Community Empowerment and Participation in Maternal Health in Kamwenge District, Uganda

A Participatory Reflection and Action Project REPORT

HEPS- Uganda
with the Regional network for equity in health in east and southern Africa (EQUINET)

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in Masters courses, specific skills courses, student grants and mentoring. This report has been produced within the capacity building programme on participatory research and action (PRA) for people centred health systems following training by TARSC and IHRDC in EQUINET. It is part of a growing mentored network of PRA work and experience in east and southern Africa, aimed at strengthening people centred health systems and people's empowerment in health.

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Foreword

The project was conceived after two HEPS Uganda staff; (Aaron Muhinda and Abrahams Mutumba Zahura) attended the training by Training and Research Support Centre and Ifakara Health Research Development Centre in EQUINET in participatory methods for training and research for community-based mechanisms to strengthen the community's voice in planning and implementing health services at the primary health care level, held in Bagamoyo, Tanzania, in February 2007.

Many people have contributed to the completion of this study; Community empowerment and Participation in maternal health in Kamwenge District, Uganda.

The Uganda team on participatory action research; We thank Muhinda Aaron, Mutumba Abrahams, Joyce Mugarura and Dr. Levi Kassime In –Charge Rukuyu HC IV for their vigorous effort and hard work, the Kamwenge district administration particularly Dr. Sarah Kasewa , George Byaruhanga, Sam Kahirita, Kamwenge health workers and the entire Kamwenge community for their good cooperation and support during the implementation of the work and compilation of this report.

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Executive summary

The status of maternal health in Uganda has remained poor despite the country's relatively fast economic growth of the past 20 years. The proportion of women delivering in health units remains low and there is a gap between the numbers attending antenatal services and those delivering in health serivces. In Kamwenge District, where as in other rural districts of Uganda, pregnancy-related complications are among the leading causes of death and disability among women in the reproductive age group, and has poorer maternal health statistics than the national average. Kamwenge has a shortfall of health facilities and is underserved in staffing.

The Kamwenge Community Empowerment and Participation in Maternal Health Project aimed to contribute to the improvement of the health of expectant mothers in Kamwenge Sub-county, Kamwenge District. We aimed, through the use of PRA approaches, to increase demand for, access to and utilisation of maternal health services by expectant mothers. This work was implemented as part of a multicountry programme exploring different dimensions of participatory approaches to people centred health systems in east and southern Africa, through Training and Research Support Centre (TARSC) and Ifakara Tanzania in the Regional network for equity in health in east and southern Africa (EQUINET). The project involved health workers and community members, including community leaders, expectant mothers, male spouses, and others in Kamwenge sub-county in Kamwenge District. Two HEPS Uganda staff members who attended the regional training working with a team involving HEPS and the Kamwenge district health team facilitated the work between May and November 2007.

Using various PRA tools the project team worked with the community to prioritise, act and follow up on the most critical barriers to maternal health at the three levels – health service, community and household. The first PRA meeting took place in June, arising from which several actions were prioritised and planned. These were implemented between June and November 2007 and involved training of volunteer community trainers; sensitisation of health workers in communication skills and the rights of expectant mothers; implementation of a feedback mechanism based on suggestion boxes; a public dialogue on the plight of expectant mothers and the delivery of maternal health services, aired on a local FM radio station; and distribution of maternal health rights and responsibilities community training manuals to community trainers. Suggestion boxes were installed at six health centres; and sensitization posters about maternal health rights produced and distributed.

At the second meeting people noted that the willingness among people to support maternal health care in the district has risen and that specific steps had been taken to improve relationships between the community and the health system. Participants unanimously agreed that there had been an improvement in maternal health awareness in the sub-county through the sensitization campaign, posters and radio dialogues. There were however still some areas raised that needed further change in the health infrastructure, poor road network and support to nursing staff for local accommodation or transport and uniforms; in the procedure for handling complaints from the suggestion boxes; in the uptake and follow up by women of VCT services, their compliance with antimalaria medication; and in the male attitudes towards and support to partners when they attend maternal health and PMTCT services.

While a comparison of questionnaires before and after the intervention suggested that maternal health problems remained high and many barriers to access services persisted, positive change was perceived in ease of access to and affordability of services, in communication between community and health workers and the respect shown by health workers, in the support given by health workers and families, and in awareness and action on maternal health in the community. The strongest positive changes were noted in the communication between health workers and pregnant women, and this seemed to be the area of greatest impact of the intervention.

The participants generally found the process interesting, effective and enabling, and urged that it be rolled out across the district. Lessons were learned about giving more time to community processes, and the value of involving decision makers and community leaders in activities aimed at communities was noted as positive and critical to sustaining and deepening the programme and the social changes yet to be produced within the community. While HEPS did lead in providing technical, skills and material inputs, this was around an agenda that had been set within the local community and health services.

The next steps on this intervention are informed by both the achievements and challenges of implementation process, and the proposals by the local community. They include expanding the sensitisation campaign on maternal health within the area and to other parts of the district, and tackling the issues of male attitudes through community leadership. It is also identified that Kamwenge District Administration liase with the central government to invest more resources in improving maternal health by ensuring its guidelines on health infrastructure, equipment and logistics are implemented, including provision of a hospital and of accommodation at health facilities and uniforms for health workers.

1. Introduction

Maternal mortality has remained high in Uganda despite the high economic growth the country has achieved over the past 20 years. The Uganda Demographic Health Survey of 2006 found that the maternal mortality rate declined by just 14% in the past 10 years, from 506/100,000 to 435/100,000, compared to a 28% decline in the previous 7 years (UBOS, 2007) (See Table 1). The report reveals that the proportion of women delivering in health units remains low at 41%, although the percentage that attends antenatal care is about twice as high. In Kamwenge District the delivery rate in health units is even lower at only 19% (UBOS 2007), while the district administration estimates this proportion to be 14% (Kamwenge District, 2005). With an average of 6.7 children per woman, Uganda has one of the highest fertility rates in the world. About 1.2 million women become pregnant every year, of whom an estimated 6,000 die from causes related to pregnancy and childbirth (UBOS, 2007). Of every 100 women delivering, fifteen suffer complications.

Table 1: Reproductive Health (RH) Status in Uganda

Indicator	1988	1995	2000	2006
Child Pregnancies (% girl children 13 yrs and below who became pregnant during the year)	5%	15%	23%	3.7%
Adolescent Pregnancies (% adolescents 14-18 yrs who became pregnant during the year)	45%	43%	32%	32%
Total Fertility Rate (average number of children per woman)	7.1	6.9	6.9	6.7
Unmet Family Planning Demand (proportion of women who need family planning services but did not access them during the year)	52%	29%	35%	41%
Supervised Deliveries (% expectant mothers who delivered at health centres under the supervision of professional health personnel)	38%	38%	37%	41%
Maternal Mortality Rate (number of women dying from causes related to child birth per every 1000 live births)	700	506	505	435

Source: Uganda Bureau of Statistics, 2007

Table 1 also shows some anomalous trends in reproductive health statistics. Child pregnancies rose over 1988 to 2000, and then fell significantly. Unmet family planning demand, which fell significantly between 1988 and 1995, rose almost as significantly to 2006. The reasons for these changes are not clear.

Uganda's second Health Sector Strategic Plan (HSSP II) 2005/06-2009/10 attributes the low numbers of women delivering at health facilities – and by extension, poor maternal health – to low levels of education and negative cultural practices, including power dynamics at household and community levels(Ministry of Health, 2007). But there is also evidence that extreme levels of poverty at household level, poor communication between expectant mothers and health workers and a host of other related factors have led women to deliver in the community, away from formal health units (HEPS, 2007). This situation is an indicator of the poor state of maternal health and the inadequate attention paid to it, despite the fact that women's special contribution to society through maternity and motherhood ensures the continuity of humanity and development.

1.1 Maternal Health in Kamwenge District

Kamwenge is a remote, rural district located in western Uganda about 530km west of the capital Kampala.

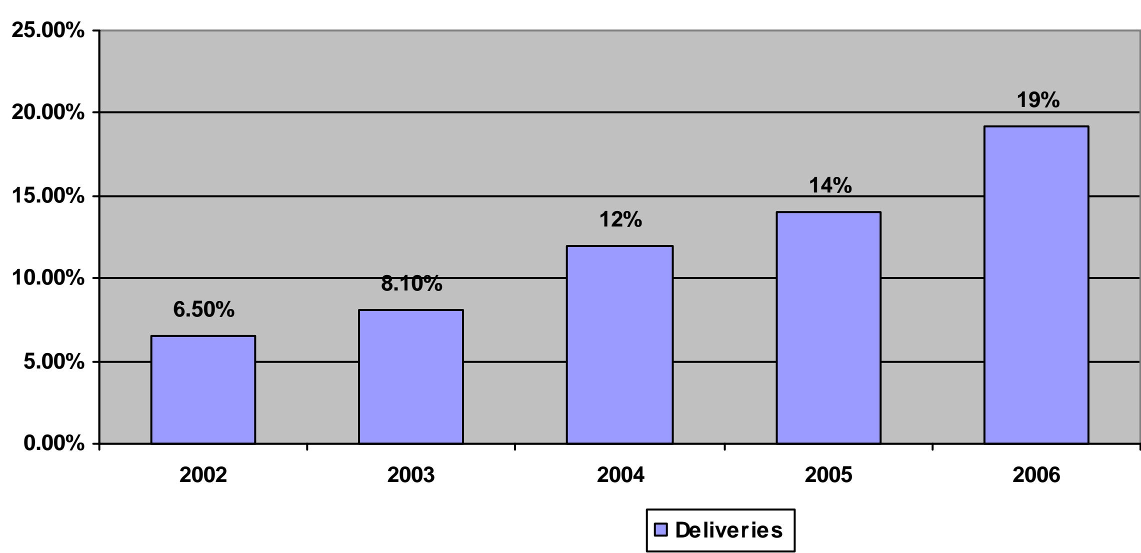
Figure 1: Map of Uganda Showing Location of Kamwenge District

Source: UBOS 2007

As shown in Figure 1, Kamwenge borders with Kabarole and Kyenjojo districts to the North; Ibanda and Kiruhura districts to the East; Bushenyi District to the South; and Kasese District to the West. The district covers a total area of 2,458sq.km, and has an estimated total population of 308,715 people (UBOS, 2005). It is divided into two counties, Kibaale and Kitagwenda; eight sub-counties and one Town Council (with three wards); and 48 parishes.

In Kamwenge, as in other rural districts of Uganda, pregnancy-related complications are among the leading causes of death and disability among women in the reproductive age group 15-49 years (UBOS, 2007). A significant proportion of expectant mothers do not seek antenatal care (ANC) and there is a huge, unexplained disparity between the number of women that attend ANC and the low rates that that actually deliver at health facilities, cited earlier.

Figure 2: Supervised Deliveries in Kamwenge District



Source: UBOS, 2007

According to the Ministry of Health's national health delivery structure, each district should have a hospital, each administrative county (health sub-district) a level-four health centre (HC IV), each sub-county a level-three health centre (HC III), and each parish a level-two health centre (HC II). These different level health centres provide different levels of service

- Health Centre IV provides emergency obstetric care ,antennal care, handles deliveries post natal and immunisation services, health education, has a theatre for general operation but not specialised and general medical services; maternity services including minor operations;
- Health Centre III provides basic primary health care like treatment of simple illness like cough, anti-natal care, deliveries; post natal, immunisation and health education;and
- Health Centre II handles simple illness only like cough, headache, malaria and makes refers .

Kamwenge, however, has a shortfall of health facilities. The district has a total of 27 health facilities: Nineteen are government and eight non government (NGO) owned. It does not have

a hospital but has two referral level four health centres (HC IVs). It does not have a private-for-profit health facility of at least referral-level standard (See Table 2).

Although a HCIV is supposed to have a surgical theatre, only one of the two HCIV in the district has a functioning theatre. Further to the shortage of health facilities, those present lack basic equipment, some lack adequate lighting and most lack and adequate professional staff to manage deliveries. The whole district has only two doctors, does not have a single anaesthetist, and has inadequate health workers trained in emergency obstetric care. As a result expectant mothers are sometimes referred to facilities outside the district for deliveries.

Table 2: Heath Facilities in Kamwenge District

Name of health sub district	**No. of sub-counties**	**Popu-lation**	**No. of Health Units**							
			Referral facility (Hospital)		Referral facility (HC IV)		HC III		HC II	
			Public	NGO	Public.	NGO	Public.	NGO	Public.	NGO
Rukunyu	4	182,533	0	0	1	0	4	2	6	2
Ntara	4	126,182	0	0	1	0	3	0	4	4
Total	**9**	**308,715**	**0**	**0**	**2**	**0**	**7**	**2**	**10**	**6**

Source; Kamwenge District, 2005

1.2 Framing a participatory approach to maternal health in Kamwenge

Kamwenge is one of the districts HEPS-Uganda had prioritised, as findings from prior work on health financing had found it to be one with high levels of vulnerable people living with HIV and expectant mothers and high levels of poverty. Two staff members from HEPS (Aaron Muhinda and Abrahams Mutumba Zahura) attended the training on participatory methods for training and research for people centred health systems convened by EQUINET through Training and Research Support Centre (TARSC) and Ifakara Tanzania in early 2007. Research, implemented in a participatory manner, can itself raise the community's voice and strengthen collective forms of community analysis and organization so people are more empowered to take up their interests in health. The Kamwenge Community Empowerment and Participation on Maternal Health Project was planned and implemented as a follow-up to the EQUINET/ TARSC/ Ifakara regional workshop, to generate skills in using the approaches and new knowledge and action on health issues. The 2007 training focused on strengthening communication between communities and health workers, and the work was implemented as part of a multicountry programme exploring different dimensions of this within the regional network on participatory reflection and action (PRA) for health equity in east and southern Africa in EQUINET.

The overall objective of the intervention was to contribute to the improvement of the health of expectant mothers in Kamwenge Sub-county, Kamwenge District. We aimed, through the use of PRA approaches, to increase demand for, access to and utilisation of maternal health services by expectant mothers.

We chose to do this in Kamwenge District for three major reasons:

- As noted earlier, Kamwenge is ranked by the Ministry of Health as among the 10 poorest performing districts in the 72 nationally in terms of health indicators (Ministry of Health, 2005);
- Kamwenge has amongst the poorest performance on maternal health statistics as noted in the introduction;
- The district is one of HEPS Uganda's "target" districts prioritised for health work (HEPS Uganda, 2005).

With a limited budget and time schedule we aimed to explore and learn from the implementation of the work in Kamwenge sub-county to build a community based approach that could be extended to other parts of the district and other districts.

Specifically we aimed to;

- facilitate the community to identify and analyse barriers to use of maternal health services;
- work with the community to prioritise, identify and implement actions for overcoming one or more of the barriers to use of maternal services; and to
- promote a cordial and mutually respectful relationship between health workers and expectant mothers in the sub-county

By the end of the work we hoped to have

- improved communication and mutual understanding between community members and health personnel on maternal health service utilization in Kamwenge sub county;
- increased community voice and participation in health services through organized joint meetings between community members and clinic personnel to discuss measures needed to enhance use of maternal and child health (MCH) services
- established joint action on identified barriers by communities and health workers, and
- improved the understanding and uptake of MCH services in the community.

2. Methods

The Community Empowerment and Participation on Maternal Health Project involved health workers and community members, including community leaders, expectant mothers, male spouses, and others in Kamwenge sub-county in Kamwenge District.

The two HEPS Uganda staff members who attended the regional training developed a proposal for the work with technical input and guidance from TARSC, both in the steps of drawing experience, reflection, action and review and in the tools used for these steps. The field work was launched in May 2007 and carried out until November 2007, a seven month period.

We began with preparatory meetings, mobilization of stakeholders in the target project area, and selection of community members and health workers involved. The project team facilitating the exercise consisted of four people: three HEPS Uganda staff (two men who had attended the training and a female social scientist with experience in community health) and a

medical officer in charge of a Health Centre IV in the target sub-county. Competencies in the participatory methods were built during the preparatory stage across the whole team.

Participants were drawn from among health workers and the various categories of community members considered relevant to improved delivery of maternal health services. They were purposively selected to ensure each of Kamwenge sub-county's eight parishes – Kyabandara, Nyamashegwa, Kabambiro, Busingye, Kakinga, Kiziba, Ganyenda and Nkongoro – were represented. Rukunyu HC IV, though located outside Kamwenge Sub-county, was also invited to select two participants from among its staff because it receives patients from the project's target area. In all, 42 people were invited for the first PRA workshop: nine health workers; and 31 members of the community, including two expectant mothers, four mothers, four traditional birth attendants (TBAs), nine male spouses/fathers, six local leaders, two representatives from CSOs, two religious leaders, and two media people. Of the 42 participants selected and invited, 40 attended the first, two-day PRA workshop. All the 40 participants at the first PRA meeting were invited for the second PRA meeting, of whom 38 participated together with an additional three uninvited members of the community.

To facilitate the community to identify and analyse barriers to maternal health service utilization in Kamwenge subcounty, activities were held to:

- mobilize grass root women and men, expectant mothers and partners, local leaders, community based organisations, local government leaders, media and health workers; and explain the activity;
- obtain through a simple baseline questionnaire current views on and experiences of maternal health services, and of the relationships between health workers and mothers, and health workers and the community.
- draw out people's experiences of maternal health issues including access to and use of services using PRA tools; and
- identify problems and barriers to maternal health services in the health services, the community and within households using PRA tools.

We then worked with the community to prioritise, act and follow up on one of the barriers identified; probing how the current health services are responding to these problems and to identify potential solutions to the barriers /problems. These formed the basis for discussion and prioritisation of areas of action to take forward after the meeting. The meeting also used participatory approaches to promote mutual and respectful relationships between health workers and expectant mothers in the sub county, to explore the current communication patterns and discuss how they can be improved. A range of participatory methods were used for this, including group discussions, problem trees, stepping stones, role plays, picture codes, ranking-and-scoring, story with a gap, and group discussions. Approaches outlined in the TARSC/Ifakara manual (Loewenson et al 2006) were adapted to suit the local conditions and requirements of the project.

Following the PRA meeting in June 2007, a range of actions were implemented within the process, including a training of trainers workshop for community volunteers; a training workshop for health workers in communication skills and the rights of expectant mothers, implementation of a feedback mechanism based on suggestion boxes placed at six health centres; a public dialogue on the plight of expectant mothers and the delivery of maternal health services, aired on a local FM radio station; and distribution of HEPS Uganda's standard maternal health rights and responsibilities community training manuals to community trainers and sensitization posters about maternal health rights were produced and distributed..

The action plan was monitored by the facilitators. After four months of implementation, in November 2007, the same group was gathered in a feed back meeting to review the outcomes and the simple baseline questionnaire administered at the beginning completed by all participants to assess how people's perception and views had changed.

3. Implementation and results

3.1 Mobilisation and networking

The mobilisation of local and community leaders, civil society organisation (CSOs), district officials and health workers started early May before the first PRA meeting. It was part of the pre-launch activities aimed at promoting the project and its objectives to stakeholders. The first contacts in the project area were: the District Director of Health Services Dr Sarah Kasewa, District Health Educator Mr Sam Kahirita, and the District Senior Clinical Officer Mr. George Byaruhanga (who is now HEPS Uganda's District Mobiliser for this project). It was with these people's support that HEPS Uganda organised a formal meeting with the relevant district officials.

The meeting, held 31st May 2007, was attended by nine district leaders and three HEPS Uganda staff:

- Chief Administrative Officer, Mr. Nyakahuma John
- LC 5 Chairperson, Mr. Musingye Edward
- District Speaker, Mr. Agaba Rwabilingi Tom
- District Secretary for Health, Ms Alimpa Aulia Rugumayo
- District Health Officer, Dr. Sarah Kasewa
- District Health Team – consisting of staff of the district health department
- HEPS Uganda staff Mr Aaron Muhinda, Mr Abrahams Mutumba, and Ms Joyce Mugarura

During the meeting, HEPS Uganda staff presented a briefing about the project. The district leaders welcomed the project and pledged to work with the project team during implementation. They expressed hope that it would supplement the existing efforts to improve the health situation in the district, including sensitising a vulnerable group, the expecting mothers, about the importance of using the services available in the district. The district officials stressed the need to identify why women do not deliver in health facilities and promised to work with the project team to ensure that more men give support to their wives during pregnancy and delivery.

The LC5 Chairman warned the team against using the abbreviation "PRA" in Kamwenge District as the population was still recovering from the havoc and trauma caused by the People's Redemption Army (PRA), a rebel group that operated in western Uganda in 2000 that unleashed terror and caused a lot of suffering, before it was defeated in 2002.The project team used the word "participatory" in place of "PRA" in the course of implementing the project. (We have used the term "PRA" in this report as we have made clear what the abbreviation stands for. In our briefings to the community we will avoid this term but also explain the different meaning if they see it in other literature).

In implementing the project we worked in partnership with other CSOs, particularly Samaritan Purse, a CSO, whom we consulted and involved in the first PRA meeting and UNICEF whom we consulted during the pre-project launch mobilisation activities and who donated obstetric care packages called "mama kits" to the health units in Kamwenge District.

3.2 Pre-test Questionnaire

At the beginning of the first PRA meeting, a pre-test questionnaire was administered to and completed by all participants attending to assess current views and experiences on maternal health service and health worker- community relationships in the sub-county.

Responses to the questionnaire indicated that the expectant mothers, men, community leaders and health workers in the meeting recognised problems in Kamwenge's maternal health services, with near unanimous agreement (94%) that women have major problems when they get pregnant, cannot afford health services and cannot easily get to services (91%). While the health services are seen to provide good support to pregnant women (60%), women were seen to face many barriers to using services (63%). For women who do reach services, the respondents felt that health workers and community members do communicate reasonably well (54%), as do health workers and expectant mothers (54%) and that health workers respect the community (60%).

At community level, a majority felt that women do not get sufficient support from the family when they are pregnant (77%), and only 49% felt the community give good support to pregnant women (See Table 3).

Table 3: Participant responses to the baseline questionnaire, N=35

Question	Response		
	Agree	Disagree	Don't Know
	%	%	%
Women in our community have no major problem when they are pregnant	3	94	3
Pregnant women in our community easily get to health services for pregnancy and delivery	6	91	0
Pregnant women in our community can afford the health services for pregnancy and delivery	6	94	0
The family (husband, children) give support to women when they are pregnant	17	77	6
The community gives support to women when they are pregnant	49	49	6
The local health services (health workers) give good support to women when they are pregnant	60	40	0
Women face many barriers to using the local health services when they are pregnant and for delivery	63	31	6
Our community is aware of the health problems women face during pregnancy and delivery	77	22	0
Our community is doing something about women's problems during pregnancy and delivery	80	17	3
Our local government is doing something about women's problems during pregnancy and delivery	66	31	3
Health workers in this area listen to and respect the community	60	34	3
In this area health workers and the communities communicate well with each other	54	40	3
In this area health workers and expectant mothers communicate well with each other	54	37	3

In what appears to be a contradiction, 77% felt that the community is aware of the problems women face, 80% claimed that the community was doing something about women's problems during pregnancy and delivery, and 60% claimed that the local government was doing something. Participants from community and leadership roles responding may perhaps have had some bias in wanting to be seen to be doing something about the situation.

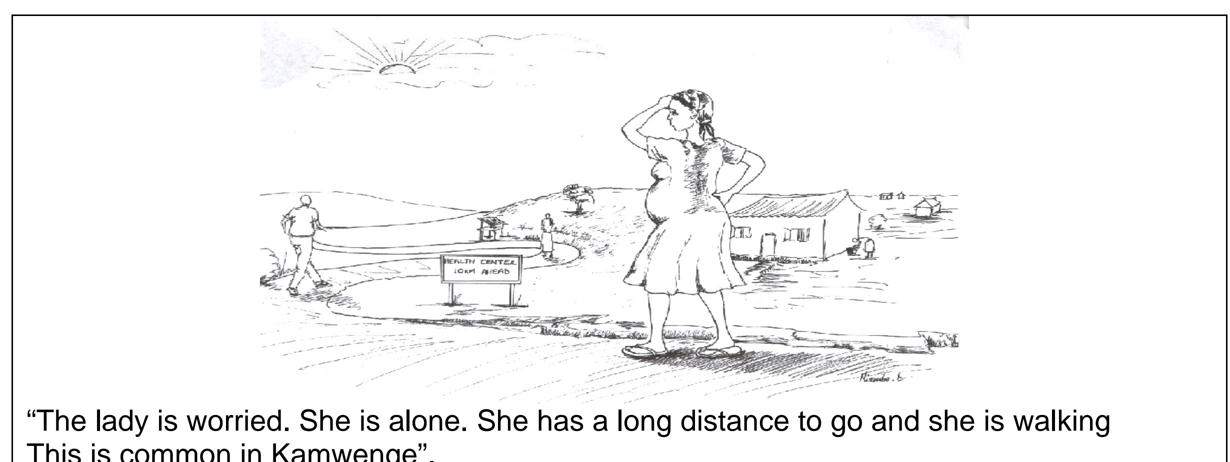
3.3 The first meeting: Drawing community experiences and priorities

After the baseline questionnaire, participants at the first PRA meeting introduced themselves and gave their expectations.

Most of these expectations were broadly in line with project objectives, perhaps influenced by the pre-launch mobilisation activities and the pre-test questionnaire. Participants were eager to understand the barriers to demand and use of maternal health care services in Kamwenge District, particularly the reasons for fall off between use of antenatal care (ANC) and delivery at health centres. One expectant mother said she was looking forward to explaining the challenges they face in accessing health care so that these could be addressed, while other participants were excited to exchange learning and knowledge, and local leaders to listen to people's problems. None mentioned the relationship between health workers and the community. On the other hand some participants expected HEPS Uganda to unveil a major and probably well-funded intervention to improve the maternal health situation in Kamwenge District.

The picture codes used to draw out people's experiences of maternal health are shown in Figure 4. These picture codes were hung against the walls and participants invited to view and discuss what they saw, the issues for pregnant women, and how they interpreted how this reflects their own situation or not and what could be done about the situations they saw. The participant discussions are summarised under the codes.

Figure 4: Picture codes on maternal health and their interpretations



"The lady is worried. She is alone. She has a long distance to go and she is walking
This is common in Kamwenge".

"The woman is being carried on stretcher over a long distance. There is not enough support, and people have problems of poor roads. This is also a problem in our area".

"The mother at this health centre is in labour and bleeding. She isn't attended to though her case is clearly an emergency. She seems to have travelled along distance and this may have been one of the causes for her current condition (miscarriage). Expecting mothers are in a long queue. This scenario is common in Kamwenge; health workers are few and patients have to stand in long queues and emergency care is insufficient".

"Pregnant woman are being sensitised on the use of a mosquito net. The woman is being told to buy some of the necessary items she did not come with. Because the expectant woman did not have come with all the necessities the health worker is questioning her. The health work is talking rudely to the expectant mother. In Kamwenge pregnant women were once given free mosquito nets by the district administration and taught how to use them. However, very few women go for deliveries well prepared, that is, with obstetric care packages (mama kits). This often provokes rude reaction from health workers".

"The mother is worried about the bill she has received for care. This happens with in both the conventional health centre and with traditional birth attendants". One person mentioned that "the woman's husband was in a bar drinking and not at the hospital clearing the bill", a practice that some felt was happening, even when women are in labour

"The woman appears tired, yet needs to go to health centre. She is in a dilemma since she has either to stay home and feed her family or go for care at the expense of her family. This definitely happens in Kamwenge".

Participants were excited about the picture codes, sharing their experiences and applying their local interpretations. For example, in the fourth picture about communication between expectant mothers and health workers, the mosquito net became a central issue and the picture was seen to be about the health worker explaining use of the mosquito net because mosquito nets were distributed in the district to expectant mothers with information on how they are used. Most importantly, the picture codes created an open interaction between participants, with some contributions drawing laughter and allowing issues to be raised, such as the report of husbands drinking instead of paying health care bills in picture 5.

The process suggested that maternal health services in Kamwenge subcounty are insufficient or inaccessible (expectant mothers stressed by long distance walking, few and distant facilities, with long queues, few health workers leading to poor service quality). People felt that some mothers face health issues like costs or distance to services with limited support from families or community and that this can be a barrier to services. While the community acknowledged and clearly remembered outreach services like the distribution and explanation of mosquito nets making outreach important in this community. At the same time they observed that health workers can be rude to mothers when they forget their "mama kits".

We read a story with a gap to participants in the local language (Runyankole) (See Box below) Participants filled the gap between the first and second part as a way of further drawing out their experiences about maternal health issues in the sub-county.

PART ONE
In the village of Kotuku lives a lady named Sheila. She is married to a man whose name is Peter. Peter is always away from the village to do business in the capital city. Sheila is pregnant and expecting her first child. She has had a few problems with her pregnancy but is generally very happy and excited about the prospect of having a baby.

PART TWO:
Sheila is in hospital. She is weeping. A neighbour is with her. She has had a miscarriage and lost her first baby.

The story provoked an emotional response in participants and elicited experiences that demonstrated the misery that women who do not get sufficient support from their male partners go through when pregnant. One female participant reported that she had been forced to go to a traditional birth attendant (TBA) to deliver because her husband did not have the means to support her to go to hospital when her labour started. She said that TBA's were more understanding, as they could provide their services on credit and sometimes free of charge if convinced that one is really unable to pay. She said she had often heard about how midwives harass women in labour.

"I was reluctant to go to hospital as the health workers are rude. The traditional birth attendants were good enough to help me deliver. Besides this, the hospitals are far"

Female community participant

One health worker said he is often forced to refer patients who need surgery to health facilities outside the district because although Rukunyu HC IV, where he works, has a theatre, it cannot carry out operations because it lacks an anaesthetist. While the facility has an ambulance to transport emergency cases to where they can get appropriate attention, many times patients are unable to raise money for fuel as required by the cost sharing arrangement. The situation is worse when women come alone or without their husbands or someone who can pay this cost if needed.

At the same time, one health worker observed their heavy workload, which he attributed to understaffing.
"The stress from overload makes health workers irritable and sometimes rude to expectant mothers who come to deliver without the necessities such as mama kits. Kamwenge is a remote place for health workers, without housing facilities or extra motivation, and not many well-qualified health workers are willing to take up a job in the area"

Health worker participant

In discussing the gap it emerged that participants felt that it is common for women to go through pregnancy without support from their partners or relatives, to have problems with money and with affording transport to the nearest health facility in cases of emergency. They thus deliver at the health facility at the last hour or use traditional birth attendants who are more flexible about payment and more accessible. Sometimes husbands are away when women are in labour and they have to be attended to by neighbours. This means that if they need money for referrals this is not available.

Poor relationships between health workers and mothers are also a barrier to women using services. At the same time health workers feel overworked due to understaffing and stressed by poor facilities.

People felt that women needed information about their health and what they need to promote their own health. At the same time they felt that the government should improve the health care at the hospital, that organisations like HEPS should sensitise the community about the need to deliver in the hospital and the local administration needed to improve the road networks.

Participants raised barriers to maternal health within the household, the community, and within the health services. These barriers were further discussed in groups, with one group each discussing the barriers at household, community and health service level respectively. Notably the groups overlapped in their discussion as the levels themselves overlap.

Within the health facilities the problems identified included the lack of on-site accommodation for staff, so some staff stay far away and are not given transport allowances. They too face bad roads and thus have difficulty reporting on time. There is a critical shortage of skilled manpower, leading to heavy workloads, and a lack of basic resources like drugs. This situation causes low morale among health workers, leading to absenteeism or late coming. Some nurses become rude when stressed by heavy workloads and this can scare away expectant mothers who come without the required basics. At the same time high levels of poverty among patients, particularly among expectant mothers, make it hard to afford even such essential items as obstetric care packages (mama kits) and other basics required at delivery.

Within the community, environmental problems were identified, like bad, untarred roads, making it difficult to get to distant health facilities, and social problems like community members not appreciating the need for women to deliver in health services, or cultural beliefs, such as grand mothers improvising with traditional and herbal treatments. These barriers are made worse by the scarce, inaccessible and poorly equipped and staffed health services and reduce the motivation to use these services. Two further social factors affect this. One the one hand traditional birth attendants are competing for clients and can deliberately or inadvertently keep clients too long that need emergency care. At the same time poor knowledge and communication on maternal health within the community, including with husbands and relatives, leaves people less well informed about these choices.

In the household the problems of poverty, social roles, relationships and knowledge were raised. Many households are unable to afford to access health care, even when it is free of charge at the point of care and households poorly plan for the costs associated with pregnancy and delivery. Mothers are burdened by their multiple roles; they have to choose between going for ANC and their domestic responsibilities and unfortunately sometimes ANC comes second. There are also negative attitudes: towards busy health workers, towards health services as being unnecessary for deliveries except for emergencies, or by male partners and husbands not giving expectant mothers the support expected, such as in meeting the costs of obstetric care kits. Domestic violence stemming from gender inequality and male dominance affects communication among spouses about pregnancies and any issues arising.

A Problem Tree Analysis was used to probe the causes of the problems identified, although with some difficulty as the participants found discussing “causes of the causes” using a problem tree difficult to relate to. Delegates observed that poor funding, outmigration of health workers and the remote nature of Kamwenge leads to understaffing. Poor tendering and procurement processes were identified to affect health infrastructure and supplies, together

with corruption and misuse of public funds meant for infrastructure, logistics and supplies. It was felt that the local authorities do not give maternal issues the priority it deserves and do not adequately involve or consult stakeholders including communities in planning and implementing health programmes.

At the same time poverty, poor education and low awareness about ANC care by expectant mothers and their spouses, was leading to the community and household level problems identified. Gender inequalities were also seen to affect this.

Finally within the same three groups, participants proposed solutions to the problems they had identified.

Within the Health Unit, suggestions were for

- Hospital management committees to strengthen supervision and follow up processes and to fight corruption at all levels
- Government to provide logistics and supplies for the effective delivery of health services to expectant mothers
- Government and health authorities to involve stakeholders from grass root and community levels in planning and budgeting for primary health care
- Regular meetings between staff and management to be systemised to involve all health staff in planning and to allow for information feed back
- Health workers to sensitise and counsel expectant mothers attending ANC and other maternal health services about the importance of delivering at health centres
- Health authorities to put in place a complaint handling/redress mechanism to handle patients' concerns. Suggestion boxes to be institutionalised to enable users to share their views including complaints and/or compliments
- Sensitisation of health workers on people's health rights and responsibilities

Within the community suggestions were for

- Improved available modes of transport, that is, the ambulances maintained in good mechanical condition and provided with enough fuel
- HEPS Uganda and other civil society organisations (CSOs) to work together in cooperation with local leaders, the community and health workers to sensitise the women in the reproductive age group on good health practices, including seeking maternal health care and delivering under the supervision of skilled/professional individuals
- Improvement to the roads, to make it less difficult for expectant mothers to travel to health units
- Government to help community members to start micro finance schemes or micro health insurance schemes to empower them to contribute to their own health care
- A bottom-up approach in the planning process in which all stakeholders are involved
- TBAs to be trained in basic health knowledge and sensitised on the need to refer emergency cases to formal health facilities

Within households, suggestions were for

- Government and local leaders to help households initiate income-generating activities to give them the capacity to play their part in maternal health, e.g. by effectively preparing for deliveries
- Local leaders and CSOs to sensitise household members about the need for expectant mothers to deliver in the health facilities

- Expectant mothers and their spouses to give maternal health the priority it deserves and plan for their pregnancies and deliveries. Expectant mothers should fulfil their responsibility by seeking ANC and follow every instruction as given by the health workers
- Men to support and communicate with their spouses before and during pregnancies

3.4 Identifying follow-up actions

Working in the groups, participants at the first PRA meeting prioritised two problems they considered most critical at each of the levels using the ranking and scoring method.

- Group 1, which was analysing the problems at the health service level, came up with inadequate health care facilities and negative attitude of health workers.
- Group 2, analysing barriers at the community level, identified poor transport facilities and poor understanding of the importance of expectant mothers to deliver in health facilities.
- Group 3, analysing problems at the household level, identified poverty and inadequate support from male spouses during pregnancy.

Participants using the ranking and scoring method — *A participant takes notes as groups present their work, Kamwenge*

Source HEPS 2007

Having identified potential solutions in an earlier activity, the two most critical problems were listed on a flip chart and participants selected the problem/barrier they would like to work and follow-up on together with HEPS Uganda in order to help improve the maternal health situation. The facilitator explained to the groups the need to choose a problem that could be addressed in a participatory manner; result into an improved health situation for expectant mothers; and was within the target area, project budget and time. The groups used the ranking and scoring method to determine the barrier to act upon at each level.

- Group 1 identified limited awareness on the side of the community about the importance of expectant mothers to deliver in health facilities as the barrier to act on;
- Group 2 identified the barrier of negative attitude of health workers; while
- Group 3 identified inadequate support from the male partners to expectant mothers.

Health workers, local leaders and the community in separate groups used the Stepping Stone method to identify which stakeholders and actions were needed and how people could work together on this. In the final work plan, the following major activities were agreed upon:

1. Sensitisation of the community to be done by the volunteer community trainers, and overseen by HEPS Uganda
2. Sensitisation of health workers about the health rights of expectant mothers by HEPS Uganda and the District Health Team. Progress on this activity was supposed to be monitored by the health centre management committees, which were already holding weekly meetings to review issues relating to their respective health centres
3. Establishing a complaints redress mechanism, by HEPS Uganda and Health Centre Management Committees, overseen by the In-Charges of Health Centres
4. A public dialogue organised by HEPS Uganda in partnership with the District Health Team and to involve the volunteer community trainers and members of the community to the debate maternal health issues in Kamwenge

After drawing the work plan and allocating roles and tasks a role play was used to raise issues of how people would work together and the way different groups affect each other. The role-play had "four situations" namely;

- Lose/lose (where a health worker has a positive but community has negative attitude)
- Lose/lose (where the health worker is negative but community is positive)
- Lose/lose (where both have a negative attitude)
- Win/win (where both have a positive attitude)

As groups acted out the four situations it emerged that in order for expectant mothers to demand and use maternal health services it was also necessary for health workers and communities to communicate and relate better producing a win/win situation for all.

Participants at the first participatory meeting
Source: HEPS Uganda 2007

4. Implementing the action plan

The allocation of roles in the action led all the institutions identified, including the community, to carry out various activities.

4.1 Community sensitisation on maternal health

For community sensitisation, HEPS Uganda prepared training materials, trained volunteer community trainers, who in turn facilitated discussions and gave information and materials at local council village meetings, women groups, burials/funerals, marriage ceremonies, worship occasions and in visits to households, especially those with expectant mothers. HEPS developed materials for community training on health rights and responsibilities on maternal health and posters on maternal health, distributed through volunteer trainers and health workers.

Four hundred and fifty posters were printed and distributed on maternal health rights in English (see poster) The poster passed a simple message: expectant mothers need support from their male partners, and good attention from health workers.

HEPS Uganda's community training manuals were modified to address the objectives of the maternal health project in Kamwenge and the issues raised in the PRA meeting by the community and health workers. These are guides for use by community leaders to create awareness among the community. The manuals contain guidelines on how to organise a community outreach training, setting target groups, maternal health rights and responsibilities, an evaluation form and illustrations to ease explanation and understanding. Forty copies were distributed to volunteers trained, mostly grass root leaders. The volunteers put posters in strategic locations in their localities and carried out follow-up sensitisation activities at the community level. Posters were also given to health workers who attended the sensitisation workshop and to the district and sub county administration for their offices.

Thirty five literate local leaders, five (three women and two men) from each of the eight parishes of the target sub county, were trained by the project team using the materials developed taking the issues raised in the PRA meeting into account. These grassroot leaders were members and executives of Local Council I's and Local Council II's, heads of women groups, religious leaders, and TBAs. The volunteers were tasked to train expectant mothers and their husbands on their maternal health rights and responsibilities in their localities. The trained group constituted themselves into Parish Maternal Health Support Teams, whose members were to work together to sensitise and support expectant mothers and their partners in their respective parishes on maternal health rights and responsibilities.

Trainees in a group discussion
Source: HEPS Uganda 2007

Working under the two Parish Maternal Health Support Teams and individually, they used forums like village meetings and community gatherings to talk to community members, and expectant mothers and their spouses about maternal health rights and responsibilities.

Religious leaders used church sermons. Involving local leaders particularly seems to have been important, as one participant at the second PRA meeting noted:

> *"The community respects and listens to their local leaders, involving them (local leaders) in all the planning and sensitization (of communities) is very important; you are sure (your) message is delivered to the masses – it's worth targeting them."*
>
> Enrolled midwife Kamwenge

The volunteers distributed materials to the communities to build awareness; and supported the installation and encourage use of suggestion boxes at six health facilities to improve communication between health workers and expectant mothers and other health consumers.

As a result of their activities, various sections of the community formed groups, reactivated those that were no longer functional, or strengthened existing ones, where their members share, learn and discuss issues that concern their community, including maternal health. In Kabambiro parish, the Mothers Union, a grouping well placed to influence the health seeking behaviour of expectant mothers, for example increased its membership from 30 to 50. The volunteer community trainers used these fora to create awareness among various sections of the community about the importance of expectant mothers delivering at health centres, planning for pregnancies by both female and male partners, and the importance of husbands supporting their wives when they are pregnant.

These Parish Maternal Health Support Teams provide an important entry point for community-level interventions to improve maternal health and will form the basis for sustainability of the project's interventions.

4.2 Sensitising health workers on community issues and maternal health rights

For health worker sensitisation, HEPS Uganda developed materials and with the District Health Team held a half-day sensitisation workshop for health workers from the various health centres in Kamwenge Subcounty. Two health workers attended from each of the six health centres as well as the District Director Health Services, the District Clinical Officer, and the District Health Educator. The workshop aimed to sensitise health workers on maternal health rights, communication skills, and the importance of having a feedback/redress mechanism at health centres.. Most of the health workers who attended the sensitisation workshop had also attended the first PRA meeting, and the content was shaped and informed by the deliberations of this meeting.

The meeting was presented with the issues raised in the PRA meeting, including issues such as the mistreatment of or poor communication with expectant mothers. They recognised the need to improve services, but also observed the challenges they face in their work: They lack uniforms/name tags, which makes it difficult to differentiate them from patients. They lack accommodation at health units and commute long distances makes it difficult for them to keep time or even to fail to report to work when the weather is harsh. They are rarely appraised and there is no provision of refresher courses or further training and they have heavy work loads because of understaffing, leading to fatigue and stress. They appealed to the district and government to address these issues.

As a way forward, the health workers made various plans. They agreed to

- set up a District Health Workers Club where they would meet quarterly to share experiences and learn from one another, discuss progress on their concerns,

- Improve their attitude to and communication with patients and expectant mothers, sensitising them on their maternal health rights and responsibilities, and encouraging them to come to health units for delivery
- Hold weekly meetings at their respective health units to discuss the comments from the suggestion boxes and act upon them

They urged the project team to sensitise the community about maternal health rights and responsibilities and to forward their concerns to district officials and higher authorities, to advocate for improved working conditions for maternal health workers.

'Surely I did not know the rights of expectant mothers but now I know '.

Health worker Rukuya HC IV

Health workers during a training session *Participants pose for a photo at the end of training*

Source : HEPS Uganda 2007

4,3 Setting up a complaints redress mechanism

A complaints redress mechanism was proposed in the PRA workshop, with suggestion boxes procured by HEPS Uganda and distributed for installation at health centres by the health centre management committees, under the leadership of the In-Charges of the respective health centres. The health centre management committees were to review and respond or address the complaints and compliments received at their weekly meetings. Any decisions reached were to be communicated to the district health educator, to pass on to the community through routine education sessions across the district; to the nurses involved in district outreach campaigns to communicate to mothers and through the weekly antenatal services.

These suggestion boxes were consequently procured and installed at the six health facilities as a channel to receive complaints from expectant mothers and other health consumers. They were proposed as a useful mechanism for expectant mothers and healthcare consumers to freely raise complaints such as about the services provided and the staff's attitudes, without being victimised or singled out for negative treatment.

For a period of two months at Kamwenge Health III five suggestions were picked. from the box and analysed. The issues raised by expectant mothers covered primarily the long lines and delays during anti-natal care and the mandatory maternal requirements being a burden to poor and vulnerable expectant mothers. The health management committee resolved to ensure poor and vulnerable expectant mothers be given first priority of getting free maternal kits.

"*During our weekly meetings, we agreed to treat poor expectant mothers differently , we don't force them to buy mandatory mama kits but rather encourage them to at least be prepare for labour "*

Health worker kamwenge H CIII

A request received through the suggestion box that women who could not afford to buy the mandatory detergent was discussed with a recommendation that the requirement be relaxed.

> *"All expectant mothers are supposed to buy detergent like Omo and Jik when they come to delivery, however with the complaint from suggestion boxes that poor expectant mothers, who cannot afford be pardoned, we discussed it in our meetings and agreed to handle differently."*

Head Midwife, Kamwenge HC III

The experience suggested however that as most of the Kamwenge population is still illiterate, especially expectant mothers, the suggestion boxes are not easily used by these communities. While sensitisation by health workers and community volunteer trainees will continue on their use, other methods will also be explored for how to regularly raise community issues with health services.

4.4 Public dialogue on maternal health

The PRA meeting proposed that a call-in radio talk show be held on a local radio station.

A public dialogue aired live on a local radio station, Efurembe FM, was held to debate and raise awareness on maternal health issues in Kamwenge Subcounty. Efurembe FM is a privately-owned local radio station based in Kamwenge town, with a coverage extending to beyond Kamwenge District, to neighbouring Fort Portal, Bushenyi, Ibanda and Mbarara districts. The radio is more often listen to by the majority of the masses who own radio sets, because it is the only radio based in Kamwenge and broadcasts in the local language. The other radio stations with a coverage in the district are based in other districts and do not have as much mass appeal as Efurembe FM.

There were three panellists, one from Kamwenge District Health Team, one volunteer trainer and one member of the project team, who discussed the situation of maternal health rights and responsibilities in the subcounty during an evening call-in programme.

5. Review of the process and outcomes

5.1 Participatory review

The second PRA meeting reviewed the activities and their impact, and gave participants the opportunity to share experiences and perspectives on the results. In total, 43 participants attended the workshop. They included 30 trained volunteers of grass root women and men leaders, religious leaders, 10 health workers and three other participants who did not attend the first PRA workshop.

Of the fifteen health workers who attended the health workers' sensitization workshop, ten attended the second PRA meeting, where they shared their experiences and gave their feedback about their weekly meetings to review and respond to complaints received through suggestion boxes, strengthened hospital management disciplinary committees and communication about the need by health workers to respect the rights of patients.

The participants observed that attendance at health services had increased. For example at Kamwenge HC III and Padre Pio Clinic (a private facility in Kamwenge town), the increased number of women attending ANC and supervised deliveries in Kamwenge and the increased deliveries at Padre Pio in the intervention months of June to November is shown in Table 5.

Table 5: ANC Attendance and Supervised Deliveries at Kamwenge HC II and Padre-Pio Clinic, 2007

Health Unit	**Kamwenge Health Centre Unit III**		**Padre Pio H centre**	
Month	**ANC**	**Deliveries**	**ANC**	**Deliveries**
January	238	4	44	2
February	258	9	55	3
March	-	4	66	6
April	-	5	65	7
May	-	8	71	4
June	238	18	67	7
July	240	12	76	9
August	258	6	79	8
September	277	2	76	6
October	307	5	76	6
November (by 20th 2007)	489	44	58	9

"Because of the maternal health sensitization going on in the community, we handled more deliveries this time in August."

Head Nursing Midwife, Kamwenge HC III

Participants also reported that the health care quality of expectant mothers improved at health care units. For instance, Kamwenge local government health department, with support from UNICEF, distributed over 700 mama kits (gloves, medicine, Macintosh paper, detergents, cotton wool, capella etc) in the month of October 2007. It was noted that the health infrastructure remains poor with only two health sub-districts and only one, Ntala HC IV, able to carry out operations. Emergency cases continue to be referred to facilities outside the districts. Nurses still do not have uniforms and still commute from their homes which are far from health centres, leading to continued late-coming, especially during rainy seasons. The road network is still poor; during the rainy season some roads become impassable, making health centres inaccessible to sections of the population.

Health workers and community members shared experiences on how the suggestion box-based redress mechanism was working. Participants noted that the mechanism had narrowed the communication gap and improved the relationship between the two sides. It was felt that complaints handling needed to be improved, especially as to who should open the boxes and how to handle them, as they can be manipulated if a complaint touches the person opening the boxes.

"HEPS campaign and UNICEF support of distribution of mama kits to health units have improved the maternal health of expectant mothers in the district is, we will document the impact in our end of year district health performance report."

DDHS, Kamwenge District

Participants at the 2nd PRA meeting *A participant presenting to the plenary*
Source: HEPS Uganda 2007

The willingness among people to support maternal health care in the district has risen. At the end of the project, the community grass root leaders were more willing to take up the challenging role of sensitizing their masses, commitment of health workers to respect the maternal rights of expectant mothers and district officials support to the project. This gives the project interventions a foundation for sustainability.

Specific steps had been taken to improve relationships between the community and the health system. Training and sensitization of traditional birth attendants was re-introduced and improved. Kamwenge has two sub-health units namely Ntala and Rukunyu and the responsible doctors of each unit took responsibility for sensitising the TBAs, who were trained on how to refer expectant mothers in cases of emergences and make recordings.

Participants unanimously agreed that there had been an improvement in maternal health awareness in the sub-county. They attributed the achievement to the maternal health sensitization campaign through trainings, posters and radio dialogues. Participants who had listened in to the radio programme felt its impact had been positive. They suggested that more talk shows be held to increase awareness and encourage stakeholders to address maternal health issues, and to use it as a platform where members of the community can raise their complaints to health workers and authorities and get direct responses from them.

There were however still some areas raised that needed further change within the community. Household poverty is still high and families continue to find difficulty in fulfilling their basic needs and find maternal health care unaffordable when it comes to transport to attend antennal care and buying mama kits.
Some remaining problems relate to social factors. Planning and saving for pregnancy is still poor. Male support to their partners is still very low. Out of 30 women who come to hospital on average only three come with their partners. This was attributed to the negative culture where men who go with their wives to hospital are despised by fellow men and are looked at as being redundant and over protective of their wives. Some expectant mothers still refuse to consent to VCT services and many of those who accept refuse the results. The ones who refuse prefer to deliver in hiding under the guidance of the TBAs rather than at the health services. The number of men attending PMTC services is very low and because of this, the majority of women deny or fail to disclose the results to their partners. Expectant mothers still default on some of their maternal health responsibilities. Expectant mothers are supposed to take anti-malaria medication during ant-natal care, but many women refuse to take them,

saying that they make them weak, and are reluctant to discuss issues of family planning with health workers.

Commending the positive changes the participants observed that these need to be sustained, specifically by

- expansion of the maternal awareness sensitisation campaign by training more trainees and reaching out to other neighbouring areas;
- the project team keeping in contact with the trainees and work with local civil society and non government organisations to update the community on maternal health issues
- giving transport refunds to TBAs when whey bring records to the hospital, and providing them with emergency mama kits
- involving leaders at all levels to mobilize and sensitize people about PMTC services, promote partner attendance and penalise those partners who refuse to attend PMTC services

As noted in the discussion above, some remaining challenges were identified

- In the health infrastructure, poor road network and support to nursing staff for local accommodation or transport and uniforms;
- In the procedure for handling complaints from the suggestion boxes;
- In the uptake and follow up by women of VCT services, their compliance with antimalaria medication; and
- In the male attitudes towards and support to partners when they attend maternal health and PMTCT services.

This implies the need to deepen this process and its leadership within the community itself, supported by HEPS Uganda, backed by the sensitisation campaign on maternal health, and to give more time to addressing maternal needs of expectant mothers by all in the district. It was also felt that Kamwenge District Administration needed to respond to the health workers needs to see how these could be addressed to improve service delivery.

5.2 The post-test questionnaire

A post-test survey questionnaire was administered to participants at the second PRA meeting, to provide a further assessment of the changes arising from the intervention. All the participants that had attended the first PRA meeting and completed the pre-test questionnaire completed the post test questionnaire (35) and those that had not attended the first PRA meeting did not. The responses to the pre- and post-test questionnaires are summarised in Table 6.

The pre and post test comparison suggests that some areas had little change: Report of the level of maternal health problems remained high, women were still reported to face many barriers to access services and the level of reported community support remained the same.

However in other areas changes was noted. Positive change was noted in ease of access to and affordability of services, in communication between community and health workers and the respect shown by health workers, in the support given by health workers and families, and in awareness and action on maternal health in the community. The strongest positive changes were noted in the communication between health workers and pregnant women, and this seemed to be the area of greatest impact of the intervention.

Table 6: Comparison of pre and post test questionnaires, Pretest N=35, Post test N=35

Question	Answer			
	AGREE		DISAGREE	
	% pre test	% post test	% pre test	% post test
Women in our community have no major problem when they are pregnant	3	6	94	91
Pregnant women in our community easily get to health services for pregnancy and delivery	6	11	91	89
Pregnant women in our community can afford the health services for pregnancy and delivery	6	22	94	77
The family (husband, children) give support to women when they are pregnant	17	40	77	60
The community gives support to women when they are pregnant	49	51	49	48
The local health services (health workers) give good support to women when they are pregnant	60	71	40	29
Women face many barriers to using the local health services when they are pregnant and for delivery	63	68	31	31
Our community is aware of the health problems women face during pregnancy and delivery	77	86	22	14
Our community is doing something about women's problems during pregnancy and delivery	80	91	17	2.9
Our local government is doing something about women's problems during pregnancy and delivery	66	80	31	20
Health workers in this area listen to and respect the community	60	89	34	5.7
In this area health workers and the communities communicate well with each other	54	89	40	2.9
In this area health workers and expectant mothers communicate well with each other	54	94	37	5.7

It would appear that in the perception of the community and health workers in the area, the participatory intervention has fostered a more cordial, mutually respectful relationship between health workers and expectant mothers and the community. While there remain issues to address to generate such improvements in access to and quality of care and in community attitudes and responses, the overall positive changes signal that the groundwork done in this first phase has been positive. The slower changes in these areas signal both the time it takes to make changes in these areas and the need for future work to focus on both health service quality factors and community processes.

Participants after the 2nd PRA meeting
Source: HEPS Uganda 2007

6. Reflections, lessons learned and next steps

Beyond the changes in communication between health workers and community and in access to and use of maternal health services noted in the previous section, the participatory intervention also provided some insight on the process of change as viewed by the project team and the participants.

The participants generally found the process interesting, effective and enabling. In the first PRA meeting, participants said that the process was a unique and effective way of gathering information, planning and acting on challenges facing communities at the grass root level. They complained that the two days allocated were not enough to exhaust all issues that came up in the sessions and give time for their contributions. They felt the meetings to be a good approach and requested HEPS Uganda and the health and local authorities to roll it out to other sub counties of Kamwenge District.

"…*two days are not enough; it should have been at least four days*".

Meeting participant

Undertaking a participatory community project where some participants are illiterate requires certainly more time to be allocated for interactive sessions to allow for translations and interpretation and sometimes lengthy explanations by people about their experiences. While the time frames for this initial exercise were determined to provide an opportunity for learning and mentoring from a pilot, an intervention of this nature also needs more time to be able to assess to real and long term impact of participatory approaches and interventions. We would regard this as a first step in a process that has many more steps ahead.

We saw the value of involving decision makers and community leaders in activities aimed at communities. In the second PRA meeting, participants pointed out that activities to sensitise the community were successful as they were implemented through local leaders, whose messages were taken seriously because of their leadership and authority. While the project team played a key role in facilitating this first step, we realise the need to deepen this involvement of and leadership by the local community to sustain and deepen the programme and the social changes yet to be produced within the community, with the support from the project team.

This balance between local initiative and institutional support is important. For example, community workers need skills in managing expectations from community members, who often assume that every intervention is meant to deliver cash or solve all their problems, personal and otherwise. We learned that community workers need to be extra patient and elaborate in communicating and clarifying the objectives of their interventions to dispel inflated expectations and yet still maintain community motivation in supporting and participating in the project.

The HEPS Uganda PRA team learned that to successfully implement a community project, it is necessary to understand social values and sensitivities. We had to review use of the term "PRA" to "participatory" to avoid the connection to a negative history associated with the People's Redemption Army. Working with local officials meant we could avoid this mistake. We reviewed our materials and inputs based on the issues and priorities raised by the community and local health workers, and through this enhanced their relevance to the community, and the commitment and involvement of the community in their own plan. While

HEPS did lead in providing technical, skills and material inputs, this was around an agenda that had been set within the local community and health services.

We also faced problems beyond our control: The outbreak of a deadly Marburg viral disease interfered with our mobilisation. The project team had to delay the activity following a Ministry of Health advice that cautioned the public to limit movement to and within the district. Kamwenge District is very remote and, being more than 500km from the capital Kampala, requires a full day's travel. This affected mobilisation and monitoring activities.

The next steps on this intervention are informed by both the achievements and challenges of implementation process, and the proposals by the local community, highlighted in the previous section. The issues to be addressed raised there included

- Improving the health infrastructure, poor road network and support to nursing staff for local accommodation or transport and uniforms;
- Improving the procedure for handling complaints from the suggestion boxes;
- Improving the uptake and follow up by women of VCT services, their compliance with antimalaria medication; and
- Improving male attitudes towards and support to partners when they attend maternal health and PMTCT services.

We will thus seek to deepen this process and its leadership within the community itself, expand the sensitisation campaign on maternal health within the area and to other parts of the district, and tackling the issues of male attitudes through community leadership. Bringing the men more centrally into the process will itself involve participatory methods, to involve and engage them in a sustainable way. We will aim to address the maternal needs of expectant mothers within the health services, particularly through Kamwenge District Administration liason with the central government to invest more resources in improving maternal health by ensuring its guidelines on health infrastructure, equipment and logistics are implemented. This means that Kamwenge, as a district, should have a hospital and that health workers are provided accommodation at health facilities, uniforms and motivation.

HEPS Uganda will maintain contact with the volunteer trainers to ensure the awareness campaign is carried forward so communities can demand and utilise maternal health services. Participants recommended that better supervisory and follow up policies and systems be put in place to hold those violating the health rights of expectant mothers accountable and all in the area will seek to work together to improve this situation.

From increasing awareness about maternal health issues, improving family and community support to expectant mothers, to building a cordial relationship between health workers and the community and expectant mothers, the PRA project not only posted achievements that need to be carried forward but also provided a learning occasion for the project team that will be important in HEPS Uganda's future engagement with communities. It has also prepared the Kamwenge Sub-county community for any other community-based interventions; the community is now more willing to work with stakeholders to improve their situation, but also more conscious on what type of work will do this and give them leadership in the process. The local community and health workers have taken an important step to act. We hope that this will now be responded to by other authorities to improve the health service, transport and logistic situation in the area to enable a people centred maternal health service.

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ACRONYMS

ANC	Antenatal Care
CBOs	Community Based Organisations
CSOs,	Civil Society Organisations
EQUINET	The Southern African Regional Network on Equity in Health
HC III	Health Centre Three
HC IV	Health Centre Four
HEPS	Coalition for Health Promotion and Social Development
MOH	Ministry of Health
HSSP	Uganda’s Second Health Sector Strategic Plan (HSSP II)
IHRDC	The Ifakara Health Research and Development Centre
LC	Local Council
LG	Local Government
MCH	Maternal Care Health
NGO	Non Government Organisation
PMTC	Prevention of Mother to Child Transmission of HIV
PRA	Participatory Reflection Actions / People’s Redemption Army
Pub.	Public
RH	Reproductive Health
TARSC	Training and Research Support Centre
TBAs	Traditional Birth Attendant
TOT	Trainer of Trainees
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UMOLG	Uganda Ministry of local government
UNICEF	United Nations International Children’s Education Fund
VCT	Voluntary Counselling and Testing

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET: R Loewenson, R Pointer, TARSC, Zimbabwe; M Chopra MRC, South Africa; I Rusike, CWGH, Zimbabwe; L Gilson, Centre for Health Policy, South Africa; M Kachima, SATUCC; D McIntyre, Health Economics Unit, Cape Town, South Africa; G Mwaluko, M Masaiganah, Tanzania; M Kwataine, MHEN Malawi; M Mulumba U Makerere Uganda, S Iipinge, University of Namibia; N Mbombo UWC, South Africa; A Mabika SEATINI, Zimbabwe; I Makwiza, REACH Trust Malawi; S Mbuyita, Ifakara Tanzania

The Coalition for Health Promotion and Social Development, HEPS-Uganda, is a Health Consumer's Organisation advocating for health rights and responsibilities. HEPS has a special focus on access to essential medicines and rational use of medicines. The organisation is a coalition of health consumers, health advocates, health practitioners, civil society and community based organisations. HEPS-Uganda is concerned about bottlenecks that hinder access to quality healthcare for the majority of Ugandans, advocates for more preventive and curative means and believes these measures should be designed from a health consumer's perspective.

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