Title
The Hidden Contribution of Traditional Birth Attendants in Central and South West, Uganda

Permalink
https://escholarship.org/uc/item/35s1w38b

Author
Newsome, Makaela

Publication Date
2018

Peer reviewed|Thesis/dissertation
The Hidden Contribution of Traditional Birth Attendants
in Central and South West, Uganda

A thesis submitted in partial satisfaction
of the requirements for the degree Master of Arts
in African Studies

by

Makaela Marie Newsome

2018
ABSTRACT OF THE THESIS

The Hidden Contribution of Traditional Birth Attendants
in Central and South West, Uganda

by

Makaela Marie Newsome

Master of Arts in African Studies
University of California, Los Angeles, 2018
Professor Edith S. Owmami, Chair

“Traditional Birth Attendant” is a term assigned to women who assist in labor and delivery care using traditional methods, usually without authorized health care licensing or regulated trainings. While the practices of these women have often been documented for the purpose of historical or anthropological research, this study aims to document the modern day contribution of these women in the Ugandan women’s healthcare system. This study uses in-depth interviews and group counseling sessions with currently practicing Traditional Birth Attendants and is supplemented with data from the 2011 and 2016 Uganda Demographic Health Surveys. Analysis of these interviews yielded six primary themes, which are: training/introduction to the practice, prenatal care, postnatal care, traditional family planning/medicinal herb use, relationship counseling, benefits and challenges of the profession, and labia pulling. These findings provide evidence for policy reform that would allow Traditional Birth Attendants to support their communities as maternal and child health advocate.
The thesis of Makaela Marie Newsome is approved.

Andrew Apter
Paula A. Tavrow
Edith S. Omwami, Committee Chair

University of California, Los Angeles
2018
Table of Contents

Acknowledgements vi
Introduction 1
Research Goals 2
Significance of the Study 2
Literature Review 4
Methods 19
Results 24
Discussion 44
Conclusion 50
Appendix 51
Bibliography 61
Acknowledgements

This research study would like to acknowledge and thank University of California, Los Angeles professors: Dr. Paula Tavrow, Dr. Edith Omwami, Dr. Andrew Apter, the staff and volunteers of Kigezi Healthcare Foundation (KIHEFO) especially Dr. Geoffrey Anguyo, Hakim Malagala, Alison Akankwatsa, Dr. Allen Obiale, Gorretti Wamala, Kate, Julius and Blessing Kamukugize. Thank you to Rosario Lopez, Nicole Robertson, and Natalie Crawford for your support and assistance in Central and South Western, Uganda. And a special thank you to Jonelle Clark for your continuous love and support.
Introduction

The terms, “Traditional Birth Attendant” or “Traditional Midwife,” have been assigned to women who assist in labor and delivery using traditional methods, often without authorized health care licensing and/or regulated training. In Uganda, the Guttmacher Institute estimated that Traditional Birth Attendants (TBAs) were present at 47-52% of all Ugandan deliveries in 2006.¹ Yet, by 2011 and then again in the 2016 the Uganda Demographic Health Survey. it was found that 10.4-11.7% of surveyed women in the Central and South West area recalled utilizing the services of a Traditional Birth Attendant during their most recent delivery²,³. The recent push by the United Nations through the Millennium Development Goals 2000 (MDGs) and now the Sustainable Development Goals 2015 (SDGs) to decrease maternal mortality, by increasing the percentage of women who give birth with a skilled birth attendant, has created a shift in the discourse of health professionals and researchers on the utilization of services provided by Traditional Birth Attendants in favor of registered skilled birth attendants.⁴,⁵ This discourse led to the 2010 law implemented by Ugandan parliament banning Traditional Birth Attendants from assisting in antenatal care and delivery within Uganda.⁶

There are a multitude of reasons why Ugandan women continue to seek the services of Traditional Birth Attendants over licensed “skilled” birth attendants. “Services” is defined as an assistance provided by Traditional Birth Attendants with or without payment.⁷ These services include but are not limited to: assistance during pregnancy, labor, and delivery, sexual health counseling, relationship counseling, and infant and women’s health and nutrition counseling. The reasons that Ugandan women opt for relying on them rather than skilled attendants include lack of transportation, geographic isolation, hospital expenses, and general mistrust of the western biomedical system.⁷ This research seeks to examine the role of Traditional Birth Attendants and
their sometimes hidden contribution to the present day Ugandan maternal and women’s healthcare system.

Traditional birth Attendants are often influential and highly respected members of their communities, especially in areas with limited access to quality affordable health services and rigid gender roles that can prevent women from seeking healthcare services.\(^3\),\(^4\) Despite diligent efforts by non-governmental organizations (NGOs) and the Ugandan government to meet the Sustainable Development Goals, there is no guarantee that these healthcare service goals will be achieved in a manner timely enough for the most vulnerable of the population. Thus, portraying the services provided by Traditional Birth Attendants in a negative light, which has been done by both the Ugandan national media and international health communities, could expose the most at-risk women to greater harm by depriving them of a trusted health resource in their community.\(^4\),\(^6\)

**Research Goals**

This study’s primary goal is to provide an inside look at the current role of Traditional Birth Attendants in present day Central and South Western Uganda. This is achieved by answering the following research questions: (1) How do Traditional Birth Attendants describe their roles in their communities? (2) What type of family planning counseling and methods do Traditional Birth Attendants advise or provide to their clients? (3) What type of pre and post-natal care do Traditional Birth Attendants provide? (4) What do modern Traditional Birth Attendants see as the challenges and benefits of their practice?

**Significance of the Study**

This is a pivotal point in time to be collecting information on practicing Traditional Birth Attendants in Uganda due to the modernization of the healthcare systems and
the changing legal status of the practice. With the push by the international public health community to have skilled birth attendants at deliveries in order to reduce maternal mortality, several countries including Uganda, have been implementing new policies to encourage the utilization of modern maternal health care. Yet, even with the rapid urbanization of Uganda and the growing accessibility to modern health care, Ugandan women are still seeking the services of Traditional Birth Attendants. Traditional Birth Attendants have historically provided services to the most marginalized and underserved populations. Recent studies on Traditional Birth Attendants primarily focus on barriers to transitioning women into the modern health care system and not the actual contributions made by Traditional Birth Attendants. Thus, this study attempts to fill this research gap, by providing a glimpse into how Traditional Birth Attendants see their role in maternal and women’s health services in the modern day Ugandan health care system.
Literature Review

Traditional Birth Attendants (TBAs) have been a staple of women’s reproductive health care in most parts of the world--both now and before the advent of contemporary midwifery and gynecology. Since women have been giving birth, there have been women informally trained in local reproductive health knowledge and traditions who assist them through their labor and delivery experiences. But there has been less research on the modern practices of these traditionally trained women and the experiences of women who seek their services. While there has been a decline in the use of Traditional Birth Attendants throughout the world, they still have a vital role to play in most in sub-Saharan African countries, including the East African country of Uganda.

The present-day Western-based biomedical healthcare structure largely considers Traditional Birth Attendants as “unskilled” birth attendants, due to their lack of formal training and licensing process. This literature review will examine the currently available research on Traditional Birth Attendants in Uganda. Due to the small amount of published work exclusively on Traditional Birth Attendants and birthing practices in Uganda, literature on Traditional Birth Attendants in neighboring African countries has also been examined and included as supplementary resources.

Background on Uganda

Uganda is a relatively small landlocked country located in East Africa, sharing its borders with the Democratic Republic of the Congo, South Sudan, Kenya, Rwanda, and Tanzania. Uganda had a population of about 41.5 million, as of 2016. It was originally a multiethnic area consisting of several diverse Kingdoms, most notably the Buganda Kingdom which still exists.
Uganda’s several kingdoms and ethnic groups were forced into one political system, and given the name Uganda, when colonized and named a British protectorate. British protectorates received considerably less oversight and development assistance than official “colonies” such as Kenya. Instead, Uganda was exploited and depleted of its natural resources including large game hunting, ivory, gold, and other mineral resources. The people of Uganda were heavily taxed and brutalized by the British forces.\textsuperscript{9,10}

In 1962, Uganda achieved their independence from the British, ushering in a period of political instability.\textsuperscript{9,10} Most notably were the dictatorships of Idi Amin (1971-1979) and Milton Obote (1962-1971,1979-1985) which claimed at least 500,000 lives due to guerilla warfare and civilian attacks, as well as massive human rights violations. President Yoweri Museveni came into power in 1986. As of December 2017, the Ugandan parliament has removed the presidential age limits allowing him to run for reelection until death.\textsuperscript{9} Museveni’s reign has bought relative stability. Yet, despite this political stability there has been continued conflict within the country, including the disarmament campaigns in the Karamoja that has led to the death and displacement of thousands of civilians.\textsuperscript{9,10,11} Recently, there has also been an increase in military and state sanctioned violence against protesters and other political activists in North West, Uganda.\textsuperscript{12} Indeed, some Ugandan news outlets have labeled some military conflict as the beginning stages of a genocide in Kasese, located in South West, Uganda. These killings included the November 26-27,2016, military assault on Kasese that left over 100 civilians, including women and at least 15 children, dead.\textsuperscript{12}

Uganda is currently categorized as a low-income developing country by the World Bank.\textsuperscript{13} Uganda’s 2017 GDP per capita in U.S. dollars was approximately $604, compared to the neighboring Kenya at $1507.82, and the average GDP of all sub-Saharan African countries at $1553.77. Uganda is one of very few countries that are reportedly getting poorer with
decreasing quality of life for local people.¹³ Youth unemployment is extremely high at 64% for those age 18-30 years in 2012.¹⁴ A majority of Ugandans also engage in subsistence agriculture, which is mainly performed by the women and children of the household. This political and economic stagnation has caused continuous disruption in the development of Uganda as a nation and has had serious repercussion on the quality of healthcare for local people. In 2016, the estimated life expectancy for a Ugandan citizen was only 60 years of age.¹⁵,¹⁶

A key marker of country development and progress is the status of reproductive rights and women’s healthcare. The past United Nations Millennium Development Goals (MDGs) (2000-2015) as well as new the United Nations Sustainable Development Goals (2015-2030) made it a goal to reduce the maternal mortality ratio, primarily by increasing the number of women who give birth with the help of a skilled birth attendant.⁴,⁵ While there has been major efforts to decrease the ratio of maternal deaths with a 44% global decline since 1990, the global community is still far from Sustainable Development Goal 3: reducing the global maternal mortality ratio to less than 70 per 100,00 live births.¹⁵

According to the World Bank, Uganda has the 20th highest maternal mortality ratio and the 15th highest infant mortality rate.¹³ Estimating the exact maternal mortality ratio for Uganda is extremely difficult due to the number of births and deaths that go unreported. The 2016 Uganda Demographic Health survey estimated the maternal mortality ratio for women ages 15-49 as 336 deaths per 100,000 live births.³ The Performance Monitoring & Accountability 2020 (PMA 2020), a report that is supposed to track, in real time, countries’ progress towards the SDGs, predicts that by 2030 Uganda’s infant mortality rate will be 476 deaths per 100,000 live births.¹⁷ This is far from the Sustainable Development Goal of 70 or less deaths per 100,00 live births. In conjunction with a high maternal and infant mortality rate, Uganda also has a fertility rate of 5.8 births per woman, significantly higher than its neighboring countries: Rwanda has an
average of 4.62 births per woman and Kenya has an average of 4.46 births per woman.\textsuperscript{13} The PMA 2020 also predicts that by 2030 Uganda’s fertility rate will only be down to 4.6 births per woman.\textsuperscript{17}

**Maternal Health In Uganda**

A major contributing factor to the high fertility and high maternal and infant mortality rate is Uganda’s low rate of contraceptive use. The 2011 Uganda Demographic Health Survey reported that more than 4 in 10 births were unplanned.\textsuperscript{2} According to the Guttmacher Institute, women in Uganda reported on average giving birth to two more children than they wanted (6.2 children versus 4.5 children). Only 24\% of married women and 38\% of sexually active unmarried women reported using some form of modern contraceptive. Additionally, only about 15\% of the poorest and least educated married women were using some form of modern contraceptive.\textsuperscript{1} Unplanned and unwanted pregnancies as well as improper birth spacing substantially increases the risk for maternal and infant mortality. In 2009 there was reportedly 490,000 unintended pregnancies in Uganda resulting in 290,000 unsafe induced abortions.\textsuperscript{1}

Abortion is illegal in Uganda, the Ugandan Constitution, in Article 22, item 2 states: "No person has the right to terminate the life of an unborn child except as may be authorized by law.” This has resulted in a network of doctors in urban areas who perform illegal abortions for extra money.\textsuperscript{19} Improperly performed and unsanitary abortions, lack of post-abortion care, and the intense shame around women disclosing their abortion status to healthcare professionals, are responsible for an estimated 9-13\% of all maternal death in sub-Saharan Africa. It is important to note that this number is also considered to be an underestimate, because many women never disclose their abortion and/or pregnancy status to clinicians or family members.\textsuperscript{1,19}

According to Caleb Rwakatungu, a board member at Kigezi Healthcare Foundation
(KIHEFO), “… if a girl lives in the city she can just go and pay a doctor 150,00-300,000 shillings (around $45-$100 USD) for an abortion. But in the village if she is pregnant then her life is over.”

Most low income or non-urban women attempt to induce abortions by themselves, either requesting someone to hit them in the stomach or inserting foreign objects into the cervix, or they turn to Traditional Birth Attendants for help. Locally, a Traditional Birth Attendant is called a *Mulerwa (Bamulerwa, plural)*, the word for an indigenous specialist in pregnancy, sexual, and reproductive health related conditions.

Traditional Birth Attendants were estimated to have attended almost 50% of all Ugandan births in 2006. As of the 2016 Uganda Demographic Health Survey (DHS) it appears this number has shrunk to about 10% of reported births. Yet, Traditional Birth Attendants are still seen as highly respected and important members of Ugandan society. Ugandan Traditional Birth Attendants have been and continue to be vital resources for local women (particularly low income) during times of conflict and stability, providing them information on child and maternal health. Traditional Birth Attendants provide everything from fertility and family planning/birth control advice to infant disease and nutrition assistance. While the dangers of choosing a Traditional Birth Attendant over formally licensed skilled birth attendants are well documented, a significant number of Ugandan women have made their choice clear.

**Traditional Methods of Family Planning**

A variety of different kinds of traditional birth control have been practiced globally since the dawn of humanity by women in attempts to control their own fertility. There is very little recent data about the current use and practice of traditional fertility control methods but there are common practices that are seen throughout the literature on Uganda. These practices include the
more well known methods of prolonged breastfeeding, sexual abstinence, and withdrawal, which do have scientific evidence to prove their efficacy.\textsuperscript{21, 22, 24, 25} There are also unproven methods that include a variety of herbs and rituals whose efficacy is unknown due to a lack of research. The most commonly cited methods in Uganda include drinking specific herbs that are said to prevent pregnancy, tying a fabric belt with blessed pieces of the umbilical cord or placenta sewn inside of it around a women’s waist during intercourse, wearing specific amulets, wearing her son-in-law’s clothing during her menstruation which is said to stop her menstruation completely, and inserting specific herbs inside the vagina before intercourse.\textsuperscript{24, 25, 26}

Additionally there are commonly performed “First child rituals” where the first born child performs a series of actions in order to stop their mother’s fertility. These rituals include the first born child carrying the last born child in the cloth used to carry the first born child, and then placing the last born on the eave of the family home.\textsuperscript{26} The first born child can also serve their mother a hot porridge or another hot dish and the saying aloud, “Mother, I have burned your productivity. Let me produce my children and after I have finished I will produce those that you are left with.”\textsuperscript{26} Right after a mother has given birth the first born can also go behind the family home where she has just delivered and cry out, “Mother how long will you go on producing? Stop and leave it to me.”\textsuperscript{26} The first born child can also take the placenta of the last-born child to an ant or termite hill, where they will invert the placenta and place a stone on top of it.\textsuperscript{26} Following the birth of a child, the child’s foot can also be inserted back into the opening of the womb and the individual assisting with the birth will proclaim, “Let the productivity stop here”.\textsuperscript{26} These methods and others extremely similar have been documented throughout Uganda and other sub-Saharan African countries such as Zimbabwe.\textsuperscript{27}

According to data collected in the Ankole region of Uganda by Population Council in 1991, rural women were able to list 24 different types of traditional fertility control and family
planning methods, but most commonly used about twelve different methods. Prolonged breastfeeding was the most popular, with 82% of sampled women having tried it. As many as 96.5% of Ankole women could name at least one method of traditional family planning, while 90% of Ankole women could name at least one type of modern family planning.

Certain methods of traditional birth control, which can also be categorized as a type of fertility ritual, require the placenta of the woman’s most recent birth. In Ugandan traditional society when a women wanted to stop conceiving she would inform the Traditional Birth Attendant during her pregnancy that she would like a break from childbearing. Once that child is born the Traditional Birth Attendant could do one of two things with the placenta. One option is that she will take the placenta, pray over it, and put it in a special wooden box within her home. The placenta will stay there until the women decides she would like to give birth again and retrieves the placenta from the Traditional Birth Attendant. The other option is to take the placenta, pray over it, cut it into pieces and sew it into a fabric belt. This fabric belt is then worn around the waist of the women every time she has sex in order to prevent pregnancy. The Traditional Birth Attendants interviewed about these methods asserted that the most effective was keeping the placenta in the box. Yet, they did warn that if for any reason the Traditional Birth Attendant dies before the woman comes to retrieve her placenta, and she cannot find it within the Traditional Birth Attendant’s home, she will never be able to conceive again.

**Changing Legalities of Traditional Birth Attendants**

In Uganda, and several other sub-Saharan African countries, the legal policy towards Traditional Birth Attendants has begun to shift towards a complete ban of the traditional practice. The Ugandan Parliament passed a 2010 policy officially banning the practice of Traditional Birth Attendants in Uganda as a response to the recommendation of the World
Health Organization and the Safe Motherhood initiative for all women to give birth with the assistance of a skilled birth attendant.\textsuperscript{8} Promotion of skilled birth attendants, whose definition excluded Traditional Birth Attendants, has led to the suspension of multiple previously existing partnerships between the Ugandan government, international non-profit organizations, and Traditional Birth Attendants.\textsuperscript{24} According to women interviewed by the few publicly available news reports and articles on issue, government official began massive arrests of practicing Traditional Birth Attendants.\textsuperscript{6} No available reports or data have been made publically accessible on the number arrested during these crackdowns, nor what their sentences or fines were.\textsuperscript{6} As recently as July 14, 2018, the State Minister of Health for General Duties, Sarah Opendi, had directed the Resident District Commissioners, Chief Administrative Officers and District Health Officers to conduct operations and crackdown on all the Traditional Birth Attendants.\textsuperscript{28} She publicly stated that she wants all practicing Traditional Birth Attendants arrested.\textsuperscript{28} According to the 2006 report by the Guttmacher Institute, Traditional Birth Attendants were present at approximately 47–52\% of all deliveries in Uganda.\textsuperscript{1} The 2016 Uganda Demographic Health reported that approximately 11\% of surveyed women who had given birth within the last five years said they used the assistance of Traditional Birth Attendants.\textsuperscript{1} This means that despite the well-documented risks, the political crackdowns, and international public health efforts there is still a population of women that prefer and seek out the services of Traditional Birth Attendants.\textsuperscript{18,19,21,22} And apparently a number of Traditional Birth Attendants continue to serve the women in their communities despite the legal risk for themselves.\textsuperscript{22}

\textbf{Traditional Birth Attendants in Times of Conflict}

As discussed earlier, Uganda has gone through multiple phases of political instability and violence. Currently, Uganda is experiencing a period of relative stability compared to much of
its history, but many areas of the country still experience frequent civil disruptions and violent
government occupations and raids.\textsuperscript{9,10,11,12} When conflict arises many of the first people to flee
the areas are higher income professionals which includes formally licensed doctors, nurses, and
midwives.\textsuperscript{22} Additionally, it is a frequent tactic of military and civil militias to attack healthcare
facilities, and patrol paths and roadways that lead to those facilities. More often than not, rape,
murder, and the brutalization of women are used as a tool of war. During these times and in
certain localities, Traditional Birth Attendants are the only form of women’s healthcare
available.\textsuperscript{23,24,29,30}

It has been documented that during conflicts in Uganda Traditional Birth Attendants
continued to stay in high risk areas, because they are the only resource women have for
healthcare. And, like the women they serve, Traditional Birth Attendants are often low income
individuals themselves, therefore lacking the resources required to flee.\textsuperscript{22,30} This contribution is
rarely documented due to the risk to researchers; however, there has been documentation in post-
conflict northern Uganda and Burundi of this pattern.\textsuperscript{22} During these times, the additional skills
of Traditional Birth Attendants become increasingly important. Besides assisting in labor and
delivery, Traditional Birth Attendants give advice on family planning and provide certain
traditional methods, maternal and child nutrition, screen high risk pregnancies, provide
traditional infertility/fertility treatments and advice, identify ailments relating to reproductive
organs, and provide care for sick pregnant and postpartum women and sick infants.\textsuperscript{22,26}
Additionally, Traditional Birth Attendants recruit and train new women to become Traditional
Birth Attendants, counsel on domestic violence and relationship issues, and are pivotal actors in
the preservation and conservation of medicinal plants and herbs in high risk areas. What a
majority of researchers have found is that their actions are largely motivated by their desire to
help women in their communities. There are numerous stories of Traditional Birth Attendants
risking their own lives to help pregnant women deliver, escape, and hide during peak conflict periods.\textsuperscript{22,26}

The importance of Traditional Birth Attendants during times of conflict was recognized by the Ugandan and Burundian governments, as recently as 2008.\textsuperscript{22} The Ugandan government provided trainings and resources during peak conflict times because of the shortage of professional nurses, doctors, and midwives in the regions.\textsuperscript{22,25,30} These trainings ranged from a few weeks to up to nine months. Many were organized by donor organizations such as USAID and other non-profit organizations. A majority of hospitals and maternity clinics were empty due to the violence, and the only resource available were local Traditional Birth Attendants and healers who chose to stay despite the risks.\textsuperscript{22,25,30,31}

**Barriers To Transitioning to Modern Health Care**

Although advancements have been made to encourage Ugandan women to deliver at healthcare facilities, including direct referrals to health facilities by trusted Traditional Birth Attendants, some women still choose to use the services of Traditional Birth Attendants despite the well documented risks. These barriers to using public facilities include issues related to healthcare facility infrastructure and service quality, physical accessibility, economic accessibility, and socio-cultural norms.\textsuperscript{21,22,30}

Hospital and/or health facility infrastructure is a common barrier as many of these facilities suffer from drug shortages, lack of refrigeration, frequent electricity and water shortages especially at night, staff shortages, and lack of beds for both mothers and children.

Bad staff attitudes are another frequently cited issue among Ugandan communities. There have been multiple documented incidents of staff members extorting bribes from patients before receiving services, as well as staff members threatening, yelling, and slapping women
during the labor and delivery.\textsuperscript{21,22,29,30} A local healthcare facility frequently visited by members of one study’s population was well known for lacking medical supplies.\textsuperscript{8} All told, some Ugandans do not see the benefits in going to the health facility to give birth, versus visiting a trusted Traditional Birth Attendant.\textsuperscript{21}

Although user fees for maternal healthcare were officially abolished in 2001 at all government hospitals, there are still hidden costs for women that give birth health facilities.\textsuperscript{16,18,22} Most hospitals require women to buy “Mama Kits” (also known as Maama Kits) which contain sterile needles and sutures for stitches, gloves, and sterile razor blades. These kits cost on average 20,000 Ugandan shillings, while the average rural middle income Ugandan makes around 50,000 Ugandan shillings per month, and the average urban middle income Ugandan makes around 300,000 Ugandan shillings per month.\textsuperscript{30} Many facilities also require mothers to bring their own sanitary pads and blankets for themselves and their newborn after birth. Some private facilities will attempt to make pads for mothers out of gauze, but only if adequate gauze supplies are already available.\textsuperscript{8,20}

One of the largest expenses and barriers is access to food for admitted mothers and their companions during their hospital stay. A majority of healthcare centers, both public and private, do not offer free meals or even meals for purchase. Some facilities provide an outside open cooking area with firewood or charcoal, where patients and their companions can cook the food they bring with them.\textsuperscript{20,29} Thus, not only must women pack their own food, but for those who may require extended stays they must plan to carry enough money to purchase local food or pack enough food for their family members to cook for themselves for the duration of their stay. For women without companions, they must cook and feed themselves while in the hospital.\textsuperscript{20,29,30}

Lastly, many healthcare facility staff members at government hospitals have often been caught and accused of requiring bribes in exchange for treatment. These costs can quickly build
up and lead to a great economic burden on impoverished women and their families. While many Traditional Birth Attendants charge a “fee”, they tend to accept any gift of appreciation including clothing, animals, food, or favors instead of monetary payment.

Physical accessibility is a commonly cited reason by Ugandan women for choosing the assistance of a Traditional Birth Attendant. For many rural or geographically isolated Ugandan women, health facilities may be physically inaccessible to them due to distance, time of year, and/or difficulty of terrain. Within Uganda, particularly in the southwestern region, there are large populations of people who live in the high altitude and mountainous areas. Traveling from these areas into town can take hours by foot and a majority of residents lack reliable transportation. Pregnant women, especially those undergoing active labor, are often physically unable to manage the distance and terrain. Additionally, during different times of the year, most often the rainy season, dirt roads can become flooded and filled with thick mud, making them unpassable by both foot and car. There have also been continuous complaints of lack of community involvement when building new health facilities. Many times this lack of involvement results in incidents of health facilities being built on particular clan grounds that prevent other neighboring groups from seeking services because of pre-existing conflicts and risks of violence between the groups. Very few health facilities have ambulances and those that do charge considerably for their use, upwards of 20,000 Ugandan shillings. Traditional Birth Attendants are often the primary source of care for women in these areas, particularly those who go into labor late at night.

Preference for Traditional Birth Attendants’ services for many Uganda women is directly tied to cultural acceptance and comfort. The majority of Traditional Birth Attendants are of the same or neighboring ethnic group of the women they serve. This provides a level of acceptance and understanding of cultural practices that are not regularly accommodated for at
private or government health facilities. For example, within multiple regions of Uganda, including Central Uganda, the placenta is viewed as sacred, being commonly referred to as the “baby’s twin”. The disposal and treatment of the placenta is believed to be directly connected to the fate of the child it shared the womb with. Thus, the placenta must be disposed of in a culturally appropriate way. When delivering in health facilities women do not have control over placenta disposal, unlike when they deliver with a Traditional Birth Attendant. For many women, within varying Uganda ethnic groups, this would cause great upset, as it is seen as a disrespectful and having the potential to bring harm or bad fortune upon their child.

Another common barrier, that has recently gained attention in Western hospitals as well, is conventional health facilities not allowing women to give birth in the position most comfortable for them. Traditional Birth Attendants allow women to give birth in a position that is most comfortable for them rather than forcing them to lie on their backs. Some Ugandan women, depending on their ethnic group and cultural norms, feel extremely uncomfortable exposing their vaginas fully even during the birthing process. Thus, many women prefer to squat, kneel, or even lie on their sides during the delivery process. And for those who do give birth on their backs, being asked to open their legs wider is less uncomfortable when coming from a Traditional Birth Attendant due to the prior trust and respect established between the two women. Traditional Birth Attendants also administer various local herbs to help with both the delivery process and post-natal healing of the mother and child. Certain ethnic groups believe that these traditional medicines should not be mixed with modern pharmaceuticals for fear of drug interactions. Many Ugandans also perceive local medicine as being safer with less side effects or potential for harm compared to Western medications.

Uganda is considered to be a male-dominated society, because a majority of decisions including the healthcare of women and children in the household are made by the men of the
family. However, the labor and delivery processes are widely considered “women’s business” by a majority of more traditionally-minded Ugandan men.\textsuperscript{26} Hence, men are not encouraged to learn about or be involved in the pregnancy and delivery process. This lack of knowledge leads to a plethora of misinformation about the risks and warning signs during pregnancy, delivery, and post-birth.\textsuperscript{26,31} It is relatively common, particularly in more rural isolated areas, for men to perceive women who give birth in health facilities as “cowards” or “weak women”, or viewing the birthing process as a “private family issue” that should not involve outside participants.\textsuperscript{26} This knowledge gap among men results in many households not understanding the potential benefits of giving birth at a health facility.\textsuperscript{26,31}

Since the 1994 International Conference on Population and Development, male involvement in reproductive health care has been advocated as a means to improve maternal and child health outcomes.\textsuperscript{32} But, to date, health providers have failed to achieve successful male involvement in pregnancy care and family planning, especially in rural and remote areas where a majority of the underserved Ugandan populations reside.\textsuperscript{31,32} In an effort to enhance community participation in maternity care, Traditional Birth Attendants were trained and equipped to ensure better care and quick referral.\textsuperscript{25} It is commonly believed by many Ugandan men that only women who are carrying high risk pregnancies or have never given birth before should deliver at health facilities.\textsuperscript{22,25} First time mothers are seen by some community members as more of a potential risk because they have not experienced the birthing process before. But women who have had children are believed to be lower risk because of their experiential knowledge. Because of the highly respected status of Traditional Birth Attendants, men are generally more accepting of the advice and directions received from Traditional Birth Attendants about their healthcare of their wives and children.\textsuperscript{24,26,30,31} It is widely acknowledged that cultural beliefs and norms position both men and Traditional Birth Attendants as powerful actors in maternal health in many
In the especially patriarchal communities of Western Uganda, Traditional Birth Attendants and men occupy dominant positions of power and are the main influencers of their communities regarding the health of women and children.\textsuperscript{20,32} Furthermore, commonly throughout Uganda it is seen as a taboo or a sign of weakness and bad luck to show any sign of fear during the labor and delivery process.\textsuperscript{16} This leads to women being concerned that giving birth at healthcare facilities may lead to staff members or other patients hearing their cries of pain and telling their community that they are weak women. Within the privacy of their own home or the home of the Traditional Birth Attendant, women are ensured a level of discretion during their birthing process. Moreover, women commonly comment that Traditional Birth Attendants are kind to them, speak to them gently, and do not laugh at them, say rude things, or abuse them during their delivery process which many fear hospital staff members may do.\textsuperscript{22,24} Lastly, many women, especially those with small children at home, are extremely concerned about leaving behind their domestic duties.\textsuperscript{21,22} They worry that without their presence no one will wash clothes, clean their home, or prepare food for their children left at home. The suggested two to three day observation period required by many health facilities leaves women concerned that their current children will suffer without their care and supervision.\textsuperscript{21,22} Additionally, many African women are thoroughly involved in local market place activities in order to provide supplementary income to their families and the required postpartum waiting periods prevent women from returning to their market activities as quickly as possible. In sum, the prestige, affordability, accessibility, and overall public trust in Traditional Birth Attendants dissuade some women from seeking outside regulated maternal health care, even after Traditional Birth Attendants have been banned by the Ugandan government.
Methods

This research used a mixed qualitative method, which consisted of in-depth qualitative interviews with Traditional Birth Attendants, informational interviews with licensed healthcare professionals, and group family planning counseling sessions with Traditional Birth Attendants and the women they serve in Central and South Western, Uganda. It was further informed with statistical information collected from the 2011 and 2016 Uganda Demographic Health Survey (DHS).

Individual in-depth interviews were conducted using a fourteen question interview guide with practicing Traditional Birth Attendant and licensed healthcare professional in the Central and South Western regions of Uganda. Recruitment and sampling was conducted by staff members of the local public health organization Kigezi Healthcare Foundation. Kigezi Healthcare Foundation is a local grassroots public health organization that works primarily out of Central and South Western Uganda. They specialize in providing healthcare to hard to reach rural areas which includes HIV testing and care, maternal healthcare, cervical cancer screenings, dental outreach, youth outreach programs, and economic empowerment programs. They are also the largest private HIV testing organizations in Uganda and have received funds from the Ugandan government, USAID, and countless private donors.

Kigezi Healthcare Foundation (commonly referred to as KIHEFO) staff members were able to recruit five Traditional Birth Attendants in each area to participate in the interviewing process for a total of ten. Three licensed healthcare professionals were also interviewed for informational purposes about their family planning counseling styles and recommendation. This resulted in a total of 13 interviews in which the interviewer used the interview guide.
interview guide prompted answers about formal educational achievement, formal and informal training, knowledge on traditional and modern family planning methods as well as preferred counseling methods on the subject, and the general services provided to their clientele as a Traditional Birth Attendant or licensed healthcare professional.

Recruitment was conducted via phone call and in-person visits by KIHEFO staff members beginning May 1st, 2017 and ending June 22nd, 2017. Known practicing Traditional Birth Attendants over the age of 21 were identified by KIHEFO staff members and then approached at their home either in person or by telephone for participation in this study. After verbally agreeing to participate in the study, the Traditional Birth Attends were visited in person by the principal investigator, one KIHEFO staff member, and one KIHEFO staff member who was the designated translator and asked to sign the informed consent forms for both the University of California, Los Angeles and Mbarara University IRBs. The consent forms were provided in English and their local language, which was either Rukiga or Luganda.

Official interview collection took place from July 1st, 2017 until September 5th, 2017. Ten Traditional Birth Attendants were interviewed. The average interview was 24 minutes long. Traditional Birth Attendants were interviewed in their home or a community meeting house within their home village. Traditional Birth Attendants in Central Uganda were only interviewed once and all interviews were conducted within the Traditional Birth Attendants’ private homes. Traditional Birth Attendants in South Western Uganda were interviewed two times, not including their group counseling session. There were two recorded group counseling sessions conducted with the Traditional Birth Attendants in the South Western area.

In addition to the individual interviews there were two recorded group family planning counseling sessions that involved local women of reproductive age (which is defined as 21 to 45 years of age) receiving traditional and modern family planning information from the Traditional
Birth Attendants. The Traditional Birth Attendants claimed that the group counseling session on family planning was representative of how they would usually counsel, when more than one woman comes to them at the same time of day. In addition to receiving information about traditional and modern family planning information, the women were able to asking questions to Traditional Birth Attendants about reproductive health and local resources.

There were a total of 12 women at the first group counseling session and 10 women at the second group counseling session. The women were identified and contacted by the Traditional Birth Attendants participating the group counseling sessions. All of the women who participated were current or past clients of the Traditional Birth Attendant they were contacted by, over the age of 21, under the age of 45, and had at least one child. All group counseling sessions were conducted in the South western region, and were done in participants’ native language of Rukiga. The counseling sessions took place in two different areas of South Western Uganda. The first group session, which took place on July 31st, 2017, was 48 minutes long for the group counseling session and 25 minutes of questions and answers from the participants, with the three Traditional Birth Attendants located in a more health service depleted area. The second group counseling session was done with one Traditional Birth Attendant in an area closer to quality healthcare facilities, about 30 minutes by foot. The two locations are only about a fifteen minute drive from one another but the more service depleted area is much more difficult to leave and return by foot due to the mountainous terrain. The principal investigator was present for each group counseling session, the sessions were audio recorded, and then later translated into English for analysis. The second group session took place on August 6th, 2017 and was 25 minutes long with an additional 26 minutes of questions and answers from the participants.

One unrecorded conversation with Traditional Birth Attendants in the South West region was had about the practice of labia pulling in the region.
Three interviews were conducted with licensed health care professionals in order to collect information on opinions and family planning counseling methods performed by registered healthcare professionals. One doctor, one registered nurse/midwife, and one head lab technician, all of whom worked in the clinics of Kigezi Healthcare Foundation primarily in the South Western location, were interviewed. These interviews were an average of 24 minutes long. Licensed healthcare professionals were asked similar questions to the Traditional Birth Attendants including experience with family planning both modern and traditional, their role within family planning counseling, and any knowledge they had on traditional practices such as labia pulling in the area.

The data from the qualitative interviews were analyzed using the mixed method analysis software Dedoose™. Common themes throughout the interviews were highlighted and categorized. These themes consisted of: (1) Introduction to the practice and training,(2) Prenatal care and postnatal care (3) Knowledge and use of medicinal herbs and traditional family planning,(4) Relationship counseling, (5) Benefits and challenges of the profession, and (6) Labia pulling.

Quantitative data was extracted from the 2011 and 2016 Uganda Demographic Health Survey (DHS) using the raw data and summary reports. The 2011 and 2016 raw data on the South West region of Uganda was run with SPSS software to check the validity of the summary reports. Specific data about the usage of Traditional Birth Attendants during surveyed women’s births in the last five years as well as data on education and wealth status to give background information on the women utilizing particular services. This data was used to provide quantitative data to support or contradict the qualitative interviews the research was based on.

Both the 2011 and 2016 Uganda Demographic Health Surveys were used to provide background information on the current estimated usage of Traditional Birth Attendants by Ugandan women,
the usage and preferences of modern and traditional family planning methods, and other information related to Ugandan women’s reproductive health.²,³
Results

Demographic Health Survey Results

In order to provide context as well as to confirm information collected during the interviews, data relating to women and their status connected to who assisted them at their most recent birth within the past five years was taken from the 2011 and 2016 Uganda Demographic Health Survey. In order to confirm the results of the Demographic Health Surveys’ key finding reports, raw data for the South western region was computed using SAS, which confirmed the numbers in the report summaries. For the 2016 Uganda Demographic Health Survey the Kigezi data as to signify the South West region and in the 2011 Uganda Demographic Health Survey the South West region data was used. According to women surveyed in the 2016 Uganda Demographic Health Survey, 11% were assisted in their most recent birth (2011-2016) by a Traditional Birth Attendant, 13.4% by a Doctor, 14.2% by a Relative/friend, 15% by no one, and 46.5% by a Nurse/Midwife.¹

A primary school level education or less was reported by 90% of women who reported using a Traditional Birth Attendant, 95% of women reported using a Relative/Friend, and 98.2% of women who reported no one assisted them, live in a rural area at the time of the survey. 59.1% of women who reported the assistance of a Traditional Birth Attendant, 70.7% of women who reported Relative/friend, and 64.3% of women who reported no one had assisted them during their most recent birth. Literacy levels were also looked at in order to provide context for the education of the women surveyed. This showed that 35.7% of women who reported No one assisted them, 31.7% of women who reported the assistance of Relative/friend, and 36.4% of women who reported the assistance of a Traditional Birth Attendant “cannot read at all”,...
compared 23.7% of women who reported using the assistance of a Nurse/Midwife and 21.3% of women who reported using the assistance of a Doctor “cannot read at all”.

In order to provide context for a level of wealth, electricity in their homes was also looked at. Only 9.1% of women who used the assistance of a Traditional Birth Attendant, 9.8% percent of women who used a Relative/friend, and 3.8% of women who said No one had electricity in their homes. While many Ugandan homes do not have access to electricity, 30% of women who used the assistance of a Doctor and 20.7% of women who used the assistance of a Nurse/Midwife had electricity in their homes.

These statistic collected by the 2016 Ugandan Demographic Health report that women who have overall lower socioeconomic status as shown by their lower levels of formal education, literacy, wealth, and are more likely to live in rural areas, are also more likely to utilize the services of a Traditional Birth Attendant or another unskilled birth attendant. These statistics attest to the overall social vulnerably of women who use the services of Traditional Birth Attendants compared to women who are able to assess the services of a skilled birth attendant such as a doctor or nurse.

In order to account for any recall bias for the year 2011 and to see any major changes over time the 2011 Uganda Demographic Health Survey underwent the same analysis for the South western region. According to the 2011 Uganda Demographic Health Survey for their most recent birth (2006-2011), 17.1% of women reported using the assistance of a Traditional Birth Attendant, 17.1% reported using the assistance of No one, 17.3% reported using the assistance of a Relative/Friend, 9.8% reported using the assistance of Doctor, and 38.8% reported using the assistance Nurse/Midwife. Of the women who reported using the assistance of a Traditional Birth Attendant at their most recent birth 98.8% of them live in a rural area, 100% of women who reported a Relative/friend, and 97.6% of women who reported No one
assisted them live in a rural area, compared to 72.6% of women who used the assistance of a Doctor and 86.9% who used the assistance of a Nurse/Midwife.

For education level, 73.8% of women who reported using the assistance of a Traditional Birth Attendant, 71.4% of women who reported the assistance of No one, and 68.2% of women who reported the assistance of Relative/Friend at their most recent birth had a primary school level education or less, compared to 58.3% of women who reported the assistance of a Doctor, 59.7% of women who reported the assistance of a Nurse/Midwife. Literacy was reported with 31% of women who reported the assistance of No one, 29.4% of women who reported the assistance of a Relative/friend, and 29.8% who reported the assistance of a Traditional Birth Attendant “cannot read at all” compared to 14.6% of women who reported the assistance of a Doctor and 17.3% of women who reported the assistance of a Nurse/midwife “cannot read at all”. Electricity in the home as an indicator of wealth reported that 3.6% of women who reported the assistance of Traditional Birth Attendant, 2.4% of women who reported the assistance of a Relative/friend, and 1.2% of women who reported the assistance of No one, had electricity in their homes, compared to 37.5% of women who reported the assistance of a Doctor and 12% of women who report the assistance of a Nurse/Midwife had electricity in their homes. These statistics, like that of the 2016 Uganda Demographic Health Survey, attest to the utilization of Traditional Birth Attendants and other unskilled birth attendants by women that are more vulnerable due to their lower socioeconomic status.

For the Central region of Uganda data was extracted from the 2016 Demographic Health Survey Key Findings report using the data taken from women surveyed in Kampala. 0.7% of women reported that No one assisted them at their most recent birth (2011-2016), 3% of women reported that a Relative/friend assisted them at their most recent birth, 0.6% reported that a Traditional Birth Attendant assisted them at their most recent birth, 72.2% reported that
Nurse/midwife assisted them at their most recent birth and 23.1% reported that a Doctor assisted them at their most recent birth. Education status showed that out of those women surveyed, 11.7% of women who reported No one assisted them, 27.1% of women who reported the assistance of a Relative/friend, and 26.8% of women who reported using the assistance of a Traditional Birth Attendant had a primary school level education or less.

These survey statistics collected by the 2016 Uganda Demographic Health Survey and confirmed that women who use the services of Traditional Birth Attendants, Relative/friend, or No one tend to have a lower education status, live in more rural areas, and have a lower wealth status than those that use the assistance of a “skilled birth attendant” which is categorized in this survey as that of a Doctor and/or Nurse/Midwife.

**Interview Results**

An analysis of 13 structured interviews and 3 other recorded conversations of conversations with Traditional Birth Attendants and licensed healthcare professionals, 10 structured interviews, 2 group counseling sessions, and 3 unstructured conversations with Traditional Birth Attendants and 3 structured interviews with licensed healthcare professionals resulted in six primary themes, which will be discussed below.

During the analysis of the English translated transcripts of the recorded conversations six common topics were repeatedly discussed. These topics with the exception of relationship counseling and labia pulling were prompted by the interview guide.

**Training/Introduction to the Practice**

The first topic discussed during the recorded interviews was each Traditional Birth Attendants’ introduction to the practice and any formal or informal training they received. A
total of 4 women were introduced and trained by other female family members, 2 women were trained by their aunt/female relative and 3 women were trained by their mothers. One study participant was introduced and trained by another local Traditional Birth Attendant, who was also a participant in this study.

“I learnt from her (other Traditional Birth Attendant present) to be a traditional birth attendant, I have never had any formal education. So if she would get a mother to attend to, she calls me to help her. And we could advise her (the mother seeking services) all together and everything she (other Traditional Birth Attendant present) has said is exactly what we do” – Traditional Birth Attendant, South Western Region

One study participant was first introduced and trained by a local nurse who also practiced traditional midwifery on the side. As explained by the other Traditional Birth Attendant during the interview:

“She was taught by a nurse and also she grew up seeing her mother who was a traditional birth attendant. She observed other nurses doing it and ended being one of them” – (South Western Region)

One study participant was also first introduced by female family members and then trained by the official USAID program.

“We were invited to go for a training at Kabale regional for one month that’s how I learnt” – (South Western Region)
One Traditional Birth Attendant in the Central region never received a formal introduction or training. Instead she gave birth to her first child completely alone and decided to become a Traditional Birth Attendant with the skills she learned during her own solo birthing experience.

"I started by working on my own projects as a birth attendant by making myself give birth to my own first born child. I saw I was capable of doing it and thus motivated me but this was in 1975."- (Central Region)

One Traditional Birth Attendant in the Central region never received a formal introduction or training. Instead she gave birth to her first child alone and decided to become a Traditional Birth Attendant with the skills she learned during her own solo birthing experience.

"I started by working on my own projects as a birth attendant by making myself give birth to my own first born child. I saw I was capable of doing it and thus motivated me but this was in 1975."- Central Region

One woman in the Central region was trained by another local Traditional Birth Attendant who began training her at the age of 12 when she showed interested in the practice.

“There was a woman who was well known here for deliveries and was one of the best of our time. She used to call me during her sessions and she would always say (name redacted) come home and I went to her home to witness deliveries. I would see her massaging women’s bellies I
think every time you massage and I would see the baby kicking. You massage slowly until the baby responds. I always find people along the way and I do what I can and what I cannot do I refer””- Traditional Birth Attendant, Central Region

All 10 Traditional Birth Attendants from the South Western region of Uganda took part in a USAID hosted Traditional Birth Attendant training around 1997 which lasted approximately 1 month at the local government hospital. According to the Traditional Birth Attendants who attended this training they were offered to attend this training, the staff members of the organization provided transportation to the local government hospital each day for the duration of their training sessions. In the Central region 8 Traditional Birth Attendants took part in a similar training. There appeared to be two trainings, one around 1997 and another 2010. One participant in the Central region also received training on modern family planning by a Ugandan non-profit organization called ProFam in 2012. Not only did they train her on counseling local women on the different available family planning technologies, they also gave her a demonstration kit which included examples of birth control pills, intrauterine devices (IUDs), male and female condoms, injectable contraceptives, and the progesterone rod that is inserted under the skin of the forearm. The Traditional Birth Attendant who received this training from ProFam said that unfortunately that organization does not provide these kits or trainings anymore. Unfortunately, none of the study participants had their original Traditional Midwifery training certificate: they were either lost or destroyed.

However, two Traditional Birth Attendants in the Central region did not attend any of these trainings. According to them, they were contacted by the organizations hosting the trainings several times. But they declined to participate in any formalized training. These reasons included not wanting to expose themselves as Traditional Birth Attendants to any
government or international officials, not wanting to expose themselves to Western medicine that they felt was either dangerous or untrustworthy, and not wanting to risk losing their traditional knowledge or practice. It is also important to note that these were also the same women who had access to and knowledge of several different traditional birthing techniques and traditional family planning and fertility herbs and rituals. These findings from the interviews with these two women will be discussed in depth in the upcoming sections.

**Prenatal Care**

Regardless of regional or ethnic differences all Traditional Birth Attendants who participated in this study provided some sort of prenatal care for the women that sought their services. While many of them claimed to refer each woman who sought their services to the local health facilities, as required by Ugandan law, they still provided prenatal care and education.

In the South western region Traditional Birth Attendants begin all services by checking the fetus. The Traditional Birth Attendant begins by first pouring warm water in a basin. She then rinses her hands in the basin and applies warm water to the pregnant woman's stomach. According to the Traditional Birth Attendants the application of the warm water would prompt the fetus to become more active during the examination. They then massage around the pregnant woman's abdomen, checking the position of the fetus, and how old the fetus is based on how many fingers from the umbilicus they can fit between the fetus and the woman’s sternum. This method of checking fetal age is also practiced by formally licensed Ugandan doctors and nurses because of the limited availability of ultrasounds. They then place their heads on the woman’s stomach to listen to the fetal heartbeat. After this check is complete they discuss any concerns
the woman may have such as pain or morning sickness. They also educate the women on maternal health including nutrition, hygiene, and newborn care.

When prompted about prenatal care by the interview guide it was described by South western Traditional Birth Attendants as follows:

“I learnt from (name of other Traditional Birth Attendant that not apart of this study) some of these skills and she was the best because her whole family lineage had Traditional Birth Attendants with specialization in traditional medicine. She would call me to help her and we would use warm water on their bellies. When the child felt something warm, it would run away” - South Western Region

“Yes, we use warm water to know how the baby is and advise to go to hospitals if they cannot handle” - South Western Region

“Yes, she educates mothers about the importance of hygiene and how to take care of the unborn babies” - Traditional Birth Attendant, South Western Region

Traditional Birth Attendants in the Central region of Uganda do things slightly differently. They use the same finger method for determining fetal age, but do not place warm water on the stomach. Instead, two of the Central region Traditional Birth Attendants provide their clients with a local black tea to help relax the mother and fetus.

When asked about the prenatal services they provide, the Central Region Traditional Birth Attendants said replied:
“They (the pregnant women seeking their services) usually come like they do with doctors. I think on average they come 8-6 women in a month and come 5-6 times a month”- Central Region

“They come and ask some basic questions like why is this part paining and where can I get antenatal care services. We also ask them for the scan results from the city hospital to assess”- Central Region

Additionally, regardless of region most Traditional Birth Attendants claimed to care for around 5-8 women per month and see them frequently, around 5-8 times per month, after the first visit. According the Traditional Birth Attendants in both regions prior to the 2010 criminalization of the practice the women claimed to see around twenty to thirty women per month, thus there has been a substantial reduction in their clientele.

**Postnatal Care**

Similar to prenatal care, regardless of regional differences, all interviewed Traditional Birth Attendants provided some type of postnatal care. Traditional Birth Attendants discussed instructing and assisting women with newborn care, recognizing and diagnosing common newborn illness, breastfeeding assistance and instruction, and newborn and maternal nutritional advice.

When prompted about postnatal care in the interview guide the Traditional Birth Attendants provided the following statements:
“Yes, after the deliveries we tell mothers to bring babies back because we cannot follow them in their homes. We want to know how the babies are if (they are) not okay we advise to go to the hospital.” - South Western Region

“I do (perform postnatal services). They (the women she serves) stay friends and we check them regularly” - Central Region

“They (the women she serves) do come back and thank me and bring other women who need the same services” - Central Region

“They (the women she serves) come after giving birth for more services.” - Central Region

**Traditional Family Planning/Medicinal Herbal Use**

All Traditional Birth Attendants interviewed attested to their knowledge of medicinal local herbs. While the uses and herbs varied based on region as well as training by local herbalist and Traditional Birth Attendants. The women who were trained by USAID and other sanctioned programs did not have knowledge of herbs used for fertility but still had local knowledge of herbs used for vaginal dryness and to promote vaginal healing and tightening after birth. TBAs in both the Central and South Western region give women black tea mixed with sugar to drink during labor to help keep them energized and hydrated in order to push.

When prompted by the interview guide the following quotes were provided by the interviewed Traditional Birth Attendants:
“(Herbs are) always available but not always as traditional birth control but surrounding reproductive health” - South Western Region

“Herbs used to increase vaginal fluid production are extremely popular as well as herbs that help for vaginal recovery post birth” - South Western Region

Traditional Birth Attendants in the South Western region who participated in this study did not have knowledge of traditional family planning. They claimed to have no knowledge of it nor had they ever used it themselves. The only forms of reproductive herbal medicine they used were to increase the production of vaginal fluid and vaginal healing and recovery post birth. The only form of traditional family planning used among these women was the withdrawal method.

However, Traditional Birth Attendants in the Central region, particularly those who refused formal training, had a vast knowledge and regularly practiced traditional fertility control rituals and herbal family planning. According to the two Traditional Birth Attendants the most effective form of traditional birth control is a tea they brew from local herbs. This tea is drank and well as soaked in cotton pads and placed into the woman’s bra. According to them this will stop fertility to up to ten years. When the woman wants to get pregnant again she comes back and they make another herbal tea that will clear the old one from her system. They claim that these traditional methods are safer than Western medicine, have no side effects, and are effective. One of the Traditional Birth Attendants uses it herself after she said her body “rejected modern family planning”, she only has four children and has had no more since. They claimed that their herbal remedies were so powerful that they had been run out of one of their homes by local men who complained that their wives were not getting pregnant.
Here are few quotes that highlight the use of traditional family planning and medicinal herbs:

“People continue to use herb based birth control because they believe that it does not have the potent (negative) side effects of western hormonal birth control” - Central Region

“Men also use herbal medicine to assist with erectile dysfunction” - Central Region

A topic that came up in both regions frequently was women’s bodies “rejecting family planning”. Women in both regions had multiple stories of their bodies “rejecting family planning”. They defined this as systems such as weight gain, headaches, bloating, and most frequently “over bleeding”. “Over bleeding” was defined as heavier or longer periods and/or breakthrough bleeding. Most of these women had only tried one type of modern family planning which was the injectable contraceptive also known by its brand name Depo-Provera. Depo-Provera was the most commonly prescribed modern contraceptive provided by government hospitals. Women who participated in this study felt that once they had serious side effects to one type of modern contraceptives that their bodies had “rejected” it and they could no longer use any type of hormonal contraceptives.

Additionally during the focus group discussion women discussed being concerned about their husband finding out about their use of contraceptives. They were gravely concerned that their husbands would react violently. Even those that wanted to use the withdrawal method were concerned that their husbands would not cooperate, especially when they were intoxicated. Traditional herbal birth control was seen as a way of discreetly controlling their fertility without the risk of their husbands finding out.
“I used the local herb on myself and have never used the western methods. When my husband found out he got annoyed and quarreled so I stopped. I even denied to taking the herbs because I wanted to save my marriage.”- Central Region

**Relationship Counseling**

During the guided interviews with Traditional Birth Attendants and the discussion group with local women and their Traditional Birth Attendants the topic of marital issues was frequent. Women often sought the advice of their Traditional Birth Attendant to deal with their “quarrels” with their husbands. The main issues that we discussed were the husbands’ chronic drinking/alcoholism, finances mainly tied to the amount of money the men spent on alcohol, and their husbands’ wanting more children. Traditional Birth Attendants provided guidance, advice, and confidentiality for these women. As well as using their homes as a meeting space for local women to gather and discuss their home lives while their husbands were at work. Due to the prestige and great respect the communities have for Traditional Birth Attendants, men do not question or argue about the women spending time with them. The Traditional Birth Attendants say they give advice about dealing with the fighting and violence as well as helping women find services when they are injured.

“But these days we are married to young men who cannot allow us (to use family planning) and some can be drunk. But do you know when you play sex with a drunkard man you can give birth to a drunkard child and a stubborn one”- Woman from group counseling session, South Western region
Benefits and Challenges of The Profession

When discussing the benefits of the profession the number one answer from Traditional Birth Attendants was friendship. Meeting, befriending, and assisting women in their community was the main reason why Traditional Birth Attendants continue to practice.

The challenges of the profession included not being paid for their services and an overall lack of supplies. Traditional Birth Attendants that participated in this study did not have sanitary supplies such as gloves, sterile blades, or plastic sheets. Women who give birth with them usually give birth on fabric they bring with them or provided by the Traditional Birth Attendant. According to them it would be much easier for hygienic and quick clean up if they had plastic sheets to lay down under the fabric. The use of gloves came up numerous times: while the women practice frequent handwashing, they feel that it would create a more sanitary environment if they had access to latex gloves. According to the Traditional Birth Attendants in the South Western region, they used to get small amounts of supplies from government/non-profit programs which included things like gloves, rubbing alcohol, and clean cotton. They no longer receive these supplies because the programs have been canceled and they cannot afford to buy the items themselves nor can the women they serve. Additionally, they were concerned with the fact that when they do refer women to the hospital to give birth, the women often ignore that advice. They said frequently women will wait until they are near crowning to come to them, knowing that it will be too late to send them away because they are so close to giving birth. If they are faced with emergencies during a birth they have no reliable forms of transportation to send women to the hospital.

“We study that when you are a pregnant what you supposed to do. You should go for ANC (antenatal care) in the hospital and when you come to me as a traditional birth
attendant to check you, it’s fine I can but it’s better to go to the hospital and I tell them, pregnant mothers, the first pregnancy and the fifth you supposed to go to the hospital to give birth because their uterus is weak and it may be hard for me to help, therefore I recommend for going to the hospital. And sometimes it’s a challenge for me when some mothers insist on me helping them give birth because they know me as a nurse and they are not ready to go to the hospital where they may not be cared for. And if she insists God will help me and she gives birth.” - South Western region

One reason women of the Baganda ethnic group found in the Central region do not want to give birth in health facilities has to do with the proper disposal of the placenta. As mentioned in the literature review, the placenta is viewed as sacred and commonly referred to as the “baby’s twin”. The disposal and treatment of the placenta is believed to be directly connected to the fate of the child it shared the womb with. According to the Traditional Birth Attendants in the Central region, the placenta is handed to mother after she has birth it, it is then wrapped in banana leaves and kept in the woman’s house for 3 days if the newborn is a girl and 4 days if the newborn is a boy. After that waiting period the placenta is then placed in the family’s garden, usually under a banana plant, where it will stay. Mishandling of the placenta is seen as great disrespect and will bring misfortune on the newborn child and their family.

Among the Mukiga, the primary ethnic group of the South Western region, there is no such tradition with the placenta. After birth they discard their placentas by either burning or burying them. This can quickly become an issue when women of different ethnic groups go to a hospital or health facility to give birth. For example, during research collection for this study in both at a private and public health facilities, the placenta is disposed of like any other form of medical waste. In one rural private maternal clinic the placenta is disposed of in what local staff
and volunteers playfully call the “placenta pit”. The “placenta pit” is a six to eight foot deep hole behind the maternal clinic main building, in which placentas are thrown in after births. Once the hole is full it is covered with earth and a new hole dug.

The poor conditions of a local health facility near one of the South Western study populations caused numerous women to refuse to give birth there. The TBAs and local women during the group counseling sessions expressed concern over the condition of the health facility, explaining that they have gone numerous times only to be told that the facility has no medications or supplies that day, so eventually they just stop going.

At that same health facility, local women and TBAs also stated that the staff had very poor attitudes. Often treating the women as though they are “stupid” or below them. One particular anecdote that was revealed during the group counseling session, was that of one local HIV positive pregnant woman, who traveled by foot, in a mountainous region, to this same health center to discuss her medication because she was experiencing vomiting and nausea. When she arrived she was required to wait, what she estimated was around six hours, to see the head of the HIV department. When she finally was seen by the department head, he told her in an impolite and aggressive manner to “just have an abortion” because there is nothing they can do for her, which is both illegal and unsafe in Uganda. She then discontinued taking her medication because she did not want to terminate her pregnancy nor did she have anyway of doing so. This resulted in rapid weight loss, fatigue, and other issues from her increasing viral load. Without proper intervention, it can be assumed, that her situation will result in mother to child HIV transmission, especially if she chooses to give birth without skilled medical assistance with access to appropriate medications.

Often Traditional Birth Attendants also commented that women do not push when instructed or do not follow directions. There were several references to what the Traditional
Birth Attendants described as “lazy” women, which they defined as women who tire easily during exhausting labors and do not or cannot push when instructed. They also said that many women do not open their legs wide enough during childbirth because of the cultural taboo of exposing their vaginas. According to the Traditional Birth Attendants this can cause the labor process to take longer.

“The same issues they face here are the same they face at the hospitals. Some women still don’t push the babies easily enough and at times I tell them to get African herbs that helps them. They are just lazy at taking drugs. Most women fear and don’t want to open their legs wide and don’t listen during deliveries. I usually tell them to stop pushing and they are impatient and just want to push” - Central region

“Some women don’t have enough knowledge about giving birth sometimes they don’t push at the time of delivery and she finds it challenge.” - South Western region

Another serious challenge is that of the criminalization of the practice. According to a majority of the Traditional Birth Attendants in both regions, prior to the 2010 law banning Traditional Birth Attendants from assisting in labor and delivery, they would periodically receive support and even training from government and international non-profit organizations. After the law was originally passed Traditional Birth Attendants continue to practice as normal until massive arrests of well known and well respected Traditional Birth Attendants began. It scared many Traditional Birth Attendants into refusing to assist in labor and caused others to continue to practice in secret. Many of the Traditional Birth Attendants that participated in this study enjoyed taking part in different types of trainings and programs that taught them how to better
assist women and children in their communities. Now with the new law, they feel the government is no longer making efforts to transition their role into Community Health Workers like they had in the past.

**Labia Pulling**

While not a part of the interview guide, the topic of the practice of labia pulling was discussed among Traditional Birth Attendants of the South western region. According to staff members of Kigezi Healthcare Foundation (KIHEFO), labia pulling is frequently practiced in the south west region, mostly among those of the farming class. Thus, women who lived in the villages and more rural regions were more likely to have taken part in the practice. But women in the cities or of a more elite class had neither heard of the practice nor been exposed to it. According to the Southwestern Traditional Birth Attendants labia pulling is the practice of stretching the labia minora to the length of your second joint on your forefinger, which is about 2 to 4 inches. If the skin is stretch any further than this it is said that it will get too cold from the wind. The practice is ideally begun when the child is around six years of age because if women waits until she is an adult her the skin is said to be less elastic and more painful. Young girls are shown how to stretch the labia themselves using their hands. Usually they are taught to do this by older girls at their school and older female cousins. One woman told a story of how she learned about the practice from girls in Senior 2 when she was in primary school, about 7 years old. The girls took them behind the school and demonstrated how to stretch their labias. They told them that if they want husbands when they grow up they must stretch the skin until it reaches the right length or no one will marry them. The older girls told her if she did not keep up with this her future husband would “chase” her away. Many families do not openly discuss it
with their daughters because they are concerned it will make the girls more interested in sex. The stretched labias are commonly referred to as “leaves” in local music and conversations.

Women who do not perform the practice as children can still do so as adults, it is just said to be more painful. Additionally, some people believe that if the labias are pulled as an adult it will make women’s sex drive insatiable and cause her to be promiscuous. When an adult woman practices labia pulling it is said to take about one month to reach the ideal length. According to the Traditional Birth Attendants some women do not learn about the practice until they are married. When their husbands see that their labias have not been pulled they instruct her to go to the Traditional Birth Attendants and learn about it. The Traditional Birth Attendants also say that women without their labias pulled is like “having a kettle only half filled with porridge”.

According to the male Kigezi Healthcare Foundation staff member interviewed about the practice men enjoy the practice because it increases the surface area of the vagina during intercourse and creates a “flapping” sound, which men enjoy hearing.
Discussion

Every Traditional Birth Attendant spoken to within this study asserted their deep desire to help and advocate for the health and wellbeing of women and children in their communities. Most of the Traditional Birth Attendants agreed with the public health community and wanted to participate in any trainings or programs that would assist them in learning new and more modern skills to help keep women who seek their services safe. A majority of the Traditional Birth Attendants in this study had participated in local health councils and other community based public health organizations in hopes of using their influence to advocate for women’s health. Yet, the current legislation and treatment by many officials has left them feeling as though they are no longer wanted in the public health sphere. Thus, a majority of them have resorted to practicing in secret, no longer talking to international public health organizations or participating in local public health activities for fear of exposure.

The policy implications for this study are clear. The Ugandan government, national and international public health organizations need to create policies and programs that encourage and accommodate Traditional Birth Attendants to serve as some form of community health workers. Traditional Birth Attendants have a pre-existing trust with women in their communities and would be excellent birthing companions in clinics, and community educators for both men and women on modern family planning and reproductive health warning signs and information. There has been such programming in the past that were successful but currently the government has been less focused on incorporating Traditional Birth Attendants into the modern medical system. Bridging the gap between traditional and cultural medicine and practitioners and the modern day biomedical system is a key step to reducing maternal mortality and improving women’s health in more traditional societies of Uganda.
One of the most concerning results seen within the Uganda Demographic Health Surveys is the percentage of women who reported that “No one assisted the during their birth”. While the risks of giving birth with Traditional Birth Attendants are well documented due to their lack of formal training, it is still less risky than giving birth completely alone with no one to assist you. Additionally, the portion of woman who report the assistance of “Relative/friend” brings the question of how many of those relatives or friends were actually Traditional Birth Attendants. Throughout the interviews with Traditional Birth Attendants and the women they serve, women often refer to Traditional Birth Attendants and their friends and vice versa due to the bond these women share through the birthing experience and cultural commonalities. This leads into one of the largest topics most research on the usage of Traditional Birth Attendants covers, barriers to transition to the use of modern health facilities. There is a great need for training healthcare professionals in new and more comforting ways to encourage women to seek care during their pregnancy.

Traditional Birth Attendants understand the difficulties women have with balancing their reproductive healthcare needs with the needs of their households. This can be a serious issue of conflict when trying to transition women into modern healthcare facilities and out of the care of Traditional Birth Attendants. KIHEFO staff often use the following anecdote in explaining the difficulties in getting women to agree to stay their 6-hour waiting period required by their health facility. During one of their routine deliveries a woman got up and began to pack her bags about 20 minutes after giving birth. The nurse informed her that they would feel more comfortable if she stayed for the 6 hours in order for them to monitor the condition of both her and her newborn. The woman informed them that this was her fourth child and that she needed to go to the market to sell her tomatoes. She told the nurses she understood the need to watch the newborn and that she would go to the market, sell her tomatoes, and come back to pick up her
baby at the end of the day. Sensing the woman’s concerns and frustration, the nursing staff took the time to sit the woman down and explain why the waiting period was so important, and that she could not leave her baby unattended because they did not have supplies to feed the baby with. Thus, the woman agreed to stay. But this anecdote highlights the concern of lost income and being unable to attend to their usual responsibilities while in healthcare facilities, as well as the need to sensitize and educate the local communities to why health facilities require these waiting periods and the importance of recognizing postpartum danger signs. The most vulnerable women have continued to express their concerns with the lack of comfort, accessibility, and affordability of modern health facilities in Uganda. With this supporting evidence it can be said that banning Traditional Birth Attendants does not create a safer environment for maternal and child health instead it forces the most vulnerable of the population into the most dangerous of situations, giving birth completely alone.

There is a continued need for social and biological sciences to combine their efforts in understanding the efficacy and risks of traditional medicinal herbs, particularly those related to fertility control and reproductive health. Women in Uganda use these medicinal herbs for a variety of ailments and conditions including helping to speed the recovery of postpartum mothers, fertility control, and increasing the production of vaginal fluids due to post-menopausal dryness. It is difficult to pinpoint exactly what is in these herbal teas and pastes and whether or not they vary per Traditional Birth Attendant or if they are a uniform formula. Traditional Birth Attendants who participated in this study were unable to give the exact names of the herbs they used because they primarily relied on their own recognition of the herbs in the wild. The women knew exactly where the herbs grew and what they looked like, but were unsure of any common names for many of them. This is where the help of researchers is greatly needed. These formulas and practices deserve and need to documented and analyzed for both the historical
preservation of their culture and for the public health community to become more knowledgeable about common local practices.

Within the topic of family planning, many women voiced continuous concern that their body had “rejected family planning”, meaning they experienced common side effects of hormonal birth control, that are uncomfortable and often severe. Women were concerned that hormonal birth control had caused weight gain, nausea, headaches, and “over bleeding” which meant heavier and longer periods with breakthrough bleeding. According to the informational interviews done with one doctor and one nurse at a private clinic this a common experience with the injectable contraceptive Depo-Provera. Depo-Provera is one of the most commonly distributed birth control in government hospital in Uganda. This raises several concerns due to the well documented and often extreme side effects many women, globally, have experience with Depo-Provera.³³ Depo-Provera is a high dose of methylated progesterone injected into the muscle of the upper arm every three months. It has been commonly associated with headaches, weight gain, nausea, and unpredictable breakthrough bleeding.³³ Its most concerning side effect is its effects on bone density for women that use it for a period of over five years.³⁴ According to the interviews with healthcare professionals at a private clinic, private Ugandan clinics are doing their best to educate women on these side effects and transition them into different forms of hormonal birth control. Yet, many women after experiencing such extreme side effects, they are worried about trying any other methods.

Educating Traditional Birth Attendants and other trusted community members about hormonal birth control, its side effects, and its management, so that they may then educate women in their communities and encourage them to talk to a physician is recommended. Currently, many women feel once they have experienced these side effects of hormonal birth control their bodies have rejected it and they can never use another method. With the help of
Traditional Birth Attendants supporting the information of doctors and nurses, women can you encouraged to talk about their side effects and switch to new less potent methods.

The results of this study provide supporting evidence to the importance of Traditional Birth Attendants in Ugandan communities and the need for greater research on their contemporary practices. These women not only provide much needed reproductive health services but also serve as emotional and social support for the most at risk women in Ugandan societies. The results acquired from the 13 structured interviews and 2 group counseling sessions is summarized within the six primary themes of training/introduction to the practice, prenatal care, postnatal care, traditional family planning/medicinal herb use, relationship counseling, benefits and challenging of the profession, and labia pulling. While it is clear that the practice of Traditional Birth Assistants is beginning to change with the new laws, it is also clear that these women are continuing to assist the most vulnerable of Uganda’s populations. When the results of the interviews are combined with the statistics from the Uganda Demographic Health Survey it can be seen that a majority of the women who rely on the services of Traditional Birth Attendants are primarily rural, low income, with low levels of formal education. Meaning the most at risk members of Uganda’s population suffer the most when the public health community does not align its efforts with Traditional Birth Attendants and other informal community health workers.

**Study Limitations**

The limitations of this study include its small sample size and limited generalizability to other areas of Uganda. Due to its short time period for research collection, ten weeks, only ten Traditional Birth Attendants were able to be recruited and interviewed. Thus, the results of this study are only generalizable to the South Western and Central region of Uganda where research collection took place. Uganda has a total of 52 recognized ethnic
groups, all with their own unique culture, language, and birthing practices. The Traditional Birth Attendants that participated in this study were primarily from the Mukiga and Baganda ethnic group. Therefore, their practices and traditions are not applicable to ethnic groups outside of their own. Additionally, 80% of the Traditional Birth Attendants that participated in this study have also participated in outside trainings and are closely involved with local public health organizations. Only 20% of the Traditional Birth Attendants who agreed to participate in this study were trained in traditional birth methods. There were several other Traditional Birth Attendants in the area that this study identified who were known to practice different methods of traditional family planning and traditional healing. Those women refused to participate due to concerns about exposing themselves to outside researchers and the possible legal backlash if they were to be found. While we were able to speak to some privately we were not able to include their stories due to their privacy concerns.
Conclusion

In conclusion this study is able to demonstrate the importance of Traditional Birth Attendants to the populations they serve. The current legalities of their practice have left both Traditional Birth Attendants and the women they serve vulnerable and unable to reach out for proper training and assistance from local agencies. Many local Ugandan news articles have bought up this concern, asking if this legislation is actually bringing down the maternal mortality ratio or just creating further barriers to women’s healthcare. The understaffed and underfunded local health facilities have left many Ugandan women apprehensive when it comes to seeking formal reproductive health services.

Traditional Birth Attendants have established trusting relationships with women in their communities and need to be utilized as a local resource by public health officials in efforts to create safer and more comfortable healthcare for the most at risk women in these communities. The skills and knowledge that Traditional Birth Attendants have been passing down for generations deserves to documented and researched to preserve their history and teach modern day healthcare practitioners more culturally appropriate ways of counseling and assisting women with their health and the health of their families.
Appendix
Traditional Birth Attendant Interview Guide

First name:
Age:
Ethnicity:
Place of birth:
Place of residence:

1. About how long have you been working as a Traditional Birth Attendant?  (Or: about how old were you when you started being a Traditional Birth Attendant?)

2. How did you learn how become a Traditional Birth Attendant?

If from a family member, how many generations of women in your family have been Traditional Birth Attendants?

3. How many years of formal schooling do you have, if any?
4. Did you ever get any formal health training or certificates? If so, when and for what subjects?

5. Do you have any other line of work or ways of making money, other than being a Traditional Birth Attendant?

6. About how many women did you see last month (e.g. June)? Would you say that is about average?

7. Besides assisting in deliveries, do you usually do any pre-natal care with women?

8. Besides assisting in deliveries, do you usually do any post-natal care with women?

9. Do you ever refer women to the medical center or hospital for delivery? If so, when do you do so?
10. Do you ever give advice to women about family planning?

a. If so, when do you give the advice? (Pre-natal, during delivery, post-natal)

b. To whom (which women) do you give the advice? Are there any women you will not provide family planning for? Why?

c. What family planning method(s) do you usually recommend to them?

d. On average how many times a month do you see women for family planning advice?

e. Do you ever give abortion advice or services?

f. If so what methods do you usually recommend or provide?
11. Have you ever used family planning yourself?

   a. If yes, what method(s) did you use?

   b. To how many children have you given birth to?

12. What do you think is a good family size for women nowadays?

13. What are some of the challenges you face in your job as a Traditional Birth Attendant?

14. What is your favorite part about being a Traditional Birth Attendant?
Provider Intake Survey

First name:

Age:

Ethnicity:

Place of birth:

Place of residence:

Type of provider (nurse, midwife, doctor, etc.):

1. How long have you been practicing?

2. What is your specialty area, if any?

3. How many years of formal training do you have? Where? What type of official certifications do you have?

4. Do you have any other work or profession besides being a healthcare provider? If yes what are they?
5. How long have you been providing family planning counseling to patients?

6. What are the common forms of family planning that you recommend?

7. Do you assist with deliveries at all? If yes in what capacity?

8. Besides assisting in deliveries, do you usually provide any pre-natal care to women? What kind?

9. Besides assisting in deliveries, do you usually provide any post-natal care to women? What kind?
10. To whom do you recommend each method of family planning and why?

11. On average how times a week do you see women for family planning counseling?

12. What do you consider to be a good family size?

13. Have you ever used any family planning yourself (or your wife) ?

   a. If yes, what method(s) did you use?

   b. To how many children have you given birth to (or your wife) ?

What form of family planning do you most commonly recommend?
Why do you recommend that method? What are the risks and benefits of this method?

What form of family planning do you recommend the least?

Are there any women you will not provide family planning for? Why?

Why do you recommend that method the least? What are the risks and benefits of this method?

14. What is the most challenging part of your job?

15. What is your favorite part of your job?
Is there anything you would like the research to reflect about family planning counseling and the way you perform it?
Bibliography


8. Kigezi Healthcare Foundation Staff Member, Hakim Malagala, Email Communication, March 2017


20. Kigezi Healthcare Foundation Board of Director Caleb Rwakatungu, Face to Face, (July 2016)


