



**Safe, Healthy and Happy Delivery as a Right for Rural
Women:
The Role of Traditional Birth Attendants in Uganda**

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This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

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Dedication

This paper is dedicated with love and devotion to My Daughter Loy Hillary Kabajungu Atwooki, and to my wonderful Mum Mrs Kajura Stella Amooti, sisters and brothers for their emotional, spiritual care and support accorded to me that has enabled me to move this far in my career.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	International Convention on the Elimination of all Forms of Racial Discrimination
CHW	Community Health Workers
DDHS	District Director of Health Services
EASSI	East African Sub-Regional Support Initiative for the Advancement of Women
EMOC	Emergency Obstetric Care
FGDs	Focus Group Discussions
GRB	Gender Responsive Budgeting
HRBA	Human Rights Based Approach
HRC	Human Rights Committee
HSD	Health Sub-District
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
MDG	Millennium Development Goals
MoGLD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
NGOs	Non Governmental Organisations
PMTCT	Prevention of Mother to Child Transmission
SBA	Skilled Birth Attendants
SMP	Safe Motherhood Programme
TBA	Traditional Birth Attendants
UDHR	Universal Declaration of Human Rights
UNICEF	United Nations International Children's Education Fund
UNCRC	United Nations' Convention on the Rights of the Child
UNPFA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

ABSTRACT

This study will highlight the fundamental contributions of TBAs towards rural women in Mpigi district of Uganda, to attaining a safe, healthy and happy delivery as women's basic right, as specified in the Constitution of the Republic of Uganda and other international human rights instruments. The study investigates reasons why rural mothers continue to seek TBAs services, explores perceptions of health workers and of rural mothers towards TBAs' services. It also considers some of the risks for rural mothers associated with TBAs' services.

The study will be significant in informing the state, policy makers and other stakeholders who are involved in designing interventions to provide and improve maternal health care services in Uganda. This study questions the priority of government to phase out TBAs, suggesting that this may not automatically improve maternal health. One key finding is that an important first step is to legalize, register, monitor and also train TBAs in order to achieve minimum health standards.

Relevance to Development Studies

Globally, every year 48 million women give birth without someone present who has necessary midwifery skills and experience. Each year, there are 358,000 maternal deaths and 814,000 newborn babies die during childbirth (Rawe 2011:1). This means that the world needs more professional and experienced midwives and skilled birth attendants if this kind of trend is to change. Instead of stressing the risks of TBAs' services, this study proposes legalising and training TBAs to assist in reducing maternal mortality in Uganda.

The study will help to understand the role of TBAs, achieve MDG5 as well as promote and protect women's rights more especially the right to safe and healthy delivery through the improvement of quality maternal health care across the country mostly in rural areas.

Keywords

Maternal Health, Maternal Mortality, Traditional Birth Attendants, Skilled Birth Attendants, Obstetrics, Uganda

Chapter 1 : Introduction

1.0 Introduction

Uganda had one of the superlative public health care systems in Africa around mid 1960s. But due to economic and political turmoil, the system was characterised by lack of trained staff, inadequate medical supplies, poor infrastructure and inaccessibility which put off patients who see no reason to move long journeys to seek services from the ill-equipped health facilities (Richey 2005: 111). Currently, there is an on-going debate regarding the funding of the health sector and the Ninth parliament is urging the government to cut funds from other sectors like security and inject it into the sector because of the prevailing alarming health conditions in the system. As if this is not enough, there are plans to ban TBAs' services who are often looked at as the only alternative for mothers in rural settings especially those who cannot access the formal health facilities (Katine, 2010). Despite the existence of good policies on gender equity, Universal Primary Education, reproductive health, decentralisation of health services and collective efforts to improve quality and delivery of maternity care services, inadequate resources and skilled staff have contributed to low utilisation of the services by rural women or an increase in the ratio of maternal deaths in Uganda (Kyomuhendo 2003: 16). In addition, National policies to address newborn and maternal health services rarely tackle the centrality of the midwifery personnel nor the imperative need to advance quality of care, in respect of peoples' rights (Hoope-Bender et al 2011: vii).

The World over promised an improvement towards maternal health within the Millennium Development Goal (MDG 5) – in order to bring down the ratio of maternal mortality by 75% and provide global access to reproductive health by 2015 (Byrne & Morgan 2011: 127, Khan 2009: 123). In 2010 the health of women and children featured prominently at the World Health Assembly, the G8 Summit, the Pacific Health Summit, African Union Summit and other high level events. This global concern culminated in the secretary General of the United Nations launching the global strategy for women's and children's health in September 2010. But still women globally, especially the poor and marginalised in both rural and urban settings continue to perish because they cannot access functioning health facilities or qualified health professionals (Hoope-Bender et al 2011: vii). Maternal mortality is a global issue that has continued to hit countries especially the Sub-Saharan Africa. The health care package guarantees universal access to all healthcare services, maternal and child health care services inclusive as clearly stipulated in the

1948 - UDHR (Banning et al 2004: 3), but this has not come a true story due to different factors like inadequate funding to the health sector.

The 2008 report of the United Nations Millennium Development Goals indicates minimal improvement on MDG 5. And yet states like Uganda had committed themselves to reduce the high rate of maternal mortality by $\frac{3}{4}$ by the year 2015. Maternal ill-health and deaths are attributed to a number of factors namely limited access to blood and inadequate supplies, few qualified medical personnel, low quality of maternal care services, few health facilities characterized by inaccessibility, limited mobility as a result of societal gender norms and inadequate involvement of men in reproductive health issues (EASSI 2010: vii & 3).

Globally, each year about 210 million women become pregnant and about 20 million experience pregnant related illnesses. Over 500,000 of these women die from pregnancy or childbirth related complications, and which can easily be avoided but are exacerbated by existing poor health and inadequate care in health facilities (Nancy and Weeks 2006: 236). There is a high probability of at least 1 woman out of 31 dying as a result of any maternal related illness in Sub-Saharan Africa compared with 1 in 4,300 in well developed regions like North America and Europe (Hoope-Bender et al 2011: vii) as Grown cited in Grown et al (2006) is quoted;

‘...maternal mortality rates remain high in many developing countries. Maternal deaths per 100,000 live births are well over 1000 in almost all Sub-Saharan African countries’ (Grown 2006: 17).

Maternal Mortality remains a critical issue of discrimination, inaction by different states, prejudice and inertia, depriving women of their rights to health, safe motherhood and life (Khan 2009: 125). Due to the above gaps still existing in the health sector countrywide, about one in three pregnant women (35%) gives birth without the assistance of a midwife or a professional birth attendant. Averagely, in some least developed countries, 59% of mothers who give birth are never helped by a midwife or any other professional medical worker. In comparison, in the UK only 1% of women deliver without the help of a midwife or a professional birth attendant just because the delivery time happened unexpectedly and the woman could not timely reach the hospital (Rawe et al 2011: 7). Utilization of formal health service for important maternal health services is insufficient, with limited coverage among the poor due to different obstacles right from cost of care and distance, to quality of care and sometimes cultural barriers. Extensive distribution of well trained medical workers and emergency back support is vital towards the decrease of maternal death (Mbaruku et al 2009: 8). Health workers’ efforts supplemented by

TBAs' services can lead to the promotion of birth care that is humane and safe for mothers and new born babies (Carvallo et al 1998: 53). The World Health Organisation recommends one mid-wife for every 175 pregnant women but this standard is far from being achieved because in Uganda where 1.5 million mothers deliver every year, there are approximately 15,000 well trained midwives to handle childbirth process (Rawe et al 2011: 17).

1.1 Background of the Study

Maternal health is the right of access to appropriate health care services that enables women to go safely through pregnancy and child birth and provide couples with the best chance of having healthy infants (Braunstein and Grown 2006: 6). It refers to the health of women during pregnancy, childbirth and the postpartum period and also encompasses the health care dimensions of family planning, preconception, prenatal and postnatal care in order to reduce maternal morbidity and mortality rates among women. Maternal health is a key policy area for many low income countries in Africa. This is clearly spelt out in the Millennium Development Goals and in the International Conference on Population and Development (Nancy and Weeks 2006: 236). At the Millennium Declaration, Heads of States and Governments agreed to reduce maternal mortality by 75% by 2015, however, it looks like the MDG 5 is the most neglected of all the goals. They agreed that no pregnant woman...should die as a result of pregnancy related complications when most of these complications can be averted, but still giving birth continues to be very risky especially in Southern Asia and Sub-Saharan Africa where several mothers give birth without a skilled birth attendant (EASSI 2010: V).

Decades of modernization and the growing availability of medical technology notwithstanding, homebirths are still common in the developing world and thus many women deliver from home annually, mainly assisted by the Traditional Birth Attendants (TBAs) most of whom not trained to recognize, manage and prevent pregnancy-related complications (Izugbara et al 2009: 36). Every year 45 million women in the world give birth without someone present who has necessary midwifery skills and experience. Across the world, there are inequalities in the provision of maternal health services, where skilled medical personnel only attend to 66% of births in developing world in comparison with 99% in the developed countries (Homer et al 2012: 5, Byrne & Morgan 2011: 127). Each year there are 358,000 maternal deaths, and 814,000 newborn babies die during childbirth. A million more babies are lost earlier in delivery – stillborn but having been alive in the mother's womb hours or even just minutes earlier (Rawe et al 2011: 1). This means that the world still needs more professional, experienced midwives and skilled birth attendants if

the Millennium Development Goals to reduce child deaths by two-thirds and maternal mortality by three-quarters are to be attained by 2015 (Ibid).

In Uganda, it is estimated that over 80% of women live in the rural areas which are poorly facilitated in terms of health facilities and only 40% are within the 5 km distance from a health facility that provides antenatal care, delivery care and immunisation services (Keri et al 2010: 75). In a study carried out in Hoima, a rural district in Mid-Western Uganda, friends, relatives and TBAs were often preferred other than health workers, who were normally considered to be strangers or outsiders and usually not recognised as part and partial of the local birth culture (Kyomuhendo 2003: 20). Traditional Birth Attendants are defined by WHO (World Health Organization) cited by Titaly as;

‘People who assist the mothers during child birth and who initially acquired their skills by delivering babies themselves or through apprenticeship to other Traditional Birth Attendants. A trained Traditional Birth Attendant is someone who has received a short course of training through the modern health care sector to upgrade her skills in order to help pregnant mothers’ (Titaly 2010: 6).

A traditional birth attendant, also known as traditional midwife, community midwife or lay midwife, is a pregnancy and child care provider, and the criteria for being accepted as a traditional birth attendant by clients is having experience as a mother. Traditional birth attendants have been part of most communities for quite a long period and this work has been handed over from one generation to another. Their expertise is valued due to their social and emotional closeness to the community especially the mothers, their long experience in providing services to mothers and infants, their intimacy with the communities which creates loyalty and understanding, especially when other health care services are not accessible, affordable, available and appropriate (ibid: 11). Therefore, this research study sought to analyse the role played by Traditional Birth Attendants, how to formalize and reform their services other than victimizing them to ensure that rural women have attained safe deliveries irrespective of their economic, cultural and social status.

1.2 Statement of the Research Problem

The public health care sector in Uganda is constantly underfunded and characterised by shortage of medical personnel, drugs, obstetric equipments and mal-geographical distribution of the services across all levels. While the government of Uganda is devoted under the Abuja Declaration

to allocate 15% of the national budget to health, its spending on health has never gone beyond 10% of the entire public expenditure. Professional medical doctors, midwives plus nurses prefer to work from urban centres, mainly in Kampala and neighbouring districts (Thornton et al 2012). In some communities, this has contributed to failure to access medical services (Andrew et al 2005: 1304). The current per capita expenditure on the Uganda Minimum Health Care Package under the Health Sector Strategic Plan according to the Ministry of Health, stands at US \$ 12, which totals to 42% of the US \$ 28 per capita calculated to be adequate to deliver that package (Awortwi & Okwany 2010: 179). Due to the above conditions, approximately 58% of births are handled by unprofessional birth attendants such as relatives, friends and traditional birth attendants (Carr & White 2012: 12). Mothers, especially those in poorest places stand lesser chances to access a professional and skilled birth attendant during child birth and in some cases end up losing their newly born babies, and their own lives (Rawe et al 2011: 1 & 2).

Uganda has a maternal mortality rate of 430/100,000 (Prata et al 2011: 86, Hoop-Bender et al 2011: 142, New Vision 6th June 2012) which still remains unacceptably so high. Thus, approximately 60% of child birth is handled by TBAs, ... although only 20 - 40% of births to mothers with little education or money are attended by trained or skilled birth attendants (Keri et al 2010: 75, Hoop-Bender et al 2011: x). Birth complications per day total up to 653,555 in rural settings due to post partum haemorrhage (PPH), infections, unsafe abortion, hypertensive disorders, obstructed labour, ectopic pregnancy and embolism (Hoop-Bender 2011: 143). Poorer women more especially in rural areas are inexplicably affected by maternal mortality and morbidity because they have significantly less access to health services compared to wealthier women in urban settings (Khan 2009: 128, Rawe et al 2011: 1 & 2).

Despite the above conditions, there is an ongoing campaign wedged in 2009 by the Ministry of Health to ban TBAs' services in Uganda and yet this is a major reliable resource for women in areas where they cannot reach the formal medical facilities. The abolition of TBAs' services will further infringe on the rights of women to choose where to give birth from, right to life, right to safe and happy delivery when the health sector is still in shambles with inadequate skilled staff, little obstetric equipments, frequent shortages of medical supplies like drugs, geographical maldistribution and poor patient-health worker relationship which result into the increasing maternal mortality and morbidity levels in the country (Katine 2010).

Therefore, this research study sought to analyse the role played by TBAs, why mothers continue seeking their services other than modern health services, the perception of mothers and health workers towards TBAs' services and the risks associated with TBAs' services during delivery.

1.3 Significance of the Study

Health issues always provoke debate and contests in most countries. Others have discussed the effective organization of delivery care – by discussing the merits of home versus hospital delivery, alternative birth attendants, or maternal waiting homes to improve referrals of complications (Parkhurst et al 2004: 1). In Uganda, matters concerning health have always been a central focus of socio-economic policy since it is a state party of different International Human Rights Instruments like CEDAW, ICESCR and UNCRC. Safe delivery as a right is a highly sensitive issue because it relates directly to the lives of women who are the backbone of the development of the country due to the role they play in different foras such as family, community and national levels. Studies all over the world (including Uganda) have been carried out about maternal health in general but little has been done, more especially in Uganda, about Traditional Birth Attendants and their contribution towards improving the lives of women in rural settings.

By exploring this gap, the study will provide a broader, multi-factor view to understand clearly the contribution of traditional birth attendants towards attaining safe delivery as a right for rural mothers and why the government is agitating for the ban of TBAs' services in Uganda. Finally, it will also help policy, law makers and implementers to understand the relationship between the conventional health system and TBAs so that appropriate policies, laws and programmes can be put in place to reform and formalize TBAs' activities in Uganda. The research attempts to bring out the voices of TBAs and mothers clearly to understand the role TBAs have played in a complex situation of high rates of maternal mortality in Uganda and Mpigi in particular.

1.4 Main Research Objective

The research will seek to explore and understand the contribution of traditional birth attendants towards attaining a safe, healthy and happy delivery as a right for the rural mothers in Uganda.

1.5 Research Questions

1.5.1 Main research question

What role do Traditional Birth Attendants played to attain a safe, healthy and happy delivery as a right for rural women in Uganda?

1.5.2 Sub Research Questions

1.5.2.1 Why do rural mothers continue to seek traditional birth attendants' services other than the modern health care services in Uganda?

1.5.2.2 What is the perception of community members and health care workers towards traditional birth attendants' services in Uganda?

1.5.2.3 What are the risks associated with traditional birth attendants' services in helping rural women to deliver and how best can these risks be reduced?

1.5.2.4 What do TBAs think about the rights of the rural mothers in Mpigi district?

1.6 Research Methods and Strategy

This section explains the area of study, how respondents were selected, the methods used to select them, how data was collected from the different respondents and challenges encountered during the study.

1.6.1 Study Area

The research study was conducted from Mpigi district, a rural district located in the outskirts of Kampala the capital city of Uganda. It is one of the 112 districts in Uganda, and was one of the first 13 districts out of the then 39 districts to be decentralized under the then Resistance Councils Statute No. 15 of 1993. This Statute was repealed and replaced by the Local Governments Act I of 1997. An Act of Parliament split the former Greater Mpigi District into two districts of Wakiso and Mpigi in November, 2000. It is among the districts characterised by inadequate human resource for maternal health specifically midwives and doctors, frequent stock-outs of essential drugs and lack of Emergency Obstetric Care (EMOC) services in Health Centres II, III and IV. A qualitative study was conducted in the three sub-counties of Kamengo, Buwama, Mpigi Town Council and they were selected using purposive sampling method after thorough consultations with the District Director of Health Services' office. According to the 2002 population housing census, Mpigi district has a population of approximately 414,757 people, 206,012 of which are females and 208,745 are males which must have doubled by now due high fertility rates of Uganda.

Table I: Distribution of Health Units in Mpigi District.

HSD	Population	Referral Hospital		Referral HCIV		Health Centre111		Health Centre11	
		Public	NGO	Public	NGO	Public	NGO	Public	NGO
Mawokota North	199,367	-	-	1	-	5	2	6	5
Mawokota South	215,390	-	1	-	-	4	1	8	-
Total	414,757		1	1		9	3	14	5

Source: Mpigi District 2012 Health Report

According to table I above, Mpigi district does not have any public referral hospital where serious complicated cases like surgery including emergency obstetric care as caesarean can be handled apart from Nkozi hospital which is privately owned by the Catholic Church. It has only one health centre IV which is located in Mpigi Town council and this means that it might not easily be accessible by the rural population in the outskirts of the town who cannot afford transport costs. It serves the town dwellers and at times it is overwhelmed by the huge numbers of patients especially on antenatal and immunisation days.

1.6.2 Research Instruments, Sources and Data collection Methods

The Researcher used both Primary and Secondary data sources. Primary data was collected by use of personal interviews, focus group discussions and key informant interviews. A combination of all these helped the researcher to gather meaningful data to ensure that high quality information was collected. The study further relied on secondary data especially from published journals and articles about the subject matter since some researchers, academicians, politicians and educational Institutions have written a lot about health issues in Sub-Saharan Africa and Uganda in particular. Government publications especially reports by the Ministry of Health, Ministry of Gender, Labour and Social Development, Uganda Demographic Health Survey reports and Policy Research Reports were used in order to access literature about Uganda's health care system. News paper articles were reviewed to understand the views and opinions from the public and district reports were also reviewed to get a clear picture about the state of the maternal health services in Mpigi district.

Primary data was collected from TBAs, mothers, health workers in Buwama, Kamengo, Mpigi Town Council and from key informants such as the District Director of Health Services, District Nursing Officer – Incharge of maternal and child health care and Incharges of the health centres. Midwives in charge of maternity wards were interviewed in order to get their views about TBAs and their services. The researcher organised focus group discussions with the rural mothers and traditional birth attendants, and where possible informal discussions were also held with some respondents.

The researcher had at least four focus group discussions in the sub-counties of Kamengo and Buwama, that is, two focus group discussions for the TBAs and two for the rural mothers who had ever sought assistance from the TBAs and those who had never gone to the TBAs but had information about them. TBAs and mothers of Mpigi Town Council were interviewed individually because they could not afford to participate in FGDs as groups due to some responsibilities they had at home and elsewhere. Views from mothers as clients to TBAs were gathered during the interviews plus discussions and their knowledge, information and experiences with the TBAs were very vital in providing information to this study. Mobilization of mothers was done on days when they attend Antenatal Clinics and immunisation of children. The study benefited a lot from key informants key informant interview schedules especially by the DDHS, Senior Nursing Officer Incharge of maternal and child care, who for their positions were very knowledgeable about TBAs and their contributions.

Traditional birth attendants were identified using the snowball sampling technique which is the process of selecting a sample by use of networks (Kumar 2005: 179). Traditional Birth Attendants were identified with the help of the health workers in Mpigi Town Council, Kamengo sub-county and village health committee members in Buwama sub-county. The ones they identified helped the researcher to get the other TBAs and the process continued until the required number of TBAs was reached. The researcher further applied purposive sampling to select health workers especially key informants like the District Director of Health Services, District Nursing Officer, In-charges of the Health Centres, midwives and nurses responsible for maternity wards. The primary consideration in this method was the judgement of the researcher as to who could provide the best information to achieve the objectives of the study (Kumar 2005: 179). The researcher in this case only selected those people she thought were knowledgeable and willing to

share information about TBAs and the prevailing situation as far as the health care system is concerned.

1.7 Challenges faced during the Research Study

There was delay in data collection because of the bureaucracy in the Office of the District Director of Health Services. The Director was very busy with a series of meetings and workshops, thus very rare in her office. Therefore, I had to wait for her to sign my introduction letter to let me go on with data collection in the district. Health workers especially those working with the mothers were always very busy, so it was hard to fix appointments and stick to them. I tried to be flexible in order to fit into their own programmes, rescheduled appointments in order to interview them.

Maternal health being a sensitive issue under the health sector which is not doing well in Uganda, the researcher faced a problem of getting accurate data depicting the real situation on the ground. Respondents especially the key informants seemed not to want to disclose pertinent issues reflecting the negative aspects especially the state of health facilities and the behaviours of the medical personnel towards the mothers. To the researcher, the silence and reluctance to respond to some of the issues indicated that there is a problem within the public health sector. They did it to further protect their jobs and not tarnish the government's name for failure to ensure women have attained the right to safe delivery. This therefore forced the researcher to do a lot of probing, have in-depth discussions and informal discussions with respondents in order to gather accurate and meaningful data about the study.

Accessing district reports was a challenge due to poor record keeping system. Some of the staff under the records section at the district and within the health centres visited couldn't actually trace monthly and annual reports which the researcher thought would use to inform the study. The researcher tried and worked with the other officials especially at the health centres to locate available documents which were used in this study.

Finally, organizing focus group discussions with the traditional birth attendants and the rural mothers was somehow difficult due to failure to turn up on the agreed time. This was because they were occupied with their own schedules in their homes on top of helping women to go through successful deliveries on the side of the TBAs. For the mothers they have all the respon-

sibility to ensure that the household chores are fully completed before moving away since their partners rarely give a hand. Thus, the researcher had to be flexible and devised ways of fitting into their programmes to enable them participate in the study.

CHAPTER 2:

TBAs AND THE RIGHT TO SAFE, HEALTHY, HAPPY DELIVERY

2.0 Introduction

Traditional Birth Attendants are commonly known as '*mulemwa*' in *luganda* and most of them learn the business through apprenticeship. They stay within the communities and are well known by their clients especially the mothers. They are looked at as the immediate providers of assistance during pregnancy, labour and delivery. This chapter will help to inform the study about the substantial role TBAs have played to ensure women have attained the right to safe delivery, conceptualize the research problem and construct the analytical framework and also look at the core roles and obligations of the state towards the right to safe delivery for rural women in Uganda.

2.1 Conceptualising the Research Problem and Constructing the Analytical Framework

This section provides a framework for theorizing and conceptualising safe, healthy and happy delivery as a basic human right for women. The study adopts HRBA as the appropriate conceptual and theoretical framework to explain how best a right to safe and happy delivery can be achieved by the mothers in Uganda. It identifies rights holders, their entitlements and the corresponding duty bearers, their obligations and works towards strengthening the capacities of rights holders to make their claims and duty bearers meet their obligations (Arbour 2006:15).

Many countries are signatories of different international human rights treaties like the UDHR, ICESCR, ICCPR, UNCRC, CERD and CEDAW. The treaties identify legal obligations of the states which includes preventing maternal deaths, morbidity and extension of suitable services to the pregnant mothers (Boama & Arulkumaran 2009: 126) as stipulated in CEDAW (Article 12);

'states parties shall ensure to women appropriate services in connection with pregnancy, confinement and post natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation' (Banning et al 2004: 21).

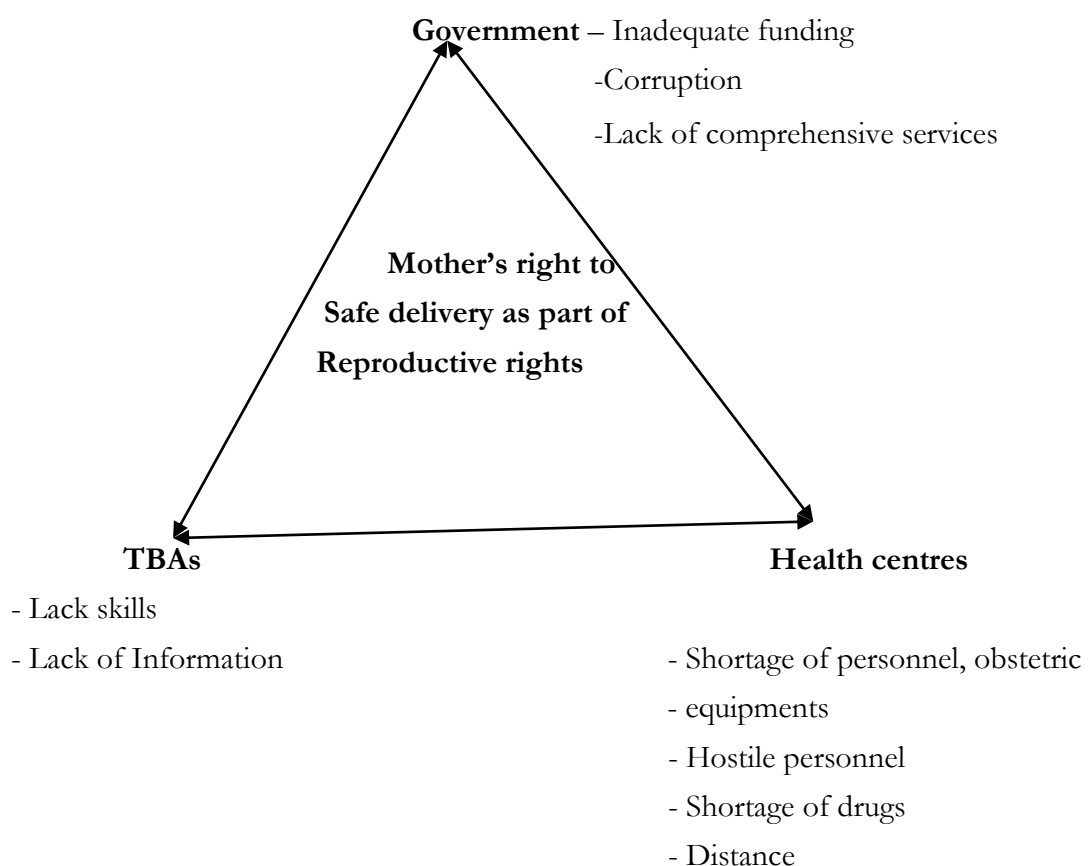
Article 12 of CEDAW tasks states to remove discrimination experienced by mothers in trying to access health care facilities throughout their lifetime especially in the areas of pregnancy, delivery, childbirth and postnatal stages. The committee observes that complete achievement of the right to health by women can only be attained when states are committed to promote, respect and protect the fundamental human rights of women. It further emphasizes that, it is the responsibility of the states parties to make sure that women access free emergency obstetric care and attain the right to safe motherhood within the utmost existing resources.

According to paragraph 17 of the general recommendation No. 24 of CEDAW, it states that;

‘the duty to fulfil rights places an obligation on states parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care’.

There are different duty bearers such as government, health centres and the TBAs who have the responsibility to ensure that women have achieved the right to safe and healthy delivery. The government is the primary duty bearer, and TBAs supplement the efforts of medical workers in areas where they cannot be accessed. However, these duty bearers are characterised by different gaps as illustrated below;

Figure I: Duty bearers to ensure the Right to Safe Delivery



Source: My own design

According to the figure above, until the existing gaps within the government, health centres and within the TBAs are addressed, then the mothers will be able to attain safe delivery as part of

their reproductive rights. Health as a human right issue emphasizes the social and ethical aspects of health care and health status. Availability, accessibility, acceptability, affordability and quality of health care are vital in attaining the right to safe and healthy delivery (UN 2000: Article 12). The Committee on Economic, Social and Cultural Rights came up with a general comment (Number 14) on the right to health. It explains that observance with this right needs that 'operating medical care facilities, goods and services' be sufficiently available, accessible and acceptable. Accordingly, if governments do not meet these standards in basic motherhood services with existing resources, they are mandated to address the violations of women's right to health (Fathalla 2006: 416). Thus, the government of Uganda has domesticated the international instruments into the national legal instruments like the 1995 Uganda Constitution which also guarantees the right to safe and healthy delivery for all women (Article 33).

TBAs bridge the gap between mothers and modern health workers, thus training them would mean empowering them with adequate knowledge, skills and attitudes to fulfil maternal needs of the women and also be able to detect complications early enough and do timely referrals. But for the TBAs to be relevant and address women's needs it necessitates cooperation and teamwork with the health workers to ensure effective supervision and monitoring because they reinforce each other. Therefore, this would imply that phasing out TBAs' services on the other hand would affect the lives of women who usually seek their services where the health facilities are malfunctioning.

2.1.1 Women's Reproductive Health Rights

CEDAW is the International Treaty which mainly promotes and protects the right of women to determine their own informed decisions about their sexuality and fertility. Under the Convention states parties are required to devise suitable ways to remove all forms of inequity against women, including those forms that contribute to low quality of health care services (Cook 1994: 515). If quality of care means to meet women's needs, then community awareness on one side and accountability to the community on the other side are a requirement from the time when the facilities are set up (Mirsky 2001: 38). '...the inclusion of women's voices in the objective of safe motherhood programmes is necessary to better serve women's needs' (ibid: 41). Sen and Batliwala (2000: 30), argue that, an approach focused on empowerment leads to a powerful integration of the rights and health agendas, because empowered women who are aware of their sexual, maternal and reproductive rights are in a stronger position to determine how they are able to access health and how they are treated by health facilities.

During the last decade, women's reproductive health and the factors which determine it throughout the life cycle have increasingly been viewed and monitored through the lens of human rights. Most countries have therefore signed up to a range of human rights instruments such as the UDHR, ICESCR, CEDAW, UNCRC and specific rights protected in these treaties can be applied to different factors contributing to maternal mortality and well being of women and children (Mirsky 2001: 39). The influence of the international consensus on reproductive health agreed at ICPD (International Conference on Population and Development), with its emphasis on women's empowerment, will increasingly be felt in maternity care because an approach focused on empowerment leads to a powerful integration of the rights and health agendas as clearly pointed out by Professors Sen and Batliwala (ibid: 42). 'Because the failure to address preventable maternal disability and death represents one of the greatest social injustices of our time', argue Professors Rebecca Cook and Bernard Dickens, co-authors of a WHO study on advancing safe motherhood through human rights. A human rights approach shows that, 'women's reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy, but rather, injustices that societies are able and compelled to curb (Mirsky 2001: 40).

2.1.2 Safe, Healthy and Happy delivery as a women's reproductive right

The UDHR (1948) states that; 'Everyone has the right to a standard of living adequate for the health and well-being of him/herself, and his/her family, including food, clothing, medical care and necessary social services'. Mothers are in dire need of safe motherhood and therefore have the right to the balanced means to attain pregnancy and delivery, which is a "win-win" deal. Achieving rights of women to safe motherhood must be considered as a shared interest (Milliez 2009: 110 &111) whereby each stakeholder has to take responsibility.

A regular response of governments and health planners to maternal death is that its decrease needs extensive reserves in human resource growth and infrastructure. Whereas it is right that safe motherhood implies a variety of strategies and that no one approach can attain victory, there are, however, two arguments to counteract that thinking. First, safe motherhood strategies engage the introduction of suitable technologies which do not need large funds in expensive drugs or equipment. Second, safe motherhood does not denote the formation of new vertical programs with all the technical, managerial and logistical consequences they entail. On the other hand, Safe motherhood programs only need a renewal of existing MCH/FP services to offer

excellent combination of protective and curative care using suitable technology and accessible to all women (Turmen & Abouzahr 1994: 152).

2.1.3 TBAs: Duty Bearers and Rights Holders

Traditional birth attendants on the other hand should be looked at as duty bearers because at times they have to ensure the safety of the rural mothers during delivery where the medical facilities are inadequate and when the mothers persistently seek their services. And as rights holders, they also have their rights which are supposed to be promoted and protected by providing them with the necessary requirements like gloves, cotton wool, razor blades and others which they can use to help the mothers during delivery. If TBAs roles and responsibilities are clear, the medical personnel develop a positive relationship with them, their rights are protected and respected, good results can be expected at the end of it all (Hoope-Bender et al 2011: 10), whereby the right to safe and healthy delivery would be realized by mothers.

Many believe that TBAs can be a vital link between women and the health system, giving advice, encouraging women to go to the clinic to deliver and accompanying mothers provide them with moral support. While a qualified, fully equipped midwife at every birth is ideal, when they are not available the option of supporting and providing basic training to TBAs... is vital to spot dangerous signs of child birth and refer women to health centres which can make incredible changes in communities (Rawe et al 2011: 5). This kind of strategy means empowering the community to be able to identify and handle their own problems whenever necessary.

2.1.4 The Core State Roles and Obligations

The government of Uganda ratified key International Human Rights Instruments like CEDAW, ICESCR and ICCPR, this requires the state therefore to fulfil, protect and respect women's rights. According to Nowak, M. (2005: 180), the obligation to protect requires the state to provide protection to vulnerable groups of people such as women from individuals or organizations whose practices, norms are very harmful to their health. The obligation to fulfil tasks the state to set up well functioning health facilities, train and recruit more personnel, improve the ambulance system, increase medical supplies and address some of the social, cultural and economic factors which hamper women to access maternal health services. Finally, the obligation of the state to respect the right to health means that the state should never meddle with traditional health care system and should respect women's rights to reproductive health.

In the National Health Policy, the government of Uganda is tasked to ensure that there is community empowerment to enable citizens have a responsibility for their own wellbeing and health, and also participate successfully in the management of their own local health services. This can be done through formulation of guidelines for capacity building to help them identify health problems, planning of health services, resource mobilisation and monitoring of all the health activities in their localities (Awortwi & Mugumya 2010: 202). Lessons can be borrowed from Indonesia whereby a village alert programme was introduced in 1998. It embraced the safe motherhood concepts through mobilizing community support for the expecting women by organising transport, access to blood and funds to go with to the hospital. The programme assists those who are financially handicapped to access professional services through a communal financing mechanism (Titaley et al 2010: 2). Therefore, to this study it means that, women's participation in issues affecting their lives is vital and should always be advocated for. All people have a right to participate in and access information relating to the decision making process about their lives and well being.

The Human Rights Committee (HRC) which monitors implementation of the ICSECR and ICCPR, specified in 2000 through its general comment 28 on equality of rights between men and women, that when reporting on the right to life, protected by article 6 of the UDHR, states parties are required to provide data on 'pregnancy and childbirth – related deaths of women'. Human rights treaties including CEDAW make specific mention of state obligations relating to the prevention of maternal mortality and provision of appropriate services for pregnant women (Mirsky 2001: 39). This means that the state bears the primary responsibility to address maternal needs of mothers irrespective of their social, cultural and economic status. In the field of reproductive health, several women's health organisations, academicians and legal bodies have begun to use human rights treaties at a national level to improve access to and quality of services for women (ibid). The state has the responsibility to domesticate the issues in different international treaties into the national documents like the 1995 Constitution of the Republic of Uganda and implement them by formulating laws and bye-laws which can be used to protect and promote the rights of women.

2.2 The role of TBAs during Delivery and complication Management: Scope for Safe, Happy and Healthy Delivery

World Health Organization Report on Health (2006) cited by Rouleau and others, highlights clearly that the healthcare workforce around the globe is facing a serious dilemma more especially in Sub-Saharan Africa which only has 3% of the global health workforce supposed to deal with 24% of the world's burden of morbidity. On average, in Sub-Saharan Africa, 11 nurses or midwifery personnel and 2 physicians handle 10,000 people, which are commonly found in urban centres, while in Europe, 68 nurses or midwifery personnel and 23 doctors handle the 10,000 people. There are inequalities as far as health resources are concerned because they are more concentrated in urban centres, leaving out the biggest population underserved in the rural settings (Rouleau et al 2012: 3). In most countries Uganda inclusive, qualified and well trained midwives seem to be a rare resource and are not posted in sufficient numbers to ensure effective delivery of health services especially to rural mothers.

Thus, Demographic and Health Surveys indicates that family members, neighbours, community health workers (CHWs) and TBAs usually provide assistance to mothers during delivery (ibid: 9), and they are usually preferred to medical workers who are normally looked at as strangers or outsiders and not considered part and partial of the local birth culture (Kyomuhendo 2003: 20). In some parts of Africa, Traditional Birth Attendants are ever-present where they represent the first line of care for 70% of the entire population. This is because they have proven unavoidable links in successfully implementing safe motherhood including prevention of the mother to child transmission of the HIV/AIDS programmes (Homsy et al 2004: 1723). In the International Journal of Gynaecology and Obstetrics, Kamal argue that;

‘Many countries have not given a serious thought to the kind of support required by the TBAs to ensure effective functioning, the most significant being access to emergency obstetric care. TBAs offer ante-natal care, screen the pregnant women for any risky conditions and mostly refer them to healthy centres when it is early. They conduct deliveries and immediately seek help from the modern health workers when they suspect serious delivery complications’ (Kamal 1998: 45).

The assertion by TBAs that they do more than offer child delivery services to rural women is so critical. Research conducted in Kenya about TBAs presented them as mere providers of birthing services. On the other hand, Leferber and Voorhoever (1997), Walraven and Weeks (1999), and Izugbara and Ukwai (2003, 2004) cited by Izugbara C. et al argues that TBAs perform more tasks than just delivering babies. They point out clearly that TBAs offer key health and non-medical services for the rural mothers. They offer advice, help, knowledge and information about matters concerning family planning, food and nutrition, preparation for childbirth, antena-

tal and postnatal care. They provide treatment for minor childhood sicknesses and also help mothers to take their babies for immunization. They further pay visits to pregnant mothers and those who have given birth plus helping them with household tasks (Izugbara et al 2009: 43). On the other hand, Jitta & Kyaddondo (2008) as cited by Carr & White (2012: 13) reported that in Uganda TBAs have transversely contributed to neonatal mortality due to harmful practices and poor hygiene during childbirth.

The National Safe Motherhood Programme (SMP) is one of the recent interventions towards the promotion of maternal health in Uganda. Different initiatives were established as part of this particular programme more especially building a supportive community network of TBAs as a supplement for a modern maternal health system, to detect high risk obstetric complications and the referral system to be strengthened (Ssengooba et al. ND: 6). Safe motherhood ensures accessibility to maternal health care and protects women from violence which usually affects them whenever pregnant (Khan 2009: 134). Khan further argues that;

There's a clear human rights case for safe motherhood. The right to health is well established in International law. Neglect, denial, discrimination and violence that take place before, during and after pregnancy are human rights abuses. An overwhelming majority of countries have ratified International treaties committing themselves to end such abuses. Maternal mortality is not a social problem that 'just happens' - it is a terrible injustice that must be ended (Khan 2009: 139).

Traditional Birth Attendants extend their services to rural women experiencing the injustice and end up seeking sexual, maternal and reproductive health care or advice (Nyanzi et al. 2007: 319). In Uganda, a good number of women go to TBAs for antenatal care and give birth in their homes with the assistance of TBAs who have no formal kind of training (Ssengooba et al. ND: 26). Mbonye et al (2007) as cited by Carr and white (2012: 13) argue strongly that despite all the interventions put in place by WHO, UNICEF, USAID, UNFPA and other NGOs, there's still need for more skilled birth attendants, adequate medical supplies and emergency obstetric equipments and care if women are to realize a right to safe delivery in Uganda.

Traditional Birth Attendants educate mothers about food and nutrition, family planning, breast feeding, immunization and prevention of sexually transmitted infections (Kamal 1998: 50). They provide such services to the mothers to ensure that they are not malnourished, develop strong immunity system to fight complicated ailments during pregnancy and ensure safe and happy delivery without any complications which might be dangerous to their babies as well. In developing

countries, the rural population depending on TBAs is heavily recognized as a reality and they remain a major element of the traditional health care system and they will continue to be so until an acceptable, well trained, qualified, accessible and economically friendly substitute is availed, not only to urban but also rural. Kamal argues that, while other TBAs' practices are positively harmless, there are others which are associated with a lot of risks leading to maternal or infant morbidity and mortality. They are not always deliberate and most of them work with rightful intentions but at times with inadequate understanding (Kamal 1998: 45) and lack of immediate support from the professional medical personnel.

According to the Safe Motherhood Assessment Survey of 1995/6 as cited by Ssengooba and others in their study report, indicate that, Traditional Birth Attendants administer local herbs on mothers before labor, during birth and postpartum period. Commonly prescribed herbs are those which are perceived to cause labor contractions, relax the pelvic bones plus those that prevent miscarriages. However, little research has been done to investigate the effects of various herbs on the entire maternal process (Ssengooba et al ND: 24). The great majority of women utilize traditional therapies at various stages of pregnancy and only resort to modern health services when complications arise. They utilize traditional therapies mostly a concoction taken orally commonly known as *emumbwa* which is used to treat illnesses including dysmenorrhoea. Other therapies include abdominal palpations by TBAs to 'feel the baby', sitting in a container of herbal medicine for cleaning, disinfecting and widening the birth canal. Other herbs are inserted in the vagina to quicken contractions or expel the placenta very fast (Kyomuhendo 2003: 20). Elizabeth Leedam who worked with WHO as a nursing educator reiterates that;

'The TBA is normally a proficient herbalist whose knowledge of roots, barks and leaves is quite so wide. A combination of herbs are usually prescribed for the mothers to stop discomfort throughout pregnancy, quicken the delivery process, as abortifacient and for treating dysmenorrhoea and other kinds of illnesses' (Leedam 1985: 250).

On the other hand, however, scientists argue that some of these herbal medicines have been discovered to be dangerous, because they contain highly toxic elements. They believe that some childhood disorders like congenital malformation plus tumours may be a result of toxic or carcinogenic constituents found in herbal medicines which are taken throughout the pregnancy (Ssengooba et al ND: 24). From a biomedical point of view, some herbal medicines are associated with the rupture of the uterus which is a serious risk that is life threatening in women (ibid).

Furthermore, during the pre-natal period, TBAs are able to identify abnormalities like bleeding, swelling of the legs plus prolonged labour and refer them to medical health facilities. They also control vomiting during pregnancy by applying traditional medicines which are not harmful to human beings. However, in most cases, some mothers fail to get funds or transportation means to reach the nearest health centres or hospitals (Carr & White 2012: 15). TBAs that are trained do carry out clean delivery and provide advice to mothers about basic pre-natal care. According to UNPF evaluation findings, TBAs have contributed to the number of women who go to the health facilities for family planning and immunization services increasing. They prevent post-partum sepsis by using the three cleans during delivery and also following the right procedures for placenta management. In settings where referral is feasible, TBAs save mothers' lives by identifying complications, applying appropriate measures before reaching the referral centre (UNPF 1996: 2). In spite of this important role the TBAs play in the mothers' lives, in some countries TBA practice has no legal recognition and some are unregistered (Leedam 1985: 251 & 253).

Rural mothers find the care of the TBAs to be of higher quality other than that at the health centres because they offer drinks, clothes, food and they readily use their own requirements such as gloves, cotton wool, mackintosh, scissors in case the woman does not have them – something that is rarely done in hospitals. A TBA quoted in the study on Referral Practices and ...among Ugandan TBAs explains that, 'Our working relationship with the rural mothers is the best, because at times we refer them to the health centres and they refuse to go' (Keri et al 2010: 78).

TBAs have become popular in different settings mainly due to continuous challenges to the entire health system such as inadequate funding, transport, few medical staff and distance from the communities (Byrne & Morgan 2011: 127). The failure by the government of Uganda to ensure effective maternal health care...brings about a very high risk and comes along with a high costs. Several pregnant women resort to the services of TBAs or other ill-equipped birth attendants to deal with obstetrical emergencies which might have been detected early and worked upon successfully by well trained medical personnel when still early. Instead such cases end up becoming costly and at times turn to be very fatal by causing loss of lives (Herz & Measham 1987: 5).

A good number of studies have showed that TBAs can effectively administer misoprostol and safely reduce the complications of haemorrhage cases among mothers in places where professional medical attendants are not readily available (Prata et al 2011: 87). Mothers therefore, look

at Traditional Birth Attendants as their fellow community members whose services can be afforded, who do not ask embarrassing questions, allow delivery to take place in any preferred position and when pain comes a woman can respond in any way she wants as one mother explains in a study conducted in Hoima district by Professor Kyomuhendo of Makerere University;

‘Nobody will restrain or rebuke you and sometimes the attendant will sympathetically cry along with you. More important nobody will be in a hurry to cut you, pull out the baby or rush you to the operating theatre’ (Kyomuhendo 2003: 16).

Basing on the above, Traditional Birth Attendants have played a vital role to successful neonatal, child health and maternal interventions, but on the other hand, they are strongly ill-equipped to handle certain emergency obstetric complications like postpartum haemorrhage, malpresentation and obstructed labor (Byrne & Morgan 2011: 127). Therefore, out of the interaction the researcher had with the mothers, TBAs and health workers, it was found out that, TBAs’ services are always available within the communities, can be afforded, accessed, they are culturally acceptable in Buganda and elsewhere and thus can easily address the women’s maternal needs. But on the other hand, according to Sengooba and others, assessment of TBAs’ work in Uganda, it indicates persistence of inadequate delivery and referral practices (Sengooba et al ND: 26).

2.2.1 Gender Perspective on TBAs in relation to Women’s right to Safe and Healthy Delivery

In Uganda, Traditional Birth Attendants are mostly women and some people look at this activity as being a feminist based business. It has not been given a higher priority because it is viewed by people as an activity typically of lower domain and TBAs’ services are looked at as those which are normally embraced by women who are not educated, who stay in rural areas and their practices are more traditional and primitive.

According to Khan, there’s persistence of inequalities of the availability and accessibility of maternal health services to women in most countries. The cross-regional study published in 2006 by WHO, indicates that the likelihood of a mother delivering in the presence of a trained medical personnel which is very vital to a safe and healthy delivery is highly linked to maternal education, wealth, geographical location and ethnicity. In some situations women are blocked from accessing maternal health services due to being illiterate, lack of money and information about the services available. Women who are financially stable can easily access the services unlike women in

poverty because their husbands always dictate about when and where to access services from (Khan 2009: 127, 128 & 129) as further discussed in chapter 3.

Dealing with maternal mortality means addressing injustice against women and their elimination from making decisions, because equality and non-discrimination are basic fundamental principles of human rights (Khan 2009: 129). In India, at least half of the women are never involved in the decision making process about their health, including those issues related to childbirth and pregnancy. Gender inequality at times delays and denies women accessibility to maternal health services hence contributing to increased maternal mortality. Thus, addressing the barriers to boost women's participation in decision making requires addressing cultural sensitivities, analysing the cultural and social norms, values and beliefs which hold them back (op.cit). Their political marginalisation leads to the marginalization of their maternal health needs, as a UN Special Rapporteur on the right to health put it; *I have suspicion that if men had to give birth, mortality and morbidity arising from childbirth would be taken more seriously and attract more resources than they do today'* (Khan 2009: 140).

In addition to the above, because of cultural practices like the need to seek permission to move away from home and religious beliefs, some women always find themselves confined and they cannot leave their homes to look for assistance whenever it is time for delivery (Rawe et al 2011: 16). Culturally in Uganda, men's and women's roles are clearly defined whereby men are the breadwinners and women are the home keepers. Gender differentiations therefore limit women to access financial resources, and rarely have any control over the resources in a home because the men control everything (Weeks et al 2005: 1307). Some mothers fail to deliver from the health centres due to lack of money to purchase the required supplies like cotton wool, razor blades, gloves and pads. They cannot go to the health clinics because they feel ashamed without them (Keri 2010: 78).

This is very similar to the findings of the study, whereby it was discovered that some women have no control over the household incomes and their husbands always give them very little money whenever they are going for antenatal checkups or when it is time for delivery as a mother in Kamengo sub-county explains;

'The hospital is good but the issue of food is a very big problem. Your partner can give you only 5000/= for food well thinking that the treatment is for free in government hospitals. But sometimes you have to buy medicine which is out of stock...then you face problems feeding yourself'
Sylvia, in FGD at Butoolo Health Centre III.

Therefore, in relation to such a scenario, gender responsive budgeting would be the best solution both at national and family levels, to ensure women attains their maternal and reproductive rights. GRB ensures that government budgets, policies and programmes initiated deal with the needs and interests of the women. The government has to warrant that all budgets focus towards the promotion of gender equality and equity (Budlender 2010: 12). GRB further determines where the desires of men and women are the same or where they are not, and health is one area where male and female needs strongly differ. Women usually use health services more often than men, for themselves and for the other members of their families (ibid: 13).

2.2.2 Legal Framework of Maternal Health in Uganda

Much as there is no clearly defined legislation for maternal health, Uganda is a member state of different legal instruments that offers a background for a legal framework on maternal health. The legal framework for solving maternal health problems in the country is embedded in the broader framework of addressing the sexual and reproductive rights founded on the principles of human equality and dignity. Maternal mortality and maternal health specifically is a human rights issue in terms of the right to health, liberty and security, right to life, non-discrimination, and freedom from any dangerous practices. Some of these rights have been enshrined in the 1995 Uganda Constitution (EASSI 2010: 6).

The Constitution provides for the Districts to involve themselves into the comprehensive and integrated development planning and implementation of the reproductive health services within the holistic approach of promoting and protecting human rights and eradication of poverty among the rural communities. The 1997 Local Government Act tasks the district local councils to ensure provision of medical and health services to the entire population in the district. Therefore, the Health Sub-District (HSD) is supposed to make the services more affordable, acceptable, available and accessible by the local users. The 2007 Roadmap sets strategies and priorities like improvement and promotion of the legal framework and policy environment for successful design and implementation of maternal health programmes which ensures accessibility, availability and high quality maternal health services, lobby and advocate for increased distribution of medical supplies, improving human resource capacity and empowering rural communities to be actively involved in care, monitoring plus evaluation mechanisms for better service delivery and effective decision making process (EASSI 2010: 5 & 6).

CHAPTER 3

TBAs: A REALITY IN MPIGI DISTRICT

3.0 Introduction

In Mpigi district, Traditional Birth Attendants were trained in 1980s by Mpigi Health Centre IV with support from the Ministry of Health, World Vision and Strides for Family Health-Uganda. They are still operating from the district but the government is trying to phase them out because of the risks associated with their services. The District Director of Health Services (DDHS) revealed that this decision has not yet been fully implemented and that is why the TBAs have continued rendering services to the women especially those who cannot easily reach the health providers during pregnancy, labor and delivery. She further explained that, in the past, health workers used to supervise and monitor TBAs' activities but they no longer do it because of that decision the government came up with – to ban TBAs' activities.

3.1 Acquisition of Knowledge and Skills by TBAs

TBAs were trained more than 10 years back and the opportunity only went to those who had long experience in the field. They were given certificates allowing them to continue helping the mothers during pregnancy, labour and delivery. They described themselves as immediate caregivers within communities who help mothers in case of any need related to pregnancy. Most of them learnt the business through apprenticeship with the help of grandmothers, mothers and elderly women in their communities. One TBA in Kamengo sub-county explained;

'I grew up from my mothers' side and all were TBAs and they used to train me to handle such matters and unfortunately they all died. I wanted to stop but their spirits came and told me that; 'we trained you to help mothers, so you better do it or else you are punished'. In addition, many people in that situation are poor, feel free to approach us than medical facilities and afterwards reward us for the work.'

3.2 Categories of women handled by TBAs

TBAs handle all categories of women like prime gravidas (beginners), multi gravidas especially those at the end of their reproductive life cycle who normally fear the wrath of medical workers who insult them for 'producing when they are aged'. TBAs in Buwama sub-county pointed out that during their trainings, they were advised never to handle cases of Post Partum Haemorrhage (PPH), prime gravidas, multi gravidas (5+), disabled and very short mothers (below 150 cm)

since some these usually develop complications which can only be handled by well trained and qualified medical workers.

TBAs receive pregnant women on a daily basis and it is them to determine who should be referred and who should not depending on the mother's condition. They always refer those with acute complications to health facilities and at times keep with them to ensure that the complications are handled by the rightful health workers.

3.3 Care provided by TBAs in Mpigi District, according to TBAs and Mothers

The mothers interacted with included those who had ever sought services from the TBAs and those who had never gone to TBAs but had information about TBAs. The rural mothers in Mpigi district were all praises for the TBAs and normally refer to them locally as '*mulerwas*'. They are found within their communities and help them with herbal medicine both for bathing and drinking such as *bombo*, *emumbwa* because culturally it is a must for every *muganda* pregnant woman to take herbs in order to become strong during pregnancy and delivery, get relieved from discomfort, bring appetite and treat ailments like dizziness, vomiting, body pain etc. Mothers claimed that tablets they usually receive from the health centres at times are not so effective thus the local medicines help them to make their bones firm, widen the birth canals to deliver very fast and successfully, to cleanse their babies and make their skins soft.

Other local herbs TBAs give to mothers include *ndeleva*, *kilala nkuba*, *olwezza*, *kayayana*, *omwetango*, *omululuza*, *kabbombo akanaba amasanda* and *mutasuuka kubbo*, *muzukizi*, *kamunye* for blood supplement, to treat ruptured uterus and all other ailments. Some TBAs argued that, though a number of medical workers despise their services, there are some conditions which can only be handled by them through the use of herbal medicine like the case of '*kamuli*' (yellow skin in new babies), and that is why mothers continue to seek their services in such situations. Some health workers also seek TBAs' services as one reported; '*medical workers from Nkozi hospital and Buwama health centre III refer women to me for herbs and even midwives from Nkozi hospital come and get emmumbwa from me*', and displayed the different types of *emmumbwa* as she explained as follows;

'Our parents did not tell us the names of some of the herbs but we consult each other. We have nabuguma which works when the woman feels much temperature in the stomach, express (emmenya) which softens the pelvic bones during the delivery process and quickens delivery and kigalanda which protects women from being operated and deliver through the natural way safely and successfully.'

Figure II: A TBA (Nababi Oliva) in Buwama Sub-county, Mpigi District displaying different types of the commonest herbal medicine known as emmumbwa given to pregnant women.



Source: In the Field (Buwama Sub-county) during a Focus Group Discussion with TBAs

Bukirwa, a mother in Mpigi Town Council who lost her baby from Mpigi Health Centre IV after delivery, and other mothers interviewed and those in focus group discussions gave different reasons for using herbal medicine during pregnancy and these included preventing miscarriages, stomach upsets linked to pregnancy and treating sexually transmitted infections. Bukirwa who visited both the health centre and a TBA commonly known as Mama Ssemanda, revealed that she went to her to get herbal medicine known as *bombo* to reduce pain in her legs, relieve her of the discomfort in the stomach and speed up delivery process.

In addition to the above, TBAs play an important role of referring mothers to the health facilities because some mothers do not know the benefits of giving birth from the medical facilities. They usually do this to ensure that mothers have attained a safe delivery as one TBA in Buwama sub-county explained;

‘due to infections we do refer them to the hospitals for medical treatment and even those who are already infected with HIV/AIDS we help them to seek medical services because us we are not perfect in controlling the scourge to the newly born babies and in case of an emergency we want to refer the mothers to the hospitals so that they can go through a safe delivery’.

Another one also narrated; *‘for me in case of a rupture of the uterus I always refer them to the hospital, but the next one said; ‘in case of a rupture we have a leaf (kikoola) which is put on as a sanitary pad after bathing and it heals with time’.* TBAs agree that there are complicated cases they cannot handle and that is why there is always need to have a good relationship with medical care givers, such that emergency cases they refer to health facilities are worked upon immediately other than the mothers being blamed for going to the Traditional Birth Attendants. Also the mothers revealed that TBAs usually refer cases they think they cannot handle like mothers who go beyond 9 months of pregnancy, prime gravidas (1st pregnancy) and multi-gravidas (many deliveries) to ensure that likely complications are detected early and handled by trained health workers.

Furthermore, during the study, mothers who usually seek hospital services were greatly concerned about the poor hygiene conditions in the labor rooms. They revealed that there is one bed in the room which is usually used in turns, lack of privacy, inadequate water supply and frequent load-shedding especially in rural settings where they have no any other source of power like solar. The same situation was also described by a midwife of Buwama Health Centre III who lamented as follows;

‘Look at this ward! There is limited privacy and mothers get squeezed in one room. There is poor sanitation and hygiene all around the centre, it is bushy, we do not have solar and at times we are forced to use candles, the sewage system blocked long time ago, there’s no water supply and the mothers have to use pit latrines which are far from the ward. The two cleaners we had ran away because of the poor pay by the government and that is why you see the floor is dirty like this’

For such conditions therefore, TBAs are looked at by mothers as the best appropriate source of help during the delivery process because they are assured of privacy, humane treatment in terms of support and care. TBAs in Kamengo sub-county in a focus group discussion at Butoolo Health Centre III mentioned that they usually encourage the pregnant mothers to attend the prenatal sessions at their local health centres within their reach. One confidently stated;

‘We should make sure that the mothers who come to us have attended antenatal visits at least three times throughout that period. They will learn a lot and this will make our work very easy. Whenever they come to me, I ask them letters from the health centres to prove that they have been going for antenatal check-ups’.

Another one in Buwama sub-county also said, *'We receive them, but only allow to stay with them for two days and after that we refer them to the health centres'* and the next one in the same sub-county also stated, *'Me, when I receive one at night, I only help her at night, and if by morning she has not yet delivered, I refer her to the nearby health centre'*.

However, besides the above contributions made by TBAs, Health workers argued that much as TBAs have tried to help the mothers attain successful deliveries, most of them still lack essential supplies like gloves, vitamin K, tetracycline (eye ointment) for newly born babies, octocin drugs to control bleeding after delivery, and have no means of transport to the health centres in case of emergencies. The only available means of transport in rural settings are motor cycles commonly known as 'boda bodas'. To the researcher, it is contradicting because the challenges TBAs are facing are not different from those being faced by the entire health sector in Uganda and Mpigi district in particular. Most government hospitals and health centres lack ambulances, experience frequent drug shortages, they are understaffed, they lack mama kits and the mothers are always told to come with their own things and buy their own medicines.

Strongly, some health workers especially those in Buwama Health Centre III supported the mothers who resort to TBAs because at times they lack adequate equipments like speculums, episiotomy scissors, artery forceps and gloves, cutgurd (threads), cotton wool, razor blades, normally referred to as 'Mama kits'. Understaffing is another factor pointed out more especially in Buwama and Butoolo Health Centre IIIs where they only have two midwives to handle deliveries, offer antenatal services and immunizations for children. The District Nursing officer lamented in relation to this; *'inadequate staffing is a serious challenge in the district yet there are so many activities to be carried out by midwives for example scanning, PMTCT, offer post natal care services, immunisation and counselling. At times I don't blame mothers who seek TBAs' services since at times we also have no way out'*. The midwife in Butoolo Health centre III also lamented, *'For the health centre like this needs to have two clinical officers, nursing assistants, guards and others but here we are so overloaded and every time we get visitors on top of our busy schedules'*. They also pointed out stock out of drugs like antibiotics, anti convulsants, octocin drugs and fansidar for prevention of malaria in pregnant women.

Health workers in Mpigi, also, appreciated the work of TBAs because they provide health education to pregnant mothers, antenatal care, handle deliveries, treatment of minor illnesses related to pregnancy by administering herbal medicines. The District Nursing officer in charge of maternal and child health care at the district clearly stated that;

'TBAs have good care, patient-TBA relationship is good. They give them hot water, food, rub their back and sooth them during labor pains unlike health workers who are always too busy attending to so many mothers with different needs. TBAs normally attend to few and serve them effectively. Mothers have trust in old women and they stay within their localities. They spend less in terms of transport and little time is consumed'.

The mothers also reported that, 'TBAs' services are effective since they can even work upon a prolonged labour as one mother explained during a focus group discussion at Butoolo Health Centre III; *'I trust the services of TBAs because one time I happened to go through a prolonged labour. The TBA insisted that I go to the health centre and I refused. After a day, she gave me some herbal medicine which helped me to deliver immediately and successfully'*. Another mother who has ever visited a TBA also gave her own experience as follows;

'Yes I have ever visited a TBA because the stomach was paining me and when I visited the TBA she told me that the baby was not in a normal position and referred me to the hospital to avoid further complications and also gave me local herbs (emumbwa). When I used the emumbwa, the pain reduced but the baby remained below the right position. I later went to the hospital'.

The mothers further pointed out that, TBAs have assisted them with health education. They educate them about food and nutrition, sanitation and hygiene, family planning and offer immediate help in case of an abrupt sickness before reaching the health centres. They help them to prepare for the delivery period, they are always welcoming and supportive during pregnancy, delivery and postpartum period. TBAs revealed that they health educate the mothers about the antenatal care services available in the hospitals, effective use of drugs as recommended by health workers, for instance iron tablets, blood supplement tablets, malaria treatment drugs etc. They also give them food, show them love especially during the time of labour and use a friendly language without being rough. They conduct follow ups by visiting mothers and see how they are breast feeding and encourage them to keep themselves clean as well as the babies. TBAs pointed it out that mothers prefer their services because of the hospitality offered to them which is not the case in hospitals, being accessible and always available, inadequate means of transport and at times it is very expensive to the health centres which are at a distance. In addition, TBAs offer motherly counselling about the condition of the pregnancy and reveal the sex of the baby the mother is carrying. One, Betty, a mother in Kamengo sub-county, at Buwama health centre commented during a focus group discussion as follows; *'these are people who can talk to us freely, console and comfort us. They help us during troublesome conditions especially at night, they are always available and enable women to deliver safely and successfully'*.

Despite all the contributions, TBAs face challenges such as non-cooperative and disrespectful attitudes of the medical staff, limited requirements such as gloves, scissors, cotton wool, forceps, razor blades and mackintosh. Most of them lack power and safe water, thus they normally use kerosene lamps which tend to be very expensive and risky to mothers and newly born babies. Some of them lack private rooms where to deliver the mothers from, and transport for emergencies is a big challenge too.

But as citizens of Uganda and where they act as a supplement to the trained health workers, they are also entitled to a token of appreciation in any form since they also play an important role in the mothers' lives, a right to all the requirements such as mama kits, safe water and power, private rooms where to help mothers from and a right to be nationally recognised as other workers and operate freely without threats from the government to ban their services.

3.4 Perception of Community Members and Health Workers towards TBAs

Health workers in Mpigi district had no kind words for TBAs. They look at them as people who are not educated, lack the knowledge and skills to offer effective maternal services, thus they think they have a hand in the increasing rate of maternal mortality in Mpigi district. They think some TBAs are witch doctors and that is why mothers resort to them thinking that will protect them from any harm to themselves and their children.

Medical personnel also reported that TBAs delay with the mothers and sometimes reach the health centres when it is too late. They think TBAs misguide mothers and make them not seek medical assistance with the intention of not losing the customers. They pointed out that it is the prime-gravidas, multi-gravidas, mothers who are not highly educated, those who cannot afford the requirements and the elderly mothers who normally seek the services of TBAs because they are cheap, they fear to be operated especially prime gravidas, distance from the health centres and the elderly mothers who fear criticisms from the health workers because some of them use abusive statements like *'who told you to produce when you are old like this? You are supposed to look after your grandchildren. To hell with your own problems.'*

The relationship between some health workers and TBAs is not good because the later think that to some extent, TBAs refuse mothers to go to the health centres, they at times conduct compli-

cated cases beyond their mandate and thus contribute to maternal deaths in the district. To others it is not all that bad because some TBAs in other places still refer women to health centres whom they think are likely to develop complications, and usually seek advice from the health workers during complications much as the government is trying to phase them out from the health system.

Finally, health workers in Mpigi district pointed out their rights that they should enjoy as public servants and these included a right to good working environment, right to maternity and annual leave which at times become so hard due to inadequate staffing, right to upgrade, a right to accommodation, a right to rest and important of it all a right to a reasonable monthly pay and enough medical supplies to use in order to save women's lives in rural areas.

3.5 Conclusion

TBAs stay within the communities and mothers have a lot trust and confidence in their services. They treat all kinds of ailments related to pregnancy using herbal medicine, refer mothers with complications to the health facilities and help mothers to understand the importance of delivering with the assistance of medical workers. TBAs educate the mothers about food and nutrition, sanitation and hygiene, immunization of children and family planning. On the other hand, health workers look at TBAs as having a hand in increased maternal mortality and morbidity because they sometimes delay with the mothers and handle cases beyond their mandate.

CHAPTER 4

TBAs' SERVICES vs MODERN HEALTH SERVICES

4.0 Introduction

The next chapter takes us through a review of the key factors that drive women to seek TBAs' services other than services from the modern health facilities as deduced from the interviews, focus group discussions and other sources. The chapter also analyses some of the risks associated with TBAs' services and also points out how such risks can be addressed by the government of Uganda, NGOs and international NGOs. Saravanan et al (2011: 255) gives it emphasis that; 'the extent of dependence on TBAs for assistance during delivery is higher in rural areas compared to urban areas and is higher in poorer communities compared to affluent households'. This indicates that there is inequality and discrimination of certain classes of people in the provision of health services which also infringes on the mother's right to life guaranteed under Article 22 of the 1995 Constitution of the Republic of Uganda.

4.1 Factors for Preference of TBAs' services in Mpigi District, Uganda

Table III below, summarises the factors which drive women to opt for TBAs' services other than those provided in the different health centres in Mpigi district.

Table III: Factors for Preference of TBAs' Services

Factors	Issues	Policy Implication
Lack of well trained medical personnel	<ul style="list-style-type: none">- Verbal and physical abuse- Neglect and poor treatment- Providers' experience and behaviour.- Previous experience	<ul style="list-style-type: none">- Comprehensive training for all the medical personnel- Educate the health professionals about sexual and reproductive health, including HIV/AIDS, gender equality and women's rights.
Poor quality of maternal health services	<ul style="list-style-type: none">- Shortages of drugs- Lack of medical equip-	<ul style="list-style-type: none">- Advocate for better local and national policies on

	<p>ments</p> <ul style="list-style-type: none"> - Lack of emergency obstetric and newborn care facilities, drugs and supplies, blood and anaesthesia 	<p>health services, HIV/AIDS prevention and violence against women.</p> <ul style="list-style-type: none"> - Decentralisation of health services. - Health management information system for routine monitoring maternal and reproductive rights.
Lack of transport	<ul style="list-style-type: none"> - Poor means of transport e.g. boda-bodas - Impassable roads in remote areas - Lack of ambulance system - Long distance to the medical institutions 	<ul style="list-style-type: none"> - Ambulance system in all health centres
Poverty	<ul style="list-style-type: none"> - Accessibility of the health facilities - Affordability of the requirements as gloves, cotton wool etc 	<ul style="list-style-type: none"> - Free maternal and newborn health services and all other medical services.
Trust and traditional beliefs	<ul style="list-style-type: none"> - Squatting position - Disposal of the placenta - Use of medicinal herbs 	<ul style="list-style-type: none"> - Training and supervision of all the TBAs' activities.
Gender Inequality	<ul style="list-style-type: none"> - Lack of equal control over resources e.g financial resources. - Domination of the decision making process by men 	<ul style="list-style-type: none"> - Gender mainstreaming - Gender Responsive Budgeting at various levels.

Source: My own design

As noted in the Table III above, the public health sector of Uganda still experience a lot of gaps and this makes the right of women to a safe delivery had to be achieved. Uganda's health sector is largely underfunded and is characterised by inadequate medical personnel, frequent shortages of medical supplies, lack of EmOC equipments and drugs, lack of ambulance system and corruption among the health officials. These and other factors like gender inequality, traditional beliefs, poverty and long distances to the health centres have been an issue towards accessing maternal health services especially in government owned health institutions. The table further gives a summary of the policies which can be adopted by the government so as to improve the quality and utilisation of the available services.

Rising mothers' access to advanced midwifery services has turned into a centre of global efforts to achieve the right of every mother to the best probable health care during childbirth and pregnancy (Hoope-Bender et al 2011: VII). But this is not the case in Uganda due to various factors according to the findings of this study as further discussed in this chapter. Hoope-Bender et al (2011: ii), clearly argues that what is needed to ensure safe delivery is access to appropriate health services including trained and experienced medical personnel and properly functioning health care facilities. But this is completely different from what the findings of the study on the ground basing on the situational analysis conducted in Mpigi district. A few health centres visited like Mpigi Health Centre IV, Buwama Health Centre III and Butoolo Health Centre III lack the basic equipments like stethoscope, forceps, ultrasound machines, episiotomy ceasars, urine sticks which are very vital for antenatal, and the drugs to enable them function properly to ensure safe, healthy and happy delivery for rural mothers in Uganda and Mpigi district in particular as the health worker in Buwama sub-county explains the situation;

'We need proper equipments, and the buildings are not in good shape, they have grown old and the toilets are not functioning at all. Women who have just given birth have to share the same space with the sick patients and at the same time the maternity ward acts as the outpatient clinic for pregnant women with different ailments. Look at the whole environment, all the cleaners decided to run away because of low monthly payments by the government. Of course women do not feel happy staying in such an environment', Zula M., a midwife of Buwama Health Centre III, during an FGD.

Thus, non provision of the basic maternal commodities and the reluctance of the health workers toward the expectant mothers leading to maternal death is an infringement of their rights to life and health guaranteed under the Uganda 1995 Constitution.

Furthermore, inadequate medical personnel and lack of ambulance system is another problem facing most rural health centres in Mpigi district as the case is in Butoolo Health Centre III in Kamengo Sub-county. The whole health facility has got only two midwives who are at times overworked because they attend to many pregnant women especially on antenatal days, they have to attend to deliveries and immunise children at the same time. Nakasiita's case clearly depicts this particular situation on the ground;

'I used to get antenatal services from Butoolo Health Centre III, where I was told I was going to deliver twins. However, I was not told that they were conjoined. When I was due my husband transported me to the health centre but we did not find any nurse or midwife at the health centre. He decided to take me to Jaaja Victor, a TBA in Kamengo Sub-county. The twins were conjoined, the TBA could not separate them and the ambulance to transfer me to Mpigi Health Centre IV arrived two hours later. By the time the ambulance reached, one of the twins had already passed away. The driver asked 60,000/= Uganda shillings for fuel to Mpigi, but reaching Mpigi Health Centre IV we were informed that it was too late and the doctors were not available. The driver decided to proceed to Mulago Hospital. We arrived Mulago at exactly 11:00pm, but as we waited for admission, the second twin also passed away' (May 16, 2012 New Vision).

Nakasiita's case clearly shows what the rural women go through in trying to access maternal health services in Mpigi district. Health workers are rare in health facilities, there is no ambulance system to transfer emergency cases to higher levels, when it is available it is very expensive in terms of fuel.

On the other hand, Hoopé-Bender et al (2011: iii) argues that, National Policies of some countries which are supposed to address maternal and newborn health services rarely look at the centrality of the midwifery workforce nor the urgent need to improve quality of care (preventive measures, promotion of successful normal births, early detection of complications, accessing of medical), in respect of women's rights. This is therefore contrary to WHO guidelines whereby every country should at least have adequate and sustainable source of medical professionals, trained within the context of current and future issues in patient safety and quality of care, and ongoing trends in shortages of nurses, midwives and workforce migration.

On the attitudes of mothers towards institutional and non-institutional deliveries, not only social cultural factors but also women's perceptions of the poor quality of the health system were found to be very vital. Health workers are rude, poorly trained, unwilling to dispense prescribed drugs, they avoid maternity patients, abandon them in critical conditions and lack ethics, give them false information and expect bribes from the patients (Kyomuhendo 2003: 16). In addition

to the above, some health facilities especially in the rural areas lack the obstetric care equipment, medical personnel, drugs and other medical supplies to enable them operate appropriately (Rawe et al 2011: 16). These and many other gaps in the health sector will continue driving mothers away from the modern health facilities unless addressed with appropriate policies and programmes to suit women's needs.

In Uganda, there is a problem of transport and distance from the health facilities. The ambulance system is not effective because most health centres lack ambulances. They are located far apart from each other and it becomes very difficult to transport mothers who normally experience complications during delivery (as in Nakasiita's case above). During emergency situations, the cost of transport become extremely so high due to long distances, and thus a major factor causing delay and failure to look for a life saving care in most communities (Ssenooba et al ND: 25). Mothers seek services from TBAs because of their affordability, cultural acceptability, accessibility, and availability prior getting organized health care services from medical institutions. Affordability is a very vital issue since the cost of drugs, transport and food make some women fail to access the health system services (Homer et al 2012: 6). Thus, where there are inequalities towards the provision of maternity services contravenes with CEDAW (Article 12) which states that;

'States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation' (Banning 2004: 21).

During the study, the researcher found out that most health facilities in Mpigi district lack the ambulance system, there are few medical personnel, frequent stock out of supplies such as drugs and mama kits, and they cannot easily be reached due to distance plus inadequate means of transport. Therefore, such conditions deprives the rural women their right to a safe and healthy delivery.

The most challenging condition is how women talk about the issue of powerlessness and helplessness, which is normally seen in all aspects of their lives in general. To others it heavily affects their access to care when pregnancy and childbirth related complications arise since at times they are unable to afford healthcare and sometimes cannot reach the health facilities due to high transport costs (Weeks et al 2005: 1302). With 80% of the population living under the poverty line, and a female literacy rate of roughly 59%, many rural Ugandan women are either ignorant

about proper maternal care, or are unable to visit a hospital during any complication because they cannot afford costs involved in the health system and this brings about exclusion among the mothers who are in need of maternal care (Keri et al 2010: 75), as one mother in Kamengo sub-county explains her ordeal;

'I was told that at the government health centre they provide assistance to pregnant women at a free cost, I just needed money for transport. So one morning I woke up and went to the health centre with only 500/= Uganda shillings, but reaching there, I was told to buy a book and a pen. I did not have enough money because the 500/= was for transport back home' Nagawa, a house wife in a FGD, Butoolo Health Centre III in Kamengo sub-county.

In Uganda, it is very expensive for the pregnant women to access medical services in terms of all the requirements needed and time to reach the health facility. Inadequate control of all the domestic resources by the women across the country delays the decision to determine when, how and where to seek the health care. Ambulance services are absent in most rural health centres, which makes it so hard for the doctors and midwives concerned to respond immediately to maternal care emergencies (Ssenkooba et al ND: 27). This was confirmed during the research study that some of these conditions are real on ground, for instance, Buwama Health Centre III which is along the highway does not have an ambulance and women are usually transported using boda bodas or hired taxis whereby the costs have to be paid by the patient or the relatives who at times fail to raise it. Thus, such conditions do not favour rural women and this means banning TBAs services would infringe on their right to choose where to give birth from and right to life.

Sometimes, even when the medical personnel, medicines and equipments seem to be available, the financial, personal factors and various cultural factors of different families and communities hinder effective utilisation of the modern health facilities. In developing countries, it has been documented that more than 80% and 60% of the rural and urban babies are delivered by TBAs respectively. Laws have ever been passed but turned out to be ineffective simply because the urgent need of the community turned to be stronger than the law because no suitable substitute was availed to the community (Kamal 1998: 43). This is the same case in Uganda, when the Ministry of Health tried to ban 'TBAs' services in 2009 but it has since failed to work because the mothers still need their services especially the poor and marginalised in rural settings as discovered during the study. It is largely believed that mothers normally have an intimate relationship and a dialogue socially acceptable with TBAs other than the bio-medically trained midwives. The trust and confidence they have in TBAs drives mothers to continue seeking their services and usually deliver from their homes.

However, Ssenooba and others argue that, TBAs tend to have inadequate knowledge on the existing risk factors and dangerous signs of complications in pregnancy and during delivery (Ssenooba et al ND: 26). This is very similar to what the health workers revealed during the study because they pointed out that some TBAs keep with the mothers without noticing any likely complications, others believe that herbal medicine work better when administered without washing hands which is hygienically wrong and infection management is low, thus putting the lives of the women and the babies at risk.

At primary health care level, mothers complain of verbal and physical abuse, neglect and poor treatment in hospitals plus the medical workers' mentality that most women are ignorant which also explains the unwillingness of rural mothers to deliver from the modern health facilities and seek maternal care for complications. Mothers are always worried about the rudeness of midwives and some hospital attendants who pinch and even slap them during labour pains, use abusive language and hurry them to the theatre for caesarean operation even when there was a likelihood of a normal delivery (Ssenooba et al ND: 25, Keri 2010: 79, Izugbara et al 2009: 44, Kayli et al 2010: 2042). The unacceptable higher maternal deaths in Uganda which are due to Government's non provision of the basic maternal health care requirements and the non attendance and irrespective handling by the health workers to rural mothers (Keri et al 2010: 77), are largely unconstitutional because they run contrary to and against Objectives 1(1), xiv(b) xx vii (b), Articles 33(2) and (3), 20(1), and (2), 22(1) and (2), 24, 34(1), 44(a), 287, 8A and 45 of the Constitution of Uganda. Therefore, such a situation drives away women from the health centres because even when they there, they are told to bring their own requirements like gloves, cotton wool, razor blades, polythene-paper and they would be advised to buy their own medicines.

An anthropological research study conducted in Zimbabwe by Jane Mutambirwa indicates that in a rural area, mothers chose to give birth from their own homes or TBAs when they were actually given ample preparation to make them accept antenatal care from the modern health facilities. They looked at the informal system as being responsible for their moral hygiene, spiritual and health while the modern health facilities only caring for their physical health. Therefore, this clearly shows that traditional practices strongly play an important role in the maternal health care of mothers much as they also accept the modernized health care. Thus, it is important for them to retain their traditional values as well as accept some of the modern concepts and services of-

ferred (Leedam 1985: 258) as one mother with both traditional and hospital birth experiences in Kamengo Sub-county remarked;

‘Once you go to give birth from the health centre, they treat you like a young girl irrespective of your age, size, status and experience. You can imagine a young nurse of the same age as your granddaughter instructing you how to lie down or when and how to push...why should I be treated as a helpless and passive patient? The pregnancy and its final consequences are my personal business and not anyone else’s’ Focus group discussion, Butoolo Health Centre IV, Kamengo Sub-county.

The wrath of health workers towards rural mothers was also pointed out by some TBAs and they claimed that mothers usually experience verbal and physical abuse from the doctors and nurses as one TBA in Mpigi Town Council stated;

‘The medical personnel are normally abusive and very arrogant, they shout at the mothers and tell them to go and bring their partners who made them pregnant. They sometimes pinch them, slap them whenever they make a lot of noise during labour pains, and it is like they prefer protecting their jobs other than peoples’ lives’, Mama Ssemenda, a TBA, in an interview.

Women interviewed in Mpigi Town Council stated that they preferred TBAs simply because they are scared of medical staff, ‘They treat us like strangers, leave us alone in the wards, undress us in front of other people, and at times shave and cut us’ (in case of an episiotomy). They emphasized that during delivery, TBAs assist them with a lot of human treatment, respect them and are always available and easily accessible. On the other hand, Key informants at the district and some health workers clearly pointed out that maternal mortality will not be reduced if women continue seeking assistance from the TBAs other than from the modern health facilities.

Finally, the mothers also pointed out their own health rights which have to be promoted and protected by the government, health workers, NGOs and communities and these include; the right to choose where to give birth from, right to access medical care, right to information about their health, right to food, safe and clean water, right to all maternal health services, access to family planning and immunization services for their children.

4.2 Risks Associated with TBAs’ Services, the 3 Delays and Lack of Access to EmOC

Health workers in Mpigi district clearly pointed out the risks involved with TBAs’ services like limited access to PMTCT services, inadequate management of neonatal infections by tetanus and septicaemia, maternal and neonatal morbidity due to delivery related complications, lack of im-

munisation schedules for newly born babies and late referrals to health centres contributing to rupture of the uterus. In addition, HIV/AIDS positive mothers are not followed up and babies born by these mothers are usually not enrolled into care. The midwife in Butoolo health centre in an interview emphasized the situation and in her own words she said;

‘the infection control is not there because of the environment they make mothers deliver from – there’s dust, they use the same polythene, they don’t dispose the polythenes, and the instruments they use are not sterilized. The government should totally ban the TBAs because of the risks associated with their services’

Lack of effective resuscitation procedures and the risk on infections such as tetanus and HIV/AIDS are the biggest causes of neonatal mortality and morbidity. Mothers helped by untrained TBAs are likely to have the highest rate of secondary infertility due to uncleanliness, rupture of the uterus and prolonged labour (Leeman 1985: 251). Recent studies of TBAs’ knowledge, practices and beliefs indicated high rates of dangerous vaginal cutting which at times lead to the development of fistula problems. There is always inadequate knowledge of when the obstructed labour should be timely referred to health facilities by some TBAs (Keri et al 2010: 75, Homer et al 2012: 10).

This is very similar to the findings in this study, whereby some mothers interviewed also believed that TBAs’ services are associated with certain risks such as failure to detect and handle complicated cases like haemorrhage, mal-presentation of the foetus and obstructed labours which need timely referral to well functioning health facilities. It is also very difficult for the TBAs to prevent HIV vertical transmission and tetanus infection to the newly born babies. Other mothers do not find any problem with TBAs’ services as Nabbase, a mother of Mpigi Town council reiterated; *‘Their services are good and effective but also modern health services have to be used. TBAs are known and they normally meet with modern health workers’*.

However, in Kaguna’s and Nuwanda’s study, they look at medical staff as more knowledgeable and understanding in how and when to deal with complicated pregnancies and obstructed labour cases. In this study, women reported the risks involved with TBAs services like untimely referrals, poor infection management and likely development of fistula. Some of these issues help the pregnant women to determine when, where and where not to give birth from (Keri et al 2010: 7). According to the findings of the study, Uganda does not have adequate medical personnel and well functioning health facilities. Thus, for the country and other stakeholders to minimize on these risks, it would be useful to learn from other countries like Samoa whereby TBAs have been

integrated into the health care system instead of criminalizing and phasing them out from the system as Barclay et al 2005 cited by Homer et al explains;

‘In Samoa TBAs are recognized as part of both the formal and informal health care system. The ministry of Health recognizes the existence of the traditional health care system, which existed before the arrival of missionaries and their accompanying ‘scientific’ western medicine. The traditional health care system provided care to the physically and mentally ill. The TBA sees herself and the mother she cares for as a confident and independent practitioner. TBAs’ credibility and reputation comes from the espousal of traditional holistic care in Samoa and the antiauthoritarian and cultural sensitivity that they possess. In Samoa, TBAs play an important role in maternity services provision’ (Homer et al 2012: 6).

Also in Chaudhury, Bangladesh and Chowdhury, training and supervising TBAs was applied with fruitful results, in that skilled birth attendance increased right from 3% to 30% as a result of paramedic administration of TBA-attended domiciliary deliveries with birth complications. Training and supervising TBAs can bring a rise to substantial referrals other than training them without follow-ups on what they do and how they do it. In Bangladesh with a big population, increased standards of care within the facilities improved skilled birth attendance from 7.2% to 12.5%, but later when merged with TBA integration, the percentage rose from 2.4% to 20.5% (Byrne & Morgan 2011: 128). The incorporation of TBAs can be strengthened with education groups to share information conducted by midwife-TBA teams, formation of committees within the community to promote maternal care ... (Byrne & Morgan 2011: 131). When fully equipped mid-wives are not available, offering ample training to the TBAs... would help to spot early signs of complications and be able to refer mothers to health facilities which can make a significant impact in the lives of the rural women (Rawe et al 2011: 5). Training them can be so helpful in standardizing knowledge and improve emergency obstetric referrals. However, for effective performance, training should be accompanied by an extensive teamwork between biomedical staff and TBAs (Keri et al 2010: 75).

Researchers have identified three major factors that are barriers to women’s access to maternal health care; delay in recognising that there is a problem and making the decision to seek care, delay in reaching care, often due to transport problems, and delay in receiving adequate treatment once the woman has arrived at the health facility (Mirsky 2001: 1).

4.3 Conclusion

The abolition approach that the government of Uganda adopted in order to phase out TBAs' services will not help the women to achieve the right to safe delivery if the quality of maternal health care is not improved. Instead the policy would infringe on their rights especially if an appropriate substitution is not introduced to address increased maternal mortality levels in the country.

Chapter 5

Synthesis, Conclusions and Recommendations.

5.0 Synthesis

The main objective of the study was to explore and understand the contribution of traditional birth attendants towards attaining safe, healthy and happy delivery as a right for the rural mothers in Mpigi. A number of good policies have been formulated on Gender equity, Universal Primary Education, reproductive health and decentralisation of health services to improve the quality of maternal health services, but underfunding of the health sector which has resulted to inadequate resources as shortage of drugs, medical equipments, poor infrastructure and inadequate medical personnel have contributed to the increasing rate of maternal mortality which still stands at 430/100,000 live births.

Despite such a situation, the government of Uganda is trying to implement a policy to ban all TBAs' services which are often looked at by the rural mothers who cannot access the formal health facilities as the only alternative to seek assistance from during delivery. But such a policy is not likely to work out if appropriate, affordable and accessible means to address women's maternal health needs/rights are not put in place. TBAs should not be looked at as competitors or rivals in the system but as colleagues fighting for the rights of rural women to attain acceptable and safe care. The emphasis should not only be put on training TBAs but also the health workers should endeavour to change their attitude towards them, their duties and responsibilities, if they are to offer them the support they require and be able to provide quality services which are accessible and acceptable to all the mothers (Leedam 1985: 259).

5.1 Conclusion

Despite all the existing efforts to improve the quality of maternal health services, Uganda government has still failed to provide effective basic health facilities, recruit more health personnel, improve on the infrastructures, stock health institutions with adequate drugs plus equipments, provide obstetric care equipment and boost the opportunities necessary to enhance the welfare of women to enable them realise their full potential and advancement, which contravenes Articles 33(1) of the Uganda Constitution. Health centres visited during the study like Butoolo Health centre III had only two midwives and one clinical officer who had to attend to all the deliveries, women in labor, immunization of children and mothers for antenatal checkups. The health centres does not have any ambulances neither standby generators to use in case of load

shedding. Thus, under such conditions it becomes very difficult for the rural women to realize their right to safe delivery. In addition, the abolition of TBAs' services will not help the rural women to attain their right safe delivery if the government does not provide strategies to address the above challenges.

If national governments and international development partners are serious about reaching the MDG 5 for safe birth practices and about protecting the maternal rights of women, more attention must be paid to the issue of migration of midwives and nurses from developing countries and the potential role of trade in this (Nancy and Weeks 2006: 255). Policy makers and implementers have to evaluate the behaviour and attitude of medical workers toward clients and also improve the appropriateness of the services rendered. To improve quality of care, TBAs should be considered as a very vital strategy in the process of improving the quality of care because they can gather and disseminate information about the communities' health needs and perceptions (UNPF 1996: 8).

There is need to put in place a comprehensive approach in order to boost the accessibility, affordability and availability of maternal health care services. Alleviation of poverty among the poorest communities especially the women will help to increase effective utilization of these services. The provision and improved infrastructures, stocking health facilities with drugs, equipments and recruiting more medical personnel to fill the vacant posts by the local government will help to boost access to the services especially for communities in rural areas. Health promotion programmes through sensitizations and workshops can also increase the awareness of the communities concerning safe delivery services (Titaley et al 2010: 12). The government of Uganda therefore should adopt the reformist approach involving equipping and empowering TBAs with medical training to enable them carry out safe and efficient deliveries other than victimizing their services, and supervise their activities such that women's rights are not abused through harmful practices.

5.3 Recommendations

To deal with the shortage of trained health workers in the reduction of a high mortality rate, TBAs should be equipped and empowered with medical training to carry out safe and efficient deliveries with the following actions: Foster a conducive environment for TBAs by legalizing them, register and monitor them in order to maintain minimum health standards. Capacity building for TBAs to train them in medical care to enable them identify complicated cases of pregnancies make early referrals and preventative procedures to avoid HIV/AIDS transmission.

Training of TBAs is one of the most important interventions to ensure child birth safe and healthy. Unless it is combined with the other essential elements of safe motherhood, MMR will never be brought down. There should be frequent supervision and ample support to the TBAs. Until the government ensures availability and accessibility of EmOC to the community, the TBAs will always be helpless when the killer strikes (Kamal 1998: 51).

Local Partnerships created by TBAs with other NGOs and service providers such as Marie Stopes and Pathfinder to continually build their capacity, improve coordination and build synergy on reduction of maternal mortality. Local information systems should be put in place to record births and deaths at TBA centres as well as records of complicated deaths to identify entry points for future planning. This option is selected because TBAs are already positioned in rural communities hence minimize on training costs; they already have the trust of the people and especially women, TBAs are already equipped in conducting uncomplicated deliveries therefore they can upgrade and learn how to medically detect complicated deliveries so as to refer them to health centres in a timely manner which is the basis for the proposed ban in 2009.

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APPENDICES

Appendix I - Interview guide for rural mothers

1. What is a Traditional Birth Attendant?
2. Do you have Traditional Birth Attendants in your Sub-county?
3. Which services do they offer to rural mothers in your Sub-county?
4. How would you describe a good TBA according to your own understanding?
5. Which category (ies) of people mostly seeks the services of TBAs?
6. In reference to the category (ies) of people mentioned above, why do they prefer TBAs' services other than services from the modern health facilities?
7. Have you ever visited a TBA? If so, how did she/he help you?
8. How much did you pay for the services offered by the TBA?
9. What is your perception about Traditional Birth Attendants?
10. What kind of achievements have TBAs made in your Sub-county?
11. What kind of relationship do TBAs have with the formal health systems' workers?
12. How have the TBAs helped the rural mothers to attain a safe, healthy and happy delivery as a right in Uganda?
13. What are the risks associated with TBAs services?
14. What are your health rights as a mother in Uganda?

Thank you so much and be blessed!

Appendix II - Interview guide for Traditional Birth Attendants

1. What is a Traditional Birth Attendant?
2. What motivated/inspired you to become a TBA?
3. What are the indicators of a good TBA?

4. Which category (ies) of people mostly seeks your services?
5. How many clients do you help to deliver per month?
6. How much do you charge your clients?
7. What role have you played to ensure that rural mothers have attained a safe, healthy and happy delivery as their right in Uganda?
8. What kind of relationship do you have with the formal health system workers in Uganda?
Describe what it involves.
9. What challenges do you normally face in your work as a TBA?
10. What kind of facilitation do you think can help you improve the quality of services you offer to the rural mothers throughout the antenatal period?
11. What do you think are your rights as a Traditional Birth Attendant?

Thank you so much and be blessed!

Appendix III - Interview guide for Health workers

1. What is a Traditional Birth Attendant?
2. Do you have Traditional Birth Attendants operating from Mpigi District?
3. Which category (ies) of people in this area mostly seeks the TBAs services?
4. What kind of services do they offer?
5. Why do they prefer TBAs' services other than services provided by modern health facilities?
6. What is your contribution towards ensuring that rural mothers have attained a safe, healthy and happy delivery as their right in Uganda?
7. What challenges do you face in the modern health facilities and how best have they been addressed?
8. What do you think are your rights as health workers in Uganda?

9. How have the TBAs helped the rural mothers to attain the right to a safe, healthy and happy delivery?
10. What do you think are the challenges being faced by Traditional Birth Attendants in their work?
11. What do you think are the appropriate strategies that can be put in place to improve their services?
12. How is the relationship between the modern health workers and Traditional Birth Attendants like in Uganda? Describe it.
13. What are the risks associated with Traditional Birth Attendants' services and how best can they be improved?

Thank you so much for your responses and be blessed!

Appendix IV: FGD – TBAS

1. Who is a Traditional Birth Attendant?
2. How many years of experience do you have as a Traditional Birth Attendant?
3. How did you become a traditional birth attendant?
4. What forced you to become a TBA?
5. How many deliveries do you conduct per year?
6. What do you think are the reasons for your acceptance in the community?
7. How do mothers pay for the services you offer to them? Is it in kind, cash or they are free?
8. What are the types of services you normally provide to the mothers during pregnancy, delivery and post-partum?
9. What challenges do you encounter when delivering the above services mentioned?
10. What do you normally do when faced with complicated situations such as transverse presentation, breech presentation, retained placenta and haemorrhage?

11. What role have you played to ensure that rural mothers have attained a safe and healthy delivery as their right in Uganda?
12. What kind of relationship do you have with the formal health system workers in Uganda?
Explain in details.

Appendix V: FGD - Mothers

1. Who is a Traditional Birth Attendant?
2. Which services do Traditional Birth Attendants offer in your sub-county?
3. What reasons make mothers deliver from the traditional birth attendants?
4. What obstacles do you find in using formal health system services?
5. Which maternal health programmes are available in your community?
6. What is your perception about maternal and health care services provided by the health centres in your sub-county?
7. What is your perception about the services provided by the Traditional Birth Attendants?
8. What kind of relationship do TBAs have with the formal health system's workers?
9. How have the TBAs helped the rural mothers to attain a right to safe and healthy delivery?
10. What do you think are the risks associated with TBAs' services?