Fluid Cash and Discordant Households: Exploring perceptions of and attitudes towards saving for childbirth
A qualitative study in Pallisa district, Uganda

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Abstract

**Background and Aim:** Maternal mortality in Uganda is among the highest in the world despite improvements in access to skilled delivery and emergency obstetric services. This is impacted in part by financial barriers. This qualitative study explores men and women’s perceptions of and attitudes towards saving for childbirth and the related decision-making processes in rural eastern Uganda.

**Methods:** Data was collected through six focus group discussions with community members, seven key informant interviews with members of the District Health Office and Commercial Office and observations. Data was analysed using thematic analysis.

**Results:** Men and women utilise savings to cope with varying demands, often taking precedence over preparing for childbirth. A gender division in preferences and ability to save, underlined by poverty and illiteracy was identified. Partners operated in separate financial spheres, with ambiguous financial responsibilities. Responsibility for childbirth was negotiated through household decision-making, but ultimately male partners held control over resources. Open communication and understanding between partners was perceived as key to saving for childbirth. Male involvement was desired but complex and its best form undefined.

**Conclusion:** Savings groups can act as a conduit for financial birth preparedness, but without increased co-operation within the household and an increased awareness of birth being a joint responsibility, money may be diverted to other priorities. Existing power structures must be recognised if male involvement is to be increased. A greater emphasis needs to be placed on improving communication between partners.

**Key words:** Maternal health, birth preparedness, Uganda, savings groups, gender, decision-making
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<th>Description</th>
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<tr>
<td>ASCA</td>
<td>Accumulating Savings and Credit Association</td>
</tr>
<tr>
<td>CBSG</td>
<td>Community-based Savings Group</td>
</tr>
<tr>
<td>CDO</td>
<td>Community Development Officer</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Healthcare Worker</td>
</tr>
<tr>
<td>DHT</td>
<td>District Health Team</td>
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<tr>
<td>DHO</td>
<td>District Health Officer</td>
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<tr>
<td>EUR</td>
<td>Euro</td>
</tr>
<tr>
<td>FDGs</td>
<td>Focus group discussions</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>HDREC</td>
<td>Higher Degrees, Research and Ethical Committee</td>
</tr>
<tr>
<td>KI</td>
<td>Key Informant</td>
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<tr>
<td>LIC</td>
<td>Low-income Country</td>
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<td>MANIFEST</td>
<td>Maternal and Neonatal Implementation of Equitable Systems</td>
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<tr>
<td>MFI</td>
<td>Microfinance Institution</td>
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<tr>
<td>MH</td>
<td>Maternal Health</td>
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<tr>
<td>MUSPH</td>
<td>Makerere University School of Public Health</td>
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<tr>
<td>RCTs</td>
<td>Randomised Control Trials</td>
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<tr>
<td>ROSCA</td>
<td>Rotating Savings and Credit Associations</td>
</tr>
<tr>
<td>SACCO</td>
<td>Savings and Credit Cooperative Organisation</td>
</tr>
<tr>
<td>SEK</td>
<td>Swedish Krona</td>
</tr>
<tr>
<td>SG</td>
<td>Savings Group</td>
</tr>
<tr>
<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<tr>
<td>TA</td>
<td>Thematic Analysis</td>
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<tr>
<td>UGX</td>
<td>Ugandan Shilling</td>
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<tr>
<td>UNCEST</td>
<td>Uganda National Council of Science and Technology</td>
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<tr>
<td>VHT</td>
<td>Village Health Team</td>
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<tr>
<td>VSLA</td>
<td>Village Savings and Loans Associations</td>
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Operational Definitions

**Household**
A household is made up of the group of people who live in the same dwelling and typically eat meals together, recognising either a man or woman as the head of the household. Members of the household may temporarily live outside the home (1)

**Maternal Health**
The health of women during pregnancy, childbirth and the postpartum period (2)

**Safe Delivery**
The presence of “an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal….pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (3, p.1)

**Savings**
Monetary savings

**Savings Group**
Any group of individuals who save together and in some format lend to each other and share received profits. Sometimes also referred to as Community-based Savings Groups (CBSG)
Introduction

This study explores both men and women’s perceptions of and attitudes towards saving for childbirth, and the related decision-making processes in rural eastern Uganda. Further to this, it aims to discuss the influence of gender dynamics on household member’s ability to prepare financially for childbirth.

Despite a 45% reduction in maternal mortality globally since 1990, 800 women still lose their lives daily to pregnancy and childbirth related causes (4). Maternal mortality remains unacceptably high in many low-income countries (LICs), including Uganda, with 438 maternal deaths per 100,000 live births (5). Sub-Saharan Africa (SSA) accounted for 62% of all maternal deaths in 2013, 2% of which occurred in Uganda (4). The situation is attributed to poorly functioning healthcare systems, major illnesses like malaria and HIV/AIDS and low utilisation of available maternal healthcare, coinciding with low levels of female education and empowerment (6).

There is general consensus that a majority of these deaths could be averted with better quality of, and increased access to antenatal care, skilled delivery and emergency obstetric services and peri-natal care (7). The widely used Three Delays explanatory model (Annex 5) identifies the delays experienced by pregnant women in seeking, reaching and receiving skilled care (8, 9). Among the factors that result in these delays, are the cost of care, medication and transportation to health facilities, women’s low status and lack of access to resources and diminished importance of women’s heath (8). These components highlight the importance of the complex relationship between care seeking, women’s status, access to resources and decision-making. Uganda has seen a reduction in maternal mortality and an increase in facility-based deliveries, rising from 41% to 57% between 2006 and 2011 (5). Despite this progress, and maternal healthcare at government facilities being free of charge since 2001 (10), women in Uganda continue to face barriers (geographical distance, cost of care, medical supplies and transport, limited transport options and unequal decision-making practices (11,12) in accessing safe delivery services.

Households that are prepared for birth are more likely to access safe delivery services (13) and the promotion of birth preparedness (including the identification of a health facility with a skilled birth attendant, organising transport to the facility, saving money and purchasing birth
items such as gloves (9)) is advocated as a strategy to overcome delays, especially in LICs (9,13,14). As identified in the Three Delays Model, a significant part is also financial preparedness, or saving for childbirth (9). There are limited studies examining behaviour and decision-making specifically in relation to saving for childbirth. Studies conducted into intra-household decision-making in relation to seeking maternal healthcare (15–19) show that decision-making processes are complex and influenced by normative and structural factors. In many LICs, including Uganda, men are in a position of greater social and economic power than women, and decisions on financial resource allocation are dominated by male counterparts (9, 18–22), yet their involvement in birth preparedness is often low (20). These factors may be crucial for the actualisation of savings for childbirth.

Background

Maternal and Neonatal Implementation of Equitable Systems – Phase II (MANIFEST)

This study was conducted in collaboration with the Makerere University School of Public Health (MUSPH) MANIFEST1 research project. Launched in 2009, the project aims to mobilize “different community and district level resources and structures to offer solutions to both demand and supply side constraints to utilization of maternal and neonatal health services” (23, p. 14). The project is currently running in three Health sub-districts in eastern Uganda. One of its objectives is to improve birth preparedness, encourage saving practices and promote linkages between households, savings groups (SGs) and transporters (or boda boda drivers2) (24).

Following the success of two earlier pilot studies (25), MANIFEST aims to harness existing SGs to promote savings for maternal health (MH) and childbirth, working with the District Health Team (DHT) to deliver sensitisation messages and encouraging savings towards childbirth. Community Health Workers (CHW) who form part of the Village Health Teams (VHTs) operating at village level, visit expectant parents and encourage them to join SGs and save for childbirth. Community Development Officers (CDOs) from the District Commercial Office also provide financial training to SGs, encouraging them to establish separate MH funds (in order to ensure funds are available to expectant mothers) and assist in setting up contracts with transporters. Community members are also engaged through a set of community dialogue meetings (23).

1 In collaboration with Future Health Systems, funded by Comic Relief
2 Boda-bodas or motorcycles are one of the main transport options in Uganda and are found across the country in both urban and rural areas.
Savings in low-income contexts, savings groups and enhanced health

Rural, low-income populations are often referred to as the “un-banked” (26) or financially excluded. Despite lacking access to formal financial services\(^3\), poor households do save (28-29), and there is in fact, “a vibrant and diverse informal financial sector” across the African continent (30, p.1) comprising of different forms of saving often used in tandem (ranging from tucking money under a mattress or purchasing livestock to using money guards or joining SGs). With an increased interest in promoting financial inclusion among the development community, informal SGs have been promoted as a sustainable and contextually appropriate way for communities to arrange for financial services for themselves (31-35). There has been a significant increase in SGs, formally trained SGs\(^4\) now operate in 40 African countries (38). Many community groups, engaged in some form of savings, also exist organically within communities, a typical example from Uganda being burial groups\(^5\) or Rotating Savings and Credit Associations (ROSCAs). Whilst there are many different types of SGs, in essence a SG comprises of community members who save money together and in some format, lend to each other and share profits. The box below provides an example of the typical formation of a SG.

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**A typical SG**

The SG model discussed here is the time-bound Accumulating Savings and Credit Association (ASCA).

Typically groups meet once a week or month, comprising of 15 to 30 members. During these meetings members deposit savings (which are recorded in passbooks). The amount saved depends on what the group has agreed upon. The savings are kept in a locked box (guarded by 3 keys, held by three different group members). Groups usually have a chairperson, a secretary and a treasurer and have a set of rules (constitution) regulating savings and borrowing.

Groups give out small loans from the jointly collected pot of money. Some groups borrow only to members, whilst others borrow to non-members. Borrowed money is paid back with interest, the rate of which is decided upon by the members, enabling the group to make a profit. Groups may impose fines for late payments or missed meetings. Groups save in yearly cycles, at the end of which savings are returned to members with profit according to contributions.

Most groups have a membership fee, (used to purchase passbooks, a savings box and locks). Groups may have a separate “welfare fund” which is set aside specifically for emergencies.

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\(^3\) The rural poor have limited access to formal financial institutions due to geographical distance, high transaction costs, and administrative processes (27).

\(^4\) Trained SGs are initiated and trained by Non-Governmental Organisations (NGOs). The NGO supported SG started in 1990, when CARE identified a need to provide women with access to savings and credit and has since promoted their Village Savings and Loans Association (VSLA) model. Other NGOs (e.g. Catholic Relief Services, Plan, Oxfam) now operate versions of SGs across Africa. These SGs are run by members, the cost of training often covered by the NGO (36). SGs are similar in function to self-help groups prominent in South Asia (37). Growth in the industry has been charged by a Bill and Melinda Gates Foundation grant of $30 million.

\(^5\) Burial groups provide assistance to households to meet burial costs (coffins, food etc...), they act as type of insurance and are popular in Eastern Uganda. (39).
### Financial inclusion in Uganda

In Uganda the rural poor particularly, have limited access to formal financial services. The Ugandan government has increased efforts to enhance financial inclusion, however in 2013, 15% of the adult population were still considered financially excluded (40). 63% of the population did however save in formal and informal institutions and approximately 29% of Ugandans were members of an informal SG (41). Most savings were targeted at covering basic needs and emergencies followed by saving to cover the cost of children’s education and purchase of livestock (41).

#### Mechanisms used to save, %

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>51%</td>
</tr>
<tr>
<td>ROSCA and VSLA</td>
<td>29%</td>
</tr>
<tr>
<td>Animals and other assets</td>
<td>18%</td>
</tr>
<tr>
<td>Banks and MDIs</td>
<td>9%</td>
</tr>
<tr>
<td>MFIs and SACCOS</td>
<td>7%</td>
</tr>
<tr>
<td>Mobile</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Figure 1: Savings Mechanisms used in Uganda 2013**

Source: (41)

### Savings groups, health and maternal health

Despite the fact that SGs are generally perceived to impact health outcomes (often as a result of enhanced social capital, improved gender relations and increased social and economic development (37)), recently conducted Randomised Control Trials (RCTs) on SGs showed that while groups do make a profit and replicate, they also had little impact of social capital, community engagement or women’s empowerment (although households engaged in savings were more resilient to shocks and had improved food security). Additionally no increases in health expenditure among group members were found (43).

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6 Since 2009 there has been a significant increase in the population considered to be financially included largely due to the introduction of mobile money and transfers which are widely used in Uganda (41). There are new initiatives to link SGs to mobile banking, Airtel, The Garmeen Bank and Plan Uganda initiated such a programme in 2014 (42).

7 See Annex 6 for a description of the spectrum of financial services.
Studies looking specifically at the interaction between SGs and health are limited, even more so for MH. A study conducted in Kenya however showed that providing low-income households with a possibility to save, did increase saving towards health and that group-based mechanisms were in fact the most effective (44). Numerous programmes run by development agencies, that tap into the anecdotal evidence that SGs can be used to improve MH outcomes, do exist. Most operate with NGO established SGs and have varying levels of integration with MH interventions. Very limited empirical research has been conducted in relation to these initiatives. A study in Pakistan however, investigated the correlation between SG membership and use of community midwives. It found that women who were members of a SG were more likely to engage with MH services, but still relied on support from the family to cover costs of seeking care (45, 46). Additionally a qualitative study conducted in Nigeria, where SGs were encouraged to have MH funds and were utilised as platforms for MH messages, found perceived improvements in accessing MH services, health literacy and a positive impact on husbands’ involvement in MH (47).

The publically available information on these programmes have little indication of addressing gender related impact of SGs despite the fact that SGs globally, including in Uganda, are dominated by women (31,34,48) and generally considered as a mechanism for female empowerment. (A summary of reviewed programmes linking SGs to MH can be found in Annex 7.)

The Household, decision-making and gender

Households with limited incomes are faced with difficult decisions in relation to whether to save, what to save for and how to spend accumulated funds. The household is an arena of consumption, production and investment involving a multiplicity of actors, preferences and abilities (49). Households do not necessarily act in a unitary manner (seeking to maximise utility on the basis of shared preferences) (50) but rather members engage in intra-household decision-making that includes bargaining, negotiation and conflict, all influenced by relative power among household members (49). Women often have lower bargaining power within the household due not only to the existing division of labour and resources, but also the prevalent gender norms and practices. This often results in women having less say in household financial decisions (49). Households do not exist in isolation, but rather within wider political, legal and institutional structures. Institutions such as customary law that govern land rights and marriage may also have a significant impact on bargaining positions within households (50).
A mixed-methods study conducted in western Uganda exploring couple relations, decision-making hierarchy and maternal health, found that seeking skilled delivery services depended on the quality of a couple's relationship compounded with women's decision-making ability within the household. Factors that undermined women's decision-making ability were low levels of education, lack of control over household assets, lack of autonomy and low social position. Conversely open discussion among partners was seen to enhance use of MHC services and family planning (18).

Only one study specifically addressing gender norms and membership in SGs was found. This study, conducted in Malawi, explored how SGs could tackle gender inequalities and enhance women's empowerment. The study found that gender norms were very influential in household decisions towards women's ability to join SGs and in relation to allocating resources to savings. Couples valued joint decision-making but although women often had the ability to negotiate participation in SGs, the male partner had the final say in how savings and loans were utilised. There was however, also a perceived increase in the value attributed to women in SGs, and a perceived increase in cooperation within households (51).

**Rationale for study**

The perceived success of SGs across LICs has led a number of development actors to examine how SGs can be leveraged to deliver other activities, such as health promotion (35). Savings are an important part of preparing financially for childbirth, yet little research exists in LICs in relation to poor households' ability to save specifically for childbirth (47). If SGs are to be harnessed as a means of encouraging savings for childbirth, there is a need to better understand the way in which gender relations and power imbalances, men and women's financial realities and perceptions of childbirth intersect at both an intra- and extra household level. Studying perceptions of savings for childbirth and the related decision-making processes can shed light on households' ability to actualise savings and factors that may deter households from preparing financially for childbirth. This in turn may assist actors working with SGs and/or MH in identifying ways to encourage more households to engage with SGs as well as increase male involvement.
Study Aim and Objectives

**Overall objective**

The aim of this study is to explore perceptions of and attitudes towards saving for childbirth amongst men and women in Pallisa district, Uganda and to consider the influence of gender dynamics on household member’s ability to prepare financially for childbirth.

**Specific objectives**

- To explore attitudes towards saving for childbirth among men and women
- To identify men and women’s perceptions of household decision-making processes in relation to saving for childbirth
- To explore challenges faced by households in saving for childbirth

As such this thesis aims to explore the following research question:

*What are men and women’s perceptions of and attitudes towards saving for childbirth, and the related decision-making processes in Pallisa district, Uganda?*
Conceptual Framework

The Household Economic Portfolio Model by Chen and Dunn was used at the design phase of this study to identify determinants of social and economic patterns, taking into consideration diverse financial demands, influence of social capital and fluctuating flows of both income and expenditures (50) (See Annex 9). This framework aided the formulation of the objectives of the study as well as the research methodology and study tools. It also incorporates gender and household bargaining, both which were identified as helpful conceptual perspectives in the perusal of this research.

Social Constructionism - Macro level theory

The underlying epistemological approach employed in this study is social constructionism. The starting point of social constructionism is that reality is socially constructed as a “result of historical, social and political processes” (52, p.17) and as such is imbedded in its context. Truth and knowledge are seen not only as born out of, but also maintained and transformed through social processes and interactions (53). Attitudes towards saving for childbirth are an expressed result of the historical past as well as current social and political institutions and trends and household decision-making processes as both products and enforcers of normative roles. Applying a social constructionist perspective also acknowledges the student researcher as an active player in the construction of knowledge “as he or she chooses to tell one story and refrains from telling another” (54, p. 26).

Connell’s Relational Theory of Gender

To examine the underlying gender hierarchy and power structures as well as expectations that govern attitudes towards saving and spending for childbirth, Connell’s Relational Gender Theory (55) has been incorporated as the main theoretical approach and is used for the discussion of the findings of this study.

Gender is differentiated from biological sex by its performative nature. It is a set of expectations and norms within which society defines the accepted roles, behaviours and features attributed to men and women (56). Gender is often seen through a lens of categorical thinking, or dichotomies, placing men and women and masculinity and femininity in set and opposing categories (57). According to Connell however, gender is a constriction of self in relation to others (55). Gender norms, whilst often expressed as dichotomous and taken-for-granted, are
not rigidly set but rather subject to transformation and are constantly constructed, contested and reconstructed across the intersections of societal structures. The theory captures the complexity of these relationships and how they relate and change over time and produce and enforce inequalities.

The theory is multi-dimensional, simultaneously considering four different gender relations or structures: “economic relations, power relations, emotional relations and symbolic relations”. These structures interact at “intrapersonal, interpersonal, institutional (Gender Regimes) and society-wide levels (Gender Orders)” (57, p. 1677). Gender orders are wider patterns of gender in society. Particularly relevant to this study is the consideration of patriarchal gender order and the centrality of the “reproductive arena” in which the “institutionalised control of women’s reproductive capabilities” has been “historicised”. Gender Orders act as constraining structures that limit the way in which men and women practice gender in their everyday lives (57) and define what possibilities they have and what the consequences of their actions will be (55).

Another example of a wider gender order is the gendered division of labour (58). Gender Regimes are the organisations or institutions within which gender is constructed and contested (55). In this study SGs are considered as a form of gender regime.

Figure 2: Components of Connell's Relational Theory of Gender

(Freely adapted from Connell 2002 (55))
Within gender regimes and orders, experiences are shaped by four intersecting and overlapping gender relations which as they interact, result in different lived experiences (55):

- **Power relations**: Power can be direct or discursive. Direct power or “organised institutional power”, could, for example, be the control that a husband exerts over his wife. Discursive power is based on Foucault’s notion of power operating through individual or group categorisation and how their bodies, identities and actions are “disciplined” through these categories. These relations are ever-changing, and always contested in some form.

- **Production Relations**: Production relations are a part of a “gendered accumulation process” (p.61) and include production, consumption and accumulation. This is displayed in the division of labour along gendered lines and the perceived notions of “men’s work” and “women’s work” and relates to how household work is valued (or often undervalued). Economic relations are heavily related to ownership of resources and income generation opportunities.

- **Emotional Relations**: Emotional relationships are linked to gendered expectations and commitments. Emotions can be expressed as either “hostile or favourable”, existing in an ambiguous relationship, being both loving and hostile simultaneously. Emotional relations also refer to sexuality and sexual relationships, expectations of “romantic love” and marriage. Emotional relations consist of symbolic meanings, but can also have practical implications such as gender based violence.

- **Symbolic Relations**: Symbolic relations are often overlapping with the other three relations, especially power and emotional relations. Symbolic relations relate to how gender is expressed, constructed and enforced through the use of symbols. Language is central to symbolic relations but gender can also be expressed through more concrete forms such as dress or built environment.
Methodology

Study Design

This study takes a qualitative approach, employing focus group discussions (FDGs), semi-structured key informant (KI) interviews and observations. Qualitative methods were chosen due to their ability to aid in understanding social phenomena and to produce “rich description” of experiences. This includes not only describing phenomena or actions, but also how attitudes and perceptions are constructed by community members and influence behaviour (59). Qualitative methods can “help to identify patterns” and thus “move inquiry toward more meaningful explanations” of the influence of gender dynamics on households (60, p.1102).

FGDs were chosen as the primary mode of data collection as they can shed light on “collaboratively produced” (61, p.187) representations of reality during which reality is “constructed, defended and modified” (64, p.314). This is in line with adopting a social constructionist and gender perspective. KI interviews support findings from FGDs by providing contextual information and assist in understanding cultural norms. Additionally, observations carried out by the student researcher assisted in acquiring a practical understanding of SGs.

Study Setting

Uganda is a landlocked country located in East Africa bordered by Kenya, Tanzania, Rwanda, The Democratic Republic of Congo and South Sudan with a total area of 41,039 km². Uganda is divided into 112 districts and has a decentralized governance system. The country experienced a period of civil and military unrest during the 1970s and 80s which shattered economic and social infrastructure (63). Despite recent economic growth, 37.8% of Ugandans live on less than $1.25 (PPP) a day (64). Uganda has a young population with 48% of the total population of 34,856,813 under the age of 15 (65). Uganda has a high fertility rate at 6.7 and more than half of women give birth by the age of 20 (63).

The MANIFEST study is being carried out in three districts: Kamuli, Kibuku and Pallisa. Time and budgetary constraints meant it was not feasible to conduct the study on all three districts. The choice of Pallisa was one of convenience. The project has a strong relationship with the District Health Team (DHT) in Pallisa which assisted in mobilizing participants.

Based on % of population living on less than $1.25 at 2005 international pricing in 2012.
Pallisa is located in the eastern Uganda, boarding the districts of Mbale, Kumi, Serere, Ngora Tororro, Iganda and Kamuli. The district has two counties, Pallisa and Butebo, 14 sub-counties, 80 parishes and 587 villages (66) and one urban center. The district is bordered by Lake Kyoga to the west. The sub-counties of Agule, Kamuge and Kasodo (each with 4 parishes) were identified as study sites.

Figure 3: Map of Pallisa sub-counties in 2010
(68, 69)

Pallisa has a population of 386,074 and is predominantly rural (65). Agriculture is the main economic activity, including the cultivation of cotton (69), finger millet, cassava and ground nuts (70). There is also a large wetland area, used for rice cultivation. 85% of the populations are dependent on seasonal cultivation. Drought and land shortage has caused food shortages and 55% of households only consume one meal a day (71). A majority of the population are Iteso or Bagwere and the main spoken languages are Ateso and Lugwere (69). Pallisa is predominantly Christian (Anglican and Catholic), with a minority Muslim population and some Pentecostal influence (72). Traditionally the Iteso were cattle herders, however during the Teso

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9 Prior to 2010, Kibuku was a part of Pallisa district, thus all figures reported here from prior to 2010 include data from both districts. Up-to-date figures were not available to the student researcher at the time of writing this thesis.
Insurgency, a period of significant unrest, from 1986 onwards the region's economy suffered due to cattle raiding from the north (39).

Literacy levels among inhabitants in Pallisa are low. In 2002 only 54% of the population above the age of 10 were literate. There is a difference in male and female educational levels, 61% of men had attained primary education, compared to only 39% of women. 70% of the population live in grass (or papyrus) thatched houses. Infrastructure in Pallisa is limited, with limited tarmacked roads and latrine coverage stands at 65% (70).

According to information collected by CDOs in Pallisa at the end of 2014, there were a total of 316 SGs in operation in the district (Agule 4411, Kamuge 38 and Kasodo 26) (73).

The district is divided into two Health sub-districts (Pallisa and Butebo). There are 14 Health centre (HC) IIIIs and 25 HClIIs and two hospitals. The closest regional referral hospital is in Mbale approximately 50 km from Pallisa town. All HCs are meant to offer routine ANC, family planning services and childhood immunisations. Each parish is serviced by a VHT, staffed by two CHWs. VHTs provide health education and referrals to HCs. In 2008 only 57% of mothers attended four ANC visits and 38% of deliveries took place at health units (70).

**Sampling and Recruitment**

Study participants were purposively recruited from Pallisa district with the assistance of CDOs who were well placed to recruit participants due to their routine involvement with SGs and the community (23). Additionally members of the VHTs assisted in recruitment.

Two FGDs were conducted with adult men and four with adult women, all of reproductive age (18-49) who had either had at least one child in the last two years, or were currently expecting a child, residing in Pallisa. A resident was defined as someone who has lived in the area for at least three months and planned to continue residing in the area. FGDs were conducted with both members and non-members of SGs. Membership of a SG was based on membership at the time of the study. It is possible that members who took part as non-SG members may have had previous experience of SGs. Factors such as socioeconomic, educational status and religion were not considered in the recruitment process. An attempt was made to ensure that the participants of FGDs were homogeneous in age. In Uganda most women become mothers prior

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11 The figures for Agule are a combination of SGs in Agule and Chelekura.
to the age of 25 (63) and due to prevailing social norms and hierarchy, groups were split into younger and older men and women to ensure all participants were amongst peers and able to participate in the discussion as freely as possible (52).

**TABLE 1: DISTRIBUTION AND CHARACTERISTICS OF FGDs**

<table>
<thead>
<tr>
<th>FGD No</th>
<th>Participant characteristics and gender</th>
<th>Age</th>
<th>SG membership</th>
<th>No. of participants</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Young women who are either mothers and/or pregnant</td>
<td>18 -24 (21-24)*</td>
<td>Yes</td>
<td>12</td>
<td>Ateso</td>
</tr>
<tr>
<td>2</td>
<td>Women who are either mothers and/or pregnant</td>
<td>25-49 (25-44)</td>
<td>Yes</td>
<td>7</td>
<td>Ateso</td>
</tr>
<tr>
<td>3</td>
<td>Young women who are either mothers and/or pregnant</td>
<td>18-24 (18-28)</td>
<td>No</td>
<td>8</td>
<td>Ateso</td>
</tr>
<tr>
<td>4</td>
<td>Women who are either mothers and/or pregnant</td>
<td>25-49 (25-47)</td>
<td>No</td>
<td>7</td>
<td>Lugwere</td>
</tr>
<tr>
<td>5</td>
<td>Young men who are either fathers and/or with expectant partners</td>
<td>18-24 (20-24)</td>
<td>Yes</td>
<td>6</td>
<td>Lugwere</td>
</tr>
<tr>
<td>6</td>
<td>Men who are fathers and/or expectant partners</td>
<td>25-49 (21-45)</td>
<td>Both members and non-member</td>
<td>10</td>
<td>Ateso and English</td>
</tr>
</tbody>
</table>

* Ages in brackets represent the actual age range of participants following recruitment. Note that for FDGs, the planned age specifications were not met.

KIs were purposively selected on the basis of their participation in the MANIFEST project and involvement with communities and were identified with the assistance of the DHO.

Observational sites were identified through a key contact.

**Characteristics of Participants**

50 FGD participants were included in the study, 34 women (age range 18-47, median age 24) and 16 men (age range 20 -45, median age 25). Six (four female, two male) of the participants were not married and seven female participants were pregnant. The median number of children
among the participants was three (ranging from 0 - 12). 32 FGD participants were members of one or more SG at the time of data collection, the remaining 18 were not.

Seven KI interviews were held with members of the DHT (3), CDOs (2) and VHTs (2). During the second CDO KI interview, three CDOs were interviewed simultaneously. KI informants worked across Pallisa sub-counties and were not limited to the Agule, Kamuge and Kasodo.

Two observational visits were carried out with a SG in Kasodo.

Data Collection

Focus Group Discussions

A FGD guide (translated to Ateso and Lugwere) (Annex 2) was used to guide conversation and provide prompts. The guide was tested during a pilot FGD and modified in consultation with the moderator and a senior MANIFEST team member (who has worked extensively with the savings component of the project) in order to further address the research aims and objectives. The FGDs were structured around two core themes as displayed in the table below.

<table>
<thead>
<tr>
<th>Table 2: Summary of FGD topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current saving practices within the community and saving for childbirth</strong></td>
</tr>
<tr>
<td>Perceived reasons for saving</td>
</tr>
<tr>
<td>Methods of savings within the community and attitudes towards saving</td>
</tr>
<tr>
<td>Perceived gender differences in SG participation</td>
</tr>
<tr>
<td>Perceived benefits of joining a SG and reasons for not joining</td>
</tr>
<tr>
<td><strong>Decision-making towards saving and determinants/barriers of saving</strong></td>
</tr>
<tr>
<td>Perceptions of household decision making on saving in general and for childbirth</td>
</tr>
<tr>
<td>Factors influencing savings decisions</td>
</tr>
<tr>
<td>Perceived challenges to saving faced by household and strategies to overcome difficulties</td>
</tr>
<tr>
<td>Perceived responsibility for saving for childbirth</td>
</tr>
<tr>
<td>Congruence of expectations for saving and spending childbirth among household members</td>
</tr>
</tbody>
</table>
Whilst English is spoken throughout Uganda, communities in rural areas may not have confident command of English to the extent to enable in-depth conversation. The FGDs were conducted by an experienced moderator in Ateso and Lugwere. The appointed moderator had worked as a research assistant with MUSPH since 2005 and had five years of experience working with qualitative data collection. The FGDs were conducted over a period of three days in January 2015. All FGDs were digitally recorded with participants’ verbal consent. Participants were given a written copy of the consent information in either Ateso, Lugwere or English (Annex 1).

FGDs were held in a location convenient for participants and were conducted outside, in shaded areas due to the heat. This meant it was not possible to arrange a location that was completely private. Four of the FGDs were held on the outside patio of a HC and the remaining were conducted outside a school, under a mango tree. The student researcher attended all FGDs in an observational role and took notes on non-verbal communication, participant behaviour and disruptions. Participants were offered refreshments during the discussion.

The number of required FGDs and participants varies dependent on the topic and context, but often time and cost restraints must be considered (60). The ideal number of participants was set at six to eight (74), but two of the FGDs exceeded eight participants due to practicalities. The FGDs lasted between one hour and 15 minutes and one hour and 58 minutes, resulting in nine hours of recorded data. All recordings were transcribed verbatim and translated directly into English by the moderator. The student researcher listened to the recordings with the transcripts and discussed issues with the transcriber, subsequently resulting in corrections to the transcriptions. Further reliability checks, on limited sections of the transcripts, were conducted by two independent native speakers.

Key Informant Interviews

Semi-structured KI interviews were conducted by the student researcher in English. An interview guide (Annex 4) was designed to reflect the issues discussed in the FGDs and piloted with one KI. The interviews were structured around three core themes as displayed in the table below.
Questions were modified throughout the interviews to reflect the respondents’ position and experience. KI interviews were conducted in the participants working environment, in a location that was private and convenient. The interviews were conducted over a period of three weeks in January and February 2015. All interviews were digitally recorded with participants’ written consent (Annex 3). Interviews lasted between 25 minutes and one hour. Following the interviews, recordings were transcribed verbatim by the student researcher. All recordings were listened to a second time with the transcriptions to ensure accuracy.

Observations

Two observational visits were conducted by the student researcher. A SG was visited on two consecutive weeks during their weekly meeting during which the student researcher sat with the group and observed the meeting process followed by informal conversations. Translation during the meetings was provided by a key contact person, who was also a member of the SG. Both site visits lasted approximately three hours. Observations were recorded in a field diary, paying attention to the following aspects:

- Composition of group and gendered dimensions
- Meeting process, including materials
- Displayed behaviours

In addition to the two scheduled visits, informal conversations with community members relating to general socioeconomic conditions, livelihoods, family structure and gender relations were recorded in the field diary. Field notes were typed out, resulting in 15 pages of typed data.
Data Analysis

Thematic analysis (TA), as described by Braun and Clarke was used for data analysis, according to whom it is used for “identifying, analysing and reporting patterns (themes) within data” (75, p79). TA was selected as the mode of analysis as it is not theoretically bound. However it does aim to make theoretical underpinnings of the research process explicit by acknowledging that “any theoretical framework carries with it assumptions about the nature of the data....” as well as recognising the researchers role in the production of themes rather than assuming that these are already present and thus “emerge” from the data (75, p80). This analyses took an inductive approach, guided by a priori theoretical understandings. As this study aims to provide both a descriptive account of attitudes towards and perceptions of savings as well as an explanatory analysis through an exploration of patterns, TA aids in moving from descriptive to explanatory production of findings.

The Analysis process

Transcripts from FGDs and KI interviews were considered to form the analysed data set. Following TA steps (75), all transcripts were initially read once whilst listening to the recording and referring to notes taken during data collection to link the transcripts to nonverbal cues. All transcripts were read again and notes were taken on observed patterns. NVivo.10 software was used to manage data and record initial codes. The codes were reviewed alongside a reading of field notes. Some codes were merged and notes were kept of data that was different from dominant expressions. KI interview transcriptions were then coded in-line with the codes generated from the FGDs. Numerous thematic maps were drawn-up as patterns were identified and sections of the data were reread. Codes were rearranged in NVivo.10 according to identified patterns. Although the data was primarily analysed inductively, theoretical texts were read alongside the analysis process. Themes were then reviewed, coded extracts within themes were read to check for patterns, some codes were moved and removed and some themes were merged. The whole data set was also read to check that themes correlated to the full data set and that important data had not been missed. Finally themes were refined and named.
Table 4: Example of coding to themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Willing and Able: Attitudes towards saving</th>
<th>Contradicting constructions of responsibility and decision-making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-theme</td>
<td>It's not a decision, it's a situation - Poverty and illiteracy</td>
<td>Saving in secret</td>
</tr>
<tr>
<td>Code</td>
<td>Lack of literacy: Barrier to saving and determinant of vulnerability</td>
<td>If you don't tell your husband it is like stealing</td>
</tr>
<tr>
<td>Data extract</td>
<td>“Secondly, I don’t know how to read and write when I take there my money they might write there other things that means they will swindle my money taking advantage of my being illiterate”</td>
<td>“If you don’t tell him, it will be as if you are stealing so it is better that I will be saving whatever little I get such that it doesn’t become an embarrassment on the day you may want to withdraw the savings. If you don’t tell him, he will start saying that you steal his things and sell them off and that is where you are getting the money you have been saving.”</td>
</tr>
</tbody>
</table>
Reflexivity

I am white woman from Finland, with no prior experience of Ugandan culture or society. As a student researcher and individual, I have preconceptions that will have impacted my interactions with community members and participants and my interpretation of the information received. For example, being in a context where gender norms are different from those with which I have grown up, may have led me to overlook nuances in interactions as I would have viewed these relations through my own ideals of gender equality and rights.

It is also important to consider how my presence may have been interpreted by others. Being a “mzungu” (a relatively cordial term used for white foreigners), I embodied multiple roles, defined by the intersections of race, education, wealth and my affiliation with MANIFEST, that may have placed me in a perceived position of power. Not solely a descriptive term, “mzungu”, is also associated to “being a rich westerner”. This was not solely in monetary terms, but also in terms of ability. During my time in Pallisa I experienced requests for advice and assistance in making contacts. Being perceived in this manner may have affected community members’ willingness to participate in FGDs. At the end of each FGD participants were given the opportunity to ask questions. Most questions addressed whether I would be able to provide support to the group, either monetary or through connections. Some participants expected to receive “health education” or guidance on savings or income generation. This seemed compounded by the “institutional authority” afforded to my through my affiliation with MANIFEST. FGD participants may have over-emphasized the role of the project or provided “socially desirable” responses. KIs were also aware of this affiliation and while I was not there to assess the performance of the program, responses may have been affected due to this association.

Informal conversations with community members may conversely have been eased by the fact that I was considered an “outsider”. During informal conversations, opinions that seemed to be converse to more accepted normative rules, were occasionally expressed.
Ethical Considerations

Ethical approval was obtained from Makerere University Institute of Public Health Higher Degrees, Research and Ethics Committee (HDREC) and the Uganda National Council of Science and Technology (UNCEST). Permission to conduct the study was also sought from the Pallisa District Health Office. The Declaration of Helsinki (76) and the Ugandan Ethical Guidelines for Research involving Human Participants (77) were consulted to guide the design and completion of the research project.

All participants were recruited on a voluntary basis. Informed verbal consent was sought from FGD participants and written consent was sought from KIs. Participants were provided with an information sheet explaining the purpose and process of the study. All documents were translated into Ateso and Lugwere. Prior to seeking consent, the objectives of the study, confidentiality and potential risks and benefits were explained to study participants by either the moderator or the student researcher.

Whilst every attempt was made to hold FGDs and KI interviews in a location that was private, this was not always possible. At times other community members where within hearing distance. Participants’ anonymity has been assured in any written text (participant names were removed from transcriptions), but due to the nature of FGDs, anonymity cannot be guaranteed. All data has been stored securely in password-protected files. Data will be stored for as long as necessary in accordance with the requirements of Uppsala University and Makerere University and will be discarded securely thereafter.

Participants were advised that there was no direct benefit of participating in the study. However FGD participants were given refreshments during the FGDs and a bar of soap at the end. Although not a direct risk, discussing finances can be a sensitive topic. Participants were selected from only three villages and are likely to be known to each other. In order to mitigate any social repercussions related to ability to save or specific savings preferences, the moderator encouraged participants to discuss general attitudes rather than personal experiences. Due to prevailing gender norms, there was a risk that discussing savings practices could lead to negative household consequences. FGDs for men and women were thus held separately.

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12 A bar of soap was considered a suitable gesture of appreciation for participation as it was considered small enough to not to be considered as a significant incentive to take part, but also something that could be shared with the household and contribute to family wellbeing.
As part of the recruitment process, CDOs and VHTs helped to recruit participants. Although mobilisers were informed that participation in the study was voluntary, it is possible that participants may have felt pressured to take part as those recruiting participants may have been in a position of power compared to the participants. The moderator explained the voluntary nature of the study to all participants and allowed for all group members to raise any concerns prior to the start of the recordings.
Results

Three themes and nine sub-themes were identified representing community member’s perceptions of and attitudes towards saving for childbirth and the related decision-making processes. Illustrative quotes, aimed at representing the main findings of the theme are presented in italics.

Figure 4: Themes and sub-themes of perceptions of and attitudes towards saving for childbirth in Pallisa, Uganda

Theme 1: Willing and Able: Attitudes towards saving

The first theme highlights three linked dimensions of men and women’s perceived ability and willingness to save in general and towards childbirth. Participants expressed varying needs and competing expectations that impinged on their ability to save. Their depiction of current savings practices highlighted poverty, illiteracy and the ensuing vulnerability as determinants of saving. The ability to save was however also attributed to the ability to prioritise and was linked to both positively and negatively expressed personal traits.
It’s not a decision, it’s a situation - Poverty and illiteracy

Poverty and lack of income were described as barriers to saving in general and towards childbirth. Many households were perceived to have such low levels of income that they had nothing to save. Although poverty was linked to lack of income and income generation options for both men and women, female participants who were not members of SGs, particularly expressed a desire to save, but noted that the lack of saving was not a decision, rather a situation that resulted from limited income or the inability to engage in income generation activities.

“I really would love to join the savings groups and I always think that if only there was a way for me, I would be in one of the groups. The biggest challenge is poverty. Like you see me here, am now pregnant and am producing almost every year, children can fall sick at the same time and you find that there is no single coin. So such a situation limits one to join a savings group without anyone deciding for you whether to save or not”

(FGD 3, Female, Non-SG)

According to participants, SGs varied in size, aims and membership. Most SGs had a membership fee (between 5000 - 7000 UGX\(^{14}\)), required members to contribute a specific amount on a regular basis (anywhere between 200 - 10,000 UGX /week\(^{15}\)) and some imposed late fees for missed meetings. Although these factors were said to impact both men and women, women were perceived to be more deterred from joining SGs due to these expectations. There was also a perceived gender division in membership which was expressed as being due to differences in preference, but in practice, SG membership was seen to be determined by one’s ability according to income.

“Yes, like that group where they save 5000 every week, it is only a man who has an income who can manage to save in it. But now a woman like me who is a housewife cannot get that money”.

(FGD 3, Female, Non-SG)

The impact of poverty on joining SGs was perceived to be further exasperated by illiteracy, levels of which participants reported to be high in the villages, especially among women. Lack of literacy and education was perceived to lead to a lack of understanding of the concept of

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\(^{13}\) Abbreviations used to identify participants are in accordance with the list of FGDs presented in Table 1 (p. 14). SG refers to the participants being a member of a SG and Non-SG refers to not being a member of an SG.

\(^{14}\) According to the exchange rate on 20.04.2015 this is the equivalent of 1.55 – 2.17 EUR or 14.50 - 20.30 SEK.

\(^{15}\) According to the exchange rate on 20.04.2015 this is the equivalent of 0.06 – 3.10 EUR or 0.58 – 29.00 SEK.
saving and its importance and was a catalyst for feeling vulnerable and potentially being exploited.

“The reason as to why I don’t save and what has really discouraged me is that when you try to go and save they tell you that first write your name. Now like me who cannot write, you may request someone to write for you, what this person writes instead is her name, not yours…”

(Group participants laugh)

“… so you keep waiting for your turn, so that you also get something, they will instead tell you that we don’t see your name anywhere.”

(FGD 4, Female, Non-SG)

Fluid cash: Competing needs and expectations

Competing needs and expectations both motivated and hindered saving. Households saved to meet communal and family expectations (for example entertaining visitors or catering for festivities) and for the well-being of the household (through saving to buy assets, investing in business or to purchase items such as plates and mattresses). Expenditure demands were often seasonal and savings were used to rent gardens for cultivation and purchasing livestock. Saving for children’s school fees was seen as particularly challenging due large family size.

Additionally households saved to cope with unexpected problems (for example saving for condolences through burial groups) and health emergencies. Health emergencies encroached upon other savings priorities and diverted money away from original targets. VHTs encouraged SGs to have a separate MH fund for lending money to mothers for transport at the time of delivery and for birth items. Whilst some SGs (mainly MANIFEST groups), did have MH funds, most groups didn’t. However an emergency fund was kept by many groups. Saving specifically for childbirth was recognised as important, but other needs were often perceived as more urgent, despite best intentions to save for childbirth.

“Sickness is a challenge when trying to save for maternal health. You may end up using all that you had tried to save because you have to treat those ones who are sick in a household.”

(FGD 1, Female, SG)

Saving preferences were also divided into gender related categories and types of SGs were identified as either male or female. There was no consensus as to which groups were more populated by men or women, but the reasons for the division were gendered. “Christmas groups”
were considered as fulfilling male interests. Christmas is an important celebration among Christians in Uganda and men, as household heads, were seen to be responsible for providing meat for the family for the festivities. This also extended to cater for their wives families. Burial groups were joined by both men and women for differing reasons: men joined in order to fulfil duties of showing condolences, whereas for women it was often due to their role as “sympathisers”, attaching a more emotional value to women’s motivations for savings. Men and women were also perceived to save in order to publically express wealth.

“Men want to slaughter bulls so that people can say that so and so took this number of kilograms of meat but a woman starts to think of how her child is going to school.”

(FGD 4, Female, Non-SG)

Further to gendered preferences, a geographical division in SG membership was also expressed, men were said to join groups in trading centres16 because these were closer to where they worked, whilst women often joined groups in the villages.

There was a perceived pressure to spend on communal and family obligations, whether it was to cater for visitors or to support other community and household members in emergencies. In some cases rather than utilising SGs as a means of savings, the primary purpose was to “store” money. In Pallisa where rural populations may not have easy access to formal financial facilities, SGs were perceived as a mechanism to keep ones money safe from oneself (avoiding the temptation to use money unwisely) and from others. For men, being able to cater to visitors, was a sign of being a “big man” or likened to success, but also raised community expectations of being catered for or provided assistance of some kind. Based on observations within the community, money occupied a “fluid state”, passing hands frequently among social support networks and expectations to assist others and share available money were ever present.

“And the cash will have so many visitors, visitors come and you are forced maybe to get some, ah you can’t go without the soda, so the little money you have saved for delivering or for pregnancy or birth preparedness, it can be moved out.”

(FGD 1, Female, SG)

“Like me who is staying with my parents, you can get money and then you are told that today we don’t have cassava, if you try to resist, they will tell you that if you know that you cannot part with your money maybe find somewhere else to go.”

(FGD 3, Female, Non-SG)

16 A trading centre is an urbanised centre usually along major transport routes that act as a centre for commerce (including shops, market and transport)
Creativity and vision: Traits of a “saver”

Those who were not saving, felt it was easy for those with an income to save. However men and women in SGs, expressed a divergent opinion. Whilst they too accepted that some people simply did not have the income to save, they also described people who do not save as lazy, ignorant, and spending unwisely as well as being rigid and incapable of change. Men who did not save for childbirth were often categorised as drunks and fools. Men specifically considered as morally upright and a trait of a good Christian and spoke of the church discouraging spending money frivolously and drinking. The difference between those who save and those who do not was summarised as the failure to visualise the future, seeking instant gratification instead.

“The reason as to why others save and others don’t save is that there is a category of people who only mind about what they are going to spend for only that day and not for the future whereas those who save consider their future lives.”

(FGD 6, Male)

Community members who were in SGs were described as flexible, adaptive, open-minded and willing to take risks. Saving was also linked to the ability to “be creative” and utilise savings to make a profit and take advantage on income generation opportunities. As such whether or not one saved, was not a question of ability, but rather the willingness to prioritise and seek change.

Theme 2: Savings groups: Beneficial but risky

Despite the difficulties in saving that community members experienced, saving, particularly for childbirth, was viewed positively and participants expressed a number of benefits of SG membership. They found that saving allowed them to prepare for the unexpected and quickly access cash. For women, SG membership was seen to enhance their control over money and increase their autonomy. However there was also a pronounced concern of fraud within SGs, which cultivated a fear of saving.

“Birth can come at any time”: The importance of fast access to cash

Labour and birth complications could come at any time, for example at night and thus savings allowed expectant mothers and fathers to cope with the unexpected more confidently. SG members saw the MANIFEST programme and its encouragement of savings as having brought
change to the community, the current situation being contrasted to the “old days when women used to die” (FGD 2, Female, SG). Rather than utilizing savings, participants overwhelmingly referred to borrowing to resolve issues in relation to childbirth as it allowed access to amounts of cash that were potentially beyond the total that they had saved. Being able access this money quickly and to pay it back overtime in a flexible manner to suit their consumption needs was seen as a benefit. This was preferred to having to rely on support networks such as in-laws and relatives or alternative coping mechanisms such as selling off assets, all of which were acknowledged to cause delays in accessing care.

“If time for delivery comes and you are taken to the health facility, you may reach there and you are referred to where they might operate you and before the operation the doctor may need the money first. If such a situation happens, and you have not been saving it means you will not have the money to pay for the services. At the end you may lose the baby while the people at home are running left and right to try and mobilize money.”

(FGD 3, Female, Non-SG)

Whilst assistance from family and for women, from male partners or husbands was seen as important, it was also acknowledged that it could not always be depended upon at the time of an emergency or birth. Relying on a husband or partner was seen by some participants as leaving oneself vulnerable. This was attributed to partners promising to save but not doing so or using the saved money on other activities such as drinking. A number of female participants spoke of disappointments and unfulfilled expectations. Polygamy and extramarital relationships were also noted as reasons for why a partner might not be present at the time of birth. One of the KIs working with community members noted that she routinely advised women to save so as not to be dependent on their partner:

“...don’t only depend on the man, because you can find that the man is having more than two wives [...] you will start labour pains when the man is in the other home with another women. If you have not saved your money, you will find that you are not able to reach to the health facility. By the time you start looking for the money, you will have died or the child has died in your what, in your womb”

(KII 3)

Changing for the better: Profit, empowerment and autonomy

A central benefit of saving was the ability to generate income and to make a profit. Not only did savings and the profits made assist in investing in income generation options, but SGs were
seen as business in themselves. This, particularly for women who did not have other income generation options, was perceived as important.

“Others join saving groups because they know it is the only way they can save their money and at the same time it can make for them profits […] For instance if you don’t have sauce (food), you will just go in the house and pick on that money […] In the savings group it will be making profits, so in other words, you are like someone who is doing a business.”

(FGD 2, Female, SG)

Some groups managed to generate substantial sums\(^\text{17}\), but there was a perceived knowledge gap by which SGs were seen to require more support on how to invest these profits.

Membership in SGs was perceived as a force for positive change in the community and in individuals’ lives. Female autonomy was perceived to be further enhanced through the possibility of savings combined with income generation. Women who were members of SGs, spoke of the way in which their lives had changed since joining a SG with a sense of pride, and presented themselves as examples for other women as well as expressing building a better life for themselves in terms of gender equality.

“When you are in a savings group you become creative, your mind opens up such that a man cannot oppress you, undermining you and treating you like women of those old days where they used to say that women were supposed to be in the kitchen and not to head a home. But now women who join saving groups have the freedom of speech and their voices can also be heard.”

(FGD 2, Female, SG)

Saving within the community was linked to lower levels of theft and the success of SGs was seen to encourage other community members to join groups. KIs specifically promoted the use of successful groups and individuals as role models to encourage more saving in communities.

This notion of “empowerment” and increased autonomy was also reflected in discussions of female leadership in SGs. Female leadership was actively encouraged. Most SGs however had either male or mixed leadership, the chairperson typically being male, whilst the secretary and treasurer were often reported to be female. There were differing opinions on the impact of male leadership on savings for childbirth and setting priorities within groups. Female led groups were said to have better repayment rates and operate with stricter repayment rules but KIs

\(^{17}\) Up to 4 million UGX. According to the exchange rates on 19.04.2015 this equates to 1242 EUR or 11,526 SEK
also spoke of instances where men had “stolen” or failed to pay back loans to groups with female leadership and noted that female leaders still struggled to assert authority over men. Some women expressed a preference to loan only to women as it was easier to claim back loans. One KI also expressed concern that if more men joined women’s SGs, they might end up dominating the groups. Based on observations from SG meetings there was a spatial division between men and women in groups, males sat on chairs, whilst women sat on the ground on mats and the male members spoke on behalf of the women, indicating that dominating gender norms were at times replicated within the SGs.

Fear of losing one’s money

Fear of losing one’s money due to fraudulent activity of SGs was a prevalent concern. This was often phrased as being something of the past, but the fear was still present. Mistrust due to personal grudges and family feuds or exclusion along clan lines were noted as deterring people from joining groups, but the two main concerns were swindling of savings by SG leaders and failure to get back borrowed money. These issues also resulted members becoming demoralised and SGs becoming inactive.

There were many accounts of leaders “eating up” member’s money and negative experiences were often used to discourage family members from joining SGs and saving for childbirth (suggested alternatives were purchasing livestock that could be sold at time of birth). Participants expressed both mistrust and a vulnerability to being exploited by leaders who were from “outside” the community or persons of authority (such as local government officials).

There were also many accounts of failure to recuperate borrowed money. While both members and non-members failed to pay back their loans, non-members were perceived to be less reliable. There was, however, friction between safeguarding group money and making a profit. As the main aim of SGs was seen to be profit generation, lending money out to non-members allowed groups to charge higher interest rates. During one of the observed SG meetings, a non-member approached the group asking to borrow money. The group agreed that if someone was willing to act as a guarantor the money would be lent. None of the group members were willing to put their own money on the line and the loan was refused.

SGs in Pallisa are encouraged to have constitutions signed by members and to register the group with the sub-county and the district. Both these steps were aimed at increasing
accountability of leadership and to provide a means of reporting those who took advantage of SGs and members. There was some ambiguity as to whether this was a legal requirement or a procedural issue, none-the-less registration was used to promote saving in groups.

In addition to general SG related fears, women expressed a difficulty in keeping their money safe from male partners as men were said to be able to “pick” a woman's money as the head of the household. Women employed a number of strategies to keep their money safe. The primary solution was to save with a SG, however alternative strategies such as using money guards or carrying ones money with them were suggested.

“If I know that my husband is a drunkard and will take the money, what I will do is, after doing my casual labouring and they have paid me, I rush direct to the savings group, I don’t keep this money with me. If not, I will look for an old woman around who can keep for me that money then when the day for saving comes, I just pick the money and go and save it.”

(FGD 3, Female, Non-SG)

Even SGs were not impermeable to loss of money. Women reported that in some cases, a woman might go to the savings groups to take a loan or to claim their savings and profits, only to find that their partner had withdrawn their savings.

Despite the fact that KIs were not aware of any cases of theft being reported, the ability to report was still presented as a means for women to safeguard their savings from their partners. However when asked if it was likely that a woman would report a husband, one KI informant responded:

“…you know woman is someone, with a very strong heart, cause for a man [...] if he quarrels with the brother, and he is abused, he runs straight to the police. But with a women, she does not want to expose, she considers that issue as a family, as internal [...] but does not go anywhere for report, they endure, it is, they endure”

(KI 2)

Theme 3: Contradicting constructions of responsibility and decision-making

The realisation of savings towards childbirth was governed by the complex interaction between perceptions of responsibility for childbirth, division of responsibility into separate spheres and male domination of the final decision. Responsibility for childbirth was ambiguous and displayed how gender norms were constructed and contested through negotiations of saving for childbirth. Despite contradicting accounts of responsibility, the final decision rested with the man, the power
of choice granted to him through prevailing norms and control over resources. Despite women having a say in savings decisions, due to the accepted position of the male as the head of the household and women’s lack of personal income, women were dependent on receiving money and permission to save from their partners. Joint decision-making was however the preferred ideal but couples often failed to communicate allowing some women to contest prevailing norms by saving in secret. Because of this inherent contradiction between responsibility and the power to decide, the notion of male involvement was also confused and undefined.

Making and taking responsibility for childbirth

Responsibility for childbirth was expressed as a dichotomised understanding of masculinity and femininity. The “ambivalent male partner” went hand in hand with the perception that childbirth was a female arena whereas the male as “protector/provider” was constructed in relation to the “dependent woman”.

The role of “custodian of health” (KII 5), not just of her own, but of family health, was attributed to the woman. Women were seen to be the ones who could suffer during childbirth, it was she who knew her own health condition and thus it was her responsibility to save for childbirth. Women expressed this in relation to the “ambivalent male partner” who could not be trusted to save or prepare for birth or was not concerned with the health of the woman or the infant. The “ambivalent male” failed to live up to the expected male role as “protector/provider”. Women also expressed feeling expendable, referring to men finding a new woman if they were to die in childbirth or turning his attention to other women, once his wife became pregnant.

“Unlike men of those days, men of today don’t bother about the health of their wives. So it is you, the woman to start saving because it is your life. The men of today just make the women conceive and don’t take responsibility.”

(FGD 1, Female, SG)

The male as a “protector/provider” was largely attributed to the male’s role as the head of the household, but was also constructed in contrast to the “dependent woman”. The notion of manhood was tied to the ability to earn and have access to money. The family was generally seen as reliant on the man. This was linked to female characteristics of being weak or weakened during pregnancy and incapable of planning and preparation, attributed to low levels of female literacy and to the inherent difference of women “assuming” things, whilst men thought things through. Some women were also seen as perpetuating this dependency by readily relying on the man and seeing their role in the household as only related to their reproductive role.
“Then there is another category of women who know that their work is only to push a baby nothing more. All the expenditure should be on the men. When they tell her that they want gloves, she runs to tell the man without trying out.”

(FGD 5, Male)

Men who expressed that the responsibility should be shared between the man and the woman were seen to be an exception to the rule. As the head of the household, the man’s responsibility to provide for birth was acknowledged, but it was the woman’s role to either convince or help the man.

“If we follow the word of God right from the creation, he said a man needs a helper and indeed they got him a helper who is a woman. It means that a woman is a helper of a man so when it comes to giving birth she should also take care of this.”

(FGD 6, Male)

As providers, men also expressed a desire to please their wives by providing for material needs. However this was also perceived to be a way to avoid conflict in the home and ensure that women continued to fulfil their household duties without complaint.

The decision to save for childbirth was far less ambiguous than the construction of responsibility. Male counterparts were perceived to control money and thus had the final say the decision-making process. Regardless of whose responsibility it was to save for childbirth, without the man’s consent to save, or their monetary assistance, women did not have the means to fulfil their responsibilities. Although most men saw it as the man’s responsibility, as the breadwinner, to provide, some men allocated the responsibility and right to decide to women, whilst acknowledging that male assistance was still needed.

Savings in secret

Despite differences in men and women’s ability to bargain about saving for childbirth, the need for couples to jointly discuss and agree upon saving was recognised. Men and women were however also said not to communicate about issues of health in general or childbirth. Men were often depicted to ignore women or failed to take women seriously. Often couples were not aware of each other’s financial activity.

“When my wife reached delivery time, I was not at home, I was at school and little did I know that she was a member in one of the savings group. When I was told that she is
in labour pain, I directed them where I had kept my small box in the house so that they break it and get money. Unfortunately or fortunately they did not see it but since she had saved in a group which I even didn’t know and it is only for women who save every Sunday that is where she got the money.”

(FGD 5, Male)

In the above example both partners were saving in one format or the other. However the opposite could also occur, where both members of the couple, expected the other to be saving and at the time of birth, wait for their partner to cover costs. The notion of separate resources was reflected through references to “personal money”. One participant expressed that women might be reluctant to use their “personal savings” and preferred to wait and see if the man had resources to cover the costs of birth, leading to delays in seeking care. This division in preferences and practices reflects the gendered division in household spheres of responsibility, with men and women seemingly making individual decisions in relation to savings and expenditure. This did not however necessarily mean that partners were making decisions purely out of self-interest, one participants expressed how separate savings converged to fulfil household aims:

“At times it comes from what you agree on as a family. A man may tell you, a woman, to join the savings group for self-help while he joins the meat group for Christmas and then at the end of the year, you evaluate and see how you can support the family.”

(FGD 1, Female, SG)

Despite women and men saving separately, or operating in separate spheres, men held ultimate control of the money. This was evident in the depictions of men utilising the money saved by women for their own personal pursuits and laying claim to the finances in the house. Men were seen to distort women’s plans to save for childbirth and a certain level of powerlessness to resist male squandering of money was expressed.

“Lack of co-operation between the man and woman in a household is also a challenge when trying to save for MH and birth. A woman may be saving for MH and what the man does is to go and withdraw some money without notifying the woman. So she goes to the savings group knowing that her money has accumulated only to be told that part of it was taken by her husband and when he is told to take back the money with interest he will simply say that “my wife will pay back.” Then there are men, whereby you save jointly then when the day of dividing comes, he is the one who takes everything”

(FGD 4, Female, Non-SG)
Women noted that in some cases, if a man was not willing to save for childbirth, women might “save in secret”, diverting some of the money received from husbands for day-to-day consumption to a SG without the man’s knowledge. This was referred to as “stealing” from one’s husband. Whilst saving in secret was a strategy employed by women, it was often seen to lead to difficulties. If the man found out about the “secret savings” he might accuse the women of having an extramarital affair or of stealing his money. This lack of trust was seen to fuel further conflict and mistrust between partners, and led to quarrelling and even divorce.

“If you don’t tell him, it will be as if you are stealing so it is better that I will be saving whatever little I get such that it doesn’t become an embarrassment on the day you may want to withdraw the savings. If you don’t tell him, he will start saying that you steal his things and sell them off and that is where you are getting the money you have been saving.”

(FGD 4, Female Non-SG)

Lack of communication was seen to hinder and discourage saving for childbirth. Participants acknowledged the importance of communication and noted a loving, respectful relationship with open communication as one of the most important elements contributing to households successfully saving for childbirth. This ideal of unity within the household, was however also based on the understanding that in order to achieve a harmonised and peaceful household, men should listen to their wives, but women should also be submissive obey their husbands.

Misunderstood male involvement

There was a lack of consensus about the definition of male involvement. Low male involvement was identified a major challenge to saving for childbirth, yet how to encourage male involvement seemed rather elusive. There was a clear consensus that due to the male role as the primary decision-maker and women’s limited space for agency due to the prevailing patriarchal order, it was crucial that men should be involved in financial preparedness for birth. Not only was male involvement seen as essential as they control resources, but also because men actively discouraged women from saving. KIs noted that more men were being involved, but this was a slow process that was dependent on behavioural change.

Women were generally perceived to be more active in groups and community dialogues and a number of KIs noted that this was in fact the case for most programmes, especially those relating to reproductive health. Men’s physical absence from SGs and community meetings was seen as
a sign of lack of involvement, but overlooked the fact that in most households, male permission to attend meetings was needed and men, in most households gave money to women to save. Male authority was also seen to strengthen the prospects of saving successfully.

“And then in the groups, what I have heard men comment that: my wife cannot be in a group when I have not consented, so why are you saying that we are not involved. If my wife it there it means I am there, because me and the wife we are one person. For me I am busy looking for other resources.”

(KI 6)

Men were perceived to have limited knowledge of childbirth and needing further information and sensitisation. It was seen as crucial to encourage men to take part, as they needed to be equipped with the necessary information to make crucial decisions. Some men on the other hand felt that it was sufficient for women to go to community meetings and discuss issues with VHTs as she could then bring the information home. Due to the perception that men were too busy to attend meetings, suggestions on how to further reach men and engage them were made by KIs, such as delivering messages where men congregated, further utilising mass media, but also continuing to encourage women to share information with their husbands and for women to utilise their ability to persuade men to attend meetings.
Discussion

Discussion of findings

Uganda’s maternal mortality rate is among the highest in the world despite improvements in increased access to skilled delivery and emergency obstetric services. Accessing services continues to be impacted by financial barriers. This study thus endeavours to shed light on women’s and men’s perceptions of and attitudes towards saving for childbirth and the related decision-making processes in Pallisa district, Uganda.

This study found that men and women utilised savings to cope with varying demands which often took precedence over preparing for childbirth. Money occupied a “fluid state”, passing hands frequently among social support networks and there were expectations to assist others, and share available money, further challenging allocation of resources to childbirth. Partners operated in separate spheres, with ambiguous financial responsibilities and preferences were constructed according to dichotomised perceptions of male and female roles. Although women were able to negotiate savings and SG membership, ultimately control of resources and decisions was held by the male partner. Open communication and understanding between partners was seen as key to achieving savings for childbirth, however this ideal of communication was rarely realised. Male involvement in saving for childbirth was desired but complex and its best form undefined.

Utilising Connell’s theory of gender relations (55) as a guide, this discussion looks at the influence of gender dynamics on households’ ability to prepare financially for childbirth through savings. The multidimensional theory is used to explore how power, economic, emotional and symbolic dimensions of gender relations interact and operate on different societal levels.

Fluid cash and everyday realities of poor households

Generally, lack of income and income generation opportunities were seen as significant barriers to saving, perpetuated by poverty and illiteracy. However for those who did save, savings acted as a valuable mechanism to cope with limited resources and varying demands. In this sense, cash was typified as “fluid” in two different ways: firstly its fluid character was linked to its transient state, the potential of money being diverted to a number of intra-and extra-household commitments and secondly it refers to the liquidity of money saved through SGs,
characterized by easy and quick access, but also the risk of loss or theft. Research conducted in Uganda in relation to general savings practices mirrors these findings; the majority of Ugandan households engage in precautionary savings, in response to uncertainty and risks (78). Savings practices reported by the participants of this study further indicate that savings were also used to aid in “consumption smoothing” as a part of management of their “economic portfolios” (79). The value in savings lay in the fast access to cash and borrowing to access larger sums. The households’ increased ability to deal with the unexpected nature of birth and the associated risks reflects the need to manage household finances in a manner that is flexible and adaptive to multiple demands on resources.

An experimental intervention conducted in Kenya, where individuals were given different savings options (a savings box with instant access, or limited access, groups with specific “health pots” and dedicated health savings accounts), found that although having a “disciplined” savings option that ensured the safety of the money (from oneself and others) was beneficial, ease of access to cater to urgent needs was given greater value. However the study also found that the provided savings mechanisms were particularly valued as they made it easier to say no to other people’s requests for money, including requests from spouses (44).

Meeting communal obligations was seen to impinge on savings for childbirth and reliance on others at birth was seen to cause delays in accessing safe delivery services. It is easy to see these communal expenses as drawing money away from financial birth preparedness. However studies have shown that reciprocal relationships in the form of community and family support networks can increase people’s ability to cope with unexpected health costs (80). The study in Pakistan linking SGs to midwifery use, for example, found that despite savings being spent for accessing MH services, women still relied on family support to cover a part of the cost (45). The depicted savings practices in the form of burial expenses, catering to visitors, purchasing meat for Christmas, express a maintenance of social relations, occupying an important place in households’ financial decisions. Caution should thus be exercised in discounting these costs as superfluous.

Intersecting gender relations

Central to the findings of this study was the way in which gender roles were performed, constructed and contested through the process of saving. The main locations of gendered construction in this study were the household and SGs, both acting as gender regimes within which the different gender structures intersect. According to feminist discourse the household acts
as a “site of women’s oppression and the locus of conflicts between men and women” (81, p.87) and as such the household can act as a patriarchal stronghold. SGs likewise are social institutions and have been endorsed from a heavily gendered perspective, promoting female empowerment through financial autonomy but could also act as mechanisms for the maintenance of accepted power-relations. The four gendered structures (power, economic, emotional and symbolic) interact within these gender regimes and have different “patterns of constraint” (54, p.52) that shape how men and women partake in saving for childbirth.

The economic dimension of gender relations is central to the findings of this study. Men and women were often seen to operate in separate spheres and expressed different savings preferences extended by the notion of “personal savings” or separate “ownership” of saved money. These “separate spheres” can be linked to the division of both production roles and land ownership. According to Guyer, (cited by Chen and Dunn (46, p.9) “the assumption that the domestic group is a tightly functioning unit […] is unattainable […] men and women have different spending preferences, not necessarily because they hold different values, but because they are in structurally different situations”. These structural differences in Uganda are fostered by both legislative restrictions on women’s rights to land ownership 19 and customary patrilineal inheritance (19) and are reflected in women’s accounts of lack of resources and income.

The notion of discordant households refers to a lack of harmony and communication within the household as well as the contradiction between responsibility and decision-making power. There was a pronounced acknowledgement that couples did not communicate enough or at all. Participants however felt that if there was sufficient communication between couples, saving for childbirth was more likely. The notion of a loving relationship was contrasted to a partnership of conflict and lack of trust, reflecting emotional gender relations. A study conducted in western Uganda, found that good relations between husbands and wives not only allowed women to gain the support of their husbands in relation to MH, but also increased their bargaining power in relation to resource allocation within the household (18).

Joint decision-making has been shown to be important to both maternal health outcomes and male involvement in birth preparedness. A study in Nepal found that joint decision-making was associated to significantly higher male involvement in pregnancy health suggesting that communication and shared negotiation strategies can improve health practices. Joint-decision making was particularly appreciated in relation to sharing the blame for unsuccessful decisions

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19 Approximately 70% of women in Uganda are employed in agriculture, however only 20% of women own land. The Land Act of 2004 technically grants women the right to land ownership (82), in practice women are often excluded from land ownership (83).
In this study, participants noted that a lack of communication could lead to conflict within the household, where couples were not aware of each other’s financial activities. The study in Nepal also found that higher levels of female autonomy were actually correlated with lower male involvement (84). A stakeholder analysis carried out prior to the commencement of the MANIFEST project also found that while women engaged with SGs, some men were perceived to render their responsibilities (as the provider) to women, thus lessening male involvement (25). SGs often promote increased female autonomy and space for female agency as a positive outcome. However, certain behaviours that might be perceived as increased autonomy, such as “saving in secret” may actually mask deeper normative constraints. Some women who took part in savings activities (with or without the consent of their male partners) did so, not out of choice, but in response to male partners failing to fulfil the “male provider role”, a lack in agreement within the household and the ambivalence shown by male partners in relation to their responsibility for childbirth.

Joint decision-making and enhanced communication between partners, could potentially lead to better outcomes than independent decision-making in relation to childbirth and male involvement (15) and arguably also in relation to saving for childbirth.

Discursive power relations steer both actions and constrain possibilities. Men and women were expected to live up to certain male and female roles, mainly expressed as the male being the provider and the woman as the obedient wife, but also a helper to her husband. Whilst gender relations are present in all forms of social phenomena, the intersection between money and childbirth is particularly pronounced with contradiction as displayed in the asymmetry of responsibility and decision-making power and reflects the “institutionalised control of women’s reproductive capabilities” (57). There was for example a noted divergence from the sexual aspects of a relationship in connection to pregnancy. Participants spoke of women fulfilling only the role of producing children and men abandoning women once they became pregnant, turning to other women. This “a-sexualisation of motherhood” was related to feelings of abandonment and being replaceable, reflected in discussions of infidelity and polygamy and may also act to enforce women’s submissive role within the household. However, it was also these concerns that propelled some women to enhance their autonomy in relation to birth preparation through savings, representing how discursive power can be contested.

Men’s physical absence from both SGs and community dialogues meetings was perceived as an indication non-involvement. However there was an expectation that men would to live up to the “protector/provider” role, reflected in accounts of specific savings preferences (often in relation
to fulfilling communal expectations), being the main breadwinner and also caring and providing for the well-being of the family. A study carried out in Guatemala found that male partners providing money to women for birth preparedness, constituted care and that male absence in birth preparations was often due to working patterns (85). As the head of the household men in Pallisa could also enact their involvement through their female partners. By allowing or requesting that women attend meetings, and by providing resources for savings to female partners, men themselves felt that they were involved. As SGs are often promoted as women’s groups, there is little research on restrictions that men might face in taking part in groups. Attempts to increase male involvement in SGs should to be cautious about “characterising male involvement as simple or monolithic” (85, p.447) and consider specific constraints that men may encounter.

Role models and income generation

Despite challenges in saving for childbirth, SGs and saving were positively viewed by study participants and changes in the community due the MANIFEST project and continued sensitisation through community dialogues and radio messages were valued. Both SG members and non-members expressed a pronounced appreciation for the achievements and personal characteristics for those saving. This finding supports the promotion of “role models” in encouraging further involvement of community members in SGs, potentially also encouraging savings specifically for childbirth and male involvement and reflects earlier findings in the stakeholder analysis carried out by the MANIFEST research team (25). Studies on SGs have also found that groups have a strong replication effect, associated with successful groups acting as examples for other village members (47, 48).

The positive attitude with which participants viewed SGs as a mechanism to increase income generation and thus to achieve their vision of a better future is encouraging, and further supports the concept of utilising SGs as positive examples to the community. Interestingly a survey carried out in Uganda showed that up to 35% of the respondents perceived saving as something that allowed an increase of funds, not just keeping money safe (41). SGs were in themselves seen as an income generation activity and as such have the potential to act as an arena for change in women’s control of resources. At the heart for microfinance discourse is income generation as a tool for progressing out of poverty and female empowerment. However the evidence to support these claims are of variable quality and the results in relation to female empowerment are mixed (86). The Wala study conducted in Malawi, for example, found when larger sums were
saved, women returned to their husbands for consultation on use of funds (51). It is important to recognize that SGs and female empowerment take place within the larger context of the patriarchal order and the potential of change in economic relations may be constrained due to intersections with prevalent power relations. Additionally harnessing the SGs as a stepping stone to further income generation, may depend on the creation of further linkages to income generation activities.

**Figure 5: Gender order, regimes and factors impacting savings for childbirth**

**Methodological Discussion**

In conducting cross-cultural research, the researcher has a responsibility to present participant views and experiences in a way that remains true to their intended meaning (74). This is challenging, especially to a student researcher who lacks experience and has limited resources and time.

Criteria developed by Guba to ensure rigor and validity in qualitative research was followed to ensure that the core requirements of trustworthiness are met by addressing the following areas: credibility; transferability; dependability and conformability (87). Steps taken included making full use of existing knowledge of the study context held by MANIFEST team members,
triangulation through the use of FGDs, KI interview and observations, utilizing software to track
the analysis process, and thus have an audit trail and practicing reflexivity and constant
comparison to ensure developed themes were based in data during the analysis and writing
process (further details of steps is given in Annex 9). Despite these efforts there were a number
of limitations to the study.

This study was developed in response to an identified need for further research as part of the
MANIFEST project. This led to the conceptualisation of a research question, aims and objects in
reflection of the larger research project. This in its self is not a limitation, but did lead to some
ambiguity in the aims of the study. Lack of understanding of the context and late identification
of the study site meant that the study tools were not sufficiently contextualised. The tools were
however piloted, which aided in rectifying these issues. The tools were modified with the
assistance of the moderator and a senior MANIFEST team member which aided in ensuring the
tools were culturally appropriate.

Perhaps the most significant limitation was my limited understanding of the cultural context and
language barriers. Firstly, I was only able to spend three weeks in the study area due to
logistical issues and delays in the ethical approval process. As such my understanding of the
historical, social and political context was limited. The FGDs were conducted in Ateso and
Lugwere, and whilst I was present for all FGDs it was not possible to gain a proper
understanding prior to reading the transcriptions. This was however mitigated to a certain
extend by discussing the FGDs with the moderator at the end of the day and by referring to
observational notes from the FGDs whilst listening to recordings with transcripts during the
analysis phase.

The moderator who facilitated the FGDs was experienced and built good rapport with
participants. Her relationship with the participants was discussed, but it was difficult to interpret
how her position as an outsider and educated women may have impacted group dynamics. The
aim of FGDS is to allow for “natural social interaction” (74). Rather than being conversations,
participants directed responses to the moderator and whilst there were non-verbal cues such as
laughter, the discussions did not result in natural conversation. This may have limited the depth
of the data to some extent.

The aim of recruitment was to have a sample of both members and non-members of SGs,
however only a minority were non-members. Male participation in SGs in Pallisa is low (88)
and it was expected that it would be difficult to recruit sufficient male SG members. Upon conducting the FGDs, only three of the male participants did not belong to any SG. It was only possible to hold two FGDs with male participants due to time restrictions. This was a concern during the data collection process, however upon analysis, it seems that saturation was reached. It may have been beneficial to hold mixed groups to examine how gender dynamics are practiced in conversation and could have provided a more nuanced understanding of gender relations. In relation to the KI interviews, participants were recruited through the DHO. Interviewing KIs who were not directly involved with MANIFEST would have allowed for a broader spectrum of insight.

Following data collection, the recordings were transcribed directly into English by the moderator. Again due to budgetary reasons, it was not possible to employ two translators. Transcription is itself a process of interpretation (74), as such the fact that the moderator transcribed and translated the data could be a strength or limitation.

This thesis concentrates on the marital/conjugal relationship. This is a conceptual weakness. There is research to suggest that in Uganda the extended family has an influence on household decision-making, and that for example mothers-in-law can enact the dominating role (19). Concentration on the husband/wife dyad may have led to over-looking important aspects, including inter-generational hierarchies of decision making. Additionally I did not collect information on whether men and women were heads of household, which could have an impact on decision-making autonomy (51).
Conclusion

This study suggests that saving for childbirth completes with varying demands and poor households must manage their resources to meet varying expectations. Translating knowledge of birth preparedness and the need to save is more complex than simply engaging in the practice of saving and may not be sufficient to increase levels of financial birth preparedness. The value of SGs may not be whether or not savings are made specifically for childbirth, but rather that SGs provide individuals with the flexibility to cater for divergent demands and expectations. Further study is merited to investigate the causal pathways by which saving specifically for childbirth interacts with the reciprocal nature of supportive spending, the fluid nature of saved money, income generation and household decision-making. Understanding the ways in which savings ultimately lead to preparedness for childbirth, could shed light on how to better encourage it.

Additionally without enhanced co-operation within the household and an increased awareness of birth being a joint responsibility, money saved for childbirth may be diverted to other priorities. A greater emphasis needs to be placed on improving communication between partners. Existing power relations and normative gender roles must be recognised if male involvement, which may lie in contradiction with the notion of female empowerment, is to be increased.
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Annexes

Annex 1: Information sheet for focus groups

English information sheet

Study title: Exploring attitudes towards saving for maternal healthcare and birth—A qualitative study in Pallisa, Uganda

1. Introduction
   The Principle researcher for this study is: Laura Hytti
   
   The Sponsor for this study is: Swedish International Development Cooperation Agency (Sida) through a Minor Field Studies grant

2. Purpose of this Research Study
   The purpose of the study is to better understand the attitudes and practices of men and women in Pallisa towards saving for giving birth and maternal health. You have been asked to attend a group discussion with other community members to help understand what kind of experiences expectant parents and parents have had with saving for birth and your thoughts on the topic.

3. Length of Your Assumed Participation
   Your participation will last for approximately 1 and ½ hours.

4. Where the Study is Being Done and Number of People Participating
   The study is taking place in Pallisa. Six to eight focus group discussions with 6 -10 participants each will be conducted. A total 60 people are expected to take part.

5. Study Procedures
   Before you take part in this research, the study will be explained to you and you will be given a chance to ask questions. Your consent will be taken verbally. You will be given a copy of this information sheet to take home with you.
   
   If you agree to take part in this study, the following will happen:
   
   You will attend a group discussion with other community members to help us understand what kind of experiences expectant parents and parents have had with saving for birth and your thoughts on the topic. You have been identified as a suitable candidate as you have had a child in the last two years, or you and your partner are currently expecting a child. The study will involve both men and women. You do not need to have engaged in any savings activities for birth to take part. The discussion will last approximately 1 and 1/2 hours and will be held in a place that is convenient for you to attend.
   
   The interview will be recorded. The recordings will be translated, transcribed and analysed and the audiotapes will be destroyed. At the end of the project, I will write a report that will be part of my Master’s thesis and the results of the study may be published.

6. Payment for Taking Part in this Study
   There is no compensation for taking part in this study.
7. Possible Benefits to You for Taking Part in the Study
There are no direct benefits for you for participating in this study. However, information gained in this study may contribute to building a better understanding of how families in Pallisa save and may contribute to the MANIFEST study being carried out by Makerere University, School of Public Health. Taking part in this study will not affect your membership in the savings group or your access to healthcare.

8. About Participation in this Study
Participation in this study is voluntary and you can decide whether or not you want to take part. If you choose to take part, you will be given a copy of this letter to keep and you will be asked to give verbal consent. If you change your mind, you can withdraw from the study at any time without giving any reason. If during the discussion group you do not wish to answer any of the questions asked, you do not need to do so. If you choose not to take part or withdraw from the study at any point, your membership with the savings group or access to health care will not be affected.

9. Compensation for Injury
By giving your consent, you will not waive any of your legal rights or release the parties involved in this study form liability for negligence.

10. Confidentiality of Study Records
Information collected from this study is confidential. However Makerere University School of Public Health, Uppsala University, and the Uganda National Council for Science and Technology (UNCEST) may review copies of the study records. Members of the Higher Degrees, Research and Ethics Committee (HDREC) may also review parts to the data collected in this study. Data collected are the property of the primary investigator. In the event of any publication regarding this study, your identity will not be disclosed.

11. Name of Contacts for Questions About the Study
If you have any questions about taking part in this study, call …………………………….. at …………………………….. who will be able to answer your questions in English or Ateso/Lugwere.

If you have any questions about your rights as a research subject, you can call the Chair of the Highest Degrees, Research and Ethics Committee (HDREC):

Higher Degrees, Research and Ethics Committee,
Makerere University School of Public Health’
P.O.Box 7-72
Kampala, Uganda

Kind regards,

Laura Hytti
Ateso information sheet

Akou: Amonokan’angaleuanu’atotokedaidoun – Aisisia ne jaikinakotoma’odisitrikita lo’ Pallisa ko Uganda.

1. Ageunet;
Itungan yen epolokitnit aingic na nges- Laura Hytti.
Nu ibikakitos akan kotoma aisisia na eras nu arionget na Swedish International Development co-operation Agency (Sida)

2. A peleikinet na’ingic na;
Erai apeleikinet na’jenun awomowomo keda aswamisio naikiliok keda’angor o’pallisa kotoma amoonoanu angaleu anu atoto nu ewuriete. Llipit isio eyesi abunere ajaikin kotoma aisisiana tetere imori awomisio anu ajenun anyokka aria bonati atikisio bari adumunit awuriak kotoma aimono anu aitemonikin aidoun keda bodo da awomisi kus kotoma eina alo.

3. Apaki neyangari einer lo;
Elosi einer adauw awojau ne sawa ediopere araaai ediopere keda atutubet.

4. Aibosit ne jai aisisia na keda enaba lo itunga lu ejaasi kotoma;
Ejai aisisia na pallisa eraisi igurupun ikanyape elosete ajaikin toma nu itunga 6-10. Kere kesit itunga 60 (akaisa kanyape) eteitemitai ajau toma.

5. Nu ebeit atupite;
Erongo ijo ejaikina kotoma aisisia na, ebeit atatamikin jo osodet ainaikin ijo arereng aingit aingisietia. Eyangario acamun kon anu jo ajaut toma sodi ilosi adumun ekopi la aiwadikaita ne.
Araai’cam ijo’ajaut kotoma ‘isisiana, nu kesiebeit atupite;

6. Aitac anu ijo ajaut kotoma aisisia na.
Emamei adio atocio kanu ijo ajaikin toma aisisia na.

7. Ameda nejai anu’ijo ajaut kotoma aisisia na;
Emamei ameda na erioro nejai anu’ijo ajaikin aisisia na konge nu elomunete kotoma aisisia na eloete aingarakin anu ajenun noi eipone lo imonot itunga lu o’pallisa osodi da eloete aiyatakin aingic na epurojekit lo MANIFEST lo eswamaete lu o’Makerere University School of Public Health. Ijo ajaikin kotoma aisisia mam elosi aisiimik ijo araut amemba ogurupu arai nati adumun amukian ne beit.

8. Ajaikin kotoma aisisia na;
Ajaikin kotoma aisisia na mam erai na’ebukinitai. Ipedori ijo aitijokor ajaut toma aria bo ainger. Arai itojoka jo ajaut toma, ilosi ijo adumun ekopi lo ebaluwa ido da ilosi aiiip jo aibikakink ecikum kon. Erai ijuilak ijo awomisiot kon, ipedor ajaalakin ari’a’lomun kinga omamu ilimunit idis bore yen imik ijo ajaikin
toma. Arai ipupi ijo ebe mam ikot alimun adio kiroto kotoma aisisia na, ejai ailajara, ipedor ijo ajiling.

9. **Egelit ejaikin ationis;**
Arai’ icam ijo albikakin ecikum apapula, mam bobo ijo ipedor ayaun edis kisil arai ejaikin adio lajara owaikon.

10. **Aiyeya ne jai toma;**

11. **Itunga lu ebeit aingit nu ikamutos aisisia na;**
Araai ejai adio ngisit anu ijo ajaikin asisia na, Inomaki .......................... Ko namba lo .......................... Ebangokin nges akon ingesita kotoma ateso keda amusugun.
Arai ejaasi aingiseta nu ikamunitosi ijo yen ingisngisio, ipedor ijo ainomakin ituet yen epoloikinit ediguri iwo okuju keda ekomit lo aingic (HDREC):

Higher Degrees, Research and Ethics Committee,
Makerere University School of Public Health,
P. O. Box 7072,
Kampala-Uganda

Laura Hytti
Lugwere information sheet

**Omutwe**: Okubisa nga be’tegekera obuíjanaji bwa’bakali’ababyaire no’kubyala-
Omusomo’gukolebewere mu disitríkit eya’e Pallisa mu Uganda.

1. **Okwanjula;**

   Omukulu mukbuliriria kuno niye-Laure Hytti.

   Abasasulire okunonereria kuno ba kitongole kya Swedish International Development Co-operation Agency (SIDA).

2. **Ekigendererwa kya kunonereria kuno;**

   Ekigendererwa kiri nti kumanya (ndowozia) ne nkola ya baisaza na’bakali mu Pallisa, kukubisa nga begegekera okubyla ne ndowozia bwa bakali ababyaire. Tubasabire okuiza okubawo mu kibina kine okukubagania eborowozo tusobole okutegera bintu ki oba buzibu ki ababyaire bye basunire mu kubisa nga begegekera okubyla ne ndowozia yanywe ku mulamwa guno.

3. **Eibanga lyetusubira okumala;**

   Tulikwaba kumala esawa moiza oba moiza nekekitundu.

4. **Aina jjebalikukola omusomo gunno ne namba yabantu abenyigiremu;**

   Omusomo guno gul Pallisa. Ebibina mukaga nga bui kimo kirimu abantu 6-10 biri kwaba okwenyiigiramu, wona wona nibo abantu 60 abasubirwa okwetaba mu.

5. **Ekyo kugoberera;**

   Nga’okali okwenyiigira mu’musomo guno, basooka kubainyonyola ekigendererwa kaisi bamale babawe omukisa okubunya ebibizo. Okwikirirya kwo kwatwalibwa ate balikwaba kabwawa ekopi ya lupapula luno mwabe nayo elika.

   Obwoba nga’oikiririe okuba mu’musomo guno, bino nibyo ebirikwaba okubawo:

   Olikwaba kuba mu’musomo naba’memba abandi abomu kitundu kina ekyo kyasobola okutuyamba okweyongera’okumanyana’basibira okuba bazaire na bazaire’bye mumaithe ku’kubisa nga mwetegekera’okubyla ne ndowozia yawinywe ku nsonga’eno. Olongerwe nga’amuntu’omutufu abyaireku mu’ibanga lye’myaka’emibiiri ejibitire oba osibira okusuna owamana muweseera bbyo kumpi.

   Omusomo gul wamak’abukubamu abakali na basaiza. Totekwa kuba nga’olimoiza kwabo abalili bubibinya ebibisa okwetegekera okubyla okusobola okuba mu’musomo. Omusomo gul kwa Mukula kumala sawa’moiza nekitundu ate mukifao’ko’wuliriramu eideembe.


6. **Okusasulwa olwo kwenyigira mu’musomo guno;**

   Wabulawo’kusasulwa kwona kwona oblo kuba wenyigire mu musomo guno.

7. **Okuganyirwamu okusubirwa;**

   Wabula kuganyirwamu okutereri okuliwo wabula ebibwoozo ebyazua mu’musomo guno bya yamba o kutegera engeri abantu be Pallisa ji babisa ate kyyagwera kukunonererwa kwa porujet ya MANIFEST erikukolebewa naba e Makerere University mulendekero eryo bulamu. Okwenyigira mu musomo guno tekirikwaba kukoza bwa memba bwo mubibina oba okusuna obuíjanaji.

8. **Okwenyigira mumusomo guno;**

   Okwenyigira mumusomo guno tekwalirimiziba. Osobola okusalawo okubamu oba obutabamu. Wasuna ekopi eyakiwandikico kina nga ekuza okwikiriria kwo. Obwo kyusa ebibwoozo kyo, oliwaidembe okuzwamu esawa yona yona nga towaireyo nsonga. Obwo wuliranti totaka kuiramu
kibuzo oliwaidembe obutairamu obwosalawo obwetenyigira mu musomo oba okuzua mu tekiri kwaba kukosabwa memba bwo mukikibiina oba okusuna obwijjanjabi.

9. Okusasulibwa ewabawo obukosefu;
Obwoba nga omalire okukiriria, tokirizibwa tete kutekamu byamateka gona gona singa wabawo obujagalavu.

10. Ebyama mu’musomo;
Byona byona ebizua’no birikwaba kukumibwa mukyama. Wabula Makerere University School of Public Health ne ekitongole ekikulu mu Uganda ekya science ne teknolajia (UNCEST) bainza okusoma ebiwandikirwe. Abamemba ba komiti enkulu ekwata kukunonereria ne neyisia (HDREC) bona basobola okusomamu mu aripota eno. Ebirowozo ebiwandikirwe bya muntu akulira ebyokunonereria kuno. Ebabba nga bafulumya eripota e kwatagana ku kunonereria kuno, amalina go te gali kwaba kuwandikibwamu.

11. Abokwebuliakuebibuzo ebikwata ku kunonereria kuno;
Obwoba nga olina ekibuzo ekikwata ku kunonereria kuno okubire .......................... owe.......................... eyairamu ebibuzo byo muluzungu oba muluteso/lugwere.

Obwoba nga olina ebibuzo ebikwata kuidembe ryo nga jjebusibwire, osobola okukubira akulira ekomiti enonereria ne neyisa muigwanga (HDREC):

Higher Degrees Research and Ethics Committees,
Makerere University School of Public Health,
P.O.Box 7072
Kampala, Uganda

Laura Hytti
Annex 2: Focus group discussion guide

FDG tool for Savings Group and Non-Savings Group members (men and women) - English

Introductions

Notes for the facilitator: Welcome everybody and thank them for being a part of the discussion. Introduce yourself as working in collaboration with a team from the MANIFEST project at Makerere University and introduce the subject of discussion. Read out the summary of the verbal consent. Before starting the discussion allow each one participant to introduce themselves.

Welcome

Thank you for joining us today, we really appreciate you taking your time to come and talk to us today. My name is ……………………………. and I work with Makerere University. With me today is Laura Hytti, she is a student from Uppsala University in Sweden and she is conducting research for her degree into community savings practices for maternal health. Laura has asked me to help carry out this discussion. We want to get a better understanding about whether people in Pallisa save, what they save for and your opinions on what factors contribute to how people make decisions about saving.

The information we get here may contribute to a larger project carried out by Makerere University that aims to improve maternal health in the district.

You have been invited to join because you or your partners have recently had a child, or are currently expecting a child.

Summary of the verbal consent

Taking part in this study is voluntary and you can decide whether or not you want to take part. What we discuss today will be kept confidential and your name will not appear in any published reports.

You are free to take part in this discussion but should you feel like you want to leave at any point, you free to do so without giving any reason. If during the discussion you do not wish to answer any of the questions asked, you do not need to do so.

If you choose not to take part or withdraw from the study at any point, your membership with the savings group or access to health care will not be affected. By giving your consent, you will not waive any of your legal rights or release the parties involved in this study form liability for negligence.

There is no compensation for taking part in this study.

We are tape recording the interview. This is to make sure that we do not miss anything you say. Please try to speak one at a time. All the data collected will be treated confidentially, and we would ask that you do the same. The recordings will be deleted once the discussion has been transcribed and analysed.

You will all be given a written copy of this information to keep. If you need any further
information about what we are doing, you can contact …………………… using the number that is written on the information sheet that we will give you at the end of the discussion. You will also get contact details for Chair of the Highest Degrees, Research and Ethics Committee (HDREC), who you can contact if you have any concerns about this study. You can also ask us questions at the end of the discussion.

**Ground rules**

- There are no wrong or right answers; we want to hear your opinions and thoughts. Please feel free to express your opinions. It is not a group consensus we are looking for but the opinions of everyone
- You don’t need to agree with others, but we would ask that you listen respectfully as others share their views
- I will assign each of you with a number, before you speak please state your number. This will make it easier for us to interpret what you have said.
- I will be moderating, meaning that I will introduce the topic to you, and ask you some questions along the way, but I will not take part in the discussion. Laura will be taking some notes, but she will not participate in the discussion. We hope the discussion will go on for about an hour and a half
- Confirm with participants that the recorders will now be switched on and ask for everyone’s verbal consent for taking part in the study and for the conversation to be recorded, ensuring that all members of the group respond. Does anyone have any questions before we start?

**Introductions**

Ask the participants to introduce themselves and assign them with respondent numbers

**Introductory vignette**

Notes for the moderator to: Read the vignette to the group to start the conversation.

*Mr Tawonia and Mrs Tawonia, Florence are a young couple living in Pallisa. They got married not long ago, and are thrilled to be expecting their first child. Mr Tawonia is a farmer; he has a small plot of land. He, like many others in the village has had problems with his crops this year, and has not gotten as big a return as he was hoping. Florence has a market stall where she sells cassava and millet. Both Mr and Mrs Tawonia work long days. They have talked about saving for the future. Florence has heard stories from women in her family of difficult births and she is worried about what may happen when she comes to give birth. She has mentioned putting a little bit of money aside for transportation, just in case, to her husband, but it is difficult, he says: there are other things that they need money for as well.*

This is a situation that many households in Pallisa may experience. What are your first thoughts when you here this story?

**Questions and prompts**

The questions below are suggestions and should be used selectively dependent on the discussion.

1. **Saving for health within the community**
1.1 Based on your experiences, what do people in the community save for?

Allow group to discuss

1.1.1 Probe if spending on health is not mentioned - Do you know of anyone who puts money aside for health emergencies?

1.1.2 If transport and birth preparedness is not mentioned – Do people save for preparing for birth and transport to health facilities?

1.2 How do community members save, what different types of ways of saving are there?

Allow group to discuss

1.2.1 Probe: Ask for clarification on different types of savings groups (giving examples of SACCOs, Burial groups, micro financing etc…)

1.3 Of the groups you have mentioned, which ones do men join and which ones do women join and why?

Allow group to discuss

1.3.1 Probe: Why do you think there are differences?

1.4 Only for groups with savings group members: If you were to recommend joining a savings group to a friend, what would be the three most important things to mention?

1.5 Why do you think some people join savings groups and others do not?

2. Decision-making towards saving and determinants/barriers of saving

2.1 Who in your household makes decisions on saving in general and specifically for maternal health?

2.2 What factors or issues influence people’s decisions on saving?

2.2.1 Probe: Do any of the following impact the way people make decisions about saving:

- Traditional norms and practices
- Religious norms and practices
- Support from family members or other community members
- If not mentioned, seasonality, business interests and other sources of income, such as loans

2.3 What challenges do households face in trying to save for MH and birth?

2.3.1 Follow-up question: How do you think households overcome these difficulties?

2.4 Whose responsibility is it to save for MH issues, like giving birth?
2.4.1 Prompt: if the conversation does not on its own lean towards discussing intra-household decision making, ask - In a household, who decides if money is actually used on maternal health?

2.5 Do you think husbands and wives (men and women) have different expectations about how much money will be saved and spent for giving birth?

3. Closing questions

Ask participants if there are any further comments and thank the participants for participating:

- Is there anything we missed that you would like to talk about relating to savings and maternal health?

Thank you very much once again for taking part in this discussion!
Annex 3: Information sheet and consent form for key informants

**Study title:** Exploring attitudes towards saving for maternal health and birth – A qualitative study in rural Eastern Uganda

1. **Introduction**
   The Principle Investigator for this study is: Laura Hytti

   The Sponsor for this study is: Swedish International Development Cooperation Agency (Sida) through a Minor Field Studies grant.

2. **Purpose of this Research Study**
   The purpose of the study is to better understand the attitudes and practices of men and women towards saving for giving birth and maternal health, birth and transport costs in Pallisa. In order to build a better understanding of current savings practices and the coverage and composition on savings groups within the areas, five key informant interviews are being carried out with experts who have knowledge and experience about savings groups in the community. You are invited to attend an interview in the study as a key informant.

   In addition to the five key informant interviews, 6 focus group discussions will be carried out with community members.

3. **Length of Your Assumed Participation**
   If you choose to partake in the study, your participation will last for approximately 45 minutes to one hour.

4. **Where the Study is Being Done and Number of People Participating**
   The study is taking place in Pallisa. Approximately 60 participants are expected to take part in the focus group discussions and a further five key informant participants will take part.

5. **Study Procedures**
   Before you take part in this research, the study must be explained to you and you will be given a chance to ask questions. You must read and sign this informed consent form. You will be given a copy of this consent form to take home with you.

   **If you agree to take part in this study, the following will happen:**

   You will attend an interview (either face-to-face, over the telephone or through video conferencing). During the interview, you will be asked about your expertise and opinions in relation to the current savings practices within the community and your understanding of saving decisions made by households within the area to help us understand the composition of saving groups in the area and the experiences expectant parents and parents may have of saving for birth.

   You are being asked to participate as a key informant in this study because you have experience or a background in the topic we are considering. The interview will last approximately 45 minutes to an hour and will be arranged at a time and place that is convenient for you to attend.

   The interview will be recorded. The recordings will be transcribed and analysed and the audiotapes will be destroyed. At the end of the project, I will write a report that will be part of my Master’s thesis and the results of the study may be published.

6. **Payment for Taking Part in this Study**
   There is no compensation for taking part in this study.
7. Possible Benefits to You for Taking Part in the Study
There are no direct benefits for you for participating in this study. However, information gained in this study may contribute to building a better understanding of how families in Pallisa save and may contribute to the MANIFEST study being carried out by Makerere University, School of Public Health.

8. About Participation in this Study
Participation in this study is voluntary and you can decide whether or not you want to take part. If you choose to take part, you will be given a copy of this letter to keep and you will be asked to sign a consent form. If you change your mind, you can withdraw from the study at any time without giving any reason. If during the interview you do not wish to answer any of the questions asked, you do not need to do so.

9. Compensation for Injury
By signing this consent form, you will not waive any of your legal rights or release the parties involved in this study form liability for negligence.

10. Confidentiality of Study Records
Information collected for this study is confidential. However Makerere University School of Public Health, Uppsala University, and the Uganda National Council for Science and Technology (UNCST) may review copies of the study records. Members of the Higher Degrees, Research and Ethics Committee (HDREC) may also review parts to the data collected in this study. Data collected are the property of the primary investigator. In the event of any publication regarding this study, your identity will not be disclosed.

11. Name of Contacts for Questions About the Study
If you have any questions about taking part in this study, call …………..at …………………., who will be able to answer your questions in English. If you have any questions about your rights as a research subject, you can call the Chair of the Highest Degrees, Research and Ethics Committee (HDREC) at …………………..  

If you have any questions about your rights as a research subject, you can call the Chair of the Highest Degrees, Research and Ethics Committee (HDREC):

Higher Degrees, Research and Ethics Committee,  
Makerere University School of Public Health’  
P.O.Box 7-72  
Kampala, Uganda  

Kind regards,  
Laura Hytti
VOLUNTEERS STATEMENT

I have been given the chance to ask questions about this research study. These questions have been answered to my satisfaction. I have been informed that if later I have any questions about taking part in this study, I may contact ……………………at ……………………

I understand that my participation in this research is voluntary. I know that I may quit the study at any time without harming my medical care or losing any benefits to which I might be otherwise entitled.

If I have any questions about my rights as a research subject in this study I may contact the chairperson of the:

Higher Degrees, Research and Ethics Committee,
Makerere University School of Public Health
P.O.Box 7-72,
Kampala, Uganda

By signing this consent form I have not waived any of my legal rights or released the parties involved in this study from liability for negligence.

I have read and understood the above information. I agree to participate in this study. I have been informed that I will be given a signed copy of this form for my own records.

___________________________   ____________________________   __________________
Name of Participant            Signature of Participant        Date

___________________________   ____________________________   __________________
Name of Person Obtaining Consent Signature of Person Obtaining Consent Date

___________________________   ____________________________   __________________
Name of Signature of person who Explained the study Signature of person who explained the study Date
Annex 4: Key informant interview guide

Welcome

- Interviewer introduces purpose of the study and institutions involved
- Advise interviewee of tape recording and confidentiality
- Provide opportunity to ask questions about the research

Questions and prompts

The questions below are suggestions and should be used selectively dependent on the discussion

Coverage and composition of savings groups in the area:

Could you please tell me about your involvement with community savings groups?

In accordance with your knowledge, could you describe the coverage and composition of savings groups in the area?

How are savings groups promoted in the area?

Are there any specific demographic patterns that you are aware of in relation to savings group membership?

Savings habits

- Based on your experiences, what do people in the community save for?
- Do people put money aside for health emergencies?
- What are the main reasons for whether or not savings are made?
- How do you think people decide upon what to save for or whether they can save or not?
- Who or what influences people’s decisions on saving?
- What kind of a role do you think household decision making processes play in savings practices?

3 Saving for MH

- Are you aware of people in the community saving for maternal health, delivery and transport cost?
- What is your opinion about encouraging savings towards MH and delivery?
- What in your opinion are the challenges or barriers to saving for maternal health?

Closing questions

Ask the participant if there are any further comments and thank him or her for their time

- Of all the things we have discussed here today, what do you think is the most important?
- Is there anything we missed that you would like to talk about?
Annex 5: Three delays model

Factors Affecting Utilization and Outcome

- Socioeconomic/Cultural Factors
- Accessibility of Facilities
- Quality of Care

Phases of Delay

- Phase I: Deciding to Seek Care
- Phase II: Identifying and Reaching Medical Facility
- Phase III: Receiving Adequate and Appropriate Treatment

Source: (8)

Annex 6: Spectrum of financial service providers

<table>
<thead>
<tr>
<th>Community-based</th>
<th>Institutional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>Regulated institutions</td>
</tr>
<tr>
<td>Community-based groups</td>
<td>Registered institutions</td>
</tr>
<tr>
<td>Money lenders, Deposit Collectors, Pawnbrokers, Traders, Shop owners, Friends/Family</td>
<td>Cooperatives/SACCOs, NGO MFIs/mutual insurers, Money transfer companies, Suppliers/wholesalers, Post Offices, Mobile savings</td>
</tr>
<tr>
<td>Indigenous: ROSCAS, ASCAS, Burial societies, Facilitated: Self-help groups, Financial service associations</td>
<td>Deposit taking MFIs, Banks, Credit Unions, NBIs, Commercial Insurers</td>
</tr>
</tbody>
</table>

ROSICA: Rotating Savings and Credit Associations
ASCAS: Accumulating Savings and Credit Associations
SACCOs: Savings and Credit Associations
NBIs: Non-Bank Financial Institutions

Note: Banks include state, rural, and savings banks as well as commercial microfinance banks

Freely adapted from source: (36)
## Annex 7: Review of existing programmes for SGs and MH

<table>
<thead>
<tr>
<th>Programme Name</th>
<th>Country and Agency</th>
<th>Description of project/intervention</th>
<th>Nature of evidence</th>
<th>Findings</th>
</tr>
</thead>
</table>
| TABASAM – Improving Maternal and Reproductive Health (89) | Tanzania, CARE Canada | • Over 45 VSLA groups aimed at empowering women and adolescent girls financially to pay for healthcare or transportation to facilities.  
• Combined with opportunity to learn about family planning and MH | No empirical evidence publicly available | No assessment available publically |
• SG component: aimed at economic empowerment of mothers through savings and IGA (Income generation activity)  
• MIYCN messages are integrated into SG meetings  
• Linking groups to local MFIs | Published presentation  
Results based on testimonials and observations | • Positive impact of savings in promoting optimal MIYCN and improved knowledge and practice  
• Strengthened social capital  
• Savings and IGAs helping to meet nutritional needs  
• Improved male involvement  
• Improved gender relations |
| AMPATH Maternal, Newborn and Child Health Program (91) | Kenya | • Target group: Mothers with HIV/AIDS  
• Promote peer support and accountability: community clubs, integrated care groups and provision of smartphones for use by Community Health Volunteers  
• AMPATH’s microfinance scheme (Group Integrated Savings for Empowerment) integrated into the intervention | No empirical evidence available publically | Whilst the SG arm is being run alongside the maternal and child health interventions, there are no reported Maternal health outcomes and no reports of utilising SGs to delivery maternal health messages. |
| Improving Maternal and Newborn Health through Income Generating Activities (IGA) of Mothers Saving and Loan Clubs in Northern Nigeria (92) | Nigeria USAID | • Target group: Mothers  
• Savings for improving healthcare seeking behaviors of pregnant mothers through SGs  
• Income generation and asset creation  
• Activities for social and economic development | Publically available non-peer reviewed report on study  
Findings from FDGs, in-depth interviews and register and record review | • Findings mainly related to group formation and functioning  
• Each club had a welfare fund specifically for emergency obstetric and newborn care  
• Women accessed and used emergency funds for the intended purposes |
| Women Investing Savings for Health (WISH) (47) | Nigeria | • Build a fund of savings women can use to pay for emergency health services, related to birth complications  
• Groups also served as a platform for providing health education outreach to the community | Unpublished study report of a pilot study  
Findings from qualitative study (FGDs and KI interviews) | • Groups conducted informal health education and expressed increased health literacy  
• Noted improvements in accessing health care services  
• Generally positive impact of husbands involvement in MH observed  
• Positive self-perception and community attitudes  
• Improved relationships between husbands and wives |
| --- | --- | --- | --- | --- |
| Chitral Child Survival Project (45) | Pakistan, USAIDs Child Survival and Health Grants Program (CSHGP) and AKF USA | • Aim: Help ease financial barriers to accessing health care for pregnant women  
• Selecting and training and Community Midwives (CMWs) in 28 villages  
• Community Based Savings Groups (CBSGs) served by the midwives  
• Combined with a Behavioural Change Communication (BCC) intervention | Published, peer-reviewed study protocol. Research findings currently published but not peer-reviewed.  
Findings from mixed-methods study (cross-sectional study and FGDs) | • Women with a family member in a CBSG were four times as likely to use the entire “continuum of care”  
• 15% of women had taken some financing from the group for health care related to pregnancies.  
• However use of health services was funded from multiple sources  
• Recipients of BCC who were also CBSG members supported and encouraged other members in taking risks and trying new behaviours more than BCC recipients who were not CBSG members |

Annex 8: Household Economic Portfolio Model

Modified form Household Economic Portfolios framework model presented by AIMS (50) based on the HHEP developed by Chen MA and Dunn E. Modified by principle researcher to substitute credit with savings (changes highlighted in blue).
## Annex 9: Steps taken to meet requirements for rigor and validity

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Requirements</th>
<th>Steps taken to address</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Credibility</strong></td>
<td>Aims to ensure internal validity of the research. Can be achieved through prolonged engagement in the context of the study and triangulation</td>
<td>Aimed to spend up to three weeks in the field and prior to the commencement of data collection made to make full use of the available expertise and knowledge of the local context within the wider MANIFEST research team. KI interviews and observations in addition to FGD to enable triangulation</td>
</tr>
<tr>
<td><strong>Transferability</strong></td>
<td>Qualitative research is intrinsically contextual and cannot be generalized; transferability rests in the delivery of contextual information so that the reader can understand and compare phenomena</td>
<td>The study uses data collected by the MANIFEST research team to obtain a thorough understanding of SGs in the district and the study sites and aims to provide sufficient information on the study context and setting to allow readers to understand the phenomena</td>
</tr>
<tr>
<td><strong>Dependability</strong></td>
<td>Demonstrate dependability by ensuring a detailed description of the design, and maintaining an audit trail</td>
<td>A detailed description of research design and implementation, in-depth details on data gathering and a reflective evaluation of the processes is presented in this thesis. Additionally Nvivo.10 software was used for the analysis of data to maintain an audit trail of the analysis process. Throughout the data collection and analytical process, an audit trail of development of thoughts and themes in relation to the data was also maintained.</td>
</tr>
<tr>
<td><strong>Conformability</strong></td>
<td>Triangulation and reflexivity</td>
<td>FGDs, KI interviews and observations have been triangulated. Feedback from colleagues has also been sought. Throughout the analysis process, constant comparison was conducted to ensure developed themes are based in data.</td>
</tr>
</tbody>
</table>

**Source:** (87)