# Silent Flight: Maternal Health of Congolese Refugees in Burundi and the Call for Women's Economic Empowerment

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ABSTRACT

In this paper we present findings from a mixed methods study that was conducted with refugees from the Democratic Republic of Congo living in Burundi, both in UNHCR camps and within the urban community. Collecting both qualitative and quantitative data, we found that maternal health services were limited for refugees within Burundi, and that there was great variation across the camps. The data collected indicated that the women's concerns were not confined to maternal health, but basic needs of food and economic empowerment were higher order. For those living in the urban community, documentation to enable work was a major concern. This data collection effort provided pilot information for a larger data collection with refugee populations within sub-Saharan Africa. Such data collection needs to incorporate a broad range of socio-economic topics, and interventions to improve economic empowerment are most called for by the refugees.

*Keywords:* maternal health, economic empowerment, refugees, forced displacement, sub-Saharan Africa, UNHCR

## 1. Introduction

According to the UNHCR[g], there are 68.5 million forcibly displaced people worldwide. This population is made up of 25.4 million refugees, 40 million internally displaced persons and 3.1 million asylum-seekers. Developing countries host 85% of the worldwide refugee population.

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[g] https://www.unhcr.org/globaltrends2017/

Sub-Saharan Africa is home to 31% of the worldwide refugee population, with a complex flow of individuals from and to the same countries with humanitarian crises. The Democratic Republic of Congo (DRC) saw 94.7 million refugees flee their country in 2017, and at the same time DRC was host to 104.4 million refugees from other SSA countries such as South Sudan and Central African Republic. Similarly, Burundi saw 37.2 million refugees flee its borders in 2017, and it played host to xx refugees. At the time of writing, Burundi hosts 45,336 refugees from the Democratic Republic of Congo.

In this paper, we focus on the DRC refugees living in Burundi, in Bujumbura (city) or within UNHCR camps. Burundi, the host country in this paper, and its people face a humanitarian crisis, "marked by economic decline, extreme food insecurity and a disease outbreak."[h] And, "[w]hile the worst of the violence has eased, the situation remains fragile, with an unresolved political situation and continued displacement within and outside the country."[i] The refugees that we focus on in this paper came from the Democratic Republic of Congo, and the UNHCR describes DRC as "one of the most complex and challenging humanitarian situations worldwide, with multiple conflicts affecting several parts of its vast territory."[j] As of August 2018, there were 536,271 refugees (international refugees[k], not including the 4.5 million internally displaced persons), most of whom were hosted by Rwanda, Central African Republic, and South Sudan, and the fourth largest host was Burundi with 46,512 refugees from DRC.

Children make up 55% of the refugee population, this includes adolescents. Women make up 25% of the refugee population (meaning men make up 20% of the refugee population). The needs of women and children then come to the fore as they make up the majority of the population. Adolescent girls stand as a highly vulnerable group. The health needs of women and children can fall under the umbrella of maternal health, assisting women during pregnancy, childbirth and in the postpartum period. Maternal health is defined by the World Health Organization as the "health of women during pregnancy, childbirth and the postpartum period[l]. Maternal health is part of a woman's sexual and reproductive health. Throughout a woman's life, she has "many and varying sexual and reproductive health needs (Barot 2017). The need for contraception to prevent unwanted pregnancies; prenatal, delivery, and postnatal care" (that is, maternal health); "information and services for the prevention of HIV and other STIs; and prevention and management of sexual and gender-based violence, including care for survivors" (Barot 2017), are all highly relevant within the camp setting.

[h] https://www.unhcr.org/en-us/burundi-situation.html
[i] https://www.unhcr.org/en-us/burundi-situation.html
[j] https://www.unhcr.org/en-us/dr-congo-emergency.html
[k] A refugee is someone who has been forced to flee his or her country because of persecution, war or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries. An internally displaced person, or IDP, is someone who has been forced to flee their home but never cross an international border. https://www.unrefugees.org/refugee-facts/what-is-a-refugee/
[l] https://www.who.int/maternal-health/en/

During a humanitarian crisis, maternal health services are severely interrupted as the crisis weakens the general health system (Southall 2011). The lack of health infrastructure (through destruction or abandonment), a poor referral system, lack of skilled medical staff and lack of capacity building, lack of quality management, inequity in who receives services, and attacks on health care providers (Elamein, Bower et al. 2017), are all symptoms of the general health system breakdown during a humanitarian crisis (Newbrander, Waldman et al. 2011). Add to this the lack of economic empowerment for locals and refugees (Spiegel 2015), food shortages, threats to hygiene and sanitation, and the breakdown of local support structures (Gasseer, Dresden et al. 2004, O'Hare and Southall 2007).

As an extreme measure of maternal health, maternal mortality among refugees (Bartlett, Jamieson et al. 2002) was recorded in the Afghan refugee population in Pakistan in 2000. A review of fifty-two refugee camps across Azerbaijan, Ethiopia, Myanmar, Nepal, Tanzania, Thailand, and Uganda, found that IDP populations in the post-emergency phase of a disaster had better reproductive health outcomes compared to their hosts and country of origin (Hynes, Sakani et al. 2012). However, around the same period, poor pregnancy outcomes of Burundian refugees in Tanzania (Jamieson, Meikle et al. 2000) were reported.

In this paper we explore the exemplary case of DRC refugees in Burundi, to gain a better understanding of the maternal health of refugees migrating within sub-Saharan Africa. The paper is structured as follows. In section 2, we outline the data collection we conducted with the refugees. In Section 3 we present our findings, and Section 4 provides a discussion of the results. Section 5 concludes.

## 2. Data

In this study we used a mixed methods approach, collecting and analyzing both qualitative and quantitative data. The qualitative interviews and workshops were conducted with key informants and Congolese refugees living within UNHCR camps and within Bujumbura, the capital city of Burundi. For the quantitative data collection, we partnered with the World Food Program and augmented their regular quarterly survey with a small list of maternal health related questions.

### *Refugee Participatory Research*

The workshops with the Congolese refugees were designed to encourage equitable participation from the group using a method of concept mapping.

*Sample and recruitment:* This research will be conducted in Burundi. Specifically, Musasa near Ngozi city; Kinama in Muyinga, Kavumu in Cankuzo province, and Bwagiriza in Ruyigi province and within the community in the capital city, Bujumbura. Across the four camps, and within Bujumbura community, we will recruit women aged 15-49 and break them into age groups 15-19, 20-29, 30-39, 40-49. There will be ten women in each group. (Five sites, four age-

groups, ten women in each group, which is 200 women). The women come together three times, and each session is about 1.5 hours long.

Interviews in Bujumbura were conducted in October 2017. The interviews within the UNHCR camps were conducted over a two-month period beginning March 19, 2018.

Participants were eligible to be a part of the study if they lived in Bujumbura or refugee camp; came from the Democratic Republic of Congo; female; aged between 15 and 49; able to participate unaccompanied in three separate sessions, each about one hour long; able to consent to participation.

The women were recruited from a central location within the community (ie a community center) or meeting spot within the camps. Women 15-19, 20-29, 30-39, 40-49 from each site were assigned a time and location for the sessions. Groups were up to 10 young women.

Verbal consent was attained from every recruitee at the time of recruitment, even the minors aged 15-17.

*Data collection:* Concept mapping research technique involves working with the refugee women directly and it is essentially a three-part workshop for the women to brainstorm problems and solutions of maternal health. The concept mapping exercise is a powerful, yet fun, way to involve the women and to hear their voice. The combination of individual work, group work, talking, writing, photos and role play, mean that there are many ways for group members to express themselves. It becomes an inclusive, empowering experience, for the women. Although the topics are grave, the activity usually invokes a lot of laughter, as interviewers and women feel they are working together to solve a problem.

The concept mapping sessions will be conducted in a community space, private from outside viewers and listeners, but known so that the participants can find it and do not have the feeling they are hiding their participation.

In the first session, the women will break into small groups of two or three and brainstorm keywords on the main questions: “What is maternal health?” and “what maternal health services do I get access to?” and “what maternal health services do I need, but can’t get?” and “what is stopping me from getting access to maternal health services?” Their keywords that they brainstorm will then be categorized into groups. The groups will be ranked in terms of what the women consider important.

In the second session, the women regroup and consider the groups and rankings they developed in the first session. Once the session leader has seen the photos, the women can discuss their chosen picture and add the themes that come from the discussion of the photos to the mix of the groups and rankings. They then develop clusters and larger themes relating to these groups.

In the third session, the women act out role-plays that they develop, and then discuss how relevant or likely the scenario is in their community.

*Data analysis*: Recordings and written exercises will be sent to the translator, translated, and sent to Finlay. Finlay used Atlas.ti to code the findings.

*Key Informant Interviews*

In addition to the participatory research with the Congolese refugees, we also conducted key informant interviews with people who worked at the UNHCR camps. Two to four people at each camp were interviewed. These interviews were conducted in the same camps and at the same visit as the refugee participatory research. Professionals who worked or volunteered within the camps were eligible for the key informant interview, and on recruitment verbal consent was attained. The key informant and interviewer had a one-on-one discussion that was recorded following a series of questions to prompt open-answer responses. The key informants were asked about the camp and their role at the camp. They were asked to discuss what the term maternal health meant to them, and the kinds of services available at the camp. They were asked their perspective on whether women seek maternal health services offered. The key informants were asked their opinion on services they felt were lacking for the refugee women. The conversation was steered to ask about adolescent maternal health, to enquire about this particularly vulnerable sub-group. The last prompt asked if the key informant had anything else to add. The recordings were transcribed and translated and sent to Finlay for analysis.

*Quantitative Data Collection*

For quantitative data collection, we partnered with the World Food Program who visited the camps every three months for a demographic and nutrition survey. Through collaboration with the UNHCR and the WFP, we were granted permission to append this regular survey with five maternal health related questions. Details of these questions are provided in Appendix 1. The data collection took place in the four camps, Musasa near Ngozi city; Kinama in Muyinga, Kavumu in Cankuzo province, and Bwagiriza in Ruyigi, not in the urban location of Bujumbura as the qualitative data collection was. WFP programed these questions into their electronic data collection software and included it in their June 2018 survey. On completion, the WFP sent Finlay the data from the five maternal health questions along with basic demographic data of the respondent and their household. The data sent to Finlay did not include names or identifiable information of the respondent and their household members.

For the protection of the identity of the research participants, both in the qualitative and quantitative research, the data analysis was conducted by researchers outside Burundi.

## 3. Findings

*Summary Statistics*

Table 1 provides an overview of the camps, and refugees living in Bujumbura. The UNHCR provide a report on the camp and Bujumbura refugee population every six months. Table 1 includes details that were published in June 2016. Table 2 includes details of the data the authors collected in partnership with the World Food Program in June 2018 at the four camps.

*Table 1: UNHCR Summary Statistics: Demographic and Maternal Health Information by Camp*

| Camp ID | Camp 1 | Camp 2 | Camp 3 | Camp 4 | Urban | Sample Total |
|---|---|---|---|---|---|---|
| | N | N | N | N | N | N |
| UNHCR Reported Statistics (30 June 2016) | | | | | | |
| Camp Population | 9,284 | 8,064 | 6,407 | 8,751 | 20,959 | 32,506 |
| DRC Refugee Population (89% from South Kivu) | 9,112 | 8,053 | 6,403 | 8,704 | 20,818 | 32,272 |
| Percent of Camp Population 12-59 yo women | 29.1 | 29.2 | 29.1 | 28.3 | 33.6 | |
| Needs relating to Maternal Health | N women | N women | N women | N women | N women | N women |
| Serious Medical Condition | 118 | 434 | 330 | 135 | 827 | 1017 |
| SGBV | 240 | 269 | 183 | 140 | 320 | 832 |
| Single Parent | 508 | 357 | 310 | 378 | 752 | 1553 |
| Women at risk | 280 | 209 | 130 | 107 | 627 | 726 |

Source: UNHCR June 2016 Burundi Statistics

Table 1 shows that each camp has a population close to 10,000 people, and most of these people are from the DRC (South Kivu). Just over 20,000 DRC refugees live in Bujumbura, living the community not within a camp.

According to the UNHCR statistics, close to 30% of the population is women aged 12-59. While our study's focal population was women 15-49, the 12-59 age group were the bounds collected by UNHCR.

Women within the camps and urban community report needs that relate to maternal health. Single parenthood and sexual, gender based violence, a serious medical condition and women at risk were reported at all locations.

In Table 2 we present summary statistics of the data collected by the authors in collaboration with the World Food Program. The World Food Program were able to ask the authors' questions to 616 heads of household. As the World Food Program was directed to the head of household, the questions relating to maternal health were asked of both men (54%) and women (46%) according to who presented as head of household.

The sex division of head of household at the camps varied greatly, with 47% women head of household in Camp 1, 71% women in Camp 2, 34% women in Camp 3, and 29% women in camp 4. The World Food Program survey was only fielded in the camps, and not within the community in Bujumbura. Most of the heads of household were married (monogamous) ranging from 57% reporting this in Camp 1 to 74% reporting being married in Camp 3. Illiteracy rates of head of household were high, with 28% illiterate in Camp 3 up to 45% illiterate in Camp 1. On average the head of household was 38-40 years, but heads of household could be as old as 87 as in the case of Camp 2.

With respect to the maternal health services offered, many knew that delivery care was offered, 84% in the total sample, and ranging from 77% in Camp 1 to 92% in Camp 4. Antenatal care was thought to be on offer by most heads of household (75%), but knowledge of postnatal care (50%) ad family planning (18%) was much lower. Other services were reported by 3% of the sample.

*Table 2: Authors' Summary Statistics: Demographic and Maternal Health Information by Camp*

| | | Camp 1 | | Camp 2 | | Camp 3 | | Camp 4 | | Sample Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HoH sex | | N | % | N | % | N | % | N | % | N | % |
| | Female | 112 | 47 | 95 | 71 | 41 | 34 | 36 | 29 | 284 | 46 |
| | Male | 124 | 53 | 39 | 29 | 81 | 66 | 88 | 71 | 332 | 54 |
| | Total | 236 | | 134 | | 122 | | 124 | | 616 | |
| Marital Status of HoH | | | | | | | | | | | |
| | Never married | 10 | 4 | 9 | 7 | 10 | 8 | 5 | 4 | 34 | 6 |
| | Divorced or separated | 22 | 9 | 6 | 4 | 5 | 4 | 8 | 6 | 41 | 7 |
| | Married (monogomous) | 134 | 57 | 86 | 64 | 90 | 74 | 84 | 68 | 394 | 64 |
| | Married (polygomous) | 4 | 2 | 6 | 4 | 1 | 1 | 3 | 2 | 14 | 2 |
| | Widow(er) | 66 | 28 | 27 | 20 | 16 | 13 | 24 | 19 | 133 | 22 |
| | Total | 236 | | 134 | | 122 | | 124 | | 616 | |
| HoH literate | | | | | | | | | | | |
| | No | 106 | 45 | 42 | 31 | 34 | 28 | 40 | 32 | 222 | 36 |
| | Yes | 130 | 55 | 92 | 69 | 88 | 72 | 84 | 68 | 394 | 64 |
| | Total | 236 | | 134 | | 122 | | 124 | | 616 | |
| Age HoH | | | | | | | | | | | |
| | Min | 19 | | 0 | | 21 | | 3 | | | |
| | Max | 73 | | 87 | | 72 | | 80 | | | |
| | Mean | 38 | | 40 | | 40 | | 39 | | | |
| Maternal Health Services Offered (choose multiple) | | | | | | | | | | | |
| | Antenatal care | 144 | 61 | 107 | 80 | 101 | 83 | 110 | 89 | 462 | 75 |
| | Delivery care | 181 | 77 | 113 | 84 | 109 | 89 | 114 | 92 | 517 | 84 |
| | Postpartum care | 119 | 50 | 17 | 13 | 96 | 79 | 77 | 62 | 309 | 50 |
| | Family planning | 41 | 17 | 31 | 23 | 15 | 12 | 25 | 20 | 112 | 18 |
| | Other | 9 | 4 | 0 | 0 | 0 | 0 | 8 | 6 | 17 | 3 |
| | Do not know | 42 | 18 | 5 | 4 | 12 | 10 | 5 | 4 | 64 | 10 |
| | Total | 236 | | 134 | | 122 | | 124 | | 616 | |
| Maternal Health Services Accessed | | | | | | | | | | | |
| | Antenatal care | 99 | 42 | 95 | 71 | 90 | 74 | 80 | 65 | 364 | 59 |
| | Delivery care* | 114 | 48 | 104 | 78 | 96 | 79 | 84 | 68 | 398 | 65 |
| | Postpartum care | 82 | 35 | 9 | 7 | 78 | 64 | 31 | 25 | 200 | 32 |
| | Family planning | 33 | 14 | 27 | 20 | 13 | 11 | 18 | 15 | 91 | 15 |
| | Other | 40 | 17 | 1 | 1 | 2 | 2 | 27 | 22 | 70 | 11 |
| | Do not know | 64 | 27 | 11 | 8 | 22 | 18 | 11 | 9 | 108 | 18 |
| | Total | 236 | | 134 | | 122 | | 124 | | 616 | |
| *If you accessed childbirth services, whom was that with? | | | | | | | | | | | |
| | Assistant | 12 | 11 | 76 | 73 | 24 | 25 | 0 | 0 | 112 | 28 |
| | Other | 4 | 4 | 0 | 0 | 0 | 0 | 3 | 4 | 7 | 2 |
| | Doctor | 7 | 6 | 1 | 1 | 0 | 0 | 0 | 0 | 8 | 2 |
| | Nurse | 90 | 79 | 28 | 27 | 72 | 75 | 81 | 96 | 271 | 68 |
| | Friend | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 4 | 1 |
| | Total | 114 | | 104 | | 96 | | 84 | | 398 | |
| Is there anyone in your hh who would like to access Maternal Health services? | | | | | | | | | | | |
| | No | 211 | 89 | 109 | 81 | 100 | 82 | 112 | 90 | 532 | 86 |
| | Yes | 25 | 11 | 25 | 19 | 22 | 18 | 12 | 10 | 84 | 14 |
| | Total | 236 | | 134 | | 122 | | 124 | | 616 | |
| Are the maternal health services here good quality | | | | | | | | | | | |
| | No | 136 | 58 | 45 | 34 | 57 | 47 | 17 | 14 | 255 | 41 |
| | Yes | 100 | 42 | 89 | 66 | 65 | 53 | 107 | 86 | 361 | 59 |
| | Total | 236 | | 134 | | 122 | | 124 | | 616 | |
| Treated with respect? | | | | | | | | | | | |
| | No | 122 | 52 | 28 | 21 | 49 | 40 | 18 | 15 | 217 | 35 |
| | Yes | 114 | 48 | 106 | 79 | 73 | 60 | 106 | 85 | 399 | 65 |
| | Total | 236 | | 134 | | 122 | | 124 | | 616 | |

Source: Authors' own data collection in collaboration with World Food Program

With cross-reference to the qualitative studies, most of the women who conducted the key informant interviews and refugee participatory projects listed services such as vaccines, basic delivery care, some (to none) prenatal care, and no postnatal care.

While most of the qualitative responses indicated little prenatal care on offer, 59% of heads of household indicated that they knew of someone in their household accessing prenatal care, and 32% had accessed post-natal care.

Of the heads of household surveyed, 65% said they knew of someone in their household who had accessed delivery services. In most cases (68%) these services were with a nurse, 28% were with an assistant, and only 2% were with a doctor.

The qualitative interviews revealed the lack of doctors at the camps, and if they were officially assigned to the camps they were not available all the time (only in the day, leaving women alone who deliver at night). Moreover, the qualitative interviews indicated that doctors were not well equipped with ultrasound machines, pain medication, and transportation to the local hospital for complications with delivery. Prenatal services were limited, as one women said “they vaccinate us and examine our ears”.

The current need for maternal health services is around 14% of the population. Many believe that the maternal health services are good quality, 59%. However, this ranged widely across the camps with 42% in Camp 1 reporting that maternal health services were high quality, and 86% in Camp 4 reporting maternal health services were high quality.

Respectful maternity care is an issue across many developing countries due to lack of resources, over-worked staff and lack of training. Across the camps 65% indicated they were treated respectfully, however as with maternal health service quality this varied widely by camp. In Camp 1, 48% said they were treated respectfully and in Camp 4, 85% said they were treated respectfully.

The qualitative interviews enabled a broader view of the camps and the needs of the women. The women were asked about maternal health, but the discussion often extended beyond this to point to their greatest needs. By the authors reading of the transcripts, they were able to rank the camps by the conditions that the women reported. Interestingly, this ranking matches the empirical narrative. With Camp 1 being the camp with the worst conditions. This could be due in a large part to the limited access of the camp to a local hospital and a high quality road to Bujumbura. Camp 2 ranked third worst, then Camp 3 came in second place. Camp 4 seemed to be the best camp to be located. From reading the transcripts, and seeing the empirical response, they had the best health facilities and access to respectful and high quality care. In Camp 4 the women also reported to being part of a microcredit scheme, and this had a significant impact on their overall welfare.

Across each of the camps, the inability of the women to work, set up small enterprises, grow their own food was the major source of frustration. Not only did the lack of work and resources limit their ability to access maternal healthcare (they had to pay for it, it was not always provided by UNHCR), but they were concerned that their labor-market skills would decline without

working. The women interviewed in the qualitative studies needed money to buy medicine, feminine hygiene products, and clothes for their children, and most of all food. Economic empowerment was the second most prevalent conversation among the women, the most prevalent was malnutrition. While the UNHCR provides rations, they did not find this to be sufficient, and as camp numbers increased their rations decreased. Without the ability to work or cultivate the land, they were concerned about the quantity of food being insufficient for themselves and their children, and dietary diversity meant that malnutrition was a major issue for the women and their families.

## 4. Discussion

The data collection effort conducted in this study not only provided information on maternal healthcare access by DRC refugees in Burundi UNHCR camps, but it also provided a pilot to a larger data collection effort with refugee populations. During the development of the data use agreement with UNHCR and WFP, the research team and authors were also reminded that the expectations of the vulnerable population must not be over inflated. With malnutrition and lack of economic empowerment, the opportunity to interact on a research study must not raise expectations of the participant's responses leading to delivery on their stated needs. Our field team were careful with their preamble to ensure that the participants understood that we were only gathering information. In the responses, however, the women did call for us to raise attention to their needs and the lack of funding that UNHCR receives from their donors.

Maternal health, quality maternal health, emergency obstetric care, basic sanitary supplies (soap, clean towels, feminine hygiene products, clean beds, clothes), and nutrition, are all lacking within the camps within Burundi. While some of the women called for donors to increase the supply of these items, the stronger demand was for economic empowerment.

This study has provided useful pilot information for a further larger study to be conducted with refugee populations within SSA. Silo topics (such as maternal health in this study) will not capture the broader and dominant needs of the refugees. Longer surveys that incorporated topics of documentation, economic empowerment, health and nutrition, household structure and care responsibilities, future aspirations, should be incorporated with any survey. Careful consideration of who to interview also needs to be addressed, not only for the implicit bias in responses (men responding for women with regard to maternal health, for example), but also for any recourse that may occur following the survey. In a confined community, as the camps are, favoring one person over another could elevate tension for them following the interviews. Care should be taken in ensuring equity.

The pilot study also pointed to the need for economic program interventions. Microcredit schemes were offered at Camp 4, and even though they were small, they led to the women in these camps having a much more positive experience than women in the other camps. While treatment and control groups within camps may not be feasible due to equity reasons, across camps may be highly valuable.

## 5. Conclusion

This study has shown that maternal health services are highly heterogeneous across the camps within Burundi, but the bar is low and services available are limited to vaccines, prenatal weight checks and baby position, delivery assistance, and paracetamol. Access to these services was highly elevated in the one camp that enabled entrepreneurial activity.

This study provides information as a pilot to then further implement a larger survey that is broad in scope, beyond a siloed topic of maternal health. Interventions that promote women's economic empowerment would have a positive impact on the refugee's maternal health and welfare more broadly.


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## Appendix 1: Additional Maternal Health Questions Added to the World Food Program Survey

The questions that we request to add to the WFP survey instrument are listed here, and in the research proposal attached.

A. *Do you know of any maternal health services offered here?*
   *[dropdown menu, choose as many as you like]*
   *++ antenatal care*
   *++ delivery care*
   *++ postpartum care*
   *++ family planning*
   *++ other*

B. *To your knowledge, has anyone in your household accessed these services?*
   *++ antenatal care [if yes, how many visits?]*
   *++ delivery care [if yes, by who? ++ friend, ++health worker, ++nurse, ++doctor, ++other]*
   *++ postpartum care*
   *++ family planning*
   *++ other*

C. *Would someone in your household like to access the maternal health services, but for some reason does not access these maternal health services? (yes/no)*

D. *Are the maternal health services offered here good quality? (yes/no)*
   *[If yes: 1) Do you feel that you/your wife was treated with respect and in a dignified way? (yes/no)*
   *2) Do you think the mother's and baby's needs were appropriately cared for? (yes/no)*

E. *Are there any maternal health services you or any of your household would like/need, but cannot get here? (yes/no)*
   *[if yes: choose from dropdown menu as many as you would like]*
   *++ antenatal care*
   *++ delivery care*
   *++ postpartum care*
   *++ family planning*
   *++ other*