Health Policy and Planning, 32, 2017, v13–v21
doi: 10.1093/heapol/czx011
Original Article

Gender dynamics affecting maternal health and health care access and use in Uganda

Rosemary Morgan[1], Moses Tetui[2,3,*], Rornald Muhumuza Kananura[2], Elizabeth Ekirapa-Kiracho[2] and AS George[1,4]

[1]Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA, [2]Department of Health Policy Planning and Management, Makerere University School of Public Health, Kampala, Uganda, [3]Epidemiology and Global Health Unit, Department of Public Health and Clinical Medicine, Umeå University, 901 87 Umeå, Sweden and [4]School of Public Health, University of the Western Cape, South Africa

*Corresponding author. Department of Health Policy and Management Makerere University School of Public Health, Kampala, Uganda. E-mail: mtetui@musph.ac.ug

Accepted on 24 January 2017

Abstract

Despite its reduction over the last decade, the maternal mortality rate in Uganda remains high, due to in part a lack of access to maternal health care. In an effort to increase access to care, a quasi-experimental trial using vouchers was implemented in Eastern Uganda between 2009 and 2011. Findings from the trial reported a dramatic increase in pregnant women's access to institutional delivery. Sustainability of such interventions, however, is an important challenge. While such interventions are able to successfully address immediate access barriers, such as lack of financial resources and transportation, they are reliant on external resources to sustain them and are not designed to address the underlying causes contributing to women's lack of access, including those related to gender. In an effort to examine ways to sustain the intervention beyond external financial resources, project implementers conducted a follow-up qualitative study to explore the root causes of women's lack of maternal health care access and utilization. Based on emergent findings, a gender analysis of the data was conducted to identify key gender dynamics affecting maternal health and maternal health care. This paper reports the key gender dynamics identified during the analysis, by detailing how gender power relations affect maternal health care access and utilization in relation to: access to resources; division of labour, including women's workload during and after pregnancy and lack of male involvement at health facilities; social norms, including perceptions of women's attitudes and behaviour during pregnancy, men's attitudes towards fatherhood, attitudes towards domestic violence, and health worker attitudes and behaviour; and decision-making. It concludes by discussing the need for integrating gender into maternal health care interventions if they are to address the root causes of barriers to maternal health access and utilization and improve access to and use of maternal health care in the long term.

Keywords: Gender, gender analysis, health systems, maternal health, Uganda

Introduction

Despite its reduction over the last decade, the maternal mortality rate (MMR) in Uganda remains high at approximately 356–438 per 100 000 live births (UBOS 2012; World Bank 2016), due to in part a lack of access to maternal health care (UBOS 2012; Bua *et al.* 2015). Increasing access to maternal health care requires both supply- and demand-side interventions. Supply-side interventions focus on improving the quality and quantity of services provided through health system strengthening. Demand-side interventions focus on increasing service utilization by influencing the health behaviours of individuals and communities (Mangham-Jefferies *et al.* 2014; Alfonso *et al.* 2015).

Key Messages

- Maternal health interventions have been successful in increasing access to and utilization of maternal health services, however, failure to address underlying gender dynamics limits the sustainability of benefits generated.
- Gender power relations can be understood by how power is constituted and negotiated in relation to: access to resources, division of labour, social norms, and decision-making, the intersection of which was found to affect maternal health care access and utilization in Uganda.
- In order to address gendered inequities affecting women's lack of maternal health care access and utilization, interventions are needed which challenge unequal gender roles and relations that perpetuate inequities in maternal health access and utilization.

To address supply and demand side access barriers to maternal health care, Makerere University School of Public Health, in collaboration with Johns Hopkins University, implemented a quasi-experimental trial using vouchers in Eastern Uganda between 2009 and 2011 (Alfonso *et al.* 2015; Bua *et al.* 2015). The demand-side intervention included two vouchers, one for transport to health facilities and one for maternal care services, provided to pregnant women and women who have recently given birth from poor communities. The supply-side intervention included training health workers, and the provision of essential equipment, drugs and support supervision. Findings from the trial reported a dramatic increase in pregnant women's access to institutional delivery, which increased from under 200 deliveries/month to over 500 deliveries/month (Ekirapa-Kiracho *et al.* 2011).

Results showing that demand-side interventions, such as vouchers, can increase the demand for and utilization of maternal health care services have been found elsewhere (Morgan *et al.* 2013, Stanton et al. 2013). Sustainability of such interventions, however, is an important challenge (Glassman *et al.* 2013). While vouchers are able to successfully address immediate access barriers, such as lack of financial resources and transportation, they are reliant on external resources to sustain them and are not designed to address the underlying causes contributing to women's lack of access, including those related to gender. In an effort to examine ways to sustain the intervention beyond external financial resources, project implementers conducted a follow-up study to explore the root causes of women's lack of maternal health care access and utilization. During data collection, gender power relations emerged as an important root cause, and, as a result, a gender analysis of the data was conducted to identify the key gender dynamics affecting maternal health and maternal health care in Uganda.

Research has shown that gender inequities have a negative effect on maternal health and maternal health care access and utilization in multiple ways (Tolhurst *et al.* 2009; Namasivayam *et al.* 2012; Singh *et al.* 2012; Kraft *et al.* 2014). On the demand side, gender divisions of labour, lack of access to and control over resources (e.g. finances, information, transport, supplies), gender norms, limited autonomy, and lack of decision-making power limit women's ability to access maternal health care services (Tolhurst *et al.* 2009; Singh *et al.* 2012, 2015). On the supply side, societal patterns of gender discrimination are often reflected within maternal health service delivery (Tolhurst *et al.* 2009). For example, the lack of 'women-centred' services, such as family planning or abortion, maternal health services being treated as 'women-only' spaces, and the mistreatment of women and men by health providers are all manifestations of gender discrimination (Tolhurst *et al.*, 2009; McMahon *et al.* 2014). In addition, the intersection of gender with other social stratifiers, such as age, race, class, ethnicity, geography, (dis)ability and sexuality compounds the effect of gender inequities on maternal health and health care for vulnerable and marginalized women, such as poor women in rural areas (Tolhurst *et al.* 2009). Finally, men affect women's access to prenatal care and women's obstetric outcomes in their roles as partners, neighbours, community leaders, and health providers due to their control over household resources and decision-making (Comrie-Thomson *et al.* 2015; Greene *et al.* 2006). However, progress towards engaging men in maternal and child health has been slow, despite their key decision-making roles in maternal and newborn care-seeking behaviour and family planning (Davis *et al.* 2012; Holmes *et al.* 2013).

Integrating gender into maternal and child health interventions has been found to positively affect intervention outcomes. A review of gender-integrated interventions in reproductive and maternal-child health, for example, found that while the effects of integrating gender into interventions were mixed, overall the studies suggested that addressing social and structural factors within maternal and child health interventions, such as gender norms and inequalities, is beneficial for effective intervention outcomes. In particular, out of 23 interventions, those of which incorporated empowerment approaches, for example, by "empower[ing] women to take actions to address health issues, [...] empower[ing] adolescents and their families and chang[ing] community norms around child marriage", had the strongest evidence in support of integrating gender into maternal and child health interventions (Kraft *et al.* 2014, p. 135).

This paper reports the key gender dynamics identified during an analysis of the data from the follow-up study which explored the root causes of women's lack of maternal health care access and utilization. After discussing the methods used, the paper details how the role of gender power relations in relation to access to resources, division of labour, social norms, and decision-making affect maternal health care access and utilization in Uganda. The findings are then discussed in relation to the wider literature, exploring ways in which gender can be incorporated into maternal and child health interventions.

Methods

This was a cross-sectional study that utilised qualitative data collection methods that comprised of group discussions. Data were collected from the project implementation districts of Pallisa, Kibuku and Kamuli located in Eastern Uganda. These districts were selected to mirror the sites within the original project locations, and to ensure the information collected was representative of all areas. The estimated population in this area is 1 219 172 (UBOS 2012). All of the three districts are rural and the means of living is subsistence farming supplemented by small scale trading in small townships. There were 31 health centre IIIs, four health centre IVs and four

Table 1. Number of group interviews and overview of respondents

District	Younger mothers (15–25)	Older mothers (26–55)	Fathers	Transporters
Pallisa	3	3	3	3
Kamuli	3	3	3	3
Kibuku	1	3	2	2
Total	7	9	8	8

district hospitals within this area. The common means of transport to health facilities include walking, using boda boda motorcycles and taxis (commercial vans that sit 14 passengers).

Group discussions were held across eight sub counties in three districts in Eastern Uganda, with women who had given birth recently (x16), fathers whose wives had given birth recently (x8) and transport drivers (x8) (Table 1). Female respondents were further disaggregated by age (younger mothers aged 15-25 and older mothers aged 26-55). The female groups were homogenous with respect to age to foster open and free discussions. However, they were heterogeneous with respect to social economic status, disability and positions of responsibility to allow for maximum variation in perspectives. Across all the subgroups, respondents were selected who would be representative of the different levels of social economic status in the community. Social economic status was determined based on commonly used indicators in the community, such as type of housing, education level, occupation and possession of assets, such as land, vehicles and radios. In addition, we included members of the community who held positions of responsibility in different capacities, such as village health team leaders, leaders of community-based organizations and local political structures (local councils), as well as some members of the community with disabilities.

Respondents were selected with the help of local gatekeepers. For recruitment of mothers and fathers, local leaders were briefed about the kind of respondents needed and helped to identify suitable candidates. Potential respondents were then informed about the study and asked to participate in the group discussions by the study team. Those community members that volunteered were included in discussion groups of 10–15 participants. Similary, as transporters are organized into groups with team leaders at sub-county level, team leaders supported the identification of transporters who could be involved in the discussion groups through a process similar to that of the mothers and fathers.

The group discussions included questions related to birth preparedness, transport and quality of care, as the initial intervention identified these as important access and utilization issues. Specifically, respondents were asked questions related to how they prepare for birth, how they save money for use during pregnancy and child birth, how they care for their new born babies, and challenges faced during birth preparedness. Regarding transportation, they were asked about the means of transport that they use to the facility, the state of roads and challenges faced during transportation. Lastly, they were asked about how health workers treat them when they go to seek care for maternal and child health, availability of amenities, drugs, supplies, and infrastructure, as well as barriers to providing quality care. Respondents were also asked to suggest solutions to the problems that they experienced. During these group discussions, researchers used a range of participatory techniques. These included: brainstorming of problems, ranking of problems, facilitated discussions on solutions to problems, creation of a roti diagram depicting solutions, enabling participants to visualize how they could support themselves and areas where support is needed, and feedback discussions. The issues identified in this initial analysis were used to design a maternal and neonatal implementation for equitable systems project (MANIFEST). The project aimed to increase access to maternal and neonatal health services in a more sustainable manner in the three districts using a participatory action research approach.

For the gender analysis, transcripts were analyzed using the framework approach, a type of thematic analysis. The framework approach uses a series of steps (indexing, charting, mapping and interpretation) to organize and interpret data and is particularly relevant for policy-orientated research due to its focus on a distinct set of stages (Ritchie and Spencer 1993). Transcripts were reviewed and coded using the themes that were pre-determined by the research team (birth preparedness, quality of care and transport), as well as a gender analysis framework (Table 2) (Morgan *et al.* 2016).

The gender analysis framework argues that gender as a power relation and driver of inequality can be understood by how power is constituted and negotiated in relation to access to resources, division of labour, social norms and decision-making. While these factors are presented as distinct categories they interact and reinforce one another, and, as Morgan *et al.* (2016, p. 3) argue, they "are not static, but are actively fostered, maintained or contested, in intended and unintended ways, as gender power relations [...] are negotiated by people and their environments." The framework was used to explore how gender power relations affect maternal health care access and utilization within these districts.

After coding the transcripts, researchers summarized the data into tables and grouped data according to emerging themes and relationships related to the gender analysis framework. Data were analyzed across districts and age groups (in the case of mothers). During the analysis key gender findings emerged upon further examination of the data, which are presented below.

During analysis, a distinction was made between gender dynamics that drive inequality, and drivers that have gender implications, such as structural constraints within the health system. For example, while lack of supplies or equipment within health facilities is likely to have a greater impact on women due to their increased use of health facilities, this is a structural constraint that has gender implications. Whereas gendered power relations which inhibit women's lack of decision-making power about when and where to seek care is a gender dynamic that drives inequality.

Ethical clearance for this study was granted from the Makerere University School of Public Health and Uganda National Council for Science and Technology. Permission was also sought from the district health offices of the participating districts. Participation was voluntarily and study details were well explained to the study participants and written consent was obtained. Privacy was ensured and data were kept confidentially with access restricted to only the study investigators and research assistants.

Results

The findings below are presented in relation to the above gender framework. Gender dynamics related to access to resources, division of labour and social norms are reported. During analysis we found that decision-making was embedded within a person's access to resources, division of labour both within and outside the household, and overall social norms and therefore is not reported separately. How decision-making intersects with access to resources, division of labour and social norms is further explored within the discussion.

Table 2. Gender analysis framework: gender as a power relation and driver of inequality

What constitutes gendered power relations	
Who has what	Access to resources (education, information, skills, income, employment, services, benefits, time, space, social capital, etc.)
Who does what	Division of labour within and beyond the household and everyday practices
How are values defined	Social norms, ideologies, beliefs and perceptions
Who decides	Rules and decision-making (both formal and informal)
How power is negotiated and changed	
Individual/People	Critical consciousness, acknowledgement/lack of acknowledgement, agency/apathy, interests, historical and lived experiences, resistance or violence
Structural/Environment	Legal and policy status, institutionalisation within planning and programs, funding, accountability mechanisms

During analysis, no major differences across the study sites or across age groups were found; the findings reported below emerged most strongly across all districts and age groups.

Access to resources

Each group reported lack of resources as a maternal health care access and utilization barrier. Both mothers and fathers, for example, reported not having money to buy key resources needed for delivery, such as: polythene paper, gloves, razor blades, cotton wool/gauze and soap. Other key resources needed included: transportation to and from health centres (for pre-natal care, delivery, referral and post-natal care) and food. The lack of basic delivery supplies at health facilities required expectant mothers to purchase and bring their own supplies (when such supplies were not brought, service was often delayed or withheld), however, respondents' low socio-economic status meant that purchasing such supplies was often difficult if not impossible. Lack of dedicated transportation, such as ambulances, also meant that respondents had to find their own transportation to and from the health facilities, both for routine and emergency visits. As reported by respondents:

> *Poverty is a big problem for us during antenatal care, delivery and post-natal care because all of them require money for transport, buying items for birth and also buying good food (group discussion with older mothers, Kamuli).*
>
> *During antenatal, most of the mother's go to the health facilities on foot or use bicycles due to poverty, being that this is the available means they have in their communities (group discussion with transporters, Kamuli).*

As a result, respondents had to either borrow money to buy supplies or hire transport to access facility care, avoided going to the health centre, and/or used a traditional birth attendant (TBA) when they reached their delivery time:

> *The placenta had [a] problem so [we] were referred to Pallisa Hospital where I had to borrow [money] in order to hire a vehicle (group discussion with fathers, Pallisa).*
>
> *Because of lack of money, [women] are forced to deliver from home until a complication occurs, for example, delay or failure of the placenta to come out then family members have to come in and sell any item in order to take the mother to the health centre (group discussion with young mothers, Pallisa).*
>
> *Due to having no money, mothers decide to use TBAs (group discussion with older mothers, Kamuli).*

Mothers often reported a lack of control over how financial resources were used, as well as a lack of male support when purchasing items for delivery or hiring transportation to the health facility:

> *Husbands don't want to buy items [for delivery] because they don't care about their women (group interview with young mothers, Kamuli).*
>
> *Husbands refuse to give pregnant mothers money to go for ANC (group discussion with older mothers, Kamuli).*
>
> *Lack of control over resources [is a problem faced while trying to seek maternal health services] (group discussion with older mothers, Pallisa).*

During the discussions with fathers, men's lack of support during the maternal health care process was often justified in relation to overall lack of financial resources within the home. When asked why some men help their wives while others do not, reasons included: lack of money, lack of income generating activities, lack of income to meet health centre costs, and lack of personal transport means (group discussions with fathers, Pallisa and Kamuli). One group identified poverty as a source of misunderstanding in the home, where "*a woman may demand for many things which cannot be met*" (group discussion with fathers, Kamuli). The gender dimensions related to men's lack of support and poverty are discussed below in the section on social norms.

While each group identified access to resources as a key barrier to maternal health care access and use, both mothers and fathers also identified cases when husbands helped to purchase needed supplies and transportation. A key difference between the two groups, however, was their identification of key barriers. For example, women identified men not providing supplies as a key barrier, whereas men identified overall lack of money as a key issue. These differences are further explored in the discussion section. While it is difficult to segregate the effect of poverty from gender, it is clear that the two intersect to influence access to and use of maternal health services. Whether resources are available, and who controls access to those resources, are a result of both poverty and gender dynamics.

Division of labour

Two gender dynamics in relation to division of labour affecting maternal health and health care were women's workload during and after pregnancy, and lack of male involvement at health facilities.

Women's workload during and after pregnancy

While both mothers and fathers stressed the need for women to be given light workloads during pregnancy, mothers identified high workload as a key problem encountered when seeking maternal health services:

> *Heavy work like digging during antenatal period and postnatal period [is a problem] (group discussion with young mothers, Pallisa).*

A lot of work given to women during pregnancy [is a problem] (group discussion with older mothers, Pallisa and Kibuku)

Both mothers and transporters identified husband's expectation for their wives to undertake house and garden work while pregnant. They also noted the lack of help from their husbands as a key problem:

Most men make their women spend long hours in gardens digging and yet they have other housework duties to perform like cooking, fetching water (group discussion with transporters, Kibuku).

[There is] too much work during pregnancy, women are not usually assisted by their husbands to do house work like cooking, washing, fetching water (group discussion with older mothers, Kibuku).

At home even if the husband sees you are weak, vomiting, he goes ahead to assign you work (group discussion with young mothers, Pallisa).

Lack of male involvement at health facilities

While both the mothers and fathers identified instances where husbands accompanied their wives to the health facilities, mothers identified men's lack of involvement as a key problem encountered when seeking maternal health services. Transporters also identified lack of male involvement as a problem. Father's lack of involvement has implications for women at the health facilities, as women accompanied by their husbands are often seen first. This has led to an increased role for transporters who sometimes have to support women financially in order for them to receive care:

A problem they face is husbands not escorting them for ANC, and at the hospital they first deal with those who have come with their husbands (group discussion with older mothers, Kamuli).

He took [a mother] to deliver, the mother did not have an attendant and he had to be the attendant, and at the same time bought the requirements and the mother and husband paid him (group discussion with transporters, Kamuli).

Husbands did not identify men's lack of involvement at the health facility as a key problem encountered when seeking maternal health services, however, when asked why some men do not support their wives reasons included: fear of being tested for HIV at the health facility, problems with drinking, ignorance, women's attitudes (as detailed below), and women not wanting husbands at the health facility.

Social norms

Social norms related to women's, men's, and health workers' attitudes and behaviour contributed to many of the maternal health and health care problems identified by respondents. These included: perceptions of women's attitudes and behaviour during pregnancy; men's attitudes towards fatherhood; attitudes towards domestic violence; and health worker attitudes and behaviour.

Perceptions of women's attitudes and behaviour during pregnancy

Women's negative attitudes during pregnancy were provided as a justification for men's lack of involvement in the maternal health care process. Negative attributes assigned to women included aggressiveness, quarrelling, laziness, extravagance, rudeness, and dirtiness:

Some men disappear from home because of aggressiveness of their pregnant mothers, and also when a wife is pregnant [she] does not want to cook in time (group discussion with fathers, Kamuli).

Some pregnancies make a woman quarrel a lot which keeps the men away; aggressive women during delivery make the men stay aside; women think everything concerning them should be done by men (group discussion with fathers, Pallisa).

Some women are too dirty, they do not want to wash, they do not want to clean themselves, even sweeping their houses, and then how will a man stay in such a situation (group discussion with fathers, Kamuli).

Men's attitudes towards fatherhood

Negative attitudes towards fatherhood were also identified as key gender related social norms, which affect maternal health and health care. These attitudes were often associated with men's responsibility (or lack thereof) for children:

Husbands abandon us and [the] responsibility of bringing up children remains entirely on us women (group discussion with young mothers, Pallisa).

[Some] women produce kids whom the husband does not want (group discussion with fathers, Kamuli).

Over producing of children can force me to run away (group discussion with fathers, Kamuli).

Some men run away from them more so if the women is disabled [. . .] they don't want [it] to be known that they are the people who impregnated them (group discussion with young mothers, Kamuli).

Attitudes towards domestic violence

The issue of domestic violence came up frequently during the group discussions. Domestic violence was identified as a key problem affecting women's health in addition to their access to and use of maternal health care and was given as a reason why some men do not support their wives during the maternal health care process. Various reasons were suggested for causing domestic violence, these included women's delay at the health facility, failure to perform their household chores as well as decreased interest in sex when pregnant:

Some husbands beat their women when they delay at the health facility (group discussion with young mothers, Pallisa).

Husbands beat their wives for not doing work, e.g. *digging, washing clothes, cooking food (group discussion with older mothers, Kamuli).*

Some women when pregnant don't like men (don't want to have sex) so they keep on fighting, thus domestic violence (group discussion with fathers, Pallisa).

Health worker attitudes and behaviour

All respondents identified rudeness and abusive behaviour by health workers during ANC, delivery, and PNC as a key problem affecting access to and use of maternal health services:

The nurses beat you when you refuse to push (group discussion with young mothers, Kamuli).

Abusiveness nature of nurses – we women suffer from their harassment (group discussion with younger mothers, Pallisa).

The midwives in health facilities are very rude and harsh, they [can] end up slapping them (group discussion with older mothers, Kamuli).

Men also gave rudeness of health workers as a justification for lack of men's involvement during the maternal health care process (this was not given as a justification in the FGDs with women). Health workers' tendency to blame husbands for women's poor health or their inability to afford needed supplies was also provided as justifications. As reported by respondents:

> *[When] the mother became anemic, the medical personnel harassed the husband so much that he was not caring for the mother (group discussion with fathers, Kamuli).*
>
> *The rudeness of health workers on men when they escort their wives to the health facility has made them fear health workers; that is why sometimes women are not escorted by their husbands (group discussion with fathers, Kamuli).*
>
> *Lack of respect for the men by female health workers causes them not to escort their wives to the facilities (group discussion with fathers, Pallisa).*

According to respondents, health worker attitudes and behaviour were worse towards women who appeared 'dirty', or for women who had a visible disability:

> *Health workers are rude due to dirty pregnant women, such women sometimes fear to go to health centres for antenatal services as they are likely to be abused by health workers (group discussion with older mothers, Kibuku).*
>
> *Health workers always have bad attitudes saying that the disabled should not conceive and deliver (group discussion with young mothers, Kamuli).*
>
> *Health workers abuse the disabled mothers (group discussion with older mothers, Kamuli).*

Health worker attitudes and behaviour can be viewed in the context of gender power relations. While health workers were rude to both men and women, as women are seeking care during a vulnerable period, such attitudes and behaviour can be quite disempowering, particularly as women's ability to react to such attitudes and behaviour is different from that of men. As demonstrated by the above quotations, the intersection of gender with other social stratifiers, such as class and disability, compounds the effect of gender inequities on maternal health and health care for vulnerable and marginalized women.

Discussion

The findings presented earlier provide a picture of how gendered power relations affect maternal health care access and utilization in Uganda within the study districts. The section below interprets the above findings in relation to the Ugandan context and wider literature. Overall, it was found that access and utilization is influenced by the intersection of access to resources, division of labour, social norms, and decision-making, which constitute gendered power relations. As we found that decision-making was embedded within a person's access to resources, division of labour, and overall social norms, it was not reported separately above. However, how these areas intersect to affect maternal health care access and utilization is discussed below. This is followed by a discussion of the ways in which gender can be integrated into maternal health interventions, with the aim of challenging and changing unequal gender roles and relations, and specific recommendations for improving maternal health and health care in Uganda.

Gendered power relations affect the division of labour both within and outside the home. For example, division of labour is often mediated by social norms delignating which activities fall under the purview of men or women. In many societies, including Uganda, men are often regarded as the sole providers, whose responsibilities include working outside the home to bring in income to support the family, including providing funds for health care (Scott *et al.* 2014). As indicated by the above findings, high levels of poverty can lead to men being unable to fulfil this role. Within this study, men identified poverty as a key constraint to them being able to provide needed maternal health and health care supplies, while women identified men's lack of financial support as unwillingness to support them by providing the required financial support. This demonstrates how social norms intersect with division of labour to influence access to resources. Similarly, division of labour within the home is often mediated by social norms, with women being held responsible for housework. As the above findings indicate, these social norms can sometimes be so strong (both within the household and community) that even when women are heavily pregnant or unwell, they are still expected to undertake housework.

At the same time, as a result of gendered social norms issues to do with pregnancy and delivery are often viewed as the purview of women by some sections of society, especially those who have not received adequate education about the role of men in maternal health. As a result, some men's lack of support during the maternal health care process (both in terms of providing resources and accompanying women to health care facilities) may be due to a belief that men are not responsible for, or should not be involved in, issues related to maternal health. Negative health worker attitudes towards men may also be influenced by social norms which dictate that "responsible" men should ensure that their wives are able to eat nutritious food and have the necessary requirements at delivery. Health workers (who are often female themselves) therefore often harass men who are unable to do so. Such abuse can deter or prevent men from escorting their wives to health care facilities, working against those who are brave enough to challenge the stereotype that men should not be involved in the maternal health care process. Another compounding factor affecting men's perceived lack of involvement at the health facility may be their work commitments outside the home, and the loss of income that would occur if they took time off work to accompany their wives to the health facility.

Decision-making related to women's maternal health care access and utilization is influenced by the intersection of the above gendered power relations. Men's roles as providers, for example, limits women's access to resources and restricts their ability to make decisions with regards to maternal health and health care (Scott *et al.* 2014; Elmusharaf *et al.* 2015). Unequal power within the decision-making process restricts a woman's 'autonomy, limit[s] her power to negotiate with her partner, increase[s] fertility rates, [and] increase[s] unwanted pregnancy', all of which negatively affect maternal health and health care (Elmusharaf *et al.* 2015, p. 7).

Recognizing this unequal power within the decision-making process, and how it intersects with the above gendered power relations, may help to understand men's attitudes towards fatherhood discussed above, as well as their perceptions of women's attitudes and behaviour during pregnancy (Kabagenyi *et al.* 2014; Nankinga *et al.* 2016). Men's criticism of women who have too many children and their lack of acknowledgement of fatherhood, for example, can be problematized in relation to their inability to fulfil strict gender roles. Men's inability to fulfil their role as providers due to a context of extreme poverty, for example, can manifest into women receiving the blame for issues related to unwanted children, men's irresponsible behaviour, domestic violence, and abandonment, among others (as we saw in Uganda). Interventions that review and challenge these

binary gender roles may help to reduce some of these negative perceptions or outcomes (discussed in greater detail below).

A key dynamic that is important to consider is how gender intersects with other social stratifiers, such as race, age, class, ethnicity, (dis)ability and sexuality, to create different experiences of marginalization and vulnerability (Larson *et al.* 2016). The discussion above shows how gendered social norms intersect with class (i.e. poverty) to influence whether resources are available, who controls access to those resources, and what happens when gender roles cannot be fulfilled as a result of a lack of resources. The above findings also demonstrate how gender intersects with class and/or disability to influence the experience of women at health facilities. As the findings indicate, women from lower socio-economic groups and/or those who have a disability experience greater levels of mistreatment and abuse by health workers. While experiences of disrespectful and abusive maternity care have been reported within the literature (see McMahon *et al.* 2014; Asefa and Bekele 2015), how gender intersects with other social stratifiers to influence type and degree of disrespect and abuse is less understood. Understanding how gender intersects with other social stratifiers can help us understand how gendered power relations shape differential needs, experiences, and outcomes both within and beyond the health system (Morgan *et al.* 2016).

Integrating gender into maternal health interventions

As the above analysis demonstrates, gender power relations play a key role in maternal health care access and utilization. Despite this, demand-side interventions and strategies fail to adequately consider and incorporate gender into intervention design, implementation, or evaluation (Elmusharaf *et al.* 2015). Evidence from maternal health interventions that have challenged gendered decision-making structures have demonstrated increased sustainability, and in some cases long-term positive change, in relation to intervention outcomes. For example, an evaluation of a community-based reproductive health project which aimed to address high maternal mortality in Tanzania through strengthening community awareness, decision-making and ownership around maternal health, showed increased demand for maternal health services five years after the intervention had completed (Ahluwalia *et al.* 2010). Likewise, significant improvements in women's knowledge and use of maternal health care were found in a community-based intervention in Zambia, which mobilized the entire community, including husbands, around safe pregnancy and delivery (Ensor *et al.* 2014). At the time of publication, steps were underway to incorporate the intervention into government programmes in an effort to facilitate long-term sustainability and improvement in maternal health.

While the above interventions challenged gendered decision-making structures, the extent to which they explicitly incorporated gender relations into the design and implementation of the interventions is unknown. What they do show, however, is that challenging unequal gendered decision-making structures allows us to not only identify, but also attempt to positively change, the underlying dynamics which necessitate the need for demand-side maternal health and health care interventions. In order to effectively address gendered inequities affecting women's lack of maternal health care access and utilization, gender must be integrated into the design, implementation, and evaluation of interventions.

The Gender Integration Continuum can be used to help policymakers and researchers consider how to incorporate gender into their interventions. The continuum categorizes interventions into those that are gender blind (i.e. fail to consider gender) and those that are gender aware (i.e. consider and/or incorporate gender) (Caro 2009; Kraft *et al.* 2014). Gender aware interventions can either be gender exploitative, by taking advantage of 'rigid gender norms and existing imbalances in power to achieve [...] program objectives'; gender accommodating, by acknowledging 'the role of gender norms and inequities and seek[ing] to develop actions that adjust to and often compensate for them'; or gender transformative, by actively striving 'to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health as well as gender equity objectives' (Caro 2009, p. 10). Gender transformative interventions are most likely to address and change the underlying dynamics which necessitate the need for demand-side maternal health and health care interventions. Such interventions 'encourage critical awareness among men and women of gender roles and norms; promote the position of women; challenge the distribution of resources and allocation of duties between men and women; and/or address the power relationships between women and others in the community, such as service providers and traditional leaders (Caro 2009, p. 10).

A number of successful gender transformative studies can be found within the literature. A randomized control trial assessing the impact of SASA!, a community mobilization intervention in Uganda seeking 'to change community attitudes, norms and behaviours that result in gender inequality, violence and increased HIV vulnerability for women', for example, found that women in intervention communities were 52% less likely to report experience of intimate partner violence in the past year (Abramsky *et al.* 2016, p. 3; Kyegombe *et al.* 2014). Likewise, an evaluation of a male engagement intervention to transform gender norms and improve family planning and HIV service uptake in Uganda reported some success in improving health-seeking behaviours and practices in men around visiting health facilities, HIV testing, and condom use. The intervention trained men in the community to serve as peer educators on issues related to male engagement in women's reproductive health services, such as 'understanding and challenging harmful gender norms, increasing men's knowledge about ways to protect their health and the health of their families, improving knowledge of family planning and HIV, and encouraging participation in health services' (Ghanotakis *et al.* 2016, p. 5). Similarly, exposure to community dialogues about gender, sexuality, and family planning aiming to shift social norms and improve family planning uptake in Kenya, was associated within an increase in use of modern family planning methods among women (Wegs *et al.* 2016). In particular, women's increased use of family planning was significantly associated with 'higher spousal communication, control over cash earnings, and family planning self-efficacy' (Wegs *et al.* 2016, p. 2).

As the above evidence shows, maternal health interventions need to integrate gender if they are to address underlying dynamics which necessitate the need for such interventions. Interventions are needed which challenge unequal gender roles and relations that affect and perpetuate inequities in maternal health access and utilization. In addition, future work must also consider how gender intersects with other social stratifiers to influence needs, experiences, and outcomes both within and beyond the health sector.

Addressing gender-related barriers to maternal health access and care in Uganda

The above gender analysis of maternal health and health care in Uganda revealed a number of gender-related barriers which need to be addressed if maternal health and health care is to be improved. At the household and community level, interventions are needed, for

example, which challenge norms that view men as sole providers and women as care givers. Empowering women to financially support themselves and their families, with support of their partners, could help to lessen the burden placed on men to provide supplies and material needed during the maternal health care process. At the same time, empowering men to contribute to and/or share household work could help to lessen the burden placed on women, especially during their pregnancies.

At the health systems level, interventions are needed which challenge attitudes that view maternal health as solely a women's domain – attitudes of women, men, and health care providers. Challenging such views would help to address the harassment that men often encounter at the health facility and encourage more men to accompany their partners when they receive care. Efforts are also needed to ensure that facilities are better equipped to respond to the needs of disabled women, including improving access and equipment, as well as training health workers to respond to the needs of disabled women in a respectful way. More broadly, health system strengthening efforts are needed to ensure that facilities have adequate supplies to respond to women's maternal health care needs, taking the burden off women and their families to provide needed medical and other supplies. Moving Uganda's health system towards universal health care would help to ensure women have adequate access to, and receive appropriate, maternal health care.

There are a number of limitations which affect the above analysis. As gender was identified as an important consideration during the data analysis process, and gender was not explored in an in-depth way during data collection, the analysis within this paper remains exploratory. In addition, because the gender analysis framework used did not underpin the study from its conception, including during the development of data collection tools, it is likely that important gender-related factors were missed. Secondly, the transcripts from the FGDs were summary notes of the dialogues that occurred, as opposed to verbatim recordings of the discussion. As a result, there are likely to be nuances that were missed in the subsequent write-up and analysis. Thirdly, the socio economic characteristics of the respondents were not captured during data collection. This could have limited interpretation of some of the results. And lastly, the main author of this paper was not involved in the initial research and intervention, and is not intimately familiar with the Ugandan context. As the co-authors were involved in the research and intervention and are based in Uganda, this helped to reduce any misrepresentations that might have occurred during the analysis and final write-up.

Conclusion

While maternal health interventions have been successful in increasing access to and utilization of maternal health services, failure to address underlying gender dynamics limits the sustainability of benefits generated. More needs to be done if the root causes of barriers to maternal health access and utilization are to be effectively addressed in Uganda. The community discussions undertaken as part of this study revealed important gender dynamics affecting maternal health access and utilization. These have laid the foundation for future interventions to address gendered power relations within intervention design, implementation, and evaluation. Gender aware interventions, particularly those which are gender transformative, are needed if access to and use of maternal health care is to be improved in the long-term.

Ethical Approval

Ethical clearance for this study was granted from the Makerere University School of Public Health and Uganda National Council for Science and Technology. Permission was also sought from the district health offices of the participating districts.

Acknowledgements

We would like to thank the Research in Gender and Ethics (RinGs): Building Stronger Health Systems Partnership for their ideas and inputs during the development and revision of this paper. We would also like to thank the Future Health Systems Consortium for their contribution to this research.

Funding

This work was supported by Comic Relief [Grant No 12531 to MT, RMK, EE], Research in Gender and Ethics (RinGs): Building Stronger Health Systems, which is funded by the UK Department for International Development (DFID) [Project No PO5683 to RM and ASG], and the South African Research Chairs Initiative of the Department of Science and Technology and National Research Foundation of South Africa (Grant No 82769 to ASG).

Conflict of interest statement: None declared.

References

Abramsky T, Devries KM, Michau L *et al*. 2016. Ecological pathways to prevention: How does the SASA! community mobilisation model work to prevent physical intimate partner violence against women? *BMC Public Health* **16**: 339.

Ahluwalia IB, Robinson D, Vallely L, Gieseker KE, Kabakama A. 2010. Sustainability of community-capacity to promote safer motherhood in northwestern Tanzania: what remains? *Global Health Promotion* **17**: 39–49.

Alfonso YN, Bishai D, Bua J *et al*. 2015. Cost-effectiveness analysis of a voucher scheme combined with obstetrical quality improvements: quasi experimental results from Uganda. *Health Policy and Planning* **30**: 88–99.

Asefa A, Bekele D. 2015. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. *Reproductive Health* **12**: 33.

Bua J, Paina L, Kiracho EE. 2015. Lessons learnt during the process of setup and implementation of the voucher scheme in Eastern Uganda: a mixed methods study. *Implementation Science: IS 108*. **10**:

Caro D. 2009. A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action (2nd edition). Washington DC: Population Reference Bureau.

Comrie-Thomson L, Tokhi M, Ampt F *et al*. 2015. Challenging gender inequity through male involvement in maternal and newborn health: critical assessment of an emerging evidence base. *Culture, Health & Sexuality* **17(Suppl 2)**:S 177–89.

Davis J, Luchters S, Holmes W. 2012. *Men and maternal and newborn health: benefits, harms, challenges and potential strategies for engaging men Compass*. Melbourne, Australia: Women's and Children's Health Knowledge Hub.

Ekirapa-Kiracho E, Waiswa P, Rahman MH *et al*. 2011. Increasing access to institutional deliveries using demand and supply side incentives: early results from a quasi-experimental study. *BMC International Health and Human Rights* **11(Suppl 1)**: S11.

Elmusharaf K, Byrne E, O'Donovan D. 2015. Strategies to increase demand for maternal health services in resource-limited settings: challenges to be addressed. *BMC Public Health* **15**: 870.

Ensor T, Green C, Quigley P *et al*. 2014. Mobilizing communities to improve maternal health: results of an intervention in rural Zambia. *Bulletin of the World Health Organization* **92**: 51–9.

Ghanotakis E, Hoke T, Wilcher R *et al*. 2016. Evaluation of a male engagement intervention to transform gender norms and improve family planning

and HIV service uptake in Kabale, Uganda. *Global Public Health*: DOI: 10.1080/17441692.2016.1168863.

Glassman A, Duran D, Fleisher L *et al*. 2013. Impact of conditional cash transfers on maternal and newborn health. *Journal of Health, Population, and Nutrition* **31**: S48.

Greene ME, Mehta M, Pulerwitz J, Wulf D, Bankole A, Singh S. 2006. Involving Men in Reproductive Health: Contributions to Development., Millennium Project.

Holmes W, Davis J, Luchters S. 2013. *Engaging men in reproductive, maternal and newborn health*. Melbourne, Australia: Women's and Children's Health Knowledge Hub.

Kabagenyi A, Jennings L, Reid A *et al*. 2014. Barriers to male involvement in contraceptive uptake and reproductive health services: a qualitative study of men and women's perceptions in two rural districts in Uganda. *Reproductive Health* **11**: 21.

Kraft JM, Wilkins KG, Morales GJ, Widyono M, Middlestadt SE. 2014. An evidence review of gender-integrated interventions in reproductive and maternal-child health. *Journal of Health Communication* **19(Suppl 1)**: 122–41.

Kyegombe N, Starmann E, Devries KM *et al*. 2014. 'SASA! is the medicine that treats violence'. Qualitative findings on how a community mobilisation intervention to prevent violence against women created change in Kampala, Uganda. *Global Health Action* **7**: 25082.

Larson E, George A, Morgan R, Poteat T. 2016. 10 Best resources on… intersectionality with an emphasis on low- and middle-income countries. *Health Policy and Planning* **31**: 964–9.

Mangham-Jefferies L, Pitt C, Cousens S, Mills A, Schellenberg J. 2014. Cost-effectiveness of strategies to improve the utilization and provision of maternal and newborn health care in low-income and lower-middle-income countries: a systematic review. *BMC Pregnancy and Childbirth* **14**: 243.

McMahon SA, George AS, Chebet JJ *et al*. 2014. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. *BMC Pregnancy and Childbirth* **14**: 268.

Morgan L, Stanton ME, Higgs ES, *et al*. 2013. Financial incentives and maternal health: where do we go from here? *Journal of Health, Population, and Nutrition* **31**: 8–22.

Morgan R, George A, Sssali S *et al*. 2016. How to do (or not to do)… gender analysis in health systems research. *Health Policy and Planning* **31**: 1069–1078.

Namasivayam A, Osuorah DC, Syed R, Antai D. 2012. The role of gender inequities in women's access to reproductive health care: a population-level study of Namibia, Kenya, Nepal, and India. *International Journal of Women's Health* **4**: 351–64.

Nankinga O, Misinde C, Kwagala B. 2016. Gender relations, sexual behaviour, and risk of contracting sexually transmitted infections among women in union in Uganda. *BMC Public Health* **16**: 440.

Ritchie J, Spencer L. 1993. Qualitative data analysis for applied policy research. In: Bryman A, Burgess R (eds). *Analysing Qualitative Data*. London: Routledge

Scott K, McMahon S, Yumkella F, Diaz T, George A. 2014. Navigating multiple options and social relationships in plural health systems: a qualitative study exploring healthcare seeking for sick children in Sierra Leone. *Health Policy and Planning* **29**: 292–301.

Singh K, Bloom S, Brodish P. 2015. Gender equality as a means to improve maternal and child health in Africa. *Health Care for Women International* **36**: 57–69.

Singh K, Bloom S, Haney E, Olorunsaiye C, Brodish P. 2012. Gender equality and childbirth in a health facility: Nigeria and MDG5. *African Journal of Reproductive Health* **16**: 123–9.

Stanton ME, Higgs ES, Koblinsky M. 2013. Investigating financial incentives for maternal health: an introduction. *Journal of Health, Population, and Nutrition* **31**: 1–7.

Tolhurst R, Raven J, Theobald S. 2009. Gender equity: perspectives on maternal and child health. In: Ehiri JE (ed). *Maternal and Child Health*. Springer, 151–66.

UBOS. 2012. *Uganda Demographic and Health Survey 2011., Kampala, Uganda. UBOS and Calverton*. Maryland: ICF International Inc.

Wegs C, Creanga AA, Galavotti C, Wamalwa E. 2016. Community dialogue to shift social norms and enable family planning: an evaluation of the family planning results initiative in Kenya. *PLoS One* **11**: e0153907.

World Bank. 2016. Maternal mortality ratio (modeled estimate, per 100,000 live births).