



‘They would never receive you without a husband’: Paradoxical barriers to antenatal care scale-up in Rwanda



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ABSTRACT

Objective: to explore perspectives and experiences of antenatal care and partner involvement among women who nearly died during pregnancy ('near-miss').

Design: a study guided by naturalistic inquiry was conducted, and included extended in-community participant observation, semi-structured interviews, and focus group discussions. Qualitative data were collected between March 2013 and April 2014 in Kigali, Rwanda.

Findings: all informants were aware of the recommendations of male involvement for HIV-testing at the first antenatal care visit. However, this recommendation was seen as a clear link in the chain of delays and led to severe consequences, especially for women without engaged partners. The overall quality of antenatal services was experienced as suboptimal, potentially missing the opportunity to provide preventive measures and essential health education intended for both parents. This seemed to contribute to women's disincentive to complete all four recommended visits and men's interest in attending to ensure their partners' reception of care. However, the participants experienced a restriction of men's access during subsequent antenatal visits, which made men feel denied to their increased involvement during pregnancy.

Conclusions: 'near-miss' women and their partners face paradoxical barriers to actualise the recommended antenatal care visits. The well-intended initiative of male partner involvement counter-productively causes delays or excludes women whereas supportive men are turned away from further health consultations. Currently, the suboptimal quality of antenatal care misses the opportunity to provide health education for the expectant couple or to identify and address early signs of complications. **Implications for practice:** these findings suggest a need for increased flexibility in the antenatal care recommendations to encourage women to attend care with or without their partner, and to create open health communication about women's and men's real needs within the context of their social situations. Supportive partners should not be denied involvement at any stage of pregnancy, but should be received only upon consent of the expectant mother.

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Introduction

Antenatal care (ANC) is an important contributing factor in improved maternal health outcomes. Attendance provides the opportunity to identify and address underlying illnesses or early signs of pregnancy complications, and appears to increase the

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usage of emergency obstetric care and motivates women to deliver at a health facility (Raatikainen et al., 2007; Rööst et al., 2010; Adjiwanou and Legrand, 2013; Tunçalp et al., 2014). Yet, both the utilisation and provision of ANC in low-income countries remains inadequate. This may be explained by the difference between the ANC guidelines and actual provision of care; the availability and previous experience with ANC; the woman's and her potential partner's socioeconomic status, educational level, and marital status; as well as sociocultural factors (Simkhada et al., 2008; Adjiwanou and Legrand, 2013; Finlayson and Downe, 2013). In the sub-Saharan setting, the sociocultural factors have been referred to as, for example; the cultural perception of pregnancy as a healthy state, traditional beliefs of practices during pregnancy, the reluctance to disclose the pregnancy too early, the need for a woman to get permission from her partner or close relative to visit ANC, and the stigma of being pregnant outside of partnership (Atuyambe et al., 2009; Mrisho et al., 2009; Magoma et al., 2010; Fagbamigbe and Idemudia, 2015).

Rwanda has accomplished numerous improvements to health services, and has managed to reduce the maternal mortality ratio from 1071 per 100,000 live births in 2000 to 487 in 2010 and 210 in 2015 (National Institute of Statistics of Rwanda et al., 2000; National Institute of Statistics of Rwanda et al., 2012; National Institute of Statistics of Rwanda, 2015). Facility-based deliveries have increased from 27% in 2005, to 69% in 2010 and 91% in 2015 (National Institute of Statistics of Rwanda et al., 2006; National Institute of Statistics of Rwanda et al., 2012; National Institute of Statistics of Rwanda, 2015). This reduction can partly be explained by the community-based insurance scheme, 'Mutuelles de Santé', introduced in 1999 and currently covering 76% of the population (Logie et al., 2008; Pierce et al., 2014; Rwanda Ministry of Health, 2015).

In 2003, Rwanda adopted the World Health Organization's (WHO) model of four ANC visits, initiated in early pregnancy (Rwandan Ministry of Health, 2003). ANC is provided both at public health centres and private clinics by a skilled provider, most commonly a nurse. The visits should include tetanus toxoid vaccination and precautionary management of anaemia and pre-eclampsia, provision of health information related to danger signs during pregnancy and prevention of mother to child transmission (PMTCT) of HIV (National Institute of Statistics of Rwanda et al., 2012). In relation to the model, Rwanda supports male partner involvement at the first ANC visit specifically for HIV testing and PMTCT. The HIV prevalence is 2.2% among women and 3% among men (National Institute of Statistics of Rwanda et al., 2012). The campaign, referred to as 'Going for the Gold', was launched to encourage male participation, and attempts to prioritise women who come for ANC with their partners (World Health Organization, 2012). Presently, Rwanda records a distinctly high number of attending partners at 87% at first visit (Jennings et al., 2014).

In Rwanda, 99% of pregnant women attend ANC at least once and 44% complete all four visits, but an estimated two-thirds fail to initiate their attendance in a timely manner (Manzi et al., 2014; National Institute of Statistics of Rwanda, 2015). Reasons for women's delayed attendance have been attributed to geographical distance, having many children, or facing an unintended pregnancy, which nearly 47% of all pregnancies are estimated to be (Basinga et al., 2012; Manzi et al., 2014). Comparably, being covered by the community-based insurance scheme or other insurance, seeking care at a private facility or being married seem to be protective factors against delays (Manzi et al., 2014). However, how men's involvement affects women's participation in ANC has yet to be explored (Manzi et al., 2014). Although Rwanda has seemingly high gender equity on legal and policy levels, intimate relationships are still subjected to gender power imbalances. Women are generally responsible for household and caretaking

duties, whereas men predominantly work outside the home (Sleggh and Kimonyo, 2010; Umubyeyi et al., 2014).

This paper is part of a larger project focusing on care-seeking behaviour and experiences of care among women with a near-miss event during pregnancy. A 'near-miss' is defined as an incidence when a woman 'nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy' and can be used as a tool to evaluate the quality of obstetric care (Say et al., 2009). The aim is to explore the experiences of antenatal care among women who nearly died during pregnancy and their partners, as well as their perspectives on partner involvement.

Methods

Study setting

The study was conducted in Kigali, the capital of Rwanda having 1.2 million inhabitants. The literacy rate is 77% among women, and 80% among men, and yet educational attainment for all remains low, with less than 12% completing primary level and less than 6% secondary level of education (National Institute of Statistics of Rwanda et al., 2012). The majority of the Rwandan population works in agricultural occupations (National Institute of Statistics of Rwanda (NISR) & Ministry of Finance and Economic Planning (MINECOFIN), 2012).

The health care system has a pyramidal structure, with the community health centres at the bottom, which are the entry level for women in labour, followed by district hospitals and referral hospitals at the top (Nathan et al., 2015). Health centre employees are mostly nurses and/or midwives, while district hospitals also employ medical doctors, both general practitioners and specialists. All midwives and most nurses have completed diploma-level training at public or private health education institutes. However, some nurses employed at health centres have only completed secondary school (National Institute of Statistics of Rwanda et al., 2012).

Study design

This study is guided by the paradigm of naturalistic inquiry, in which emergent design is a useful tool. Naturalistic inquiry thereby allows for a constant redefinition of interview questions to gain a deeper grasp of the complex phenomena and emphasises the importance of prolonged engagement in the field to engage informants in their 'natural' environment and maintain the study context (Lincoln and Guba, 1985). All data were collected in Kinyarwanda by the first author with assistance from a local research assistant, who functioned as interpreter. The interviews were conducted using a dialogical approach and resembled a conversation. Participant observation was also conducted during fieldwork by the first author, together with the research assistant, at both the hospital and during interviews, to capture the local and individual context and to observe the non-verbal communications (Bernard, 2006). Trustworthiness of our interpretations was sought by continuous member-checking during data collection and informal interviews, and data were collected until topical saturation was met (Lincoln and Guba, 1985). Ethics approval was obtained from the Rwanda National Health Research Committee, Kigali (NHRC/2012/PROT/0045) and the Institutional Review Board of Kigali University Teaching Hospital.

Recruitment and data collection

Participants were recruited by purposive and snowball sampling (Bernard, 2006) at three public hospitals between March 2013 and April 2014. We used the inclusion criteria for ‘near-miss’ according to the World Health Organization definition, modified to match this low-resource setting (Say et al., 2009; Nelissen et al., 2013; Roost et al., 2009). These were: shock; emergency hysterectomy; uterine rupture; sepsis or signs of severe infection (temperature > 40); hypertensive diseases, such as eclampsia and severe preeclampsia; management-based criteria of blood transfusion (adapted to ≥ 3 units of blood); and severe anaemia (< 6 HB).

Local health care workers at the hospitals identified women fulfilling the inclusion criteria for ‘near-miss’, and informed the first author and/or research assistant. When the women were physically fit, the first author and research assistant approached the woman before discharge and asked if she wanted to participate. All participants were informed about the study, that participation was voluntary and that they could withdraw at any time. The interviews were conducted in the woman’s hospital room or in a private room. Similarly, the first author and research assistant approached the partner when he was visiting, but always after consent to do so was obtained from the woman. The partner was informed about the study, and interviewed separately in a private room. All participating women, except one, and all men agreed to be tape-recorded. Two ‘near-miss’ women and one man declined participation with no reasons given.

In total, 47 women with a near-miss event, 13 partners to those women, and 34 female and 26 male community members were included in the study. First-round in-depth interviews (IDIs) were completed with 47 women and eight partners. Later, 14 second-round IDIs were conducted up to nine months after the near-miss event at the women’s respective homes or at a public place where it was possible to achieve privacy. The second-round IDIs were completed with the participants who agreed to be revisited, were available and did not live too far away from Kigali. Seven of these women were interviewed together with their partner. Each first-round interview took approximately 20–60 minutes, and each second-round interview 60–120 minutes. Eight focus group discussions (FGD) were conducted, with five held at a conference centre in November 2013, and three independent FGDs at a participant’s home in April 2014. All FGDs comprised three to nine participants both including near-miss participants and community members. These were recruited using snowball sampling by asking the women or men with a ‘near-miss’ experience to bring one or two friends with pregnancy-related experience. Two of the FGDs were conducted with women, three with men, and three were mixed. Each took approximately 90–180 minutes. The interviews followed a semi-structured guide, including topics covering: experiences with antenatal care; attitudes about and understanding of the current ANC guidelines; and perceived disincentives to meet ANC recommendations. Data were transcribed and translated into English with the help of three individual translators. Each transcript was then validated by another translator for consistency to ensure trustworthiness (Squires, 2008).

Analysis

Emergent data analysis commenced by performing multiple readings of the transcriptions and field notes made by the first author during fieldwork (Lincoln and Guba, 1985). When all of the transcriptions were available, two of the co-authors read and re-read the transcriptions and independently identified preliminary intuitions, which were then discussed together. From there, the authors applied framework analysis to the dataset, which is a tool designed to respond to ‘top-down’ policy which allows for the presentation of the ‘bottom-up’ voice (Ritchie and Spencer, 2002;

Srivastava and Thomson, 2009). This procedure was conducted as follows: all data were organised, incorporating field notes, and deductively coded in ATLAS.ti (Scientific Software, 2013) using relevant concepts drawn from the current Rwandan ANC guidelines. We used such codes as, for example, ‘attitude to partner involvement’. The resulting coded sections were then mapped and interpreted by constant comparison between each other and the relevant ANC guideline. All co-authors came together to identify and agree upon the conflicting perspectives found between the guidelines and participants, which we interpreted as paradoxes. Disagreements about which paradoxes to emphasise as findings were resolved by referring back to the depth and consistency of the participants’ responses until agreement was reached. Three main paradoxical themes then became evident.

Findings

The women who experienced a near-miss event were between 16 and 38 years old. The other women from the community had an age span of 21–52 years. The male partners to near-miss women were between 23 and 35 years old, and the other were 21 and 62 years. Almost all of the participants had completed primary level education, and some had completed secondary or higher. Not all women were covered by the community-based health insurance. Several were uninsured and a few were covered by another type of insurance scheme. The most common professions were daily wage-earners or smallholding farmers. Several among both women and men were unemployed and expressed having limited affordability of care due to their being uninsured. The women were either in a relationship, which included marriage or registered partnerships, or single. The single category included those women who had recently separated, including separation that occurred either during, or as a result of, the pregnancy. Physical or sexual abuse was mentioned as taking place within a few of the intimate relationships. One woman specified that her miscarriage was a result of physical abuse.

Despite the country’s well-intended ANC guidelines, our participants presented experiences that suggest a potentially serious mismatch to widespread ANC utilisation in this setting. The influences of such paradoxical barriers are described in Table 1 and are further elaborated below. The first theme, ‘No husband – no reception’, responds to the perceived and experienced obligation of male attendance at first visit, whereas the second theme, ‘Husband attends – restricted participation’, elaborates the limitation of extensive male involvement. The third theme, ‘Disincentives for continued attendance’, develops additional barriers found to demotivate women from meeting the current ANC policy, which promotes four recommended visits.

No husband – no reception

Both women and men were well aware of the recommendations to attend ANC four times and to have the partner attend on the first visit, initiated early in pregnancy. As one woman put it, ‘if you respect the plan, you start prenatal visits when you are 3 months pregnant’ (FGD3: 31-year-old woman, near-miss). However, both women and men also interpreted the recommendation of being accompanied by a male partner as an obligation. Among women with a less than supportive partner, or no partner, the described alternatives were to either go to the Chief in the neighborhood (‘umudugudu’)¹ to obtain an official document containing information about the partner’s

¹ When referring to what in Kinyarwanda is called *umudugudu* we chose the term “neighborhood”, grouping 50–150 households into the smallest administrative unit, headed by a chief. In rural areas it is usually referred to as ‘village’.

Table 1
The paradoxical actions and potential consequences of current antenatal care guidelines.

Antenatal care guidelines	Participants perceptions and experiences	Paradoxical actions	Potential consequences
Early initiation, preferably within first trimester	<ul style="list-style-type: none"> Women aware of need for timely ANC initiation, but perceive negative reception by care staff if too early or too late Women avoid public disclosure of pregnancy before known viability 	<ul style="list-style-type: none"> Women avoid seeking care too early If unsure when pregnancy was conceived, women wait till the pregnancy can be seen or fetal movement can be felt 	Women delay and/or are demotivated to meet the recommended visits
Free antenatal care (ANC)	<ul style="list-style-type: none"> Perceived prerequisite of insurance coverage Costly examination tests, but price reduced if covered by insurance 	<ul style="list-style-type: none"> Delayed or non-existent initiation of ANC because of the perceived prerequisite of health insurance 	Limited risk awareness and preparedness for timely action in case of complications
Consultations to include precautionary management and health information	<ul style="list-style-type: none"> Health care staff not engaged Consultations short and basic Limited provision of health education 	<ul style="list-style-type: none"> Women's failure to report suspected symptoms and concerns to health staff Detection of preventable complications missed Delayed care-seeking if struck by a sudden complication 	<p>Increased perceptions of trust in traditional medicine and solutions</p> <p>Single pregnant women discriminated against by care staff and excluded from maternal health system</p>
Support partner involvement for PMTCT	<ul style="list-style-type: none"> Women attending alone are not consulted or are put last in line Men included primarily for initial HIV testing, inconsistency in provision of health education and not welcomed in the health consultations 	<ul style="list-style-type: none"> Delay attending ANC because of restricted availability of partner If no active partner or single: <ul style="list-style-type: none"> Ask or hire random man to attend as pretend male partner during first visit Obtain a document from chief of the neighborhood confirming lack of known husband Choose against ANC attendance Partner's refusal to disclose HIV status, time constraints, or feel unwelcomed at clinics Men perceived missed opportunity to receive pregnancy information Partner distrusts available pregnancy care 	<p>Increased dependency on male approval for care-seeking</p> <p>Increased risk of delayed care-seeking</p> <p>Decreased partner support</p> <p>Increased risk of maternal morbidity/mortality</p>

inability to attend, or to ask another man to pretend to be the husband and join the woman for the check-up.

Obtaining the official document was described as a potential delay-causing problem, or as being unlikely to happen altogether, exemplified by the following quote: 'Take for example a young woman who gets pregnant accidentally. Should she have to spend her time running after local authorities for a document that they are probably not going to give her, instead of going to work for money for her sustainability?' (FGD3: 30-year-old man). Women were reputed to solve this problem by asking someone to pretend to be their partner, or by hiring a random man, as one female participant explained: '[The health care providers] would never receive you without a husband ... The women who do not go with their husbands have to come with some other male person – it can be your brother, your neighbor or friend – but you have to make it look like the person is your husband' (FGD1: 35-year-old woman). Apparently, no identification of the partner was ever required at the ANC visit, making this a fairly viable solution. Nevertheless, it was perceived as altogether less than optimal:

When I was [at the health center], a woman came for her medical check-up and she waited for her baby's father for hours and he didn't show up. People told her to just go outside and pay one of the guys who were idling on the street and ask him to come with her as the baby's father. She went and paid the guy, and he came with her and they got the check-up over with. (FGD8: 34-year-old man)

This problem of access was interpreted as negative by both women and men, and described as discrimination against a pregnant single woman. For example, 'The day when I went for antenatal care, a lot of other women went back home without being checked up. They were chased away because they had come

alone, without their husbands' (FGD4: 30-year-old woman, near-miss). The ANC recommendation appeared paradoxical with what participants recognised as provoking serious negative implications on the outcome of the pregnancy: 'This rule is nowadays a great barrier, and many women are victims of this. If your man fled you cannot run after him to go to the hospital together.... This leads to many consequences, sometimes the woman delivers at home, she might even die or the baby dies' (FGD3: 30-year-old woman).

Those men who were supportive but not available expressed worries about whether their own unavailability would make their partner delay attending the first ANC visit. Limited availability was related to income obligations, such as working at a distant location or simply not being able to receive time off from work. For example:

I think the requirement of a man [attending] should be stopped. A woman might need to go for consultation when the one who impregnated her is not around. If you take my life as an example, if I am working in the countryside and it is the job I make a living out of, either I could not come or [my employer] would not give permission to leave the job. During that time my wife cannot go for prenatal consultation, and so she becomes late to her appointments.' (FGD3: 51-year-old man)

None of the single 'near-miss' women, whose pregnancy was described as unintended, had attended any ANC check-ups. This was in sharp contrast to those 'near-miss' women with supportive husbands, who had not only attended ANC, but who also did not perceive the requirement to be accompanied by a partner at first visit as problematic.

Husband attends – restricted participation

The primary reason for bringing the partner to the first ANC visit was understood to be for HIV testing. According to the men,

the actual HIV testing was not seen as a deterrent or concern. Joining the woman at the ANC check-up was also explained as a responsibility one takes as a partner, and being tested for HIV was perceived as being important in ensuring the health of the infant. One participant offered: 'I think that getting your woman pregnant and refusing to go with her to her doctor's appointments is a form of abuse because she is going to think that you do not care' (FGD8: 28-year-old man).

In contrast, several of the women believed or had experienced that the actual HIV testing was the main reason why some partners refused to join them, with the consequence that detection of HIV infection was delayed. One woman shared an anecdote about a friend who had attempted several times to go for ANC without her husband because he had refused to join her on suspicion that he was HIV positive: 'After the third try [and] being refused care [at the health center], she had to find the local authorities, and she received an approval document. When she finally went to the ANC check-up she found out she was HIV positive' (FGD3: 33-year-old woman).

Most participants saw the HIV testing as a positive aspect of the ANC recommendations. However, both women and men described men's involvement as being restricted as, once the testing was completed, the men were not allowed to participate in the actual health consultation. This appeared to provoke low trust in the value of the ANC check-up altogether among the men, and, in a paradoxical way, appeared to keep them from becoming more involved and increasingly supportive. Participants felt further antagonised against embracing the ANC visit as a vehicle for increasing knowledge about the pregnancy or, for the men especially, about gaining more insight into the health of their pregnant partner. The men questioned why they were only included in the HIV testing at the ANC visit and not welcomed at the health consultation. Therefore, some perceived that the consultations were an entire waste of time. This negative attitude was confirmed by some women, who elaborated that their own partners felt uncomfortable and unwelcomed at the health centre. Several men openly expressed a wish to be more involved, and assumed a position of having limited trust in the ANC care provided. As one man said:

There is something I do not like about those check-ups. During the first check-up, they will test for HIV together, but when it is time to examine the pregnancy, they will examine the woman on the side but lock the husband out. I feel like this is not fair, because we should know what they are doing to our wives. You do not know if they hurt her, or whatever they did to her during that check-up... If the husbands were allowed to be there, they would be watching everything that happens in there, and they would know whom to blame in case there was a mistake. (FGD8: 26-year-old man, partner to near-miss)

Among the men expressing a wish to join the health consultations, they wanted to receive more information and to have a better awareness about their partner's pregnancy. They also wished to know how to become more supportive to their pregnant wife. For example: 'When you go you can actually know what is happening to her, especially since the files they bring home are usually written in languages we do not understand' (FGD7: 33-year-old man, partner to near-miss).

The attitude toward wanting men to join in on the health consultation also appeared to be grounded in men's lack of trust in the story explained by their partner. Some women raised this issue, claiming they would be better 'protected' if their partner could receive advice and information first-hand, as one explained:

When you go for consultations, they might find a problem and tell you to avoid hard work, but most of the time our husbands

do not believe it. It may be that the husband thinks you are lying to avoid work, and he might start treating you bad. If we could go together, and the nurse could explain to him, then he would accept it easily. (IDI: 30-year-old woman, near-miss)

Disincentives for continued attendance

Only two of the 'near-miss' women had attended four times, and several described disincentives for not having returned, most of them because of delayed initiation of their first visit. Attending ANC appeared to enable access to facility-based childbirth. The women explained how they received a card, referred to by the women as an 'access pass', only after attending ANC. The access pass shows dates of ANC attendance and the HIV test result. Without the card, the women believed they could be fined, or worse, punished. One participant explained:

The incentive to go [to ANC] is to get the access pass. If you have not been tested for HIV, then the cleaners at the hospital will refuse to wash your bloody clothes or the linens used on your bed during labor. Your relatives will be the ones to wash them, and the nurses will simply not treat you well. (FGD5: 23-year-old woman, near-miss)

Attending ANC at a private clinic appeared to bring possible difficulties, exemplified by a woman who had attended ANC at a private clinic, but then went to deliver at the public hospital where she was asked to show the note from the check-up: 'They did not seem to like that, they told me that next time there will be a penalty' (FGD4: 26-year-old woman, near-miss). In her case, she had been turned away at the public hospital because of coming too late for her first check-up, as she explained, 'They told me that I was late, so I went back home, and the next day I went to a private clinic and paid'. Women expressed being cautious about not coming too early or too late for the first check-up, perceiving that it was not appreciated among the health-care workers.

Aside from the benefits offered by receiving the 'access pass', additional incentives for the women attending ANC were checking their own health, as well as that of the fetus, and obtaining the required vaccinations. Yet, the consultations were experienced as having room for improvement. There also appeared to be very limited actual information provided about danger signs or risks during the pregnancy. Both women and men explained about disliking the superficial information they received while attending a shared session with other couples, which appeared to be provided at some clinics, but not all. Even fewer participants had received any type of information booklet. In addition, if the ANC consultations provided health information, it was presented in such basic terms that participants complained about having no possibility to discuss personal concerns. For example, 'You get the vaccination, and they give you new appointments until you give birth. But they do not give you much more' (IDI: 21-year-old woman, near-miss). Several women described having to spend a long time queuing, but then not being well received. Some women recalled insufficient consultations, with early signs of pre-eclampsia gone undetected. One woman recalled being told she had no problems, but without her blood pressure being taken. It was recommended that she avoid hard work and she was given pain-killers. This experience of low quality care seemed to be a disincentive to meet all four recommended ANC visits or an incentive to switch to another clinic, as exemplified by one 'near-miss' woman:

When I went to the health center they could not do anything for me. They only told me that during the first pregnancy the problems can be like that, with some women sleeping the entire time, and that it was normal to feel sick. I started feeling

discouraged, and not able to trust that the health-care workers could help me. I do not give a credit to health check-ups because they were just treating me as if I was a complainer. (IDI: 23-year-old woman, near-miss)

Although ANC is supposedly provided to women free of charge, the 'near-miss' women described themselves as being burdened by delays resulting from having no insurance card – in many cases because of the lack of a man to accompany them, as described above, or simply because the pregnancy was unintended – as well as having limited financial capabilities or dependency on an unsupportive husband's income. Some participants recalled incurring extra costs for tests that had been conducted during the visits. 'Near-miss' participants believed that insurance was needed prior to the first visit in order to access ANC and they thus delayed attending. For example, one man explained:

I wasn't around and she was already pregnant. I spent two months working outside of Kigali. When I returned, we went to get [the health insurance] but the electrical power was often off during these days, and so they delayed making our membership card. Because of this, we delayed for months before going to the check-up. (IDI: 26-year-old man, partner to near-miss)

Discussion

We have identified several paradoxical barriers to women and their partners attending ANC, despite Rwanda's well-intended policies. The promotion of male involvement was experienced as a requirement, and created a number of delays to women's care-seeking and utilisation of ANC. Thus, if a woman has missed her opportunity to acquire the 'access pass', this may limit her ensured entrance into maternity services. Moreover, the requirement for having the partner accompany the woman on her first visit, but then restricting men's access after that point, denied men the opportunity to invest a continued interest in the pregnant woman's situation. Women perceived the quality of ANC services as suboptimal, and they were aware of how the poor quality of care created missed opportunities for health-care workers to provide preventive measures and appropriate health education. The suboptimal quality of care discouraged our participants from completing the four recommended visits. The potential outcome of these paradoxical barriers suggests several failures in the widespread scale-up of Rwanda's ANC initiative, which aims to ensure safe pregnancy.

The health system would benefit from the creation of a more flexible avenue for women without partners to circumvent these paradoxical and potentially discriminating consequences. Given that the current initiative seems to be regarded as a requirement, the power of decision-making for seeking ANC is given to the men, which, consequently, can act to disempower women. A recent analysis of the DHS data indicated no association between the currently high number of men attending ANC and women's empowerment (Jennings et al., 2014). Nevertheless, Rwanda aims to decrease gender inequities, even if the traditional male role as head of household persists (Delvaux et al., 2009; Sleghe and Kimonyo, 2010). A dependency on men, especially where there is lack of partner support, poses barriers for women's care-seeking, which is a finding supported in other sub-Saharan studies (Biratu and Lindstrom, 2007; Hjarlath et al., 2014). Additionally, our findings indicate that the current initiative for partner involvement consequently prioritises normative relationships and reinforces the vulnerability of women who become pregnant outside of partnership (McPhail, 2008). The single women in our study who indicated that they had unintended pregnancies had not

attended any ANC. The alternative solutions of finding a stand-in partner or obtaining an approval document from the Chief of the neighborhood both serve to increase shame on women. This may be especially true given the stigma surrounding unintended pregnancies outside of partnership (Atuyambe et al., 2009).

Importantly, our findings identify that the men accompanying the pregnant women to their first ANC visit are not necessarily the father of the baby. This highlights the potentially serious problem that, if single women perceive that they can access care only when accompanied by a stranger, then the original health system incentive is lost. Additionally, while not assessed here, there is considerable economic waste when investing in testing these substitute 'fathers' for HIV. Notably, our male participants showed positive attitudes toward partner testing, which is in line with earlier reports from Rwanda (Kelley et al., 2011; Kayigamba et al., 2014). It may thus be that the 'Going for the Gold' initiative has decreased the fear of HIV testing. However, our participants suggest that men who know or suspect that they are HIV positive are less willing to accompany their partner for testing. Reasons for such reluctance have been identified in the literature as men fearing the revelation of infidelity, and HIV testing posing a threat to men's perceived masculinity (Matovu et al., 2014; Siu et al., 2014). In addition, several of our participants stated job obligations as the main reason why they were unable to attend with their partner for testing. The health system tries to meet this barrier by offering flexible opening hours and giving couples the opportunity to attend ANC appointments on Saturdays (World Health Organization, 2012; Hagey et al., 2014). However, it may also be that work obligations can be used as an excuse to cover up the fear of partner testing (Katz et al., 2009).

The men in our study expressed dissatisfaction about being excluded from ANC care beyond the first visit, which barred them from accessing their partner's consultations at the public health facilities. Generally, ANC is seen as a female domain and it is considered rare for a man to accompany his partner (Aarnio et al., 2009; Katz et al., 2009; Christianson et al., 2013; Singh et al., 2014). However, the initiative for partner involvement in Rwanda might have triggered an increased interest among these men to take part in the ANC consultations. The advantages to partner involvement in ANC are numerous. These likely go beyond men's increased support, and include their readiness during pregnancy, as well as women's increased adherence to facility-based delivery (Mullany et al., 2007; Tweheyo et al., 2010; Kakaire et al., 2011). Our findings strongly imply that the main incentive for a man to accompany his partner is grounded in distrust of the available care, and to attempt a measure of control that the care provided does not cause harm. This reasoning may have been strengthened by the fact that most of the men in the study had a partner who nearly died due to pregnancy-related complications. We recommend that the health system continues to embrace the encouragement of partner involvement, but to extend it only through obtaining the consent of the pregnant woman. Although these women expressed a willingness for increased male involvement, a recent review point out that women are uncomfortable with their partner being present, especially for HIV testing (Ditekemena et al., 2012).

Whereas a causative link between some of the women's 'near-miss' experiences might be made with their own limited ANC attendance, a similar adverse outcome can be anticipated as a result of the suboptimal care provided, according to the women's perceptions. This finding has also been reported for other low-income settings when signs of complications are left undetected (Rööst et al., 2010; Tunçalp et al., 2013). In addition, missed opportunities for the provision of important health information about pregnancy risks to both the women and their partners were a common problem among our participants. Improved health education and risk awareness are thus emphasised here as being

essential for increasing women's timely care-seeking. Similar calls have been made in other sub-Saharan settings, and yet availability of such counselling remains limited (Pembe et al., 2009; Mbalinda et al., 2014). Rwanda has the possibility to overcome women's low completion of the four recommended visits. However, if the care provided does not serve women's needs, they are less likely to continue engaging with it (Finlayson and Downe, 2013).

Strengths and limitations

An advantage of using mixed focus groups was that both women and men became able to raise their opinions, over which further discussion might segue. In this way, both women and men were given the opportunity to obtain a deeper understanding of each other's gendered perspectives. Similarly, interviewing women and men separately paved the way for sharing matters about which participants were not comfortable raising in a mixed group. These were captured and used as the emergent line of questioning during the focus groups (Lincoln and Guba, 1985). The strategy of the design thereby allowed mixed participants to elaborate their gendered perspectives, even if the concepts were offered individually. A potential limitation was our inadequate probing about HIV testing and the revelation of results. This is suggested for further study.

The men included in this study appeared to be actively involved husbands, or wanted to give the impression of being so. Another recruitment procedure might have been considered to obtain the general voice of men whose partners had not experienced a near-miss event. It might be that their partner's experience of nearly dying had heavily influenced the attitudes of the men in this study. To maintain a standard of ethics, the specific care provided at any individual health centre is not elaborated here.

The researcher's position as a foreigner is a potential limitation, yet was not experienced as such as it instead appeared to facilitate the interviews, and several participants expressed their gratitude about a 'stranger' coming to hear about their experiences. Participants stated relief that their experiences could then be reported to the health authorities. However, being dependent on a translator created certain limitations, especially at the beginning of the study. For example, there were initial misunderstandings about the translation of 'antenatal care' per se. Throughout the entire study period, transcripts were checked for quality by using a variety of external translators to minimise misinterpretations and errors (Squires, 2008).

Conclusions

This study highlights that women who do not have a supportive partner are currently lost in this health system initiative of partner involvement, potentially putting them at higher risk of maternal morbidity. Parallel to this finding, supportive men are turned away from further health consultation, presenting a missed opportunity to embrace their commitment. The recommendation for partner involvement may need to be re-evaluated and afforded increased flexibility. Further, the suboptimal quality of care may lead to missed early signs of complications, and fail to provide appropriate health education. Both are needed to strengthen women's and men's preparedness to act efficiently in case of pregnancy complications.

Conflicts of interest

The authors declare they have no competing interests.

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References

- Aarnio, P., et al., 2009. Male involvement in antenatal HIV counseling and testing: exploring men's perceptions in rural Malawi. *AIDS Care* 21, 1537–1546.
- Adjiwanou, V., Legrand, T., 2013. Does antenatal care matter in the use of skilled birth attendance in rural Africa: a multi-country analysis. *Soc. Sci. Med.* (86), 26–34.
- Atuyambe, L., et al., 2009. Seeking safety and empathy: adolescent health seeking behavior during pregnancy and early motherhood in central Uganda. *J. Adolesc.* 32, 781–796.
- Basinga, P., et al., 2012. Abortion incidence and postabortion care in Rwanda. *Stud. Fam. Plann.* 43, 11–20.
- Bernard, H.R., 2006. *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Rowman Altamira.
- Biratu, B., Lindstrom, D., 2007. The influence of husbands' approval on women's use of prenatal care: results from Yirgalem and Jimma towns, south west Ethiopia. *Ethiop. J. Health Dev.* 20, 84–92.
- Christianson, M., Boman, J., Essén, B., 2013. "Let men into the pregnancy" – men's perceptions about being tested for Chlamydia and HIV during pregnancy. *Midwifery* 29, 351–358.
- Delvaux, T., et al., 2009. Determinants of nonadherence to a single-dose nevirapine regimen for the prevention of mother-to-child HIV transmission in Rwanda. *J. Acquir. Immune Defic. Syndr.* 50, 223–230.
- Ditekemena, J., et al., 2012. Determinants of male involvement in maternal and child health services in sub-Saharan Africa: a review. *Reprod. Health* 9, 32.
- Fagbamigbe, A.F., Idemudia, E.S., 2015. Barriers to antenatal care use in Nigeria: evidences from non-users and implications for maternal health programming. *BMC Pregnancy Childbirth* 15, 4–13.
- Finlayson, K., Downe, S., 2013. Why do women not use antenatal services in low- and middle-income countries? A meta-synthesis of qualitative studies. *PLoS Med.* 10, e1001373.
- Hagey, J., Rulisa, S., Pérez-Escamilla, R., 2014. Barriers and solutions for timely initiation of antenatal care in Kigali, Rwanda: health facility professionals' perspective. *Midwifery* 30, 96–102.
- Hlarlathie, M.O., et al., 2014. Economic and social factors are some of the most common barriers preventing women from accessing maternal and newborn child health (MNCH) and prevention of mother-to-child transmission (PMTCT) services: a literature review. *AIDS Behav.* 18, 516–530.
- Jennings, L., et al., 2014. Women's empowerment and male involvement in antenatal care: analyses of Demographic and Health Surveys (DHS) in selected African countries. *BMC Pregnancy Childbirth* 14, 297.
- Kakaire, O., Kaye, D.K., Osinde, M.O., 2011. Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. *Reproduct. Health* 8, 12.
- Katz, D. a, et al., 2009. Male perspectives on incorporating men into antenatal HIV counseling and testing. *PLoS One* 4, e7602.
- Kayigamba, F.R., et al., 2014. Provider-initiated HIV testing and counselling in Rwanda: acceptability among clinic attendees and workers, reasons for testing and predictors of testing. *PLoS One* 9, e95459.
- Kelley, A.L., et al., 2011. Knowledge and perceptions of couples' voluntary counseling and testing in urban Rwanda and Zambia: a cross-sectional household survey. *PLoS One* 6, e19573.
- Lincoln, Y.S., Guba, E.G., 1985. *Naturalistic Inquiry*. Beverly Hills, CA: Sage.
- Logie, D.E., Rowson, M., Ndagije, F., 2008. Innovations in Rwanda's health system: looking to the future. *Lancet* 372, 256–261.
- Magoma, M., et al., 2010. High ANC coverage and low skilled attendance in a rural Tanzanian district: a case for implementing a birth plan intervention. *BMC Pregnancy Childbirth* 10, 13.
- Manzi, A., et al., 2014. Assessing predictors of delayed antenatal care visits in Rwanda: a secondary analysis of Rwanda demographic and health survey 2010. *BMC Pregnancy Childbirth* 14, 290.
- Matovu, J.K., et al., 2014. "Men are always scared to test with their partners ... it is like taking them to the Police": motivations for and barriers to couples' HIV counselling and testing in Rakai, Uganda: a qualitative study. *J. Int. AIDS Soc.* 17, 1–11.
- Mbalinda, S.N., et al., 2014. Does knowledge of danger signs of pregnancy predict birth preparedness? A critique of the evidence from women admitted with pregnancy complications. *Health Res. Policy Syst./BioMed Central* 12, 60.
- McPhail, B.A., 2008. A feminist policy analysis framework: through a gendered lens. *Soc. Policy J.* 2, 39–61.
- Mrisho, M., et al., 2009. The use of antenatal and postnatal care: perspectives and experiences of women and health care providers in rural southern Tanzania. *BMC Pregnancy Childbirth* 9, 10.

- Mullany, B.C., Becker, S., Hindin, M.J., 2007. The impact of including husbands in antenatal health education services on maternal health practices in urban Nepal: results from a randomized controlled trial. *Health Educ. Res.* 22, 166–176.
- Nathan, L.M., et al., 2015. Decentralizing maternity services to increase skilled attendance at birth and antenatal care utilization in rural Rwanda: a prospective cohort study. *Matern. Child Health J.*, 1–7.
- National Institute of Statistics of Rwanda, 2000. Rwanda Demographic and Health Survey 2000 - Key Findings, Kigali, Rwanda.
- National Institute of Statistics of Rwanda, Ministry of Health & ICF International, 2006. Rwanda Demographic and Health Survey 2005, Kigali, Rwanda.
- National Institute of Statistics of Rwanda, Ministry of Health & ICF International, 2012. Rwanda Demographic and Health Survey 2010, Kigali, Rwanda.
- National Institute of Statistics of Rwanda, 2015. Demographic and Health Survey 2014/2015 Key Findings Rwanda. Kigali, Rwanda.
- National Institute of Statistics of Rwanda (NISR) & Ministry of Finance and Economic Planning (MINECOFIN), 2012. Rwanda Fourth Population and Housing Census. Thematic Report: Characteristics of Households and Housing, Kigali, Rwanda.
- Nelissen, E., et al., 2013. Applicability of the WHO maternal near miss criteria in a low-resource setting. *PLoS one* 8, e61248.
- Pembe, A.B., et al., 2009. Rural Tanzanian women's awareness of danger signs of obstetric complications. *BMC Pregnancy Childbirth* 9, 12.
- Pierce, H., Heaton, T.B., Hoffmann, J., 2014. Increasing maternal healthcare use in Rwanda: implications for child nutrition and survival. *Soc. Sci. Med.* 1982 (24), 61–67.
- Raatikainen, K., Heiskanen, N., Heinonen, S., 2007. Under-attending free antenatal care is associated with adverse pregnancy outcomes. *BMC Public Health* 7, 268.
- Ritchie, J., & Spencer, L., 2002. Qualitative data analysis for applied policy research. In: Huberman, A. M., Miles, M.B. (Eds.), *The Qualitative Researcher's Companion*. Sage, London. pp. 305–329.
- Roost, M., et al., 2009. Priorities in emergency obstetric care in Bolivia – maternal mortality and near-miss morbidity in metropolitan La Paz. *BJOG* 116, 1210–1217.
- Rööst, M., et al., 2010. Does antenatal care facilitate utilization of emergency obstetric care? A case-referent study of near-miss morbidity in Bolivia. *Acta Obstet. Gynecol. Scand.* 89, 335–342.
- Rwanda Ministry of Health, 2015. Key indicators. Available at: (<http://www.moh.gov.rw/index.php?id=3>) [last accessed 19 February 2015].
- Rwandan Ministry of Health, 2003. National Reproductive Health Policy, Kigali, Rwanda.
- Say, L., Souza, J.P., Pattinson, R.C., 2009. Maternal near miss – towards a standard tool for monitoring quality of maternal health care. *Best Pract. Res. Clin. Obstet. Gynaecol.* 23, 287–296.
- Simkhada, B., et al., 2008. Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature. *J. Adv. Nurs.* 61, 244–260.
- Singh, D., Lample, M., Earnest, J., 2014. The involvement of men in maternal health care: cross-sectional, pilot case studies from Maligita and Kibibi, Uganda. *Reprod. Health* 11, 68.
- Siu, G.E., Wight, D., Seeley, J. a., 2014. Masculinity, social context and HIV testing: an ethnographic study of men in Busia district, rural eastern Uganda. *BMC Public Health* 14, 33.
- Sleggh, H., Kimonyo, A., 2010. Masculinity and Gender Based Violence in Rwanda: experiences and perceptions of men and women. Rwanda MenEngage Network.
- Squires, A., 2008. Language barriers and qualitative nursing research: Methodological considerations. *Int. Nursing Rev.* 55, 265–273.
- Srivastava, A., Thomson, S.B., 2009. Framework analysis: research note. *JOAAG* 4, 72–79.
- Tunçalp, Ö., et al., 2013. Assessment of maternal near-miss and quality of care in a hospital-based study in Accra, Ghana. *Int. J. Gynaecol. Obstet.: Off. Organ Int. Fed. Gynaecol. Obstet.* 123, 58–63.
- Tunçalp, Ö., et al., 2014. Understanding the continuum of maternal morbidity in Accra, Ghana. *Matern. Child Health J.* 18, 1648–1657.
- Tweheyo, R., et al., 10, 2010, 53. Male partner attendance of skilled antenatal care in peri-urban Gulu district, Northern Uganda. *BMC Pregnancy Childbirth*.
- Umubyeyi, A., et al., 2014. Women are considerably more exposed to intimate partner violence than men in Rwanda: results from a population-based, cross-sectional study. *BMC Women's Heal* 14, 99.
- World Health Organization, 2012. Male involvement in the prevention of mother-to-child transmission of HIV, Geneva, Switzerland.