

Received Date : 30-Jul-2015

Revised Date : 22-Feb-2016

Accepted Date : 18-Apr-2016

Article type : Original Article

Understanding the Meaning and Role of Gifts Given to Ugandan Mothers in Maternity Care Settings: “The Help They Give When They’ve Seen How Different You Are”

Sarah Rudrum¹, Helen Brown² and John L. Oliffe²

¹ Institute for Gender Race Sexuality and Social Justice, University of British Columbia, Canada

² School of Nursing, University of British Columbia, Canada

Abstract

The provision of gifts to new mothers in Uganda is laden with significance that varies by the social location of the giver and receiver and the context and conditions under which the gift is made available. Here, we examine the act of gift giving and receiving within a Ugandan maternity care setting, describing the connections between these material objects and social relations. A study investigating the social organization of maternity care in post-conflict northern

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the [Version of Record](#). Please cite this article as [doi: 10.1111/1467-9566.12456](https://doi.org/10.1111/1467-9566.12456)

This article is protected by copyright. All rights reserved

Uganda found that gift-giving to new mothers functioned to create a material and discursive context wherein women's desire to access these goods was leveraged to create an incentive to attend formal maternity care during pregnancy and for delivery. In this article we describe the material and discursive processes surrounding gift-giving to new mothers in this global south health care setting. This article contributes critical analyses of the function of gifts in healthcare settings as constructing shared identities and social differences, normative values about health citizenship, and an incentive politic that affects equitable access to maternity care. Drawing on intersectional theory and analysis of how specific practices function ideologically to reward or incentivize pregnant women, we integrate material culture studies into the sociology of women's reproductive health.

Keywords: Women's health, Maternity services, Social support

Introduction

When new mothers welcome their baby, they sometimes bring home a gift of baby care items. Whether or not a gift is received from health care providers varies depending on the health system in which the child is born. For example, in Finland, new parents are given an extensive layette via a longstanding state-sponsored program whose goal was to increase prenatal care attendance (Lee, 2013; Zimmerman, 2014). In the United Kingdom, a private company, Bounty, provides samples and coupons. In contrast to the Finnish program, Bounty pays the National Health Service (NHS) to access mothers in order to collect their personal information and sell it to third party advertisers (McCartney, 2013). Gifts to new mothers as part of health care provision have the potential to serve an equalizing role even in the context of the relative wealth of the global north, where access to basic resources for parenting challenges fewer women than in the global South (Grede, de Pee, & Bloem, 2014; Nayar, Stangl, De Zaluondo, & Brady, 2014).ⁱ In a rural, northern Uganda community, Amuru sub-county, a gift to new mothers consisting of basic baby care items was distributed by health centres on behalf of non-governmental organizations (NGOs). This gift, or mama kit, played an influential role in shaping women's uptake of antenatal and delivery care services. Tracing the effects of the mama kit

project during a study examining the social organization of maternity care and birth in Amuru, Rudrum (2015) discovered that NGOs, the health centre, and birthing women often held competing priorities. Ideologies of scarcity, responsibility, and deservedness created a set of discursive practices shaping delivery of the mama kit project and its relationship to maternity care – including antenatal care (ANC) and delivery care – and to childbearing women. Our discussion of the consequences of the mama kit project examines the impacts on women in Amuru sub-county and then situates the project in relation to other examples of gifts to new mothers in health care settings, drawing on the sociological literature on gifts and material culture.

The work of Marcel Mauss is foundational to sociological and anthropological theories of gift giving. Focusing on ‘archaic societies,’ Mauss discusses the requirement for reciprocity and contests a framing of gifts as freely given: “In theory such gifts are voluntary but in fact they are given and repaid under obligation” (1990). For Mauss, gifts to the poor share features of other gift giving, but introduce an element of justice: “Alms are the result on the one hand of a moral idea about gifts and wealth and on the other of an idea about sacrifice” (1990). His work has been taken up in anthropology, prominently by Lévi-Strauss who viewed gifts as inherently political in nature. Lévi-Strauss conceptualized gifts as “vehicles and instruments for realities of another order: influence, power, sympathy, status, emotion; and the skillful game of exchange consists of a complex totality of manoeuvre, conscious or unconscious, in order to gain security and to fortify one’s self against risks incurred through alliances and rivalry” (Lévi-Strauss, 1996, p. 19). Sociological analysis of gift giving has also been taken up in development studies, such as by Stirrat and Henkel (1997) who draw on Mauss to make the case that in development as elsewhere, there is no such thing as a free gift. Rather than representing a one-way flow of goods and altruism, charitable gifts in fact bind the global North and South in complex and problematic ways. In the field of maternal health, gift-giving has primarily been theorized in relation to surrogacy and its potential for altruism or commodification (Ragone, 1999), along somewhat similar lines to discussions of other potential “gifts of life” such as organs or blood (Titmuss, 1970). In this article, we hope to contribute to this body of work by extending a discussion of gift-giving to gifts that are given to newly parturient women in health care settings.

Methods

Study setting

Understanding the context in which women in Amuru live and seek care is crucial to this discussion of gifts. Since 2007, people have returned to their villages to begin rebuilding following the long and brutal conflict between the Lord's Resistance Army (LRA) and Uganda's People's Defense Force (UPDF). This war was characterized by widespread abductions and mass displacement. The majority of people are subsistence farmers with little income. Their household groupings are often remote, located far from each other, the road, and trading centres. The remote location coupled with a paucity of health care facilities impeded access to health care, particularly for delivery in a facility for which timely access to transportation is essential.

Amuru is a large, rural subcounty extending from the West Nile region to Gulu district; it is part of a new district formed in 2005, and its borders are currently contested as part of a series of land disputes involving local farmers, government, and industry (Refugee Law Project, 2012). It has low-population density and inadequate health centre coverage. Women in the most remote areas are 47 kilometres from a functioning health centre; many women have to travel more than 15 kilometers (a potential benchmark for a safe and reasonable distance for pregnant women to travel for health care, based on the United National benchmark of a travel time of 3 hours assuming a walking speed of 5 kilometres per hour [Gabrysch, Simushi, & Campbell, 2011]). Preparing for the arrival of a baby and accessing maternity care are difficult. Local infrastructure, including roads, remains worse than in many other areas of Uganda, although during the fieldwork period, an often-impassable major north-south route was being upgraded and power-lines were being extended.

There are several health centresⁱⁱ within Amuru sub-county, but only one health centre was, at the time of fieldwork, fully operational when it came to providing ANC and support for deliveries. Located at the site of a former Internal Displacement (IDP) Camp, the health centre was a hub for Amuru sub-county. It was run by Gulu's Lacor Hospital, a Catholic hospital under the joint operation of Italian and Canadian NGOs. As a health centre III, it was required to have a senior clinical officer and a lab, but was not required to (and did not) have a doctor or an operating theatre. As such, the health centre had the capacity to support normal deliveries but not

to provide emergency obstetrical interventions; emergencies and complicated cases were referred to a hospital in a neighbouring district. Delivery support was provided by qualified midwives as well as by nurses of various cadres, including educated professionals and minimally trained lay people.

In 2012, eight months of fieldwork was completed to examine the social organization of maternity care and birth in Amuru. Guided by the overarching research question, *How is maternity care and childbirth socially organized in Amuru sub-county*, the study employed institutional ethnography (IE) methods, an approach to social research developed by the Canadian sociologist Dorothy Smith (1987, 1990, 2005). IE was used to focus on the processes of social organization through observing and describing people's everyday actions and experiences and how they were coordinated via institutional processes (Smith, 2005). Maternity care and birth were understood as situated within social, as well as medical, institutions. Conversations with 45 mothers of children under age two and 22 formal and informal health care workers were conducted via individual and focus group interviews. **The mothers ranged in age from eighteen to forty-one (mothers under eighteen were excluded), and had between one and thirteen children (including those deceased). Residents belonged to similar socio-economic groups, though the degree of financial security ranged from concern over daily meals to the ability to pay all pregnancy-related costs without hardship. Participants were Acholi, except for two who indicated that they were members of neighbouring ethnic groups and had moved to be with their husbands.** Interviews were digitally recorded and then translated and transcribed. The interviews were read and a coding schedule developed to organize the data and make comparisons within and across interview participants. The data from interviews with childbearing women and those with health care workers were analyzed separately, but interpretation of findings was undertaken across the two groups. The study was approved by [a Canadian university blinded for peer review's] Ethics Board, Lacor Hospital's Ethics Review Board, the Uganda Council of Science and Technology, and the President's Office in Uganda.

Analytical Perspective

The analytical approach guided by IE included positioning participants as experts, attention

to the work people do, and attention to texts as coordinating activities translocally. IE defines work as “intentional: it is done in some actual place under definite conditions and with definite resources, and it takes time” (Smith, 2005, p. 154). Understanding people's activities in relation to maternity care was crucial to mapping how that care was organized and accessed. Within IE, texts are broadly defined as written or graphic materials that can be reproduced; relevant texts might include a law or policy referred to by participants, a document to be presented at a certain time, or a form to be completed. Texts produced in one place are influential in coordinating activities and knowledge in a different place.

Understanding power through an intersectional lens was also key to our analysis. Intersectionality is an approach that examines how multiple social and structural factors overlap and constitute systematic power relationships based on oppression and privilege (Weber, 2006). Intersectionality “requires a consideration of the complex relationship between mutually constituting factors of social location and structural disadvantage so as to more accurately map and conceptualize determinants of equity and inequity in and beyond health” (Hankivsky et al., 2012, p. 18). In the context of this research on maternity care and analysis of gifts to mothers, it was important to consider how power relationships and structural inequalities shaped access to care.

While IE and intersectionality were foundational to the analysis when considering the role of the mama kits in coordinating maternity care and birth in Amuru, we also turned to sociological and development literature on gift-giving to further examine how the mama kits operate and discuss our findings in relation to other types of gifts given to parturient women by hospitals and clinics within the Global North. This strand of analysis is picked up in greater detail in the discussion section.

Findings

The mama kits

The mama kits were a bag of baby supplies given to women post-partum. As described by participants and observed the kits contained: soap; a washing basin; towels; jelly (baby cream); sheets, towels, or cloths (for wearing the baby, for warmth, for drying, and to absorb blood); and tetracycline eye ointment (to prevent or treat neonatal eye infections). The mama kits

were supplied as a project of the Japanese Red Cross and the Uganda Red Cross. Registration was organized by the Village Health Team (VHT), a group of voluntary lay health workers. The kits were distributed to women post-partum by formally-credentialed health care workers at Lacor health centre III. Because of the way the project was organized, mama kits were scarce in comparison to the large number of mothers seeking them (interview with Jonas, the health centre's clinical officer in charge). **While all women were aware of and wished to receive the mama kits, at least 20 of 45 women interviewed did not receive a kit, or received only part of the kit's contents.** Scarcity and gatekeeping created competition and uncertainty for many pregnant women. For example, Beryl, an Alur woman who had moved from the West Nile area to be with her husband when she was fourteen and was now twenty-three, found the unevenness and unpredictability of distribution frustrating. She said:

That friend of mine who is wearing the kitenge [African fabric] blouse registered together with me because we live together [are neighbours]. She was given a gift and I wasn't given [. . .] I was so hurt. And yet my friends are getting, and my name was registered, then they did not give me... I was so annoyed.

The inequity of being excluded was unsettling.

For childbearing women participants, the mama kits were important and valued, yet created work, competition, and divisiveness. They functioned as a form of access to items useful for post-partum recovery and newborn care. Within the post-conflict northern Ugandan context, poverty and limited access to resources contributed to the influential role of the mama kits. This context enhanced their utility and desirability, and contributed to the role the mama kits project played in influencing women's willingness to access ANC and delivery care.

A context for understanding the value placed on mama kits in Amuru was the challenge of ensuring adequate nutrition and avoiding overwork during pregnancy. Eating well and avoiding heavy or prolonged physical labour were known to be important to the health of mother and unborn baby and were emphasized in health talks and during ANC. Yet, in many instances, participants found it difficult to eat well and avoid overwork while simultaneously preparing for the arrival of a baby. For example, Betty argued that despite the advice from health providers to eat well, mothers would not supplement their own diets when they knew their children's diets were insufficient: "Nutrition is good, as they tell us [. . .] But it is not easy. [. . .] While the

children are hungry, eggs cannot be eaten. It is impossible”. All capable family members typically farmed by hand with a heavy hoe and it was difficult to avoid this work. To compensate for the cost of preparing for a baby, pregnant women sometimes worked for neighbours or sold snacks in the market.

Participants identified the necessary supplies for delivering at the health centre and receiving the baby as including: a plastic bed cover on which to labour (to contribute to a sterile environment), clothes and cloths for the baby, lamp paraffin for night waking, and prepared food. Most participants considered obtaining supplies and preparing foods to be part of the work of pregnancy, although it was more difficult for those with particularly limited resources than for others. The lack of access to material goods was shaped by poverty, poor infrastructure including roads, and the isolation engendered by such factors. These factors contributed to women’s vulnerability during pregnancy, necessarily a time when additional resources were required and often a time when personal resources were diminished.

While participants shared the view that the mama kits were useful, responses regarding the purpose of the mama kits project were strikingly varied. Participants described the mama kits as an incentive or reward for attending a full program of ANC; as an incentive or reward for delivering at a health facility; as support for mothers; or as a charitable gift. Focusing on these four perceived purposes, we describe how these resources shaped the ways in which maternity care was sought and accessed. We go on to examine impacts of the project on health centre capacity and women’s access to care, identifying how NGO withdrawal or project closure affected NGO-health centre partnerships and ultimately childbearing women’s perception of formal care.

Rewarding ANC compliance with the Mama Kits

Among childbearing women participants, attending ANC – and having the ANC card to demonstrate that they had done so – was seen as the requisite ‘key’ to securing care and a mama kit. Without this key, one might be turned away, or ‘chased,’ as participants described it; thus, the ANC card became one of the texts coordinating access to care. Participants’ view that receiving the mama kit was also dependent on attending ANC, an emphasis reinforced by the health care workers’. Betty, who had not received a kit (citing problems with registration), saw the use of the mama kit as coercive but helpful: “It is true that when you don’t go for ANC three times, they don’t give you [the mama kit]. They are right, because we women need orders”.

Herein Betty understands the connections between ANC and the mama kit, amid conceding the health care workers' prerogative, and perhaps responsibility, to determine one's eligibility. Attaching provision of the mama kit to participation in ANC was a way of exerting power to make compulsory women's ANC attendance. Betty's acceptance of the mama kits as a way of giving orders and rewarding compliance confirmed the mama kits' influence on women's ANC participation. Yet the mama kits and their conditional gifting reinforced power differences between care providers and birthing women.

This power imbalance was also felt by health care administrators and providers, who were under pressure to determine who was the most deserving, an exertion of their own status that they did not welcome. **For example, Jonas, the in-charge at the health centre, stated that the kits were intended to be distributed selectively, but that selection criteria were neither clearly articulated nor followed.** Peter, the district health officer **and the only other health administrator interviewed** identified the difficulty of deciding on and following distribution criteria when supplies were so low as one of the reasons he had advocated for the program's expansion. "They were targeting the most vulnerable . . . the most poor," he said "but in our setting here, who is the most poor?" He felt this was not a question that health care providers should have to grapple with in distributing scarce material resources.

An eighteen-year-old first-time mother living near the health centre, Rose, explained that health care staff had told her she received the mama kit because both she and her husband had attended ANC:

They said we followed measurements [ANC] very well. Some people don't follow measurements in the hospital [health centre] well, they don't finish, but for us we finished ours, and we saw our health [tested for HIV and learned status].

As Rose emphasized, compliance was rewarded with mama kits as well as with praise. Used as a reward for complying with ANC, the mama kits were a mechanism signaling that there were positive and negative modes of citizenship with regard to health during pregnancy. HIV testing during ANC was presented as "an offer you can't refuse," which was how Malawian women HIV testing during pregnancy due to coercive practices in that country (Angotti et al., 2011). In Amuru, women were also charged with bringing their husbands to an ANC appointment for HIV testing, an additional hurdle to receiving the mama kits and future care (Rudrum, Oliffe Brown

2015).

Incentivizing birthing in a health centre

Another view was that the purpose of the mama kits was to incentivize giving birth in a health facility in the context of high maternal mortality, measured at 438 per 100,000 in Uganda (Uganda Bureau of Statistics, 2011). Skilled birth attendants (SBAs) assisting with birthing have been identified as the primary means of reducing maternal mortality (Achadi, Pitchforth & Hussein, 2013; Say & Raine, 2007; Wirth, 2008). The practice of delivering in a health centre was encouraged as a means of reducing maternal and infant deaths, a practice supported by a policy shift away from supporting traditional birth attendants (TBAs) who worked in the villages (Rudrum, 2015). Due partly to the nature of labour as a process whose timing cannot be planned and which impedes mobility, delivery care was oftentimes less accessible than ANC. One could walk, bike, or be doubled by bicycle to ANC; there was also some (albeit limited) flexibility in when to attend. For labour, a boda-boda (motorcycle taxi) was necessary and added to the expense and logistics of transportation. It was also necessary to bring an attendantⁱⁱⁱ, usually a co-wife, sister-in-law, or mother-in-law^{iv}, increasing the cost of transportation. Since cost depended on distance, those in the most remote households faced the highest costs in reaching a health facility. Birthing at home assisted by a TBA or a family member was common in remote places, especially compared to areas close to a fully operational health centre. This reflects access issues elsewhere in the global South: “Poor geographic access has its greatest influence on the potential of women to reach a health facility during labour” (Munjanja, 2013, p. 146). Significantly, TBAs were not involved in mama kit registration or distribution. Indeed, for childbearing women participants, TBAs’ lack of access to this resource further distinguished their care at delivery from that offered by SBAs at health centres.

Florence, a 36-year-old mother, lived in a remote area and found transportation challenging to secure. She completed a full cycle of ANC, but stated:

It’s the delivery that made me not to reach there [the health centre], I did not have money. Moving from here to Amuru needs money for transport [. . .] so it’s true that I gave birth from home.

She explained that her co-wives^v assisted at this difficult labour:

The person who helped me? There wasn’t anybody, but I was with my co-wives, and they

are the ones who helped me. I began pushing the baby at 10 am and delivered at about 1 pm to 2 pm. I was in a very bad condition, but the child came out.

Participants from remote villages often related such stories of home births wherein there was little choice or resource for attending the health care centre. Due to the greater prevalence of home births in these remote villages, women were also less likely to have received a mama kit.

In one focus group situated in a remote village, four of the five participants had delivered at home. A fifth participant, 30-year-old Julia, gave birth on the way to the health centre. This group included a first-time mother and a mother of twins (who had been advised to deliver in a hospital). The focus group situated near Amuru health centre, similarly included five women, and also included a first-time mother and a mother to recently born twins. These five women, however, had all given birth in the nearby health centre (including one woman who was waiting for an ambulance to transport her to hospital for a caesarian section when her baby arrived). This stark contrast speaks to the influence of distance on access to care.

Asked whether mothers in her village always received a mama kit, Sophie, a 24-year-old with three children confirmed: “When they have gone to the hospital [health centre], they get, but when you have given birth from home, you don’t get.” Indeed, no mothers reported having received mama kits when delivering at home or if they delivered on the way^{vi} to the health centre – regardless of their previous use of ANC.

Jacky, a 28-year-old mother of three, was among those who did not receive a mama kit because they delivered elsewhere than a health centre. She said: “I did not get those gifts because when I delivered they should have taken me there [to the health centre], but because it was late^{vii} they did not take me”. Asked whether she was disappointed, she said no, that she would receive a mama kit the next time she had a baby. Such an attitude depended on women’s ability to purchase the equivalent supplies themselves. Among women who had little money, the mama kits were an especially valuable resource, offsetting costs of about \$5 (Mbonye et al., 2013, p. 5), a substantial amount of money.

Birthing at home meant women were denied a mama kit regardless of whether they had attended at ANC. Jane, an 18-year-old first-time mother who had an older husband and co-wife, said that she had been unhappy to be pregnant and to therefore have to marry. Jane was afraid of giving birth, and struggled to walk between her home and the health centre, a journey so long

that she had to spend the night at a relative's home after each ANC visit. She wanted to go to the health centre to deliver as well, but the labour progressed very quickly, such that her husband was concerned that she would give birth on the way if they tried to reach the health centre. The baby was, in fact, born before the TBA they had called could arrive at their home. Jane did not receive a mama kit when she took her baby to the health centre for a check-up following his birth. If the purpose of the mama kit was to reward compliance with ANC, as some participants posited, Jane surely "deserved" one for her efforts. However, because she "failed" to deliver at a health centre, she was not eligible. In such situations, the withholding of a mama kits might be reasonably viewed as punitive, especially given that birthing at home was determined by circumstances outside the women's control including remote location, financial hardship, and/or precipitous labour.

For Jane's neighbor, Janet, the mama kits were part of what distinguished health centre delivery from home delivery. A 41-year-old mother of eleven children, she had given birth to her first nine children at home, attending a health centre for the birth of her two youngest. Asked about the difference between giving birth at home and at the hospital, she said:

Yes, there is some difference, as I saw with this child from the health centre. They gave some medicine for the eye, they gave soap, a bag, jelly, a basin, towels, and a pillow [case], which I saw as being different [. . .] as compared to the TBA. Also the delivery service at birth is different from the TBA, where they squeeze you for long to get the child out, while at the health center they use some modern ways, and if they find that there is a difficulty they would then check up to know what could be the problem.

While Janet cited clinical differences between the care provided at the health centre and that provided by TBAs, the mama kits were highlighted as a tangible and significant benefit.

Supporting and signaling 'vulnerable' women

Despite the commonly held belief that the purpose of the mama kits was to incentivize the uptake of formal health care, many women also understood the mama kits as a form of economic support (help). For example, Margaret, a thirty-year-old mother of five with one co-wife, considered the reason mama kits were distributed to be as follows:

The hospital [health centre] has thought of helping mothers, that they should be helped, because some might be having a lot of problems and might not be able to buy those

things, so they should be helped. Even if you will buy yours, that of the hospital should also be there.

It made sense to Margaret that mothers were offered these material goods after having a baby, perhaps due to experiences of humanitarian aid during the conflict and the scarcity of resources post-conflict. Such interpretations were illustrated by Hazel's suggestion that nutritionally enhanced foods distributed during the post-conflict period of return should still be offered. Familiar with humanitarian aid delivered in displacement camps on the basis of need and suffering, childbearing women continued to foreground their need for material goods when interpreting this "gift," the goals of which appeared to be developmental rather than humanitarian. This exemplifies a disjuncture between childbearing participants' understanding of the gift as useful and necessary, and the extra-local attempts to use the gift as a means to promote participation in ANC and skilled attendance at birth.

The context for providing support and levels of vulnerability also drew an array of commentaries and conversations from the participants. For example, Florence had heard that the mama kit was specifically for those with HIV:

To me they just told me right to my face that the [mama kit registration] card is for people who are HIV positive. That if you were positive then they would register you when you are pregnant but if you were healthy then you would not be registered. . . . She told me with her own mouth, that person registering.

In contrast, Rose said she had learned the mama kit was for child mothers, older mothers, or mothers with disabilities. Within this context, Florence and Rose, along with many other participants, hinted at additional criteria being used to determine their eligibility for the mama kits. Extending beyond compliance there was recognition that disease, age and/or disability were taken into account when deciding which new mothers received the kits. Poverty and hardship emerged as relative here, signaling relationship between such aid and narratives of deservedness.

Florence's response revealed suspicion about the collusion of forces and discursive practices shaping ANC and childbirth. She suggested that the most needed change was transportation between areas where delivery care was unavailable and the health centre at Amuru. In clarifying, she contrasted transportation with the mama kits:

Yes, [a vehicle] that comes and gets people to take us there. But not like cloths or what, because those things will not help us. That's the help they give when they've seen how different you are. But what connects us [i.e., transportation] should at least be there.

In the focus group, Julia agreed with Florence, adding that such an approach would prevent deliveries from occurring on the road while women were attempting to walk to the health centre. Mildred also agreed that transportation was a priority, suggesting that an alternative to the vehicle Florence recommended would be for women to be given money to pay a boda boda driver (motorcycle taxi). For these participants, facilitating access to care was more important than the material goods offered via the mama kits. Florence further questioned the mama kits benefits suggesting instead that they operated to signal difference. NGOs were often associated with Westerners or non-community members: for Florence, the mama kits re-inscribed the differences, including wealth and poverty, between those supplying and among those receiving the mama kits. While marking local women's poverty and lack of access to basic supplies, the mama kits had little capacity to address the causes of poverty or to significantly change women's circumstances. When asked for recommendations to improve care, two women suggested improvements to the mama kits, specifically adding clothing and providing additional supplies to mothers of twins. More commonly, women in five of six villages raised the issue of distance to care, identifying the need to build health facilities nearby as well as suggesting various means of improving transportation to access existing centres.

NGO withdrawal and shortages

With NGO projects like the mama kits, program closures and supply shortages are a constant threat. This issue was raised by several senior health workers participating in the study, **including by all participants with an administrative role.** The clinical officer in-charge at the health centre, Jonas, framed his concerns in reference to a similar previous project provided by the Northern Uganda Malaria Aids and Tuberculosis Program (NUMAT): "These mosquito nets we used to distribute during antenatal clinic, and then the mama kits we would give at delivery. And this one ended because the program also ended." Distributing mosquito nets was part of the ANC goal to reduce the incidence of malaria among pregnant women (a major cause of infant death), but it was an NGO initiative, not a health centre initiative. Its sustainability was beyond

the control of the health centre.

Peter, the district health officer, also brought up the closure of the NUMAT program, describing its demise as typical. He said that the program had increased women's attendance at health centres:

So because of that they will come in big numbers and it was something really the government will provide, they were providing, but you know our government. Things are not ... they usually end, even if the idea is very good, somewhere the idea breaks.

NGO withdrawals or program closures were something that health workers anticipated, but whose timing they could not predict. As the public health educator, Alex, explained: "with the Red Cross, they may withdraw if they find that their work is needed somewhere else". This uncertainty had consequences for the ways NGO interventions in maternal health were structured. When projects on which women rely end or have limited reach, it contributes to the health system's fragility and skepticism among providers and users.

In Amuru, many NGO programs had moved on now that the war was over and resettlement was underway, such that NGO withdrawal was a prominent feature of Amuru and post-conflict northern Uganda. McElroy (2012), in her study of childhood in the transition period, notes this problem arguing that "a gradual withdrawal of services that is responsive to the rate of transition" would be preferable to the rapid withdrawal of services on which people still depend (p. 147).

In addition to the problem of NGO withdrawal and project closure shaping health care delivery, providers faced the challenge of managing the mama kits stock. All participating health centres received the same number of kits, without regard to the numbers of deliveries they supported. Lacor Health Centre III cared for a large number of births, partly due to the lack of capacity in neighbouring health centres. As Jonas described it: "[NGOs] do their calculation uniformly, with all the other health facilities in the other sub-counties, not knowing that other sub-counties have like two HCIIIs or one HCIII plus three or four HCIIIs that are well-functioning." Jonas indicated that this left his staff in the position of having to explain to mothers when the mama kits had run out. One strategy for managing the limited supply was to divide the kits. Jonas explained that, "sometimes when the bags are few we give them one-one [i.e., the contents of the kit are divided]." This stretched supplies but contributed to the confusion

over and disparities in the kits' contents. Similarly, when they had supplies, the health centre staff sometimes gave bars of soap to husbands who had attended ANC and tested for HIV, in order to encourage this practice.

Discussion

Gifts given to mothers as a feature of maternity care can call into being different modes of citizenship and relationality. As Petersen, Davis, Fraser, and Lindsay (2010) describe, “the mundane striving for ‘good’ or ‘perfect’ health involves intensive ‘work on the self’ or self-governance, and despite the language of empowerment and freedom, this striving for health entails compulsion, added responsibilities to others, and often punishment and social exclusion in the case of those who fail to conform.” (p. 392). An example of a responsabilization strategy in the Ugandan context is in the rationale for the VHT approach, which utilizes volunteers in rural areas where health care has poor reach. This rationale makes claims about empowerment and taking responsibility, and shifts the blame for health problems to individuals and communities, rather than health systems of other public sectors: “Community participation and empowerment is a strategy that enables communities to take responsibility for their own health and wellbeing [. . .] In Uganda, over 75% of the diseases are preventable if only people changed and adopted appropriate and well known behaviors geared towards better health” (Uganda Ministry of Health, 2005, p.7). Being a good citizen through seeking health care is to take charge of one’s health, in the parlance of neoliberalism. In Uganda, mama kits acted as a mechanism signaling that there were positive and negative modes of citizenship with regard to health during pregnancy. Sinding (2010) connects health care provision to belonging, writing that “Receiving health care, not receiving health care, and how health care is offered all affect physical health and at the same time carry messages about citizenship” (p. 1657). The question of citizenship is particularly important in the post-conflict context of northern Uganda, as Acholi people in the north continue to strive for substantive political recognition and equality (Oosterom, 2011). The mama kits emphasized compliant subjectivity, thereby influencing identities and inscribing social differences and hierarchies. The kits both addressed a need vulnerable women shared and, at the same time, reinscribed that vulnerability.

Gift giving in maternity care in context

The Bounty program in the UK, the maternity boxes in Finland, and the mama kits in northern Uganda differ in terms of their messaging and whether they worked in tandem with or counter to health care provision and public health goals. We draw on existing literature on the global North gift giving programs to further emphasize how gift giving in maternity care reinforces particular ideological, material and discursive practices that serve to reward compliant subjectivity, thereby shaping and identifying social differences albeit in different contexts and with diverse impacts on women. As there are numerous contextual differences between the program and our insights into the global North programs rely on existing literature and not first hand study, these programs are not introduced in order to make a full-scale comparison, rather they are introduced in order to tease out issues with gift giving in health care situations as well as to avoid looking to the case of the mama kits as exceptional or isolated to development contexts.

The Bounty program, in which baby items were exchanged for access to mothers as consumers of baby goods, emphasized the consumer discourse inherent in health citizenship ideology and that is also part of gift giving (Schouten, 1991). In this discourse, better consumption practices are linked to better health:

While we are surrounded by incitements to consume, there is an increasing requirement for individuals to make ‘good’ and responsible consumption decisions in the face of a wide range of available consumables and a plethora of public health, social and cultural information about possible consumption choices. (Petersen, Davis, Fraser, & Lindsay, 2010, p. 395)

In contrast to the Bounty program, maternity kits in Finland included such an extensive supply of clothes that they limited the need for individual consumption, instead emphasizing collective identity among parents and signaling a welcoming environment. When these practices are considered in relation to the mama kits in Amuru sub-country, what comes into view is the stark differences in how gift giving shapes citizenship in positive and negative ways depending on the ability of the community to access basic resources as well as the fit between what is given and what is required, a pertinent question for low-resource, remote, post-conflict communities.

In the UK, Bounty bags are “bagsful of freebies [. . .] given to expectant parents from companies keen to promote their products—nappy creams, vouchers for photos, washing powder

samples, and ‘special offers’ to buy bibs, workout books, and buggies” (McCartney, 2013, p. 1 of 2). In exchange for access to patients’ contact information and the opportunity to sell baby photographs, Bounty pays an annual fee to the NHS. This practice blurs the line between commercial interests and public health (McCartney, 2013). Women, trusting in the professional setting of care, may not realize they are consenting to direct marketing. The inclusion of state benefit forms in the packs contributes to the perception that they are part of public health care. Women are being targeted for marketing at a vulnerable time; as McCartney (2013) notes, “the hours after birth are hardly an optimal time to obtain formal consent” (2 of 2). The Bounty program positions childbearing women primarily as consumers. This work to position mothers as consumers through “free gifts” creates a scenario in which good parenting is set up as entailing consuming the ‘right’ products (Martens, 2010).

In contrast to the approach to birth as a marketing moment, the gift given to Finnish mothers emphasizes a collective national identity and supports public health. The program started in 1937 targeting the poor. Since 1949, all Finnish mothers who have had health checks have received a large box containing a gender-neutral layette for the baby from their government (Lee, 2013; Zimmerman, 2014)^{viii}. The program is similar to the mama kits project in northern Uganda for being tied to receiving formal care and for delivering necessary baby supplies, but is distinct for being a universal program and for the high quality and comprehensive goods included. The maternity box was initially implemented to address the problem of high maternal mortality attributed to low rates of ANC (Lee, 2013). The box itself doubles as a crib, which supported recommendations that parents stop the practice of sleeping with infants (Lee, 2013). The program has also engaged with other public health goals, for example, by excluding formula and including condoms. These boxes have acted to meet public health goals while at the same time sending non-judgmental and welcoming messages to parents. As Zimmerman (2014) writes, “The arrival of a box filled with baby clothes carries a powerfully tangible sign that the baby is both real and a welcome member of society” (p. 209). Zimmerman quotes a Finnish parent as stating “This felt to me like evidence that someone cared, someone wanted our baby to have a good start in life. It strengthens the feeling that we are all in this together” (209). The program aims to give babies an equal start in life, and the sameness of the items within each year emphasizes a collective identity (Lee, 2013). In contrast, the mama kits project in Amuru tended to highlight poverty and other social stratifications rather than emphasizing a shared national or

parental identity.

The Finnish maternity boxes and the Bounty program represent two distinct approaches to gifts to mothers by global North countries with publicly funded universal health care systems. The NHS partnership with Bounty represents a public health system's willingness to exploit its patients as consumers, while in contrast, the Finnish approach is to invest in families with babies as a means of reaching shifting public health goals. As well as being situated in wealthy countries, the programs are both universal, rather than targeted, in their approach. To a significant extent, the overall contrast in social context between European countries and Uganda dictates that a gift to new mothers in Uganda would be different from either of these programs. A low-income country with an underfunded health system, Uganda is ill-positioned to offer a program matching the reach and generosity of Finland, and, with fewer middleclass families to be targeted as consumers of baby care items, an extensive private sector partnership seems similarly unlikely. The gift of mama kits to new mothers is nevertheless influenced by a neoliberal approach to health care provision. The vulnerability of pregnant women due to material, financial, and post conflict contexts means that social interventions during pregnancy are both necessary and highly sensitive; this was the case with the mama kits.

Gifts to new mothers in Uganda and material culture in international development

Inequalities in access to the basic supplies necessary to care for a newborn are structured by power relationships and are not simply a problem of resource supply and/or allocation. While the Finnish maternity kits are identified as contributing to equality and to shared identity, the mama kits program sets apart its recipients as different from the general population who aren't 'in need' and from their benefactors who have the capacity to give. Women are targeted both for their poverty and for what is oftentimes constructed as their reluctance to seek formal care. The attempt to improve the numbers of women attending formal care is an intervention that occurs in the context of high maternal mortality, a major public health problem throughout Uganda and particularly in the north. While it is clear that addressing systemic barriers, particularly a lack of health care services and transportation options, would have the greatest impact, providing an incentive to women can play some role in promoting skilled delivery. For example, Mbonye et al. (2013) studied the effect of a "motivation package," including a similar mama kit as well as education, in improving rates of adherence to malaria prevention and facility delivery in another area of Uganda. They found that the motivation package did play a role in improving adherence,

with the mama kits being a factor, but that “Despite this, relatively few women delivered at health facilities. Constraints like high costs, long distances to health facilities and the role of the husband could have influenced this outcome” (p. 6 of 7). That is, in the absence of adequate access to care, incentivizing care seeking has a limited impact; it also, as is argued here, can shift attention away from the systemic changes that are required to the behaviours of individual women, responsabilizing individuals for the poor outcomes that in reality are a problem of a neglected health system and its limited reach.

In a discussion of gifts within development, Stirrat and Henkel (1997) make the case that “Gifts, like charity, do not lead easily to identification but, rather, to a reaffirmation of difference” (p. 80). The difference affirmed is the poverty of the recipients. A study participant, Florence, cited earlier, echoed this insight when she referred to the mama kit as “the help they give when they’ve seen how different you are,” lamenting the lack of more meaningful assistance that would directly improve access to safe care in her community. In the absence of help that could facilitate such access, she rejected the idea of ‘cloths or what’ as offered in the mama kits. **Strikingly, she referred to transportation to care as “what connects us,” implying that the priority in her view should be a tangible support for reaching care, rather than a token form of support.** The recognition of difference is inherent within development NGO gift giving, and the maintenance of this difference is crucial to the continuation of such NGOs. **NGO gifts such as the mama kits cannot meaningfully alter the experience of poverty, whereas transportation to care would improve access and likely save lives.**

In considering the role of giving in humanitarian NGOs, Krause (2014) suggests that recipients are beneficiaries of assistance yet are simultaneously positioned as commodities leveraged for funding. This process of commodification is different from the commodification that occurs in the NHS system in which mothers are targeted as consumers, yet, like the Bounty package, the mama kits are a gift that carries a set of expectations about its recipients and that capitalizes on their vulnerability. **In contract law, a conditional gift is one which is only given once specified conditions are first met. We know from Mauss and Levi-Strauss that gifts are never freely given without an expectation such as reciprocity or a social bond. However, the offering of a gift to mothers that is conditional on compliance with health care expectations should be theorized as distinct from the gifts often given to new mothers by friends and families.** Krause (2014) writes that “the populations served are also part of the

product that agencies plan and account for, if they work for institutional donors. [. . .] they are part of a commodity being sold to donors in a quasi market” (p. 40). Krause emphasizes that being a beneficiary entails labour on the part of the recipient; the gifting is conditional on such labour. Therefore, she suggests that as well as looking to Mauss (1990) and his theories on gift exchange, one also has to look to Marx and his theories on wage labour to understand humanitarian aid: “we have a set of specialized producers, who have a professional interest in encouraging gift giving and gift taking. We also have to consider the context in which these exchanges take place, specifically that the gift concerns basic needs of the recipients” (p. 58). Hope, a mother of five who lived near the health center, was one participant who spoke about the mama kit’s key role in meeting basic needs. She said: “if you find that there is no money, you may deliver very well, but when you reach home there is no sheet for carrying the baby. So if you are given from there [health centre], it can save you”. Hope emphasized that without support with basic resources, the safe delivery of a healthy child could still lead to a precarious start for the baby. The mama kit project exemplifies an exchange in which the gift meets basic needs yet is given under conditions requiring work and over which recipients have little control.

Unlike some gifts to new mothers that primarily signal welcome and support (Afflerback, Anthony, Carter & Grauerholz, 2014), these gifts affirm mothers in northern Uganda as vulnerable and create a new task during pregnancy of complying with project requirements. Krause writes that while relief helps its recipients, “recipients also give something in return: consent, time, and labor [. . .] They give this labor under conditions over which they have very little control” (Krause, 2014, p. 60). This tension was evident in the case of the mama kits: childbearing women both needed and wanted to receive the kits. A finding that thread throughout the larger study of how maternity care and birth were organized in Amuru sub-county was that pregnant women had to shoulder a disproportionate burden of work. This work also takes place in the context of power dynamics in which women were particularly vulnerable. Despite the value of the mama kits to childbearing women, the work entailed by the project diminished some potential benefits of receiving the kit. For example, unlike Finnish parents, participants didn’t articulate feeling recognized through the kits or that their child was being welcomed. Instead, it contributed to an embattled atmosphere of struggle.

Receiving or not receiving a gift is not abstract to recipients. For project recipients, “what

starts off as an anonymous abstract donation becomes personalized and concretized” (Stirrat & Henkel, 1997, p. 77). This is evident in participants’ feelings about being “passed over” for the gift. These feelings included envy of their neighbours who had received a kit, blaming VHT members or health centre staff for stealing the kits, and frustration over having worked for the mama kits without results. Such negative feelings on the difficulty of receiving a kit would not occur unless the kits were viewed as valuable. In this as in other international development projects, community members who do not benefit from a project nevertheless have to organize their lives in relation to the project. As Krause (2014) writes: “only a small share of those who might be said to need help actually receive help, that there is thus a competition among gift receivers but that those who do not receive also give” (p. 58). Competition, work, and embodying difference are some negative effects of the mama kit project for childbearing women in Amuru subcounty, who nevertheless both need and desire the material goods distributed by the project.

Conclusion

While participants wanted and appreciated the mama kits, these gifts were supplied in the context of a neglected health system in which adequate facilities, medical staff, and transportation were in short supply. When considered as an overall approach, the layering of a marginal form of social support onto a health care system that is not working can be seen to act as a form of governing through scarce resources in this marginalized region, thereby contributing to the ongoing pathologizing of poverty (Farmer, 2008, 2010). As Pfeiffer and Nichter (2008) explain: “There is growing recognition of the urgent need to build or rebuild health systems, yet the increasing flow of aid from donors continues to promote narrow interventions and specific projects. This “stove-piping” of projects creates additional stress on government health infrastructures while providing little in the way of institution building” (p. 411). The mama kit exemplifies such a project in that it takes considerable resources yet does not develop health care institutions.

Examining the role that a gift to new mothers accessed through maternity care providers plays in the northern Ugandan context reveals the fraught role materialism and gift giving can

play when it occurs in health care contexts. A gift to pregnant women can affirm their vulnerability and need, or encourage their belonging to a society with shared responsibility for the wellbeing of a new generation. While the mama kits were often referred to as a gift, they operated to govern care because their distribution was mediated by discourses of scarcity and deservedness. Because they were often framed as a reward or incentive for attending ANC or health centre delivery, these resources shaped the ways in which maternity care was sought and accessed. They attempted to create and reward compliance with ANC and delivery care, but failed to address the primary barriers women faced in accessing care. Access barriers and coercive power are issues that contribute to poor maternal outcomes in Uganda. Understanding the role of gifts to new mothers in this context suggests that a more critical and less ad hoc approaches are necessary for projects that wish to intervene to effectively advance mother-child health. **Projects similar to the mama kit are popular among small and large NGOs working throughout Africa and offer donors a sense of contributing something tangible. Meanwhile, a project emulating the Finnish baby boxes is being piloted as part of a research project in Alberta, Canada (Dunn, 2016). As the idea of a gift to new mothers appears to be gaining momentum in public health and in development organizations, understanding the different ways such gifts are offered and received contributes to the potential for such programs to reach their goals without reinforcing social inequities and divisions.**

ⁱ We use the terms “global South” and “global North” in order to point to those features this study’s setting share with other settings in sub-Saharan Africa and low-income countries in other continents, and to contrast the setting to Canada and other countries with similar economic profiles. Unlike the term “developing countries,” “global South” does not indicate that these countries need to catch up to “developed countries.” While preferable to “developing countries,” the term “global South” is not ideal. In using it, we do not intend to disregard the tremendous in-country disparities of health, income, or status within global North countries such as Canada, or to suggest that countries within the global South are more similar to than different from each other. As Bulbeck writes, “wealth and poverty, advanced industrialism and underdevelopment do not lie in neatly divided geographical hemispheres” (2007, para. 5).

ⁱⁱ **Health services are identified by levels corresponding to local political entities. A health centre I corresponds to the village level, and is comprised solely of Village Health Team members (VHT). A health centre II is the lowest level of health centre to have a physical facility, and corresponded to a parish level. A health centre III corresponds to a sub-county level, and is required to have a senior clinical officer and a lab. A health centre IV also has a doctor and an operating theater, and corresponds to the district level; there was one HC IV in Amuru district, located north of Amuru subcounty in Atiak, near the border with South Sudan.**

ⁱⁱⁱ Since health centres do not offer food or laundry services, patients need the assistance of a family member to prepare food and wash clothes as well as provide support. These family members are referred to as attendants.

^{iv} Marriage is generally patrilineal within Acholi communities (Baines & Rosenoff, 2014), hence the importance of

in-laws.

v Polygynous marriages are commonplace in this area, (Westerhaus, 2007; Patel, 2012) including among the study participants.

^{vi} Because of the long distances to a functioning health centre and transportation difficulties, women sometimes gave birth “on the way” to a health facility.

^{vii} At night, it was difficult to arrange transportation, as boda-boda drivers had left their stations for the day, and if reachable, might refuse to travel at night because of poor road conditions and other safety concerns.

^{viii} More recently, in 2009, Chile implemented a similar program (Gobierno de Chile, 2015).

Address for correspondence: Sarah Rudrum, University of British Columbia - Institute for Gender Race Sexuality and Social Justice, 038 – 2080 West Mall Vancouver Manitoba V6T 1Z2, Canada. E-mail: sarahrudrum@gmail.com

Author Manuscript

References

- Achadi, Endang, Pitchforth, Emma, & Hussein, Julia. (2012). Quality of Care. In Julia Hussein (Ed), *Maternal and Perinatal Health in Developing Countries*. Cambridge, CABI. 181 -192.
- Afflerback, S., Anthony, A., Carter, S., & Grauerholz, L. (2014). Consumption Rituals in the Transition to Motherhood. *Gender Issues*, 31(1), 1-20.
- Angotti, N.; Dionne, K.; Gaydos, L. (2011). An offer you can't refuse: Provider initiated HIV testing in Malawi. *Health Policy and Planning*, 26. doi: 10.1093/heapol/czq066
- Baines, E., & Rosenoff Gauvin, L. (2014). Motherhood and Social Repair after War and Displacement in Northern Uganda. *Journal of Refugee Studies*. doi: 10.1093/jrs/feu001
- Bulbeck, C. (2007). Hailing the 'authentic other': Constructing the Third World woman as aid recipient in donor NGO agendas'. *Advances in gender research*, 11, 59-73.
- Dunn, Carolyn. (2016, January 9, 2016). Alberta's baby boxes help new parents get through 'terrifying' 1st few months: Landmark study gives parents essential supplies for newborns but also mentorship. *CBC*. Online resource available at <http://www.cbc.ca/news/canada/calgary/finnish-baby-boxes-maternal-family-health-study-alberta-1.3394637>. Accessed January 31, 2016.
- Farmer, Paul. (2008). Challenging orthodoxies: The road ahead for health and human rights. *Health and Human Rights*, 10(1),5-19.
- Farmer, Paul. (2010). *Partner to the poor: A Paul Farmer reader* (Vol. 23). Oakland, CA: University of California Press.
- Gabrysch, Sabine, Simushi, Virginia, & Campbell, Oona MR. (2011). Availability and distribution of, and geographic access to emergency obstetric care in Zambia. *International Journal of Gynecology & Obstetrics*, 114(2), 174-179.
- Gobierno de Chile. (2015). President Bachelet: "Chile will be a country where every child is born and grows up with all the opportunities to develop". Accessed April 29, 2015. <http://www.gob.cl/2015/04/08/president-bachelet-chile-will-be-a-country-where-every-child-is-born-and-grows-up-with-all-the-opportunities-to-develop/>
- Grede, N., de Pee, S., & Bloem, M. (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 and Behavior*. 18(5), 516-530.
- Krause, M. (2014). *The good project: Humanitarian relief NGOs and the fragmentation of reason*: University of Chicago Press.
- Hankivsky, O., Grace, D., Hunting, G., Ferlatte, O., Clark, N., Fridkin, A., Rudrum, S., and Laviolette, T. (2012). Intersectionality-Based Policy Analysis. In O. Hankivsky (Ed), *An Intersectionality-Based Policy Analysis Framework*, 33-45.
- Lee, Helena. (2013, June 4 2013). Why Finnish Babies Sleep in Cardboard Boxes. *The Guardian*.
- Martens, Lydia. (2009). Creating the Ethical Parent-Consumer Subject. In J. A. Sandin & P. McLaren(Eds) *Critical Pedagogies of Consumption: Living and Learning in the Shadow of the "Shopocalypse"*, 180.
- Mauss, M. (1990). *The Gift* (WD Halls, Trans.): London: Routledge.
- Mbonye, A. K., Yanow, S., Birungi, J., & Magnussen, P. (2013). A new strategy and its effect on adherence to intermittent preventive treatment of malaria in pregnancy in Uganda. *BMC pregnancy and childbirth*, 13(1), 178.
- McCartney, M. (2013). Profits from pregnancy: how trusted organisations sell out women to commercial interests. *BMJ*, 346.
- McElroy, Theresa. (2012). Early childhood before, during and after war and displacement in northern Uganda. Dissertation. Available at:
<https://open.library.ubc.ca/cIRcle/collections/ubctheses/24/items/1.0076895>
- Munjanja, S., Magure, T., & Kandawasvika, G. (2012). Geographical Access, Transport and Referral Systems. In J. Hussein (Ed), *Maternal and Perinatal Health in Developing Countries*, 139.
- Nayar, U. S., Stangl, A. L., De Zaluondo, B., & Brady, L. M. (2014). Reducing stigma and discrimination to improve child health and survival in low-and middle-income countries: Promising approaches and implications for future research. *Journal of health communication*, 19(sup1), 142163.
- Oosterom, M. (2011). Gender and fragile citizenship in Uganda: the case of Acholi women. *Gender & development*, 19(3), 395-408.
- Petersen, A., Davis, M., Fraser, S., & Lindsay, J. (2010). Healthy living and citizenship: an overview. *Critical Public Health*, 20(4), 391-400. doi: 10.1080/09581596.2010.518379

Pfeiffer, James, & Nichter, Mark. (2008). What can critical medical anthropology contribute to global health? *Medical Anthropology Quarterly*, 22(4), 410-415.

Ragoné, H. (1999). The gift of life. In Linda Layne (Ed), *Transformative motherhood: On giving and getting in a consumer culture* (pp. 65-88). New York: New York University Press.

Refugee Law Project. (2012). Border or Ownership Question: The Apaa Land Dispute.

Electronic document,

http://www.refugeelawproject.org/files/ACCS_activity_briefs/The_Amuru_and_Adjuma_ni_land_dispute.pdf. Accessed June 2013.

Rudrum, Sarah. (2015). Traditional Birth Attendants in Rural Northern Uganda: Policy, Practice, and Ethics. *Health Care for Women International*, 37(2), 1-20. doi: 10.1080/07399332.2015.1020539

Rudrum, Sarah, Oliffe, John L, & Brown, Helen. (2015). Antenatal Care and Couples' HIV Testing in Rural Northern Uganda A Gender Relations Analysis. *American Journal of Men's Health*, 1557988315602527.

Say, Lale and Raine, Rosalind. (2007). A systematic review of inequalities in the use of maternal health care in developing countries: Examining the scale of the problem and the importance of context. *Bulletin of the World Health Organization*, 85, 812–819. doi: 10.2471/blt.06.035659

Schouten, John W. (1991). Personal rites of passage and the reconstruction of self. *Advances in consumer research*, 18(2), 49-51.

Sinding, C. (2010). Using institutional ethnography to understand the production of health care disparities. *Qualitative Health Research*, 20(12), 1656-1663.

Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*: University of Toronto Press, Toronto.

- Smith, D. E. (1990). *The conceptual practices of power: A feminist sociology of knowledge*: University of Toronto Press, Toronto.
- Smith, D. E. (2005). *Institutional ethnography: A sociology for people*. Oxford, UK: Rowman Altamira.
- Stirrat, R. L., & Henkel, H. (1997). The development gift: The problem of reciprocity in the NGO world. *The Annals of the American Academy of Political and Social Science*, 66-80.
- Titmuss, R. (1970, 1997). *The Gift Relationship*. The New Press. New York.
- Uganda Bureau of Statistics. (2011). Uganda Demographic and Health Survey.
- Uganda Ministry of Health. 2010. "Village Health Team Handbook." Available at <https://www.k4health.org/sites/default/files/VHT%20BOOK.pdf>.
- Weber, L. (2006). Reconstructing the landscape of health disparities research: promoting dialogue and collaboration between feminist intersectional and biomedical paradigms. *Race, class, gender and health*, 21-59.
- Westerhaus, M., Finnegan, A. C, Zabulon, Y., & Mukherjee, J. S. (2007). Framing HIV prevention discourse to encompass the complexities of war in northern Uganda. *American Journal of Public Health*, 97(7), 1184-1186.
- Wirth, Meg, Sacks, Emma, Delamonica, Enrique, Storeygard, Adam, Minujin, Alberto, & Balk, Deborah. (2008). Delivering" on the MDGs?: Equity and maternal health in Ghana, Ethiopia and Kenya. *East African Journal of Public Health*, 5(3), 133-141.
- Zimmerman, F. (2014). It's the Thought That Counts. *JAMA pediatrics*, 168(3), 209-210.



Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:

Rudrum, S; Brown, H; Oliffe, JL

Title:

Understanding the meaning and role of gifts given to Ugandan mothers in maternity care settings: "The help they give when they've seen how different you are"

Date:

2016-11-01

Citation:

Rudrum, S., Brown, H. & Oliffe, J. L. (2016). Understanding the meaning and role of gifts given to Ugandan mothers in maternity care settings: "The help they give when they've seen how different you are". *SOCIOLOGY OF HEALTH & ILLNESS*, 38 (8), pp.1318-1335.
<https://doi.org/10.1111/1467-9566.12456>.

Persistent Link:

<http://hdl.handle.net/11343/291642>

File Description:

Accepted version