when using family planning	Only baked <i>bundazi</i> ( <i>small baked bread</i> ) by <i>the roadside</i> Easily finishing small cooked <i>obutyere</i> amounts (rice) People going hungry Buying own meals	Buying water after cleaning, washing Buying water after delivery for cleaning

**Appendix IV: Analytical model depicting the themes and categories related to barriers to utilization of pre-paid postnatal care services**



## Appendix V: Letter of introduction



**LUND UNIVERSITY**  
Faculty of Medicine  
Dept of Clinical Sciences, Malmö  
SMGH, Social Medicine and Global Health

2018-01-08

Dear Sir/Madam,

**Re: Introduction letter for Denis Muwanguzi**

Denis is a graduate student in our Masters of Public Health Program at Lund University, Sweden. As a requirement for completion of his master's degree, he is writing a Master's Thesis of 30 Higher Education Credits. Denis will be conducting an academic study titled "Barriers to access and use of postnatal care services among mothers under Uganda Reproductive Health Voucher system". The study aims to explore the reasons for the low turn-up of voucher-registered women who seek postnatal care services within six weeks after childbirth in Luuka District, Uganda.

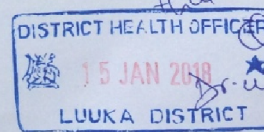
The purpose of this letter is to confirm that Denis Muwanguzi is one of our students and that he is undertaking the above-mentioned study. He intends to interview women who have given birth under the voucher system but did not attend the pre-paid postnatal care services offered in Luuka District.

Allowing him to collect data for his master's thesis and any other support rendered to him will be highly appreciated.

You are welcome to contact me should you have any questions.

Yours sincerely,

Dr Markus Larsson  
Associate Researcher  
Supervisor  
Division for Social Medicine and Global Health  
Faculty of Medicine  
Lund University



Accord Mr. Muwanguzi  
Denis Assistance  
that he requires  
Dr. Wabwire mup  
15/1/18

## **Appendix VI: Consent form for the study**

My name is Denis Muwanguzi and I am a student in the Master of Public Health program at Lund University, Sweden. I am recruiting people to be part of my master's thesis titled "Barriers to access and use of postnatal care services among mothers under the Uganda Reproductive Health Voucher Project in rural Uganda". The study aims to identify reasons for the low utilization of postnatal services by women registered under voucher card.

Your participation in this study is voluntary and you are free to end the interview at any time you so wish. You will not be forced to answer any question or questions you feel not comfortable with and you can interrupt the interview at any point. All the information collected during the interview will be treated with utmost confidentiality and your personal information will not be reflected on scripts in such a way that someone could potentially identify the source of the information.

I would also like to let you know that this information might be used in publications or presentations to support efforts aimed at improving the quality and positive of postnatal care services in this geographical area and beyond. Your answers to the questions will be completely anonymous and no one will be able to trace your information back to you.

Incase you have any questions, concerns or comments before, during and/or after, feel free to contact me and I will give you the necessary assistance.

I would appreciate your participation in this interview which will not take more than one and half hours. The interview is non-renumerated. During the interview I will be conducting an audio recording but if you don't want to be recorded I can write down what you say instead. The audio recording of your interview, or notes, will be destroyed upon completion of my thesis course in early June.

Could you please confirm that you have understood this information by saying yes?

## **Appendix VII: In-depth interview guide**

**Study Aim:** The study aims to explore the reasons for the low turn-up of voucher-registered women who seek postnatal care services within six weeks after childbirth in Luuka District, Uganda

### **Interview Guide:**

Read and explain the consent form for the study. Obtain a verbal consent

#### *Socio-demographic*

- 1. Can you tell me about yourself?** (Probe for age, number of children, living, distance of house to health facility)

#### *Perceptions and understanding of postnatal care services*

- 2. Describe your thoughts and associations when you think of postnatal care services.**
- 3. In what ways are postnatal care services important to the mother and her newborn baby?**(Probe: in what way are they important or NOT important?)
- 4. Thinking about postnatal care services under the voucher card, could you describe specific healthcare services you and your baby could get from the health facility?**
- 5. What would make you want to go for postnatal care services?** (probe: what drives participant to seeking postnatal care)

#### *Socio-cultural barriers to utilization of postnatal care services*

- 6. How would you prepare yourself to go for postnatal care services?** (probe: permission, money, organizing home)
- 7. Describe what you would need in order to be able to reach the health center.**
- 8. What do people in this community think about seeking postnatal care immediately after giving birth?**
- 9. Tell me about other cultural beliefs and values about child birth in this community?** (probe: after childbirth values and beliefs)

#### *Health facility-based barriers to postnatal care services*

- 10. Tell me about your impression and experience of the actual health services during prenatal period and delivery.** (probe: how reception staff treated you, how health workers



treated you, waiting time, your impression of the other patients

(friendly/suspicious/stressed/relaxed), whether you got help, satisfied the service)

- 11. Describe recommendations given to you by health workers before you leave the health facility about what you need to do after giving birth.** (probe: clarity of recommendations and instructions, opportunities to ask for clarification)

## **9. Popular Science Summary**

Postnatal care services are essential in preventing ill-health and death related to childbirth within the first year of a child's life. Globally, most deaths of mothers and their newborn babies occur during the first month after giving birth and half of those deaths happen within the first 24 hours after delivery. Severe and uncontrolled bleeding, infections and complications are the major cause of these deaths and ill-health. In Uganda, 336 deaths occur in every 100,000 live births and this is one of the highest figures in the world. Despite cutting off fees paid at the counter for postnatal services in some parts of Uganda, very few mothers utilize these pre-paid services. Data from a health center providing pre-paid postnatal care services in the rural Eastern Uganda revealed that only 17.9% of the mothers came back for pre-paid postnatal care services. The main aim of this study was to find out the reasons that bar mothers from using pre-paid postnatal care services.

The study results reveal there are gaps in the healthcare set-up including a lack of access by mothers to information about services they can use after giving birth. Mothers also do not understand what goes on while health workers perform certain medical procedures. There are also social and gender norms and expectations of being a woman which puts mothers in a difficult situation to seek and use postnatal services. And lastly, mothers did not seem portray the correct description of postnatal services such as time frames and details as assumably being told by service providers.

From these findings, the researcher concluded that there was a lack of understanding and importance of postnatal care; inaccurate information and socioeconomic barriers with gender bias. The author recommended that creating and using communication platforms that enable back-and-forth flow of information at health facilities and in communities would help overcome some of the barriers.