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Connective Care and Broken Bureaucracies: An Ethnography with Uganda's Outlawed Midwives

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Connective Care and Broken Bureaucracies:  
An Ethnography with Uganda’s Outlawed Midwives

A Dissertation submitted in partial satisfaction 
of the requirements for the degree of

Doctor of Philosophy

in

Anthropology

by

Kara E. Miller

June 2017

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ABSTRACT OF THE DISSERTATION

Connective Care and Broken Bureaucracies: An Ethnography with Uganda’s Outlawed Midwives

by

Kara E. Miller

Doctor of Philosophy, Anthropology
University of California, Riverside, June 2017
Dr. Juliet McMullin, Chairperson

This is an ethnographic exploration of care in Uganda, from everyday tending, to bio-bureaucracies, to inter-personal relationships. I focus on traditional birth attendants (TBA’s), who are local medical experts carrying significant cultural capital, in order to understand civic care and its entanglements. And I study birthing events and the dynamics of risky responsibility in order to speak to care-based obligations. The practice of the TBA was recently outlawed by government mandate, leaving significant uncertainty for the fate of emergency obstetrics in Ugandan villages, and threatening the authority of local providers. TBA’s have been the bridge for health development projects to rural villages and have been a voice for women and a link to global discourse. I investigate health policy and the genealogies of health intercessions in order to translate lived implications of the ban, and I look at the ways in which this ban highlights relational politics of care in Uganda.
I argue that the TBA contributes to informed policy that considers all manner of women’s lives and that her practice is based in advocacy. I consider how women’s health is compounded by social factors in Uganda, namely through reproductive consequences, and I ask how the TBA’s participation in politics can be a form of dispossession for women. I explore women’s emotion-rich experiences and I campaign for intimate, relational, and embodied understandings. I platform a humanistic approach and contend that medicine should be interpersonal. I further offer that care is a feminist endeavor that dismantles the supremacy of super-structures of medicine that have instated women’s oppression. Through everyday scenes and private spaces, I witness care’s mutuality and make the case for harnessing these sentiments in health policy. I consider the implications of connective care in public health as well as ethnography and I champion the idea that international health discourse should obsess with care because it is through care in our considerations of the world that we arrive at reliable interpretations, creative approaches, and nuanced praxes.
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INTRODUCTION

I was introduced to Yoda when I first visited Mbarara in the Southwest of Uganda in 2009 through my participation with Healthy Child Uganda, an NGO locally operated – one of many community health organizations in town. From their outreach projects and personal networks, they were in communication with several traditional birth attendants (TBA’s) to whom they often referred in mobilization and education efforts. I began to get more and more interested in the TBA because I saw the power that she had and the ability to insight movement. Yoda was particularly regarded around the villages close to town. She would hop on the back of a boda-boda (motorcycle taxi), and ride out into the fields of matoke (local staple food, starchy banana) with coolers of vaccinations on her back or with some news about free HIV clinics coming to town. Yoda ate honeycomb raw and was more outspoken than any Ugandan woman I had met. She touched everyone that she spoke with and she spoke with everybody.

I stayed in touch with Yoda and would work with her during every visit on years following. When my dissertation began to truly take shape and I focused in on TBA’s, Yoda became my mentor, or sometimes more like my guide. She took me all around and casually introduced me between boisterous greetings, long speeches about nutrition, and expressions of faith and gratitude. I watched her speak with rural families as well as district officials. I saw her singlehandedly discretely “acquire” enough de-worming tablets for 20 schools and then ride out in a dust cloud to distribute, and I stood in shock as she, standing around 4’11” carried a teenage boy having convulsions into an ambulance. She was, by all measures, a badass.
I also sat in on many of Yoda’s consultations, check-up’s, and some deliveries with women. She had a stern, direct, and yet very tender manner, and she was always sure, about everything. Yoda is renowned for her delivery skills, her professionalism, and her reputation as the "emergency TBA," capable of handling dire situations with poise. On a visit in 2014, I sat with Yoda on what was a rare scheduled interviewed. I had wanted to talk formally about she felt about her profession and the future of her practice, which was feeling more and more against the grains of “progress,” and which had in fact become outlawed by that time. The timing was terrible, because Yoda had delivered a baby late the night before and was feeling tired. She was behind on some things in the “garden,” meaning her small farm, but insisted that we talk because she wanted tea, but after tea she would need to go. Her attitude was different on this day. Maybe because of sleep deprivation but I also suspected that the delivery the previous night had been stressful. Yoda mentioned a few times that she was glad she brought her own gloves, so I had the thought that the mother may have been HIV +. She also knew what the topic of our conversation was to be that day. TBA’s were banned from practicing at this time in Uganda, and Yoda knew we were discussing her outlawed line of work. I was familiar enough with her work that we could get right to the point. I began by asking Yoda how she felt about the next generation of village midwives.

She wrinkled her forehead – something that she did often, but this was more than usual. I had grown to know her annoyed face well, and I was being pesky. She put her hand up for me to stop, and sighed a troublesome sigh, and it was at this time that the polite, hospitable, and extremely accommodating pleasantries fell away. She looked at
me and in that stern, pissed off voice that she uses with stubborn patients or community members unreceptive to health care, she leveled with me. She asked if the TBA services are on the way out, her country is increasingly moving toward modern medicine, and my home is one with incredible, life-saving technologies, then what the hell am I doing in Uganda?!

She said basically that my project seemed futile and she spoke dismayed about the fate of the TBA as doomed. She was being honest but also genuinely confused: “Why does anyone need to know this stuff? We are doing it the hard way out here.” I was used to explaining my meddling, but that ethnographic spiel about honoring traditional perspectives and proficiency seemed undue. I found myself switched from anthropologist to concerned citizen as I proceeded to explain my own frustrations with the bureaucracies that I have seen in place in Uganda. We eagerly agreed on the misfires and the gaps to health care. She asked if it was much better in America, and I explained all of the ways that our system of medicine in the US is not what she might expect. I described hospital births, anesthesia, costs, the business of pharmaceuticals, and all of the technologically alienating forces that go into a c-section, for instance. She was appalled.

For the next two hours, the woman who had been my research muse, who had consistently left me wanting more information and feeling rather silly for asking the simple questions that I do, was finally giving in. We sat and mutually professed about how each of us participates in systems of medicine that desperately need the resources of the other. I had access to clean, stocked, high-tech and fully functioning health centers and hospitals that in the eyes of most Ugandans are equated to life-saving services,
treatment, and even survival. Yet, I was criticizing structures of medicine that could save probably anyone suffering in the village where we were. I was instantly aware of the irony, ignorance, and privilege in my comments, but this wise woman looked at me disheartened and said, "You people have all the advances and the resources. It may not look good for us sometimes, but at least we take care of each other." My analysis of biomedicine and the candid criticisms of each of our health systems offered the most poignant ethnographic moment in my research that brought Yoda and I to the same page. How is such a simple human concept as care absent from so much of what we do? And how is it that Westerners preach, teach, and regulate health care in Uganda without accounting for its crucial connectivity or taking proper care of people at home?

The TBA’s work is not perfect. It is un-resourced, provisional and more and more contingent on support efforts. This work is often dangerous and sometimes begrudged, but the strength of this care is in the connectivity between the provider and the community. Yoda and other traditional birth attendants in Uganda are witnessing the strains of development and the tensions with change and pragmatics. Yoda’s health practice is obligatory and now illicit, but her mode of treatment is personal, which I argue is the element most critical to medicine and most absent from biomedicine, especially when it is clunkily emplaced. As Yoda and her colleagues shoulder responsibilities for rural obstetrics and face the restricting of their social roles, I look at responsibility and relationality and how care policy can benefit form genuine mutuality.

~
The issue with Western medical development in Uganda is that it tries to emplace careless health care in a care-filled place.

I began this project focused on the traditional birth attendant because of her expertise, cultural nuances in birthing and care practices, and her active role in community remediation. I was interested in how and why people provide care in difficult or dangerous situations with strained resources, but what I found was a prosaic sense of duty and interpersonal engagement that actively responds to others. I found in the care provided by traditional birth attendants (TBA’s) vibrant connectivity that makes up a kind of relationality. This connected sense of caring became the focus of the present work, wherein I argue that care’s entanglements inform the effectiveness of locally rooted sources of health services. TBA’s are primary providers whose work actively adapts to inadequate health centers, forsaken clinical infrastructures, violence and corruption, and unsustainable medical aid. They oversee communities and are liable for the health of generations. I argue that the work of these practitioners showcases the ways in which everyday care, 1) de-centers mega structures of biomedicine; 2) sustains lives through culturally accepted and thus enduring health-tending; 3) reveals critical humanism that medicine, as a global entity, often fails to account for.

TBA’s are an essential resource for women in rural villages. They are embedded in the communities that they serve and therefore have exceptional authority, therefore are the mobilizers of all manner of health reform and implementation. For these reasons, TBA’s are knowledge brokers in local care networks and inform institutions, perceptions, and reception of health care. My work documents the medical ideologies of these
practitioners and I study the kinds of care exchanged as well as the generative nature of this care and the bases for impactful health resources. I use care as the lens for understanding public health and networks of health resources, and document the fundamental role that TBA’s have in care systems. I examine the ways in which care techniques and networks weave into daily life, from medical perspectives to health care preferences to beliefs and practices, and with changes in the health landscape in Uganda, I study the compulsion to care in order to see the effects of obligatory and duty-based care. As the face of local health care and a decisive broker of care knowledge in the region, I look to TBA’s, to illustrate care praxes and ideologies. I investigate how relationships are formed and maintained via care exchange, and I record how care experiences entangle in order to draw out and recognize local care praxes.

**Relational care**

In looking at these services for women’s and community health, I found that TBA’s are effective because of their connective accountability, and I make the case for care as that ultimately sustains life and builds and supports community as a basis for health policy. Critical yet ordinary care practices are immediate and rely on personal investment as opposed to reparation. I consider care’s contingencies in terms of sentimentality and praxis as well as the cultural politics and inter-relationality of care. I document the health heritage of the Southwest region of Uganda and ask what the outcomes are of minimalistic forms of care. I consider care that may be at the expense of development and ask what the tensions are between localized and foreign-imposed care. I ultimately make
the case that it is invaluable to document and honor the care practices that make up everyday maintenance, namely from TBA’s, in a place with legacies of medical aid collapse and medical testing grounds. It is imperative to see the ways in which development has impacted the landscape of medicine in Uganda in order to see not only what the effects are of remotely-intervened care, but also the health operatives that maintain despite aid work that either diminishes or looks to replace consistent, stable traditional medicine.

A local institute of health…

TBA’s serve their communities in deeply impactful ways and contribute greatly to health practices and health ideologies in the area. It is important to note the sociality of care and the networks of reciprocal care and shared health in Uganda and to account for the collective senses of wellbeing, which not only insight care but should inform health programs in the region. I explore how social elements and processes are tied to health and the ways in which the TBA manages life events, particularly in regards to women’s health. This dissertation defends the impact and support of the traditional birth attendant in the face of increasing governmental management that threatens her service. Not only are TBA’s in Uganda the keys to aid projects, but with their community regard and skill sets, they are a principal health resource in the region.

The present research follows the TBA and her contributions to maternal and women’s health as well as other details of women’s lives. TBA’s mentor women through the processes of becoming a mother, coach her through the challenges of family, and
provide psychological and emotional support. As authorities on women’s health, the influence of TBA’s knowledge and practice is pervasive in ideologies and processes of care. The ways in which TBA’s support and manage women’s health give them the cultural capital to resituate gender parity. She is the casual activist who validates women’s concerns, endorses her choices, and risks her own safety to serve this mission, and so I look at the sway and the reach that these women have in women’s empowerment through health, and I consider various efforts to regulate and bolster TBA’s which I argue have failed because they have divided her medical and care treatments.

... on the global health stage.

TBA’s are health gatekeepers in development projects. They have interceded aid and outreach for decades, and their participation in such agendas, I argue, has at least held a position for rural African women in global health discourse though their voices were undoubtedly stifled. Wider discourse on TBA’s notes the historical participation of the TBA in health development and aid strategies throughout Africa and other colonized, under-resourced regions of the world. This role has been out of necessity and on the part of international aid for reaching rural and disenfranchised areas, and has largely been along the lines of the goals of those in power. This dissertation considers this legacy of the TBA as a liaison and the vital impact that she has had with sensitizing and translating public health programs, initiating rural participation in global health, and filtering medical mega-strictures. I consider how this harnessing of the knowledge and skills of
the TBA has been gratuitous at times and disingenuous often, but I show that TBA’s have steadily worked around and despite flailing public health agendas.

TBA’s have been active agents in public health campaigns and development as well as in mobilization efforts on the ground. I argue that this connective role from local communities to global entities has informed policy, but also allows the TBA to inform women – of health information and available resources. These providers have been consultants representing the village woman in international policy while ensuring women’s rights to health locally, so TBA’s have become a voice for village women on national and district levels. They have been community strongholds serving women’s needs and helping women to navigate health challenges. In this way, TBA’s are advocates for women that may not only connect them with development projects, but possibly protect them from the effects of misinformed public health strategies. TBA’s speak and advocate for women on local and global platforms and they represent a sector of empowered, capable, and attentive traditional providers that are both privy to the intimacy of women’s experiences as well as abreast of community health and the barriers to such.

I draw out and analyze the vital, vocal role of the TBA in health discourse, and show how the TBA’s knowledge and skills combat risk in the area. I argue that her advocacy is interpersonal and bound to sentiments of liability and responsibility, and I look at the ways in which health intercessions either bolster or diminish that. TBA’s are the link from health policy, agendas, and programs, to communities, but what is critical to consider is how the TBA is an advocate for communities on global stages as well as how
that could be cultivated further to benefit women’s health. My research evolved when I began to focus on TBA’s as promoters of health and advocates for women’s sexual and reproductive rights. I started to see the immense impact that TBA’s have on everyday foundations of health, and that TBA’s comprise the connectivity of health services in Uganda. But what stood out in these discoveries was how little support TBA’s have in doing so, yet how much responsibility they shoulder. Then, when their services became illegal, I saw a blatant disregard for this health resource and a severing of that connection to policy and health programming. I explore the confusion and irony, and the danger, of outlawing this community foundation.

The ban on traditional birth attendants

The Ugandan government has undertaken various efforts to train, incorporate, and certify these “informal” providers to fit into models of Western medicine. Then, in 2010, the government’s Ministry of Health, along with several other Sub-Saharan African nations, banned TBA services, largely due to pressure from international health agencies to address increasingly staggering rates of maternal mortality and infectious disease. World health entities have waxed and waned in their support for the training and regulating of TBA’s, from providing funding to train and organize, to now recommending that all “unskilled,” (traditionally trained), providers refer patients to the formal health sector for treatment. This projects looks at what this fractured relationship with international aid does to local care and how TBA’s tap in and out of public health discourse in order to provide optimal care in their communities.
These groups of mostly older generations of women are medical professionals and cultural purveyors in global health initiatives, yet their practice was outlawed. This government mandate leaves significant uncertainty for the fate of obstetrics in Ugandan villages. My findings show that women consistently prefer the TBA because of her methodologies and attention to local birthing customs and, importantly - the investment and quality of care that she provides. The techniques, procedures, and expressions of care are the lenses through which I explore medical treatment in a range of Ugandan maternal health sites while asking how these practices will continue, change, or fade away. I investigate health policy and the genealogies of health intercessions in order to translate the cultural implications of the ban, and I argue that outlawing TBA practice is significant because this threatens women’s health advocates, and leaves TBA’s a) burdened with dangerous and illegal obligations, and b) barred from medical authority.

TBA’s continue to practice regularly out of necessity and because the community calls for it. Women especially depend on the TBA, which puts her in a position of risky responsibility because not only is she unsupported in her health service, but her work is now criminalized. The obligatory and dangerous work that rural birth attendants provide prompts conversations on duty and care, and the now illegal nature of their work invites discourse on risks to care providers. The ban on TBA’s is an example of a misfired attempt to regulate and develop health, because it ignores the systems in place currently as well as the cultural praxes. Women’s preference for TBA’s speaks to the power of localized knowledge and cultural competency as well as the barriers to the sparse government-funded clinical spaces. I argue that the TBA ban threatens not only women’s
safe deliveries and birthing customs, but also women’s health advocates of the region. I further show how bureaucratic health decisions burden impoverished African practitioners with blame for failing health campaigns, dangerous duties to care for communities without resources and supplies, and illegal obligations to provide in the absence of other infrastructure.

Through indigenous and feminist epistemologies, I show the TBA’s enduring position in models of care despite forbidden futures of her practice. TBA’s continue to be stakeholders and gatekeepers, because they are symbols of tradition and because they have access to the complex, nuanced, and personal lives of community members, making them an informed organization. The TBA issue is perhaps more hotly debated in the literature and in global health summits than it is on the ground. Statistics on maternal mortality incite incredible controversy, as the TBA is a marker of the frictions between the specific and the universal in women’s health, yet she continues to inform constructions of health. I show how this ban further incites disparate medical systems and has the potential to further silence women.

*All the while, the TBA is delivering babies...*

**Bringing health care frictions into focus**

The ban on TBA’s draws out and spotlights some of the deeper issues of health care in Uganda and acts as a conduit in this dissertation for understanding the fissures between health policy and lived realities in Uganda. Though some statistical data exists on rates of
maternal mortality in the years following the ban outlawing TBA services in Uganda, there is no comprehensive qualitative study of on-the-ground outcomes. And though much literature exists on maternal mortality and care provided to village communities, no such work exists that focuses on the recent ban of TBA’s in regards to how this affects women’s health and essentially endangers local medical systems. I show how the decision to outlaw TBA practices emplaces risks not only on safe delivery practices, but also on local health curriculum.

The ban pulls out the issue of health justice as women’s health access is made more limited through these regulations. It also displays an utter disregard for preference and local lifeways. With decreased emphasis on TBA platforms, officials may begin to see how much communities rely on TBA’s as well as how imperative they have been for rendering health policy’s pragmatism. The issue with blunt health policy from afar and in sweeping movements is that, over time, it strips the local practices of their effectiveness, or their very existence. In the case of the ban on TBA’s, resources are taken away and not replaced and the role of TBA is strained of its power and ability. This ban makes it obvious that health care is not set in women-based, women-serving, or women-informed agendas. It also brings to light the incongruencies and ill-fitting management of women in clinical domains of Uganda.

The ban, I argue, is an act against indigenous knowledge and local systems of care as well as a step in the wrong direction for health equity. I will consider some transitions within village communities, as set out by the Ministry of Health (MoH), that both strip the TBA of her power while simultaneously summoning her health outreach abilities. The
ban is an example of the ways in which biomedicine, and Western philosophies of medicine generally, separate and distinguish between medicine and care support services, which is not only inappropriate in the communal care context of Uganda, it also shows how medicine goes astray and the mission of restoring humanity and building community gets lost, muddled, or ignored.

**The detachment of TBA’s from health discourse and impacts for women’s rights**

Incidentally, the ban sort-of formalizes TBA’s as advocates in their community outreach roles, but importantly this disconnects the TBA from her role in international health. It is both symbolically and pragmatically injurious and unjust to cut the TBA out of health discourse given that she has been a representative for women. I argue that TBA’s are caste out of medicine because of imperialist agendas that privilege Western science and dismiss local perspectives and praxes. Traditional medicine is often overpowered and dismantled in missions of development and conquest, and the clinical infrastructures that replaced them have caused devastating consequences of sustainability and corruption.

The ban and the forbidding of TBA’s services further contribute to the complicated web of liability, blame, and dependence for TBA’s. These accessible health resources have been posed as unruly and wrong, when in reality they are underfunded, ignored, and repeatedly dismantled. I explore women’s health experiences through the inter-relational dynamics with TBA’s and I argue that removal of TBA’s from health repertoire take from women immense histories of support, current labor and solidarity, and future potential for empowerment. Furthermore, it reifies cycles of shame and burden
that Ugandan women have endured and further entrenches African women’s bodies in powered structures of supervision and regulation.

With the transitions currently underway, communities are at risk of losing the TBA who has carried the power to address intervention with care. TBA’s have been able to infuse, albeit slightly perhaps, local understandings into policy, discourse, and agendas that may otherwise misfire or cause harm. Filling tremendous gaps, TBA’s have held significant responsibility and have defended women’s rights to health. I demonstrate the ways in which current reforms discount the connective power and care that TBA’s have constructed. I will not argue that TBA’s work is perfect or that health reform was undue, but I do show how the kind of partial and misdirected policies such as the ban on TBA’s threatens women’s health rights by oppressing and dismantling women’s health resources and ignoring deeper issues of health infrastructure in Uganda.

The ban on women-based health services risks snatching away womanist perspectives in health intervention and severely stunts the advocacy platform for TBA’s by impeding upon or inhibiting TBA’s hands-on abilities, but more importantly by separating their medical treatment from community service. This threatens women’s health and thusly women’s rights, progress, and advancement. The ban on TBA’s is an issue of health justice, because it silences women’s advocates and forces women to seek care from unreliable, corrupt, or nonfunctioning clinical sources set forth by the government. Structures of medicine are simply not in place in Uganda, so for the ban to recommend that women seek care from clinics that are empty, absent, or noncompliant with local standards is an act of violence. Such a sanction on care is an example of
feigned, misplaced, and offensive politics that ignores women’s experience in favor of bureaucratic standards that confounds health care by dismissing local women’s knowledge and disempowering the primary source of women’s health in Uganda.

I consider historical and contemporary health rhetoric and describe the effects of neo-colonial frameworks of women as well as depictions of health. And I show the tensions between the care found in social connectivity and the promise of care in agendas emplaced from afar. Importantly, I put forth that development and progress issues lay not in the structures themselves or in the people, but in the relations, connections, and interchanges between those constituents. For these reasons, I argue that health and advocacy belong together and that health intervention should be innately activist.

**Care as a mode of action**

Relationships are the social tendons of care, and I suggest an understanding of care as based in mutuality through understanding and responsibility. Care is best when collaborative, and an enlivened version of care means a departure from bare life ontologies, which I argue ultimately are acts of violence. I suggest that a palpable sense of thriving or wholeness is animated by a response to the multiplicity of the human condition and that understandings of health need more textured accounts of bodies and the lived experiences of community members, so emotional, fleshy dialogue is imperative. I suggest that agendas of intervention consider the messy, everyday processes of care and their leakages, or the “cruddy” sores of humanity (Povinelli, 2011) addressed through rough and risky kinds of care as well as the agony or triumph of true care, the
sense of which I consider herein. Policy that recognizes and understands the array of factors influencing women’s lives, from interpersonal to ecological, is imperative for genuine care that people trust and participate in.

Forms of connectivity help to recognize and put forth genuine care systematically. Medicine deserves care-based recognition and relational exchange. I argue that not only is this ethical and sovereign, it is essential for effective collaboration. I offer my interpretation of the complicated transitions happening in women’s health and emphasize women’s preference and barriers within clinical spaces in order to highlight the real impact of incongruent health ideologies. I show how local knowledge is a means of, or opportunity for embodied understandings that spur interconnectivity. And I argue that interventions must account for structural and systemic health as well as ontological disparities in order to reach sustainable solutions.

Studying the TBA offered me understandings of the more broad ways in which Ugandans are confronting conflicting ideals about contemporary change and development. Policies do not consider the myriad factors of women’s experiences and challenges nor how these influence health, yet surface solutions are being posed to intervene in women’s care. Uganda’s health officials continue to promote the formal health sector for obstetrics care, despite dissimilar and even conflicting cultural rites and rampant abuse and barriers in clinical services. I show that TBA’s are visionary in their progressive and adaptive methodologies and I argue that these women are imperative to global empowerment because they share experiences with rural women in real time yet have knowledge of the inner workings of health agendas. TBA’s are morally and socially
bound to community health efforts and this ethical attachment is reflected in the care that they provide. This kind of investment in others is the connectivity that I propose is harnessed in health policy.

**Care is the crux: The TBA’s health advocacy**

So, care is the crux of this work. And the connective and relational care that I consider by way of the TBA is inherently an act of advocacy for its ability to ease the oppressions that restrict women’s health rights. I make the case that TBA’s are advocates that help to alleviate the domination and brute policies of neo-colonial agendas and thereby they help to disallow the righteousness of confining and harmful policies. The TBA’s advocacy is critical and based in a kind of connective, collective care. TBA’s have protected women from dangerous events and illnesses as well as from harmful aid. Their work is a feminist project for the health and safety it provides for women. The present work shows how TBA’s, in their very service, act against racist, sexist structures and agendas in Uganda. I re-frame notions of risk and responsibility in order to show how the global standards of medicine can do a disservice to rural communities and I demonstrate the ways in which TBA’s are an antithesis to experiences such as shame for women.

The historical forbidding of female experts and knowledge brokers, precisely as what we see with the ban, has undermined, de-centered, and diluted the work of women. Care provided by TBA’s and other local medical experts deserves recognition as labor and as a medical service, and the benefits that go along with that. TBA’s work against the bureaucratic displacement of women in Uganda and their care is made subordinate by
mega-medicine. So, with these pulls in mind, I frame the TBA’s praxes as women-centered, woman-serving and essentially restoring communities of women, including from damages caused by public health intercessions such as this anti-women ban. The work of the TBA – both in her providing to mothers as well as in her participation in health outreach and programming, is a means of health support. TBA’s contribute to the dispossession of women by their actions which undo prescriptive, medicalized understandings of women’s bodies and ungrip women from control and disempowerment. I argue that policies must account for systemic disparities in order to reach sustainable solutions and invest in relational care. There must be local women’s representation in any bureaucratic procedures that affect women’s health, and that includes accounting for women’s experiences. In order to understand the complexity of women’s lives, health officials have to honor the authority of local figures of power and that means acknowledging that village women have and deserve power! This dissertation claims that women’s health advocacy is a route to women’s empowerment and poses the question of how to harness the connective care of the TBA rather than diminish it.

BACKGROUND AND HISTORICAL CONTEXT

In rural Uganda, among the bright green *matoke* plantations and red, clay-like soil, are ubiquitous messages of health campaigns from an array of aid programs or come-and-gone community outreach efforts with painted slogans in fading paint. Medicine and progress go hand in hand and these optimistic techno-rich aesthetics make up an ideal or a façade for medicine in Uganda. These are powerful discourses that represent
development and good morals, but they also represent modernity and change and a movement out of the bush and into the imagined global cityscape. Medical research and practice brings a constant flow of foreigners to Uganda, funded by well-meaning institutions whose selfless purpose is to improve health access. Aid projects often do great things and provide opportunities for those who are mentored or trained to carry out health missions locally, but they also have lasting effects on those local health systems. The treatise of medical aid in Uganda can be bombastic, self-righteous, and quite vacant as is evidenced in the poster-strewn shells of the health clinics or the peeling HIV prevention billboards or in the five kilometers of space between the woman in labor and the maternity ward of the referral hospital. The steady, difficult yet simple commitment of the TBA, on the other hand can be observed in her boiled and reused latex gloves that she makes to last as she is helping a woman deliver at 2am by the light of an oil lamp.

Though there is some unrest and strong memory presence of Joseph Kony’s terror in the North, Uganda is a cheerful place where cultures of civil service and other Christian-based values permeate. Mbarara, the region where my field work was conducted, is approximately 120 kilometers West of the capital of Kampala and situated in the hilly southwest corner of the country that enjoys the relative advantages of good roads (thanks to the President who is from the area), and a fair agriculture-based livelihood. Everywhere there are signs that encourage right-doing, allegiance to missionized ideologies of monogamous relationships, kindness to neighbors, and hygienic practices that keep one safe, healthy, and in good standing with God. There is no shortage of work being done in Uganda on health and medicine. The country is known in
the global health world for being a friendly atmosphere for foreigners who wish to participate in African cultures. Uganda is politically calm and it is small enough to travel through, and there is plenty of work to be done in terms of access and quality of health care.

![Image of Government Health Center](image)

*Figure 1: Intake area of Government Health Center - photo by author*

Uganda has survived an AIDS crisis, genocide, and terror, but today maternal health is one of the most pressing problems, namely for women in rural villages who suffer from otherwise very curable issues. The World Health Organization (WHO) reports that 435 in 100,000 women die in childbirth, mostly from hemorrhage, ranking Uganda as one of the most at-risk nations in terms of maternal and infant mortality. Such mortality rates compare with neighboring African nations, which are high among the list of priorities for global health entities like WHO. This is a compounded and incredibly
difficult issue that requires all hands on deck, but in general low-status women experience obstetrics problems at higher rates than more-resourced women, because of overall poor health, nutrition, disease, tenuous labor, and limited access. Uganda also has one of the highest fertility rates and the demands on women in the region are widely recognized. International aid and development efforts are vast in the region, but there is yet to be notable progress in the way of sustainable health solutions.

Figure 2: Maternity Ward of Government Health Center - photo by author

Health care after independence in 1962, introduced efforts to mandate resources a lot of the early medical research was in competition with community development at a source level. Fissures in the reach and implementation of public health began in the early post-colonial eras in Uganda. The 1960’s were times of stability and affluence for health services in Uganda, but the 1971 Idi Amin takeover introduced destruction, fleeing health
workers, and abandoned facilities (Adome, Whyte, and Hardon, 1996). Some of the hostile leaders such as Amin and Kony have targeted health care services directly as a way of affecting suffering among Ugandans. The National Resistant Movement of 1986 restored some sense of control and succeeded in distribution of a drug supply, but this was not enough to recover (Adome, Whyte, and Hardon, 1996). After decades of teeter-tottering control of health infrastructure, district-run facilities are now managed by the local Ministry of Health, a state-run branch of government with a base in Kampala and appointed officials in every district.

![Figure 3: Government Health Center facilities – photos by author](image)

The formal health sector in Uganda includes district hospitals, sometimes as far as 200 kilometers away from remote villages, and sparse government-sponsored health clinics, which are severely under-staffed and under-stocked. One health worker trained in
either nursing or community health, most likely at Mbarara training hospital, frequently runs these. She usually has some basic supplies like a scale and some pain medicine, and refers to district hospitals for anything serious, but there is nothing in the way of transportation to these facilities. Health workers, unless they are specialists, are not prepared, equipped, or trained to deal with medical emergencies or childbirth, but some of the larger Health Centers (HC’s) have nurse midwives and maternity wards. The clinics are typically associated with some past or present foreign aid efforts, volunteer medical care, or community health campaign and show the wear and tear and the growth lines of resources poured in and then pulled completely. There are jagged edges to the health landscape here as waves of intervention have come in and retreated, often washing over local procedures by changing, canceling, or negating them while in operation. The horrendous cycle of development includes bolstering from local resources, who are left to do recovery and clean up when foreign entitles fail or disappear. The difficulties of sustainable development have become a mark of our times, and in Uganda it comes down to tools and facilities for health services.

Textures of medicine and the medical landscape

Concrete block shells adorned with health posters are reminders of what was once an outpatient or maternity ward, but due to lack of funding and trained health workers have faded. Local providers, known as THP’s (traditional health practitioners), make up the informal health sector and provide the majority of health care in rural areas, and unfortunately the extent to which the government supports THP’s in formal policy is in
requiring them to refer to health centers and hospitals. Generations of policy makers and scholars have debated the efficacy and ethics of indigenous and international solutions in colonized Africa, but today the Ministry of Health, as informed by rhetoric from global health agencies, recommends that community members strictly use facilities with “skilled,” and “trained,” providers. The frustrating cycle of referral and deferral comes when district health campaigns encourage people to make use of the health centers (the alternatives being either ignoring problems, using the family’s money to get to hospital, or relying on traditional practitioners), and they visit the HC only to find it empty or being used for community meeting. Because Uganda has deep history of perpetually diminishing health installations and forsaken infrastructures, the tension is in whether health crises directly lead to or are replaced with crises of sustainability.

![Newly Constructed Health Center IV - photo by author](image)

Health clinics and hospitals are thresholds of Western, Christian, biomedical practices and value systems. In fact, biomedicine is fairly synonymous with what a
Ugandan would refer to as *muzungu*, meaning foreigner, but more specifically white, which is an indication of opportunity, wealth, power, development, and wellbeing, but also of security, goodness, or honesty and these moral modes are wrapped up in medical ideology. Some people told me that Ugandans who go to school to study medicine are merely carrying out the orders of foreign missions, a neo-colonial attachment to consider in terms of medical pluralism in the area. I found that biomedicine, as an entity, is praised and sought after for the “quickness,” “ability to cure,” “measured medicines,” “injections and tablets,” and associations with advanced technologies and “potent medicine that is made in labs,” as one participant stated. Ugandans strictly distinguish between Western medicines and local medicine and the practices around each are totally distinct in terms access, distribution, usage, source, content, perceptions, and personal associations.

In my research, almost across the board, the supplies, drugs, and facilities of biomedicine were ranked high in the list of preferred medical treatments, however, the care and treatment of local practitioners was almost always ranked above all else. It is the *care* itself that sets apart local practitioners and makes their services indispensible. This is, of course, in addition to cultural literacy, local trust and social networks, and simple availability. In early stages of this research, more than any other provider, traditional birth attendants were commended for not only services but also for the role that they carry out in the community. They were ranked highest among community members for community members’ likelihood to utilize/have utilized their services, satisfaction with the care that was provided, and the degree to which TBA’s have influence over participants’ lives and the health of themselves and their families. TBA’s remain the only
viable option for many women in the world because of low cost, privacy and care, to name a few reasons.

**Traditional birth attendants in Uganda**

Traditional birth attendants provide routine as well as critical emergency treatments that make up the majority of services comprising maternal health in rural Uganda. The World Health Organization estimates that TBA’s assist in 95% of all rural births in developing nations (Kasilo, et al, 2010). A district health official cited that 80% of women seek services of TBA’s in Uganda. Most reports cite these practitioners as an inexpensive solution, the value of which has been exercised and evaluated for half a century by foreign efforts. Locally, TBA’s are well known and well regarded traditional practitioners whose local presence has been celebrated and sought after for their grandmother/neighbor reputation. It is not uncommon for a TBA to have delivered four generations in one family (Kityo, 2013). TBA’s comprise a viable profession wherein they use their own labor experiences (as women and mothers) and generations of oral traditions to go through the birthing processes along with women (Langwick 2011). Many have given birth themselves, gaining first-hand experience, while others undertake lengthy apprenticeships with community midwives or other TBA’s.

Based on their own memory, TBA’s with whom I work have delivered sometimes over 1,000 babies. In interviews, most TBA’s explain that they simply became the go-to, by nomination, organically, rather than seeking out the profession. Mainly, TBA’s operate out of necessity and they are the only option for most rural Ugandan women.
TBA’s, like most rural Ugandans, live in impoverished settings. They operate with no technologies to speak of and they seldom have access to simple supplies like latex gloves. They rely on manual labor and folk knowledge and they constantly are met with incredible obligations and dire decisions, namely when to transport women to health facilities and when to attempt to deal with complications on their own.

There are varying categories and levels of TBA’s; some are an elder family member who has assisted in deliveries of friends, neighbors, or relatives, and who has adopted the informal title of TBA, whereas others have been taught through a particular program by another TBA, often a mother or grandmother; while still others seek out the profession and have been trained by one of the many training programs of the past, most organized by district health centers or by NGO’s. Many TBA’s have attended at least some degree of training or education from national and international entities, and there has been a steady, if unrealized, effort to harness the knowledge of the TBA. There are some claims that distance and logistics alone force women to seek care from TBA’s out of default (Kiguli, et al), but I argue that it is a cultural preference and a choice that speaks to aligning ideologies as well as trust. TBA, as a category, is simply a community-recognized authority with no formal certificate but with significant authority and respect. TBA’s are often well versed in local herbs and remedies, in addition to traditional ways of conceiving, preventing or terminating pregnancy, and securing newborn health and safety in addition to a range of other health issues. TBA’s are a social service and work with families to optimize health, counseling women on everything from mother-in-law
troubles to irregular bleeding. TBA’s often reach out to people during difficult or important times, and they are abreast of inter-personal happenings within a community.

TBA’s operate where there are no other options, and because of their abilities to bridge gaps between community and public health Uganda’s “informal” health sphere is often posed as standing in for or making up for stolen and depleted resources, shattered infrastructure, corruption, insufficient professionally trained health care personnel, and other gaps in the biomedical register. But the reality is that the informal health sector is health care for most rural community members. I argue that TBA’s create connectivity between the fissures in medical systems rather than simply play substitute as it is often framed. Biomedical interventions wax and wane alongside these local medical sources and occasionally sustain or influence local practices to varying degrees. Remaining steadfast after waves of aid, the TBA’s still uphold responsibility for rural delivery services, maternal health, and community health more broadly. Day in and day out, they remain central to women’s health, even if in a supporting role. The TBA’s seem almost immune to the corruptibility and unsustainability of foreign aid as they provide critical and risky work as well as delegate women’s rights to health within aid agendas.

The ban outlawing TBA’s

In 2010, the Ugandan government officially declared the work of unskilled or untrained rural traditional birth attendants illegal. Though this ban did not emerge in popular discourse until after 2012, TBA’s were made aware of it mostly through radio campaigns, a source of local news and gossip in the countryside. This decision is due largely to
pressure from international health agencies to address increasingly staggering rates of maternal mortality and infectious disease and was part of a larger movement set in motion by the United Nations. All over Africa, governments were discussing healthcare for pregnant women and children under 5 years in the rush to meet two of the United Nation's Millennium Development Goals (MDG), which were set in 2000 as an agenda for the world’s poorest. These goals, eight in total, were a blueprint for nations to galvanize efforts to meet the needs of their populations by 2015. Number four on that list was decreased infant mortality and maternal health was number five.

Figure 5: United Nations Development Goals for 2015

Though the ban is difficult to impose in remote villages, the law forbids the funding, managing, or training of TBA’s, which presents communities with dangerous issues of standardized care and practitioner liability. TBA’s are the primary source of health care for most rural women, providing everything from family planning to prenatal care to counseling for pregnancy loss. Women rely on TBA’s and often have no access to
the formal health care sector. Additionally, a range of cultural and social factors act as barriers that prevent quality care in clinics and hospitals, including rampant abuse on the part of overworked, underpaid health workers and incongruent handling of significant bio-matter, such as the placenta.

At the onset of the ban, health officials in Uganda instructed TBA’s to refer women to modern facilities and to adopt a policy of referral, meaning that they could hear people’s issues and tell them to seek medical care from a biomedical site, namely clinics and hospitals. This is, in no way, new to regulations of the TBA. As early as 1992, the WHO decided that if TBA’s were going to contribute to safe motherhood, it would be through their integration into “modern health,” and thus they were deemed, “link workers,” meaning they are a vehicle to maternal health and not a viable solution (Sibley and Sipe, 2006: 473). Today one of the main responsibilities of the TBA remains to refer mothers to clinics for antenatal care and hospitals for emergency obstetrics care. Studies indicate that the training modules which incorporate this model have led to increases in use of antenatal services, which speaks to the influence of the TBA, but the referral system itself is tricky and multi-faceted, mostly because those facilities are not always prepared and because the communication between traditional health practitioners (THP’s) and biomedical health practitioners (BHP’s) are not congruent or fluid (Sibley and Sipe, 2006).

The government cites the simple claim that TBA’s do not “help to reduce mortality rates in the country,” and so their services are not needed. To this rhetoric, officials claim that TBA’s deter women from using skilled clinical services and are a
“barrier,” to medical help as they “capture the patient in her home and make it unnecessary for her to travel to a hospital,” (Personal Interview). Moreover, health campaigns sometimes shun the “unsafe,” and “unhygienic,” work that traditional practitioners of all kinds offer. Some community health outreach has associated traditional practitioners with the spread of contagious diseases, which they do through connotations of the TBA as backward or a strain on modern development. One radio announcement that I heard tell women that their kids “Do not want to suffer in ways of the past,” and explains that TBA’s are what their grandmothers did but now contemporary medicine is available to offer them the best for their families. I heard this announcement while we sat in an unlit hut and a community member tended to a kid with the “flu.” TBA’s in my project are fully aware of their sometimes inadequate facilities and list training, tools and space, and updated methods and skills as the things that they most need in order to improve.

Up to now, the government has been tolerant of, and sometimes dependent on traditional practitioners. Many attempts thus far on the part of community health and foreign aid seem to fall in one of two categories – either to train and certify TBA’s to deal with complications or to ignore the local health sphere and require women to visit clinical facilities. The direction of the ban clearly follows the latter option. This split reinforces the didactic nature of the biomedical-traditional divide and highlights the duality of health options in Uganda. But what this divide does not do is help to fill in the many larger gaps in the medical system that do or do not bridge these systems. Moreover, the

1 Flu is a general term for cold-like symptoms and general ill health that is common within communities with water-born and air-born bacteria, with open cooking fires indoors, and with probably malnutrition.
ban shrouds women’s health in uncertainty and creates a vague regulation that may actually make the TBA’s practice more dangerous and difficult, especially in regards to protections for TBA’s in the critical services that they provide. Conversely, this dismissal of TBA’s in health policy means that there is also no protection from unskilled or mal-practicing TBA’s and no national authority to regulate or ensure patient health (Kyomugisha, 2008). Importantly, the government does not distinguish between the two.

**Documenting the effects of the policy…**

I was doing research on TBA’s before the ban, and many people actually did not realize that the policy was in place until around 2012, and though I did not focus on legality, I did try to account for reactions and changes. TBA’s did present a switch in their reception to my work and to my presence after the ban became a popularly known piece of jurisdiction. What stands out most from these conversations are women’s declarations of obligation. Commonly, TBA’s insist that even if they try and retire or refer or even refuse to treat women, that they are faced with duties to save and sustain the lives of their friends, neighbors, and family members. One senior TBA, Yolanda, explains, “Women come to me in the night, they are paining, they are in labor, the baby needs to come, What will I do? Leave her to die at my doorstep?” Yolanda’s sentiment is echoed by many of the TBA’s in my study. Sometimes, women are handling delivery on their own, but they need support, and therefore TBA’s feel comfortable in this hands-off approach. Other times, there are serious concerns. The relatives of delivering women appear at the TBA’s home and insist that they come quick- there is a baby crowning or someone’s water has
“flooded the yard.” The consensus is that TBA’s are necessary and so embedded in the fabric of delivery services that they themselves find it difficult to remove themselves from women’s care provisions.

Now operating as renegade maternal health providers, these women, mostly over the age of 60 and many closer to 80 or 90, seem somewhat relieved, in a way. They say that they are tired and they, themselves, fear the new generation of HIV. That being said, they explain that their duties as TBA’s and as village community health providers are foremost to their identities, to their everyday concerns, and to their roles as leaders and community members. For the most part, TBA’s have not changed their practice because they continue to face the need for their services, except now they do so knowing that they are not supported in their efforts and increasingly adhere to referral mantras, encouraging antenatal visits, testing, and clinical deliveries more than ever. Because the ban has a fine associated with it there are jokes that women will, “need to bring an extra 10,000 UG [Ugandan shillings],” to cover the fine. This is satirical because TBA’s often recommend women bring at least 2,000 UG to any TBA delivery to cover the cost of supplies and to prepare for any transport should that be necessary, but women rarely bring the money and very rarely pay the TBA anything, so to suggest that she add five times that amount makes people laugh. Moreover, most TBA’s are rural agriculturalists who have less than 5,000 UG at hand, so a fine that is twice that is an impossible and irrational expectation.

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2 HIV rates are back on the rise and the culture of positive patients has returned to Uganda after moving to the back of the minds of many following the near eradication in the late 1980’s. But the TBA generation of women are often grandmothers who care for young children whose parents were lost in the HIV heyday.
Transitions for the TBA

Most TBA’s in this study explain the situation of the ban as a sort of permanent retirement of the profession with an imminent end to THP’s in a move toward modern medicine. In Uganda, this would be a formal push toward nurse midwifery, or as it is being phrased as of now - skilled birth attendants SBA’s. Skilled refers to clinical training, and there is no direct route for TBA’s to transition to SBA’s. The merging of TBA skills with measured accreditation would be a brilliant option for this transitional times. With the skills and services of the TBA and the resources and support from district MoH, women’s health would be on solid foundations. Instead, there is no clear plan stated or formal new position, health campaigns sway TBA’s to become members of the village health teams (VHT’s), which focuses on their community duties like education and outreach. This both severs TBA’s connection to global health discourse and attempts to divide medical treatments from local networks of care, while failing to sustain indigenous knowledge. While some birthing centers and cooperative facilities emerge in response to obstetrics services, TBA’s and others find themselves in newly defined roles. The weak attempts to bolster community development in place of health development both weakens medical infrastructure and widens the gaps between local and biomedical praxes. This work addresses the affects of simply combining or imposing policies without instilling cooperation or connectivity.

Ugandan district officials are in the early stages implementing these VHT’s, appointed by the community or by district health workers. They are to provide a lot of the same counseling and outreach services that TBA’s typically provide, such as mobilizing
vaccination efforts and distributing HIV education materials, without any of the birthing services. This is not being framed as a replacement for TBA’s and not all participants are midwives, but the distinction is not quite clear in the communities. This is a government-funded effort, so the only initiatives privy to this program are through the Ministry of Health. VHT’s are decidedly community-based, which is a step in the right direction but what ends up happening is that it attempts to create an ambiguous divide between hands-on delivery and health services from community interests, which are indistinguishable in Uganda. Furthermore, it asks the TBA to do her existing service work while stunting her abilities to provide to the fullest. More to the point, this switch simply does not work, and people continue to seek maternity care from TBA’s. The VHT feels like a change in title or a fleeting effort to change TBA’s care practices. What I see is actually happening is that there is a recognized need for the community health advocacy that the TBA typically provides and an urgent effort to replace it.

**Current considerations and TBA trajectories**

My work discusses the ways in which the ban has unintended effects in terms of the direction of TBA’s. Not only does the ban spotlight the need for these knowledge brokers, but it has spurred efforts to organize traditional providers in various ways by self-formed groups. Incidentally, the transition to village team members stunts the continuation of traditional medicine and detaches local providers from health discourse. The very idea of VHT’s is an indication of the need for community-based social services that TBA’s provide, but the crux of the TBA’s work has been in the connections to policy
makers. Without these traditional providers, communities would lose family health and entire curricula of medicine in addition to losing a health liaison. TBA’s have influence over the ways in which development and community health operatives are carried out and the care for how they are introduced. What is at stake with the ban is that health policy is stripped of the shared sense of community that makes for relational care.

TBA’s roles as advocates could be officially solidified, making them the formal village representative. Their participation in district and national politics should be the direction for local health agendas, but instead TBA’s are put in remediation positions. VHT members’ roles are, indeed, to organize, mobilize, and assemble community health and development projects. But the issue is that this kind of community health is detached from augmentation of national and international agendas for health. The TBA has taken on the task of local representative for women in Uganda and the negative effects of losing local inclusion in policy are projects that are misguided, misplaced, or totally diffused.

**METHODOLOGICAL approaches and processes**

My ethnographic process was focused on emotion, embodiment and everydayness. I use private ethnographic space and personal narrative to examine intimate praxes of care, and I attempted to see and uncover care through close-up, personal engagement within those spaces. My ethnographic process is decidedly ordinary, and I chose to slow and quicken the pace of the research by following relations and genuine interactions as they unfolded in the field. I tried to settle into places like the birthing clinics in order to be in the vulnerability and sit with the tensions, for myself and those around me. I depended on
open disclosure for this work, so that required that I invest emotionally and expose
myself as well. I did this through exchange and sharing of my own worries, desires, and
fears, and often this was reciprocated. In this work, the subjects of care, relationality, and
connectivity, became the lens and the framework for my understanding the lived realities
of those who allowed me. I used care as the lens through which I explore moral duty by
documenting health ideologies and perceptions paired with observation of praxes,
interactions, and processes of health-tending. I examined how care is embodied by asking
about feelings, sentiments, and emotions. And I uncover and discuss where emotion and
corporeality come together in bodies and connections between people.

The intimateness was key for finding connections in the field and connectivity
directed me to further findings. I was interested in how people show care and what
motivates care when it is difficult or impossible, as well as how people receive care and
seek it out. I examine the ways in which care techniques and networks inform daily life,
and explore care practices as meaning making and as mutual constructions. I became
most focused on how people’s care seemed to be collective and shared, most especially in
traditional providers. I document the TBA’s health philosophies in addition to her
reflections on duty, responsibility, and obligation to the community in order to
understand what motivates her practice and what this means for her sense of being in the
world. I was fascinated with how TBA can witness the changes to their regions, and I
wanted to document the sensibilities and reflections of older generations in contrast to the
impending tides of development and progress celebrated by younger folks and
propagated by cities. I was most curious about how the TBA’s would see and perceive
the ban given their participation in health discourse, and I wanted to draw out and analyze the role of the TBA as a systematic function within communities, so I observed her practices from medical procedures to bureaucratic involvement.

In order to account for the TBA’s connectivity between local care and policy agendas, I investigated waves of health policies in order to translate the cultural implications of the ban, and I traced strategies of public health from diplomatic agendas to the lived experiences of the people on which these plans are imposed. My research focused both conceptually and topically on connectivity, and I was concerned with how health policy affects people – literally, physically, emotionally, and theoretically. So, I traced fleshy events to jurisdiction over time, and explore the ways in which the scarcity of health structures and anxieties of the rural poor are compounded for women. I extrapolated women’s care preferences, beliefs, and navigations, and I situated myself in spaces for women in order to truly hear the secret, underpinning, and organic reactions to daily tending. I chose a position of casual being-with and asked women about their thoughts, feelings, and dreams for the good life to better understand how it feels to carry out womanhood, which I conceive of as the most ethical route to women’s health.

The site and evolution of the project

My introduction to the site began by conducting research in the Mbarara district of Southwest Uganda on maternal health needs and quality and availability of health and obstetrics services. This entrée into Ugandan health care systems was amidst medical anthropology’s days of medical pluralism. I was awarded an internship though the
Minority Health International Research Training (MHIRT) initiative of the National Institutes of Health and our team of three had a specific goal of conducting a feasibility study on the potentials for “cooperation” between local and biomedical providers. We surveyed people in communities and clinics about their health beliefs, perspectives, experiences, and preferences, and we incorporated questions about the potentials for cooperative health care, such as, “How would you feel if your health clinic distributed herbal medicines?” or “How would treatment change if bonesetters worked in hospitals with modern equipment?” The results were fairly in line with what we predicted, which is that there are certain elements of biomedicine that community members praise, appreciate, and prefer, such as measured doses of drugs, labeled drugs, technology that assists doctors, potent medicine (most especially those in the form of “tablets and injections,” a common mantra). But local care came out on top, exceptionally for maternal health.

This work accounted for health procedures and preferences from providers and community members. I examined health-seeking behaviors, and found care networks entangled with political, historical, religious, ecological, and social factors. During 2010-2013, through the guidance of study participants, I focused secondary phases of the research on TBA’s as promoters of health education, mobilizers of public health agendas, and advocates for women’s sexual and reproductive health. I documented, in real-time, the reactions to the ban, and was able to see the slow transitions and shifting ideologies in Uganda. I investigated TBA’s long-standing mobilization work in public health through news, health campaigns, and TBA’s own reports as well as in the literature. I explored the
TBAs’ role in global health agendas and the dynamic role that they play in global health initiatives. I observed the range of services that TBA’s provide from family planning to counseling to organizing, and considered the contrariness that these were outlawed services.

From 2013-14, my research focused on the obligatory care provided by village birth attendants and the ways in which they mediate and navigate between legality and the dire needs of patients and neighbors. Data from this phase shows some of the early impacts of the ban, most notably a frustrated class of TBA’s who feel simultaneously saddened by the vanishing of their revered position overseeing communities, and also frustrated by compulsory care that puts them in danger of fines and is hazardous to their health and safety. I collected the embodied knowledges in addition to the practical skills of these birth attendants through informal interviews and observations in birth events, routine check ups, health events, community summits, training sessions, outreach agendas, and testing and immunizing days. These showed me not only the processes that manifest health ideologies, but also the nuances, preferences, and implications of health intervention and outreach. By investigating health-seeking behaviors and maternity services, I found complex networks of care influenced by myriad microstructures, and sought out understandings of those inter-personal, inter-structural matters. As TBA’s expressed to me the complicated commitment to women and community members that they experience, I became more interested in the relationality between midwives and mothers, and wanted to understand care as a mode of being.
What essentially started as observations of deliveries and prenatal care became a means to see the entanglements of TBA’s with their constituents. Shadowing the TBA’s along her routines, on her outreach rounds, and during a range of deliveries allowed me to see her connections with women and community members and her adherence to their lives. This also brought me into private spaces. Because I was aligned with the TBA as a health researcher, my attendance at birth was fairly ordinary, and because these are typically very long sessions, even for a routine visit, I was made to stay all day, share meals, and be in the workings of a home. I tried my best to offer assistance in mundane tasks and attempted to make myself more pedestrian by sharing in women’s duties, such as cleaning or tending to children.

Homes became a central place for my research. Most TBA’s practice out of their own homes and sometimes we went on house-calls. I was brought into women’s worlds, and in these quiet spaces full of labor, tending, and work, there was a steady exchange. These are the times where grievances are aired and hindrances are lamented. I saw the ways in which care and bodies and the treatment of such are connected to and understood in terms of relationships, kinships, and family. I began to hear the ways in which Ugandan women make a way for themselves and I was keen to understand their thoughts, opinions, and aspirations as well as the reasons why these are ignored. From there, I organized focus groups and surveys and would bridge into emotional and lived experiences by way of conversations about health and community. What began as an exploration of delivery and childbirth became about relationships and care connections,
especially once I saw how women’s complex lives are contingent about social networks and how reproduction and sexuality are tied to notions of how women see themselves.

**Long-range and multi-modal research**

It is significant to note that my work in Uganda spanned seven years, as I account for rural midwifery before and after the ban against TBA’s. This allows me long-range perspective to follow the ban and its reverberations. My data from more than 100 interviews, countless observations, surveys, and focus groups with TBA’s, mothers, families, community members, policy makers, district officials, and other health providers yields insight of lived experiences. And the long-term nature of the project yielded a sense of time lapse as well as rapport with long-standing participants earned from recurring visits with mostly TBA’s. I spent countless hours in clinics and birthing rooms conducting observations and collecting narratives. With some experience and knowledge from there, I was able to gain access to district officials and policy-makers, who offered me admittance to archives and political insight. It was important for me to trace policy and systematic currents to the lived, fleshy realities of participants, and that included gaining insight to the ideological and practical knowledges around medicine.

I attended all manner of health efforts from round-table delegation and community outreach campaigns, and I conducted semi-structured interviews along the way. I have witnessed proceedings from ritual conjuring to improvised perineum stitching to bureaucratic fanfare. Some helpful insight came out of community health meetings and from clinics and hospitals, and this was where I met many of the mothers.
who have participated in my research. But the core of my data and that which I hold to be
the most valuable comes from the participant component of my work. I conducted intake
and bookkeeping in clinics; I consoled sick people in their homes; and I volunteered to
accompany women on the long walk home after giving birth when she would otherwise
be alone. Such intimacy allows a richly detailed story to emerge, but these encounters
were also the times when my participants and I really recognized one another’s humanity,
and it was downright therapeutic for us both.

FRAMEWORKS

In order to counter themes of uncertainty and vulnerability in discourse of African
women, I present images of everydayness and ordinary aesthetics in thick life format,
meaning with an ecologically and physiologically sensitive lens (Povinelli, 2006). My
research sites are decidedly everyday, but some pivotal data comes from the in-between –
in the walk home after the meeting and in the aftermath of a clinical encounter. My
approach is to shadow people and participate only in basic tasks, such as washing and
cleaning, so my role becomes ordinary. I look for non-events as well as what the critical
events with heavier reverberations. Anthropology has long-proven what insight can come
from being in the everyday alongside people. One of my primary methodologies was
what I began to refer to as, walking with, meaning simply going along with women from
clinics and hospitals to their homes. It was a decidedly pedestrian way of being in the
everyday along with women. It felt natural and truthful, and I could be of help with
carrying things for them. I see this as active participation as well as an investment in
people. It was a kind of intercorporeality that allowed for open-endedness. Tim Ingold’s notions of walking through the fieldsite also applies (2000) as rural expanses and car-less villages in which I work enable a certain rootedness that can lead to ethnographic profundity. Being set into village life gave me a vision for locality.

I champion humanistic inquiry as a mode of citizenship as well as scholarship, and I think that it is important to account for our own experiences not only as an ethical consideration toward transparency and truthfulness, but also because as a human science, we know that discoveries of the human condition necessitate humanistic modes of inquiry and overt humanity in our practices. The intimate ethnography that I advocate for herein is, importantly, a project of care and certainly based in care. Just as care is the basis for the health-tending that I spotlight herein and that I propose be harnessed in health policy, so too should this be taken up and centered in the ethnographic encounter. As Maria Puig de la Bellacasa writes, human praxes require thinking through and with care and require an intimacy that is an entirely personal investment and commitment, relationships and structures included (2012). Not only do I find that this is a helpful tone and lens, but also that personal and intimate questions can provide a platform upon which someone can place their feelings and wishes, and so if done right, these kind of discussions can become a practice in clarity that can help us to see yearnings and worries more in focus.

I utilize intimate methods of engagement that I believe yield sound ethical cultural understandings as well as reflexive, and perhaps nurturing, experiences. And I argue that care, as a methodology, is generative in its relationality and connectivity. My aim was to share connections with people on a basic human level in private worlds and moments,
realizing that these are fleeting or momentary experiences. I see fieldwork as a relationship with and through power dynamics, unnatural circumstances, and time restraints and I express this through participatory engagement and coalesced meanings formed from an aggregate of experiences and interactions. Using intimate encounters, I use care and health as the lens to understand experience and interpret women’s actions and ideas in order to contribute to a new kind of discourse on women that is textured, rich, and lucid and provides a means to de-mystify women’s bodies in order to contribute to women’s health.

**Intimate Ethnography**

Because I was exploring concepts of care, relationality, and interpersonal investment, I harnessed those lenses as methodologies and those began to inform my pedagogy, my theoretical standings, and my identity as an anthropologist. This proved to be wholly helpful to my understandings in the field and hugely contributive to my sense of self and development as a person during the dissertation process. I discuss throughout this work several examples of times where my relating with participants in personal ways led me to not only a deeper relationship with participants, but also a greater understanding of what I was doing, both in life and in ethnography. In asking women about their desires, pains, triumphs, worries, regrets, and imagined futures in regards to family, health, and making a life for one’s self, I needed to be a person and a woman first as the role of researcher seems trivial at those times. This work is based in moments of openness and so the deeply felt experiences are foregrounded – ethically and informationally. I found that my
role as an ethnographer was to be an ally and to return the same level of disclosure that I was asking of participants. So, I opened myself up, shared my own intimate problems, fears, and hopes, and that, itself, consequently became a method.

This required my own vulnerability and it was only fair that I met their vulnerability with my own. This research came at a time that I needed some serious mentorship, so maybe these sentimental discussions were selfishly serving my own needs, but it seemed that we all benefitted from these interactions. In a way, this became another layer of advocacy, as TBA’s mothers, and myself would sit around and discuss the exquisiteness and despair of life, womanhood, health, relationships, or bodies. My work is methodologically personal and borderline therapeutic, at least for me. Ruth Behar’s approach to acknowledging vulnerability in the ethnographic process is harnessed here as I employ transparent and reflexive methods in order to inform, fuel, or handle fieldwork experiences (1997). In my attempts to get conservative women in what is, in many ways, an oppressive context that historically silences women, particularly in regards to their bodies, to talk about their bodies, I was tasked with deriving ways of opening dialogue to exchange on issues from sex to pregnancy to the frustrations of living with unloving or undeserving men. This started with my asking about how women were feeling and what they wanted or needed and about what makes life difficult or beautiful for them. These emotional discussions were met with resistance at first, but with time became the tone of my work.

Listening, in those times, was a mode of being and not a structured method, which I believe is what we should offer to our participants in exchange for the deeply helpful,
selfless, and uncovered things that we ask of them. In order to do justice to the tremendous, rich potentials of documenting the field experience as well as the complex, dynamic lives of the people with whom we work and research, I ask ethnographers to consider all manner of personal iterations for relating to others and for uncovering, translating, and presenting those revelations. This allows for true relatability and interaction as the ethnographer forms a relationship, that although temporary, powered, and perhaps artificial, has potentials for coalesced meaning.

**Ethnography with care**

The ethnographic endeavor is often a challenging, meditative, and philosophically poignant personal engagement and investment in which we lose and gain hope, health, and a sense of self, among other things. At best, and when we allow it, ethnography is a praxis that reveals the lives of others and lends itself to some insight about one’s own existential place. The personal investments and applications of this project were tremendous for me. Discussions about women’s struggles and plans often paralleled my own life navigations. Having regular, intimate, and open conversations with women on what it means to be a woman gave us both the opportunity to exchange ideas about motherhood, sacrifice, and uncertainty and often felt like a kind of therapy.

In a recent conference workshop, Connie McGuire presented on some innovative and exciting theories that she is formulating on the ethnographic encounter as a space for co-therapy (CoLed Conference, UCSD, 2016). She says that holding space for one another in caring and genuine ways can actually be healing for both parties. Because the
ethnographic interview is already close, personal, and often based in sensitive disclosure, that it parallels and is an opportunity for therapy in many ways. She is currently conducting work on how following an organic path in the interview process, which she defines as holding a loving presence, following intuition, and active listening, can make for a generative and therapeutic path, but this requires that the interviewer “get out of the way,” and let the interaction unfold. In other words, putting the data and the findings after the human interaction based in care and intimacy will benefit both the work as well as those involved.

I see this as a different type of improvisation for the ethnographic encounter and one that insists on humanistic frameworks of relating with and investing in not only the research, but the people that shape, inspire, and live it. And the benefits of such an approach of truly relating with one another are that some genuine thoughts arise with lessened social obstacles for sharing, but moreover there is a critical human exchange that we needn’t lose, especially in the fieldwork encounter where this, incidentally, is easily lost.

LENS AND APPROACH

Relationality

Many of my moments and memories in the field were emotional, and most were highly personal, but what I realized what the most important element of the encounter was relationality. Relationality is the basis of humanistic practices, care and ethnography not withstanding. Ethnography is personal, but is it practiced through others, so to see the self
through and with others is not only productive and generative, it is integral for ethnographic investigations. To distinguish one’s corporeal experiences from others and then to acknowledge when those cannot be discerned is an act of radical humanity. To form some sort of generative connectivity is the ultimate human act. The exchange and didactic nature of ethnography entails an asking, but the beauty and the magic are in the responsiveness and in the listening. I contend that all ethnography, especially the good ones, are unarranged and amorphous, and this opens up modes of practice and presentation within the genre. Such unfurling through interaction requires truly relating with one another and in that togetherness there is the act of meaning-making.

In a recent conference presentation, Michael Montoya spoke on precisely this issue. He said that collaboration is the thing that is constituted in the ethnographic encounter (CoLed Conference, 11/2016). The relationship is formed and that is the lasting effect and in the larger scheme of life and humanity, matters much more than the collection of some sort of interpretive insight. In other words, investing in and making with, others is the act of ethnography. The project is a side affect. This entails an attempt to share and gain a true sense of one another through not only disclosure, but also understanding in the form of empathy or some parallel to it. Sharing is self-exploration as a means of relating, and sharing can always lead to social precarity or personal vulnerability, but such exchange is also the root of human practices, like care or love. Judith Butler has written beautifully on the idea of being undone by another (2005). In ethnography, just as in other kinds of relationships with people, we let go of ourselves and relinquish the secure and certain sense of self in the name of gaining insight,
learning, and understanding. As a way of making the self legible we have to fully extend to others and surrender knowing. Butler and Athanasiou write that being moved to and by an other (or by another’s life world) is a practice of knowing or, a “knowing practice,” in and of itself, which is not only a humble and gracious pursuit, but is a way forward (2013). It is a way of seeing and addressing convictions and is a form of anti-persecution.

There is a radical human power that is implicated in practices of exchange and relationality between people. Zoë Wool writes about care as connective tissue, and she finds that the personal, social circuits of connectivity are what enflesh our worlds and hold social structures, elastically, together (2016). In other words, it is in the collaborative tending and in the exchange that social worlds are constituted, so for those of us who venture to understand people or places, those relations are the substance and the body is the mode. The art of attempting to know or at least empathize with another person is a noble and complicated one. Marilyn Strathern has the well-known and poignant mantra that the field experience is an act of constructing relations to uncover relations, and this could not be more fitting here (1995). Relationships of care in the research have substance and emotion and can be very real even through their prearranged and structured ways. Ruth Behar and others have proven what vulnerability in the ethnographic encounter can offer to the work and to those involved (1997). In was not my intention to be vulnerable in my encounters with women, but I found myself empathizing more with their burdens than I had planned. I was sensitive not only about my place in the field as much as my place in my career and in my love life. I remember the physical feeling of letting go and surrendering to not knowing and to my own worry, including
having open conversations about the difficulties of my project and how I was concerned about my relationship, which was indeed falling apart. So, that became part of my methodology – to share, to hurt, and to let that inform my work.

**Embodied understanding**

Conversations about people’s bodies are invasive and personal but also immediate in their intimacy and their potential for generative disclosure and therapeutic textures. My work is essentially collections of stories of lives and practices starting with the body. In exploring care, I have attempted to understand a kind of intercorporeality and I have accessed such information through shared narrative on embodied experiences and relational encounters. In a way, I have garnered a phenomenological exposé on women’s lives in Uganda in conversations that begun with childbirth and lead to guttural declarations, carnal desires, or deeply felt emotions of joy, shame, or frustration. That raw sense of feeling or experience is what anthropology pines after and does well, as our felt, intuitive, and embodied data is real and invaluable. It is my hope that my ongoing contributions will contribute to efforts that aid the academy and the public in recognizing and valuing sentiment, narrative, and humanistic, embodied interpretations, especially as these privilege ways of knowing from local communities.

Ethnography inherently reveres the body as a site of knowing in our sensuous worlds. Brophy and Hladki call for ways of utilizing bodily praxes and uncovering the experiences of others that will, “mobilize the cerebral,” and manifest the inner worlds of others (2014: 249). The body, in all its injuries and innovations, *is* embodied agency
(Butler and Athanasiou, 2013” 178). Respondent ontologies, arrived at through active exchange, offer an avenue to what Spry refers to as, *enfleshed epistemologies*, (Spry, 2001: 716). This approach underscores envisionings and mediums from the vantage of the bodily self, with the understanding that bodies are produced through powered practices. In the politics of lived textures, “bodies are implicated materially and discursively,” in all relations and thusly, in order to think with and *become with* another, in an effort to understand, there is an enduring place for sensuous knowledge production (Brohy and Hladki, 2014). There is a necessary de-sacrilizing of the body’s terrain in an effort to make bodily knowledge speak. I aim to bring discussion of women’s bodies and experience to the fore in order to make women’s obstacles for equity more visible.

Embodied understanding, in the form of sensory, felt, experiential, emotional, and sensuous knowledge, are critical in discourse of and on women’s bodies. And it is important for the ethnographer to recognize her own corporeality and embodied understandings to fully see herself and others. The moral responsibility of bodily knowledge in ethnography is essentially accounting for existential lives and feelings. For me, it was the sights of childbirth and the smells of the operation rooms and the agony of waiting areas that allowed me to see more fully what had been told to me over and over. Of course I think about my own blood and my own sexual encounters when I watch people tested for HIV. Of course, I think about my own carnality when I watch a woman bravely make her last push to deliver a nine-pound baby. More to the point, these sensorial, imaginative, and embodied ways of seeing are important and viable means of knowing. The body is the primary mode of actions and receiving, and is therefore
implicated in any observational science, and that primacy of the body as a mode of being and understanding should not be ignored in any experiential report (Weiss, 1999: 136).

To be embodied is to be capable of being affected by the bodies of others; therefore, it is a necessary and sufficient condition for the generation of bodily knowledge. Embodiment accomplishes a through-ness and offers sensitivity to the felt and lived experiences of others. In other words, the body is the foreground of our personal engagement and investment in our envisioning the lives of others. “Ethnography is not a method of generating data – it is a mode of being,” said Keith Murphy at a recent CoLed Conference (11/2016). Embodiment is part of the holistic vision of ethnography. Often what ethnographers do is essentially what Alma Gottlieb described on a recent episode of AnthroPod as, “eager questioning,” that attempts to get in to the thick of people’s lives, see the nuances, and maybe feel and understand alongside someone (2016). Anthropologists attempt to be in the nitty gritty of people’s lives and the challenge remains for our work to do justice to, and at least in some ways, translate the complexity of people’s lives. Judith Butler calls this the ethnographer’s challenge: That the density of social representation meet the density of actual social world (Butler, 2006: 21). Such accounts of the thick life require dialectic interpretation to enflesh worlds and create vivid ethnography so that the stories that we collect can be amplified in a way that appropriately depicts those with whom we work.
Fleshy ethics

In order to iterate the lives of others, the ethnographer’s own feelings, sensory observations, and imaginaries can be explored as a means of gaining clarity about the field encounter. Ethnography ideally serves as a memoir not only of that particular stint in what may or may not have been a context strange and unfamiliar to the ethnographer, but also of the nature of collecting knowledge of people lives. Such reflexivity is common and familiar in anthropology, but the role of the body in research is implicit and un-wholly regarded. After all, the ethnographers’ fleshy bodies continue to menstruate, cry, and ache throughout the research. Sawchuk points out that the lives, people, and the embodied politics that we adopt to analyze them, have guts (2014). Such fleshy and, “phenomenological aesthetics,” compel a, “somatic cognition,” for sense making within a carnal existence (2014: 155). It is consciousness plus corporeality and our fleshy worlds call for it (Sawchuk, 2014). Hortense Spillers writes about the “primary narrative,” of the flesh, and says that flesh is the immediate, visceral ruptures that serve as bodily, “hieroglyphics,” inscribed in the life world (1987: 68). She draws a distinction between flesh and bodies in that the flesh is the raw human and is therefore not so affixed to social conceptualizations, and she argues that because of this it has immense and substantial potential as a site of interpretation (1987).

The flesh does not live on, and so we have to listen when it speaks
- Spillers, 1987: 68

Ethnography depends on the power of the human tool. It is the human science and sensorial and reflexive accounts give dimension to this methodology. Our worlds are
constantly constituted, so I ask what it does when we as ethnographers acknowledge the togetherness and constructiveness of the ethnographic encounter. How do we harness guttural, visceral awareness? Emotional, intuitive, and instinct-based work makes for the best ethnography. As ostentatious as it sounds, it takes a certain kind of being-in the world to think clearly through ethnographic encounters, especially with a morally tuned approach to others.

My understandings of people’s lives came mostly out of conversations about their bodies, so there is closeness and a bodily orientation to my work, but my human intuition led me to care enough to employ certain strategies as ways of knowing. The body is always a cultural object and is always, already performative, so in order to see more fully the sociopolitics of body representation, it helps to give flesh to the processes of embodiment (Weiss, 1999). Embodiment through intercorporeality, as a methodology, is constituted through processes of relating and exchanging, and there is an ethos to these convictions. Such “flesh to flesh scholarship,” motivates a, “critical self-reflexivity,” that invigorates knowledge,” (Spry, 2001: 726). Theorizing, body-to-body entails a presence beyond textbook participant observation and it nothing short of embodied. “We commit our bodies to the intimacies of experimental encounters,” so we become witness to ourselves (Kreiger, 1996: 911).

IMPLICATIONS for humanistic inquiry

As someone who has spent countless hours in clinics, homes, and everywhere in between, I know that the most valuable element in ethnography is engagement. I believe that in
order for us to break the powered dynamic of subject and researcher/ knowledge
producer, we have to be willing to let go of our precious claims to science and rigor and
embrace the fact that knowledge is a human commitment and takes trust in other’s
perspectives so we need to attend fully to the relationships with local experts.

Anthropology, an inherently self-critical discipline, grapples with an on-going crisis of
representation. As a discipline that is meant to shed light on subtle and structural power
injustices, anthropology continuously tries to find ways in which to systematically
balance or reverse power in the ethnographic encounter. We work in the shadows of
colonialism and we see its parallels in our work. Our efforts are to work against and de-
center hegemony, and often that begins in our manner of approach to the field. We call
for humanistic and ethical practices as well as claims to knowledge, and we understand
the implications of treating research participants like subjects, informants, or datum. Yet,
the academy still squirms at projects that are openly interpretive, based in emotion, or
have methodologies that favor the human spirit.

I argue that in order to truly de-center rigid methodologies, ethnographers de-
center the findings in exchange for the relationships; let go of the self in favor of the
other; and allow the field experience to unhinge us as part of the process. Relations do
that to us – they undo and redo us and that is not always cozy. Discovery and meaning-
making happen through one another - through exchange and engagement which render
experience legible. Ethnography is a call to be moved by and to another’s life world with
“radical realizability,” that leads to invulnerability, in its mutuality (Butler and
Athanasiou, 2013: 162). The necessity and danger of speaking for others is great and the
risks are many, but to do so with integrity requires genuine relationality (Alcoff, 1995: 159). Ethnography is personal and it is also an act of co-creation. The act of ethnographic inquiry is based in relations and those relations insight *bodily imperatives* that implicate and transform the bodies of others (Weiss, 1999: 158). The moral duty of the ethnographer is commitment to humanity, and the vivid realness of genuine human interaction and exchange is the essence of human life as well as necessary for projects of representation.

Sylvia Wynter speaks to this: “Human is a verb,” and the action that we take is therefore the humanity that we enact (McKittrick, 2015). The enchantment of humanity lies in interaction and can only be understood through mutual configurations. I explore the beauty and impossibility of human togetherness, and refer to Simone de Beauvoir’s intellectual theories of knowing one’s self through knowing others, or Luce Irigaray’s poetry, *When our lips speak together*, which vows for a certain multi-human humanity (1980). My work depends on personal narratives and lends itself to approaches of health as I champion mutuality and emotionality in medicine. I focus on what Paul Stoller calls the blood and guts talk (1980), which leads methodologically to understandings of body experience. The power of intimate connections demands a ethnographic endurance, which is based in a humanistic ethos that is cultivated through care.

Anthropological methodologies call for their own conditions of care, the ethics of which are being adapted in cross-disciplinary pedagogy and medical practice. This dissertation informs humanistic medical inquiry and makes a case for these frameworks in global health. Inter-professional health policy is increasingly attuned to the
competency that collaborative and affectionate medicine provides. This work shows the need to truly honor story and sentiment as a way to overcome partial knowledge, and shows the criticality of the expert local lens. I show the discrepancies between public health movements and everyday life in Uganda as well as the enduring affects of disingenuous care. I show the ability for policy to create perilousness and I platform humanity-based decision making, which I argue is resistance against an assemblage of powerful positionalities. Care is an undertaking from a place of subordination, and women’s sexual and reproductive health are riddled with injustices.

This project platforms the indigenous woman as knowledge producer and shows how this disrupts the same power structures that created conditions for women. Through this depiction of women’s lived realities and their unravelings within health agendas, I call for inter-agency coordination in international aid and development that bridges the factions and creates international configurations rooted in integrity.

**CONTRIBUTIONS to the field**

As TBA’s quietly receive laboring women in the night, my dissertation is an exposé on the harsh beauty of care as unscripted and highly contingent. My project informs discourse on the imperfect nature of care, and I complicate reductionist models of childbirth by demonstrating the sociality of such events. Global health initiatives will benefit from my work because it enlivens what can often feel like population studies’ census reports. Public health particularly necessitates such stories that honor the person within the patient, and policy should reflect real lives. For African women, voicing one
own’s narrative helps to undo assumptions about suffering and recognize agency in those who have been historically oppressed. The cross-cultural considerations of care that my work offers have the potential to enlighten global aid and development on a policy level. My work will be of interest in programming for health care professionals as I contribute to the growing need to incorporate integrative care, and my project offers particular insight for midwifery, an industry whose practitioners must perpetually defend the efficacy and ethics of their work.

This project offers a feminist update to the notion of care by investigating difficult, ambiguous, or arduous care-taking devices that widen our understandings of civic duty in global communities. I explore the personal techniques and the social tools invoked for creating or maintaining physical and social health and tending to contingent conditions, which I study through clinical and household practices. As a celebration of the deeply humanistic practices of care, this research frames the processes of care as vital and fundamentally medical, as opposed to menial as they have been presented in the past. TBA’s in Uganda provide essential, life-saving care daily. These care providers carry out the promise that Western medicine claims, but often fails, to do. Their care is the immediate, radical, and enduring version of medicine. This is an important recognition for practitioners whose work is globally overshadowed by regimes of biomedicine. My work de-centers the mega structures of biomedicine and points out the problematic nature of bio-bureaucracy, which has important implications for the regulation and support of care networks or industries such as midwifery.
It is important that I honor and underscore the complexity of emotion and contemporary entanglements for the women in my project, which I realize through intimate, narrative-filled ethnography. In order to unravel the reproductionist model of women’s bodies, it is imperative that all elements of women’s health, histories, ideas, and lives are acknowledged as viable in health and medicine. This informs the current turn in the US and other Western nations wherein medicine is being met with a certain humanism on the part of providers, who are being trained not only in empathy and cultural competency or fluency, but also in dialogic consultations in which patients have the time and place to elucidate openly, which proves to be both an effective treatment and a therapeutic experience. This generative approach to medicine is about personal investment and tending and is a move away from the capitalist enterprise of care-for-profit. Traditional medicine in global health receives similar treatment to complementary and alternative medicine in the US; it is secondary to biomedicine not only because of accreditation and techno-science differentials but also because of the privileging of revenue over sentiment. Particularly for women’s and maternal health, patients’ viewpoints should be valued rather than seen as weak, inappropriate, or irrelevant. My work speaks to efforts to renovate medicine to be more collaborative and personally engaged, and my wider hope is that I promote integrating research with community engagement to produce outcomes.

Working with traditional practitioners, my dissertation contributes to greater understandings of health needs, issues of access, and women’s lives. Addressing the root causes of health determinates and highlighting the processes by which community
members’ agency is undermined and dismissed will help to enlighten power brokers, policy makers, and intervention projects. In the midst of debates on the legality, safety, and effectiveness of traditional birth attendants in many African communities, the purpose of this work is to reframe the TBA as a women’s health advocate who is both a necessary stronghold who defends women’s right to health and an influential stakeholder with the power to do so.

My dissertation explores emergent treatises of care in the shifting medical landscape, and offers an update to understandings of health, care, and the institutions of women’s health. This work is critical as older generations of TBA’s, the gatekeepers of the communities, are potentially phased out and new generations of maternal health providers are disallowed. As Ugandan communities manage their health and negotiate the changing medical climate, I explore the legacy of colonial health aid and the development networks that the Ugandan government proposes replace TBA’s as the solution to obstetrics and maternity care in the area. My work contributes a context-rich ethnography of care in Uganda to cross-disciplinary understandings of health; studies in medicine and care providers; and institutions of womanhood.

APPLICATIONS

Global health humanities

Medicine depends on understanding and empathy for effectiveness as well as to maintain dignity and integrity. Medical students in Western programs are being trained in cultural literacy in order to serve diverse communities, and open dialogue that honors a patient’s
story and history. Growing trends in medical anthropology have largely informed these moves toward a more ontologically humanistic approach to medicine and therapy by way of understanding care and its facilities. But the same lessons are not being translated to cross-cultural considerations of health and medicine. In Uganda’s communal villages, health and social status are intrinsically linked. Social politics influence health conditions and access to care, yet are unaccounted for in health policies. Humanistic applications of care have the potential to not only change the face of medicine, but also to acknowledge the deeply important work that care-givers do every day that responds to injustices. Such attention to the moral and ethical imperatives of care is critical in a site like Uganda, saturated with medical hegemonies that threaten to deplete and ignore labor-rich and effective local medicine.

I offer an updated approach that considers the complexities of womanhood in Africa, which have been privy to fixed, outdated conceptualizations. I contribute to discourse that complicates what were once reproductionist models, to move toward the sociality of care and potentials for sustainability. My work could be applied to understandings of development projects and could inform interventions made both by international aid and NGO participation. In terms of development and policy, I demonstrate the ways in which something as abstract as care can, indeed, be systematically integrated. This takes local knowledge and resources as global communities well know. But how to write and implement policy with and through care is more difficult. I think that this starts with the empathetic, humanistic approach that medical entities are beginning to embrace. Such an approach incorporates moral and
ethical considerations of lived realities and everyday life for people. This necessitates understandings of those lives through close and personal examination and intimate engagement. Having local stakeholders invested in the policies and practices of the state or development organization will be critical for Uganda’s participation and interpretation of global health agendas moving forward.

![Image](image.png)

*Figure 6: Family Planning information in the Maternity Ward, Health Center - photo by author*

**Care in policy and feminist frameworks**

This work considers how to implicate local care in global health and the ways in which care and medicine should come together. In an effort to move care discourse beyond precarity, toward wholeness, I suggest an approach that uses models of political and biological ecology to better understand health as fleshy embodiment of institutional regimes of care. In an effort to deny the justifications of despair and to champion moral renewal in the next generation of global health, I advocate for understandings of care
based in interaction, engagement, and relationality. Understanding that care exists in mutuality and that care is the basis of health de-centers power perceptions and prescriptive, medicalized understandings of women’s bodies. In Uganda, it is important to see the interconnections within society that make up care networks, and that care is mediated and managed through one another. I suggest that such knowledge of local lifeways can inform policy that conforms to community praxes and propels care processes anew.

I put forward that care is a mode, a register, or a method, rather than an act. In order to get away from the sympathy entities that humanitarian efforts often take, care must be harnessed as a lens to combat bare care and other feigned efforts to ease suffering. Solutions cannot be found within the “awkward engagement[s],” of biomedical enterprises that often alienate community members and instill blame and shame ideologies (Holten, 2009: 93). When global ideas are imposed upon local processes they often become confused, so to achieve sovereign care, I see the most informed agendas based in localized notions of care, which I further argue are inherently feminist. To systematically account for care and mutuality in medicine, I propose working with models that re-script bio-bureaucracies making them hyper-humanist and detailed starting with the community’s own perspectives.

Furthermore, I argue that any intervention within a colonized context must consider the ecological trauma and historical violations of personhood that actually deconstruct systems of care, so to build care structures people themselves should be empowered to inform, construct, and maintain such structures. Infrastructures of care are
the antithesis of uncertainty. This is implicitly a feminist project and one of anti-capitalist and anti-oppression that insists on asking who the institutions serve and calling out “sorry,” renditions of care (Povinelli, 2006: 57). In a recent talk that I attended at University of California- San Diego, Peter Redfield said that, “life is always an intervention,” and that humanity responds to a loss of coherence, but focusing on interactions rather than intentions is a healthy form of aid (11/2016). Care and justice are two parallel, simultaneous projects, writes Weiss, and one is certainly fueled and informed by the other (1999: 137). I propose that the global health community begin to see health in terms of human rights not as an experiment or a disposable minimum. This has obvious implication for medical practice and the turn in health humanities is a viable start for the re-imagining of global health.

Anthropological discourse has a history of delineating between applied work and that of the theoretical or exploratory kind, but I propose that these merge with work that is committed to highlighting injustices and empowering historically violated and underserved groups. By pointing out the fissures in minimalistic or veiled forms of state or global involvement in health agendas, my project provides critical information that will lead to better decisions that more appropriately serve the needs of our global communities, the necessities of which we have recently witnessed during Ebola and Zika virus outbreaks. My work is not a dismissal of biomedicine, but is a critique of the ways in which foreign policies do not meet the needs of particular groups. I am committed to the idea that comprehensive care structures demand not only cultural competency but also community-derived solutions that are both sustainable and integrated. In order to respond
humanely to suffering, we must acknowledge factors that contribute to failing infrastructures and unequal access to care, and promote indigenous perspectives and models of health that come from those who live out the effects, particularly women whose voices have been excluded from discourse as well as policy.

I contend that the ultimate objective of the humanities is to honor lived experiences and to foreground ideas, beliefs, and behaviors as \textit{knowledge}. My critique of biomedicine in rural Africa is not only a rejection of the power and politics affixed to a Western standard; it is also an argument that the culture of biomedicine is in contrast with communal societies who prioritize care exchanges and rely on inter-personal relationships to organize their worlds. Medicine often forgets the human component in the name of profit and time valuation, but it has historically been the TBA in Uganda who has maintained a womanist perspective and who has defended humanist approaches to health in the villages.

\textbf{Women’s empowerment through women’s health}

This dissertation fully promotes women as advocates in the changing role of TBA and I argue that equity and women’s empowerment involves fundamentally recognizing women in all capacities in a way that ungrips them from control and regulation, which are at the root of disempowerment. I show before and after the ban that TBA’s play women’s advocacy roles in their communities and point to ways that this could be maintained or bolstered in the wake of this piece of jurisdiction. I show the kind of care and support that
TBA’s provide in Uganda and the contexts for women’s worlds that make this health resource essential, particularly for movements of dispossession through empowerment.

TBA’s are woman-centered care at the hands of women leaders whose knowledge is not only localized and specialized, but is embodied. This kind of self-organized authority on women’s bodies is a form of liberation as TBA’s continue to contribute to the health and empowerment of women, writing their own definitions of health, desire, or suffering.

This kind of emancipation of women’s bodies is increasing in the wake of the ban. In the face of an oppressive regulation on women’s health, the unforeseen impact of this piece of legislation includes self-formed groups of mostly women finding ways to give and receive care with or without the aid of notional and international agencies. Spillers writes that bodies provide an ontology of agency (1987). Real, hands-on, on-the-ground knowledge has the power to make policy and legislation legible and relevant. Bodily knowledge provides an ineffable understanding that is critical to all forms of medicine. When women act in, carry out, and inform policy, women create the conversation for themselves – with a particularity that undoes the generalizability and misguided homogeneity of standard care practices. There is not a single femaleness, and radical biopolitics recognizes this need for personal recognition in medicine.

When women participate and guide health treatises, this helps to demystify womanhood and show women as citizens, helping to ease what has historically been a de-humanizing and silencing projects against women, especially in the colonized world. Silence equals distortion, as Spillers says (1987), and transcendence through articulation
means an enfleshment of putting the skin in to lived and felt understandings. Desire and other personal experiences are filtered and framed by law and policy and are privy to the regulation and constitutions of sexuality (Butler and Athanasiou, 2013), but the advocacy that TBA’s represent ultimately leads to the kind of advocacy and conversations that contribute to a dismantling of authoritative and paternalistic control over women. Empiricism is injurious to morality, writes Weiss, so we must be in touch with our passions and honest about how those inform actions and practices (1999: 129, 133). This is certainly an important conversation for contemporary women in the Trump era, and critical especially for African women and women in other nations that remain quarry to such powers.

A brief interjection on current global biopoltics of women…

Justice for women’s health requires understandings of the totality of women’s lives. A direct and contemporary example of brute anti-womanist politics that disregards such understanding of systemic health inequity exists in the contemporary climate in which I write. Regulation-based policies that leave no place for local imperatives conflate reproductive, sexual, and maternal health paradigms and make women invisible for ideological the purposes of un-liability and domination. For instance, the Global Gag Rule reinstated by Trump in 2017 disavows international organizations for women’s health by pulling funding from any agency that offers or otherwise promotes abortion in the areas where these global health institutes are based. Such a sweeping disrespect is an act of de-sensitization and formulates context for women’s suffering. Women’s health
need fleshy, embodied, humanistic, relational, connective, intimate, ethically sensuous, and radical discourse to transcend bizarre and detestable politics.

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OUTLINE OF THE CHAPTERS

My research offers insight on emergent treatises of care in the shifting medical landscape of Uganda. Chapter 1 explains how the TBA is an institution of care and how her care is entangled in community networks. I address what local care and advocacy is comprised of and examine the TBA’s role as a women’s resource. Chapter 2 discusses the global actions of the TBA as an agent of both tradition and development and looks at how she has warded off some versions of necropolitics in Uganda. Chapter 3 considers care and its intimacy in health and in ethnography. I suggest understanding care as connective tissue (rather than mechanics) through which life fields are coordinated and posit that eventness and body are attached via relationships and relational affects, including care. This piece speaks to current literature on improvised care and the ways in which communal groups forge their own care networks and medical treatments outside of intervention and neo-colonial jurisdiction.

Chapter 4 explores women’s worlds and the paradoxical burdens for women. As Ugandans manage their health and negotiate changing medical systems, I explore the ways in which the scarcity of health structures and anxieties of the rural poor are compounded for women in a male-dominated nation with one of the highest fertility rates in the world. I posit that TBA’s relieve some of the strain and shame on women, and I consider TBA’s as a source of education and empowerment that helps to ease
uncertainties for women with accessible, localized medical knowledge and services. Chapter 5 speaks to this potential empowerment as a key to the dispossession of women. Explored through examination of women’s lives and health and in their own experiences, including relationships, this section champions health equity and suggests that radical changes in sexual and reproductive health may be necessary, including changing men’s attitudes to get them on board with women’s health. Overall, I ask what the effects are when connective care is broken; how this ban is anti-womanist; and what is to come of the TBA in these transitional times.
Chapter 1 – Outlaw Midwives, Frictional Resources, and Oppositional Care

The local word for a TBA in Uganda, *omushaho wokazarisa*, literally translates as “doctor of birth.” Her work is defined as someone who assists in deliveries, or attends births, but the village TBA plays a much larger role as a stronghold within the community. The TBA has served a foundational role in women’s health in Uganda on many levels, from national health agendas to local education. Her most critical duties are in assisting women in childbirth, and it is through investigations of childbirth, in particular, that I found women’s adamant preference for TBA’s over the clinical birth that
the Ministry of Health recommends. In events of childbirth, a variety of issues arise dealing with sexual, reproductive, and community health in addition to women’s burdens, challenges, regrets, hopes, and desires. But what also is revealed in observations before, during, and after childbirth is that the TBA fulfills the social, personal, and cultural penchants of local women. Childbirth presents an event in which women are physically at risk and socially vulnerable, and there are a number of threats to women’s identity, selfhood, and social capital. TBA’s preserve women’s dignity, choice, and strength, and are highly valued for doing so. This chapter considers the events and the ideologies around childbirth and other services of the TBA in order to understand how the ban threatens, undermines, and muffles local care practices, and explores some grassroots efforts to organize TBA’s as local resources.

Criticisms of the practices of TBA’s include the fact that their work is dangerous. TBA’s in Uganda are fully aware of this and express growing concern with the compulsory and obligatory services that they provide that put them in not only hazardous, but also liable positions. The ban opposing the TBA frames her as an obstacle to care in the area, but I found that TBA’s remain a preferred method of care. The ban encourages TBA’s to send women to clinics and hospitals, but herein lies the gaps of this referral system. This chapter lays out some of the nuanced ways that biomedicine misses opportunities to contribute to health development in Uganda. I explore the TBA as a resource, a village advocate, and institution of care that provides respite from the clinical encounter rather than acts as a barrier to it. Women in Uganda are often met with daunting, shameful, and ineffective provisions in clinics and hospitals. These encounters
are damaging to their personhood and can be harmful for them psychologically, physically, and socially. The effects of the distressing clinical experience include women’s decisions to not participate, which is harmful for future health agendas. It may also impede on movements of women’s empowerment, because the clinical atmosphere intimidates, humiliates, or violates women’s bodies as well as their values. Issues of ineffective and insecure clinical structures compound the responsibilities of the TBA and create further divides between these systems of medicine.

The fissures between biomedical standards and local practices make for an “awkward engagement,” in the sense that the imagined universality of biomedicine does not meet up with the cultural ideologies of impoverished, neo-colonized Africa (Holten, 2009). There is a certain friction wherein global ideas are mediated through local processes and become confused. In other words, medicalized and gendered practices are often ill-fitted to global health entities (2009: 93). Moreover, pregnancy, as a biological event, asks women to re-negotiate bodily discourse in order to receive treatment in a structure that defines the very experience for the patients and other practitioners, namely TBA’s, which differs widely from local understandings and praxes (Holten, 2009: 94). TBA’s cannot simply be taken away from care networks as their practices are at the root of childbirth and women’s health in the area. The long-standing attempts to reconcile traditional and biomedicine have failed because clinical medicine is always the standard. But my research shows that TBA are infused into women’s health in the region and that local standards cannot be met with the strictly structured kind of biomedicine historically witnessed in African development. For this reason, TBA’s continue to practice and
provide for community members. The ban on TBA’s forces them to provide care and makes care all the more contingent on outside resources and further development, while putting blame and pressure on the TBA.

The recent policies and debates around Ugandan TBA’s has hinged upon the push for provisions from a SBA (skilled birth attendant), a problematic term used in public and global health discourse that is meant to distinguish midwives with formal biomedical training from those with local and self-taught knowledge. This term, growing in popularity amidst the TBA debate, insinuates that TBA’s do not, in fact, have skills, which I believe Ugandan TBA’s might argue is sometimes all that they do have- the wherewithal and the local knowledge to work with women. In a focus group conversation from 2010 about the lack of supplies and resources that TBA’s face, one TBA explains, “We work with our hands. You [first world] people have all of these machines. We are the machines! I am the Beatrice machine! I feel, I touch, and I know [about the status of a pregnancy].” Beatrice’s words powerfully explain how TBA’s operate with very few apparatuses and the importance of having a deep experience-based understanding of local obstetrics.

**An awkward engagement**

TBA’s are distinct from certified nurse midwives who are the only other midwife that village women typically work with. SBA’s undergo a two-year training program, often in the capital of Kampala. These midwives will be staffed at the maternity ward of a hospital, or more commonly, at government-funded clinics for obstetrics or general
practice. Some are employed by private clinics, like the Teso Safe Motherhood Project that I visited in Soroti, Uganda in 2013. Nurse midwives are often assigned to a village and not from that area, so there is significant work for them to do to prove themselves and garner respect. Whereas TBA’s are members of the community long-term, it is difficult for the trained midwives to prove their qualified status. Sometimes when nurse midwives come into an area their work is usurped or ignored due to preference for TBA’s and they will then move on or conduct administrative duties (Mbiydzenyuy, 2012).

With the exception of the more organized and well-funded private clinics, nurse midwives rank among other public health workers in their reputations as overworked, underpaid, and sometimes infamously intolerant, impatient, or downright abusive. The mistreatment, typically just referred to as “abuse,” locally, is in keeping with other accounts of mistreatment in obstetrics care, which is mostly in the form of verbal abuse, rough handling, or insisting on monetary fulfillment (Davis-Floyd, 2000). I have collected many accounts of mothers who report being slapped, screamed at, insulted, and/or left dirty, bleeding, or exposed for long periods of time. At the very least, most participants report, they expect to be ignored or disrespected by the stressed out clinical workers, which they explain in powered terms. Ugandans associate biomedical facilities with powered Western structures of superiority. Women say that they feel very “village-ish,” and uncomfortable in the clinics, and the health workers often respond in kind, calling them dirty and telling them to clean themselves better, often pointing out that they do not have showers, or shoes on, or that they fail to wear garments or pads that stop bleeding or discharge. Indigenous women encounter more violence and abuse than do
more educated or empowered women (Reyes, 2014). A commonly uttered sentiment is one that places issues of accountability and blame on the mother for her (pregnant or delivering) condition, making the pregnancy itself problematic or shameful, citing failures to control their husbands or themselves and telling them that they ignore family planning services.

Some interactions that women report include clinical workers saying, “I did not get you pregnant, so this is not my problem,” “You had no problem opening your legs before, so why are you shy now?” [in regards to hesitations to get up on examination tables], and “If you were screaming like this with [your husband], it probably would slap you too.” Women say that support staff can be helpful in these times, as they break the powered medical hierarchies and often sympathize with women, bringing them water or covering them when they lay exposed. Family accompaniment helps to deter this abuse as well. I have observed that when the mothers or aunts of delivering women are present, the verbal mistreatment does not necessarily decrease and these village women, often older and possibly non-English speaking, are fairly powerless to defend their family members. Many biomedical clinics conduct exams in English and will become annoyed if women are unable to respond. This is partially because of the Western associations within the medical clinic, but also because health workers may come from other districts and do not necessarily share the same local dialect with the women from nearby villages.

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3 In Uganda, visits to clinics and hospitals are a communal undertaking. Because Ugandan clinics and hospitals do not offer food options and rarely practice routine housekeeping as one might expect in the US, family members are expected to accompany patients and carry out such duties. There are typically communal cooking areas outside of a clinic where sisters, mothers, and daughters will cook and clean and do laundry in service to whomever is hospitalized, though delivery.
At a recent meeting of the American Association of Anthropologists (AAA), a central theme in panels on motherhood and delivery was, unfortunately, obstetrics violence. From issues of humanizing birth to negotiating women’s reproductive rights, obstetric violence came up so frequently that there was an entire session dedicated to the issue. Among those working in various sites and geographical contexts, the conversations were parallel, which was that obstetric violence is perpetuated through the disempowerment of women, the treatment of childbirth as a crisis, and the structurally violent ways in which medicine operates in care-deprived and gap-ladden systems. The majority of the contemporary research on obstetrics violence traces back to pluralistic systems of medicine, but there is plenty of work coming from American hospitals as well. Local healers and care networks emerge in this literature as the repositories of social accountability and care-full safe havens where women may retreat to avoid violence and abuse. In other words, the majority of this work presents biomedicine as the culprit of obstetric violence though we know that it is not that simple. Gaps in medical infrastructure set workers up for burdensome work without proper compensation, and the medicalization of birth has the potential to pose women as noncompliant in situations where women resist certain interventions or insist upon traditionalisms, agency, or collaboration (Reyes, 2014).

In these conversations, often TBA’s and other local medical authorities come out as the savior or solution. TBA’s relationships with women and community members make her less likely to outright abuse and even if she is stern or verbally harsh with a patient, one mother explained to me, “It is like granny yelling at you. She has your best
interest at heart and she will discipline you.” Women’s disillusionment with clinics and hospitals leaves development and policy planners unable to account for such “unwillingness” to use modern facilities, which they attribute to some kind of ignorance. It is a “measured judgment” on the part of expectant mothers to give birth at home, weighing the options and with knowledge of what “goes on,” within those spaces (Denise Roth Allen, 2002). For decades, the Ugandan government’s solutions for maternal mortality and morbidity were to encourage women to visit health facilities and encourage TBA’s and other local practitioners to refer women and community members to hospitals and health facilities. There is an entire public health idiom around the referral system, though to call it a solution is a farce. TBA’s are instructed by the government to refer women to health facilities, but the reality is that if women had the means to visit these facilities, they would go on their own. The government is criticized for instilling a referral system whilst neglecting to send any resources or attention to the empty clinics and maternity wards.

**Deliveries with the TBA**

For women in Uganda, who are generally overworked and frequently exhausted, anemic, malnourished, or suffering from either a chronic or acute disease or illness, attendance on a personal level goes extremely far. Because TBA’s know the women whom they assist, they are more likely to ensure the women are fed, coached, or cared for in ways that can dramatically affect delivery outcome.
For antenatal and routine checkups, TBA’s are almost the sole resource in villages. TBA’s are known for their abilities to conduct touch-based analysis of the baby, including heart rate and position, and many pride themselves on the fact that they are able to slowly, over time, turn a fetus that is positioned awkwardly or dangerously. It is at this time that a mother’s health is checked as well. TBA’s often analyze breathing, sweating, and pulse to look for signs of distress, overwork, or hypertension. Also at this time, a TBA will recommend other interventions if she suspects that it may be necessary, Many traditional birth attendants encourage women to go at this time to receive an antenatal card, which are available at many health facilities and hospitals. The antenatal cards and delivery cards are the product of various interventions designed to encourage health clinic births and to encourage women to seek out care prior to delivery. Many operate on a voucher system with a two-slot stamp or signature on the cards that must be filled in order to be received for delivery at that facility.

Figure 8: Prenatal and Delivery Voucher
Such vouchers document prenatal care and a woman’s condition. She must have this card to be admitted into a hospital or clinic for delivery and it must show that she has come for prenatal checkups. Women have to make the decision to get the card, which does cost about 4,000 Ugandan Shillings (about $2), but could save them the cost of a private clinic delivery, which is about 40,000 UG. In Uganda there are three requisite visits, so many opt for the TBA. The fact that voucher-accepting clinics are trained to refuse delivery services to women who have failed to visit for prenatal is indicative of the gap between these medical systems though the effort is to have women sustain care from the same practitioners or facilities. Most women say that they would like the option to visit the clinic only for delivery and not antenatal. If, mid-delivery, a TBA decides that a woman needs to be admitted to the clinic, that TBA who brings her in without a card is chastised for a refusal to cooperate with this system (Allen, 2002). TBA’s like for women to have the card in case of complications during delivery at which time she may decide to transport to the nearest hospital or clinic. The issue of transport, like that of referrals, is a heavy barrier to care and is seldom incorporated into public health protocol.

Transport in rural Ugandan villages is rare and difficult in any capacity. Four-wheel drive vehicles are typically required to pass over unpaved, uneven roads with deep holes and some rocky surfaces. In the dry season, passing cars and motorbikes spray the red clay-based dirt in a fine dust that adds to the layers that cover every surface. In the rainy season, the roads are fast-flowing, shallow rivers and pot holes become mosquito breeding ground. Small sedans for hire, known as shares, come through remote village a few times a week to drop people off from town. The motorbikes, or boda-bodas are a
more efficient way to traverse these obstacles and pass through sometimes once a day. Villagers often make use of these modes of transport using their one remaining minute on an uncharged flip phone to call someone who knows someone with a vehicle.

Figure 9: Young boda-boda taxi driver working - photo by author

So, needless to say, emergency transport is an issue, and it is one that the government and other health organizations recommend as a priority for local practitioners: Have a plan to transport the patient; it is really more of a joke than anything else. Even when a call can be made to hire a share, the ride to the hospital is expensive at around 10,000 UG, which is what these agriculturalists may make in a month.

For delivering women especially those who have encountered a complication, even when shares are called in and one can afford the ride, the game of telephone, the
wait, and the time it takes for the small sedans to get through the rough and distant roads, many women are far into labor, which means that they will arrive in a compromised condition to frustrated health workers and the situation may be out of their hands. Health clinics do not want to be responsible for maternal deaths and they do not want the numbers of infant morbidity and mortality to be projected onto them, so the issue is extremely political. As aforementioned, this circumstance is relatively common and leads to a slew of issues, namely poor treatment for the women and exasperating issues for health workers, but also if a TBA has accompanied the woman, she is also blamed and berated for allowing this to happen. “When transport a women with complication, both the mother and the midwife are often mistreated for failing to have prenatal a birth plan, or have arrived sooner,” explains one community health advocate. In this way, TBA’s are seen as a barrier to health and absorb a lot of the blame of the wider medical infrastructure.

Most women walk to the clinics, trying desperately to hide their labor. Women tell me that they try to incorporate transport in their birth plan, but it is difficult to predict. Commonly, women use transportation to return home, as drivers are empathetic to women with day-old babies and will charge them very little. The scene of a mother with a new-born on the back of a boda-boda in not at all uncommon. There is an ever-present request on the part of most facilities to have a working mode of transit, but the fact is that TBA’s simply do not have the means to arrange for such services in their practice.

One phrase of praise echoed by many women in Uganda is that the TBA does not “force her to push.” What this means is that the TBA, in contrast to clinical staff, do not
rush a woman and make her either rush through contractions or rhythmically push along with breathing techniques, which is common in Western obstetrics. TBA’s, rather, allow a woman to squat, walk around, scream, cry, drink tea, roll around, and hang from doorways and furniture all while fully dilated. This means that a woman will be in labor for quite some time and she only pushes once the baby crowns. Clinics, however, have women push at the onset of contractions, a practice that Ugandan women fiercely oppose for many reasons. Women report that this makes it much more painful, that they fear tears and fistula, that they are embarrassed that they may not know the breathing techniques, and often defecate as a result, and that they hesitate as this may harm or distress the child. Furthermore, the pushing is also associated with an intense pulling at the baby, which Ugandan women oppose as this has the potential to deform the baby’s head. Also, the pushing and pulling Western practice is done with the woman lying down in the lithotomy position with legs raised, a position that Ugandan women report is very unnatural and uncomfortable.

There is much literature and discussions of the lithotomy position and the rejections and criticisms of such (see Davis-Floyd, 2000). Many critics refer to the fact that the lithotomy position dis-empowers women and removes them from their birth experience. Ugandan women do not typically discuss their involvement in their childbirth in such spiritual or personal terms, but they do deplore the position for logistical reasons. The freedom with which Ugandan women move around and vocalize during childbirth is criticized by the clinical practitioners of the area as being obscene and perverse. Some nurse midwives explained to me that such a scene is “uncomfortable,” for them and that it
makes the women seem, “out of control.” This freedom during childbirth is an example of the ways in which TBA’s are criticized for “spoiling” women, meaning that once a woman has delivered slowly and without restraints she will have a much harder time adapting to the lithotomy position and the perceived violence with which this position is administered. Furthermore, TBA’s are seen as “spoiling,” women by allowing them such time and choice in the matter, something that is seen as unprofessional in the biomedical contexts.

The squatting position is a common delivery position for TBA’s. They rarely have women lay down, and often squat with them, hold them up, let them hang from their arms, or hold their waist. Some routines seem to be very effective in the TBA delivery room. Keeping mothers hydrated, stimulating the uterus, and emptying the bladder are all very low tech protocols that most Ugandan TBA’s practice that have shown to contribute greatly to reduced hemorrhaging, yet no such manual has been made popular which names the TBA’s solutions for delivery (Sibley and Sipe, 2006). Sibley and Sipe suggest, among others, that these practices along with basic first-aid care probably save thousands of lives a year in the country (2006). Herbs in Vasoline are often rubbed along the vaginal opening, along the cervix, and inside the vagina whereas nurse midwives and hospitals typically excise the vaginal wall and perineum with a blade for enlarging, which Robbie Davis-Floyd explains as unnecessary damage (2000, 1).

An overwhelming majority of TBA’s report that they are most proud of their skills in removing a retained placenta. They do this with hot tea, herbal drinks, careful massage, and lots of time and patience with slow, slight moves. Sometimes a stick is used
to remove the placenta. The tea can be pretty important. It is usually a black tea with sugar, known locally to be the ultimate power boost. Sometimes the teas are herbal and meant to relax the mother. Removal of the placenta is becoming a dicey measure and one that younger TBA’s refuse to address because of the risk of HIV and because they say that they have seen TBA’s put their entire arm inside women, which makes them very uncomfortable and also puts them at risk. The stretched out and worn thin gloves that local practitioners often boil and reuse are of no help here.

Placenta removal is critical as a retained placenta can be very dangerous and cause hemorrhaging. A broken or torn placenta is equally dangerous as the contents leaked into the body could cause infection. Attention to the placenta is also important, because it carries a lot of symbolic meaning attached to ideas of ancestry, lineage, and the connection between the mother and baby as well as to the mothers’ personal ideas about reproduction and selfhood. Women do not trust strangers and biomedical facilities to properly dispose of the placenta and is cause for refusal to admit themselves to a hospital. It makes Ugandan women very uneasy to think that it may be treated as medical waste or become food for stray animals. The extremely high rates of women who report being humiliated by doctors and nurses and refuse to return to the clinical atmosphere include those who have requested to keep their placentas.

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4 A common practice is to bury the placenta in a particular spot, sometimes under the house, or put it on the roof until a woman is ready to get pregnant again, at which time the TBA will dig it up and have her drink a mixture made partially with the ground placenta.
TBA Knowledge and Practice

In speaking with Ugandan TBA’s over the course of this research, I have collected accounts of many of the specialties of these women. I asked the question, “Are there any special skills that you have as a midwife?” and I also asked, “What specific skills would you add to discourse of training midwives and TBA’s?” Some of the skills that were reported more than 75% of the time include: Diagnose anemia by looking at the tongue; Cut the umbilical chord after just the right amount of time to ensure sustained nutrition (done with a dried reed from a plant that grows locally); Tying a string with certain herbs and clays at the right place low on the abdomen to prevent pregnancy. (Some say that it is the herbs that induce failed conception and other claim that the tight constriction of the
ovaries that prevents ovulation); Deliver a retained placenta; Turn a breech with massage.⁵

Some women in my field site suggest that without a TBA at hand, they would deliver totally alone. In fact, some women I’ve talked with have delivered by themselves. There are many reasons for this, which are discussed in Chapter 3, but mothers also report that they are a lot more comfortable when they have a midwife present. Men typically do not accompany wives and family members, and often the TBA will play the role of female family member. Similar to what may be more familiar as a doula’s role, TBA’s will cook and clean for a mother for a couple of days if she is unable or struggling. While in her care, TBA’s feed mothers and often counsel them on nutrition.⁶

TBA’s are active agents in education and implementation of other family planning and child spacing methods as well. In addition to encouraging women to breastfeed and assisting them in finding and administering herbs that are known to prevent pregnancy, TBA’s also educate women on how to access birth control, which is locally an extremely controversial and difficult to research topic. Years ago, a supply of Depo Provera and Norplant made its way into the villages of Mbarara, and like a lot of the drugs that poorer African nations receive, may have been expired or spoiled. Inaccurate dosages and misinformed administration caused the drugs to have terrible

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⁵ Ugandan women insist that the massage is critical in loosening the placenta, relaxing the cervix, and allowing the baby to “drop,” during labor. Massage techniques rank among the top characteristics that women cite as distinct among traditional birth attendants.

⁶ When I was there in 2014, some TBA’s had started a sweet potato initiative to share the cuttings of fast-growing sweet potato vines, which have a lot of fiber, vitamin A, and beta-keratin. Ugandans are particularly keen on Vitamin A, because it helps with eye health. Mothers and care-takers report vision as a high priority in their concerns for the health of their family. Night blindness is a common malady in the area, which is probably a diet-specific dysfunction.
effects on women, who report that they still bleed irregularly or suffer from abdominal pain and other issues due to pills or implants taken over three years ago. Other birth control pills exist marginally in pharmacies, but women often have to hide them from husbands and religious issues also interfere with women’s taking birth control in many families. Women report that attempts to “resist” their husbands often result in domestic violence.  

There is no grand solution for family planning currently other than sensitizing and educating men alongside their wives so that the two share responsibility for a household and mutually understand one another’s roles as well as the effects of adding children to the family. In my experience, TBA’s are offering outreach and education on partnerships and marriages more and more, and men are quickly becoming central to the conversation around birth and child spacing. In years past, public health campaigns only targeted men in terms of faithfulness and fidelity. In HIV education and outreach, men were the central concern as they were seen as the carrier of the disease and their faithful wives and children the victims. Locally, people understand HIV to come from cities, prostitutes, or from specific positive individuals whose sexual pursuits are closely followed. Marital infidelity and HIV go hand-in-hand in this context, and many men who have gone off to work in the capital are suspected of being HIV positive.

Today these conversations are more couple-oriented and much counseling is available as well as ARV treatments for those who are positive. In addition to pre and

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7 A local pattern, unfortunately is that women are made to “sleep outside,” a literal and deplorable habit and also a figurative idiom indicative of domestic abuse and quarreling. Because women typically move into the home of the husband and the husband’s family, women are easily cast out of the politics of domestic claims, which I will discuss further in Chapter 3.
post natal services, TBA’s hold the brunt of the responsibility to counsel and educate on issues of HIV as well, but this is a good example of the limitations to her abilities as TBA’s are not equipped to do much more than meet and make dialogue on the subject. TBA’s who are willing to deliver for HIV positive mothers, which is a far-cry from the rejection and treatment that HIV + mothers are met with at clinics. PPTCT – Prevention of Parent to Child Transmission – is something that some clinics work toward, but that requires a lot of dedication and intervention on the part of patients and providers. One older TBA told me once that there are “folk methods,” that she has utilized that prevent mother to child transmission at birth, including a specific tying off of the umbilical chord and a more familiar deterrence for breastfeeding. No other TBA, however, had knowledge of such abilities at birth. For the most part TBA’s say that they are unequipped to deal with HIV positive mothers though many claim that they have navigated that situation at least once. Rates are on the rise and everyone seems aware, and fearful, of that trend.

Figure 11: TBA manually examining position of the baby – photo from Mother Health International

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8 One reason that clinics insist on mothers having a health card is that it displays her HIV status.
The social role of the TBA

My ethnographic data shows that women consistently prefer to give birth with a TBA because of 1) her attention to local birthing customs, 2) her birthing space and methodologies, and 3) most notably - the investment and quality of care that she provides. They are the support system for women in the region offering counseling and health advocacy far beyond delivery services and often coach women through the challenges of family. I observed TBA’s providing marriage counseling; accompanying men and women to HIV clinics; organizing edible garden and safe water projects; holding accountability sessions for school children; mobilizing efforts in mass immunization events and malaria prevention summits; counseling and consoling women through pregnancy loss, rape, abortion, and fertility challenges; housing community members struggling with family, financial, or addiction problems; and assisting new mothers in welcoming babies into the family, including teaching her how to feed and bathe, how to deal with the stresses of a newborn, and counseling the father on when it is safe to resume sexuality activity.

TBA’s are praised and appreciated within the communities for their abilities to not only deliver babies in crisis situations, but also lead the mother through the pregnancy and provide a range of crucial psychological and social services. It is not just skills that TBA’s offer to their communities. The role of the TBA is that of a social cohesive. These female health providers are gurus of socio-cultural rites; they are leaders and elders; and they are economically and politically savvy repositories of precious local histories (Nyanzi, Mannel, and Walraven, 2007). The traditional birth attendant is synonymous
with delivery and the event of childbirth, but her role is so much more. Historically, these women act as elders, the grandmothers of the village, and provide a range of assistance, advice, and advocacy for women, families, and mother. Moreover, TBA’s advise on and lead traditional rituals, healing ceremonies, and carry out and carry on customary rites and rituals in a community. They are also responsible for contact with outside health campaigns, so TBA’s truly are more of a health liaison. Community health and development projects often put TBA’s in lead positions for mobilizing efforts such as mass immunizations sponsored by the government; health campaigns that seek to educate and inform; new efforts in water safety or feeding. TBA’s are the bridges between local networks and foreign aid as well.

**TBA’s as the keepers of motherhood**

TBA’s help women to *become* mothers, literally and symbolically. The making of a mother is the TBA’s duty as the custodians of local birth culture, so women who use only their services and consult only TBA’s are well equipped and respected, especially for the minimalistic intervention. When I first started my work, surgeries, including cesarean sections were fraught with stigma and embarrassing for women, but I have noticed with the merging of local and clinical practices, that these conversations seem easier and women are more willing to share. This may be because women are receiving higher

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9 TBA’s often speak English better than the average village woman and have connections to the district health officers through various work in district-wide operations. When visiting doctors, nurses, volunteers, researchers, and tourists show interest in a given area, it is the TBA to whom they are directed.
quality care and therefore do not associate the birth experience with trauma or negative memories.

TBA’s are compelled to other women in several ways. TBA’s are often involved with fertility ceremonies and help counsel women through conception, so it is the institution of motherhood, and not just childbirth, to which women are tethered in the role of TBA. In the spiritual realms in Uganda, motherhood is all women’s issue. Spirits of fertility and safe childbirth belong to all women, not just the delivering woman. It is a woman’s duty to ensure safe deliveries, generally speaking. So, TBA’s are not just members of the “cult of womanhood,” but as the person to whom women come for a range of issues that affect women in particular, including reproduction, TBA’s are really women’s health advocates as they aim to help, support, or save women in and outside of the role of mother, including more and more by working with men.

TBA’s manage women’s motherly rites of passage, To support and strengthen the “baby who slept there,” the TBA symbolically seals off the womb by coating the woman in certain oils as a gesture to show the birth completes the difficult passage of pregnancy and delivery. TBA’s symbolically demonstrate to the woman and to the community that she is a fit mother. They also conduct a specific rituals to ensure a safe, easy delivery- an easy delivery is a mark of a good woman/mother, so this tells the woman and others around her that the TBA believes this to be so – it is a mark of approval in a sense, in addition to a blessing (Bianco, 1991). TBA’s also importantly make the womb “sweet again,” with massage (to flatten belly), and do some cleansing, some herbs, some oils, and sometimes with ghee (a type of renowned fermented cheese). In Uganda, ceremony
and celebration are often marked with trills – a high-pitched, loud, quivering sound-performed by women. At the announcement of a birth or a safe delivery, it is a TBA who performs the trills, a role reserved for those who have stake or authority in an event.

Figure 12: Author in a mother’s home, showing baby’s belly string

TBA’s perform the protective ceremonies and construct amulets for babies as well, sometimes making a slit in the ear which makes the baby imperfect so the witches who eat children will overlook them. Many TBA’s also ritually bathe and bless the baby – a red string around his belly and wrists shows that this has been done. TBA’s perform the protective ceremonies and construct amulets for babies as well, sometimes making a slit in the ear which makes the baby imperfect so the witches who eat children will overlook them. Many TBA’s also ritually bathe and bless the baby – a red string around his belly and wrists shows that this has been done. The ceremonies that TBA’s can perform are highly valued and associated with that child’s health for the rest of his life, which is another reason that global health initiatives around childbirth and

10 Ankole women of Southwest Uganda tie strings around the waist and wrists of the baby to protect them from the spirits, but also to monitor their growth – as the string becomes tighter, then the mother will know how the baby is gaining in girth.
the role of the midwife fail to match up with what local people hold sacred. TBA’s can bless the birth because they are not jealous or spiteful like other women and family members may be. In particular, women with poor reproductive health and infertility are said to envy expectant mothers. Childless women suffer harsh stigma and are believed to cause others to suffer in retaliation. Pregnancy is a sign of good fortune, so it has the potential to arise jealousy, particularly if women are in competition for wealth and resources within familial relationships (Chapman, 2006: 497). Jealousy within the family is a common source of stress and sickness in Uganda, and can cause real problems for women. TBA’s are, in many ways, a way around those issues or dynamics.

As Grandmothers of the village, TBA’s are not only custodians of local customs; they also garner permission and support in between family members. Older women are considered immune from many social restrictions because they are not an active threat to reproductive abilities or competition for resources. They also are blessed by virtue of their age so they can bless others. Because they are near to the ancestral spirits, they are considered “good. Post-menopausal women have access to all forms of knowledge that younger people may not, because they are outside of the realm of reproduction, they are immune to the kinds of envy that younger people experience. This works with the so-called granny model in evolutionary anthropology that states that women cease menstruation so that they can care for the next generation’s children and not contribute to the competition for resources in a group. So, it is considered safe to share personal information with older TBA’s because they have no reason to start gossip and evil eye. Moreover, women are not considered the bearers of knowledge – but old women are the
exception (age trumps gender), so to consult with an older TBA is to seek knowledge from a viable source.

TBA’s are at the fore of co-care among women. Kinship is coalesced through need in Uganda in that neighbors and family will take in children if the mother passes away or is otherwise unable. Generally, most children are equally cared for by many women in the community. Women’s care groups are evidenced in their entrusting each other with their children. Bianco argues that it is not just a woman’s “calling,” or her moral requirement, but is rather the political structure of the society (1991). In other words, this is a matrilineal convention within a patrilineal society. Because women are authorized to support and bolster the clans of their husbands and lovers, the domestic politics of care even out this jurisdiction (Bianco, 1991: 771). In communal societies such as those of rural Uganda, the notion of kinship, and access or authorization of such, is blurred by the priorities of need and the category of mother is effectual and behavioral rather than biological. Barlow and Chapin argue that the category of mother is based in cooperative behavior, namely through flexible and improvised relationships with kin and fellow members of a group. Such is seen in allocare theories, for instance, where offspring are ensured safety and care not just by biological parents, but by allo-mothers who are somehow aligned with the group and invested in the well-being of the group – the “it takes a village,” mantra refers to this reality (2010: 326).
**Arguments against the village midwife**

At a recent (October, 2015) Bixby lecture at the Center for Population Studies at UCLA, a renowned global health scholar, noted that Ugandan women’s preference for TBA’s is a “false sense of choice.” She went on to argue that TBA’s have the reputation for being preferred by women in Uganda, but a Ugandan nurse midwife present at the meeting countered this by stating that women often do, in fact, prefer TBA’s because of the care that they receive. The scholar explained that this so-called preference is actually by default, and is a product of mis-trained and begrudged health workers who famously abuse but are not ill-prepared. She argued that many TBA’s, however, *are* ill-prepared to deal with complications. One woman in the audience noted that with prenatal care and when women are confident in a normal delivery, they could be cleared to deliver at home. The scholar insisted that this is not the aim in global health, and that safe and skilled birth attendants should be the direction for women’s birthplans in rural Africa. She echoed the sentiment of many both in-country and within applied scholarship, which is that TBA’s are potentially spreading disease, they have no way to deal with complications, and should therefore not be willing to try, and that some, if not many, are unqualified and ill-equipped to practice outside of the space of trained, outfitted, and standardized clinical spheres.

Moreover, critics of the TBA argue that to have TBA’s practice at all allows for unnecessary risk because having the TBA to fall back on and the option to avoid the clinics and hospitals means that there is unnecessary risk all around – for mothers, children, health workers, and the TBA’s. Though I believe this to be an outright wrong
claim because TBA’s are the only life-saving option for many women, I do think that it is important not to romanticize their role or make them into martyrs of women’s health or perfect saviors either.

Roger and Patricia Jeffrey warn of the over-romanticism of TBA’s, reminding that not all give good care and not all protect; some, in fact, use harmful procedures (1989). There is plenty of literature that aims to vilify the TBA, and others that call for midwifery as a whole to reach out to their own kind (Fleming, 1994). Some reports of the risks of using TBA’s outline their lack of resources and the dangers of practicing medicine without facilities and back-up. The statistics for maternal deaths are tricky because many come from small-scale hospital reports and the others from villages are typically estimates that are collected at a time of annual or semi-annual census-taking, but generally 435 in 100,000 is the number cited most in Uganda. The ban on TBA’s claims that the majority of these are at the hands of village health workers and traditional doctors, though severe cases often fall in the hands of these practitioners in dire, last-minute situations, thereby situating the blame of an entire failed medical system and insufficient medical infrastructure on TBA’s and village health workers. What I adamantly oppose are the aforementioned claims that TBA’s somehow lack training or skills, though I will agree to the risks that these women face in practicing village midwifery.

Grace Bantebya Kyomuhendo writes, in 2003, that women choose TBA’s for cultural reasons and to deliver in ways that are in keeping with local beliefs and practices. She adds that in doing so women compromise their health and increase risk due to
preferences for TBA’s and because of the mistreatment that is commonly reported in clinical settings. Women frequently are presented with few options, and the lack of skilled staff, the abuse, neglect, and mistreatment, and little to no patient agency or informed course of action make women very dubious about visiting the health centers. In fact, most only go as a last resort and the clinics being unprepared to treat, are often the site of maternal loss, making them more resentful of delivering mothers and more inclined to maltreat, adding to the cycle of frustration and abuse at clinics discussed above. Ugandan women sum up the mistreatment as being talked to like they are ignorant, careless, and disposable.

Kyomuhendo points to statistics that show the number of maternal deaths at the hands of TBA’s, which is what the government has historically used to deter TBA practices and ultimately to ban them. Kyomuhendo poses it as a baffling reality: why would women continue to choose risky delivery solely for the sake of tradition and out of stubbornness to demonstrate strength and endurance in adherence to the lifeways around a normal, healthy birth? (2003). She brings up that women potentially subscribe to two stereotypes in the area, which is that maternal death is normal and people are desensitized to such, and that women are expected to suffer rightfully through childbirth. Again, I respectfully add that especially in fearful times, it is the trusted TBA to whom women will go and the fear of potential complications makes the trek to and the navigating of the district hospital all the more daunting. So, another baffling issue is how the government intends to keep TBA’s out of deliveries when she is woven into the, “daily life of the family and the community,” (Mbiydenyuy, 2012).
The debate around banning and regulating TBA’s is polarizing. There are many factors complicating the issue and little common ground among the points. There are “mixed and often controversial pictures,” of what TBA’s provide in Sub-Saharan Africa, and chances are that these different countries have varying situations though the commonalities are great and comparisons are ripe (Mbiydzenyuy, 2012). There are many stories of failed or gratuitous efforts on the part of TBA’s, the more dire of these become well-known and uttered across many tables. In Malawi, a similar ban on TBA’s installed in 2007 was consequently lifted in 2010. Also similarly, Malawian authorities put in place Community Action Groups (CAGs), parallel to Uganda’s VHT’s as an alternative to TBA’s meant to bolster participation in biomedical facilities and clinical services (Claire Ngozo, 2011). Ngozo reports that the Malawian Ministry of Health cited lack of skills and failure to provide measures to prevent HIV transmission or to recognize obstetrics emergencies as the reasons for the ban (2011). The three-year period before the ban was lifted has provided research teams with a comparative point from other nations that have banned TBA practice. The government of Malawi claims that many life-threatening complications, such as ruptured bladders, declined during the time of the ban (Ngozo, 2011).

This is, of course, difficult to gauge for many reasons, one of which being that deliveries and thusly complications involving village midwives are not well-recorded, but also many TBA’s did not cease their practice, though the fear of being fined was there (Ngozo, 2011). Some reports suggest that maternal deaths actually rose during the ban (Mbiydzenyuy, 2012). The ban was lifted upon the return of President Bingu wa
Mutharika from a Millennium Development Goal meeting, at which time the President called for training for midwives in safer methods of delivery (Ngozo, 2011). The RAND Corporation and others are in the process of conducting “natural experiments,” in the area to assess the effects of the ban for both midwifery practices as well as maternal health (Ngozo, 2011). Kityo argues that TBA’s may be resistant to quit or refer not because they are ultra-committed martyrs of health and wellness but simply because it is their livelihood and they wish to earn a living (2013). I would partially disagree as many fear to treat now and pay is seldom and little.

It is important to recognize that this back-and-forth debate about the role of TBA’s is not new in Uganda or other Sub-Saharan African nations. I elucidate this dynamic in the next chapter. For instance, a long-standing WHO effort consisted of training and integrating TBA’s in Uganda, but the government has claimed this effort as, “unachievable and ineffective intervention” (Kityo, 2013). The ban cites lack of hygiene and TBA’s inabilities to deal with complications, stating that they “take risks,” with women’s lives (Kityo, 2013). Additionally, the government claims that children born at home are less likely to receive vaccinations (Kityo, 2013). But again, vaccinations are not always available even in clinics, and though the interactions at the clinic may inspire informed interest in vaccination, that does not guarantee that mothers could make the trip to the clinics or hospital again to receive vaccinations. Backlash from citizens who oppose the ban explain that the rhetoric is great and the health care options sound stable in theory, but they have been disappointed one too many times by a failure by the government to provide what they claim on the part of district clinics. Community
members explain that TBA’s at least can be counted on whereas health workers will not be there. Discourse on the subject in response to the lifting of the ban on TBA’s in Malawi reads that TBA’s need to be trained to better manage pregnancies and predict complications earlier – a simple first line of cooperation among providers of maternal health care (Kityo, 2013). This, importantly, implies integrative health care.

**It’s complicated**

Beyond the threat that the ban poses to potentially eradicate the traditional birthing knowledge of Uganda, it presents logistical issues and personal conundrums for those who make it their life’s work. The difficulty is that TBA’s are not legally protected by law or policy, so as there is no formal protocol for them to follow in administering care, so there is no structure for community members to follow in the case of mistreatment on the part of TBA’s. The Ugandan government did not necessary encourage the TBA practice prior to the ban, other than the occasional support through supplies and training, but now there is zero liability, which exposes TBA’s to dangers and health hazards and also erodes patient safety because the government fails to regulate TBA practices as part of their obligation to protect citizens from unsafe medical practices (Kyomugisha, 2003: 21). Furthermore, the health facilities to which women are encouraged to go are seldom successfully utilized because of the correlating endemic lack of resources and low use (Kyomuhendo: 2003, 17).
In the United States and Canada, the dawn of the lay midwifery renaissance in the 1970s, generated by white women of mostly middle-class origins responding to a growing demand for home birth, paralleled the twilight of older forms of folk midwifery,
which had largely served marginalized rural women and was faced with the same challenges in legal protection and support. Although most folk midwives were eliminated in the United States and Canada by a systematic medical campaign (see Fraser 1995; Smith and Holmes 1996; Susie 1988), in a few places the two strands of midwifery have merged, as seen with the Earth-birth Center (Davis-Floyd, 2001). The challenges and issues raised on the Global Health Stage at the onset of this ban parallel many that midwifery faces in the developed world. That is, the regulation of a practice that remains clouted in skepticism and distrust. In the next chapter, I discuss the ways that biomedicine eclipses and casts doubt on such subordinate practices. Ugandans, say that the worst part of the ban is the issue of training the next generation. “There will be these village ladies catching babies,” says Claire, a 50-year old TBA, “but they will not know what they are doing.”

**Deliveries in necessary resistance: Emergent TBA collectivity**

Following the ban on their services, some gossip among TBA’s is that they are embarrassed to practice not because their work is illegal, but because of the status and the fate of their profession. TBA’s report having very little confidence in the next generation of traditional practitioners, especially since the ban forbids any official organizing and training between TBA’s. In general, the ban calls into question traditional lifeways and creates discrepancies about how medicine and other care practices should be carried out. TBA’s say that they have observed that younger TBA’s do not demonstrate the care techniques that they pride themselves on and that they are more removed from the health
of fellow community members, which makes them reckless in their practice. “They give us a bad name… They do not take the precautions,” explains Prudence, a senior TBA. In this way, TBA’s are concerned about the survival of their practices and about the integrity of the work, and there is no protocol for them to wane off as providers or process for the changeover. TBA’s are beginning to take on new roles, but not significantly. Though most TBA’s continue to practices perhaps with the added affects of guilt or uncertainty, some small changes in the wake of the ban have affected their places. In 2013, I visited such an emergent kind of facility that aims to sustain TBA knowledge and work around the ban. The Earth-Birth eco birthing center was begun by two American midwives (one of whom is also a medical anthropologist!) who used donated funds and materials to construct a sustainable center far in the North in a town called Atiak almost to the Sudan border. I visited there with a local colleague who became more and more anxious the closer we got to the border and the further we were from any town. The center is situated along a trucking corridor on land that the local people gifted to the center. It sits on the horizon set back from the road and the first view was like seeing a bright, beautiful utopia. Colorful round huts are designed in the vernacular of the North and with donated solar panels there is some access to electricity. Smaller huts for staff and for staying mothers surround the main birthing hut. Inside the main hut, there are hammocks hung along the radii of the center and small birthing rooms along the outside. Each room has a inset concrete space that was originally designed for water births, but since this birthing trend was strange and did not catch on in Uganda, mothers go inside the empty insets and use the edges to hang from in order to squat.
When I first arrived at Earth-Birth, there was a small commotion among the five or so volunteer midwives from America, Canada, and Israel. There was a new mother with a 100% tear in the perineum. A familiar sound came in the form of a thick Mississippi accent. That was Teresa and she was about to stitch her up! The debate was on whether to use the truck that the center has on hand to transport the women to the hospital over two hours away, or to care for the women there. Since we had just come from that direction and the roads were flooded from the recent rain, I told them it would likely be twice that. Teresa gave Alice a swig of her personal rum and performed the
surgery by lamplight. I was amazed. Afterwards, everyone washed up and the adrenalin settled. We had supper and played with babies while the volunteer midwives explained to me the mission of the center. They house midwives from all over the world who either want to travel and practice or need practicum hours for certification. In exchange, the midwives bring along and provide all of the supplies that stock the center. Visitors fund their own way and often donate to the center in gratitude. The founders cover any costs for repairs and the like, which they say are minimal. Because there is no source of water in the near-by community, the center staff dug a well that they opened to all, so community members pass through their facilities all day long, which they say encourages people to come by and check out the center, and also familiarizes the staff with local folks.

A main mission of Earth-Birth is to bring in TBA’s from the community and actually make then the center of the practice. Western-trained midwives exchange skills and knowledge and they say that, as a tenant to the center’s ideology, they default to the TBA’s if there is ever a difference of opinion. This is an idyllic solution to the ban for some inspiring and for some very unfortunate reasons. In this way, TBA escape the banishment because they practice under the protective fortification of biomedicine (and whiteness, frankly). Earth-birth is definitely a best-case scenario but brings concerns in terms of how such a model can be replicated and how secure the organization is operating under the radar. The main issue with preserving the heritage and skillsets of the remaining TBA’s is to find sustainable solutions, and these utopias only exist for birthing mothers in a few areas.
With the outlawing of TBA’s, there is much more at stake than just the omnipresent, knowledgeable labor attendant. TBA’s are a stronghold of Ugandan societies. As I explain in Chapter 3, these women are an institution of care in the region, and what is alarming is that TBA’s find themselves having to silence and restrain their knowledge. Their civic duty is providing for the community, and this is challenged by the ban, which speaks to the further subordination and monitoring of women in African communities. Indigenous regimens of childbearing and the ways in which women conceptualize their bodies, experience pregnancy and birth, and perform child-rearing tasks are informed by idioms of health, and there are often competing discourses from foreign-instilled health programs.

Figure 15: TBA’s do Community Outreach - photos by author
Medical discourse generates strategies for treatment and care, so when these are confused, there are ethical dilemmas, including the avoidance of care, mistreatment in care interactions, and displeased medical consumers. Health efforts must consider the cultural character of women in the region, and understand that the TBA cannot simply be erased from structures of care in the region, nor would you want her to be. There are critical opportunities for the formalization of a women’s health advocate, and successful care programs depend on the TBA’s role as a resource. But the fissures between local care and health policy are great and made increasing considerable by misaligned health campaigns and medical aid misfires. The work of the TBA alone does not provide the full solution to women’s health crises in Uganda, but barring her from authority and from health curricular is an act of injustice to women that silences and stifles local care. In the next chapter, I explore the foundational role of the TBA in discourses of women’s health and how global dealings affect her doctrines, positions, and praxes, and I consider the implications of obstructing and inhibiting these mediators of aid and development agendas for women’s health as well as women’s empowerment.
Chapter 2 – Women’s Health Gurus and Bio-bureaucratic Intervention

As TBA’s are downgraded to referral systems and health team members, village communities in Uganda are presented with some clumsy changes to their health care. These changes prompt question of who makes the decisions for the community and where these policies come from. TBA’s have long represented village communities, especially women, in public health discourse and programming. TBA’s have been a vital voice between rural people and the district-wide, nation-wide, and international agendas of aid and development in Uganda. Stacey Langwick refers to TBA’s as cultural liaisons for this reason (2006). TBA’s are often the bridges between local networks and foreign intervention in community health and development projects. This is largely a product of

Figure 16: Senior TBA poses for picture - photo by author
organized efforts to put TBA’s in lead positions for mobilizing efforts of education and outreach sponsored by the government or foreign organizations. TBA’s continue to be responsible for the implementation of foreign-started health outreach or community health initiatives. These women act as a local contact for most of the governmental health campaigns, which is why their transition to Village Health Team members is obvious, if flawed and incomplete.

Many of the TBA’s with whom I spoke have attended at least one workshop geared toward fashioning TBA’s as local ambassadors of health. And many report that such initiatives eventually fell completely into their hands, including work with HIV education, family planning, and antenatal care. In other words, health campaigns are initiated from outside sources, and then forsaken, leaving community providers to continue with care. The downgrade in medical authority that the TBA’s have experienced in some ways highlights the other roles that she plays as advocate and community health officer, but the transition forces TBA’s to attempt to direct agendas in which they have no input and no authority. Furthermore, it places TBA’s in fairly diminutive roles, which is a waste of their care capital. Distantly derived programs are often informed by larger global health initiatives, so they are disjoined from the communities. This is not a new challenge to health cooperations in Uganda. This chapter investigates some of the histories of these efforts and the ongoing role of the TBA as women’s health authority and representative, and extrapolates the most fundamental problem with these efforts, which is a constant attempt to have local medicine convert to fit into hegemonic models of global medicine.
Legacies of the TBA as a Local-Global Agent

The traditional birth attendant has deep history as an agent on a global scale. In fact, Langwick argues that the TBA is the global subject when it comes to medical aid in Africa (2012). There is a significant relationship between the TBA and the World Health Organization (WHO) and other agencies of aid in Africa. The identity and the role of the TBA in global-local projects was “forged” in a health crisis, and one that was based in feminism of the late 20th century. TBA’s began to be part of WHO discourse and policy as early as the 1960’s (Langwick, 2012). In the early days, “indigenous midwives,” were central to projects aimed at increasing rural health. In the 1960’s, training imperatives were put into place, partially out of the impossibility to avoid these women who development teams would have consistently met in the field. The WHO was instrumental in first acknowledging TBA’s, defining their roles, and designating the importance in local health practices. The definition that was initially rolled out stands today and that is, “a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants,” (Langwick, 2012). These policies say nothing about the important cultural role that TBA’s play or her participation and authority in public and community health.

Other accounts say that TBA’s were active agents of access and quality of health perhaps before that time. Early UNICEF (The United Nation’s Children’s Fund) programs began supplying delivery-kits to TBA’s as early as 1952 (Sibley and Sipe, 2006). This sponsorship was part of the transition to independence from Colonial Britain, and was perhaps a reaction to some observations made during the colonial era regarding
the state of maternal health care, or it was under the assumption that aid should continue because resources would be depleted upon Independence. Regulating TBA’s proved to be difficult in earlier times for reasons such as linguistic or cultural issues that lead to confusion among foreign agencies (Langwick, 2012). But these actions are important because they show three things: 1) TBA’s were chosen to carry out medical care as part of the transition from colonialism and appointed with the responsibility of women’s health. 2) they were “given,” this duty without structures to support it, 3) they already had the role in the community, so this was more a way for Western medicine to mark TBA’s as delegates. These are the foundations of the collaborative efforts between TBA’s and biomedicine. The supervision of the TBA is a project of colonialism, and the history of collective work between these groups is based in efforts to inundate folks with biomedical ideologies.

**Development disengagement and incoherence**

WHO was fully funding efforts to organize and train TBA’s as primary healthcare providers by 1978 (Sibley and Sipe, 2006). Uganda was not alone in this trend. At the time of Independence, economically strained African regions and the crews that visited and intervened recognized the TBA as community leaders who held a tremendous amount of responsibility for health security. So, what does it tell us that WHO and others would designate TBA’s as a solution for better birth outcomes and therefore maternal and child health? I see this as recognition of the importance of their work, but also of the singularity of available birthing options. Proponents of the ban today argue that with
modern medicine these services are not needed, however this ignores the advocacy component and the fact that during decades of interactions with foreign policy holders and development agents, TBA’s have become health historians, medical associates, and local representatives whose reach extends far beyond what district politicians can claim.

Countless aid and community health projects over the last three decades have attempted to train, incorporate, and coalesce health services, but these efforts are met with considerable issues and the rhetoric is often problematic, as evidenced by the failure as a whole to incorporate. As far as such health strategies go, the emphasis has been on training the TBA to adapt her practices. The TBA of independent Uganda was viewed as a mobilizer, an outreach worker, and never as a colleague- her actual practices were never or rarely mined and she was not involved in imagining the national goals though she remained the face of strategies to implement (Langwick, 2012). Agencies such as WHO were simply not involving Africans in the conceptualization of health policy. TBA’s remained active in their communities while a great deal of work was done elsewhere, distantly conceptualizing the needing subject (Langwick, 2012). Many of the health strategists of the 1970’s and 1980’s were continuations of mission and colonial parties. Health, itself, has come to be defined in Uganda in missionary terms. What was once missionary health agendas became development health programs and these programs were not looking to local stakeholders for solutions.

The Safe Motherhood Initiative (SMI), project of 1987, for instance, called for healthy, safe and hygienic births. TBA’s were introduced as sources of information in this national agenda. As statistics were compiled and World Health imagined, the TBA
came forward as bearing the health duties of the communities in rural areas of the world
due to her embeddedness and omi-presence. She was, an “always available resource to be
tapped,” and was made into an “articulate global subject,” (Langwick, 2012: 33).
Langwick argues that the TBA as a development associate and consultant was invented
as an international actor constituted through assemblages of international councils and
studies from afar in order to feign locality (2012: 33). In order to coordinate constructions
of world health, the cultural insight of the indigenous person is tokenized and, yet after
nearly five decades, the fact that the TBA is diminishing rather than incorporating speaks
to the frictions between biomedicine and traditional medicine and the ineffectiveness
one-sided collectivity.

Intervention programs fabricate their collaborations with TBA’s and simulate the
interactionist model for community health while essentially pasting their agendas onto
these agents of outreach and attempting to convert the indigenous practitioners to
Western protocol. By doing so, development projects miss the chance for genuine and
generative engagement with local networks. Langwick breaks down the process of
conversion movements in East Africa as follows: around 1975, TBA’s were guides
utilized in health agendas; around 1979 on-the-ground efforts used TBA’s as field guides
for evaluating current health systems; in 1981, some case studies emerge that indicate
TBA’s as the gateway for intervention, and the bureaucratic tools were fashioned from
there (2012). The technologies and tools of medical bureaucracy are ultimately used in
international health as governance, but what falls through the cultural cracks is
substantial as evidenced by the incomplete cycles of care currently in Uganda.
Safe Motherhood International, for instance, has been based around training TBA’s in order to reduce maternal and prenatal mortality in the third world, David-Floyd writes, while focusing on educating village midwives, they also made transportation central to their advocacy, which was probably the early stages of efforts to rally for “transporting,” meaning accompanying women to health facilities (2003, 2). However, the TBA’s in my study told me that initially they were told only to transport exceptional and dire cases, and this is perhaps where the blurriness began between TBA’s and transport issues. Such confused and muffled efforts to collaborate have real consequences on TBA’s practices and the women that they treat. SMI survives today, in some iteration, generations after the original. It, like many aid and development programs, has changed hands so many times and has secured funding from so many agencies and Universities that it is almost impossible to identify a project leader or contact. Mbiydzenyuy explains that SMI has focused on trying to discourage harmful practices on the part of TBA’s, the guidelines of which basically call for hygienic practices for reduced maternal risk (2012). Meaning, again the agenda falls to basic health education, which is a responsibility of the TBA, creating more liability for the traditional birth attendant.

Health outreach that demonizes practitioners aside, the TBA’s demotion from provider to liaison is certainly a product of the unavoidable nature of the TBA as the guardian of the village, and it is telling that WHO and other international agencies see this as beneficial to their gains. More astonishing, though, is that these health and development programs decide that TBA’s are most helpful integrated into modern health practices while it is precisely the local knowledge and the cultural-ecological expertise
that make them powerful. Sibley and Sipe sum this up as an indication that TBA’s are a point of admission, or a medium to maternal health and not a viable solution themselves (2006). TBA’s in Uganda describe a lot of what they do as “mobilization,” an idiom that is perhaps a product of the neo-colonial agendas discussed herein. They are mobility managers who work on both ends to gather the community members and rouse them to participate in health events and to administer supplies or information from the government or foreign agencies. In other words, attempting to use them not for their expertise but in recruiting people to the Western agenda.

**TBA’s as auxiliary informants in Western health discourse**

Langwick writes about the nuanced ways in which TBA’s act as points of contact in global health discourse and practice. She says that global work depends on local responses and that TBA’s provide the feedback and inform the rhetoric of foreign aid projects, because TBA’s have the duty and obligation to speak on behalf of the community (2012). TBA’s, as global subjects, are privy to the language and praxes of global health, which is essentially biomedicine. On the global stage, TBA’s often play the role of the, “third world woman,” representing “gendered worldings” of biomedical discourse and action, especially those concerned with giving facetime to knowledge sets and cultural imperatives of bodies and healing (Mohanty et al, 1991). Such feigned cooperation further deflates the intervention strategies as these appeals to authenticity symbolize local authority and traditional knowledge without actually connecting with it.
There is no doubt that traditional birth attendants have a history of being involved in global health programatics as auxiliary informants, but what is the effect of this flow of information and implementation? Langwick argues that the manuals, training modules, and published protocols of the WHO and others have supervisory and evaluative tones (2012). Many current initiatives and those remaining from previous delegations emphasize cleanliness and safety, more specifically- hygiene and the “proper,” use of tools and instruments. TBA’s were introduced into international health discourse as a play to authenticity and incorporated through training instigations. Their work and their practice stayed in the literature and the curricula because of cultural proximity and willingness to cooperate with biomedical agendas, but this discourse has been riddled with gendered, racist, and colonialist ideologies.

In Sierra Leon and other SubSaharan African nations, the World Bank is funding a scheme where TBA’s are paid about one Euro for every woman that they bring into a hospital, encouraging them to refer and transport, though the cost of that transport may not always make it worth the trek (Mbiydzenyuy, 2012). In Cameroon, a similar program is being considered. Maternal and Child Aid Cameroon program is underway, which recognizes TBA’s as “vital resources,” yet they recognize that TBA’s are unequipped to deal with delivery at all levels, therefore the “Call a Midwife,” policy asks TBA’s to have a working cell phone to call for help or transport should complications arise (Mbiydzenyuy, 2012). This allows women to reach out to TBA’s and make use of their trusted services yet gives them the structure of an emergency plan, and speaks to the goals of the Safe Motherhood Initiative which encourages TBA’s to focus their training
on recognizing danger signs and being in communication with a facility to assist. In
Nigeria, the Dr. Bassey Kubiangha Education Foundation has helped TBA’s to form an
association which recognizes TBA’s and conducts cross-training with nurse midwives
(Mbiydzenyuy, 2012). As is common in the policy literature on TBA’s, the skills of the
women are attributed to their own embodied experience. This is an issue not only because
this assumes that all TBA’s have children themselves, but it frames their knowledge as
anecdotal rather than professional, undermining their practice and skills.

**Institutionalizing Ugandan midwifery**

TBA’s have experienced marginality and responsibility simultaneously from Western
medical authority (Langwick, 2012). They are sought-after representatives but patronized
and compelled to unknown terms. So-called attempts to collaborate with local authorities
have been via operations and regimens foreign to the TBA, and these powered, gendered
operations are intrinsically biased. The TBA as the indigenous gatekeeper is both the site
and the tool for intervention, and development efforts have depended on her to offer
authenticity to agendas that are not her own. TBA’s are at the fore pages of policy
documents, which Langwick describes as, “discursive colonization,” of women’s bodies
built in to efforts to increase quality of care (2012: 32). TBA’s, as the custodians and
overseers of community health, are access points for development projects, and in so
doing, TBA’s ride the line between local and biomedical understanding and practice. In
this way, TBA’s represent the binary. They are the common denominator in the
overlapping biomedical and indigenous health systems, which is why TBA’s are leaders
among the efforts to conjoin the two, but these efforts highlight the differences between the health structures and the difficulties in attempting to make cultural postures match policy procedures.

In some ways, TBA’s are the icons of the struggle for a hybrid system of medicine in developing nations. The work being done to understand and utilize local practices underscore the inherent differences in the health philosophies and logistics between the systems of medicine. Most commonly, struggles to incorporate TBA’s work are uni-directional. Stacy Leigh Pigg ‘s work with TMP (traditional medical practitioners), states that TBA’s are the products of international health development (1997). She writes that the very mention of a TBA in health treatises marks the literature or the project as based in the “third world” (1997), which would categorize a biomedically based project as one in need of training, transforming, or developing. Projects that aim to incorporate TBA’s into clinical structures put development projects as the base and ask for a dose of “local forms of knowledge,” which devalues and denigrates the practice (Pigg, 1997). Health initiatives mostly work to transition TBA’s and further regulate health practices, which attempt to make something that is shared and social in the region into something bureaucratic.

Langwick points out that in the Tanzanian contexts, the relations between clinics and TBA’s are not typically fluid. She writes that TBA’s are only successful “extensions” of the clinic if they train to adapt to the protocol of the clinic (2012: 40). This speaks to the deficient vision of development work. There are inconsistencies in methodology and that is just the beginning. The difficulties in merging medical systems are glaring and the
TBA becomes, in this way, a metaphor for how local medicine does not fit into models of Western medicine (Langwick, 2012). The struggle is not always pragmatic – the biopolitics of development projects present gaps among the abstractions and particularities of healthcare services; between policy and practice; between the global and the local (2012). In other word, there are ideological differences between these practices, including notions of how to interact and treat people in care practices. In Ugandan midwifery, these fissures come in the different approaches to care. Because TBA’s are invested and entangled with the community members that they treat, they have a certain relationship that is a departure from the powered dynamics of providers in biomedicine.

This binary exists through-out global development literature, because there are real distinctions between ways of medicine with very different histories and meanings. And unfortunately, it seems the case that traditional knowledge is “trained” out of people and the indigenous practices are “bettered” by biomedicine. Rarely is there an authentic attempt to learn the low-tech, highly skilled practices of the TBA. Reproductive knowledge is defaulted in development and policy literature to Western medical procedures. The vast majority of the literature on training TBA’s that I came across refers to ‘training’ based in biomedical protocol, rather than an exchange of knowledge and practice from an indigenous perspective. In the discourse on TBA’s, “training” is implied biomedical training, which have serious moral, ideological, and interpersonal implications.

Particularly with such a ban outlawing local practices, traditional midwifery is being subjugated in a way that Western midwifery has experienced through the
systematic subordination to biomedical obstetrics. There is a call in Western midwifery to reclaim authority by fostering globalization of the midwifery model of care in culturally sensitive ways, work in tandem with traditional medical providers, and become worldwide agents of mutual accommodation for positive change (Davis-Floyd, 2003: 7). In other words, some see the struggle of the Ugandan TBA as inherent to this kind of care-based, bucolic midwifery.

Implications for midwifery and the subordination of care

Leslie Barclay refers to this imbalance as the midwifery hegemony, and she says that the most symbolic indication of this powered dynamic is in birthing position-communities who have birthed upright for countless generations now find themselves on their backs, which clearly shows the dominance of biomedicine over their local counterparts (2005). In a Doctoral Midwifery Research Summit in 2009 at Cardiff University, Fiona Dykes, PhD and midwife, explains the intersections of critical medical anthropology and midwifery and the need to apply such methods and theory to a practice that is feminized and overshadowed by big medicine (2009). She explains that midwifery is due for treatment that focuses on the role of capitalism in medical practice, and, in fact, points out the many contradictions between micro or local health promotion and the imperatives of capitalism (Dykes, 2009). Health and health care must be understood in terms of relationships to powerful groups – namely medical equipment, medical research, pharmaceuticals, and food industries (Dykes, 2009). In terms of medicine and maternal health in developing African nations, there is a need to treat the constraint on micro
communities as part of a long process of emancipation from hegemonic structures that script not only disbursement of capital but also ideologies around labor, ability, and inhibition (Dykes, 2009).

Brigitte Jordan, of *Birth in Four Cultures* fame, calls for “mutual accommodation” of medical systems to allow room for the practices of one another and build through growth (1978). As early as 1978, Jordan called for replacement of “top-down,” culturally inappropriate, biomedically oriented birth models, pointing to the worldwide hegemony of Western biomedicine that fails to adapt to systems of health at least partially because of the structures of superiority that disallow accommodation to something made inferior through racist conquest. Typically the influence is one-sided and the recommendations are too costly, too dependent on technology and drugs, and harmful when incomplete, unsustainable, or incorrect. The irony is that many developing countries aspire to the standards of biomedicine. Brigitte Jordan argued almost four decades ago, that this preference, or adherence to, is *not* due to the success of biomedicine in these regions, but is due to dramatic success of biomedicine as a global entity and mega-structure; the association between biomedicine and socio-economic rule and power; the disempowering and oppressive legacy of colonialism; and the global dominance of Western ideologies.

Davis-Floyd points out the bizarre reality that most rural birthing places do not have clean delivery rooms or clean drinking water, yet very rigid biomedical formulas for delivery are recommended that would require an immense collection of resources that are simply not in place (2003: 3). She goes on to write that the biomedical approach to health
is one that is based on individual cases – “problems inhere in individuals and should be treated on an individual basis,” – obscuring the fact that major causes of disease and death for rural women are structural, requiring large-scale systemic change, the funding of which would (and perhaps should) divert monies from regional and district hospitals (2003: 5). Efforts to incorporate TBA’s and local authorities speak to the needs of addressing sustainability and ecologically-sound knowledge and lifeways which work to correct the issues most pressing for those who spend their lives there, but as noted above, many of these incorporation movements include TBA’s as auxiliary sources.

**Potential partnerships, emergent cooperatives**

Historically, programs in Uganda aimed at collaboration between traditional and biomedical care have been designed by institutions with methods to manage births with biomedical thinking rather than tailored to local birthways, making the efforts a mismatch within these communities. Such mismatches further detach the fundamental goals of community health from the systems that operate it. The effects of this are incoherence within local care networks. UNICEF and others have recently discontinued funding for TBA’s for this reason – citing the perpetual and ineffective cycle of training and mobilizes local agents (Davis-Floyd: 2003: 2). Davis-Floyd describes a sentiment that many on the ground in Uganda share, and that I echo, which is that many intervention programs identify the ‘problem’ as lying within the indigenous system of health. As Sally Graham describes in her doctoral dissertation work with the Karamajong of Eastern Uganda, the area that really merits change is in the *interface* between biomedical and

Figure 17: TBA measuring woman in prenatal exam - photo from Mother Health International

Separating out professional midwives from traditional/ community midwives enters TBA’s and other practitioners into a hierarchical, intensely colonial system of medicine where doctors are at the top and community midwives on the bottom, with no power and very little to no governmental support (David-Floyd: 2003: 6). This flow of power not only stunts the authority of those not on the side of biomedicine, but also imposes upon the very foundations of information and knowledge. To ignore the skillsets as well as the deep cultural authority of the TBA is to blindly cast aside socio-cultural
politics and central beliefs around care, personhood, and family. Moreover, it says that these are not important or relevant considerations. The push for skilled nurse midwives seems logical, but such a one-sided approach mines solely from biomedical structures and represents the very hegemonic power that has historically violated and disempowered this region. To train and equip the ones who already have medical clout is to directly invest in valuable, trusted, and long-standing resources of the area.

The support for and insistence upon skilled midwives (SBA) in Uganda requires tools and equipment, close supportive supervision, access to continuing training and education, recognition by the formal health system, and collaboration with other health professionals (Mbiydzenyuy, 2012). What could TBA’s do with such support? There are organizations that answer this question, including the emerging caste of Western midwife-initiated organizations like EarthBirth. Another such entity in Uganda is known as Shanti, a Sanskrit word meaning peace. Shanti’s motto as presented on the entrance of the birthing clinic is written in the local language of Eastern Uganda, *Ekyama kyetulina mu buwangwa bwaffe kiri nti okuzaaia tekuiuma wabuia abakyai abakya abanya mu,** which translates as “Birth is not Painful, Women are strong.” This is a phrase used by women of the area to eradicate women’s fears going into childbirth, especially first-time mothers who often hesitate to pursue assistance out of fear and uncertainty, so it is also an encouraging motto meant to bolster women’s decisions to seek health care for delivery. Shanti was founded by an American yoga instructor and doula and, like the members of her board of directors, is trained in international relations. Shanti is staffed by Ugandan
TBA’s and nurse midwives along with lab technicians and other health specialists with medical degrees from the university.

Shanti’s mission is to offer mother-centered, individualized care that meets the needs and desires of local women. Situated in the Luwero district of Eastern Uganda, Shanti offers supportive, respectful, compassionate, and connected care for a minimal fee. The organization is robust with income-generating programs, including a textile workshop, the wares from which are sold locally and online. The growing trend in grassroots organizations allows for TBA’s to have spaces to practices and pass along skills, though the fact that these are foreign-operated, though locally staffed, cannot be ignored. Having seen these centers in operation, they are blissful, encouraging spaces where it is hard to find fault, but one must ask if these are continuations of the dependence, though now more informed and sustainable. Shanti’s programs include TBA’s leading yoga sessions and meditative meetings like you might find in a Sonoma peace retreat. This kind of reverse-appropriation is unsettling at first, but after speaking with the nurses and midwives at the center, I found that they are enthused and feel like they are heard in these assemblages. They find Shanti to be a great solution for the current maternal health issues and they are thrilled to work for such a supportive and joyful organization. I hear TBA’s and midwives talk about yogic breathing and balance, which are not traditionally concepts invoked in Ugandan bodily theories, but the center also honors local birthing customs and demonstrates significant efforts to understand feeding and bathing newborn rituals, for instance.
Are these cooperative an idyllic or unrealistic standard? Maybe, but they are also an effective and efficient goal in terms of genuine collaboration and collectivity. This becomes problematic if it is excluding or taken away from the community members that it is meant to serve, for instance when it delivers to urban middle-class women interested in the “alternative” birth movement rather than rural poor for whom TBA’s are the primary forms of care. In other words, when community-based practices are elevated by power and class privilege, they are stripped of their village milieu. This brings to light the racist, classed, and gendered operatives that undermine women-center indigenous medicine where it remains critical in the everyday. This is a familiar dispute in conversations of globalization, appropriation, and power.

Are these kinds of cooperatives a potential loophole in the ban on TBAs’ practices? It seems like one viable solution as these centers for women are based in a decided effort to incorporate TBA’s. TBA’s are on hand as overseers, guides, or gurus. Even if the TBA’s are not performing the majority of the deliveries, they are there to offer advice and insight, and to maintain local lifeways. Because this is a setting that privileges local knowledge and grassroots efforts, nurse midwives and technicians here are perhaps more willing to treat TBA knowledge with reverence. This helps to ensure that the particular skills of the TBA do not disappear with this generation of women, and such facilities create a space where TBA praxes are fostered.

Most initiatives that aim and claim to cooperate with traditional midwives simply reduce them to postpartum assistants or support staff (Whittaker, 2009). And disingenuous cooperations end up diminishing care where services are most critical,
which is doubly diminishing to mutual learning and collaboration. In efforts for health development, the cultural expertise and skills are of these long-practicing professionals are susceptible to being altered by powerful perspectives, so Shanti’s adherence to, relating to, and veneration of TBA’s praxes is an important move for community health and a significant gesture for authentic cooperation.

**Well-meaning violence? Humanitarianism and neo-colonial agendas of aid**

Given the ideological and logistical structures of development that operate with and upon TBA’s in Africa, it is important to recognize the histories and potentially harmful impacts of intervention, especially as these relationships and approaches to medical aid and development are changing. Mbarara town, where I stayed for my first two stints of fieldwork, has a training hospital with practicum-seeking medical students from Europe and the Americas, so rural areas within the district are saturated with visiting doctors, medical students, and health-based researchers. The compound where I stayed housed many Ugandan students and foreigners affiliated with the hospital. It also houses people who have come to participate in one of the many organizations working on public health projects in the area, so medical tourism has become the bedrock of the town. This is significant because I have begun to see community interest in the power, authority, and civic influence of medicine rather than health outcomes. Because medicine and conquest are historically conflated in Uganda in the form of mission work and aid efforts, it is important to see the direct references that medicine and aid have to power, wealth, and opportunity. In other words, in this colonized context medicine and power are
It seems now more than in the past that the majority of aid is in the form of individual volunteers and small-scale projects that do appeal to personal sentiment, rather than hefty USAID teams, for instance, that arrive in more bombastic fashion. This kind of volunteerism and humanitarianism rings similar to a new aid ontology that Didier Fassin says produces a new kind of intelligibility regarding world affairs (2012). The new global citizen invests in humanitarianism rather than politics, agrees Miriam Tiktin (2006). In her work in France, Tiktin found that humanitarianism has grown substantially beginning in the 1990’s and the shift also involves a move from human rights to sheer humanitarianism (2006). In other words, the kinds of interventions being conducted today tend to be more geared toward individual fulfillment and identities of morality, creating a divide between politics and action and also disconnecting on-the-ground insight from international action, which helps to understand potential explanations as to why no efforts are underway to affect the policy that bans TBA’s.

Fassin notes that humanitarianism necessitates the victim. In his work researching Iraqi war interventions, he finds that the, “landscapes of risk and uncertainty,” compel the crisis hunter and that the sense of sacrifice and altruism that goes along with such efforts ends up sacrificing the weak while denouncing the strong and selecting life through hierarchies of need (2012: 228-230). Tiktin points out that humanitarianism operates through a notion of, “bare life,” that is unqualified by political and social communities and the humanity of which is partial, making the subjects of humanitarianism disposable.
figures of self-seeking agendas (2012). It is the politics of compassion and the pragmatics of humanitarianism that inform and produce socio-political intricacies within the communities that they affect. As humanity is minimized or objectified, narratives of the disempowered subject are constructed on a global staged and signed with racial, political, gendered, and historically supremacist ideologies that belittle community members as they claim to save them.

Legacies of dependency and neo-colonial assistance facilitate channels for further intervention, and those interventions grow more deeply scripted by foreign hegemonies, so biomedical regimes at once create need and impress solutions. In Ferguson’s review of development projects in Lesotho, the almost inevitable failures only more deeply situate poverty and powerlessness as these become further engrained in local identity and political processes (1994). Ferguson further states that these foreign institutions are ignorant to the realities on the ground and that the misguided and incomplete efforts leave these historically violated areas further crippled, which prime them for future aid, thereby creating a cycle of “development” and need (1994). In Uganda, the presence of foreign organizations invites further investment from afar. I have seen trails of NGO assistance and dependency models in action. The issue with this is not only that local agenda get stifled as organizations adapt to fit a variety of agendas from donors and partners. It is also that every failed program creates more distance between local providers or health activists and the entities of medicine and aid. Furthermore, people like the TBA who are the face of these initiatives are seen wavering in their outreach and curricula.
The distance, reverberations, and debris of development aid

Erica Bornstein and Peter Redfield link long-standing suffering and charity in terms of international moral discourse, stating that distance plays a role in the production of global sentiments that disparage local actors (2011). In other words, detachment is key to moralities of aid, particularly in crisis or within agendas of bare care. They further argue that sites of crisis are conducive to governance, and that governance from abroad means the systematic undoing of local knowledge. I see this in the case of Ugandan TBA’s. The ties between intervention and medicine are ties of power. Angelika Wolf refers to this as bio-bureaucracy (2012), referring to the management of the health sector and its economic chamber through hierarchical power plays and strategies that detach community members from national action, including administrative politics, red tape, and business-like (non) membership in decision making (2012). Bio-bureaucratic mechanisms include delegated well-being and restricted admittance into chambers of professionalism, evidenced in Uganda by the language of “skilled,” birth attendants and the clinical mis-treatment of villagers.

Wolf emphasizes that the bio part of bio-bureaucracy has dual meaning as these global industries are bound to biomedicine, in addition to it being about bodies (2012). Medicine is arguably the root of colonial legacies of prestige, well-being, and goodness. In the Ugandan context, health care spaces are marked with foreign aid efforts and decades of layers of health campaigns. Public health agendas are scripted by foreign efforts, so the rehearsed responses about referral, clinical births, and hygiene that fill my interview transcripts feel more like I am reading the pages of a global aid manual rather
than the perspectives of locals. I came to understand in the early stages of my speaking with TBA’s that there were two layers of information to glean from them – their initial responses would be the protocol of a health scholar and when I was able to get beyond that, we would have a real exchange.

The often unstocked and unstaffed government clinics in Uganda are the markers of collapsed health projects. Tattered posters along the walls serve as a scrapbook of those efforts. Marissa Mika’s work on the historicity of health care and medical infrastructure in Uganda depicts these faded shells stamped with health agendas of yesteryear as debris (Mika, UCR African History Colloquium Series, December 9, 2014). The artifacts are often all that remain of various failed attempts in neo-colonial medical endeavors. Mika states that nonfunctioning freezers and disembodied blood sampling kits are mere artifacts in a medical landscape of ruins (2014). These remnants depict a medical infrastructure in a state of atrophy, and the remains only emphasize the failures (Mika, 2014). Not only do the layers of medical debris showcase the disconnects and expiration of health campaigns, but they highlight the sheer number of attempts as well.

Figure 18: Waiting area with public health posters and information - photo by author
In my Master’s thesis, I refer to these remains that line the walls of empty and sometimes collapsing rural health centers as not only a scrapbook of previous health campaigns, but as a guestbook\textsuperscript{11} of the many NGO’s and aid organizations (Miller, 2010). I analyzed not only the institutions’ logos as signatures in a registry, but also as a coded collection of iconographic and medical imagery. Illustrations of needles, crosses (from the Red Cross), pills, hand washing, and bookkeeping serve as pictorial representations that simultaneously convey good health as a means of championing these practices and feigned community health in the place of actualized or sustainable campaigns (Miller, 2010). The stamps of foreign and national health organizations give the appearance of action and officiates the space while scripting the ideologies of health through familiar imagery. Dilger’s work resonates exactly with this analysis; he writes that the biomedical health spheres in Tanzania are similarly defined through the transformation and circulation of development capital in iconic and textual ways (2012). In this way, global policy makers and project runners blaze through, marking health spaces with the promise of well-being and with the message that actions are underway to serve the community while these actual maintain links to need and dependency.

\textbf{Figure 19: Waiting area of Health Center with clinic statistics - photo by author}

\textsuperscript{11} A common Ugandan practice of etiquette is signing a guest registry when visiting someone’s home, business, church, etc.
Medicine & mission work: A one-two punch

Ties to mission work and religious outreach compound the colonial savior identity of foreign aid in Uganda. America and several European countries have played major roles in some of Uganda’s darkest times, offering safety, security, and health during times of corrupt and violent rule by Amin and Kony, for instance. Bornstein and Redfield present that by the middle of the nineteenth century, medicine had become a popular component of missionary work in Africa and the majority of medical infrastructure that emerged on the continent grew largely out of religious activity (2011). The problem with this, beyond issues of reliance, is that Christian ideology, powerful Western privilege, and medicine become conflated.

Figure 20: Public Health Posters - photo by author
Health promotions become entangled with moral ideals and wellness becomes indistinct from deservingness, grace, or devotion. Christian missions have dangled health over people’s heads in impoverished settings. Glory and righteousness were promised as part of the mission of conquest. What continues to reverberate from those movements are frameworks of health and the very ways that health is defined. In Uganda, often risk, uncertainty, and illness are understood through lenses of piety and goodness. Governance and deservingness of health permeate every aspect of life, but become amplified when health crusades target specific issues, especially if those issues are sensitive or infused in local landscapes, as are health outreach campaigns, often with a punitive tone.

The “Living positively” campaign in Uganda is geared toward HIV-positive people and promotes a healthy lifestyle and a proactive approach to dealing with symptoms and preventing transmission. This campaign has been ongoing since the early 2000’s, and includes language about “healthy relationships,” urging people to, “take care of their mind and body.” This type of bio-power (Foucault, 1988) shapes the lives of actors in a community through socioeconomic and legal conditioning. In particular, tone and language influence knowledge and practice, and no entity has more power than religion, except maybe medicine. Such moral regimes, as Dilger refers to them, consists of religious and secular projects, the efforts of which need not be overtly ideological to affect health discourse and self-defining practices locally (2012: 74). Though on a state level, regulation and control is aimed at a population as a whole, ultimately discipline and control of the individual exist through the ordering of the body, via the ordering of desire, for example, and the “refashioning of the responsible self,” through, “rational… choice
and agency,” (Dilger, 2012: 75). In Uganda, it is easy to see how health campaigns directly influence ideology. The Living Positively campaign, for instance, platforms a proactive, optimistic stance, and this affects how people talk about their status today. In a HIV+ community meeting, one older woman told me, “Look at me. I am alive and I have taken control of my life. I am in control so I decide to live.”

Health subjectivities are built around shifting concepts of personhood. Proper gender roles, for example, are assumed through engagement in proper bodily practices and kinship dynamics, which are written or constructed through production and dissemination of health structuring. Women in my study tell me that they participate in healthy lifestyles by being a “good woman.” A good woman, they explain keeps a tidy compound and protects her family from everything from curses to contaminated foods. The status of her family is directly linked to her ability and dedication to an ideal of goodness. Such ideals of goodness have formed over time and are infused with Christian ideals of hygiene, and fidelity. These internationally accepted neoliberal ideas around family and industriousness often come directly from health intervention. Global health industries and public health sectors shape the behaviors and practices of the community through appeals to one’s values, including religious values, and because Christianity promises glory and salvation, this appeal is a reference to one’s spiritual citizenship as well as her earthly responsibilities. Dilger is critical of any such influence. He says that the aim of population-wide outreach is biological “collective solidarity” or uniformity, to control the living conditions or life practices of the citizens and move people toward “moral beneficence,” meaning goodness and wholesomeness as defined by the powered
entity (Dilger, 2012: 87). If goodness is emphasized through personal duty, then the antithesis or failure of such piety and loyalty may have shameful impacts.

**Sediments of shame**

In order to best understand how powerful medical creeds influence communities, it is helpful to see how these systems are emplaced and the ways in which other kinds of care are subordinated. Understanding the moral culture and the knowledge infrastructures of these medical systems is vital in accounting for notions of health and the meanings around wellbeing. With the pride, fulfillment, and social capital of a healthy status also comes counter-affects of blame and shame when there is a failure to achieve or maintain such a status. These direct products of colonial, missionary, and medical aid influences are observable in Uganda not only in the tone of clinical medicine and how it is carried out, but also in the ways that community members, particularly women, describe deep guilt about the challenges of caring for their families. The well-documented punitive nature of the interactions between patient and practitioner in colonized contexts speak to biomedicine’s patronizing of the patient as subject, whereas I find that local providers, namely TBA’s, do not operate through the same discourses of regulation.

Ironically, TBA’s and traditional practitioners are privy to blame and obligated for the “goodness,” of entire communities. Powered orderings of science and biology place indigenous practitioners in a position of unofficial care, which translates to ineffective, unprofessional and even precarious. Moreover, traditional practitioners are viewed, from hegemonic spaces, as diminishing the biomedical efforts, stifling progress,
and negating the effectiveness of drug therapies with counteractive or unsanitary herbal treatments, and those affects of shame are projected onto the rural community members who partake in these medical practices.

I have heard first hand Ugandan medical doctors openly condemn the practices of “village medicine,” because he sees these practices as somehow threatening to his mission and in opposition to his practice, both pragmatically as well as philosophically. The only other time I hear of such censure of tradition and of the village in Uganda is in reference to jobs, the global market, and technology from teenage and young adults. When I asked these same young people about health and medicine, they insist upon trained medical doctors, see hospitals as the epicenter of medical treatment, and view traditional practitioners rather unfavorably, citing “witch doctors,” and “quacks.” The disconnects between multiple medical systems are commonly referred to in literature on medical hybridity, which in discourse on international and global health often presents the omnipresence of biomedicine and the ways in which local therapies butt up against it. American models of complementary and alternative medicine (CAM) echo this debate, and just as indigenous medicine typically must be defended so too CAM therapies are commonly villianized and made into phony or dicey endeavors.

Dilger argues that the constructions of, or promises of, health, wellness, and decency exists largely in “briefcase NGO’s” for the benefit of politics and for the authors (2012: 66). In other words, the treatises of health that exist on paper are largely

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12 Ugandans who are either raised in the capital city, or who have moved there on their own for University or to pursue a career, are usually more disapproving of the ways of the village. They see the people who practice traditional lifeways as stifling progress, as making a bad name for Africans, and for perpetuating issues of un-development, poverty, or an absence in movements of globalization.
discursive. Finger pointing and dismissal of community perspectives are easier when the theoretical solutions are far away from community-based perspectives and care practices, and interventions are powerful, sentiment-laden cultural-political moves that incite all kinds of emotions and inter-relations. Bornstein and Redfield write that interventionist strategies are at once a feeling, clusters of moral principles, and a basis for ethical claims as well as political strategies. Aid and medical intervention in Africa have existed within or at the very least alongside of the production of goodness, hygiene, and, as Bornstein and Redfield argue, *dignity*, which is a concept that has played into and informed discourse of human rights on a global level (2011: 30). This removal of stakeholders from lived realities means that solutions only have to work in theory. Moreover, it makes it easier from a supervisory standpoint to blame local service providers when the efforts fail.

**Moral constructions of womanhood as threats to women’s health**

In terms of reproductive health, women are particularly privy to imposed scientific constructions and surveillance (Takeshita, 2011). This is partially because women are arguably in charge of *life itself*. Janice Boddy’s work with gender and colonialism in Africa is unparalleled in her ability to showcase the multi-dimensional problems of science production in neo-colonial arenas, especially when it comes to the surveillance and regulation of women’s bodies (2007), and religious crusades of moral purification and civilization (2011). In an article from 2003 in which Boddy discusses a colonial midwife-training program in Sudan, she found the refractory African female, at once
sexualized and dis-empowered, perpetually in need of taming and management in colonial discourse. The quest for the “normal” female body is compounded by Christian notions of godliness and betterment, and furthermore health is commodified by the bureaucratic forces that conflate health, power, and capital (Boddy, 2003). In the policymaking imagination, the manipulation of Afro-modernity and unruly women holds stock in sexuality and reproduction as the bodies of women (and their own bodily practices) require civilization as a means of proliferating useful, intelligible future generations (Boddy, 2003). It is imperative in the debates around TBA’s in Uganda to address that the subordination of local authority is happening to women providers for women’s health in women-centered care. I will return to the conversation on the dismissal, obsession, and control over women’s bodies in Chapter Four, but here I would like to focus on the morality and ethics of development work in terms of women’s health.

The power and jurisdiction over bodies and people fuels the neo-colonial medical invasion. When we consider the biomedical model within a concentrated context, such as that of East Africa, the bio-power becomes compounded by global structures of violence and racism. As an empire, biomedicine affectively blame-places through ideologies of scientific medicine in which a goal is to find the source of an ailment. Often that search obscures root causes like poverty, inequality, and power. Additionally, blame becomes rooted in unequal and brutal configurations, making gendered bio-capital further corrupted. The ways in which the self and other are construed, defined, and controlled through hegemonic biomedical structures are strongly scripted through bio-power (Foucault, 1988). As a structural process, medicalization places blame, obscures root
causes, and forces acultural meanings to illness (Kleinman, 1997). Traditional medicine has been wrongly aligned with non-biological processes, and under-appreciated as witchcraft, sorcery, and spiritual malaise, which is an utterly racist analysis (Denham, 2012). Boddy agrees that this “othering” of traditional medicine serves to place indigenous practitioners as foils, and the cultural insensities of colonialism do not allow for changing perspectives of bodies (2003).

As early as the 1920’s, physician conquests aimed directly for correcting “backwardness” of African women’s domestic and childbearing practices as the catch-all foundation by which to explain infant mortality and health deficiencies (Boddy, 2003). In order to level the playing field, medical missions commonly “correct” technique first, so the midwife training programs in Sudan, for instance, begin with birthing position and hygiene (Boddy, 2003). Boddy finds that the explanation for such alterations situates
squarely on blame and operates with blame as the primary sentiment (2003). Blame and fault-finding are the mechanism by which to justify colonial rule, but blame is also a motivating force that invokes medical concurrence or at least enlisting in the biomedical agenda. In the Ugandan medical context, campaigns of shame continue to operate as a means of engendering health, specifically as health and tradition are made binary. Boddy argues that this is a process that first involves combating harmful customs and offering a correct knowledge set, then ideologies become entwined, so there are marked associations between dirt, poor health, and failure, for instance (2003).

Women often told me that their happiness and self worth are directly gleaned from their ability to care for others. They say that they feel punishable when the health of a family member is compromised. The punitive tone of health workers has a lot to do with this. Relationships between community members and white coats are steeped in power dynamics and those in positions of medical prestige feel that community members are at their mercy and often their frustrations lie in patients’ apparent non-compliance or self-imposed complications. But, there is another layer of blame and shame in operation at many of the health facilities. In addition to any mistreatment or abuse, I believe that illness and sickness, itself, invokes a sense of shame. I will return to the discussion of women’s bodies, women’s work, and shame, but for now I foreground medicine and disciplinary ideologies in order to draw the link directly from bio-conquest to structures of blame on women.
Jean Langford argues that health and blame are co-produced due to biomedicine’s pragmatic and diagnostic delegation (1995). By default, biomedicine is associated with truth, clarity, and correctness. Sickness and illness are aligned with uncertainty and mystery. Susan Reynolds Whyte has written extensively on uncertainty in Uganda in terms of health security, and she along with Sjaak van der Geest, find that local understandings of bodies often depersonalize illness and attribute it to environmental and spiritual factors, while biomedicine operates in the pursuit of blame (1997). Traditional practices function through acceptance of mystery and thusly the local, spiritual practices are inherently marked as the antithesis of biomedicine. In a biomedical space, patients who have evidence of utilizing traditional medicine, such as scoring of the skin for pressure release, are harshly scrutinized and blamed for their condition. Biomedicine’s failures are mostly attributed to inappropriate behaviors of the patient, arriving too late,
for instance in the case of delivery. Whyte presents, in her work with the *Nyole* of Uganda, that narratives of the, “failure of the good life,” meaning failures in marriage, health, prosperity, and reproduction, are principally cast in shame (1997). Women’s tasks of childbearing and childrearing are especially wrought with ideas of liability, dependability, and reliability, which are adjacent to emotions of blame and guilt, while the infrastructure in Uganda sets up impoverished communities for inherent hazards and health difficulties, so the cycle of fault effectively falls on women.

**TBA’s: In defense of women’s bodies**

The overpowering ideals of goodness and deservingness that women are exposed to in Uganda can be eased or magnified by the kind of care that they receive. The architects and providers of such care have the responsibility to respond to the context and not just the individual. Practitioners must have an understanding of women’s lived realities and holistic awareness of ecological and structural obstacles as well as solutions. TBA’s have the unique position to know the women that they treat to a degree that they do not separate the person from the patient, an outright opposition to framework from biomedicine. The architects of public health programs have the challenge and duty of undoing the patronizing, patriarchal legacies of medicine in colonized Africa. TBA’s provide complex examples of ways in which women, their bodies, and their health have been commanded in medical programming. TBA’s have long played the role of women’s health advocate in Uganda through their participation in national, international and global health discourse and action. TBA’s have operated as guardians who infuse policies with
some actualized understandings of women’s lives. This is imperative to their role, as they
do not just treat women but are inherently acting as an advocate and activist on their
behalf. Not only does this mean that the TBA is the institution of women’s health, but
this care and embodied understanding makes her a better provider.

So, by her actions, the TBA carries out the feminist agenda. The act of providing
communal and relational care is feminism and it is activism. What other than pure
necessity keeps the TBA involved? It is exactly her long-standing participation in such
delegations about health and access. And her exposure to bureaucratic instruments that
makes the TBA’s role one of citizenship, service, and politics. The TBA is the
representative for the rural woman globally. And her contributions to intervention and
development are powerful and imperfect, and have symbolized women’s reproductive
health. Much of the women’s health and empowerment movements in Uganda today are
informed by Western feminism, especially in the 1970’s and 80’s as Western women
were invoked by feminist movements of the time. The TBA aligns with feminist agendas
because she represents health on the grounds of obligation, duty, and care. Her work is
social justice yet has been enveloped by epistemologies of measure-based evidence and
other empirical, neo-liberal agendas, so her fight is a feminist one. She defends
womanhood, because she speaks for women. Her insight is imperative because she
provides for the global push for local solutions based in compassionate and agentive
ideologies. TBA’s are the empowerment surge in the local-global network, but as a rural
African woman, her’s is an already subordinate manifesto of women’s rights and women-
centered care.
TBA’s must be an integral part of the primary health care system, because they are an integral part of that system. I discuss in the next chapter the fact that TBA’s inform and contribute to birthing and mothering practices, therefore maternal knowledge and behaviors continue to be informed by TBA’s. As of now, TBA’s are told no longer to treat women or assist in delivery on the premise that they do not help to reduce mortality rates, but we know that these practitioners continue to work steadily across the country, and it is important to note that this transition is marked by TBA’s formal role of advocate. This chapter has shown the histories and complexities of TBA’s involvement with global discourses of the African woman and the rural women’s health provider. The next chapter explores the other end of this dynamic, local care practices and the relational interactions between care and its constituents. I emphasize the need to renovate the interface between factions of development and community members in order to generate genuine collaborations rather then the disparate actions considered herein.

TBA’s are necessary not only for pragmatic and logistical purposes, but because they bring feminist politics to the hegemonic and authoritative actions of development that help to de-institutionalize care in such a way that makes it humanistic, effective, and personally connected. The next chapter considers the experience of care in Uganda and the role of TBA care-givers. I look to how health is engendered and the ethics and risks of providing services for women in an effort to further understand the role of the TBA, her power and responsibility, and her struggles and sacrifices as the guru of woman’s health. And I consider the relationships between mothers and providers as well as how these relational affections spur or are a means to care.
The village TBA informs the institution of motherhood in Uganda in her role as director of care configurations and participation in health intervention. The other side of the TBA’s care commitment that makes her an institution of women’s health and an invaluable resource is her relationships and embeddedness within her community. TBA’s are praised and appreciated within the communities for their abilities to not only deliver babies in crisis situations, but also lead the mother through the pregnancy and provide a range of crucial psychological and physical care. Women and mothers appreciate and insist upon care methodologies of the TBA’s. The ban outlawing the practice of the TBA states that they are ill-equipped to deal with the complicated health situation in Uganda, but the cultural implications of the ban are not that simple. The care provided by the TBA
is a radical form of community connectivity that maintains humanity in medical interactions and eases the brutality of bureaucratic agendas. This Chapter lays out the ways in which I understand the intricacies and character of care provided by the TBA in Uganda. I argue that her care provisions are based in obligation and her tremendous connections with the community. I look at various levels of care that the TBA provides, and consider the challenges, limitations, and risks to this level of entrenched care in order to ask how and why this kind of approach could and should be systematically integrated into structures and policies of medicine.

The relationships between mothers and midwives reflect the significant socio-cultural capital, interpersonal entanglements, and moral imperatives that TBA’s represent. TBA’s themselves experience a personal investment with the women who they support and typically keep up with the community members whom they have served. TBA’s are usually neighbors, family, or friends and so they have a duty to properly treat the women and the children who will become a part of their own social groups, networks, or potentially families. Simply, TBA’s are accountable in an intimate way that other professional care-takers typically are not.

Birthing events are risky and sometimes difficult practices. Bringing babies into the world in Uganda has a significant amount of uncertainty associated with it prior to and following delivery as well. In the villages, childbirth is associated with some fear, especially for first-time mothers, so TBA’s help by closely coaching. These communal-based care provisions help women with the challenges of feeding, watching, and keeping families in health. Informal training through support helps new mothers, unsure mothers,
and those who are hesitant for any reason, including those who have had a traumatic or painful experience or have undergone loss. Women need networks at the time of birth and introducing babies into a household. As the guardian of womanhood embedded in the community, TBA’s are deeply involved in processes of helping women become mothers, from prenatal training and teaching, to soothing fears and anxieties, to easing women back into their homes and, importantly, with their husbands.

Most rural women in Uganda typically have a TBA participate in their birth to some degree. Even mothers who deliver at hospitals will go to a TBA for prenatal or ask a TBA to accompany her for a hospital delivery for support. In this way, TBA’s act as what we in US and in many Latin American societies refer to as doulas, who differ from a midwife because their services are for the woman, particularly to ease some laborious burdens, including preparations and jobs after birth. This practice shows how TBA’s are primarily social resources and that role entails intimacy and relationality. As women’s health advocates, TBA’s delivery and obstetrics as well as civic services are geared toward the health of the woman, and in support of women. TBA’s provide valuable advice and help women navigate the psychological to the logistical components of birth. In accompanying women for a clinical or hospital birth, TBA’s ensure that mothers are treated fairly and that her delivery goes smoothly. She also helps her make decisions about her health. TBA’s hold district officials accountable for outreach and distribute important health information. In many ways, TBA’s are spokeswomen for rural people.

TBA’s are invested in the community members whom they serve. As neighbors, friends, and family members, TBA’s live alongside community members, so health and
safety are a sustaining reminder of their service. TBA’s tell me that much of the care that they provide in the time leading up to a delivery consists mostly of convincing women that they are capable and easing their fears and mental obstacles. Just as Elly Teman’s work in, *Birthing a Mother*, discusses the ways in which surrogate mothers help intended mothers to become a mother by sharing with her the physicality of being pregnant and growing the baby, TBA’s help women to become a mother by telling her what to expect and assuring her that some things that seem abnormal or wrong are, in fact, to be expected, and importantly, that she is doing a good job (2011). Though discussions of self-ness and pride are rare with women in Uganda, being a brave mother, including and most especially during childbirth, is central to not only one’s identity, but also is said to be indicative of her character and that of her child. Delivering women, like other times and contexts in women’s lives, are expected to be poised and strong during delivery. TBA’s help women to preserve integrity. The techniques, procedures, and expressions of care that TBA’s provide, in part, deflect components of embarrassment or shame covered in the previous chapter.

“Healthy Delivery is everyone’s goal”

Rural Southwest Uganda is communal and people are deeply involved with the happenings of one another. Welcoming ceremonies are informal gatherings hosted at a mother or neighbor’s home that ensure babies and mothers will have the supplies and the resources that they need. Women of the area bring supplies from their own children or
sugar, flour, and soap, or even a meal of matoke. This fellowship serves as an opportunity for neighbors to visit with the baby, wish the mother well, and offer things to make life easier. In these communal times of aid, TBA’s are typically at the fore. TBA’s also accompany women home from a birthing center or clinic. Whether or not they delivered the baby, this is an important thing that TBA’s do. It gives them the opportunity to speak with the family or the husband and offer advice that will benefit the mother. Sometimes they will mentions things that a woman may not, like when sex should be resumed or what to expect from the woman emotionally. The TBA may also do some doula-like things, like help prepare a meal or sleeping area. But this accompanying of woman is really just to get her home safely. Women typically leave a clinic or hospital the day after birth. The trek can be difficult and anxiety-ridden, and women are walking through town, exposed to the attention of the community, which is especially glaring with a new baby. Such conspicuous attention is not ideal for women during this time, so having someone to walk with helps.

Walking-with was an important part of my participatory research I volunteered to carry women’s things back home after birth during which time we were able to exchange and relate. Though I was more of a helper, these times provided open, raw, and emotional sharing that were impactful for the project, for me personally, and often very evidently for the mothers. In these times, there was an excitement and a kind of connectivity that did not involve me, but there was often a very real opportunity to gain a sense of one

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13 Staple food source, starchy banana plant.
another. Women talked to me about how happy, nervous, or scared they were, and I provided casually optimistic encouragement and validation during this important time.

The intimacy of care

There is an emotionality to care that both presupposes it and is also a product of care’s embrace. Care is a tenant of the culture in Uganda, and there are stakes to this moral endeavor. Care is sentimental work, which is the easiest way to diminish the importance of the work in contrast with biomedicine, where emotions are seen as dangerous distractions. TBA’s deal with especially personal, emotional, and intimate issues of health, disease, personal truths, relationships, domestic problems, the state of kin position, family life, fertility, and psycho-social or spiritual issues. Care is connected to ways of being and is intrinsically intimate, and the ethics of social healing animates caregiving and demands that care take shape.

I observed one birth scene where the TBA told a woman that she had syphilis before she ever examined her. She said she could tell by the smell. The discharge and the ulcers have a very specific odor, she told me, and she was very angry that she was having to deal with this woman and shaming her for bringing a baby into the world under these circumstance. Congenital syphilis is passed from mother to baby. The mother got very upset and broke down crying, explaining that her husband cheated on her and that he passed it along to her. The husband of this woman is known for being a good farmer and a family man, so this secret was shocking and upsetting to the TBA, and it also explained why the woman had not sought care for the condition. Many of the TBA’s with whom I
spoke told me that they are privy to the most personal information, including her relationships, fertility (which TBA’s can assess through a woman’s placenta, and all manner of women’s health. TBA’s are exposed to a variety of secrets, and this exposure and confidential care, even when it is difficult and non-idyllic adds to their connections with women.

Delivery is an extremely physical process, even for the birth assistant. Infections, pathogens and culturally contaminated material quite literally fill the space, and TBA’s are exposed to all matter of bodily material. It is a visceral undertaking—from the smells to the fluids to the pain, resistance, or fear, which make it a powerful event full of sentiment, strength, weakness, and everything in between. Birth is also incredibly emotional. Care-givers, Livingston points out, are exposed to repulsive, agonizing, and empathy-inducing circumstances as part of the process (2012: 112). The permeability of the bodies, thoughts, and actions of a care-taking scene are vast and contribute to the inter-experiential nature of care practices. Livingston mentions that to provide care in a situation where there is an onslaught of bodily matter and emotion is like trying to control a flood—the oozing wounds, or bloody hemorrhage, or the release of fecal matter are dealt with by any means necessary (2012). And all means are often necessary for TBA’s. Though most TBA’s in my research expressed fear or hesitation regarding the hazards to their health, I rarely to never saw or heard of TBA’s denying women care.

The improvised and personal kind of care that TBA’s provide in Uganda necessitates that people work together and mutually care, and there is a great deal of cooperation between mothers and midwives in rural Uganda. Annemarie Mol writes that
care has defining characteristics, such as attentiveness, specificity, and choice, and breaks all of those in the name of necessity (2008: 85). In other words, the necessity and criticality of their work compels TBA’s to coalesce experiences, knowledges, and practices with mothers. Livingston notes that nursing is social healing, and that unlike doctoring, is highly visible, accessible, and public (2012). Nursing, like traditional birth attending, is not protected by the shield of medicine or science, therefore it is a truly public domain and everyone is implicated. Moreover, the response-based nature of TBA care means that there is not the prescribed protocol of medicine. Genuine care compels a relinquishing of certainty in favor of trust, accountability, and relational adjustability.

Particularly in communal societies, care is set in reciprocity, familism, and interaction, care also is based in roles, which are inherently social. The ways in which care is the basis for the formation and the endurance of relationships; and care’s generative nature means that care permeates social ties, particularly in Uganda where care is an interpersonal, improvised process that is a reaction to needs and is directed by social entanglements

**Relational entanglements of care**

Care is a radical endeavor as its practices permeate social systems, and care is relational in its exchange and offerings. Care is a social act with the goal to *restore* (happiness, functionality, wellness, ability, vitality, consciousness, etc) or reinstate the position of the one receiving (Simpson, 2010). TBA’s not only inform the mother’s birth plan but also teach the woman how to become a mother in an effort to reinstate fortitude, suredness,
and ability for women. The conjoined efforts of TBA’s and women demonstrate a shared competency, a composite of knowledge, and a coalesced ideology of motherhood that the two exchange and engage in. Substantial work has been done on the subject of guidance or accompaniment and co-constructed models of birth in discourses of doulas and midwives, including work that refers to midwives and doulas as birth ambassadors (Morton and Clift, 2014), who make the experiences of mothers visible and familiar while navigating between emotion, flesh, and policy. The recent film, *Mama Sherpas* (2015), likens the job of the midwife to the Tibetan experts who guide trekkers through extremes to the summit on Mount Everest. It is because of their experience, skill-based knowledge and familiarity, as well as embeddedness in the cultural ecology of the climb that Sherpas are able to assist others. More to the point, there is a mutual objective with mutual stakes and shared affectual outcomes. In Uganda, the TBA’s care practices are highly affected by her own experiences, her localized expertise, and the burdens and triumphs that she shares with other women; and her subscription to the health of the community means that she is implicated in their sorrows and triumphs.

The moral sphere of care is not separate from the social activity of a group, and is in fact entangled in all of those processes (Mol, 2008: 86). The amorphous nature of care practices means that care processes continuously change form and adapt to the social and political currents of the care group. Holloway writes that care is imposed by the network of the community and commands a sense of connectedness because members of a community will have ideas and plans of how and where to navigate and seek care (Holloway, 2006: 125). In other words, there are currents of care in the social landscape,
and the inter-connectedness of care-based relationships means that there is a mutuality to care. Care has a sense of mutual obligation, or reciprocity, particularly in a communal village where community members have a shared sense of health. Project participants told me on more than one occasion that they resent people who have HIV or other contagious diseases, including malaria, because they perpetuate the sickness, and the group is only as well as the sickest member.

The TBA is invested in the health and survival of families because of her role in family dynamics and her liability in pregnancy and delivery services. The relationship between the midwife and the mother is strengthened by sustained health-tending practices. A study led by Josephine Green reports that the “continuity” of a carer and consistency from caregivers contributes to health outcome and patient satisfaction (1999). Many mothers in my research tell me that the same TBA has assisted her in all of her births. She may have even delivered the mother herself or her children’s children, and she “knows her birth plan,” I would add that the birth plan itself is informed by the practices of the TBA who has mentored the woman through the processes of becoming a mother, from pregnancy to breastfeeding. With her community regard and skill sets, the TBA greatly influences mothering and maternal health ideologies and processes of care in Uganda. TBA’s have a significant amount of care capital, meaning authority and ability, so mothers are largely informed by doctrines of care from the traditional birth attendant.

The intimate and entangled networks of care have a unique position from which to reduce stigma, burdens, and hardships for women. I work closely with an organization named Healthy Child Uganda that promotes community-generated health development
projects and has trained and organized TBA’s in the past. Through the influence of some of the more vocal TBA’s in the region, Healthy Child Uganda has helped to redirect health campaigns away from shame and blame toward culturally literate and informative pieces. For instance, one image on family planning posters depicts a woman whose many children are literally atop her and breaking her back. She is surrounded my clouds of mess and chaos and the message reads, “Space your children so that they don’t break you.” More recent materials depict partners, with messages such as, “talk with your husband or wife about family planning,” which shares responsibility and lessens ideas of disgrace. This shift, informed by TBA’s, represents a move away from blame on women and toward partner health and collective responsibility.

The kind of “pastoral” counseling, to borrow from Angela Garcia’s notion, that TBA’s provide fits into the idea of what we would refer to as therapy in the American medical model (2010). Talk-based generative therapy looks a lot like what Ugandans would refer to as “having dialogue,” which means to basically discuss something openly. Having dialogue on a given subject, commonly spousal issues, health concerns, and interpersonal conflict, with a TBA or elder is often an alternative to seeking results from a witchdoctor (as the term is used locally), or other traditional practitioner. The difference is that an omofumu, or witchdoctor, would cast spells and conduct rituals to affect the situation, whereas the dialogue with a respected community member not only leads to generative narrative and potentially cathartic effects, but it also makes known any social or marital strife in which the TBA can discreetly intervene, either directly or via members of family.
For instance, a community member, Grace, told me that she was having some issues with her neighbor who was leaving things like bad talismans around the yard and giving her bad looks. She felt like the conflict was affecting her health and she thought the neighbor had probably cursed her. She knew that she was cursed when the bewitchment caused problems with her husband. Grace told the TBA of her issues and the TBA spoke with Grace’s neighbor’s mother who told her that the neighbor believed Grace was stealing from her. Through a series of inconspicuous conversations and observations, Grace learned that her husband, who was drinking a lot at the time, had, in fact been stealing from the neighbor. Grace was able to make things right by monitoring her husband and speaking with her neighbor. In all of this, the TBA quietly directed the peacekeeping. In this way, the TBA was serving a social service role and providing remediation, and it is her enduring, trusted role as TBA that is based in care and collectivity that makes her privy to these personal issues.

**TBA’s are an institution of care**

Traditional birth attendants have special access to men that other health providers certainly do not. Men typically have very little participation in health clinics and in health programs within the community, and are less likely to seek care. In fact, men often dissuade their wives from seeking intervention from clinics and private hospitals as these are usually costly and are known to distribute birth control, but the TBA’s have the respect of the men and have access to their health information. I will discuss in further detail in Chapter Five the ways in which TBA’s sensitize men on a range of subjects, and
have special influence over their health decisions due to their community-embedded positions. Such access to men’s health as well as the power of the TBA to mediate between men and women demonstrates the authority of the TBA to influence health and care in Uganda. It is care that defines the work of the TBA, and care is the basic foundation of her networks.

TBA’s literally, physically enable and empower women during childbirth with encouragement and support. They help women to maintain vigor during delivery with strong tea and physical support. But they also help women to maintain integrity, relationships, and dignity outside of the birthing event. These invaluable women’s health advocates are just that because of the social fielding that they provide. The TBA is quite simply an institution for women’s health. Through her care ventures far beyond birth support, the traditional birth attendant is an advocate who is both a necessary stronghold defending women’s right to health, and an influential stakeholder with the power to do so. She is the purveyor of an instinctual feminism and casual activism who provides service as a rally for women’s safety though it sometimes jeopardizes her own. TBA’s management of birth, and the perceptions of pregnancy and motherhood, gives her the cultural resources to resituate gender parity. The TBA validates women’s concerns and endorses her choices. Relationships are the hidden threads in the tapestry of maternity care (Hunter, 2008), and I argue that in order to bolster women’s health initiatives and properly address health challenges, interventions in the area should treat TBA’s as consultants, in a fragmentary medical landscape, rather than as catch-all’s.
Elly Temen writes that becoming a mother requires stock in an array of self-defining practices including understanding one’s place in family and community politics, and relationships with others, notably fellow caretakers (2011). The everyday, enduring nature of the relationships between mothers and midwives in Uganda informs the structure of maternity and the social roles of mother. Lesa Freeman, et al (1999) suggest that the business model of partnerships may be useful for framing midwifery care to properly reflect the needs of women or patients as well as to facilitate communication within the profession leading to long-term strategies for improving care. This partnership model would be achieved, the authors suggest, through agency-increasing practices such as shared decision making and trust building exercises prior to delivery. I argue that relationships between mothers and midwives in Uganda exist at least partially in a partnership framework, which has significant impact on overall health outcomes.

Sheila Cosminsky, in an edited volume on birth rites and the significance of birthing practices and rituals in cross-cultural considerations, notes that the midwife, historically, is associated with sociological specialties and general civil service (2003). As purveyors of cultural rites and administers of truth and knowledge, the TBA holds a grand position outside of her obligations in delivery and obstetrics care. Ugandan TBA’s are considerably woven into the inter-relational fabric of the community and it is precisely her relationships and her social and spatial proximity to her community that makes the TBA compelled to care. TBA’s are cultural liaisons whose moral imperatives of compassion and duty reveal deep interpersonal dynamics. Their everyday care, the processes of which are nuanced, essential, and enduring, are contingent on myriad
microstructures. TBA’s and community members’ entanglements of care show morphing ideals that depart from biological attachment and acknowledge contemporary citizenship. Women told me that there is a comfort and trust with the TBA that they cannot find in clinics. Furthermore, TBA’s and community members are close; they work together and cooperate to coexist, so there is a respect in their bond. Women report that TBA’s have helped preserve their integrity or otherwise affected their socio-cultural lives.

As people who manage vulnerability, TBA’s experience a specific combination of duty and burden. In this male-dominated society, women’s personhood is particularly impacted by her care-taking abilities, for family, neighbors, etc. And this has an affect on women’s social value (Geurts, 2002: 85). Alyson Young’s work in Northern Tanzania points out how biosocial care is particularly privy to notions of failure of the part of the care provider (2012). TBA’s in this project told me that they feel responsible for delivery outcomes and that they share failures and shame with mothers. Because of the crucial and impulsive nature of care, it is not always perfect, or even good. Emergent understandings of care allow space for poor care, bad care, and all of the unethical, inconvenient, and anxious versions of care in between. Miriam Ticktin writes that care is a response to current conditions and that care is set in moral imperatives of benevolence and compassion (2011). The assumption that care must also be empathetic or generous is erroneous if we consider care’s persistent needs and constant calling. TBA’s regularly provide care that is callous or half-hearted, they admit. Mol, et al propose moral ambiguity and explain that wrong and ambivalent care is care nonetheless (2010). TBA’s
who tend to critical deliveries report that they care about the woman, the baby, and the outcome, even if they are displeased with the circumstances.

**Compulsory care**

TBA’s in Uganda have well-known authority, status, skills and knowledge that compel and obligate them to provide. Care is doing what needs to be done, and sometimes these practices are a burden. They deter vulnerability for people and sacrifice their own well-being in so doing. But, as the TBA’s make clear, they frequently have little choice in the matter. Many TBA’s express that they often begrudgingly provide care when the situation is compromised. They are frustrated that there is seldom another viable solution in the village for delivery and obstetrics. They actually want women to be more open to birthing options, though they understand the preferences and customs. TBA’s are aggravated at their obligation to treat. Though they are rather indifferent to the ban itself, they know better than anyone that this deeply embedded practice cannot so easily be dismissed or removed. Angela expresses her concern with the diminishment of TBA training. She said, “Where will all these [skills] go? Who will take on the knowledge?” In the meantime, TBA’s are clear in their current position in their work. “What will I do, leave her to die?” asks senior TBA, Yoda, and I heard this question posed repeatedly.

TBA’s are the cornerstone of the community, whether they like it or not. Someone must help women deliver, and it has to be them. In dire and routine ways, TBA’s continue to treat and help out of obligation and duty, but also out of force, in a way, because there is often no other option. Her civil duty, especially in a communal
village, is a strong influence, and TBA’s are incapable of ignoring someone in need. Her
gendered responsibility and servitude is as assumed as it is essential. Livingston explains
that obligatory care is found in other communal societies of Southern Africa. In fact, the
word in Botswana for care is botho, which means care for fellow human beings out of
duty (2012:95).

Parallel and interesting considerations of care come out of the recent Ebola
outbreak and the ensuing flux of improvised and compulsory care that resulted. Because
of the extremely fleshy and contagious nature of Ebola, care tactics need to be
meticulous, and isolation and separation are sometimes mandatory. This is interesting
from a care perspective, as the patient must literally be removed from care. We heard
stories of familial abandonment and health workers refusing to provide care. Stories that
emerged from the crisis included many cases where the health workers themselves fell
victim to the disease. Diseases like Ebola force people to desert one another in the name
of survival. It is the ultimate example of the risks of caring for others. Everything that a
care-giver, tending to the sick, must do is a risk for those who provide. Yet, Ebola
presents a unique situation in which acquired immunity makes a patient automatically in
a position to provide care, so lay-persons and survivors found themselves in heroic
positions and compelled to care out of duty and biology. This is necessary obligation. An
NPR story from November, 2014 presents the case of a man whose family had all been
taken by Ebola. He remained with only a young granddaughter. He fell ill with Ebola,
and was posed with a care crisis, in which him providing day-to-day care for the girl
literally subjected her to death.
Maternal care during the recent Ebola outbreak was at a stand-still as blood and amniotic fluids, both highly infectious, took on new meaning during the epidemic. Many midwives who did continue to treat are reported as having died during the outbreak as a result of their duty. One is faced with questions not even of letting live or letting die, but to offer some sense of care and support, with full knowledge of probable death all around. In *Forced to Care*, Evelyn Nakano Glenn explains that complying to provide care is unconditional (2010). Coerced care is a product of social organization; the degree to which caretakers surrender certain aspects of their personhood is not simply a gallant act of altruism, but rather is a product of restricted autonomy, compliance, or, in the case of Ebola treatments, pure despondency. TBA’s in Uganda express that they, too, feel forced to care at times.

**Care is imperfect**

Care is not fixed and has conflicts. The “frictions and twists,” in sentiments of care for TBA’s in Uganda seem to wax and wane often between empathy and irritation. Care practices are modes of humanity, so care is complex and wavering in its humanness. The inter-relationally of care is its fallibility, and the micropolitics of the community have the potential to obscure care. Ugandan women tell me that maintaining relationships, including with TBA’s and other practitioners, directly impacts her health and well-being on physical, social, and psychological levels. The revered position of the TBA means that she is privy to respect and the benefits that come with social prestige. The reciprocity within the midwife-mother relationship has the potential to provide social support and
care security, but poor relationships with a TBA could impact a woman’s health access negatively. It is a woman’s social standing that may dictate the kind of care that she receives as opposed to, in clinical spaces of the region where care is highly contingent upon socio-economic standing.

Care is not necessary the soft coddling that it connotes. Care can be violent, irrational, ambivalent, or damaging in its necessity and dynamism. Care is the enduring processes of the people, and there are very real effects of giving and receiving in these messy, tangled praxes. In Uganda, I see that women form life-long relationships with women and the providers who offer them health services in the villages, but there are also instances of bonds being broken through the efforts to care and provide for someone. One example of such is a mother with whom I spoke who was a bit older than many mothers in my study. She reports that she is in her upper 40’s and was delivering her 8th child. She has six living kids ranging from five to 25 years. She is a cook in the community, well regarded, and told me that she takes great pride in spacing her children properly and providing for her family. Her TBA told her that she should not have any more children after her last one as she could see that her uterus lining was beginning to deteriorate. The TBA simply told her that her womb was spoiled. When she delivered her next child, she had what I perceived to be a child with Down’s syndrome. This condition is understood as severe impairment and a great burden on the family. The woman blamed the TBA for “putting that on her,” by warning her about her body, and their relationship became severed.
Care is simultaneously unconditional and extremely conditional, in the sense that care endures but is human-based. Care is collective, coordinated hope, says Annemarie Mol (2008:86). “Good,” is arbitrary when it comes to care but “better,” is the goal; improvement or restoration of one’s condition depends, says Mol, on a quality consultation, which is not or should not be debate but rather conversation. Care is an exchange of knowledge, suggestions, and information- it is a together-ing in the sense that care is communication and narrative and news (2008). Miriam Ticktin explains that health matters conflate social, political, and medical worlds and renders forms of alienation, isolation, malaise, and violence (2010). Livingston’s considerations of care from the perspective of the nurses are groundbreaking and poignant because it shows the fluid categories of patient and care-taker (2012). As practitioners, the nurses (not unlike birth attendants) are in positions of obligation bound in ethics of professionalism, citizenship, and religiosity, but also the personal, moral investments play a large role. Wendy Holloway argues that physicality and social relationships are the two most important parts of the human experience, and she says that these coalesce in care practices (2006, 12). Communities and the developments of such are based in care and tending. Care points out and draws out changes, problems, and relations, says Holloway, whether on the state level, within a family, or at the market (2006:14). Particularly in a communal village such as in Uganda, care lessens oppression by providing that needs are met.

Ambivalence may be seen as the antithesis of care. But feminist psychotherapist, Rozsika Parker explains that ambivalence is a part of care. She writes that the care-taker,
entrenched, embattled, and possibly, enraged, is spurred by a kind of “creative aggression,” that leads to possible solutions and can oddly mobilize care (1997: 25, 29).

Parker claims that there is often a disbelief in caretaking where certain emotions are obscured by the external and internal happenings of an event, such as childbirth. TBA’s tell me that they often feel irritated or feel a sense of helplessness in emergency deliveries. Unmanageable situations in Uganda are often approached with ambivalence as a way of averting weakness. Parker says that ambivalence denies unmanageability and saves face; it is a way of having control over an out of control situation (1997: 33).

TBA’s will actually avert weakness on behalf of mothers, assuring them of situations that are out of the mothers hands or undermining issues that threaten women’s pride or honor.

When I asked TBA’s if they ever don’t want to help someone or if they ever just feel like they want to leave a mother on her own, they said of course! It is like a job, one woman describes, “You sometimes don’t feel like it or the woman is particularly [annoying].” And because Ugandans do not usually hold back with these feelings, they will tell the mother. I once heard a TBA say, “You are paining my ears. You are making everyone around feel as though they are in pain!” When I later asked the TBA about that experience, she rolled her eyes and said, “That one… I wanted to walk away and leave her to figure it out.” Rozsika Parker finds that ambivalence saves the care-takers from over-submission as well as excessive overpowering or domination (1997: 29). But TBA’s simply do not look away when things get tense in a delivery. The aesthetics and sentiments of their care can be unintuitive or harsh. TBA’s are personal and physically invested in their work, and they are frustrated at the lack of assistance. They are burdened
by the hazardous forms of duty presented to them. And they express that they are the only ones who manage hazardous and dire women’s health.

**TBA’s actionable risk**

The immense irony of the ban on TBA’s includes the fact that the Ministry of Health cites risk as the reason for forbidding services, because the ban further implants TBA’s in sites of risk. Given the rural setting, it is risky for TBA’s to care for delivering women. Moreover, they say, the fact that women rely on TBA’s creates further risks for women as it deters them from seeking health in clinics and hospitals. Much of the discourse of maternal health care in Uganda is centered on ideas of risk. Policies are meant to respond to risk, and now that conversation includes TBA’s as risk. The criminalization of the work means that there is no support, no training, no resources, no supplies, and no certainty or security for TBA’s. Because no laws protect them from mistreatment or unfair action, there is no structure to which they could turn in times of need or doubt. No supplies and no training means that TBA’s are left with no consistent supply of gloves, for instance, to protect them. It is unsafe and it is a gamble, now in more ways than one.

Risks to mothers and children are widely discussed and analyzed in the literature, especially in the context of impoverished settings, the risks of childbirth have been collated and worked into global and national health policy across nations and organizational agendas. But what there is very little of in the literature, as well as in the conversations with stakeholders around the proverbial tables, are the risks to the caretaker and the risky nature of care work. Found more in journals of midwifery and provider-
based literature, the risks to the care-giver are understandably exasperated in rural settings, and maternity care ranks among the most risky endeavors because of the urgent nature of the work, the adjacency to infectious disease, the most culturally sensitive and symbolically potent, and the invasiveness associated with the work (JA Kornelsen and SW Grzybowski). Risks to caretakers are associated with issues of obligations to care, and the most risky health processes are also the most critical.

The work of the TBA is now, more than ever, outside of the laws that protect her, and outside of the systems that support her. The work is, thusly, more risky than ever. Conversely, illegality of TBA services means that TBA’s are outside of any jurisdiction that would keep TBA practices from doing harm or hold them accountable for mistreatment as well. Also, no further training means that TBA’s are less informed of emergent treatments or upcoming health opportunities such distribution of condoms, testing and screening days, or immunization campaigns. TBA’s in Uganda describe their work as dangerous. They fear rising rates of HIV and infectious diseases, and they also express to me that sometimes, if unprepared, they are forced to participate in risky, dangerous work.

“What kind of situation is this,” asks Angela, senior midwife, “I am exposed, I am at risk here, yet the [radio campaigns that deter use of the TBA’s] abuse me, the one who is risking!” Affected by this deterrence more and more, TBA’s are retiring or refusing to treat, and that only makes it harder for those who continue. “There is a lot of pressure,” says Angela. “Pressure to help, but if there is a complication, it is almost as if the government says, ‘See, I told you’.”
Risky policies

The constructions of risk, including the continuum of risk and the scale of risk, are incorporated into health policy and biomedical treatment (Chadwick and Foster, 2013). Risk is engineered, and the labeling of risk is based on a need to monitor and control, which depends on governmentality (MacKenzie, et al, 2010: 489). Especially pertinent in colonial models of control and subversion, more worry and more anxiety is more cause for protection and jurisdiction. The institution of risk is directed by boards, policyholders, and organizations with or without political ties and the actual resources to reduce risk. In the social model of care in Uganda, risk is socially based in networks of kin, allies, and reciprocal relationships based in social, political, and cultural constructions that are ignored from policy standpoint. Risk predictions neglect the scarcity of health services, legacies of colonial tirade, warfare, exploitation, state-planning failures, and debt as well (Chapman, 2006). The risk approach fails many international settings and is a poor predictor of obstetrics complications. For instance, in Uganda, emergency birth and pregnancy complications cannot always be predicted and therefore timely detection-based intervention fails. Women who do not engage in the formal sector for prenatal care or childbirth and women who initiate formal care late in their pregnancies will not benefit from the medicalized risk approach to safe motherhood. The notion of risk also carries with it notions of agency. Focusing on risk keeps the focus of maladies and prevention in the domain of the individual, yet in Uganda the most salient threats are from shared social realms.
Cultural practices that account for low participation in clinical health settings and the traditional beliefs of the community explain risk more accurately than standard models of risk and risk management (Chapman, 2006). Moreover, risk perceptions are based in corporeal experiences and gendered, social, and economic marginalization (Chapman, 2006: 507). Anxieties around personalistic reproductive threats have very costly consequences for women, both economically and physically speaking. Reproductive threats are best addressed outside of the biomedical sphere and the practitioners who treat and help them are “sources of reproductive knowledge and therapeutic processes that address meaningful aspects of women’s reproductive experiences,” (Chapman, 2006: 507). In other words, TBA’s help women deal with the uncertainties of pregnancies and childbirth in a way that they understand and that makes sense to them, which is an invaluable kind of care. TBA’s help women navigate social upheaval and interpersonal austerity as well, and that is difficult to include systematically in public health discourse. Meanwhile, TBA’s continue to provide life-saving services.

Given the aforementioned difficulties of transfer, TBA’s manage and measure risk all the time. It is precarious, because if they transfer mid-labor, they risk the mother’s safety as well as their own positionality. If they do not, they risk the outcome for both mother and infant. Transferring also means that a TBA risks the delivering family’s privacy, finances, and likely the cultural preference not to be separated from the community during labor. Hospitalization is a major and delicate situation for families, as this means that many people will need to leave the home to be with the mother, and they will have fees to pay, and often it is the TBA that directs this decision, not the family.
The pressure to treat and to save does not end with the decision to assist a birth; there is a tremendous amount of social risk and interpersonal accountability associated with the practices of the TBA in Uganda. Obstetrics work in rural communities make up the most socially risky health care one could provide (Kornelson and Grzybowski, 2012). Rural maternity health providers like the TBA are faced with the stressors of strained resources while the close communal ties create a unique situation in which a sense of kin and social capital are tied to work that is extremely difficult to provide, creating a compounded liability for providers.

Figure 24: Birth Plan campaign - photo by author
Cultural politics of birth attending

Care practices carry huge responsibilities and the failure to care may have deep social consequences. The intense personal risk and accountability inherent in rural maternity care can be understood by noting that pregnancy and delivery are two culturally sensitive situations with many ties to ritual and religious beliefs. The accountability, for the provider, goes far beyond sustaining life. TBA’s are responsible for new life, which is closely monitored by community members and is significant and personal for all the members of a community. “Mamas and babies,” one community member said to me, “These are the most important parts of the village.” The psycho-social wellbeing of the TBA hinges on her successful birthing procedures. Ugandan TBA’s do not have the luxury of anonymity that some medical professionals might as they live alongside the communities for their whole lives typically. Furthermore, as advocates who enter into the process of birth along with a mother, they are responsible for not only her successful outcome, but for her personhood during labor.

The experiences of the mother and the TBA coalesce during birth. TBA’s not only take on a great amount of personal risk because of health hazards and the inherent dangers of performing invasive and now illegal medical procedures. They also have high emotional and personal investment. Loss of life impacts the whole community. As the protector of the community, the TBA has great pressure to protect the collective well-being and to ensure the continuation of her community. TBA’s provide fertility treatments and perform fertility rituals, so sometimes literally and directly affect who becomes a mother. Livingston writes that health instantiates politics, and in the global
south, particularly rural African townships, the weight of survival overwhelms the processes of care, reducing care down to the webs of relationships that sustain the community (2012: 94). Care is a social form of healing that is far more public and present than the doctors’ opaque, closed-door policies. Care is personal and bound to responsibilities and entitlements, and because of the personal investments of care there are high stakes associated with these fleshy, messy practices.

Mistakes on the part of the TBA can have heavy consequences in this society where many maladies are attributed to interpersonal conflict and bewitchment. In impoverished communal villages with histories of war and disaster, dislocation, and insecurity, such as those of Mozambique or Southern Uganda, ruptured social organization and contexts of vulnerability present social risks that actually outweigh and eclipse medical risk (Chapman, 2006). Interpersonal, domestic, and relational events make for a certain social vulnerability, and reproductive issues can be particularly susceptible to suspicion and sensitivity, which have the potential to affect women’s economic security and her entire web of kin-based or social contracts (Chapman, 2006: 488). TBA’s have the important role of managing precarity and uncertainty as they are entrusted with the most personal details of people’s lives, which carry significant value in communities where gossip and secrets are ammunition for bewitchment.

**Reproductive threats and vulnerability**

Misfortunes inflicted symbolically make people suffer psycho-socially and often physically as a result. Because childbearing and kin are central to personhood and one’s
role in a community as well as survival, maternal vulnerability and reproductive threats rank high among worries for women. The implications of family-making for power, satisfaction, and happiness in communal villages are vast. Health and wellness in many African communities are linked to obligations between living and spirit kin. Ugandans practice an ancestral cosmology, so spirits of both maternal and paternal parents and grandparents have a say in one’s health and happiness. Women are particularly exposed to risk and vulnerability during their fertile years. Pregnancy itself invites gossip and jealousy. Physically, it makes women susceptible to colds, malaria, and other infections; then there are the symptoms of pregnancy itself, including nausea, back pain, and edema. On top of this, personalistic harm provoked by bad spirits and difficulties cast upon women from jealous kinswomen or neighbors makes the condition of pregnancy laden with worry (Chapman, 2006: 495).

Social threats, as one community member described to me, “are much more powerful of a concern than a breach.” TBA’s deal with breaches and obstructed labor all the time, but they have the skills and knowledge to deal with these. TBA’s do not, however, typically have the capabilities to reverse a curse. Gossip and rumors have real power. Evil words invite ill fortune, so women do not expose themselves by flaunting a pregnancy. The best way to protect one’s state is to keep it a secret. This makes the TBA all the more a confidant and point of solace. Without her, women would be forced to seek advice and care from others who may or may not have their best interest at heart, especially when economics are involved. That being said, the TBA is also in a position to

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14 Ancestors dictate the fate of their descendents, so one must always take the necessary steps to avoid angering the spirits, which include having children and performing rituals to keep them safe.
affect pregnancy and birth, so she is potentially responsible for conception and delivery. Thusly, she may even be the target of the infliction or subjected to sorcery. Moreover, the fleshy matter that the TBA deals with during delivery is symbolic and associated with ritual and contamination. After a delivery, both baby and mother are subjected to scorching baths that serve to both remove birth matter and blood, but also to ritually clean off any fragility.

Mistakes on the part of the TBA can have heavy interpersonal consequences. Her psycho-social well-being depends on her acting appropriately, protecting private information, and being strong enough to ward off inflictions cast upon her and the women who she treats. Moreover, the close community networks mean that there is what Chapman refers to as, “endangered collectivity,” (2006: 499). In other words, the TBA who watch over and protect communities are tasked with keeping threats at bay for the sake of the whole of the group. TBA’s carry the secrets of pregnant women, whose very safety and health depend on not exposing their pregnancy and vulnerable position to the afflictions of others, and it is the job of the TBA to protect that position, avoid exposing women, and manage the physical risks that may or may not be a result of social vulnerability. TBA’s deal in fragility. They take on and manage vulnerability and the very work that they do serves to counter uncertainty as they provide answers that demystify health for women. I turn to the powerful placenta to understand how TBA’s casually and imperviously work with sensitive health situations.
Placental perspectives

Ugandan midwives see a fair share of retained placentas and are well known for having the abilities to deliver or remove them. TBA’s in this study considered the placental delivery a point of pride in their practice. The placenta, because it is the center of nutrients and provisions for the baby, is highly regarded as a symbol of fertility and nourishment. Along the same lines as breast milk, the supply of which is seen as symbolic of a woman’s ability to care and provide for a child, so too is the placenta. TBA’s will pull the placenta out slowly, wrap it around a stick, evaluate the condition, and often announce that to the mother. TBA’s closely analyze the placenta after removal to ensure the entire thing has been removed, so that retained bits do not cause infection. Some more negligent hospital staff have been known to leave pieces inside, so sometimes mothers evaluate it themselves.

The placenta is linked directly to a woman’s future reproductive abilities. I discuss in Chapter One that sometimes women will keep the placenta, and bury it somewhere in the house for future use or symbolic fortification of the baby and the bond with him. Some TBA’s dry it out and crush it for women to consume the powder when they are ready to conceive. TBA’s are able control a woman’s next pregnancy by keeping the placenta out of sight until she is ready to get pregnant again, when they “release,” the placenta to the mother, she will be able to conceive again. In most hospitals and clinics, there are placenta pits where all of the placentas are dumped. Some women take major issue with this, not only because the placenta is not kept or dealt with carefully, but also because her blood and maternal matter would be out of her controllable reach. Placentas
are a key ingredient in sorcery as well, due to their supernatural powers and because they come from a place that is unseen. It is said that *omofumus* will dig up and use the placenta, allowing him to control the fate of that woman and her family. Custom says that it shall be disposed of where no one will see, as is the case with any other bodily matter including defecation. So, sometimes women take the placenta to the bush. TBA’s are, of course, an exception to this, and deal openly with the placenta. This is another way in which TBA’s are immune to taboo. TBA’s sometimes perform the task of digging a place for the placenta or even making the trek into the bush on behalf of the woman.

As risk is linked to social threats and interpersonal processes, such phenomena influence health-seeking. Risk is, of course, subjective. Ugandan health programs typically do not have a spectrum of risk in the same way that Western medicine does. For instance, placenta previa is where the placenta blocks the cervix, a very dangerous scenario of obstructed labor. TBA’s, for the most part, say that they could not detect this. Except Alice, who says that she is able to detect by the kind, or lack, of discharge a woman expresses. This condition could be seen as a risk, but TBA’s who have encountered this issue say that they are able to deal with the scenario when it was presented by keeping calm and preparing for a longer delivery. Alice explains that maintaining calm in front of the delivering woman is key. She says that it matters not to tell the woman extra things to worry her. Labeling her as “at-risk,” prior to the birth would definitely make her anxious and is anti-intuitive for successful delivery. The perception of risk is based on experience and knowledge of other’s experience, and it is the perception, itself, that matters most, especially when considering delivery where fear
and hesitation can lead to complications. So, this makes it all the more critical to have a provider with a full understanding of health perceptions and what influences those, which diminishes risk and makes care more attuned, such as avoidance of language that comes across as deprecating.

**Care’s subversion of risk**

TBA’s, as women’s health advocates and support systems, give agency to women, subvert biomedical structures of fear, and lessen perceptions of threat in childbirth (Chadwick and Foster, 2013). TBA’s take risks upon themselves with every delivery, so they absorb that risk and therefore emplace the risk as well as parallels of blame and vulnerability. Risk and uncertainty are related phenomena. Risk is defined in Uganda by dominant discourses of biomedicine and foreign health aid campaigns. So, the risk that is “mapped” onto Ugandan mothers, providers, sex workers, or domestic laborers is linked to moral imperatives and religious ideologies, and created by science, technology, and notions of modernity and development (Boholm, 2003: 159). From the standpoint of the practitioners, midwifery, as an entity is generally understood as a subordinate alternative to medicalized birth, and is thusly always defending against risk assessment models which, across cultures, mark low-tech, home-based practices of birth as inherently perilous (Byers, et al, 2010, 489). International risk and delivery configurations define birth outside of a hospital as risk, notably because deliveries are performed according to risk (Byers, 2010). Risk, and the defining of such, is a protocol in the biomedical model that allows providers to manage the administration of care and intervention, but this ill-
fitting mechanism does not apply to local care in Uganda, and shows how care is deflected through bureaucracy rather than reaching the public.

For many African women, the birth for the shame-free woman is as important as the birth of a live infant (Asowa-Omorodion, 1997). The presence of the TBA who has the social strength and honor to potentially ward off threats and to culturally perform in ways that keep the woman austere and protected means that she literally helps her to labor her own dignity and therefore her social position and cultural immunity. The customs by which people manage living and spiritual afflictions that lead to loss, grief, or suffering must meet the social order. The disruption of such order provokes ill fate, and such vulnerabilities both, “constrain and engender reproductive agendas,” (Chapman, 2006: 508). Demonstrations of fertility partially define the social attainment of womanhood in Uganda, and TBA’s help women arrive in such a role. The moral value of risk shapes perceptions of health and informs prenatal action and engagement with medical practices.

I was visiting with TBA Claire one day when two women arrived separately about five minutes apart. One was an older mother of four who was experiencing early signs of labor and walked herself slowly and calmly into the birth room. The other was a 16-year old girl delivering for her first time, who arrived frantically with her mother, fully dilated and very scared. Mother 1 began to have painful contractions. She walked around moaning while Mother 2 went into labor. With a lot of coercing, pulling, and encouraging, Mother 2’s baby emerged. Half of her face was out and I could see she was inside the sack which was fully in tact. Claire stopped her from pushing, and let the baby
slowly slide out another inch or two, at which time we saw her looking around and moving her head. She nuzzled the sack and pushed through, and as soon as she did, Claire snatched her out and began the processes of clearing her nose, wiping her, and encouraging her to cry. She announced the birth and everyone rejoiced. Babies born in the embryonic sack are said to be special. They are considered protected and looked upon by angels, so birth attendants let them emerge themselves and rupture the sack on their own. Otherwise, they are said to have disrupted her protective powers.

Such traditional pregnancy beliefs are not accounted for in clinical agendas, and to ignore the social threats is a form of health injustice. The idioms of impoverished woman are severely dissociated within biomedical constructs of individual and population risk. Interpersonal dynamics define health in this community, and therefore should be incorporated into development efforts in such a way that does not obscure or blame community. Plural health systems are strategically used by women seeking to minimize both social and biological harm, and to optimize security and well-being, but often the participation in biomedical sphere forbids the use of “other,” kinds of medicine (Chapman, 2006: 509). Improvements in reproductive care will respect the multiplicity of resources that women invoke and utilize, and such progress will include care that is confidential and embedded in the community. This is especially critical given that following the ban, hospitals and clinics have increasingly demanding protocols from community members, including full patient profiles and health records, for example.
Radical catalysts for care

Care practices, especially indigenous ones, are fundamentally stifled by hegemonic powers. It is vital to consider care as not only a viable means to wellness and treatment but as a humanizing practice that critically responds to the power inequalities embedded in formal biomedical discourse and practice (Mol, et al, 2010). Simple care practices save people and keep them well more often than invasive techno-rich biomedicine, and by widening the definition of medicine we begin to see the multitude of ways that care is carried out. Care is inherently radical in its departure from medical mega-structures, and by the ways in which on-the-ground care processes de-center biomedical hegemony, especially in a colonized nation such as Uganda where agendas of aid and development continue to be based in biomedical ideologies. The current concepts of care in medical anthropology move away from overly rationalist agendas in biomedicine and recognize that care, in the truest sense, is community-driven. García’s version of care is immediate, experimental, and sometimes tragic, illegal, or unjust (2010). This highlights care as something organic or rooted in local, natural processes rather than something introduced or a product of intervention. Inherently, care is a humanistic endeavor set against prescriptive regimens. Care is about investment even if the qualities are obligatory or forced.

Care is radical in the sense of being fundamental and rooted is in its everydayness. Care, runs through daily practices of maintenance, tending, and life sustaining. Angela García’s work shows the ways in which care can be ethically and morally ambiguous or adjustable, but localized and temporary, especially in contexts of
chronicity (2010). Garcia’s depiction of care in chronic addiction displays the ways in which care is constant and feeds a hunger that humans have to be “well,” or normal, however that may be understood. Care’s new amorphous analysis recognizes the menial and the urgent and is arguably a viable avenue for illustrating the ways in which the everyday trumps the hegemonic. Livingston offers that sentiment and politics are revealed through practices of care and that, in fact, these practices are adaptive and explorative and have disjointed, conflicting, or uncertain versions (2012).

**Care transcends uncertainty: Feminist politics and everyday advocacy**

In contexts saturated with neo-colonial health agendas and ideologies, TBA’s keep the bio-bureaucracy at bay by fielding development pursuits. The socio-cultural power of the TBA helps to de-center biomedical regimes in Uganda that have historically played a role in conquest and mission work, and subsequently morality and wellness. The care networks of the TBA are feminist platforms of advocacy for women as TBA’s often work as informal activist raising concerns about health injustices and calling for (or more accurately- acting out) relevant and contemporary solutions for women and mothers on a local level. Because of her aforementioned roles in development and aid projects, this has the potential to transfer to policy and nationalist ideologies. Client or patient-centered models of care are the means to which midwives can negotiate “street level” bureaucracy (Finlay and Sandall, 2009). In other words, community midwives have up-close access to shifting cultural politics, and the personalized public service that they provide is activated in emergent frameworks. The midwife’s allegiance to the community makes it so that her
policy is more likely to guard patient’s (and women’s in particular) rights in the production of knowledge and the “processing” of people, to borrow from the bureaucratic model. This type of obligation is set in deep and interwoven microstructures, which have the kind of power potentials that grassroots efforts are known for.

The relational side of care makes it markedly distinct from agendas in biomedicine that follow models designed to limit time and avoid messy emotions or non-crucial narrative. Care is radical because it takes guts! Care providers put themselves on the line in so many ways. They offer their health, safety, and security in the name of obligation and social role. Puig de la Bellacasa (2012) holds that thinking with and beside care fosters understandings of one another, and offers ethics to empathy. The care-giver may not be a selfless martyr, but TBA’s in Uganda are offering care that is outlawed – that is a profound and radical move. Moreover, they do so through a mutuality that entails a connection to community members and an investment long-term.

These renegade care providers are doing what Karen Barad refers to as “holding oneself at a distance,” meaning that causality is disregarded and the self is not the center of subjective thought (2012: 206). Many theorists link care to constructions of the self, though often in terms of care being the process by which the self is constructed or restored. Caring, like narrative, is an exposing of the self at the expense of other. I believe that TBA’s in Uganda are exposing themselves in many ways, biologically, socially, and as agents of international modules. Holloway argues that care is tied to subjectivity and morality (2006:14). TBA’s in Uganda hold an ethical obligation through civic duty and community responsibility. Care’s ethical obligations means that care has a certain
command and a nearness to it, especially as care is linked to attachment, need, or vulnerability. There is certainly an intersubjectivity to care because care is exchange, by definition. Care makes one experience an other, drawing out difference or relatedness (Holloway, 2006: 125). And this is precisely what policy, bureaucracy, and clinical institutions bypass – disassociated care is not care, which is why “briefcase care,” collapses when it is set into motion.

Care’s nearness is felt in a close, communal village in which health is felt more in terms of social relationships rather than physical conditions. Holloway writes that, “caring agency” transcends constraints, in the sense that there is a limitlessness to the ways in which selves and relationships are built through care practices (2006:118). Care is a campaign for justice, and TBA’s in Uganda are indeed advocates for women’s rights to health. Ugandan TBA’s are enacting a point of agency insofar as they are fulfilling a social role and thusly keeping social networks alive (Holloway, 2006: 118). TBA’s are responding to a civic duty and a community responsibility, because someone has to. Fears and institutionalized thinking can blindfold compassion, says Holloway (2006, 118). TBA’s are not in the business of allowing people to die, and I partially attribute my own astonishment at the strength of the TBA to utter refusal to allow women to die.

Care inherently follows a feminist agenda as carers attempt to humanize failing bodies, and bring the vanishing back to life. Caretakers carry out the humanistic promise that medicine claims but often fails to do (Garcia, 2010; Livingston, 2012). In Uganda, care also calls out medicine, the global entity, as biomedical policies and programs fail to address local beliefs and practices, lose footing, fade without funding, or solve one
problem at the expense of another. Care calls disadvantage into question because the point of care is to lessen suffering (Holloway, 2006: 117). But suffering persists just as care processes persist, and medical policy and aid comes and goes.

**Contingencies of care**

The previous chapter lays out some of the ways that medical aid and intervention have failed in the past because of the inability to collectively work with local knowledge. TBA’s continuously have picked up the pieces of health campaigns and carried the burdens when health service structures fail. Women’s health in Uganda has been disregarded, and the primary providers whose work is to keep these women safe and speak on behalf of women to families, clinicians, and policy makers, has been forbidden, ignoring the broad manner of care that TBA’s provide. Health services for women remain contingent on policy that will systematically care. More proximately, reproductive and other health services for women remain contingent on the willingness of the TBA to practice despite her being barred from doing so. Contingent means occurring or existing only in relation to other factors. Contingent is uncertain, pending – that which is reliant upon other factors. Contingent is changeable, unstable, leaning upon, or susceptible to change. Care is Uganda is contingent upon myriad micro and macro structures, with the TBA often acting as bridge between those structures. But what is evident is that care needs the backing of policy and that policy needs the textures of care.

Care, as the persistent management of lives, fosters relationships. The version of global medicine that manifests in Uganda is one of fleeting security and uncertainty.
Whyte adds that Uganda’s history of colonial rule adds to the sense of uncertainty – as subjects of international agendas, the opacity and oppressiveness of medicine that is imposed and unincorporated creates pressures that perpetuate worry, rather than alleviate it (2997: 204). Often, those pressures are taken up by the TBA. Most rural Ugandans agree that there is an indeterminacy to their lives that strains them. This existential uncertainty is the product of the landscape of diseases in the area, the history of violence and depletion of resources, and the structural harm that a lack of control over one’s life does to well-being.

Whyte argues that uncertainty and trouble refine abilities and imaginations, and help establish or recognize meaningful social relationships, (Whyte, 1997: 18). Contingency, and its relationship to risk, are ways of understanding how people respond to the present against an understanding of the future (Heil and Macdonald, 2008: 302). In other words, the politics of contingency include continuous struggles for answerability. There is a management of chance, even in uncertain worlds, that TBA’s can provide because of their relational care and connectivity with community members. The promise of care transcends the contingent and the uncertain, though these affects may remain.

**Systemization of care**

In Uganda, the key to health is care: kin-based and social care, direct healing care, and care-infused policies and programs. Care-takers and care networks are a means of dealing with uncertainty. Health insecurity calls forward the need for collectivity. Radical and systemic infusions of care are a means to more coherent health interventions and
operations. What is missing from medicine is exactly what TBA’s and community members say they have, at the most fundamental level: care. Mol writes in, *The Logic of Care*, that care-takers make choices, but do so along with and in tandem with active patient agents (2008). She says caring requires citizenship in a community or a collective, and that care is a practical activity that takes true interaction (2008: 86). In other words, care is a relationship, a collective act, and a mutuality. TBA’s in Uganda are effective due to their embeddedness, investment, and relational entanglements. For care practices to have elements of response and adaptability, they must be directly informed by network constituents and participants, which takes interaction, exchange, and understanding. The ban against TBA’s is a direct disregard for such connectivity and exchange, as it fails to address how TBA’s might work with or alongside clinical practitioners and it fails to consult women and other community members complex, entangled experiences.

Biomedicine does not operate in the way that care form the TBA does as it follows linear planned regimens of clinical structures that do not always respond directly to the needs of the patient. The TBA’s work, on the other hand, is based in responsability. Medical protocol must be abandoned in order to care at times. Livingston adds that, in southern Africa, the weight of survival overshadows sustained structures of care, so nurses and care-takers embody a certain *flow of care* that responds to patients’ immediate needs rather than following a dreary task list that is beneath them, hierarchically (2012, 107). TBA’s display and engage in deeply meaningful care mutuality in Uganda, but such care on a wide scale needs backing with policy and functionality. Susan Reynolds Whyte points out that true care, must be met with enduring therapies
such as antiretrovirals, and that takes resources (1997). Care, in all of its radicalness, has a certain fragility when it comes to wide scale access and sustainability. Because of care’s improvised character, care practices require a backing for longevity and substance, which is why researchers like myself advocate for interventions and policies that demonstrate the same kind of care that we see every day from the village TBA applied to interventionist strategies, but this requires a surrendering of risk measurements and other bureaucratic clinical scripts.

My critique of biomedicine in rural Africa is not only a rejection of the power and politics affixed to a Western standard; it is also an argument that the culture of biomedicine is in contrast with communal societies who prioritize care exchanges and rely on inter-personal relationships to organize their worlds. Medicine often forgets the human component in the name of profit or time valuation, but as one Ugandan midwife told me, “All we have is care.” Care is medicine’s greatest asset; it is fundamental; it is the utmost display of humanity as a practical and emotional response to human universals of pain and inability. It is through care in our considerations of the world that we arrive at reliable interpretations, creative approaches, and nuanced practices of medicine. Care involves truly relating to others and understanding their experiences, which takes connectivity. Health policies in Uganda, including but not limited to the ban, simply do not reflect women’s obstacles, preferences, or praxes. Care is a constant holding of what is important, and women’s opinions, goals, and sentiments are ignored in the biomedical regime. Care asks different questions than biomedicine, and for health policy to truly respond to and serve a community, it takes tending and witnessing. Care policies should
respond to the moral and political, and demand adaptive and explorative strategies for doing so.

The gendered regulation, repression, and exploitation of the TBA is blatant sexism that targets, blames, and attempts to bar indigenous women from authority. Her care services are an institution of community and women’s health and though TBA’s have been informants for global health agendas, their practices are shunned by those same entities. TBA’s have been used as a way to access rural women as they are outstanding, trusted resources with the power to influence and induce behavior. That policies can be put in place to ban these women, who have played an advocacy role for decades, is to essentially ban women’s health advocacy. Moreover, it exposes TBA’s to great danger. The next chapter investigates the history of women’s oppression in Uganda and considers the deeply personal role of interceding in reproduction in a society where childbearing has incredibly impactful consequences for women and the dynamics of their lives.
CHAPTER 4: Women’s Paradoxical Burdens and Reproductive Consequences

“Women’s heads are full. They have everything to worry about and much to fear.”
- Yoda, senior TBA

“Women are Uganda... Just look at them!”
- Nasa, married man, 42 years

The ban barring care practices of the TBA is an issue of women’s rights and health justice. The political and economic contexts in Uganda are such that women often depend on men for achieving social status and for creating care networks. This chapter lays out some of the ways that women are structurally and historically silenced and
managed in such a way that they are made to be static and subservient. As such, women are disallowed from decision-making and participation in discourse, policy, and systems that impact their very being. Moreover, women are excluded from agency and the pursuit of the good life due to the burdens and blame placed on her. This section illuminates those obstacles and exclusions by looking at the tensions between life goals and the perceived failures that are products of this male-dominated, colonized, and impoverished region. The supervision, regulation, and punishment of women deplete women’s agency and selfhood in ways that stifle their abilities to make their own way. Health and social structures in Uganda are such that women do not have access to the resources necessary to create the ideals and expectations placed upon her. Control of women is a colonialist endeavor and development programs that speak only the language of biomedicine perpetuate the hushing, shaming, and threats to the agency of African women.

Having control over one’s life affects health completely, and women are forced to make a way for themselves, including the formations of care collectives. These women-based informal networks provide supportive platforms that help women make informed decisions and depart from the prescribed structures of patriarchy. Women’s networks are liberating as they are informal resistance to obedience-based interactions and help ease the tensions of womanhood through togetherness and mutual understanding. With TBA’s often at the fore, empowered women’s practices happen on a small scale in Uganda, but these are sturdy and steady and harness ideologies of empowerment. I highlight the impact and significance of women-led collectives for the betterment of women’s health in
order to make the case for women-focused movements of empowerment with or against development interchange.

The complicated identities of womanhood in Uganda are a paradox of expectations around duty and blame. Womanhood is especially defined around concepts of motherhood. With that comes complicated terrain around chastity, piety, and sexuality. Patriarchal structures put women in positions of compliance and often the rhetoric around women’s roles is veiled forms of servitude to men, including through reproductive abilities. The history of women’s place and the economy and their struggles has roots in Africanness and presents a dynamic juxtaposition between traditional lifeways and impending foreign-fueled development. Women find ways of negotiating roles and finding care in the uncertainty. Uncertainty and risk in Uganda are managed by cultivating social ties and accumulating resources, including kin that can be useful in times of need. Though Ugandan women are presented with circumstances that put them in vulnerable positions, their womanhood is expected to survive many tests and they are cherished for characters of strength and endurance while nurturing and selfless. Women’s self-formed care collectives are ways of transcending the oppressive expectations for them and enacting their desires despite forces of dominance upon them. African women continuously prove that they do not need saving - they need a platform for their activism.

**Nationalist constructions of womanhood**

In the 1950’s, Uganda saw some effects of international movements for the advancement of women, including marginal involvement in city centers, localized commerce, and
industry (Obbo, 1980: 12). Uganda gained independence in 1962, at which time women were called on to participate in politics, mostly elite women responded and there was some general attention to making space in commerce and politics for women (Obbo, 1980: 12). During President Idi Amin’s bizarre and cruel era of rule, there was a switch. As part of his anti-foreigner and pro-Africa rhetoric, Amin introduced pro-women sentiment but focused on traditional women and the need for women to remain in the villages and to represent Africa as it should be – that is, without development imposed by whites. In fact, Amin released a statement in 1970 condemning the clothing that women in the business sector where sporting, calling this attire, “injurious to public morale,” and subsequently banning the skirts and blazers of the time (Obbo, 1980: 11). This basically undid the progress made in the 1960’s and created an identity crisis for Ugandan women who were encouraged to contribute to nationalist efforts and progress, but were being told that any woman involved in what was considered to be men’s worlds was wrong and problematic.

At the time of independence, elite Ugandans inherited and took over colonial cities and Kampala grew to become a small metropolis. This is when Ugandans began to see planned development, the emergence of urban slums, crime, migration, and hawkers (Obbo, 1980: 24). Amin used this as justification that development brings suffering, that foreigners destroy, and that cities are no place for women. Urbanization meant a separation from family, and even clan or tribe as women stayed in rural areas while men moved between cities, so this movement quite literally disrupted the ethnic fabric of the country and uprooted or mystified people’s identities, including along gender lines.
The rhetoric around women’s roles in development in post-independence was that women were needed to “fight ignorance, poverty, and disease,” which would be done by rearing children and nation building (Obbo, 1980: 13). Obbo expands on this crisis of women’s advancement, writing that the discourse of the time had a defensive tone that made it clear that while oppression was being opposed in theory, the actions being taken were reinforcing submissiveness (1980: 14). Many of the statements made during this era included addendums which state that while women are a crucial part of the society and are encouraged to contribute to civil welfare overall, they were not to challenge or rebel against men (Obbo, 1980: 14). In general, urban migration and civil progress were perceived to be “too fast,” in Uganda in the 1960’s and the changes that came with women in the workforce and city life were made to be seen as a corruption of virtue (Obbo, 1980: 26). This may partially explain why Amin’s presidency was somewhat successful and acceptable prior to his intensely violent turn; Because he upheld the idea that women are, “better off in the village,” a sentiment that men had begun to express at the time. Obbo goes on to say that the idealism of pastoral life and the village woman was at once a hindrance to emancipation and a peculiar celebration of women, mostly in the role of mother (1980: 28).

Cities, commerce, and even migration, have been made to exclude women, and consequently policies and other public decisions as well. In terms of Ugandan development agendas, electronics and communication that enable women’s progression have been systematically posed as men’s arenas, and movements geared at empowering women have been by way of education and skills on a domestic level (Obbo, 1980: 6).
Mostly, women’s empowerment movements in Uganda have been in the form of grassroots efforts with some key figures, but also through media, notably journalism of the 1960’s. Tit for tat, women’s progress of the 1960’s and 70’s in Uganda was met with equal denial of women’s power and criticisms of the women who participated in women’s advancement. Directly and indirectly, both through campaigns and general discourse of the time, the urban woman, and by proxy the progressive woman, has been constructed as “loose,” (Obbo, 1980: 9). During periods of rapid urban progress, jobs for women meant sex and infidelity, as this was the rise in sex work and city migrations (Obbo, 1980: 14). In other words, moral deterioration, a product of urban development in which men participated and administered, was seen as cause to rebuke women’s rights.

Even after Amin was exiled, the new urbanism in Uganda during the 1970’s cast business women as a threat to moral structures and particularly to family values and production of family and community. Various campaigns accusing unmarried women of being prostitutes, and migrant women, especially those on their own, were particularly disreputable. Spinsters and divorcees challenge men’s supremacy further as these women are both a potential member of the business class and also not liable to succumb to the same claims of supremacy over women that young, unmarried girls are (Obbo, 1980:16, 9). These women generally do not accept men as superior and do not depend on men, which threatens the power structure in place in this male-dominated society. Modern working women produce fewer children and participate in empowerment agendas that threaten male supremacy. Furthermore, locusts of modernization are sites for the use and
distribution of contraception, making cities and developed regions places of decreased fertility and thusly of diminished womanhood.

**Pastoral idealism**

Most Ugandans consider “the village,” in both abstract and literal terms. Participants used village in reference to “the real Africa,” and “where you will find Uganda,” Most Ugandans grew up in a village and associate the pastoral life with childhood, simple times, and home. Some even tell me it is where love is – from mothers, from family, and in memory. The cornerstone of the village is the plantation, as it is referred locally, or farms. Small-scale agriculture remains a symbol of old-fashioned values, work ethic, and lifeways in Uganda. Agriculture has fed and formed rural life since plantations were begun, and the state has recognized the value of agriculture and the opportunity to capitalize on this industry. So in some ways, rural life, and thusly agriculture, upholds the country and maintains the integrity of Uganda. And women, most associated with pastoral life are the gatekeepers of such.

The notion of the village as the embodiment of Africanness was a central tenant of Amin’s cultural overhaul, his creed, and his mission to bring Uganda down to a concentrate of its greatest values. The attachments to rural life are seen in the philosophies of birth as well. Women are praised for delivering their children in the village. Staying in the village for birth means that a woman has a normal delivery, free of complications, and that she relies on her own community for support rather than on outside facilities and foreign-associated clinics. It means that she is strong enough to
handle the birth. Transferring women to city centers, hospitals, or distant clinics presents the chance for adverse effects, including increased intervention, stress, financial loss, separation from spouse, children, and community, and lack of continuity of care (Kornelsen and Grzybowski, 2008: 944). So, the home or village birth is seen as not only traditional but less complicated and associated with adherence to local values.

![Figure 26: Village Homestead - photo by author](image)

Today, overwhelmingly, men tell me that they want a “village girl,” citing that she can cook and clean and that she is faithful, unlike women in the city, who only want your money. “A taste of Kampala life will have her wanting all the fashion and the
lifestyle,” Andy tells me. “She will want to go out every night, and she will want to take these [alcoholic] drinks, and eat at [a very expensive hotel restaurant].” Men really respect a woman who can dig.\textsuperscript{15} To see a woman with a hoe means that she is working on her plot, and contributing to the resources and finances of her husband or family, so it is a symbol of relationships and of a woman’s cooperation with family. Often, women are seen in colorful dresses with babies strapped to their backs digging in the fields, a very prideful scene for a Ugandan. Women tell me that digging is duty and is respectable labor, but that it is back-breaking and “makes one to grow old quickly.” While women adorn the wax dyed fabric and colorful dresses, men are dressed in casual business attire every day, including slacks and a button-up collared shirt. Even when chopping matoke, this is the uniform and this juxtaposition shows that men fit in the modern realm and conduct trade and participate in commerce, albeit on a small scale, while women remain domestic, get dirty, and literally sow the seeds of home.

There is a romanticized notion of the village as the hearth of Ugandan culture, but the village is also a place of want and an unsavory image for Ugandans who pride themselves on progress, on financial growth, and on being modern, wealthy, and cosmopolitan. Women navigate these aesthetic and cultural aesthetic carefully, but generally women and girls expressed to me a desire for the kind of modern honor that is found in education and careers. There are a lot of factors making such progress unfeasible and obstructed for women, including overt conceptions of women as complacent with

\textsuperscript{15} “Digging,” is the term used to describe work in the fields, which is both essential for Ugandan survival and trade and is symbolic of true Ugandan-ness and heritage. Women typically wield the digging hoe more than men as this is used for tilling and planting mostly matoke but other vegetables and roots as well, while men wield machetes for cutting the thick matoke stalks from the trees. Digging is collective labor.
austere ideologies. It is a complex identity, however, because women also tell me that they take pride in their abilities to carry out the idyllic Ugandan traditions. Ugandan women are subject to a double standard of and a challenge of participating in modernity and changing cultural practices while also upholding the image of the good woman, which for women in Uganda does not include a sense of self-domination; Quite the contrary, in fact. Women tell me that they have to be tough but never, “big headed.”¹⁶ Women are meant to display honor and integrity, but sometimes the preservation and pursuit of these ideals imposes obstacles to, and is in conflict with, claims of power.

You can’t keep a good woman down (well maybe through systematic manipulation)

Women are the, “bearers of Africanness and culture,” a forced cultural construction that purposefully and incidentally impedes women’s progress (Obbo, 1908: 15). The paradox that Ugandan women endure is perhaps at the stem of what contemporary women and girls experience today. Women are expected to maintain a fixed social position yet are compelled to participate in development programs to alleviate their own suffering and burdens. This is especially clear in women’s relationship to men. Women see that they are responsible for creating community, but must be controlled while doing so. Their power is limited, historically, as a matter of national concern, and this reverberates in identity concepts today. Women are the keys to Ugandan men’s claims to power, notably through women’s ability to make a father out of a man, but when they want power and control for themselves, it has been problematic.

¹⁶ Big headed means too proud, too boisterous, or displaying too much power, which draws attention to women and threatens the power of the men.
I would be amiss if I didn’t mention that the fragility of men’s claims to power is fundamentally an imperialist anxiety. Isidore Okpewho explains that Africanness entails a “humane regard for womanhood,” altered only by the “joyless patriarchalism of the Indo-European world,” (1987: 331). But in Uganda the rise of progressive, feminist politics directly threatens Ugandan’s connection to their history and their cultural traditions. In East Africa, change for women is a threat to men’s power structure as well as to the traditional way of life and to notions of family and pastoral community building (Obbo, 1980: 6). Women’s progress and empowerment is in direct contrast with the pastoral identity politics that celebrate Ugandan womanhood.

Figure 27: Ministry of Health Poster - photo by author
Ugandan women pride themselves on being accommodating and cool-headed. They tell me that good womanhood consists of a combination of strength and sweetness, and as one woman adding, “Like honey, but also like a hot pepper.” Maintaining a reserved and non-reactive character is critical in close-knit communal societies where everyone keeps up with the goings-on of everyone else. Self-preservation is key and includes control over emotion and temperament. Women describe the ideal woman as protective, organized, and “smart,” meaning put together and nice looking. They say that women should be sexual but not too much. But mostly, the good woman is regarded as tough, hard-working, and resilient. Women’s ascendancy is only acceptable in so far as women remain subordinate to men. Men tell me that a woman should be “well behaved,” and not too powerful acting. This confinement of women speaks to the complex that women steady and is a display of the ways in which women are expected to operate within a subordinate position with great command and clout. Seldom are women allowed to voice displeasure or feelings of discontent in Uganda, so that resiliency entails an implied contentment with harsh circumstances.

**In pursuit of honor**

For girls in Uganda, balancing school and domestic duties within the household is difficult enough, but one of the greatest challenges to young girls in Uganda is maintaining honor, including sexual integrity. Because of the economies of marriage, including a fixation on virginity, and the public and social impact of women’s reproductive status, girls’ sexual status has great value. And because of sexual risks and
rampant young pregnancies, health campaigns preach sexual restraint without much education or consideration for appealing to boys who propagate the acts. Postponing the first pregnancy is not only to avoid the obvious pitfalls, but also to evade a dishonorable entry into the category of mother. Premarital pregnancy is problematic, because it is an ambiguous status – her “reproduction is out of place,” (Johnson-Hanks, 2006: 193). A mis-timed pregnancy is a shameful failure of self-control and results in women losing their place in society because of a lack of self-discipline and foresight. Men are deterred from pursuing women with children from another man because of the particular importance of blood lineage and progeny in Uganda.

Marriage and birth go hand in hand, and women who birth without the right resources, including kin support and familial preparations, are looked down upon. I emphasize what Johnson-Hanks refers to as the, “fallen schoolgirl,” a culturally dishonorable and logistically problematic status for her and her family (2006: 242). Pregnancy before marriage disrupts brideprice and results in girls being shunned or sent away.17 These threats to girls’ prestige have very real impacts on her abilities to form solid family foundations that ensure her care and security. Much of women’s honor depends on her ability to thwart men and boy’s advances. Premarital sex is not a problem because it is premarital; is a problem because her status is ambiguous – her reproduction is out of place (Johnson-Hanks, 2006: 193). Meaning, that without the bond of marriage

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17 Ugandan marriages are typically paid for by the bride’s family and friends, but the groom’s family is expected to pay a bride price. Some contemporary couples do this in the form of wedding contributions but many still practice the dowry system, and in the Southwest of Uganda, where cattle is king, this does come in the form of cows sometimes.
women are not guaranteed to have access to the rights and financial benefits of a married woman.

Because fertility is demanded and insisted upon in Ugandan marriages, there are ways that men inadvertently “test” women’s abilities to produce, namely through unprotected sex before marriage. When women become pregnant, the man will rush to marry her and have her move in with his family. This is a precarious balance because women seldom outright tell their men, families, and others until far along in her term, so women often find themselves moving in with in-laws and in marriage-type situations far along into a pregnancy. Relocation and life with in-laws can be trying. Women report a slew of issues that arise with mother-in-laws, including economic frictions of competing for resources with an in-law, especially if her son is the only male in the family. Women typically stay close with their own kin and have the option to return home if a marriage or in-law situation does not work out.\footnote{18} This game of time and fertility is not uncommon and there are similar instances in the Nigerian context, in which a bride is not typically relocated to the husband’s house until she becomes pregnant (Whitehouse and Hollos, 1998). Mistimed births mean shame and loss of capital, so women must coordinate life events in order to maintain viable positions in the community.\footnote{19} All the while, men must ensure women’s fertility before marrying, so women risk investing in relationships without the promise of partnership in order to secure the relationship.

\footnote{18} It is shameful for a family to have an unmarried adult girl or one who returns home, because they will lose out on the bride price and she will be a strain on the household resources. In most cases, adult women at home will serve the role of domestic laborer.

\footnote{19} Ugandan women seldom give away a child for reasons of inability to care and there are no formal abortion or adoption services available, though informal adoption is fairly common.
Economies of womanhood

Economic deprivation from lack of opportunities for wage-earning hinders women’s freedom and advancement. In an impoverished setting such as that of rural Uganda, there are very few avenues for women to gain status financially. Women’s strategies for economic survival have typically either been to find or create a stable form of work or business, which is rare in the rural villages, or to have children as a way of ensuring a relationship with a man and thusly taking on the resources and care networks of his family and perpetuating kinship through children (Obbo, 1980: 5). Women’s economics and access are tied up with sexual relationships and exchanges of kinship, power, or money. Mark Hunter, in his imperative book, *Love in the Time of AIDS*, writes poignantly about sexual economies and provisions-based love. He says simply, “In a climate where men earn ten times the wages of women, sex has an immediate materiality,” and I would add that in a rural, impoverished setting where women do not and cannot own land, sex holds significant power where authority is elsewhere impossible to command (2010: 179). Hunter argues that sex is, “enmeshed in forms of emotion and reciprocity,” and exchanges marked by mutual, if uneven, obligations that extend over time,” (2010: 180). In other words, women’s relationships, fertility, sexuality, and even womanhood are bound to economic survival and interpersonal dynamics.

Jennifer Cole, in the book *Love in Africa*, writes that women in Madagascar told her simply that guys get women pregnant, and children take money, so the economics of a relationship are straightforward women have to see that they will be supported to survive and take care of a family (2009). In my research, women explain that although it
is frequently posed that women play the game of love for economic reasons and to utilize the resources of suitors, they actually postpone or delay marriage to ensure a stable partner. Just as many women tell me that they would prefer school or business, but family presented a means for them to make a way for themselves, women also navigate strategies for survival including labor options and pooling resources with family members. Marriage and economic stability do not necessarily go hand in hand as Ugandan women are often financially subjected to the whims of their husbands. If they depend on him and he drinks away the finances, she would have been better off alone.

My conversations with women were very frequently on the ways that they suffer from the habits of their husbands’ drinking, often followed by a desire for independence.

Unfortunately, drinking often leads to violence within a domestic partnership, including rape and sexual assault, as well as infidelity, which directly threaten women’s health and security. Sexual violence and abuse are too-frequent ways that men exert control over their wives in Uganda. “Men and husbands force themselves on women and wives, sometimes they are drunk and they need to release, but…the men always want to make the woman become pregnant,” says Peace. “They take pride in the children, but even they take pride in impregnating the woman – they gloat about it too.”

**Women’s servitude and sacrifice**

Women tell me that in order to maintain respectable family units, they often endure or ignore such injustices, namely infidelity or domestic violence. Domestic abuse is a well-known social problem in rural East African communities as is HIV infection that results
from infidelity. Women have to be able to monitor their men’s sexuality, at least partially, in addition to their own in order to protect themselves. This is central to women’s honor and abilities to manage her self and sexuality, and sometimes includes her having to keep secrets from the public gaze (Johnson-Hanks, 2006: 187). Women attempt discretion and even excuse and defend men’s behavior for the sake of maintaining their own prestige. This is a complicated position for women because of the need to preserve relationships and to keep their own honor in tact. Some women try and use a condom with their husband if they suspect infidelity, but he likely will refuse. This is yet another way that women are dishonored and their well-being threatened by disempowering practices. Actions for sexual and reproductive justice must bear in mind these complicated and compounded experience for women in the context.

Women endure a range of gendered cultural expectations and responsibilities and women’s self-worth are wrapped in milieu of fertility, family, and duty. Because Ugandan constructs of masculinity are partially based in a man’s abilities to provide for a family and demonstrate control over his situation, women tolerate and deal with infidelity by withholding sex or cooking, but more so they appeal to a man’s sense of obligation as a provider and his duties as a father in order to gain some power in the relationship. Especially if a woman can prove that his children are suffering as a result, a man would be personally blamed and/or publically punished. So, women do manage men and keep

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20 A common display of control, abuse, and marriage inequality is the idiom of women being made to “sleep outside.” This is both a literal and figurative phrase that refers to men making women sleep outside of the hut and the threat of doing so. This practice hinges on the fact that homes are considered as belonging to men through women provide the vast majority of the work to construct and keep those homes.
their secrets at the expense of her integrity and despite the risks. Women’s personal negotiations are deployed through a range of social networks, and depend on support from fellow community members, mostly through other women.

Ugandans traditionally practice a marriage by capture, where a man’s family addsucts and stows away the woman in a hut deep in the bush for some time so that she is prepared for the wedding and cannot escape. At the beginning, a trial marriage is fairly common where the couple will live together and “test the bond,” but most likely testing fertility. Ugandan women are said to have fertility issues if they are not pregnant within months, and certainly within a year. So, women are tasked with synchronizing socially accepted motherhood with marriage, which is a difficult task with a lot of self-perception and pride at risk and a lot of public attention. Marriage is balance of power between men and women, with swaying benefits for women, but women overall say that they just try and maintain poise and discipline to their husbands to avoid quarrels.

Particularly in villages, marriages are described in practical rather than romantic terms. Because marital status allocates and legitimates social privileges, rights, resources, and obligations, marriage is also a public institution, and women secure their place in the dynamic of marriage through children. Children legitimize and authorize marriage, because making family is the best way to have social capital and people on your side.

“Having people,” or kin relationships, is critical social wealth that provides security and

21 In general, men’s infidelity takes away from the family’s resources as he spends on courting other women. Ugandan men are very focused on having children and couples often stay together because of children, but I did not find that having children kept men from cheating though women tell me that having a baby around will keep the man in the house more.

22 This is seldom practiced today. The church wedding is the ideal, women tell me, but it is very expensive and rare for village people. Civil marriage is more common and then a traditional marriage is the most common, which takes place in the village with very little fanfare.
resources, and marriage, in particular, provides not only the opportunity to build social wealth through children but also linkages to more kin, essentially doubling the wealth in people (Miers and Kopytoff, 1997: 54; 1977). “The children are the horns of the marriage,” is the phrase that I heard from participants. This means that children will secure a marriage and children are also a kind of social fortitude, especially later in life. Women describe having children as having care in later years. Kids are part of women’s strategies for living, and for actively creating meaningful lives, so childbearing is socially complicated as it is done along the contours of men’s needs and desires, but it is part of the patchwork ways that women find to command authority or control their environments.

**Children are the horns of womanhood?**

In a rare couples interview with two young married people, I asked about how the children affected their marriage. Both the husband and the wife responded that love for the children is much more important than their relationship with their partner, but that having the kids made them see one another in a new, deeply bonded way. Parenthood is a paramount objective and basis for the durability of marriage, and in Uganda men and women report having children as one of their top, if not the most important, goals in life (Smith, 2009: 175). So, if children are the horns of marriage, is childbearing also a marker of womanhood?

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23 Because Ankole people of the Southwest are cattle keepers, imagery with horns are a reference to their identity. A bull is nothing without his horns, so this expression speaks to the idea that children complete and mark a marriage.
Motherhood is a source of power for women and the ways in which women draw on this role to construct paths for themselves span political and economic spheres. Women’s economic empowerment can begin with the empowerment that they find through motherhood, an important aspect of women’s identity. Importantly, women in Uganda explain that motherhood alone does not provide them the joy and satisfaction. It is through being “good,” mothers, wives, and household managers that women become valued and find deeper gratification. Holten argues that motherhood is a virtue, not because it fulfills a social norm, but because it is an exhibition of certain, highly valued sensibilities (2009). For many women in Uganda, hospitality, chastity, trustworthiness, and showing restraint and patience are all virtues that women take pride in and all of which are displayed in child rearing. In this way, motherhood may help to solidify one’s character or reputation. Motherhood is arguably where women have an active decision-making role and agency, and thusly motherhood itself can be empowering.

Children ensure a continued lineage for men, but for women children ensure that there will be someone to care for them when they are old. It also is an opportunity for women to have great power and influence over men. Women may use pregnancy and motherhood as a way of securing relationships, of demanding financial support, or as a way of becoming infused with ethnic, familial, or clan-based affiliations. Producing children provides a certain type of honor along an honor spectrum, that differs from the pride and empowerment that comes from education, training, or other moves toward women’s progressiveness (Johnson-Hanks, 2006). That is to say that motherhood should not be seen as a sole source of women’s power, but rather I urge us to think about how
the role of mother informs that of woman and how motherhood is one avenue for honor and prestige in the region of East Africa. It is important to note the attachments of the mother role to social belonging in order to understand the magnitude of the work of the TBA who is essentially an institution of motherhood.

Becoming a mother is a stage in life that marks maturation into womanhood in Uganda. Failing is shameful and often suspect, and fertility falls solely on the woman. In a barren marriage, women are blamed first and often solely, so women must work around and manage even the fertility of the man.²⁴ Women bear the consequences of infertility totally and a man will often leave if the marriage is childless. He is expected to get a new wife, and this is completely acceptable cause for divorce or separation. Kathleen Barlow and Bambi Chapin remind us that although motherhood is a constant and “natural,” category, that we should approach the study of such not as a practical given, but observe how it is richly produced, culturally, interpersonally, and psycho-dynamically. They write that women are “defined by the role,” quite literally sometimes (2010: 333). For instance, women in Uganda can be called by their children’s names or are given name affiliations according to their maternal status. A mother of twins, for instance, will have Nalongo, attached to her name, so Alice who birthed twins will be Nalongo Alice, or just Nalongo. The implications of conflating womanhood and motherhood are that women’s status is

²⁴ A man’s impotence or infertility is rarely discussed. If a woman fails over and over to conceive, she may visit a traditional practitioner, and it is rumored (and one male traditional practitioner did verify this) that the practitioner will have sex with the woman. If she becomes pregnant, then it is said that he cured her, where it very well could have been an issue of her husband’s fertility. So the practitioner who impregnates the woman will never claim the child and the man will never know that he is, in fact, sterile.
reduced and jeopardized, so outreach for women should speak to the whole experiences of women, including the choices to deny motherhood.

The mother-woman hemisphere is a complex, hyphenated identity that may not be literal but is a discursive multiplicity, referencing the constructs of the maternal (Juliana Makuchi Nfah-Abbenyi, 2005: 101). Ugandan women feel that their identities, relationships, and sometimes very existences are contingent upon being a mother and a good mother at that. Expectations are for a woman to be a good representation of mother, even without motherhood itself. Notions of motherhood largely equate to notions of responsibility, which is a central tenant of motherhood. Women in Uganda represent mother by bearing burdens and carrying the community in many ways, and there is a great deal of pride in the enactment of motherhood and the image of mother.

Figure 28: Poster that reads: Mama, the power is in your hands - photo by author
Aesthetics and ideals of Ugandan motherhood

Cultural representations of mother in Uganda largely adhere to women’s abilities to care for families. *Maama* soap, for instance, an ever-present bar soap in the country, has advertisements with slogans like, “nobody cleans like mama,” and, “nobody cares like mama,” and more recently, “nobody loves like mama,” as if cleaning, caring, and loving are all the same. Boddy notes the direct links between soap, mothers, and goodness, and that sex, pregnancy, and childbirth are all “unclean,” and potentially odorous bodily experiences for women, and a fragrant soap will mask that shame, filth, or pollution (2005: 177). This preciousness of the nurturing mother exists in tension with the realities for women in impoverished settings, which I will touch on to follow.

“She is the beloved,” one man said to me of his mother. Many Ugandans disregard fathers, especially if they are not around, but most people worship their mothers. I was observing a delivery one day with one of the senior TBA’s. After the successful delivery of a healthy baby boy the TBA says (in a baby voice talking to the mother as the kid), “I love you mommieee,” and then she turned to me waving the newborn’s hand and said, “If he is loved by mama, he will be ok.” “Now you have a man who will always love you,” the TBA said to the mother. She was trying more than usual to enthuse the mother, because the new mother did not particularly want another child and had issues with the father, so she was having a hard time. The TBA kept encouraging her through this language of what she would receive from the baby in terms of love and companionship, and by celebrating the woman’s status of mother as if that category itself ushers in the promise of love, both giving and receiving.
Interestingly, I attempted asking women about “becoming a mother,” over and over and was seeking some phenomenological or analytical explanation about identity and life transitions, but the question flopped every time. I realized at some point that this is because the position of mother and the act of mothering is not understood in the Western sacred sense. It was explained to me that motherhood is not a dramatically different practice than what women have done for most of their lives, but having one’s own children and solidifying a connection with a man is what dramatically affects women’s lives. In fact, women conflate becoming a mother and becoming a wife. When I asked participants about when they “became a mother,” they would respond with, “When I became a wife…” . Women consider themselves a “mother” when they have had their own children though they have ‘mothered’ for most of their lives.

In the villages where most families require children to take care of younger siblings and neighbors, girls and women “mother” others from a very early age. Girls impart the aesthetics of motherhood and perform this powerful role. Young girls carry siblings and neighbors on their back in the way that mothers do, and begin to care for younger siblings and neighbors very early. It is imperative, in particular that girls know how to tie and carry a baby on their backs, an iconic cultural image for Ugandans. Women carrying babies is a powerful image of Ugandan motherhood. It represents the strength and duty of the woman. Because village life in Uganda includes small-scale agriculture for almost all people, women are also praised for being hard-working and contributing to the farms and daily commerce, to see a woman “moving about,” with a
child means that she can balance the care for her family with work in the fields or with tasks within the village.

Ugandans insist that a child must have a mother – even if this is not biologically connected. A motherless child is the worst thing for many Ugandans, so informal adoption is very common. Because there is no official foster system, if a woman relinquishes her role of mother at the time of delivery or any time after, the baby will automatically go to a family member or in some cases a close female friend or neighbor. This is not incredibly common as it does result in social stigma for the woman, and often family and friends are no more prepared for an extra mouth to feed. If a girl is too young, she may have family members care for the child and act more like a sister to him or her. Ugandan women do not have the option of abortion unless they have a very good relationship with a TBA who is willing and able to handle the task.\textsuperscript{25} This is yet another way in which the TBA is an irreplaceable resource for women.

\textsuperscript{25} Abortion is not widely discussed. I did not collect information on this subject other than TBA’s telling me that they are capable of conducting abortions with herbs or inserting items into the vagina, referred to as miscarriage to protect the woman and the TBA and it can cause damage including impacting future fertility.
As the guardians of the young, women are to protect and safeguard children, and they are considered the one who truly keeps children safe. To be abandoned by one’s mother means that a child, or a person, is subjected to many of life’s ills. In a country with a recent history of genocide, war, disease, and waves of migration, the child with no mother is exposed to a whole world of dangerous possibilities. “Men can be scary… they are strong and powerful, but to not have a woman in one’s life is the most scary thing,” Rashid told me. Ugandan novelist, Lillian Tindyebwa, writes that in a context where ancestry and religion are linked, family, particularly mothers, can haunt a person, literally and figuratively (1998, 1). The mother sets the stage for home and for family and she is seen with great power in these arenas. She also takes great pride in the wellbeing of her family. Conversely, women take the blame for the suffering of their families despite what is available to her. Ayeta Anne Wangusa explains that a common sentiment in Uganda when a child or even an adult does wrong is that the “mother will bow her head in shame,” meaning that it is she who is disappointed but also that the behavior reflects on her character and life choices (1998, 46). Women carry responsibility for the welfare and the behavior of the entire family, and her attachments directly affect her identity.

One of the ways in which women in Uganda carry great power is in the traditional practices surrounding, “little spirits,” or, obusambwa, which are fleeting, almost mischievous spirits that have the power to inflict sickness and are mainly interested in women, children, and the young-acting (Whyte, 1997: 132). Unlike clan spirits, which are based in men’s lineage and are attached to male family members, little spirits do not protect. In fact, they require manipulation and control to keep them from doing fowl
things. Little spirits are of the domestic sphere and mostly concerned with the home, conception, birth, and survival of children (Whyte, 1997: 147). In my observations, women keep small talismans around boundaries of a home or thresholds to ward these off. They also attend to open doors and windows at night and sometimes construct wearable protective ties for the children. Health, spiritual genealogies, and even care are traced through matrilineal kin and part of the female domain. Women confront vulnerability and are tasked with great responsibility for a range of obligations for ensuring safety and security of young often with selfless disregard of her own risks.

**Women’s sacred burden**

Pregnancy and motherhood are women’s inevitable burden in many ways in Uganda. With few to no viable options in birth control, and the added cultural capital of childbearing and kin building, pregnancy is a constant “threat,” and one that is also imbued with danger and risk. Forced, coerced, and chosen states of motherhood are common in Uganda, but most women agree that without resources, finances, and people to help, it is the biggest threat to their own health and survival. Women in my research describe pregnancy as, “going on a dangerous walk,” and with such a journey, there is a certain bravery that is needed and social credentials that are earned. Complications in a pregnancy are looked down upon and the details of such are not shared beyond close confidants. Joking discourse around pregnancy includes new mothers and newly delivered women to declare that the will never, “walk that road,” again, though many
do. I heard many women talk about how motherhood is an expected and assumed role, and that motherhood “gives purpose,” to a woman. It is a social compulsion that women have to prove to a man, her family, and her clan, village, or community, and even when women partake in motherhood through no choice of their own, they need the informed support of trusted leaders like the TBA.

Women take great pride in their ability to bear and deliver children and in their care-taking abilities. Women are the primary ones who participate in health events and outreach. Women’s responsibilities are heavier and more demanding in the heavily patriarchal society with inadequate resources and unpaid domestic servitude (Gailey, 2010). Not only are mothers responsible for care-taking and thusly blamed for failures but they are also directly related to child’s health, so the health of the family (and the condition of the homestead) are a direct reflection of a woman’s ability to “manage,” her life. Home-based health care is a point of pride for women and something that women share and exchange knowledge on, but arguably this becomes a source of selfhood because it is a responsibility and not the other way around. The idealization of women and mothers as omnipotent must be unraveled and viewed through lenses of responsibility and obligation. It is labor, after all, that women provide, not some magical or innate ability to heal, love, or care. And it is possible that such mothering is conducted with ambivalence and a moral and ethical duty, similar to that of the TBA. It is important in discourse and policy surrounding Ugandan motherhood to recognize the work that is often burdensome and dangerous in contrast to Western notions of magical, affection-

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26 This is, in part, to ensure that if a woman does not become pregnant again, it will be assumed to be a matter of her choice.
filled maternity and mothering. Accounting for social pressures, compulsory circumstances, and psychological and physical exertion for women helps to see the dynamism of women that is more complicated than suffering, nurturing, or producing.

![Image of TBA's homes](image)

*Figure 30: TBA's homes - photo by author*

**THE WOMAN’S BATTLE and Going Alone**

Pregnancy, childbirth, and motherhood carry great social attachments and dynamic identity politics, and although these provide kin claims and capital for women, they also present great danger and liability. Childbirth is undoubtedly the biggest risk for women and thusly something that is point of vulnerability. Helen Regis says it well – “Pregnancy accentuates the permeability of women’s bodies,” and as one of her research participants in Cameroon told her, “A woman in labor has one foot in the grave,” (2002: 91).
Childbirth is a test of endurance in Uganda and a spotlight on women’s abilities, and by proxy her selfhood. Kyomuhendo writes about childbirth in Uganda as “the woman’s battle,” a huge risk that when women emerge, they can claim victory (2003: 17). In Uganda, there is a certain reverence for childbirth but not overly celebratory, sympathetic, or obsessive in tone. “She must go through the pain,” one senior midwife narrated to me as we sat with a screaming woman mid-delivery. “She must feel it… the pain is part of it.”

It is fairly common for Ugandan women to deliver totally alone if she does not have a TBA or trusted relative to assist. This is partly a matter of logistics and availability of kin, birth space, etc, but it is also much more complex than that. There are several reasons that Ugandan women choose or default to give birth alone. One is, unfortunately, due to social outcasting and isolation that result from any number of events, gossip, or witchcraft. Secondly, delivery is a sensitive and vulnerable time for women in the sense that their medical history and physical conditions are revealed. Personal information about infection or deformation that impact her social standing are exposed, so women with concerns or in embarrassing situations may forego assistance. Also, women lose a sense of self-domination and succumb to the event of childbirth, screaming, pooping, and crying, which is fine if they have a trusted confidant in a TBA, but if not she will be uncomfortable and hesitant, and some women choose to avoid this altogether. Additionally, the threat of complications often drives women to go unassisted, which is doubly problematic and regrettable. These are obviously cases that would call for even more assistance, but shame and social loss are extremely powerful affects.
On the other end of the spectrum, women may choose a “lioness,” birth that displays her intense stamina and courage. Kyomuhendo writes, "Birth represents a rare opportunity for a woman to demonstrate the proverbial virtue of courage and bring honor to her and her husband's families by her stoic demeanor. The woman who manages to deliver without indication that she is in labor and without calling for assistance until the child is born is especially esteemed..." (2003: 13; 17). All romanticized metaphors of journeys and battles aside, there is tremendous respect for women (perhaps only among other women who are privy to such information) who “handle the birth,” meaning who give birth with little to no intervention and who do so fearlessly and stoically. Older women are praised for surviving many births, and generally women get “better” and more accustomed to the pain of childbirth, so later births are generally more esteemed and dignified.

Figure 31: Woman walking and carrying items - photo by author
In between the two extremes of social outcast and the esteemed lioness are the facts about the event. Firstly, Ugandan women, perhaps optimistically, ignore many danger signs unless they are severe, because 1) they may not be able to do much to address them in the village, and 2) many successful deliveries follow signs of danger. Also, recall that Ugandan women are not supposed to make a big deal of things, especially themselves. Secondly, women who are not in a particularly great position to welcome a baby due to financial, health-related, or relationship issues, try very hard to “sneak” the baby into being. Some women go away to deliver and return a week later in the middle of the night- perhaps so that she can be unnoticed or at least not draw too much attention to her baby and thusly her situation. Thirdly, women may deny being pregnant, thusly denying seeking care. Because of threats of jealousy and a number of taboos, women often guard pregnant status carefully, and sometimes this includes not actually acknowledging the pregnancy to others. This is a vital issue for health projects in the area to address. Let me explain.

Out of fear that someone will curse the pregnancy or that the very act of talking about the pregnancy will make it fail, women will simply not address being pregnant. This kind of ignoring the condition is a tactic to divert evil eye and bewitchment but also this is in keeping with the Ugandan practice of not putting too much attention on something. For this very reason, people seldom compliment one another or boast about their triumphs. I was walking with Yoda, senior TBA, around a village one day and we approached two women working in a field, one of whom was visibly very far along in a pregnancy. Yoda didn’t know this woman who we will call Sassy. Yoda, introduced
herself to Sassy and tells her that we are doing some outreach for pregnant mothers, and she asks her if she wants to talk. Sassy declines. Yoda said ok and wishes her well in her pregnancy. Sassy giggled shyly. “You do know that you are pregnant, don’t you?” says Yoda. Sassy shakes her head no. I was very confused. Yoda later explains that of course the woman knew that she was pregnant but sometimes women do not discuss the pregnancy at all until labor begins at which time she will need to jump into action. “These are the ones who will be banging at my door!” Yoda growls. She says that she pretty frequently has women with clear health risks tell her that they are doing and feeling fine.

Maybe these women have been silently preparing themselves all along, and maybe not. Perhaps it was a display of modestly and self preservation that led Sassy to choose not to disclose (especially to a white stranger!) that she was pregnant. Reserved self-domination is after all a celebrated character trait here. It is also not right to talk about pregnancy with a pregnant woman, because the pregnancies mutually affect one another, so TBA’s will often not practice when pregnant, and many did not begin practicing until they were done having children themselves.

The fourth and related reason women go alone in childbirth is that failing is shameful. Women may slip out of the house if labor begins so that if they return without a newborn, there are less people waiting to greet her and less embarrassment or disappointment for her return. Going alone means not only that there are less witnesses to the pain or vulnerability, but that there is some ambiguity around the condition of a baby that did not make it (Regis, 2002: 95). If it is a stillbirth or if complications led to the loss
of the fetus or newborn, women will at least have the opportunity to make sense of the event and present information of her choosing. Thinking back on the notion of the good woman, the good birth is also a part of the right kind of motherhood, and women can craft their own birth narrative if not closely observed by those around her. In brief, speaking of a pregnancy is taboo. Also, because there are chances that women will lose the pregnancy, she will often not discuss the baby until it has arrived, as her social standing and her contract with her husband and her in-law’s is heavily reliant on a successful delivery.

Reproductive Loss or disability

TBA’s are a resource in achieving and stabilizing women’s roles as mothers, so their work helping to avert reproductive loss contributes greatly to women’s social networks and wellbeing. Additionally, one of the most important and overlooked services that TBA’s provide is guiding women through loss and counseling women who are experiencing such challenges. As counter-intuitive as it may seem in an area with one of the highest fertility rates in the world, infertility and loss exist in the African context and is both a medicalized condition with few local, clinical solutions, as well as a deeply social form of personhood devastation (Sundby, 2002). Fertility is certainly an economic concern, and there are social politics engrained in not only the role of mother but also the possibility of motherhood and ability. In Uganda, this is discussed as “producing,” and there is no doubt that marriages are based on the ability to produce.
The TBA is a particularly fitting solution to some of the issues around women going alone for delivery as well as dealing with loss. TBA’s, as culturally appropriate resources in the community, are the route that most women choose. TBA’s are minimally intrusive and do not normally chastise women’s health, hygiene, personal, or financial faults. The presence of the TBA during birth is more normal. They understand practices like denying the pregnancy for instance. Also, the birth is “off the books,” or ‘unofficial,’ according to clinical standards, meaning there is no record kept, so a stillbirth, a chosen unofficial adoption, or an abortion is not traceable or attached to a woman’s name. If women experience a loss in the presence or in the hands of a TBA, there are very few formalities that in the eyes of Ugandan women would make it worse or underscore the blame placed on her. One woman told me that she was “paraded,” around a clinic after experiencing a stillbirth, at which time it was announced across the maternity ward and then they had her sign “many things, maybe admitting it was my fault.” In other words, the woman felt that her heartbreaking loss was sealed into her health record and her social repute because of clinical protocol that stamped this onto her name and seemingly placed the blame on her to avoid liability for the clinic.

Loss with a TBA can be a non-event, especially if the woman has made no announcement of delivery. TBA’s can help to preserve a woman’s honor by keeping her information private and helping her to construct a narrative about the birth, or even telling her a version to ease her mind. For instance, TBA’s tell me that they will explain a loss to a mother in terms of things that are out of her hands instead of letting her know that she did something wrong or that her body was, “unsuccessful,” in some way. In
Uganda, a “good healer does not give bad news,” so discussions of loss are tactfully skirted or avoided. Needless to say, the rhetoric of loss and blame in clinics is misaligned. It would be wrong to tell a woman that she lost a pregnancy by some fault of her own, and this happens in the clinical encounter to the detriment of women’s character, an experience that would prompt them to avoid clinics and hospitals in the future. This is also why informed consent and patient autonomy do not translate well in Uganda—women do not want to hear their trusted practitioner tell them that they may fail or what the risks or conflicts may be.

One TBA told me that a woman had been too slow to push a baby that had its umbilical chord around her neck. In clinical terms, the woman (or the practitioner) may have been blamed for the loss of the child, but the TBA told the woman that the loss happened earlier on and there was nothing that she could have done, so it was no fault of her own. Moreover, accepting such a fate during childbirth can be viewed as more honorable than the disgrace of a traumatic hospital birth. Impersonal and culturally inaccurate practices can be seen as not “African” enough for some. TBA’s help women to embrace pain as a natural and expected part of the experience, so even though women are to remain tough during delivery, if they claim that there was no pain, this is suspect. On the other hand, in medicalized births, pain is seen as intolerable and unnecessary. To have a provider with whom a woman can “let go,” or “give up,” to means a confidence in their abilities and in their care (Bryers, et al, 2010: 491). TBA’s provide that confidence of cultural aptness, so women truly seem to let go with the TBA. TBA’s, for instance, allow and accept when women defecate during delivery whereas in the clinics this is cause for
chastisement. A “good birth,” is a positive transition into motherhood, whereas a highly clinical birth with significant intervention may be seen as a “bad birth,” or a failure of some sort, particularly following the biomedical model that high rates of surveillance equate to risk and complications (Bryers et al, 2010: 492).

Beyond the medical definition of infertility, discourse on the subject considers the effects - grief, social stigma, and economic deprivation (Bruce Whitehouse and Marida Hollos: 2014). Because children are a source of power for women, especially in relation to men, honor and respectability are conflated with fertility. And because fertility and childbearing mark women’s progression through life stages, it allows them to attain womanhood, and take their place in the lineage and in the genealogy of the clan. It is more than a reproductive issue. Fertility is political and economic in multiple ways. In Uganda, married women have much different rights and obligations. Status as a mother gives women access to things like rotating credit associations, cooking and dancing at gatherings and cultural events, and in general, performing adult roles within the society (Whitehouse and Hollos, 2014). My research participants mentioned, in reference to bearing children, that women are not typically given the same funerary rites as a woman with children. There are ways that childless women obtain such roles and children to care for – namely by fostering a relative’s child or by taking on responsibilities in place of giving birth (Whitehouse and Hollos, 2014). But generally, producing your own children is the rightful entrée into womanhood. In Uganda, the health and success of a pregnancy and an infant up to the age of one directly influences a woman’s future pregnancies and fertility, so the successful and dignified birth is of utmost importance to her position in
society. TBA’s are instrumental in helping women to handle pregnancy and childbirth in such a way that is not damaging to her social wellbeing and the vitality of the self.

In Uganda, “denying” a man children, in any way, risks a number of things for women, namely that he will stop supporting and will leave or find another woman (Delgado, 2005: 133). Fertility, for men, affects his whole clanship and is a shared concept; it is shared among the clan and impacts social wealth. Ugandan lineages share spirits and ancestors, which are directly linked to fertility (Whyte, 1997, 56). And people are wealth, so families are invested in the production of all members. Importantly, however, fertility is not shared between partners. Men do not see productions as much of a partnership than they do expectations for women. In other words, the success of conception depends totally on the woman and his fertility is rarely questioned. For women, it is much more complicated because women must secure various access and financial means as well as relationships and health, and then perform the duties to sustain those relationships. Plus she works to act in honor and to bring esteem to her family. Quite simply, Ugandan marriage is based in subordination. Women must answer to men but it is the women who carry the burdens for the community, which they often do through the role of mother.

**Shameful affects of the mother complex**

Janice Boddy has written extensively about the colonized body in Sudan and womb politics. She finds that the irony in the British invasions are in the fact that colonialism left the country with very low standards of living, yet the standards of health and science
remain affixed to technological advances, stark notions of cleanliness, and an insistent regard for methodologically sound biomedical devices, leaving idioms of blame and shame in the wake (2007). Mission work’s individualized calling to righteousness and the “civilizing” of Africans was founded in cleanliness, goodness, and sexual restraint, so continued attachments to this in development work are impactful. Janice Boddy says that in colonized Africa, the anti-barbarian sentiment of moral development encouraged women to be clean, to control themselves sexually, and to educate themselves to live better lives (2007). In Uganda, shame comes, in a big way from Christian-based ethics of moral goodness imparted in colonial Africa.

The colonial affects of shame and chastisement reverberate in Uganda from the unsustainable standards of interventionist medicine coupled with the challenges of rural resource-depleted contexts. Ugandan women’s responsibilities have consequence to their selfhood, and the ecological, social, and economical constraints and demands of health-keeping create guilt and disappointment for women. In a cultural context where one’s reputation provides her very existential standing, survival and wellness depend upon an ability to suffer for loved ones (Holten, 2009: 65). Women are expected to suffer, and her quality of life is excluded from efforts to improve and develop the region. Impoverished circumstances create a certain inability to cope with risks that normalizes suffering and vulnerability for women and mothers, because they are responsible for the health of families and communities (Holten, 2009). Such gendered experiences of health and medicine are based in an ethics of shame and contribute to the moral fiber of this vulnerable region.
The perpetual disempowerment of women is based in praxes stemming from women’s flesh being feared, denied, and regulated, including sexuality. Efforts to manage or dilute African women’s sexuality and reproduction in the interests of good public health, to save and protect women, or to eradicate disease as though women themselves are the vector, are products of the Anglo-Victorian obsession with purity, hygiene and a perhaps displaced preoccupation with longevity (Boddy, 2005: 171). Today, in conversations of reproductive health, problematic frameworks continue to be based in rhetoric of regulating, controlling, and taming the unruly, fertile woman. Religious rhetoric in colonial Uganda forbid women’s pleasures as these take her out of her rightful place “under the control of men,” but also because a mother cannot be uncivil and immoral, and women’s responsibilities to reproduce cannot be derailed (Parikh, 2005: 152). Poverty is at the root of women’s shame in colonized Africa. Without the means for full autonomy, existential comfort and complete security do not exist. And shame has some anti-self pressure, so the affects are further repressive (Ahmed, 2004: 105). The institutional pollution of the woman is well known in anthropology, and the associations on women’s bodies around pollution call forth the historical surveillance of women (Masquelier, 2005).

The clinical atmosphere in Uganda is a combination of factors that set up women for shameful affects. Issues of dignity and inattention to cultural practices often contribute to women feeling a sense of failure on their part. One woman that I spoke with at a private clinic in Kabale explained to me a big issue for herself and her neighbors. She lives far and walks the entire distance to the clinic. Although she bathes and is prepared
for the exam, by the time she gets there, she is sweating and she worries about her smell. She says women are often accused of being unclean when they come form the village, and this greatly deters her and other women that she knows from coming into the clinic. Frameworks of women’s health exist disparately from the lived experiences of women and are uncritical mediations of biologies that ignores social contours and ecological facts.

This is a major issue considering that women in Uganda are being told to visit clinics exclusively. Women’s fear of being shameless makes them avoid biomedical facilities altogether as the clinical interactions are full of awkward interactions that break all manner of modesty preferences. For instance, a good women does not undress in front of anyone normally and clinical protocol often violates this. I have also seen women have a problem with the “closed door” policy of the clinic as there is no other instance in their lives where this is the case, besides while conducting witchcraft or having sex, so this feels wrong to them, especially given that their doctor may be a man which would feel like infidelity to them. I have already mentioned the unease of laying on one’s back as well as the directness with which clinics have women open their legs.

Making a way for one’s self

The gender marginalization that Ugandan women experience by being excluded from choice and prohibited from power are compounded by the pressures of the good life and the guilt and shame of its failures. Lack of agency, limitations to their decision-making power, and confinement or subordination manifest in frustrations and despondency.
Women tell me that because of or despite these strains, anxieties, and demands, they have to have strategies for their own well-being. “One must have a plan,” said Joan when we were walking from the clinic where she was seeking care for a sick child to her home. Autonomy and support come in all forms and help women to ensure a sense of certainty, solidarity, or strength. Often, the rhetoric and ideologies that emerge from moments and circumstances of frustration are of empowerment and independence.

One day while conducting a focus group with several women in a quiet city center, a woman who had been standing back behind the group approached and wanted to participate. At first I was nervous that she would somehow sabotage the interviews because she was rather outspoken and a bit drunk, but Patricia ended up being the greatest asset to the research that day. Her uninhibited speech allowed her to discuss her feelings freely, which can be rare with some groups of Ugandan women who protect their personal information with their lives and see emotion as weakness and disclosure as vulnerability. This woman explained to me that she is a mother and that she is single, and she thinks that she has unlocked the perfect combination to motherhood in doing so. She explained that she takes care of herself first and foremost, which allows her to take care of her child. She is relieved that the little money that she does make by selling baked goods does not go to “a drunkard who will only use it as fuel to abuse me.”

Her independence, as she sees it, allows her to be a good mother, because she is not distracted by the pains and trials of dealing with a difficult husband. “If he is good, that is another thing. That is good, but they rarely are.” She goes on to say that women work and worry for their whole lives with a man, then he dies and leaves you with his
problems, including debt. She had been in an abusive relationship, as have many rural women, and she claims that her biggest lesson in life is learning that taking care of one’s self will get you everything you need and that depending on others will only bring suffering.

Many Ugandan women echo the sentiment that Celeste Delgado found in the Kenyan context, which is that “money, not fertility [or men], becomes the currency of motherhood,” (2005: 143). In other words, with economic autonomy, women have a certain independence that frees them from the struggles of a strained, forced, or unhealthy relationship. Many of the women with whom I spoke reported being with someone with whom they had significant problems, and said that they could not leave because he supported her or her children. Perhaps Patricia is an example of feminist freedom and autonomy, and thusly transcended the cycles that rural women suffer, through financial security. In general, women report a need for some sort of agency or autonomy as one of their greatest desires. Women are inspired by others who have made businesses or gone to college, and they see some of the repercussions of motherhood as in conflict with such autonomy. Doreen tells me that birth control and education are the way forward for Ugandan women.

**Managing Life Trajectories: Education**

Similarly to what Johnson-Hanks finds in Cameroon, Ugandan girls’ education and family-making exist on a sort-of spectrum along which they are posed with the challenge of managing their status and coordinating life events in such a way that maintains dignity
and respectability while keeping in mind the smartest path to economic and familial stability (2006: 56). In the midst of social and economic uncertainty, delaying motherhood is the smartest path to ensure not just status but also control of resources, but the careful balance comes in both the pressure on young girls to participate in sex and the cultural weight that motherhood carries. Honor is practiced through discretion and pride, among other things, but social distinction and worth are claimed through identities of motherhood, but this is changing in rural African regions to include modern notions of independence and self-sufficiency (Johnson-Hanks, 2006: 59).

Youth pregnancies are central challenges to the improvements in health education, outreach, and community development projects in Uganda. A common message to young girls currently is simply, “Wait!” Honorable sexuality is to marry before children and to stay in school, but this paired down, accusatory message defines health policy approach to this astonishing issue. Women in Uganda express their own bewilderment at such a dismissive policy. Violet explains that the challenge is that women are expected to have children while they are still young, so in terms of timing, school and womanhood are in direct competition. Pregnancy ends a girl’s childhood; she discontinues school and sometimes marries or moves in with the boy’s family. She will watch her classmates walk to school while she is at home with her baby. I spoke with one young mother who could not stop crying. She had a newborn and moved in with the boy’s family because her own family was displeased. Her mother-in-law abused her and used her as a housegirl. She was devastated. In some ways, she is living the “destiny,” constructed of Ugandan women, but the trajectories of womanhood do not align and so
her life is out of her hands. The proper life course is out of women’s control sometimes
and incompatible with the multi-directional pull of duties and ideals for women.

The policies and programs in place in Uganda further disjoin women from
empowerment as their rights, preferences, and realities are ignored and worked against.
Health operations have immense power to change the minds and practices of people. The
rhetoric that comes from national, international, and global powers can drastically
contribute to the dispossession, particularly medical dispossession of women, and so
there is an obligation for health interventions to do so. Recognizing the power and
authority of local women is a foundational movement in that direction. TBA’s and local
women’s collectives already demonstrate collectivity and authority and are an important
part of the fabric of women’s lives that offer support, knowledge, and empowering
mutuality. Many informal collective of women exist in rural Uganda, from TBA’s to
health-based support groups to widows co-habitation to business and service
partnerships. These community-based networks are the roots of many women’s lives and
offer the structure necessary for forming women-based procedure and the voice for
growing agendas of empowerment for women.

**Women’s solidarity**

There was a group of women with whom I would regularly hang out during fieldwork in
2014. We lived on the same road and these women ran the shops at the end of the road
where it intersected with a busier thoroughfare. Dorrine ran a small supply shop with
soap and sugar and the like; Edred had displays of fruits and vegetables for sale; and
Winny sold phone cards and was also a tailor. Between the three of them, there were probably 10 visitors a day on average. In between visitors, the women would chat and tend to their households that were adjacent to their post. Their children walked to and from school together and when they returned the kids would greet each of them equally. I began to realize that this group depended on one another and had formed a family-like alliance wherein they provided and cared for one another. Though each of them was married, they spent very little time with their husbands. They freely borrowed from one another, cooked for one another, disciplined and loved each other’s children, and teased one another in the classic Ugandan, loving way. Of course, they discussed their relationships, current events, and gossiped about other neighbors, but they also built each other up and called each other out when one was making mistakes.

One day, Dorrine was clearly upset because another neighbor woman had been gossiping about Dorrine’s husband and his drinking. She wanted to get the witchdoctor involved and do something to this woman. Edred advised her not to “start a war,” and though Dorrine seemed determined, after some conversation, she heeded the advice and decided to play it cool. In this collective community social support has tremendous impact on health, and Edred’s advice may have saved Dorrine from a long-standing battle of bewitchment that could drain resources and lead to exhaustion and sickness. In this communal society, suffering is social so the solutions must be met with social support. Bodily fragility and political economy entanglements are affixed to social worlds, so health is directly linked to relationships with people and ancestors (Smith-Oka, 2014: 107).
These women act as support groups and resources for one another. They empower and counsel each other, and in doing so provide continual, if ordinary, support that keeps one another safe and contributes to health-keeping. Friendships in Uganda remain rather reticent because revealing personal information to others makes one vulnerable, but this threesome displays a kind of care beyond those confines where trust, reciprocity, and social bonds inform the network on which they rely beyond kin and marriage.

(M)othering advocacy

Nfah-Abbenyi argues that such female bonding, in the African context, develops out of a sensuous maternal love that speaks to the source of care, admiration, and appreciation of self and co-women and that “paves the way for both women to shift in and out of their marginality,” (2005: 109). In other words, it is precisely the oppression and the “otherness” of women that forges a shared, resistant subjectivity within a male-
dominated, hegemonic society. For women to experience selfness they do so reflexively with other women, which is a way around complicity and the “problem of womanhood,” which limits or denies women’s pleasure, (Nfah-Abbenyi, 2005: 102). Barbara Bianco, writing from the Kenyan context, says that power and authority need not be understood solely in terms of place holding or roles. Pokot women are authorized to give and withdraw support for the clan and the community, which they do largely through and with other women, namely through the care for other’s children (1991: 770). So, the cultural politics that bind women together are ultimately shared senses of maternity, regardless of mother status, and these bear power that sustains women’s collectivity.

Having someone to confide in can make all the difference to one’s health as silence can often means suffering. Angela the senior TBA explained that often women speak with her rather than with a family member. Village marital arrangements do not always configure communication and partnership, so women rely on other women for camaraderie and counsel. I find that the relationships among groups of women sustain communities, provide structure for women and mothers, and resemble shared, multi-women households or partnerships. From formally organized women’s groups to neighbor/kin collectives to friendships based in resource allocation, women tend to work in partnership with fellow women for company, for social alliances, and to pool cooperation. And so it is critical for policies of development and intervention to acknowledge the mutuality of womanhood and the effectiveness of women-centered care as well as intimacy in care relations.
Easing the strains of womanhood

The shared experiences of womanhood are the foundations for care within women’s social systems. Women empathize with one another regarding the complicated challenges of financial insecurity paired with the paradoxical interpersonal and social pressures. As the bearers of duty and responsibility for entire communities and clans in Uganda, women must first protect and care for themselves in order to deal with the precariousness and challenges of caring for others. This echoes what Patricia explained— that women must be cared for first and foremost because they carry the well being of the community. Furthermore, the health, safety, and security of women are matters of women’s rights with or without the maternity factor. Such approaches are difficult because of the ways that womanhood and motherhood are entangled, but I propose that empowering women and fueling discussion of women’s bodies, experiences, and dynamic interpersonal phenomena opens public health up to a significantly more clear, broad, and accurate depiction of women and their health. This begins with recognizing the fuller spectrum of factors that contribute to women’s health uncertainties and the obstacles to not only women’s survival but their wellness, security, and equity. Biologies and physiologies are not universal and policies upon which women’s care are contingent should be comprised by the custodians of women’s health— women.

The quotes at the start of this chapter were said to me in the same day and led me to think about the ways in which women have all forces against them and the deeply paradoxical burdens, enduring challenges, and taxing obligations that women bear for their families, communities, and relationships seem impossible. The risks, dangers, and
hazards are great, but as I watched a group of women in colorful, perfectly tailored clothes, carrying bundles of firewood on their head and babies on their backs while other young ones ran ahead, I thought about how despite what seems scary, impossible, or daunting, women make ways for themselves. As structures and policies work against them, they constantly, vigilantly tend to what they care about, and they do that with help and togetherness. Where public health and development policies do not incorporate women’s mutual understanding, women and the care collectives that they form often do. Public health agendas in Uganda fail to account for women’s complex and often contradictory interpersonal frameworks, the constraints and demands of the structural and cultural contexts, and the gaps between these. The next chapter considers some of the social relations that implicate and compound women’s health, I look at how those relationships could be the basis for health policy revision and ideological approaches to health development in the global south, including relationships with men and partners. And I look at the role of the TBA in spurring this process of empowerment.

Figure 33: Clothes and dishes drying in compound - photo by author
In Uganda, reproductive consequences greatly affect women’s wellbeing and are compounded by structures of medicine that alienate them. Health policies have historically disregarded and violated women’s choices, bodies, and the complex factors that influence them, including relationships and interpersonal experiences. Issues for women’s health are obstructed by oppressive body politics and agendas that do not reflect everyday realities and these reproductionist frameworks reduce women’s roles and health to mothering and maternal health, eclipsing sexual health and women’s health more broadly and holistically. This chapter considers the implications when womanhood is conflated with motherhood and the tensions between women’s autonomous desires and
her management of the paradoxical burdens of mother. I look at the ways that health is implicated when women’s roles are conflated with women’s reproductive capabilities. In male-dominated societies, it is important to look further than masculinist control of women and consider the entanglements of sexual and partner health. In Uganda, the major risks to women are associated with relationships, including sexual and reproductive, which are based in issues of equity and health justice. Powerlessness of women is dangerous in sexual relationships in many ways, but shifting contemporary arrangements and ideologies create space for informed sexual partnerships and shared responsibility.

National and global health agendas ignore personal and sexual health of women in favor of reproductive or maternal health, which, coupled with the cultural politics of Uganda, infringes upon women’s agency and autonomy and fails to account for the fuller picture of women’s lives. Women’s wombs have been a conduit and symbol for development and they continue to bear the burden of their societies. Furthermore, women’s sexuality is wrapped up in maternal shame that forbids and discounts the pleasures of women in fear or favor of reproduction. The tensions between women’s desires and their liabilities to prevent and manage pregnancies are wound up in public health idioms that ignore women’s goals, preferences, choices, and the complexity of their lives and relationships. I consider the Ugandan couple in terms of maternal health and reproductive health, and the ways in which partnerships and marriage influence and are influenced by health initiatives.
Making decisions for women without their participation, and reducing women to their physiologies is not only a violation of health justice and human rights, it is an ineffective way to develop, build, or remodel structures of public health. The bureaucratic mis-management of women can compound the threats that they face, and imperialist, neo-colonial agendas disregard women’s decisions and personal sentiments. Agency, autonomy, and empowerment depend on informed, women-based health care. The TBA is an institution for women’s health that ultimately de-institutionalizes women’s bodies through her relational care practices based in women’s choice. TBA’s have sustainable and intimate access to women and know the dynamics of women’s lives. Her work contributes not just to women’s rights but also to the pursuit of the good life. TBA’s are a sort of social service that is privy to private discussions with both men and women, including on sexuality and family planning. This chapter considers some of the ways in which women’s health can be reframed to speak to a dispossession of women and how TBA’s help to subvert shame through education, sensitization, and communication as a womanist resource embedded in the community.

**Conflations of motherhood and sexuality**

The feminist project entails an unraveling of the ambiguity of women’s roles in reproduction and upfront conversations about women’s lives, bodies, and desires (Morgan and Michaels, 1999). The feminized role of mother inflates the devices of patriarchy that belittle, exoticize, or sexualize black women (Cradoock, 2014). In terms of reproductive health, women are particularly privy to imposed surveillance (Takeshita,
2011). And black women in colonized nations much more so. As Uganda experiences shifts in modernity and culture, it becomes obvious how family and sexuality are linked to various social, economic, and political factions. Women suffer from stigmatization of sexual and reproductive health because of their inability to influence health decisions in regards to sexual health with their partners. Sexual health conversations necessitate communication and disclosure so that women may have more means to care and safety in their family making decisions and practices. It is important not to reduce women’s health to maternity or to conflate women’s health into reproductive and populations health, because it takes away the personal agency of the women and overlooks her sexuality and sexual health. The denial of women’s desires is wrapped in paradoxical dynamics of women’s sexuality and responsibility, namely that of mother. This kind of maternal shame is a construct that not only stifles women’s empowerment, but is detrimental in health development.

Figure 35: Sexual health campaign -photo by author
In Uganda, men are known to be the sexual authorities and sex is on men’s terms and situated around his preferences and readiness. Sex is to serve men and to reproduce. This is an issue of equity based in the burden-blame dichotomy previous discussed. Women tend to define sexual encounters in terms of pleasing the man, and all too often I spoke with women who had to deal with violent, coerced, or non-consensual sex from their husbands or partners. Women’s own sexuality is stifled through the power and prestige that claims and controls women. Historically, of course, this has included female circumcision to remove that which invites a voracious sexual appetite which has the potential to “halt progress,” (Boddy, 2005: 183). Locally, family planning and reproductive health campaigns are about limiting aberrant sexuality rather than any actual, “planning.” The spectrum of honor, sexuality, and goodness is a difficult and incompatible balance for women, especially those with a history of oppression. The incongruence of moral self-mastery and women’s appetite for sex creates shameful milieu for women and women’s health generally.

Furthermore, women’s bodies are constructed as sites of infection and contagion and are seen as the antithesis of the proper, white, British, male, disease-free, and liberated body. Biomedical practices are bound to agendas of rational science and servitude. In post-colonial Uganda, biomedicine is inseparable from mission work and Christian-based doctrines of morality and cleanliness, which is why sexuality and desire are such important concepts to address in this context as women’s lives are at stake.

Hilda Twongyeirwe, in her short story, *Becoming a Woman*, discusses the degree to which womanness and female biologies were wrong, taboo, or dirty for her growing up.
in Uganda (1998, 85). She tells the story of her first menses and explains that this is a particularly complicated time because everyone knows that she can now become pregnant. Having the first period, or - *okuza mukwezi*, which translates to “going to the moon,” is Ugandan girls’ first step toward becoming a woman and it is shrouded in shame precisely because it means the possibility of fertility. Twongyeirwe explains that the conversations are not exactly open in the conservative Ugandan household, which makes girls confused about sex, pregnancy, and their bodies altogether (1998). It is important to note that many Ugandan women grew up in a context where rape is common and girls are constantly warned to protect their virginity vigilantly, not necessarily because it is her’s but because it is an asset, particularly in marriage arrangements, where virginity tests still sometimes exist.

Ideals of sexuality, purity, and danger in Uganda have been bound to discourses of HIV/AIDS for some time, which is important to note in terms of public health. Following the anti-sex era of the HIV/AIDS epidemic in the late 1980’s, public health campaigns and messages confronted pleasure and risk directly in commercial media, namely radio and newspaper columns (Parikh, 2005). Parikh points out that in the wake of HIV and the reverberations of the outbreak as well as other STI’s, that conversations around sex in Uganda is often along a risk/pleasure divide and that public health and sexual industries, like porn, exist on medicalized/ commodified spectrum (2005: 127). Movements of modernity in Uganda have introduced an age of public sexuality where risk and pleasure exist simultaneously and campaigns around sexual and reproductive health at once attempt to restrict sexuality while imagining sexual possibilities. This sort
of “managed pleasure,” merges health messages with sensuality but also perhaps encouraging unrealistic responsibilities on mostly women (Parikh, 2005: 154).

Rapid change in the last 20 years has introduced new forms of moral particularities, medical and scientific treatises, and also new forms of media for the exploration and circulation of sexuality, including advice columns and papers that discuss pleasure and casual sex openly. The threat of HIV officially turned sex and intimacy into a public health project in the past, and countries such as Uganda experience conservative values around sex not just for reasons of missionization, but because of such severe stigma and risk that came about because of the threat of disease (Spronk, 2009: 186). As Ugandans actively interpret and deploy new ideals and new concerns in transitions to various forms of modernity and new social arrangements, sex and sexuality take new forms and incorporate new ideas around religious faiths, for instance (Parikh, 2005: 148).

Parikh says that foreign ideas, including religion, interact with local beliefs and practices in complex ways around sex, where modernisms could be seen as moral decay (2005: 151). I posit that empowerment for women fits into the complicated terrain wherein ideological and social progress is stunted by structures of power based in oppression. As a developing nation, Ugandans grapple with modernity and the changing perspectives of family, most notably the rise in working women and educated women who postpone or negotiate motherhood in favor of such advancement. The issue with women’s subversion of motherhood is that her identity is set in her reproductive abilities and her sociocultural roles and standing affect her access to valuable health resources. We cannot consider women’s worlds without health – because of the risks to women; the
physical processes that women endure; the taxing work and the obstacles to care; and the paradoxes in her identity politics (Gammeltoft, 1999).

I spoke with countless women and mothers who describe contracting HIV, STI’s, or other infections from sex with their husbands and partners. The main cause for such spreading of disease is usually cheating. Some forms of infidelity are fairly accepted in Uganda, and cheating on the part of men in unfortunately very common in the area. One man even admitted to cheating on his wife of many years because she had only given him daughters and he wanted a son. This “dark side of social capital,” is involved in enduring violence and other forms of abuse (Holten, 2009: 159, 179). The paradoxical commands on Ugandan women are constructed around submission and preservation of a hierarchy, so solutions must begin with a resistance to those structures. The conflation of women’s health into maternal health is dangerous because it ignores the broad pictures of women’s worlds and the ecological, political, and social spectrums of factors that affect her.

Conflating sexual health into reproductive health is dangerous because it disregards the complexities of sexuality and confuses morality and with ethics. Existing models of women’s health in Uganda do not give rightful space for attention to sexual practices and the health and safety around these that obviously involve and inform, but are not synonymous with, reproductive wellbeing. An avenue for improvement in reproductive health is in tending to women’s health and sexual health, namely in the form

27 Polygamy does exist and there are less formal polygamous marriages as well as the more formal, traditional kind. In many African contexts, polygamy is the result of a woman’s inability to have (enough) children, or subfertility (Whitehouse and Hollos, 2014).
of multi-dimensional approaches to family planning. Desires for women are in tension with their constrained abilities to control their families and care for them as well. Issues of sexuality and fertility are connected to all sectors of development and security, and thusly should be seen as issues of health justice and human rights.

**TBA’s and sexual health advocacy**

Enhancing the health structures currently in place in Uganda means making use of the pivotal role of the TBA, who has unparalleled access to women’s private worlds and disclosures, including sexual practices. TBA’s can speak to the nuances of women’s health issues in relation to sexuality, sexual behaviors, and sexual experiences. For instance, TBA’s understand that women in Uganda often have a hard time laying down and spreading their legs, as this is an extremely private symbol of intimacy and submission, so they instruct practitioners to start with women sitting. Women and TBA’s participate in conversation that could only be described as secret. They share information and experiences that make women exposed and susceptible elsewhere, and they provide the kinds of services that help women have some choice in their care and family planning. TBA’s often fill the role that female family members or educational programs would or should, teaching girls and women about sex and sexual health.

TBA’s tell me that they often explain menstrual cycles to women as a way of educating on natural birth control methods. TBA’s also offer some traditional methods of contraception, including tying cloth tightly around the waist during sex, drinking certain herbs that affect fertility, and timing the cycles with moon beads. Some TBA’s can
induce abortion or terminate pregnancies with herb as well as with vaginal enemas, but generally they try and work with women to get other forms of contraception. Women’s secret health practices generally take place on journeys, “to the bush,” so out of earshot of family and neighbors. These journeys to the bush are not uncommon as TBA’s make these trips for curative, replenishing, or other therapeutic practices. For example, TBA’s take women to the bush to administer a series of herbs in order to increase milk production after childbirth if it is lacking. This is a great example of women’s secretive, precious, and supportive communities that form as extensions of kin and care networks.28

Many traditional family planning practices are unsafe or unreliable, but the position and influence that the TBA’s has to intervene or inform women’s practices is invaluable. In order to avoid desperate measures, there is a need to harness the TBA to expand access and quality of family planning methodologies. There is also a need to affect the receptions to family planning on the part of both men and women. TBA’s are a covert link to family planning because of their deep knowledge of women’s and thusly men’s sexual praxes. They are privy to women’s sexual particularities, and they are an accepted, situated, and powerful link between confidential and protected knowledge, including women’s complaints and struggles, and the more public conversations and processes around family health. Because TBA’s are on women’s side, so to speak, they help to rally for systems that will venerate her choice and best respond to her experiences. Critically, TBA’s also have the connections with men, so their rallying for women does

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28 Another such women’s sexual advocate is the *senga*, which is a paternal aunt who is supposed to teach girls about sex, pleasure, and procreation at the time of their marriage. *Sengas* are uncensored sexual advisors whose training takes place in extreme private. Today, with diminishing traditional ways, there are *sengas* for-hire who will share their great insight and the keys to womanhood for a price.
not have to be in subversion or secrecy from men, but rather as a conduit to collaborative family health (though sometimes TBA’s do have to do things for the betterment of women despite or without men’s wishes or command direction).

**Empowering sexuality**

Family planning issues fall completely on women in Uganda with no mention of women’s desires or pleasures, but much of the bureaucratic scripts around women’s health encourage women to attempt to control men’s pleasures and desires. Despite the assumptions about rural, poor women, who are often depicted as sexually exploited and non-desirous, women in Uganda enjoy a certain amount of agency when it comes to sexuality. Muhanguzi says that even women who hold little power elsewhere with their husbands may find it within the sexual encounter (2015). In fact, women report that passion is a normal and regular part of their lives and sexual experiences, and that they have options within passionate acts. Economic inequality is implicated for inhibiting women’s freedom to build loving relationships, but it remains that Ugandan women have sex and sexualities.

I didn’t get into many lengthy conversations directly on the subject of sex with participants and these conversations were reserved for the right place and time, but the majority of what I spoke with women about was proximate to their sexual relationships, namely reproductive issues and the dynamics of their marriages and partnerships, which were inescapable in speaking about health but also often on women’s minds. These sensitive, incredibly intimate topics are engrained with taboo, but we did discuss pleasure
as well as performance a bit. Women told me that it was an obligation, not just for them, but for the men to return the women’s needs as well. Women say that they can demand pleasure, but often only insofar as it does not threaten, but rather bolsters, the power and vitality of the man. Moreover, women in stable marriages reported being able to have healthy conversations about sex, including desire. Muhanguzi finds that Ugandan women, though subordinate in many ways within their partnerships, are not excluded from enjoyable and pleasurable acts (2015). She says that, within a marriage, women initiate, enjoy, and lead sexual acts, whereas outside of marriage these behaviors would be seen as out of control and acting like a maraaya (prostitute) (2015: 65).

In this way, it is the security of the marriage itself that allows women the openness and the freedom for expressing sexuality. I found that women who reported being in a stable companionate marriage were the ones who enjoyed some influence in sexual acts, including condoms for HIV incongruent couples and the use of other family planning methods. I did frequently hear quite the contrary in terms of women’s submissive sexual practices, including men’s refusal to use condoms. These were often from women in volatile or unstable partnerships. Couples with a great deal of communication and a balanced sense of partnership make healthy sexualities a part of their relationship, and often this sense of reciprocity and health collaboration came directly from sensitization and education program initiated within the community, often from TBA’s. Women in stable relationships enjoy sexual agency with husbands, and these women have much more close control of their health, which is imperative given that the complex nature of interpersonal dynamics include the potential for the
relationship to cause harm or make women vulnerable to sickness and disease as well as pregnancy. This is critical to understand for implications in sexual and partner health, which depend on disclosure and a just and balanced respect for the health of both partners.

**Partner health**

Women’s subordination and passivity contributes to poor health, and sexual passivity is particularly dangerous and increases women’s vulnerability. Women in positions of agency within a relationship have much more voice for expressing choice, including family planning and other protective measures. Women tell me that in dealing with family planning or incongruent HIV status relationships, for instance, men famously refuse condoms and other protective measures. One of the primary ways that women exercise control over men is in withholding sex from them. But, as one woman explains, she is further at risk if this causes him to cheat. Affecting the attitudes of men is imperative for women’s health development. Means to increased women’s health is through partner health, which entails increasing male involvement in women’s sexual and maternal health. The way to accomplish this is through a look at partnerships, including sexuality.

Whyte has seen the vast efforts to eradicate HIV in Uganda, and says that one product of those efforts was community conversations involving partner health and campaigns that emphasize health as shared between partners, especially in regards to HIV and other sexual and reproductive issues. Whyte further states that in this discourse some
deeper issues emerged on relationships, including gender dynamics and disparities, which actually shined light on the women’s empowerment movement (2014). Men’s active involvement in the health of women’s bodies is a challenge for public health initiatives. How could men’s awareness of women’s pleasure, suffering, needs, and safety be bolstered for the betterment of public health? I posit that compassionate, open, and enfleshed conversations would help spur men’s awareness and culpability. The kind of “modern honor,” that reconciles the prestige and passions of marriage, for instance, includes a true image of women including her susceptibility.

Global health agendas systematically fail to recognize that women act far beyond eroticized submission, and this framing of women impacts the cultural politics in Ugandan communities. Women tell me that they have so much to worry about in terms of their honor and character and that it is difficult, frustrating, and hazardous when these are contrasting with the behaviors of men. “You can be so perfect, but if your husband goes about and embarrasses you, you will feel the shame,” one women told me. Women’s dignity as well as their abilities to maintain and manage healthy households depends on cooperation and partnership. Because in Uganda women’s health issues are mostly sexual and reproductive issues, a more equal stance of women could lead to inclusive feminist politics and to a more broad and de-mystified approach to women’s health.

**Contemporary partnerships and avenues for health intervention**

In many ways, partnerships are claims to modernity, because romantic love is an empowering emotion that allows an imagined future. There is the opportunity for the
promotion of women’s empowerment and advancement through health campaigns and
public venues to emphasize fidelity and communication and help undo assumptions of
loveless arrangements. African intimacy has been historically reduced to sex with no
emotional framework (Cole and Thomas, 2009: 4). But modern lenses around
satisfaction, communication, and shared decision making are changing that. I listened,
along with women in my sites, to radio talk shows where people called in and discussed
the dynamics of their relationships, and the changes to Ugandan partnerships were a topic
of focus. In particular, callers discussed deliberations with their partners who adhere to
old-fashioned standards or gender roles and expressed a movement away from such
ideologies in favor of balanced, reciprocal coupledom that is increasingly an essential
component of a happy life. We also watched television dramas, and participants often
expressed admiration at the romance and passion in relationships depicted there.
Although these praxes mostly come from urban areas, the sentiment exists in the villages.
People tell me that many Ugandans are focused on careers and self-development, so
people are marrying later and thusly have the opportunities to be more selective and
focused on finding a partner rather than fulfill the fertility project.

Young people are beginning to see the roles and social capital of marriage as a
performance and while older generations may be reluctant to change, they are on board
with delaying children and establishing a stable base. Isidore Okpewho writes that the
ideals of true love fabricated through African lifestyle magazines, advice columns, media,
picture stories, and the like is actively adapting to contemporary values of friendship,
loyalty, trust, respect, and appreciation in a marriage (1987: 331). These shifting ideals
result from changing cultural attitudes around marriage. Postponement and alternative coupling are actually a result of young people attempting to gain optimal self-satisfaction and have more, decisive command over their lives (Moore and Govender, 2013). Women and girls, in particular, express desires to suspend marriage or to approach cautiously as a way of avoiding the pitfalls and especially to pursue education. Marriage and partnership are also financial issues, and it is important to see that the decisions, negotiations, and deliberations that Ugandans make for themselves entail economics.

Literature on modern African love is increasingly being understood in terms of romantic love, which displaces or contrasts with notions of marriage as a functional mechanism of exchange between kin and community, which is a result of, or has contributed to, movements in women’s empowerment (DJ Smith, 2009: 159). Such empowerment is largely through the current focus on couples health, family communication, and conjoined efforts for wellness. This entails that partners are invested in and care about their partner’s health, including reproductive health (Dilger, 2012: 69). It is important not to make marriage a social problem, but rather an interpersonal dynamic with the power to affect health and security in the region. The majority of anthropological considerations of love in Africa have favored kinship over emotion; sensation over reflection; desire over decisions; and fertility over feelings (Cole and Thomas, 2009: 8). These social and economic issues are certainly viable as they do play a role in people’s lives. However, we must give texture to the details of those lives. Historically, discourse on African marriage has been more concerned with systems and structures than private life, and we now understand the importance of incorporating
emotion, frustration, desire, forlorn, and personal quests into portraits of African love and marriage.

Just as anywhere, Africans constantly “deploy and rework ideologies of love,” and this is to be understood not solely through functionalist lenses (Cole and Thomas, 2009: 16). Second wave feminism touched on this, and lessened the obsession with transactional sex in an impoverished or transitional society (Cole and Thomas, 2009: 8). It is important to acknowledge the productive and reproductive value of marriage but to understand the complex ways in which women create, forge, and sustain kin networks, including through relationships. In projects of women’s health, it is particularly important to know how or when women need or call upon men in the process of family-making in order to understand romance, ambivalence, and, importantly sexuality, childbearing, and family-making (Okpewho, 1987: 342). Relationships are health concerns and occult forces with attachments to everything from the state to magic (Cole and Thomas, 2009: 7). And relationships dictate health and security, often through sexuality. Efforts from TBA’s and now teams of VHT’s are targeting partner and sexual health as a means to reproductive and population health in Uganda.

Taraneh Salke, from Family Health Alliance in California, does research in Afghanistan and elsewhere in the Middle East on the subject of women’s health in male-dominated societies. She stresses the importance of including men, saying that they are implicated in the demands on women and mistreatment, so they also must be part of the solution. Men’s practices and ideologies highly influence women’s health, so they are a valuable asset and potential ally for women’s advancement, and not just survival. Family
planning, in particular, only targets women, which not only magnifies their responsibility, but creates an incomplete circle of strategies in community health because it leaves out half of the contributors. Salke employs what she refers to as the Rights and Empowerment Model, which has three parts: local health workers to inform and mobilize efforts, education and outreach to get men and women involved, and training sessions for community leaders to proliferate these praxes. Mostly these consists of teaching men the nuance of women’s burdens but also showing the value and low-impact effects of birth control. In Uganda, TBA’s have been instrumental in conducting campaigns that closely parallel Salke’s model, mostly in the form of encouraging men’s sensitization about family size and the risks of rural delivery. They also have pushed for partner health.

![Figure 36: Examples of Partner Health approaches - photos by author](image-url)
Partnered positionalities and partner health

Nefissa Naguib, working in Egypt, urges us to consider masculine constructions within cultural identities and how patriarchy and social domination affects notions of care and health. She considers how men hinge their abilities to cultivate caregiving on manhood (2015). Naguib says that we must ask men, too, how they endow their lives with meaning, and the complex and contradicting ethos of manhood in the region (2015: 89).

Andrea Doucet argues that to do better work in maternal health, we should consider “taking off the maternal lens,” (2010). In other words, studying men through the lens of mothers and women ultimately limits our understandings of men, so in order to ease the strains of patriarchy and appeal to men in public health, we have to understand men’s values, insecurities, and anxieties as well. In Uganda, I found that women’s honor includes her having access to contemporary roles and family-making strategies that include shared responsibilities and room for her to pursue independent goals. Health and wellness take resources. If resources are divided and responsibly shared among partners, this can drastically positively affect a couple’s wellbeing. HIV and ART’s are expensive, so when one person is sick with HIV, all the resources go to that.

Women’s health and security are contingent upon their partners. Therefore, these issues should be seen with shared responsibility and as conditions of a couple rather than having the woman handle it alone. Taiwo Lawoyin et al, working on men’s perceptions of maternal mortality in Nigeria, write that healthcare reforms must be coupled with socio-economic improvements as well as efforts to improve men’s attitudes and knowledge in such a way as to make them active stakeholders, and not barriers, that
support efforts to reduce maternal mortality (2007: 299). Men and their own health should be seen as contingent, liable to, and directly affecting that of their families. Such efforts exist currently in Uganda led mostly by TBA’s in small-scale campaigns that they conduct by household. I accompanied TBA’s for several trips to conduct this outreach, and saw that men were receptive to hearing the outreach from the TBA and willing to take part in programs that are TBA-led. In contrast to this, I rarely saw men accompany their wives to clinics and only occasionally did they attend health events organized at clinics or government health centers. Ugandan men have a reputation for avoiding clinical spaces and this divides the men’s care from that of their wives.

Often, men and women treat sexual health issues in particular separately due to infidelity, shame, or incongruent status, but there is a push away from this in local community health agendas. TBA’s and other local providers have special access to men in their communities and they often encourage partner health. In order to reach men, health programs have to have this personal approach because of men’s non-participation in clinical spheres. Lucy Kululanga et al write about male involvement in maternity care in Malawi and find that male participation in women’s health happens outside of the facilities. They stress that men play a pivotal role and have utmost influence on women and children’s health and well-being (2012), but this happens apart from clinical facilities. In other words, TBA’s are community resources with the ability to impact and influence men, without whom change in public health is not possible. TBA’s with whom I spoke are beginning to talk more and more about involving men directly in their wives’ health.
Spurring participation in women’s health

Accessibility, affordability, and availability are not the only obstacles to women’s sexual and reproductive health. Men are responsible for a large proportion of ill health suffered by their female partners. Spousal communication is a major issue threatening the success of reproductive health interventions, and community-based resources like the TBA have proven to be a viable means of delegating health tasks and responsibility between a couple and remediating men and women’s health strategies. Contraception, in particular, is paramount in reducing unsafe abortions and overwhelming family size. Fertility and family planning research and programs have ignored men’s roles, but more so these efforts have ignored the need for methods to spur communication on these issues. Men are overwhelmingly more willing to interact with health venues including clinics when they had enhanced communication around the issues, or when they have a motivator to mobilize their efforts. These are especially impactful when it is a non-medical professional but with great knowledge like the TBA. I even met one elder man trained by TBA’s who now conducts sensitization with men in the community.

Some clinical health campaigns in the area have included a focus on family size and other collaborative partner approaches to family planning, but men are unlikely to even be exposed to these. The TBA, on the other hand, has direct affects on the ideas, images, and attitudes of family. And she advocates for family as the way to greater health and happiness. I attended several outreach sessions along with community TBA’s. These informal, friendly sessions are casual, respectful conversations in which TBA’s talk about a range of issues, including community betterment or crops in addition to family health.
These welcome neighbors have the attention of family members, and TBA’s tease and reprimand men and women with casual ease. TBA’s are some of the few Ugandans who I heard frequently and openly use the word love, encouraging loving behaviors like support, honestly, and helpfulness. But they had serious and specific issues to raise.

TBA’s tell me that they feel 100% comfortable discussing contraception with men, and, in fact, I found that several men in one particular village had begun using condoms after a TBA discussed with them that their wives may be at risk while childbearing. TBA’s are the loophole in women being perpetually denied of family planning services, because TBA’s have the respect, authority, and confidence from their communities, and thusly the abilities to bring men not only into health agendas for women, but also to sensitize men on the deeper implications of family planning. For
instance, TBA’s in Luwero, Uganda train and sensitize men on child spacing by telling them that the women’s body needs time to recover (Turinawe et al, 2016), thereby educating them on women’s bodies and experiences and aligning them with empathetic approaches to women’s health, and it matters that it comes from the trusted TBA.

TBA’s are often a conduit to the clinical methods of family planning, and their communications with men on behalf of women is an important and delicate act. In the Ugandan context, where power relations as well as conservative ideas and cultural stigma around preventing childbearing all possibly hinder conversations around birth control, the TBA has significant power. In fact, TBA’s can leverage their services by refusing to treat a man’s wife unless he helps her in her birth. Turinawe et al found that one of the few reasons that men are present during childbirth is if it is with an accessible TBA (2016: 7). TBA’s are “awareness creators,” and “agents of behavioral change,” (Turinawe, 2016: 8). Not only do TBA’s have the ability to solve the crisis of men as barriers to women’s health, they are also a source of medical knowledge and information for men who may not otherwise be exposed within a clinical sphere.

Alice the TBA explained to me that the community needs men on board. She told me not just because of the reasons regarding shared and partner health, but directly in regards to women’s care. Women’s health, including care from clinics and hospitals separate form the TBA, is often moderated through the TBA. Alice says that she frequently has to talk men into allowing their wives to visit facilitates where they themselves do not feel comfortable. Women’s ability to seek health care or implement birth strategies depends on input from head of household- the husband. Men need to be
involved in health care utilization during pregnancy, for instance, in case there is a need to transport. A study in Kabale, Uganda found that men who were knowledgeable of antenatal care and whose wife shared medical information at last pregnancy were most likely to accompany their spouses to further antenatal care and possibly for delivery (Kakaire, 2011: 6). In other words, men are more likely to be involved with pregnancy and delivery if they associate the experience with positive outcome and if they have confidence in the situation, and the TBA can provide that buoyancy.

**Family planning and shared reproductive health**

I found in my interviews with both men and women that family size tends to be one of the principal factors that contribute to people’s notions of a happy, healthy family. It is also an effort that takes agreement on the part of both partners. Community members report that limiting and spacing children rank among the top three ways that they can control the resources within their families as well as maintain their own health, nutrition, and labor expenditures. Women especially wish to limit family size and discuss family planning as one of their priorities as well as something that they feel is within their control. However, this easily becomes an issue for women without access to birth control but also without lines of communication open between themselves and their husbands. TBA’s are an avenue to reach and influence men. TBA’s help to alleviate men as an obstacle to service, and can be an asset in improving women’s health. We know that TBA’s in Uganda have influenced men in terms of risky behaviors, such as unprotected
infidelity, but Turinawe finds that the training and knowledge of TBA’s is multiplied in their exchange with men, who then share with other men (2016: 8).

Men often prefer to stay away from clinics because of the expenses associated with treatments and supplies there. Alice says that men fear a hospital birth will cost them much more money than they have, so they tell their wives to deliver with her, even when there are complications. This is incredibly dangerous, so Alice says this is when she will intervene and tell the husband that he will lose his wife if he refuses to allow her to go to the hospital. Husbands are much more likely to listen to the TBA than to their wives and head the advice of this trusted provider. Men’s behavior contributes to women’s poor health in many ways, but Turinawe argues that most directly by restricting them from
...care in clinics and other biomedical facilities where men feel “vulnerable,” (2016: 3). Men can actively deprive women from access to health resources in the form of denying them finances or other liberties. For instance, because clinics charge for family planning methods, men will refuse to give their wives money to visit the clinic, even for other issues, because he knows that she may have access to birth control that he may not approve of, plus it will cost. Family planning along with birth preparedness are primary issues that men avoid and that TBA’s have special authority on (Turinawe, 2016).

Men’s cooperation is strong with the TBA because of her embeddedness in the community and the authority that she has. TBA’s attract men to maternity health care through their shared social positions, and the confidence and familiarity of the TBA’s position. Community-based strategies cannot be replicated through clinical approaches alone; they require a facilitator. TBA’s promote all manner of care and she often encourages clinical care. For some community’s members’ TBA’s are the only point of access to clinical technologies and information. Part of the reason why TBA’s continue to practice after the ban is because of men’s insistence of their practices, so to promote men’s involvement in sexual and reproductive health while undermining the power and authority of the TBA is a contradiction. The most critical and significant services that TBA’s provide are more akin to social services that entail advocating generally for health, and these hinge upon their access to the community and influence in people health-seeking behaviors, including encouraging men and women to use other facilities and participate in the public health developments in the area.
TBA’s not only advocate for women in local and international politics, they facilitate women’s health by negotiating with men on their behalf. As heads of household, men control resources in addition to deciding power, so they allocate access to things like family planning and birth plans. Men’s jurisdiction over women’s health can be a direct barrier to care for women. They control resources that facilitate decisions concerning sexual relations, family size, and access to health care. As such, men not only impact women’s health risks, they can also act as barriers to women’s health and access to care. TBA’s are avenues for women to influence and mobilize men and thusly contribute to partner health and increased health equity in the project of women’s health. Their work is women-centered care, and they are some of the few women in positions of authority to sensitize men to women’s challenges, thereby instilling feminist politics into local public health as well as offering a feasible and practical approach to developments and interventions in institutions and processes of health.

**Partnership and cooperation in birth preparedness**

One area of women’s health where TBA’s have strong influence is in birth preparations. In thinking about the issues of *going alone*, it becomes clear that these are unnecessary risks for women. Some simple changes to women’s health ideology could impact maternal and child mortality rates drastically. Male involvement in antenatal care is associated with positive outcomes for mother and baby including antenatal care, cessation of smoking and alcohol, prevention strategies for vertical HIV transmission and birth preparedness (Kakaire, 2011). Perhaps the most imperative point at which men can
influence maternal health is in having a plan for the birth. Just as mothers are being encouraged to invest in Maama kits, men are encouraged to have a plan as well. Kakaire et al, found that partner involvement had critical impact on reduction of maternal morbidity and mortality, even if it is as simple as agreeing to buy a kit or saving for delivery or arranging for transport (2011). These simple birth preparedness strategies are the most crucial and accessible component in avoiding the stages of delay during delivery emergencies (Turinawe, et al, 2016).

![Maama Kit](image)

**Figure 39: List of supplies for birth as recommended by the Ministry of Health – photos by author**

The birth plan, as defined locally, includes plans to have a birth companion. Many women choose the TBA, but TBA’s are encouraging women to have their husbands there for support. A comprehensive plan with complication-readiness means that a husband
must be informed and willing in order to aid in a quicker response to emergencies, which means he must know his options. By and large, this information is distributed by a TBA.

Some specific programs are being put in place in Uganda to spur male involvement. For instance, KIHEFO clinic, with whom I worked in 2016, initiated a program that utilized a portable ultrasound machines, which clinicians brought around to show men their unborn babies in hope that this would increase his investment in the pregnancy. This effort was short-lived as it depends on the functioning of the device, but it did make a point that Turinawe’s study corroborated, which is that men are more keen on following a practitioner’s orders if it involves the health of the baby (2016: 6). Furthermore, men’s participation depends on the health service coming to them in an environment where they are comfortable and available.

Men’s health literacy comes largely from TBA’s and other community members, because they are less likely to attend outreach sessions or to visit clinics. In fact, the pivotal report from Turinawe et al (2016) states that male involvement with pregnancy and childbirth in rural and remote areas of Uganda involves a critical and fundamental relationship with TBA’s. The team of researchers found that the configurations in which TBA’s and men together affect women’s health are tremendous. TBA’s not only have great access to and influence over men’s behaviors, they have the authority to negotiate and broker conversations and practices between a man and his wife. Moreover, TBA’s have the power to secure resources from men on the part of the women (2016: 2). Men actively seek advice and services from TBA’s and encourage their wives to see the TBA over the clinics, and TBA’s sensitize and involve men to an extent that clinics cannot.
TBA’s play a role that is irreplaceable with men in villages of Uganda in regards to women’s reproductive and sexual health. TBA’s are allies with women for influencing men to provide and participate in family and partner health. Where women may be powerless to initiate conversations on reproductive health, especially as family planning and HIV testing and transmission reduction are concerned, TBA’s collaborate with women and intervene as community leaders and knowledgeable practitioners (Turinawe, et al, 2016). This is crucial to consider, especially since national and global agendas largely ignore men in reproductive health policies.

Part of what is being left out when agendas for health and development ignore men’s roles in the causes and implications of gender inequality that play a large role in women’s access and utilization of health care facilities, resources for family planning, and sexual and reproductive practices. The TBA’s that I spoke with emphasize that the strategies that they employ and advocate for with women are to incorporate men rather than depend on men. When I asked women about their TBA’s interactions with their husbands, many women told me that TBA’s teach the man how to love the baby. In other words, TBA’s actively construct family values and play an essential role in the lives of women in regards to the social conduits of their health.

So, the ban outlawing the services of the TBA is counterproductive in many ways, but perhaps the most important way is that it undermines potential solutions from within the community. Failure to address underlying reasons and obstacles in women’s access to care will only reciprocate the unequal and unjust socio-cultural conditions for women in Uganda. Furthermore, failure to address the reasons why TBA’s continue to be a primary
provider of obstetrics care is turning a blind eye to potential strategies for improvement. Prescriptive policies reproduce inequalities (Turinawe, 2016:10). Ignoring the sociocultural milieus in which people operate is unrealistic, ignorant, and displays an arrogance not unfamiliar to neo-colonialism. The issues addressing men’s involvement with women’s health have great implications for policy. Namely, recognizing the TBA as a source not only for women but of women in regards to men may drastically influence the approach of where she stands in the ongoing scramble for public health in Africa.

**Men’s participation in reproductive and women’s health**

I have discussed the social impact and role of reproductive health on women’s identities, places in societies, and status in communities in rural Uganda as well as the ways in which TBA’s ameliorate partner health. I also mentioned in the last chapter the ways in which attention has been growing on men and men’s health as a means of improving women’s reproductive health in the region. I see issues of reproductive health as health justice in the area. The expectation of reproduction as a means of economic stability and social status is a form of violence as it displays women’s lack of freedom as well as exposure to health risks. My findings indicate a need for active male involvement through education and participation in order to combat the historical subordination of women. Promoting women’s empowerment and partnership equality can alleviate the consequences of reproductive global health issues such as women’s morbidity and mortality rates associated with HPV and cervical cancer. Thus, strategies that emphasize
men’s shared responsibility and active involvement in sexual behavior will be most effective in combating women’s reproductive health.

Because so much of the deciding power remains with men in the region, the responsibilities for health justice reside, in part, on them. Furthermore, most issues that threaten women’s health are either reproductive or sexual, meaning the practices of their partners play a major role. So, to exclude men from women’s health is a partial effort. The rebirth, and revolution of domestic development, inscribed on women’s bodies is certainly a kind of violence in and of itself, and if pregnancy and childbirth continue to be viewed as solely women’s issues, then responsible feminist politics are excluded from development programs because of the chasm between policy and women’s lives. If men see these issues solely as women’s duty, then there remains women’s exclusion from choice and prohibition of power through blame and gendered marginalization. The exclusion of men from women’s health, I argue, actually actively continues female subordination because men are not informed of women’s issues and hindered from breaking society’s standards on gender roles in order to participate in alternative interactions. In other words, feminism depends on men’s informed involvement and a more equitable balance of power between partners can enhance a woman’s control of her reproductive health and lessen her sexual risk.

In my research, I found very clearly that the partnership dynamic between husband and wife would suffer due to the gendered role of women as mothers. Marriages that hinge narrowly on reproduction give women little autonomy over her body and expose her to sexual health risks. I also found that women in relationships where there is
open conversation about sexual health, there is also much more content with the relationships and lessened chance of sexual violence, sexual health risks, and other kinds of mistreatment. Sexuality is a kind of agency for women to be empowered and a conduit of steps toward gender equality and more equal health outcomes. Partner openness and sexual communication is currently a theme of health campaigns in Uganda for these reasons. Communication also means testing, visits to the clinics, and keeping active control over one’s health. Men in Uganda are overwhelmingly more willing to interact with the clinics when they had enhanced communication around family planning issues, and felt that they understood the issues at hand. Women tend to be much more informed because they are much more participatory. Simply bringing men into these conversations not only naturalizes women’s bodies and women’s health but gives men the opportunity to share with the women in their communities. When women are forced to do these things in secret, their health suffers. TBA’s and VHT’s are some of the main voices encouraging partner health and leading the current focus on couples’ health, family communication, and conjoined efforts for wellness.

This first entails that partners are invested in and care about their partner’s health. Dilger argues that this investment is more likely when there is understanding and empathetic concern (2012: 69). This necessitates education, outreach, and conversation. I posit that issues that most affect women should be considered partnership issues and should be discussed as such. Diseases that burden women and the consequences that fall on the shoulders of woman can be eased when we start to share responsibility. I argue that this starts with health campaigns and policies. The tone of community health
projects, as simply as the wording or the target audience, can greatly affect how those are carried out. This means training and informing men alongside women so that the two mutually understand one another’s roles in meaningful and impactful ways so that there is personal and social equity that can lead to health equity and empowerment. If men are more involved in promoting equality in their partnership women will be empowered to express choice and men with lobby for outcomes that promote their wife’s greatest health and well-being.

The means to increased women’s health is through partner health, which entails increasing male involvement in maternal health. I think that the way to accomplish this is through a look at partnerships, including sexuality. We know that women’s subordination and passivity contributes to poor health. Women in positions of agency within a relationship have much more voice for expressing choice, including refusal or protection. And we know that women’s sexual passivity increases women’s vulnerability. Powerlessness is dangerous in sexual relationships in many ways, and spousal communication is the biggest issue threatening the success of reproductive health interventions. Risk reduction entails sensitization of men on all areas of women’s health and empowerment means acknowledging women’s desires as well as her needs. Such empowerment is largely seen through respecting and accepting women’s power. Steps need to be taken to emphasize not only men’s shared responsibility but also women’s rights, worth, and abilities. The benefits of male involvement can be translated to combat the global public health issue of increasing incidence and related morbidity and mortality and this starts with feminist politics and women asserting their ideas and leadership.
TBA’s and women’s health empowerment

The village TBA is an advocate for women’s health as she foregrounds women and women’s health as a primary concern for the community. This is an example of local feminist politics, because TBA’s are helping to show men why it is important to respect women’s bodies. TBA’s sensitize men to women’s issues and explain to them women’s challenges in a way that the power dynamics in this context will not allow a wife to do. TBA’s help men see women’s needs and work to involve them, because when men are conscious of childbirth complications, they can help to reduce emergencies and thusly, maternal mortality. As directors of women’s health, TBA’s provide crucial counseling and social services that help to ease some of the burdens of blame, relieve some of the strains of responsibility, and ameliorate some of the injustices of a system that has historically disempowered women. The TBA is a constant ally providing immediate and intimate accountability and reassurance for women. She is a confidant fulfilling a civil service, and her connections to health interventions means that she is an informed mediator of the latest health campaigns, so contact with the TBA increases people’s access and quality of health care from a practical perspective.

The TBA represents the rural Ugandan woman, and she facilitates family health through her access and ability to influence community and family practices. She knows the processes and social entanglements that influence women’s experiences, and it is imperative to have these local understandings where women have been unheard in health programming. Health policy should reflect women’s experiences, and in order to account for those experiences, women must be recognized with a platform for voice. Women live
the challenges to health intervention, and the issues that affect them are much more complex than a diagnosis or infection rates. TBA’s empower families by involving men in women’s health. With more support in the arena, perhaps TBA’s could help to change men’s minds in a way to systematically reduce inequality. A healthy awareness of women’s bodies is good for women and for public health. Understanding that the entirety of women’s complex lives affects their health is imperative to incorporating these intricacies in policy and intervention or development. The TBA is in a powerful position to help incorporate family and target couples for the sake of coalesced health. Enhancing the structures in place in Ugandan, such as the TBA, who is privy to the intimate details of life there, can create considerable change and make the necessary connections to optimize women’s health.
Conclusion

“We can think of nothing more revolutionary than supporting mothers so that they are healthy and strong to nourish and support their babes.”
– Mother Health International blog, 10/22/2015

“Respect during childbirth is a right not a privilege,”
– Mother health task force (MHTF.org)

![Mother with baby after an interview - photo by author](image)

The traditional birth attendant represents connectivity in the combination of care with its applications. Relational connections and interactions with TBA’s are both a means to health and part of social community, which are intertwined in Uganda. Importantly, the
work of the TBA is entangled within networks of the community, which is tied to her effectiveness. The question I pose herein is how such care investments can be implemented in policies. I believe that this demands that policy embrace care’s responsiveness and engagement. To make care meaningful requires a combining of community outreach and empowerment with health and medicine. The criticality of the services of the TBA is not best measured by her emergency deliveries in the night, but in her steady, embedded, and deeply understanding treatment in a holistic range of provisions. The necessity of this kind of support is made obvious in the wake of the ban outlawing TBA’s rural practices, because there is an urgent need for her skills and a revolutionary turn toward seeking out, preserving, and harnessing her advocacy and knowledge.

I have seen the need to systematically harness the work of the TBA and an imperative call to sustain her practices. I have mentioned a few collectives organized in various ways to assemble TBA skills and scope. With the threat of the TBA practice disappearing, certain efforts like the community-based grassroots birthing clinics and cooperatives have worked to sustain this medical tradition while adding to the expertise as well as available labor hands. But on my final follow-up visit to Uganda in 2016, I saw an effort to bring TBA’s into the subsidized clinical sphere even in the wake of the ban. I was told about a health worker at a governmental Health Center that was successfully merging her clinical practice with that of the TBA in Mukono in Eastern Uganda. I visited this clinic that breaks legal and Ministry of Health protocol by employing TBA’s. I met with the doctor who pragmatically brings TBA’s into her clinic, and she described
doing so out of a need to incorporate TBA’s in birth plans and to merge the care and community service of the TBA with health applications. This clinically-trained physician has a unique take on maternity practice in Uganda. She is familiar with women’s preference for TBA’s and she has had issues with women either avoiding the clinic or coming delayed and mid-labor, so she had a simple solution. She has TBA’s work for her and provide the majority of maternity services. She is on-hand should need be, but she says mostly the TBA’s require only the supplies available at the clinic.

This is one of very few clinics that I know of working against the ban to provide space for TBA’s. These efforts are not as much intended to preserve the TBA as an institution as they are a necessity for dealing with critical need in the area. In this way, the ban has spurred some collaborative efforts between clinical and traditional health practices – a cooperation attempted many times over in the history of Ugandan medical pluralism, but this clinic is doing so through a process that is criminalized and there are no programs to train or continue such collectives. So, this interest in TBA’s practice, perhaps once taken for granted in the communities is sought after currently – an unexpected positive outcome of the ban. But how sustainable are these efforts and what is the fate of such work that is unlawful and unsupported? I met with other private clinics and health centers interested in similar arrangements as what is being done in Mukono. They all spoke of the sources necessary for such movements and some are exploring insurance schemes and other means to support a similar cooperation. Because this is being done in defiance of the Ministry of Health and therefore would receive no government or state-affiliated support, organizers look solely to the community in
seeking partnerships through locally-situated sources – an important transition in the landscape of NGO and foreign-funded health campaigns.

The rallying of the TBA is happening in resistance or opposition to the Ministry of Health. Importantly, these efforts prioritize local and cultural preferences, needs, and practices, largely through and with the TBA, as well as local wherewithal. Now, perhaps more than ever, the TBA is being sought out for sustainable women’s health issues and low-tech delivery options amidst the mass transition to clinics and hospitals. The ban, perhaps oddly, works to spark initiatives for locally sustained health efforts, but these efforts beckon for structures in place to support indigenous medicine, which is difficult given the forbidding of traditional training and practice. Oddly and unfortunately, this may mean that support for TBA collectives will increasingly come from outside of Uganda. The positive effect is that these efforts would exist with an insistence to and coherence with local representatives. Development efforts, particularly in this transitional time, must act in tandem and in combination with these local augmentations. New versions of the birth clinic are based in care and empowered and informed local resources. It is imperative that this remains so, particularly in regards to any agencies, operations, or initiatives that may fund or fuel such efforts or be involved with the transition.

Drastic policies and radical changes to health care should be presented as a response-based solution rather than a diminishment of services and available means. In Uganda, various health venues have met this challenge but only where empowered growth and robust community efforts are possible – without such support, the decision to
ban TBA’s has potentially severe and harmful impacts. The growing numbers of TBA’s working in hybridized settings are enacting their abilities to span across medical domains and community health outlets. The urgent movements to involve TBA’s demonstrate the powerful link that she is within the communities. The need for the TBA goes beyond preference or cultural insistence to the fact that they are part of community foundations that comprise the vital connection between medicine and local familiarity. The question is how best to hold this unparalleled position of the TBA and how to employ the kind of cooperation that she can facilitate. As experts on women’s health, the TBA’s rightful place is as a consultant on these issues. Her work should be redirected back to women and solid policy motions would make good on the potential of the TBA as a link from development to everyday care. The budding cooperatives currently in Uganda make visible the radical need for her services.

Unintended motivators for health reformation

The ban outlawing TBA’s has had some unforeseen consequences of spurring action and organization within or for TBA’s and a need for her community work has bubbled to the surface. Out of necessity, TBA’s are being beckoned to participate in grassroots collectives that aim to maintain and honor the TBA’s comprehension and competency in maternal and women’s health. Though these efforts are few, technically illegal, and unsupported by government backing, they are garnering attention and resources. Meanwhile, the community education and outreach portion of the TBA duties are being fulfilled by village health teams (VHT”s), which are meant to help mobilize services and
do basic resource training. This transition within community health programs undermines and dwindles the advocacy role that TBA’s enact, because it takes some authority and support away from TBA’s, especially in regards to her role in international conglomerates but mostly because it divides community outreach from health care. The community-driven care that TBA’s have provided has been vital because it is inherently connected to outreach and social services, but the work of the VHT is incredibly limited and plays out more like a placeholder. TBA’s have hinged between community care investment and medical applications, and this separation essentially mimics the model of Western medicine, where clinical applications exist outside of relational and interpersonal connectivity while separate social services are meant to help with social welfare.

This is not an acceptable divide given that villages in Uganda are communally based and health and social relationships mutually affect one another. Women in Uganda cope with suffering not through institutionalized or government structures, but through social networks, and the systems that affect them should respond to this. Additionally, the ban detaches the TBA from policy, intervention strategies, and development or aid agendas. This disconnects and excludes the TBA from the vital role as a representation of rural Ugandan women, and suddenly estranges her from an ambassador position in which she was able to infuse politics on women’s bodies with at least some sense of local experiences. Her position in the communities has been valued for some time for pragmatic reasons, namely to influence how health care can reach people. Now the indigenous woman is further barred from power, authority, and global politics, and the
systems of medicine in Uganda are further disjoined. What does it mean to de-legitimize what is ultimately an institution of knowledge? I have argued that this refusal or failure to admit the TBA into formalized roles is that the third world woman is uncanny or mystified in such a way that makes her inscrutable and difficult to standardize. Furthermore, the TBA’s practices are based in amorphous and contingent care praxes, so her work will never fit into the formulas and models of imperialist procedures.

The issue is one of ideology. Western science and medicine cannot and will not yield to that which cannot be measured. Just like the systematic methods of risk prediction discussed in Chapter 2 do not match up with local understanding or methodologies, so too the efforts to make traditional practitioners “fit,” into clinical shapes have fallen, broken, or backfired for decades. These failures and the culpability reflect on the TBA, framing her work as an ill-fitting institution or an unstable form of care while she remains steadfast in her services to the community. The ban is dangerous not only because it deters TBA’s from practicing, creates uncertainty for women, and casts a shadow of insecurity on the practice of traditional midwifery, but also because it dis-involves women and local voices from the decisions that influence their care, and it further fragments the structures of medicine in rural communities. Incidentally, movements in place in Uganda, though still shaky and pending, all employ, engage with, or otherwise rely upon the traditional birth attendant. Furthermore, emergent and developing strategies to supplement or stabilize care within the communities are all hyper-local and based in harnessing local know-how.
There is an irony to the fact that the ban that outlaws the practices of the TBA’s have, in fact, made the attention to her services urgent, but moreover it reduces the criticality of her care down to a concentrate of what is needed – locally informed and relational care that works to wholly invest in functionality and wellbeing. The role of the TBA fluidly lends itself to that of the VHT, because the advocacy and outreach were already in place. But how could such a transition be solidified? How could the TBA be a more formal advocate while connected to health care applications? There is incredible substance to the TBA resources, and communities in Uganda are responding by looking to and seeking out the TBA while she is simultaneously stifled and threatened from a policy standpoint.

**Connective care**

Health services should subsist with an understanding of local operatives of care. Furthermore, genuine care exists not in recipients or stakeholders, but in the connectivity between and shared among those systems and actors. What is missing from medicine-based interventions is a tending to the tendons and attachments in the interface of care networks. Such mutuality is necessary for authentic and effective care. This kind of understanding is gleaned from interaction, engagement, and true investment in one another. When people are a part of the health care, as they are in local health services, there is simply better, more responsive care that honors the grit of humanness. This relational involvement and concern informed my ethnographic approach, and fundamentally made sturdier my methodological and personal commitment to
participants. This kind of engagement is important for social science, and also critical for durable and relevant health development strategies, and more importantly for applying any agendas that are meant to serve communities. The fissures in health programs lay in the fact that care is separated from medicine. Care depends on interaction and understanding to rightfully respond to need. This sentiment relies upon human labor, including emotional, unregulated, or unscripted.

It matters to have care as the lens for and in policy and interventions. Acting and enacting with care actually changes the affectual and aesthetic processes of public health. Care exists in the in-between an in the exchange. The TBA is impactful for the connectivity of her work, which bridges gaps, reaches disenfranchised sectors of the public, and treats people with the kind of care that one would offer a relative. Considerations of the TBA are issues of women’s rights and health justice, and the aftermath of the ban is a call for women in these agendas. Otherwise, care loses its place in health and moreover, rural Ugandan women are silenced, made complacent and static, and stripped of their opportunities to inform progress that could create opportunities for the good life. Beyond policy, the global health conglomerates are posed to systematically incorporate women’s interests and agendas that serve women, and the TBA is an advocate who could aid in doing so.

**Necessary resistance and women’s health advocacy**

What we are seeing with the community-driven and grassroots efforts to put into motion women’s agendas whether or not the program calls for it explicitly, is a form of necessary
resistance that aims to coalesce TBA’s knowledge and skills with her place in the community. These are mostly formed by and with women and they foreground the knowledge of the TBA. Without governmental assistance or backing, so far these efforts are under the radar, but they illustrate the fact that care services cannot be taken away without services to replace them, and they validate the continuing role for TBA’s in agendas of health equity. TBA’s have been informal activists for women and constant ambassadors for their challenges. The ban makes services available to women all the more uncertain with undesirable forces and interrupted care processes. The fate of the TBA both depends on and enlightens projects of empowerment for women in Uganda, and it is worthwhile to point out that this ban ultimately de-authenticates the TBA and attempts to deprive local communities of an advocate who has defended the rights of women with little to no backing.

This is a form of possession and oppression of women, particularly indigenous, poor, African women. What does it say about empowerment agendas when local women’s health authorities are barred from participation in medicine? The TBA has fended off more invasive policies and her accessibility on a global scale has made her even more of a resource for mobilizing health. To have her authority stifled, silenced, and forbidden is not only an attack on women providers; it is an assault to the women who depend on these services. The ban is based in the supremacy of biomedicine, but yet again shows how the care, comfort, and confidence of local therapies can transcend these rigid and confining frameworks. In the long-term, perhaps the most important benefit to TBA’s involvement in development in women’s health in Uganda and the potential to
strengthen policy is the voice and choice that she provides to women. In terms of reproductive justice, the TBA as a means to empowerment is through not only her authority and participation in grander schemes, but the fact that her work is intrinsically women-based and responds to the complexities of women’s lives.

It takes women-centered care to impact and empower women, and health processes must be informed and led by women to reduce the confining regimes of control and manipulation brought on by misplaced courses of action. A holistic, culturally ecological approach to understanding the experiences of women is necessary to inform policies on their bodies, including the complexities of education, sexuality, and all of the in between as well as how these all interwoven socially, politically, and historically. Super structures of biomedicine are oppressive to local care, which are majorly women-centered and women-led. This is a regulation of women’s bodies that actually becomes an obstacle to good care as it brings women’s objectives out of focus. Distant politics impede local authority as we have seen with the misfiring of the ban on TBA’s. These sweeping movements misdirect resources and restrict and confine care within formulas that do not translate in local discourse and action.

The emerging efforts to maintain and solidify TBA’s are frail still, but coming out of a place of essential inevitability, so they are powerful and forceful in their resistance and in their pragmatic convergence. This is ultimately a women’s health and advocacy issue. The work of the TBA is sexual health and reproductive health but framing it as women’s health helps to see the more broad vision of the compounded impacts on women’s lives as well as incorporate women’s realities and lives into policy. The kind of
pastoral politics that the TBA enacts are ultimately a form of feminist perspectives. Such discourses of endurance and the pledge to care are feminist standpoints that decenter the medical hegemony and situate care as the basis and the mode of health interventions and community development.

**Enfleshing policy**

The embodied politics that I champion herein is such that there is an imagining of one another in policy and health care realizations. To add flesh and feelings and dynamism to the scripts of development and intervention entails a vivid understanding of women’s lives that asks stakeholders to truly see the other ends of connective care. This kind of embodied politics is a form of enfleshment that dispossess women from discourses projected onto her. The disempowerment experienced by women in mis-managed clinics in Uganda is a product of mismatching policies, structural mistreatment, and missed opportunities for healthy development. The tensions in women’s lives must be understood and should be part of implementations and applications of health. This entails enlivening the discourse around women’s conditions and contexts as to include the sentimental, personal, realistic and messy parts of women’s lives. Such dispossession through health rights requires policies to ungrip from protocol in favor of response.

The amorphous nature of care makes it difficult to standardize and more difficult to model. But the power of care is in the human, and these direct and makeshift actions compel a constant and incorporated care factor. Furthermore, care and its applications must hinge upon one another, which demands a shedding of adherence to bureaucratic
manners in favor of the human tool. This is the quest for humanistic medicine at its finest and at its core. In fact, I posit that the same approaches being harnessed in health humanities, such as the valuation of personal narrative and the move toward inclusive, holistic, and literate patient profiles, should be utilized and applied to global health. The move in medical and health humanities does exactly what I argue for – enfleshed and embodied perspectives in politics and policy agendas and in the treatment and applications of care.

Briefcase policies do not work because they are flattened and fleshless. Understandings of women through engagement, disclosure, and interaction, including through qualitative research, helps to add dynamism in health agendas and make them come to life in a way that serves the recipient community. This enfleshing of discourse perspectives and bureaucratic agenda makes women real so that the processes that affect them can be realized with humanity, dignity, and care. Health frameworks should reflect how women forge their lives in order to see what they need to make those processes more just. The ways in which forms of knowledge are routinely excluded from care policy in Uganda constricts and conceals types of local embodiment. Dimensionality and embodied understandings are direct avenues for legitimate care that meet up or speak with the entanglements and arrangements in people’s lives.

Justice and its antithesis are felt within the sentiments of a health encounter and that greatly affects not only the treatment but also the experiences with health and medicine. Incongruent care will simply prompt people to seek care elsewhere in a form that more closely aligns with their sensibilities, as we have witnessed with maternal
health and TBA’s in Uganda. Implementing successful strategies for women’s health directly depends on the experience that health care offered to women. We have seen that women’s preference and choice are enacted through and despite regulations, and furthermore that women’s health-seeking practices intersect with broader post-colonial affects, including and compounding conditions such as uncertainty or guilt. The threat of forbidding local care is truly a threat to women-empowered health strategies, but the affects are deeper and have implications for the continuation of women’s subordination.

New and changing assemblages and arrangements for the TBA point to the fact that relational, up-close, and connected is the appropriate wavelength, mode, or register for care.

**The feminist project of the TBA**

TBA’s have been enacting feminist politics not only through their involvement and infusing of women’s values into national and global discourse, but ultimately, the TBA is preferred because of her attendance to women’s choice, voice, and lifeways. The preference model within the polarizing discourse on TBA’s refers to the idea that TBA’s work persists simply because women insist on their services. Those who contend against this model argue that preference is actually a default option limited by identifiable and accessible resources. Furthermore, opponents of the TBA challenge the preference model stating that women’s penchant for TBA’s should be overridden by those in power who “know better.” In other words, women’s choice and preference are not to be trusted, do not matter, and should not be taken into account. Not only is an offense against women
and indigenous people, it is simply wrong. I have seen that what is actually happening is that TBA’s are preferred not merely for the ways that she delivers or tends to placenta health, for instance. She is more broadly preferred for the willingness to offer treatments that women choose and where women are heard and cared for in a way that empowers them. TBA’s work is a kind of relational care that is effective because it is bolstered by support, resources, and advocacy that gives women agency and autonomy in the care encounter.

So, more than anything that I have mentioned about TBA’s particular treatment methods and adherence to cultural praxes, I actually think that women in Uganda are steadfast in their health loyalty to TBA’s because of the TBA’s feminist affects of choice, empowerment, and engagement. The feminist politics of the TBA are set in the fact that women-based advocacy is care and is a response directly to the needs of women. Her care implicates advocacy, and the project is ultimately one of feminist defiance of mega-structures that have historically put pressure on her and women overall in a number of ways, including attempts to recruit the TBA and unsolicited efforts to train and standardize her. The TBA has been the link to policy and decision agendas, but more regularly and significantly, she is a women’s health resource center. Her enduring, risky, fleshy work is set in criticality but also in a routine tending, and her steady attention to women’s betterment, wellness, and security make her care a feminist endeavor.
Reflective ANALYSIS

Ultimately, this work is a contemporary consideration of more informed and more just ways that medicine, as an entity, should embrace women’s health. This is a call for utmost humanity in medicine and global health in particular, and I highlight three modes of feminist politics that I believe offer not only a radical incorporation of the human element but also an effective means of gaining the critical understanding that medicine insights. I highlight *relationality* (for the ethnographic as well as the clinical encounter); *sentimentality* (and emotion as a part of a holistic and personal account); and *carnality* (in the sense of enfleshing social worlds and recognizing the corporeal effects of policy and other structural praxes).

Relationality, I argue is a necessary factor for care. Seeing the connectivity among people and between people and systems helps to collapse strict constitutions of the world. I also see relationality as self-dispossession, an inherent and noble pursuit in ethnography. Sentiment brings a dimension to care practices that de-centers empirical claims and attends to the emotional landscape. In order to eradicate hegemonic regulation of women’s bodies, there must be a recognition of women’s stories, and this necessitates disclosure and self-description as viable knowledge and data that informs policy and health care. Carnality is a necessary reality of embodied politics. To undo the puritanical management and supervision of women’s bodies, the public as well as law-makers need to see and participate in overt discussions of women’s physiologies and feelings in a way that naturalizes and honors women’s sexuality, power and desire in order to confront and counter issues of shame and vulnerability.
Broadly, this is a subscription to and a spotlighting of feminist politics. I see the TBA’s support of women in Uganda as feminist advocacy and just as this kind of service is ignored, misunderstood, or overlooked on an international stage, I believe such grassroots, women-centered advocacy is often overshadowed, dismissed, or worse in favor of capitalist, emperialist, and hegemonic systems that govern women’s bodies. Though a simple concept, it is important to begin with the personal and emotional accounts herein because feminism is concerned with how women create, forge, and sustain their lives. Talking about women’s bodies in informed ways is good for women, and anthropologists are in a unique position to contribute to understandings of women’s complex arrangements and challenges under the premise that all parts of a system affect health, so holistic knowledge and considerations should be incorporated in policy and more “hardline,” data within global health. I believe that it is in women’s best interest for global health to revamp their approach and embrace the familiar, everyday woman with an up-close lens and seriously incorporate local advocates. Embodied politics are the only kind of politics worthy of implementation and those are achieved through knowledge that combines visceral experiences and intersubjective understanding of bodies with balanced perspectives of the systems and sociality that dictate health.

Reproductive justice demands that policy makers accept that respect and integrity are rights not privileges. Recognizing women’s experiences helps to unravel that which threatens women’s choice and agency, namely far-removed and feigned neo-colonial projects that ignore the contexts of women’s lives. My project looks at women whose work contributes to the freeing of women from the confines of powered inequalities.
through local advocacy. And my research shows that women cope with social suffering not through some institutionalized or governmental structure, but through social networks, so this is where global health should place its resources in terms of building and facilitating care – in local resources who continue to dismantle the medical hegemonies and empower women and indigenous ideologies with socially meaningful strategies. Women’s health is connected to shifting roles and ideals of women in developing regions, and global partnerships must see these actions as what they are – social change, and not just obstacles to empirical takeover.

My hopes for my dissertation project and moving forward as a scholar are that I de-formalize the study of women’s bodies in such a way that respects the mundane and the might of the everyday woman. Such ordinary aesthetics of the lives of women, I believe, allow us to undo the hidden parts of women’s worlds that have historically produced shame, puritanical vagueness, and gendered powerlessness. I argue to showcase with fortitude the lives, bodies, and sexual health of women in such a way that changes the face of biopolitics. I believe in processes of knowledge production and I think that to de-mystify the bodies of women moves us toward lucidity in practice. Everyday accounts of women’s lives importantly provide ordinary aesthetics to the experiences of women that de-sacrilize yet commemorate the complexity of life. The argument here is that celebrating women as sentient beings make her problems problems of the world rather than of her gender. It is important, then, to generate and circulate ideas of women in the way that she wants you to understand them, how she portrays them, or how she would describe them, and moreover to ensure that men, partners, and fellow community
members not only recognize the issues that most affect women, but are incited to participate in alleviating the hardships that women face, particularly in regards to reproductive and sexual health.

The more women write or show about ourselves, the less that can be applied without permission. Spry writes that attempting to fit into existing models of knowledge production and discourse is essentially “grafting the skins of patriarchy,” on the body, and this is no way toward empowerment (2001: 721). For women to speak for themselves and each other helps to undo where women’s flesh is displaced and subjugated. Spillers says that, collectively, women’s desires engender futures (1987). There is a simple but difficult task of telling what we see and what we want where there has been a violent forbidding of such. This begins, I argue, within the institutions and the modes of understanding that affect women. So, in order to act outside of those confines or custodies, Butler and Athanasiou argue that women have to host the conversation for ourselves (2013). And I would add that we must do so in loud, redolent ways, or what Brophy and Hladki, say is with, “voluptuous validity” (2014: 11). Such enfleshment draws attention to the realities that women face and makes it okay to show condemnation of the ways of the past, especially the unjust practices that continue.

A moral podium for ordinary carnality of women is an act of resistance and empowerment. Making our desires known is an act of feminism that rejects the silent suffering that women have endured. The very tone of resiliency, a concept often attached to women, especially women in impoverished, under- or un-resourced, or oppressive contexts, is problematic because it assumes that injustices are given and that women are
just “tough enough to take it.” The new age of feminism embraces anger, despondency, and in-your-face rejection of misplaced values and subjugation of women. I think that Western women can take a queue from the steady, fired-up, selfless advocacy that the TBA’s of Uganda embrace in order to find a platform for the latest era in the cult of womanhood.

Final thoughts and go from there…

It is a long-standing and oft-repeated sentiment for women in many places in the world and we see the parallels in American currents today: women’s participation in the bureaucracies and policies that script our health is imperative. TBA’s have been a resource and a representative for women for a very long time. The vital, vocal role of the TBA has depended on her involvement in health campaigns, but she is sidelined and forced to practice in quiet resistance. My concluding remarks come with some recommendations, a bit of an update, and an appeal for perspective in global health communities. I do not think that the ban against TBA’s is all bad, and the unplanned outcomes have actually shined a light on some of the gaps and the potential trajectories for women’s health moving forward. I see a need for training and skill bolstering for birth attendants, but I think that it is the care itself of the TBA that should become the standard. For women’s advancement and for new generations of practitioners, I believe that advocacy and grassroots are the way to empower, inform, and heal, and I see vast opportunity for Ugandan women to look to the global women’s movement for prospective ideas regarding women’s centers and women-based care.
The preservation of TBA is important, but the formalization of her modes of care is critical so that women’s health does not suffer any more damages. This is a call for indigenous women to be recognized as the locus of knowledge. The revolution exists in the formation of collectives for women, but also an emphasis for the need to incorporate local representatives in global deliberating, devising, and delegating health justice. The challenge will be incorporating the TBA and other women’s health advocates in structures of care moving forward. The embodied and interpersonal knowledge of the TBA is not possible to mimic in briefs and distant roundtables, so women’s collectivity has to remain rooted in local communities. It is crucial that global conglomerates and health superpowers are aware of the power and influence that they have on local governmentality. Following the declaration of the Millennium Development Goals, the ban ousting TBA’s may have come from a desperate attempt to abide by recommendations and appear proactive on the global stage, but local nuances were ignored. Sweeping guidelines such as these must tend to on-the-ground politics. For instance, in attempts to bring women’s empowerment to the stage in Uganda, actors are encouraged to have foresight on matters regarding corrupt politics or women’s suppression in government and to navigate these issues accordingly, namely through local representation.

Women’s formations are acts of resistance in the face of the ban, and women-centered care has the potential to free women from oppressive and disempowering structures. Support is social change, and it begins with cohorts of women. Solutions for women must offer socially meaningful strategies. Women must be heard and their lives
made three dimensional in the discourse. Reproductive justice recognizes women’s experiences and offers the opportunity for choice, equity, and agency, especially in health. More largely, reproductive, maternal, and sexual health should be understood more completely as women’s health and women’s health should be a priority for community health. Involving and sensitizing Ugandan men is as important as sensitizing global communities to the realities of women’s lives and the structures that bear down on their power. The 2015 update to the MDG presented us with Sustainable Development Goals, which are aimed for 2013 and replace “Maternal Health,” with “Reduced Inequalities,” emphasizing the structural causes for women’s subordination. This illustrates the growing awareness that systemic reformations are critical to the women’s health agenda. The frameworks are there – now there must be enfleshed understandings, embodied actions, and collaborative connectivity to fill these in!

Figure 41: Home under construction - photo by author
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