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Administrative Decentralization and Maternal Healthcare Service Delivery in Rural Communities of Mitooma District

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ABSTRACT
Decentralization has been promoted globally as a means to improve health service delivery by bringing decision-making closer to communities. In Uganda, despite decentralization reforms, maternal health care outcomes remain suboptimal in many parts of the country but largely in Mitooma district where the study was conducted. This study explored the implications of decentralization on maternal health service delivery, focusing on the experiences, challenges, and perspectives of stakeholders at community, facility, and district levels.
An interpretivist phenomenological qualitative design was employed, using in-depth interviews and focus group discussions (FGDs) with key stakeholders, including healthcare workers (Midwives, and nurses), pregnant and lactating mothers, and local government officials. Participants were purposively selected across multiple communities served by four health facilities at the level of HC111, and HC11 within Mitooma districts. Data were transcribed, coded, and thematically analyzed using **ATLAS.ti** software to identify key themes and patterns. Ethical principles were observed throughout the research, including informed consent and confidentiality.
Findings revealed that while decentralization has enhanced local autonomy and community engagement in some districts, significant challenges persist. These include limited financial and human resources, inadequate decision-making capacity at the local level, poor referral systems, and delays in emergency health care for expectant mothers. Participants also highlighted disparities in service availability and quality, particularly in rural and hard to reach communities like Kanyabwanga HC111. Despite these constraints, decentralized structures offered opportunities for locally tailored interventions and improved accountability when adequately supported.
In conclusion, it was observed that decentralization alone is not sufficient to ensure improved maternal health outcomes. Strengthening district-level capacities, enhancing coordination mechanisms, and addressing systemic resource constraints are critical for the success of decentralization reforms. The study recommends targeted policy actions to bridge implementation gaps and promote equitable health care package mostly maternal health for which the gaps were identified in service delivery.

Keywords: Administrative, Decentralization, Maternal Healthcare, Service Delivery, Rural Communities, and Mitooma District.

Introduction

Antenatal care (ANC) is a vital health service that ensures pregnant women receive essential medical attention throughout pregnancy. Despite its recognized importance, Uganda still experiences a high maternal mortality ratio, approximately 336 deaths per 100,000 live births (UBOS, 2021; WHO, 2022). This alarming rate is largely attributed to systemic healthcare challenges, including limited access to skilled birth attendants (UNFPA, 2023), poor infrastructure, and delays in accessing emergency obstetric care (Atuyambe et al., 2020; Kiwanuka et al., 2008). Barriers such as geographic inaccessibility, workforce shortages, indirect costs, and sociocultural factors continue to hinder full ANC utilization (Kabakyenga et al.,

2016; UBOS & ICF, 2022; Nankwanga, 2020; Tann et al., 2007).

Studies from other regions reflect on these concerns about weak referral and emergency transport systems in maternal health care. In a study conducted in northern Uganda, researchers found that the lack of ambulances and poor road conditions were major contributors to delays in accessing emergency obstetric care. Women often relied on boda-bodas or bicycles, even during labor, which increased the risk of complications and maternal deaths (Wilunda et al., 2014). Another study from rural Ethiopia reported similar findings: despite improvements in antenatal care, the absence of a reliable referral system meant that many women could not reach hospitals in time during emergencies. In some cases, this led to home births or deliveries in private clinics with no trained staff, which undermined the benefits of earlier care (Tura et al., 2017).

In Mitooma District, maternal health challenges are particularly acute. Skilled birth attendance (SBA), a proven strategy for reducing maternal mortality, remains inadequate, especially in rural areas (Kungu et al., 2021; MOH Uganda, 2020; WHO, 2019; Benova et al., 2014). Inadequate postnatal care (PNC) is also a growing concern, with contributing factors including low awareness, cultural practices, and weak health infrastructure (Takahashi et al., 2021; Waiswa et al., 2015; Nalwadda et al., 2010; Campbell & Graham, 2006). Health facilities in Mitooma District are often understaffed (no lab technician), poorly equipped (no ambulance services), and located far from the communities they serve. Only 9.7% of the national budget was allocated to healthcare in FY 2019/2020, reflecting chronic underinvestment in maternal health (Mbonye et al., 2022; MOFPED, 2020; World Bank, 2020). Emergency obstetric care (EmOC) remains critically underprovided. Many facilities lack basic services, including operating theatres, trained personnel, and reliable transport systems (Atuyamuza et al., 2023; Nabulo et al., 2023; BMC, 2018; Mitooma District Health Department, 2024).

Access to maternal health care services remains a significant challenge for women in Mitooma District, Uganda. Various barriers hinder women's ability to receive adequate care, ultimately impacting maternal health outcomes. Financial constraints, distance to health facilities, poor road infrastructure, and cultural beliefs significantly restrict service utilization (Kabia et al., 2023; Macha et al., 2022; Dahab & Sakellariou, 2020). The lack of knowledge and awareness about available maternal health services also contributes significantly to the problem (Hatt et al., 2013). Reports indicate that some women experience disrespect or mistreatment from healthcare providers, which can discourage them from utilizing maternal health services (Kabia et al., 2023).

The Social Determinants of Health (SDH) theory emphasizes that health outcomes are influenced by social, economic, and environmental factors (Solar & Irwin, 2010). For maternal health, poor road networks, lack of skilled attendants, weak referral systems, and low education levels directly affect women's ability to access services (Victora et al., 2003; WHO, 2010). When local authorities fail to coordinate across sectors, barriers women face during pregnancy and childbirth are heightened.

Despite ongoing efforts to improve health outcomes, Mitooma District, located in Western Uganda, faces several challenges in maternal health care service delivery. The district has made strides in reducing maternal mortality rates, but barriers remain that impact the quality and accessibility of maternal health services (Uganda Bureau of Statistics, 2021).

Mitooma District has several health facilities, including health centers and a general hospital. However, many of these facilities are often under-resourced and struggle with inadequate medical supplies, staff shortages, and insufficient training for healthcare providers (World Health Organization, 2019). The quality of care can vary

significantly between rural and urban health centers, with rural areas often facing greater challenges due to limited access to trained professionals and essential medical services (Ministry of Health Uganda, 2016).

Access to maternal health services in Mitooma is hampered by geographical and logistical barriers. Many women live in remote areas and may need to travel long distances to reach health facilities (Brett et al., 2020). Poor road conditions, especially during the rainy season, further complicate access (World Bank, 2018). Additionally, the lack of transportation options can deter women from seeking timely care, particularly during emergencies, as reliance on personal or communal transport can be inconsistent and unreliable (Graham et al., 2016).

Cultural beliefs and practices significantly influence maternal health care utilization in Mitooma District. Some communities still hold traditional beliefs about childbirth and prefer to rely on traditional birth attendants rather than seeking help from formal healthcare providers (Khan et al., 2019). This reliance on traditional practices can lead to delays in receiving critical care, particularly in cases of complications during pregnancy or childbirth, which can have severe consequences for both mothers and infants (Mishra et al., 2020).

Additionally, there is a general lack of awareness about maternal health services among some segments of the population. Educational initiatives aimed at promoting the importance of antenatal care, skilled birth attendance, and postnatal care have been implemented; however, challenges remain in reaching all community members effectively (Nabyonga-Orem et al., 2019). Efforts to educate women about their reproductive health rights and available services are crucial for improving maternal health outcomes, as informed women are more likely to seek and utilize health services (Hounton et al., 2019).

The Ugandan government, along with various non-governmental organizations (NGOs), has launched several programs to enhance maternal health services in Mitooma District. These initiatives focus on increasing the availability of antenatal care, improving emergency obstetric care, and training health workers. Community health workers also play a critical role in bridging gaps in service delivery by educating communities and facilitating access to health services. While there have been improvements in maternal health indicators, such as increased rates of facility-based deliveries, the maternal mortality ratio remains a concern. As of recent reports, Uganda's maternal mortality ratio is estimated at around 336 per 100,000 live births, reflecting ongoing challenges in maternal health care access and quality (Uganda Bureau of Statistics, 2021). The general objective of this study was to assess the contribution of decentralization in addressing maternal healthcare service delivery in rural communities, with a focus on Mitooma District in Southwestern Uganda. This paper examines the barriers women, face in receiving maternal health care service delivery in Mitooma District.

Literature Review

Theoretical Review

A theoretical framework refers to the structure that guides research by relying on a formal theory or set of concepts that explain the relationships between variables or phenomena under study. It provides a foundation for understanding, interpreting, and analyzing the research problem by linking it to existing knowledge and theories (Creswell, 2014; Grant & Osanloo, 2014). Theoretical frameworks help researchers clarify definitions, make assumptions, develop hypotheses, and choose appropriate methods (Anfara & Mertz, 2015). Essentially, it serves as a lens through which the research is conducted, ensuring that the study is grounded in established academic thought and contributes meaningfully to scholarly discourse (Swanson, 2013).

Social Determinants of Health Theory

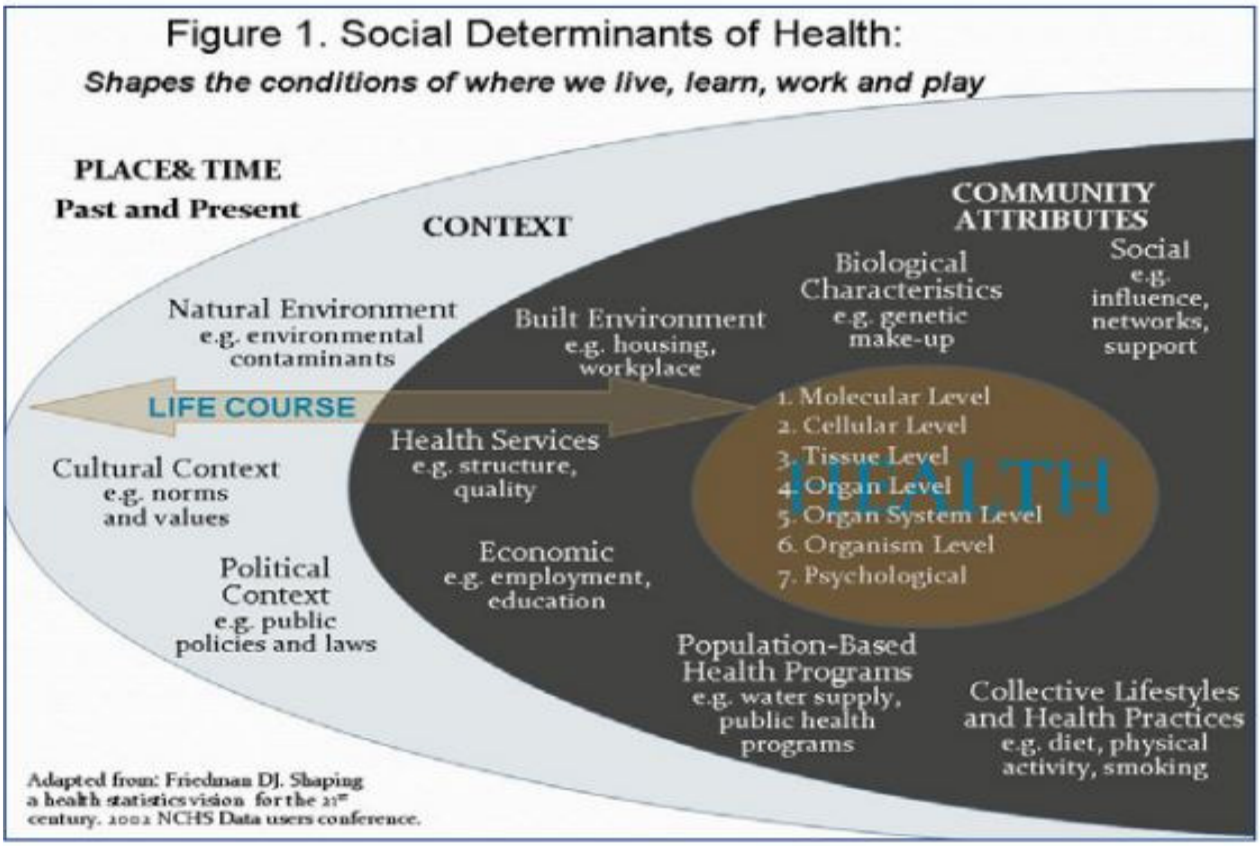

Figure 1: Social Determinants of Health Theory

Source: Maio & Mazzeo (2013)

The Social Determinants of Health (SDH) Theory highlights the broader social, economic, and environmental factors that influence individual and community health outcomes. These determinants include factors such as income, education, employment, housing, access to healthcare, gender equity, and social support networks. SDH Theory asserts that health outcomes are not solely the result of individual behaviors or healthcare access, but are also shaped by structural inequalities and social conditions.

Key Components of the Social Determinants of Health (SDH)

One of the key components include, "Social Inequities" where the SDH emphasizes how poverty, gender inequality, education, and social exclusion impact access to and quality of health care. Women in low-income or rural areas may face multiple barriers that limit their access to maternal health services, such as long distances to health facilities, limited financial resources, and cultural or gender norms that restrict mobility or decision-making. (Frontiers in Public Health, 2019), (BMJ Open, 2021). Additionally, the SDH theory highlights the "Health Systems and Policy" whereby SDH theory links the role of social policies (such as decentralization) in influencing health care access. Decentralization, if not accompanied by policies that address social determinants like poverty, education, and infrastructure, may worsen health inequities. (Bennett et al., 2020), (De Silva et al., 2021). Finally, the SDH underscores the idea that the way health systems are structured can perpetuate inequalities. For instance, poor health infrastructure, unemployment, or low educational levels in rural areas may undermine decentralization efforts by limiting the effectiveness of local health institutions in delivering quality care. (Kawachi & Berkman, 2020)

Maternal health outcomes are heavily influenced by the broader social determinants of health, especially in decentralized settings (WHO, 2008; Marmot et al., 2012). Issues such as economic

inequality, gender-based violence, education levels, and transportation access are critical factors that affect women's ability to seek and receive timely maternal health care (Gabrysch & Campbell, 2009; Say & Raine, 2007; Bhutta et al., 2010). Hence, decentralization may offer potential to improve access to maternal health services at the local level by bringing decision-making and resource allocation closer to communities (Bossert & Beauvais, 2002; Saltman et al., 2007). However, without addressing underlying social determinants such as poverty, lack of education, and cultural barriers, decentralization may inadvertently exacerbate disparities between urban and rural populations or among different socioeconomic groups (George et al., 2019; Gilson & Raphaely, 2008). On the other hand, when paired with targeted efforts to reduce structural inequalities, decentralization can support more equitable, responsive, and context-specific maternal health interventions (Brinkerhoff & Bossert, 2008).

Barriers Which Women Face in Receiving Maternal Health Care Service Delivery in Mitooma District

Access to maternal health care services remains a significant challenge for women in Mitooma District, Uganda. As a researcher focused on maternal health, I have noticed that various barriers hinder women's ability to receive adequate care, ultimately impacting maternal health outcomes. Understanding these barriers is crucial for developing effective interventions to improve access and quality of maternal health services in the region.

One of the primary barriers the researcher has identified is financial constraints. Many women in Mitooma District face economic hardships that limit their ability to pay for maternal health services. This includes costs associated with transportation to health facilities, fees for medical services, and expenses for necessary medications (Kabia et al., 2023). The lack of financial resources can deter women from seeking timely care, leading to adverse maternal health outcomes. In my discussions with local women, many expressed regrets over their inability to afford essential services, which often resulted in delayed or missed appointments.

Additionally, distance to health facilities poses a significant challenge. Many women in rural areas of Mitooma must travel long distances to access maternal health services, which can be both time-consuming and costly (Macha et al., 2022). Poor road infrastructure exacerbates this issue, making it difficult for women to reach health centers, particularly during adverse weather conditions. During interviews, several women recounted their struggles with transportation, emphasizing how the journey often left them exhausted before they even received care. Another critical barrier is cultural beliefs and practices. In many communities, traditional norms regarding gender roles can restrict women's autonomy in decision-making related to their health (Dahab & Sakellariou, 2020). Women may need permission from male family members to seek care, which can delay or prevent them from accessing necessary maternal health services. I have witnessed firsthand how these cultural dynamics play out in households, where women's health decisions are often secondary to those of male relatives.

The lack of knowledge and awareness about available maternal health services also contributes significantly to the problem. Many women in Mitooma District may not be fully aware of the maternal health services offered or the importance of seeking timely care during pregnancy (Hatt et al., 2013). Educational initiatives are essential to inform women about the significance of regular antenatal visits and skilled delivery. In my outreach efforts, I have encountered numerous women who were unaware of the benefits of prenatal care and how it could improve their pregnancy outcomes. Moreover, stigma and discrimination within healthcare settings can deter women from seeking care. Reports indicate that some women experience disrespect or mistreatment from healthcare providers, which can discourage them from utilizing maternal health services (Kabia et al., 2023). Addressing these issues is vital for creating a supportive environment that encourages women to seek care. I often emphasize the need for training healthcare providers on respectful maternity care to foster a more welcoming atmosphere for patients.

Inadequate healthcare infrastructure is another barrier affecting access to maternal health services. Many facilities in Mitooma District may

lack essential medical supplies or qualified personnel, leading to long waiting times and suboptimal care (Mubyazi et al., 2004). Strengthening healthcare infrastructure is necessary to ensure that women receive timely and adequate care during pregnancy and childbirth. In my assessments of local clinics, I have observed that many are under-resourced and struggle to meet the needs of the community effectively.

The shortage of skilled healthcare providers is a pressing issue that impacts service delivery. In many cases, there may not be enough trained personnel available to provide comprehensive maternal health services (Dahab & Sakellariou, 2020). Increasing the number of qualified healthcare workers in Mitooma District is critical for improving access to quality maternal care. I advocate for targeted recruitment and training programs aimed at building local capacity within the healthcare workforce. Additionally, transportation challenges further complicate access to care. Women often rely on public transport or informal means of transportation to reach health facilities, which may not be reliable or readily available (Macha et al., 2022). Improving transportation options could help mitigate this barrier and facilitate timely access to maternal health services. In my discussions with community leaders, we have explored potential solutions such as community transport initiatives that could assist pregnant women in reaching clinics safely.

Decision-making power within households significantly influences women's access to healthcare. In many cases, women may have limited authority over their own healthcare decisions, often deferring to male family members (Wong et al., 2022). Empowering women through education and community engagement can enhance their ability to make informed decisions about their maternal health. I believe that fostering an environment where women's voices are heard is essential for improving access to care. The lack of community support networks also plays a role in hindering access to maternal health services. Women may feel isolated or unsupported when seeking care, particularly if they lack family or community support during pregnancy (BMC Women's Health, 2024). Establishing support groups for pregnant women could foster a sense of community and encourage service utilization. In my work with local organizations, we are exploring ways to create peer support networks that can provide encouragement and information.

Furthermore, policy-related barriers can impede access to maternal health services. Existing policies may not adequately address the specific needs of women in rural areas like Mitooma District (Chol et al., 2023). Policymakers must consider local contexts when designing interventions aimed at improving maternal health access. I actively engage with policymakers to highlight these issues and advocate for more inclusive policies that reflect the realities faced by women on the ground.

Finally, healthcare system inefficiencies, such as bureaucratic hurdles and inadequate referral systems, can prevent women from receiving timely care. Women may face challenges navigating the healthcare system due to poorly defined referral pathways or lack of coordination among different levels of care (Hatt et al., 2013). Streamlining healthcare processes can enhance women's experiences and outcomes when seeking maternal health services. I emphasize the importance of creating clear guidelines and support systems that assist women in navigating these complexities.

To address the barriers faced by women in receiving maternal health care services in Mitooma District requires a vibrant approach. Interventions must focus on improving financial accessibility, enhancing healthcare infrastructure, empowering women through education and community support, and addressing cultural norms that restrict access. Hence, tackling these challenges comprehensively, it is possible to improve maternal health outcomes for women in the region.

Literature synthesis

The researcher acknowledges that Kabia et al. (2023), Macha et al. (2022), Dahab and Sakellariou (2020), Hatt et al. (2013), Mubyazi et al. (2004), Wong et al. (2022), and Chol et al. (2023) all point to key barriers that affect women's access to maternal health care. They agree that financial barriers, poor infrastructure, limited decision-making power, and weak health systems contribute to poor outcomes. Kabia et al. and

Macha et al. highlight cost and transport as major challenges, while Dahab and Sakellariou focus more on cultural and gender-related constraints. Hatt et al. and Mubyazi et al. stress weak systems, lack of supplies, and poor staffing. Wong et al. link poor decision-making power to broader social structures, and Chol et al. point to policy-level gaps. Some authors give more weight to structural and systemic causes, while others focus more on personal or cultural factors. Despite these differences, they all agree that improving access requires looking beyond medical care alone.

In my own work in Mitooma District, I have seen how these barriers overlap and make it hard for women to get timely and adequate care. What stands out from the literature is that while each author highlights specific factors, in practice, all of these problems show up together in people's daily lives. Women deal with long distances, high costs, poor service, and limited autonomy all at once. These findings support my view that solutions must be practical, community-based, and grounded in real conditions. Policies and programs that ignore these day-to-day realities often fail. My work aligns with the literature, but I also push for a more hands-on approach that starts with what women say they need and builds from there.

Methodology

This study employed an interpretivist phenomenological qualitative research design to explore the barriers women face in receiving maternal health care service delivery in Mitooma District (Creswell, 2014; Grant & Osanloo, 2014). The study was conducted in Mitooma District, located in Western Uganda, which has several health facilities including health centers and a general hospital (Mitooma District Health Department, 2024). The study population consisted of pregnant women, lactating mothers, healthcare workers (midwives and nurses), and local government officials. The target population included women of reproductive age and service providers directly involved in maternal healthcare, with purposive and snowball sampling techniques used to select participants (Anfara & Mertz, 2015). Data were collected through multiple qualitative methods to capture diverse perspectives on barriers to maternal health service access. In-depth interviews were conducted with healthcare providers and local government officials, while focus group discussions (FGDs) were held with pregnant and lactating mothers. Participant observation was also used to understand the lived experiences of women in accessing maternal health care services. The tools employed included FGD guides, key informant interview (KII) guides, and observation checklists, all tailored to address Objective 2 (Booth et al., 2016; Jesson et al., 2011).

To ensure credibility, dependability, and validity of findings, several strategies were employed. Pre-testing and expert reviews helped refine the instruments, while triangulation was achieved by combining interviews, FGDs, and observations (Musoke et al., 2014). Trustworthiness was ensured through credibility, transferability, dependability, and confirmability checks (Swanson, 2013). Reliability of data was enhanced by maintaining consistent procedures across interviews and discussions, while reflexivity helped minimize researcher bias during the study process (Randolph, 2009).

Ethical considerations were strictly observed in line with research protocols. Informed consent was obtained from all participants, and privacy and confidentiality were guaranteed (UNCST, 2020). Approval was sought from the Research Ethics Committee (REC). Data analysis involved transcription, coding, and thematic analysis using ATLAS.ti software, focusing on patterns of barriers women encounter in seeking maternal care (Bazeley, 2013). Findings were disseminated to stakeholders including local government authorities, healthcare workers, and community members to inform maternal health policy and practice in Mitooma District (Cohen et al., 2016).

Results

The barriers women, face in receiving maternal health care service delivery in Mitooma District.

The findings for this objective are based on data from both Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with pregnant women, new mothers, and family members of the mothers. The analysis focused on understanding the practical, infrastructural, and systemic challenges that women encounter when trying to access and utilize maternal health services. The

data was grouped into three major themes, each supported by verbatim quotes from the participants to provide a detailed and authentic account of their experiences.

Theme 1: Shortages of Human Resources and Gaps in Service Quality

This theme highlights the critical challenge of understaffing and the resulting impact on the quality of care. Participants reported a lack of essential personnel, particularly midwives, which leads to overworked staff and compromises the level of care. There are also instances of poor staff attitude, which has a negative effect on women's trust in the healthcare system. A participant explicitly calls for an increase in personnel to meet the growing demand for maternal health services. This suggests a direct contradiction: while decentralization has successfully brought services closer to the community, resulting in a higher number of mothers seeking care, the human resources have not been scaled up to match this increased demand. This creates a new set of challenges, as overworked staff may struggle to provide quality care, potentially leading to dissatisfaction and a decline in overall service delivery.

The participant explicitly stated:

"The local government should Increase on staff to attend to an increased number of mothers seeking for maternal health services." (Key informant, 2025)

The participant pointed out that due to staffing issues, pregnant women are given appointments for only one day a month. This rigidity creates a major barrier, as missing an appointment for any reason means a woman must wait another full month for care. This not only delays critical antenatal care but also highlights the over-reliance on a limited number of staff, particularly midwives, which directly compromises the accessibility and timeliness of care. In her narrative she noted:

"Due to staffing challenges, and mostly midwives. Because here they give us one visit in a month and in case one misses the appointment, she must wait for the next month." (Key informant, 2025)

One of the FGD participant's highlighted that the physical distance to a health center with specialized staff is a significant problem. This revealed a critical imbalance where local facilities may be geographically closer, but their lack of skilled staff forces women to travel to more distant, better-equipped facilities. This undermines the intended benefit of bringing services closer to the community and creates a burden for mothers who must travel further, incurring time and cost, to receive the care they need. The key informant informed the interviewer that;

"There is need to have skilled workers here at Kigyende HCII so that women are relieved of the burden of going to Kanyabwanga HCIII." (FGD participant,2025)

Figure 2: FGD with Mothers at Nyakishojwa HC1V

Another FGD participant highlighted a critical issue related to poor staff attitude and its direct impact on patient trust and care-seeking behavior. The discussion revealed a critical breakdown in service delivery: a health worker failed to respond to a call for help from a pregnant mother in labor. This neglect forced the mother to seek care at a different, more distant facility (Mitooma HCIV), and left her with a negative experience that would likely discourage others from using the first facility. The key informant demonstrates that even when services are physically closer, negative interpersonal experiences can become a major barrier. The perceived lack of empathy and professionalism from health workers can erode a community's confidence in the healthcare system, undermining the positive gains of decentralization and potentially leading to a return to risky practices like home deliveries.

Actual word by the key informant:

"One pregnant mother went to Kanyabwanga HCIII at night to deliver and the care giver called a health worker to conduct a delivery and she did not wake up. A pregnant mother decided to go and deliver from Mitooma HCIV and she was not happy with health workers in Kanyabwanga." (FGD participant, 2025)

Figure 3: FGD with Women at Mayanga HC1V

Theme 2: traditional beliefs and religion

Data suggests that some women continue to seek maternal health advice and services from non-medical sources such as their mothers-in-law, elderly women in the community, and traditional healers. Mothers-in-law often share experiences from their own time, claiming that childbirth was manageable without hospital visits. They emphasize the use of herbal remedies and assert that they were able to give birth to healthy children without modern medical intervention. In addition, some women reported visiting traditional healers, who advise them to listen to ancestral spirits for guidance regarding the health of both the unborn child and the mother. These practices are often rooted in long-standing cultural beliefs. Data also revealed that religion also plays a significant role in shaping health-seeking behavior. Some mothers indicated that certain religious leaders, particularly those from newly established "Born Again" Christian churches, actively encourage the community to rely solely on prayer for all forms of support. These leaders preach that God is the ultimate provider and source of healing, thereby discouraging the use of formal maternal health services.

A key informant narrated the story as follow:

"You see, some women still ask their mothers in-laws about maternal health and those in-laws complain to us that we waste money going to the hospitals and yet they were able to produce our husbands without hospital innervations, they tell us to use herbals, "emumbwa", and steaming to prepare for a healthy delivery" FGD (participant, 2025)

Another mother added:
"Let me tell you another problem. The new religion called "Abalokole" has diverted people from reality to spiritual beliefs. They tell people including mothers to seek everything they want through prayers, and as a result some people die in the churches and nothing is done about them. You doctors should come to the community and educate people about the se churches" (FGD participant, 2025)

Figure 4: FGD with Mothers at Kirengye HC11

2. Inadequate Infrastructure and Lack of Essential Supplies

This theme addresses the physical and material shortcomings that serve as barriers to effective maternal healthcare. Participants noted that even when facilities are available, they may be incomplete or lack essential equipment like lab facilities, ultrasound scans, and even basic supplies like maama kits. A statement from one of the key informants, revealed a gap in maternal health care services under the decentralization framework. It shows that While services may be closer geographically, they lack the necessary infrastructure and equipment to provide comprehensive care. The key informant explicitly stated the need for a theatre and an ultrasound scan, revealing that without these essential tools, patients are forced to travel to other facilities, such as Bitereeko HCIV, to access crucial diagnostic services. This creates a burden on patients, negates some of the benefits of having a nearby facility, and highlights a disconnect between the policy of bringing services closer and the provision of adequate resources. During the interview, the key informant mentioned;

"We need a theatre and ultra sound scan because if you want scan services you must go to Bitereeko." (Key informant, 2025)

Another key informant emphasized the reality that even after facilities have been upgraded, they may not be fully functional. Her statement suggests that some facilities have been physically improved but still lack critical equipment and supplies. This

statement underscores a key challenge: a policy of decentralization that focuses on building new structures without fully resourcing them with the necessary tools and services will not fully meet the needs of the community.
She states:
"Finishing and equipping the upgraded HC III and providing laboratory services is crucial, and yet here at our health center, we lack we have many services we offer to mothers but we still lack some equipment even though the facility has been upgraded to HC1II " (Key informant, 2025)

Another FGD participant pointed the discussion to timeliness and consistency of supplies especially mama kits. The lack of timely provision of these kits forces mothers to either purchase them themselves, which presents a financial burden, or go without, which compromises the safety of both mother and child during delivery. This directly contradicts the goal of providing free and accessible services under the decentralized framework.

The participant narrated that:
"They health workers should always give us maama kits in time to get prepared before giving birth but they wait when it is very late and give us maama kit when some women have already wasted money to buy items which are the same time provided in maama ki." (FGD participant,2025)

Theme 3. Dysfunctional Referral and Transport System

While services have been brought closer to the community, the referral system remains a major barrier, particularly during emergencies. Participants consistently pointed out the lack of ambulances, which forces them to rely on unsafe and costly alternatives for transportation. One of the key informants highlighted two critical and interconnected barriers to effective maternal healthcare: the shortage of staff and the dysfunctional referral system. The request to "increase on the number of staff" directly addresses the issue of understaffing, which is a recurring theme in the provided data. The second part of the request, to "provide an ambulance for transporting women who are referred for operation," underscores the severity of the referral system's failures. This patient-level perspective makes it clear that the lack of a reliable transport system is not just an administrative problem but a direct risk to the health and safety of mothers who require emergency care. The need for both more staff and an ambulance to transport patients for "operation" shows that even with services brought closer to the community, the most critical medical needs cannot be met without these two fundamental resources.

She remarks:
"To increase on the number of staff, and provide an ambulance for transporting women who are referred for operation. This is because our mothers suffer and some can even die on a boda-boda. We request the government to address this problem to save the lives of mothers" (Key informant, 2025)

One of the key informants revealed that it shows that while antenatal care (ANC) may be accessible and satisfactory, the system fails at the most critical moment: the participant's personal story being in labor on a rainy day, a "boda-boda" refusing to take her due to poor roads, and being forced to deliver at a private clinic is a powerful illustration of the failures in the referral and transport system. This experience underscores that even with a nearby health facility, poor infrastructure and the lack of an ambulance can directly compromise a mother's safety.
The emotional impact of her experience is also clear: she was "not happy" because she was unable to complete her journey with government health workers. This points to a loss of trust in the public system. Furthermore, delivering without a "maama kit," which she had been promised, reveals a failure in the supply chain and a direct contradiction of the government's promise to provide essential materials for delivery.
Finally, her comment on postnatal care that only babies are immunized and no other services are provided exposes another critical gap in the continuum of care. This demonstrates that the challenges are not isolated to a single service but exist across different stages of maternal healthcare.

Participant's narrative:
"Very good ANC services, but when it comes to deliver, we meet problems. Like me when I got labour pains, it was a rainy day, boda-boda refused to take me up, to Kanyabwanga HC III due to poor roads, I was forced to deliver from a clinic and I was not happy because I started with government health workers but could not end with them, I even delivered without a maama kit because they had promised to give it to me when I come to deliver. For postnatal, they only immunize babies and no other services are given to them and yet young babies have a lot of complications." (Key informant, 2025)

A statement of one of the participant's pointed out that the community is comprised of "subsistence farmers" who have "meager incomes," which means that even small expenses can be a major obstacle. This is especially true for the cost of transport, which is often a financial burden for families. The fact that a woman might be hindered from attending antenatal care because she cannot afford a maternity dress, which "health worker always encourage us to put on," shows a disconnect between the medical advice and the economic reality of the community. This indicates a lack of culturally sensitive and economically appropriate guidance, where a seemingly minor social expectation becomes a major barrier to essential healthcare. This highlights that challenges to maternal healthcare are not only medical but are deeply intertwined with economic and social factors. The participant explained that:

"People here are subsistence farmers and earn meager incomes, husbands can offer some money to their wives in case of need. Lack of maternity dresses can hinder women from attending to ANC since health worker always encourage us to put on maternity dresses." (Key informant, 2025)

The effects of the financial barriers were further emphasized by other participants as below:

Poverty may hinder some mothers from seeking for services e.g. if someone doesn't have money to buy a pamper for a baby to be taken for immunization, she may skip that visit. Or someone may opt to go and work for money or food when the home is poverty stricken instead of attending to ANC. (Key informant, 2025).

Discussion of Findings

Barriers Women Face in Receiving Maternal Health Care in Mitooma District

The findings from interviews and focus group discussions revealed that women in Mitooma District continue to face several serious barriers when trying to access maternal health services. These barriers fall under three key issues: staff shortages, service quality concerns, and poor health worker attitudes.

Theme 1: Staff Shortages and Delays in Service

According to data, women across the district face delays in receiving maternal health services because of a shortage of health workers, especially midwives. Most health centers do not have enough trained staff to match the growing number of mothers seeking care. In some cases, women are given appointments only once a month. If they miss that one visit, they must wait another full month to be seen. This delay creates a real risk for pregnant women who need regular antenatal check-ups. This was observed when a key informant stated that the local government should increase staffing to meet the high demand for antenatal services here at ***Mayanga Health Center Iv***. The current staffing levels cannot support the workload, and overburdened midwives cannot provide the attention and adequate care each patient needs. As more women now seek services due to decentralization, the shortage of staff is becoming a bigger issue.

Challenges related to delayed maternal services are common not only in Uganda but in many parts of Africa. Women face delays in getting maternal health care when midwives are in short supply. For example, a study in villages around Addis Ababa, Ethiopia, shows that midwife shortages force health centers to reschedule pregnant women, sometimes delaying their appointments by weeks or even a month. That delay means many women never make it back (Abebe et al., 2021). In rural areas of Uganda, facilities often lack enough staff, and absenteeism is a big problem. Researchers found that doctors often do not show up for work

during contracted hours. That absence slows responses, leads to delays in care, and drives up risk for pregnant women and newborns (Nabudere et al., 2016). In addition, a survey in the Karamoja region in Uganda found health centers missing nearly half of the required midwives. That under-staffing left many women waiting longer and getting less care during visits (Adazu et al., 2015). Also, Midwives themselves describe being stretched thin. In focus groups in Ugandan public hospitals, they talk about working all night without breaks, juggling multiple roles, and losing focus. One midwife said, "when you are tired, you do not give proper services" highlighting how overwork directly affects care quality (Namukwaya et al., 2020). As compared to this study, putting it all together: not enough midwives, frequent absenteeism, and heavy workloads create real delays. Pregnant women cannot get timely check-ups. They may wait a month for the next appointment. That builds risk and frustration. Therefore, this study is very relevant and timely because issues to do with maternal health cut across the country as indicated by previous studies.

Limited Skilled Staff at Local Health Centers

While some facilities have been brought closer to communities, they often lack skilled health workers. For example, a participant pointed out that women in Kigyende still have to travel to Kanyabwanga HCIII to access better maternal health services, as their local health center lacks enough qualified personnel. This means that even though decentralization has reduced physical distance to health units, it has not solved the issue of unequal access to skilled care. Hence, without skilled staff, women are forced to travel further or delay treatment. This increases the cost, time, and risk involved in receiving care and can lead to complications that could have been avoided with timely intervention. This is a serious finding which the local government should pay attention while planning to ensure all the lower health facilities get skilled personnel as recommended by the national health guidelines.

A similar situation was reported in a study conducted in rural Tanzania, where decentralization expanded the number of health facilities in remote areas, but most of these centers remained poorly staffed. The study found that although health posts were geographically closer to communities, women continued to bypass them and travel long distances to better-equipped hospitals because the nearby centers lacked trained midwives and nurses. This behavior increased delays in accessing care and raised out-of-pocket costs for families (Kruk et al., 2010). The researchers concluded that improving access alone does not guarantee improved health outcomes unless facilities are staffed and resourced well enough to provide quality care. This supports the finding that without skilled personnel, decentralization risks becoming a cosmetic reform rather than a functional solution.

Poor Staff Attitude and Lack of Trust in Services

Another major barrier according to the data is the poor attitude of some health workers. This was revealed by a woman who explained her experience that a pregnant mother in labor arrived at a health facility (name with-held) at night, but the staff on duty ignored the call. The mother had to travel again to another facility to deliver. This kind of neglect is not just disappointing but dangerous. It also damages trust in local health services. When women lose confidence in health workers, they may stop seeking care altogether or return to home deliveries. These negative experiences spread quickly through communities and undo the progress made in expanding access to care under decentralization framework.

Several previous studies highlight how negative attitudes and neglect by health workers create serious barriers to maternal care. Research from Tanzania found that disrespectful or unresponsive staff behavior discouraged women from using health facilities for delivery, pushing them instead toward home births with traditional attendants (Kruk et al., 2014). Similarly, a study in Kenya reported that women who experienced rude or inattentive care during labor were less likely to return for postnatal services or recommend the facility to others (Mackintosh et al., 2016). In Uganda, accounts from mothers show that such poor treatment not only endangers women physically but also erodes trust in the entire health system (Namatovu et al., 2017). These findings align closely with the data from Mitooma district, emphasizing that improving health worker

attitudes is essential for maintaining confidence in decentralized maternal health services and ensuring women seek timely, facility-based care.

The influence of traditional beliefs, and religion is health seeking behaviour

The data reveals that traditional beliefs and religious ideologies remain deeply embedded in the maternal health-seeking behavior of some women. Despite the availability of modern healthcare services, several women continue to rely on informal sources such as mothers-in-law, elderly women, and traditional healers for maternal health advice and care. These sources promote herbal remedies and cultural practices such as steaming and the use of ***emumbwa*** (a traditional herbal mixture), with the belief that they ensure a healthy delivery without the need for hospital intervention. Therefore, the influence of mothers-in-law, in particular, reflects intergenerational transmission of health practices. This not only sustains traditional norms but also creates a barrier to the uptake of modern maternal health services, especially when young mothers feel pressured to conform to family expectations.

Additionally, traditional healers and ancestral beliefs continue to play a role in maternal care, where women are encouraged to seek spiritual guidance from ancestral spirits for insight into their health and that of the unborn child. This belief system often results in a delay or complete avoidance of seeking skilled care from health facilities. Data also revealed that religious beliefs, particularly among some “Born Again” Christian groups (locally known as *Abalokole*), further complicate the situation. These groups reportedly discourage reliance on medical services and instead advocate for prayer as the sole solution to all health concerns. The data suggests that such teachings have led to preventable maternal deaths, with calls from community members for healthcare professionals to engage more actively in educating the public about the risks associated with this approach. These findings highlight how cultural and religious influences can undermine maternal health initiatives and hinder progress toward improving maternal and child health outcomes.

Implications of the staff shortages and delays in service

These findings show that the maternal health care system in Mitooma District still faces serious gaps, even after the implementation of decentralization. While decentralization has led to increased demand for services by bringing them closer to communities, the system has not adequately kept pace with this demand, particularly in terms of staffing. Many health facilities remain critically understaffed, especially with regard to skilled personnel such as midwives. This mismatch has resulted in delays in care and a decline in service quality. As a result, many women continue to travel long distances to reach better-equipped centers, undermining the very goal of decentralization, which is to provide accessible care at the community level.

Compounding these structural issues are deeply rooted cultural, traditional, and religious beliefs that influence maternal health-seeking behavior. In some cases, women may choose to consult traditional healers, elderly women in the community, or rely on guidance from their mothers-in-law, who advocate for herbal remedies and home-based care rooted in past practices. These beliefs, passed down through generations, often discourage women from seeking formal medical attention unless complications arise. The persistence of these practices is often reinforced by the lack of trust in the health system due to poor staffing, limited equipment, and disrespectful treatment by health workers.

Religious influences also play a significant role, particularly among followers of some "Born Again" churches in the district. These groups often promote the idea that prayer alone can ensure safe delivery, discouraging mothers from attending antenatal visits or delivering in health facilities. In an environment where health services are already strained, such spiritual messaging can further delay or prevent women from seeking necessary care, sometimes with fatal consequences. In addition to these cultural and religious factors, the attitude of health workers significantly shapes whether women feel safe and respected when accessing services. Even when facilities are available and somewhat staffed, negative experiences, such as disrespectful language, dismissive behavior, or lack of empathy can deter

women from returning or recommending care to others. Improving professionalism, accountability, and respectful care is therefore just as important as addressing physical infrastructure or staffing shortages.

Moreover, the rigid scheduling of services, such as limiting maternal health appointments to once per month adds another layer of difficulty. For women who have already overcome cultural reluctance and logistical barriers, being turned away due to inflexible schedules can be deeply discouraging. Health centers must explore more patient-centered approaches, such as staggered appointments or extended service hours, to better accommodate expectant mothers.

Ultimately, mothers in Mitooma District face a complex situation of practical, cultural, and human barriers to maternal health care. Addressing these challenges will require more than constructing additional facilities. There must be a concerted effort to invest in human resources, ensure reliable services, engage respectfully with cultural and religious norms, and rebuild trust in the health system. Only then can the promise of decentralization, of accessible, respectful, and quality maternal care, be fully realized.

Theme 2: Inadequate Infrastructure and Lack of Essential Supplies

According to data, health centers across Mitooma District continue to operate with serious infrastructure and supply gaps. Participants reported that even after upgrading certain facilities, many still lack key services and equipment. For example, several health units have no theatres or ultrasound machines, which forces pregnant women to travel to distant facilities like Bitereeko for essential diagnostic services. This defeats the purpose of decentralization, which aimed to bring services closer to the community. This was narrated by a key informant who called for the immediate provision of both a theatre and an ultrasound scan at the health facility in the community. Another emphasized that despite an upgrade to HCIV level, her facility still lacked laboratory equipment and other critical supplies. This shows that construction alone is not enough. Without equipping these facilities, the system cannot meet the needs of pregnant women or ensure safe delivery. Also, the supply chain for essential items like *maama kits* is also unreliable. A focus group participant explained that these kits are often given out too late, after women have already spent money buying the same items. For women with limited incomes, this creates unnecessary financial pressure and undermines trust in the health system.

Similar challenges with infrastructure and supply gaps have been documented in other low-resource settings. A study in rural Tanzania found that many health centers were upgraded in name but remained poorly equipped, lacking essential tools like ultrasound machines and functioning theatres. This forced women to travel long distances for basic diagnostics and emergency care, increasing risks and costs (Kruk et al., 2016). In Uganda, research showed that health facilities frequently experienced stock-outs of critical supplies such as delivery kits and medications, leading to delays and extra out-of-pocket expenses for patients (Waiswa et al., 2015). These shortages not only hinder safe delivery but also damage community trust in the health system. Both studies highlight that investing in buildings alone does not improve maternal outcomes unless accompanied by reliable equipment, supplies, and effective supply chains, echoing the concerns raised by participants in Mitooma District.

Theme 3: Dysfunctional Referral and Transport System

Lack of a working referral and transport system remains one of the most dangerous weaknesses in maternal health care in Mitooma district. Participants repeatedly mentioned the absence of ambulances and the use of unsafe transport methods during emergencies. A key informant described how mothers are forced to travel on *boda-bodas* or rely on personal vehicles. Data revealed that some health centers share a single ambulance across many units, and in some cases, the ambulance is simply not available when needed. A participant described a personal experience where she went into labor during a rainy day. Poor roads and lack of transport forced her to deliver at a private clinic instead of the government health facility where she had received antenatal care. She was disappointed that after all the preparation, including being promised a *maama kit*, she had to deliver without any

government support. She also reported that postnatal care was limited to baby immunization, with no other follow-up services. This shows that even when antenatal care is available and of good quality, the system often fails when it matters most. The emotional and physical toll of this gap is clear. Mothers feel abandoned and unsafe. When emergency services are unavailable, it puts lives at risk and discourages others from seeking care.

Studies from other regions reflect on these concerns about weak referral and emergency transport systems in maternal health care. In a study conducted in northern Uganda, researchers found that the lack of ambulances and poor road conditions were major contributors to delays in accessing emergency obstetric care. Women often relied on boda-bodas or bicycles, even during labor, which increased the risk of complications and maternal deaths (Wilunda et al., 2014). Another study from rural Ethiopia reported similar findings: despite improvements in antenatal care, the absence of a reliable referral system meant that many women could not reach hospitals in time during emergencies. In some cases, this led to home births or deliveries in private clinics with no trained staff, which undermined the benefits of earlier care (Tura et al., 2017). These studies show that without dependable transport and referral systems, the progress made through antenatal services can be overlooked at the point of delivery, as also seen in Mitooma District.

Poverty and Social Barriers

During the study, poverty was identified as major underlying issue among community members especially among the women. Several participants noted that families often lack the money to meet even the smallest costs, such as transport to the health center or buying a *pamper* for postnatal visits. In some cases, women miss antenatal appointments because they cannot afford a maternity dress, which health workers recommend they wear when coming for care. This expectation, while perhaps well-meaning, becomes a real barrier when it does not account for the economic realities of the community. Many households depend on subsistence farming. When women have to choose between going to a clinic or working to provide food for their families, healthcare often loses out. This makes it clear that improving maternal health is not just about having facilities in place. It requires an understanding of the social and financial conditions that determine women's ability to access care.

Poverty as a barrier to maternal health care has been well documented in other settings. A study in eastern Uganda found that indirect costs, such as transportation, clothing, and supplies, often prevented women from attending antenatal care or delivering at health facilities, even when services themselves were officially free. Many women prioritized daily survival needs over health care, especially in farming communities where income is irregular (Ekirapa-Kiracho et al., 2011). Similarly, research in rural Ghana revealed that women delayed or avoided care because they could not afford basic necessities like soap, baby clothing, or even a meal before traveling to a clinic. These non-medical costs created shame, anxiety, and practical barriers that kept women away from services they otherwise valued (Ganle et al., 2015). These studies reinforce the finding from Mitooma district that economic hardship, even in small amounts, has a direct impact on whether women can access maternal health care.

Implications for objective two findings

These findings point to four major gaps in maternal healthcare delivery under decentralization in Mitooma District. First, having physical structures without equipment does not improve care. A health center without a theatre, ultrasound scan, or functioning laboratory cannot safely manage maternal health complications. Simply upgrading a facility's status, such as from HCIII to HCIV, is not enough unless it comes with full equipping and adequate staffing. Second, poor transport and referral systems create life-threatening delays. Many women still rely on unsafe methods like boda-bodas or personal cars during labor. Without ambulances and decent roads, they often end up delivering in unsafe conditions or in private clinics far from their original health facility. This not only puts lives at risk but also erodes confidence in the public healthcare system. Third, the supply chain for essential items remains unreliable. Key resources like maama kits do not always reach mothers on time. When supplies arrive late or not at all, it forces families to spend money they may not have,

or to go without. These delays waste resources, raise personal costs, and cause mothers to lose trust in health facilities. Fourth, poverty continues to block access to care. Even small costs, like transport, basic baby items, or the maternity dress recommended for antenatal visits, can prevent women from going to health centers. Most families depend on subsistence farming, so healthcare often loses out to more immediate needs like food or work. Advice from health workers and national policies must consider the financial realities rural households face every day.

In Mitooma District, decentralization has improved physical access to some maternal health services, but major gaps remain. Facilities need more than buildings, they need equipment, trained staff, and consistent supplies. The referral system must be strengthened to respond to emergencies in real time. Most importantly, maternal healthcare delivery must be designed around the actual challenges women face, especially poverty and transport. Without addressing these issues, the goal of ensuring safe maternal health for all women in the district will remain out of reach.

Conclusion

The findings indicate that the current decentralized health system in Mitooma District struggles to deliver consistent and high-quality maternal care. Health worker shortages, frequent drug and supply stock-outs, poor infrastructure, and weak referral systems are major barriers. Supervisory structures are in place, but many local officials lack the vehicles, resources, and incentives to monitor services effectively. This limits the quality and consistency of care delivered, especially during emergencies or complicated deliveries. Similarly, the findings clearly indicate that traditional beliefs and religious ideologies significantly affect maternal health-seeking behaviors in the community. While these practices are rooted in long-standing cultural and spiritual norms, they often pose serious risks to maternal and child health by discouraging the use of skilled medical care. The continued reliance on non-medical advice, herbal remedies, and spiritual healing in place of professional healthcare services contributes to maternal morbidity and mortality, especially when complications arise that require immediate medical intervention.

Recommendations

To improve healthcare delivery at the district and sub-county levels, it is critical to increase central government funding to adequately cover operational costs. Many local health facilities in which this study was conducted struggle with limited budgets, which affects their ability to provide consistent and quality services. Therefore, increased financial support would enhance the day-to-day functioning of these facilities, ensuring that basic needs such as utilities, staffing, and maintenance are adequately met.

A critical component of effective healthcare service delivery is the availability of essential medical supplies. Hence, strengthening supply chains is therefore essential to ensure the timely and consistent delivery of key items such as maama kits, essential medicines, and medical equipment. Reliable supply systems reduce stock-outs and interruptions in care, particularly for maternal and child health services.

Regular refresher training for health workers, coupled with systematic support supervision, is vital for maintaining high standards of care. Training helps healthcare providers stay updated with current medical guidelines and practices, while supervision ensures accountability and encourages continuous improvement in service delivery.

Improving the working conditions of health workers is equally important. Ensuring fair and timely salaries, along with providing incentives for those serving in hard-to-reach or underserved areas like Kanyabwanga HC1V, can help address challenges related to staff motivation, retention, and performance. Well-supported health workers are more likely to deliver better care and remain committed to their roles.

Finally, strengthening referral systems is necessary for efficient healthcare service delivery, especially in emergencies. This involves improving road access to major health facilities and providing reliable ambulance services to ensure timely transportation of patients in need of specialized care. A strong referral system reduces delays in treatment and improves health outcomes, particularly in rural and remote areas.

To address the influence of traditional beliefs and religious ideologies on maternal health-seeking behavior, several key recommendations can be

made. First, health authorities and healthcare providers should effectively implement targeted community health education and sensitization programs through the outreach and health camps. These initiatives should focus on educating families, especially influential figures like mothers-in-law and religious leaders, about the importance of antenatal care, skilled birth attendance, and timely access to emergency obstetric services. Educating these key decision-makers can significantly shift community perceptions and encourage greater utilization of formal healthcare services.

Engagement with religious and cultural leaders is equally important. Collaborating with these leaders to become advocates for maternal health can help dismantle harmful narratives while still respecting the spiritual and cultural fabric of the community. By involving them in health promotion activities, they can act as trusted messengers who reinforce accurate information about maternal health. Culturally sensitive health communication should also be prioritized. Health messages must be designed in ways that acknowledge and respect existing traditional and religious beliefs while clearly explaining the risks associated with non-medical practices. The goal should be to find a balance between preserving cultural identity and promoting safe health practices, encouraging the integration of beneficial traditional practices with modern medical care.

In addition, trusted community figures, such as elderly women and traditional birth attendants, should be trained and included in maternal health programs. Their involvement as community health advocates can help bridge the gap between traditional systems and formal healthcare, making medical services more acceptable and accessible to local populations. Strengthening the visibility and trust of the health system within communities is also vital. Healthcare professionals should be more present in community spaces through regular visits, mobile clinics, and active participation in local events and meetings. This direct engagement helps dispel myths and build trust in the formal health system, particularly in areas where misinformation or skepticism is prevalent.

Finally, there is a need to monitor and, where appropriate, regulate religious teachings that negatively impact public health. Government bodies and local government authorities in particular and relevant stakeholders should work with faith-based organizations to ensure that spiritual guidance does not endanger maternal and child health. Encouraging religious institutions to align their messages with public health priorities can help create a supportive environment for safe maternal health practices.

Authors' abbreviations

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Authors' contributions

The authors of this manuscript made the following contributions to this manuscript: Concept: **BP**, conceived the concept; Data collection: **BP**; Data analysis: First draft: **BP**, **NK**, **JA**. Final revision: **BP**, **NK**, **JA**. Read and approved final manuscript: **BP**, **NK**, **JA**.

Competing interests

The authors declare that they have no competing interests.

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