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Maternal Healthcare in Eastern Uganda: The Three Delays, Mothers Making Empowered Choices, and Combatting Maternal Mortality

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Eastern Uganda: Mbale District, Manafwa District and Kween District

"She's happy. She comes and she smiles with her beautiful baby girl. So, you touch people's lives and likewise their lives touch you sometimes. It's really nice being with people." – A Midwife

I want to dedicate this project to all mothers, as being a mother is the most difficult job around.

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Abstract

Maternal and child health has been noted as an international concern and issue. While access to maternal healthcare has improved in Uganda since 2000, maternal mortality rates have remained high in the country as of 2015. However, maternal and child healthcare are inherently important in promoting sustainable and positive development. For that reason, I have explored maternal healthcare in Uganda's Eastern region, specifically in Mbale Town and surrounding rural areas including Kween and Manafwa districts. Specifically I have looked at what factors influence women's decision to give birth in a health centre or hospital, versus at home. I have also looked at what factors are contributing to high maternal mortality rates and what can be done to combat this issue.

Throughout this study I have used a variety of qualitative ethnographic methods including participant observation, in-depth one-on-one interviews, as well as focus groups to explore why women choose to give birth in a health centre or hospital with a biomedical midwife, or with a Traditional Birth Attendant (TBA). Midwives are trained and their certification is nationally accepted while TBA's may have not received any professional training and are not necessarily recognized by the government. However, they play a highly important yet contested role in Uganda. Further I will look at what delays and boundaries are contributing to high maternal mortality rates and what interventions are being used and can be used by hospitals, health centres, TBAs and the government alike.

In maternal health care, scholars and organizations alike often talk about the three delays. The first delay refers to a lapse in making the decision to receive care. The second delay refers to that of being unable to reach a health facility while the third delay refers to that of not receiving high quality, appropriate care. Throughout this study, I found that each of these delays were present and took form in a variety of ways in Mbale Town and the surrounding rural districts. I also discovered that despite these delays being present, mothers felt empowered by making the decision to give birth where they wanted whether it was in a health facility, or at home with a TBA. I also discovered that most biomedical health workers were aware of these delays and the many challenges they faced, and had deeply considered ways in which they and others can reduce the rates of maternal mortality. Finally, maternal health care is inherently important when considering the development of Uganda. When looking to implement solutions to reduce the three delays and improve maternal healthcare, it is important to approach this not only in terms of human development but also economic growth.

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Introduction

In both the Millennium Development Goals (MDG) created in 2000, as well as the Sustainable Development Goals (SDG) in 2015, maternal and child health has been noted as an international issue and concern. Specifically noted in Goal 3 of the SDGs, by 2030 maternal mortality should be reduced to a ratio less than 70 per 100,000 lives births globally. That being said, while access to maternal and child health care has increased since 2000, according to WHO maternal mortality rates remain "high at 440 maternal deaths per 100,000 lives births" (WHO, 2015, p. 1) in Uganda as of 2015. Therefore, maternal and child health care are incredibly important in improving the livelihood and well being of all Ugandans in order to contribute to positive and sustainable development.

For that reason, the exploration of why women in Uganda choose to give birth at home or in a health centre or hospital, and their perception of what good quality maternal health care entails, is important in understanding why these rates are so high. It is also important to look at the specific boundaries or delays that are contributing to high maternal mortality rates, as well as what can be done to combat this issue. Specifically, this is important in the Eastern region of Uganda as according to the 2011 Demographic and Health Survey of Uganda, out of over 1300 births, 51.2% of women gave birth in a health centre. (The DHS Program, 2011) This is not an exceedingly high rate and means that about half of the women gave birth from home in this region. Finally, it is important to address what action plans can be put in place to reduce these rates and promote development of the nation.

Throughout this study I have used a variety of ethnographic methods including participant observation, in-depth one-on-one interviews, as well as focus groups to explore this issue. Each of these methods was important in gaining an understanding about this issue as a

holistic complicated problem. By using these methods I was able to talk to a diverse group of individuals, be on the ground integrated into the healthcare system and overall receive a great wealth of versatile information. However, working in health is challenging due to the inevitable possibility for emergency. Therefore, while interviews allowed me to receive the greatest amount of information, at times it was greatly limited. Therefore, had I restructured my methods and was able to access succinct data; I would have dedicated more time to narrative analysis of data from the hospital.

Background

More than half of Uganda's population is under the age of 15 and more than half of Uganda's population are women and girls. (UBOS, 2014, p.2) Without this large part of the population being healthy and alive, Uganda will not be able to progress and develop at the rate that it should. Therefore, access for all to good quality maternal healthcare is fundamental to Uganda's development. According to D. Kaye, lecturer at Makerere University, "Good quality maternal health services are those which among others, are readily accessible; are safe, effective, acceptable to potential users and are staffed by technically competent people; provide prompt comprehensive care and/or linkages to other reproductive health services; provide a continuity of care, and where staff are helpful, respectful and non-judgmental." (Kaye, 2000, p. 558) In Uganda specifically, women receive maternal health care in health centres of different levels and hospitals from biomedical midwives, as well as from TBAs inside homes. The internationally accepted definition of a midwife is "a person trained to provide care to women during pregnancy; trained to recognize problems, and whose training is recognized by the government that provides a license for him or her to practice." (Kaye, 2000, p. 558) TBA's however are

often taught via apprenticeship or have very minimal professional training and are not necessarily recognized by the government. Despite being contested, TBAs carry great weight throughout Uganda as "62% of women are delivering outside health facilities, without skilled care." (WHO, 2015, p. 2)

For that reason, throughout this six-week period of study, I have conducted comparative research between care provided by biomedical midwives in Mbale Regional Referral Hospital, Namatala Health Centre IV and Maluku Health Centre III in Mbale Town, as well as care provided by TBAs in the surrounding rural areas, specifically Kween District and Manafwa District. Mbale Regional Referral Hospital (MRRH) is one of 14 regional referral hospitals in Uganda and currently serves 14 districts. I have looked at why women choose to give birth with a biomedical midwife or a TBA. I have also looked at the specific factors that influence this choice, or lack of choice and how this contributes to maternal mortality rates in Uganda. All in all, the choice to receive good maternal healthcare is of utmost importance. This study addresses the problem of maternal mortality in Eastern Uganda and how biomedical midwives and TBAs and the government can combat this issue.

I have completed this research with biomedical midwives, TBAs and mothers in Mbale Town and the surrounding rural areas including Kween District and Manafwa between October 24th and November 26th. Mbale Town sits approximately 245 km from the capital city, Kampala and is home to just over 96,000 people. (UBOS, 2014, p. 12) It is one of the largest urban centres in Uganda. Manafwa District originally was apart of Mbale District and was made its' own district in 2005. Manafwa and Kween alike are primarily agricultural districts as farm produce is the backbone of their economy. I have completed

this research using a variety of qualitative methods. Using qualitative methods is important to truly understand and grasp the methods that are used by biomedical midwives and TBAs. Ethnographic methods have allowed me to be on the ground and integrated into the setting in which these women practice which has offered me a fuller picture. This has aided me in coming closer to reaching my objectives. It has been important that I interviewed both healthcare providers as well as mothers in order to understand the complexities of this issue from both points of view. I have aimed to make my information as versatile as possible by using a wide variety of key informants who are health professionals in different wards from different health centres and hospitals as well as interviewees from different socioeconomic classes, lifestyles and ages.

Justification

This study is important for a variety of reasons. As suggested maternal mortality rates are high in Uganda and this inevitably affects development of the country. Without healthy and live mothers and children, the country will not be able to progress at the level it should. Second, this study helps to understand why mothers choose to give birth from a hospital or health centre, or from home. In healthcare, and specifically maternal healthcare, scholars and organizations alike often talk about the three delays. The first delay exists at an individual level and consists of someone making the decision to go for care. The second delay happens when physically reaching the health facility while the third delay happens within the health facility and may limit the provision of appropriate care. While discussing a woman's ability to decide where she wants to give birth from, this addresses all of the factors that may contribute to delay one. When interviewing TBAs, midwives and mothers alike, I was able to gain greater insight into what factors are causing maternal mortality

rates as well as what is being done or can be done to reduce these rates. Ultimately, this study offers great insight into one of many ways Uganda may be able to further grow and progress as a country.

In regards to specifically choosing Eastern Uganda, I was remarkably able to find a wide variety of scholarly articles and organizations addressing this issue in other regions of the country. However, there was little information about this region and specifically this district. More specifically MRRH acts as the referral hospital for 14 districts in Eastern Uganda. This is a vast area and a large population to offer services to. This region also faces the challenge of having a large part of its' population living in mountainous territory leaving these individuals with a greater issue of inaccessibility.

All in all, the study of maternal health as a whole is very important when addressing development. As stated, only with healthy mothers and children alike can a society advance at the level in should.

Problem Statement

Access to quality maternal healthcare is of utmost importance to Uganda. As stated, healthy mothers and children are necessary to promote positive growth and development of the nation. However, this access is not always granted. There are three delays that are often spoke about in health care; 1.) Delay of choosing to go to health facility, 2.) Delay of actually getting to health facility and 3.) Delay of receiving quality maternal healthcare. Each of these delays has a vast number of factors and ultimately contributes to high maternal mortality rates. Therefore, understanding each of these delays is important in reducing maternal mortality rates, improving the health of mothers and children, and thus, contributing to positive development of Uganda.

Objectives

My objectives for this project have been to determine the following;

- Why women choose to give birth from a health centre or hospital or with a TBA,
- What delays or boundaries are contributing to maternal mortality and
- What interventions are currently being used or can be used to prevent maternal mortality

Literature Review

Throughout this study I read a variety of scholarly articles as well as reports offered via organizations regarding maternal healthcare in Sub-Saharan Africa as well as Uganda. More specifically I utilized a wide variety of sources offered by World Health Organization. The first article that I looked at is titled "Maternal and Child Health: Uganda". This report offers an overview of Uganda's slow progress in the improvement of maternal healthcare. Specifically it speaks about the main physical causes of maternal mortality and the rates of maternal mortality in the country. Women in urban Uganda give birth in health facilities at a much higher rate of 79% than women in rural areas at 36%. This is due to a variety of factors including education level, income level which contributes to access to antenatal care and family planning. This report also discusses the government's commitment to improving maternal and child health in Uganda. For example, the Safe Motherhood Program has implemented a variety of initiatives with the goal of improving maternal health care for women in Uganda. However, Uganda is still off track despite these commitments. As of 2011, Uganda was one of 10 countries contributing to the highest maternal, child and newborn mortality rates in the world. Despite these issues, the report

also addresses the important role that parliament can play in improving healthcare for women and children and ultimately improve development in the country.

Yet another article I looked at provided by WHO is titled "Applying the lessons of maternal mortality reduction to global emergency health". This is a policy article that argues that other emergency health issues contribute to greater mortality rates than maternal illnesses do as a whole. However, it also argues that the policies implemented to improve maternal healthcare have been effective and should be utilized in other areas of health. I mainly used this source for it's in depth description and analysis of the three-delay model. It claims that the recent decrease in maternal mortality has been due to the adoption and acceptance of the three-delay model. This refers to three critical time points including seeking care, reaching care and receiving care. Each of these delays occurs due to variety of factors. However, by combating these factors and thus the delays, maternal mortality rates have been and can continue to be reduced. The article also suggests that this model can be transferred and used in global emergency health as a whole. However, in order for this to be done, major infrastructural change and growth will have to occur and this may be difficult in low-resource areas like Uganda. However, by targeting the delays and particularly providing transport to limit delay two can make a huge difference.

I also used information from Safe Mothers, Safe Babies, an organization based in Iganga, Uganda that strives to reduce the three delays for mother and child survival. According to their website, 6,000 mothers die in Uganda each year due to pregnancy-related causes. This organization works throughout Eastern Uganda to combat the factors contributing to these delays including lack of knowledge, unhealthy traditional practices, extreme poverty and a

lack of continuing health education to empower women and men alike to make informed, positive choices regarding maternal and child healthcare.

I also utilized an article written by Makerere lecturer, D Kaye, "Quality of Midwifery Care in Soroti District: Uganda". This article is extremely pertinent in that it is addressing issues of maternal healthcare in a district that is very close to Mbale district. It also discusses care in one of the other referral hospitals in the region. Researchers interviewed and observed patients admitted to health facilities with complications, attendants of the patients, midwives providing care in the health facilities and pregnant women exiting from antenatal clinics. Therefore, the sample of individuals interviewed shared similar characteristics to interviewees in my study. Their findings indicated that many of the midwives were providing poor quality care for both antenatal and delivery care due to their inability to identify and manage women with or at risk of complications. The study found that due to understaffing, gaps in basic knowledge, inadequate on-the-job supervision and absence of standard management guidelines in the facilities led to the provision of poor quality care. Understaffing leads to overwork which reduces staff morale and motivation. Many of these themes were highly present throughout my study and therefore this article was very beneficial. However, I did not feel this study accurately represented the voice of the health workers. Despite the challenges that they face, the midwives that I interviewed were dedicated to doing their best work. They were aware of a lack of knowledge on their part at times and even wanted to attend trainings to better themselves. However, this was not financially possible if not provided by the hospital. Overall this article was beneficial in that it addressed challenges, but it did not address the needs or goals of the health workers specifically.

Finally I utilized statistics from the Uganda Bureau of Statistics and the Uganda Demographic and Health Survey to further grasp maternal mortality rates in the country as a whole, as well as the rate at which women give birth from home in Eastern Uganda specifically. This information set a solid base prior to beginning my research.

Methodology

Research Approach – Data Collection Methods

Throughout the study, I used ethnographic methods to explore this issue in Mbale Town and Kween and Manafwa Districts. I used participation observation, one-on-one interviews and focus groups with 10 midwives, 6 TBAs and 11 mothers. Specifically I interviewed 10 biomedical midwives as key informants in both in-depth one on one interviews as well as focus groups. I completed two focus groups with mothers, a one-one-one in-depth interview with one mother as well as in-depth one-on-one interviews with 6 TBAs. I selected these individuals using snowball sampling by allowing my existing study subjects to recruit future study subjects among people that they know. I also utilized a local Village Health Team member to help locate TBAs in the communities in this region.

	One-on-ones	**Focus groups**	**Survey**
TBA	6 women		
Mothers	1 woman	2 with 5 women	100 women
Biomedical midwives	7 women	1 with 3 women	

Table 1: Breakdown of Respondents

I used participation observation to document the space in which I was completing my research. Barbara Kawulich states that participant observation "is the process enabling researchers to learn about the activities of the people under study in the natural setting

through observing and participating in those activities." (Kawulich, 2005) Specifically I paid attention to body language and facial expressions of mothers, congestion and cleanliness of clinics as well as tone of voice used between health practitioners and their clients. This was important as it allowed me to grasp what the true relationship between practitioner and patient might be like. There are things that individuals may not express verbally but can be understood by paying attention to body language. I also wasn't always able to understand the conversations between practitioner and patient as they were in the local language, so paying attention to body language and facial expression also allowed me to further gain an idea of what was going on. I also observed space available and the overall morale of the staff. This has offered a more "holistic understanding" of the practices of the health providers I interviewed. Interviews and focus groups revealed a wealth of information that could not be obtained through surveys or participant observation. For that reason, I discussed directly with the women I obtained my information from. Finally I completed a survey throughout Mbale with 100 mothers addressing age, number of children, location of birth, and what rating women would give the care they have received throughout their pregnancy. This offered a wider sampling of some of these important factors. This number of surveys was easy to obtain over the course of six weeks and gave me a greater insight into a mother's choice as well as how mothers in Mbale Town feel about the healthcare system. I utilized a hired translator throughout my study; as I was not able communicate with all of the interviewees. **(**Questionnaires and Survey attached hereon as appendix 1A and 1B.)

Ethical Considerations

While completing my research it was very important that I take ethical issues into account. First of all, I worked with a vulnerable group of individuals. I worked in the health sector. Health is a sensitive, private topic that must be kept confidential. I also worked with mothers, many of whom were low income. Women, mothers and low-income individuals are all vulnerable groups of people as well. For these reasons, I aimed to be sensitive to these issues and I always treated the interviewees with care and respect. Moving forward, I will keep all of the information confidential and I will not use the names of the interviewees throughout my writing. I also made sure all of the individuals I interviewed sign a consent form prior to an interview or offered oral consent if they were not keen on signing the form. (Consent forms attached hereon as appendix 2) This form was translated verbally as needed throughout my study. I have and will maintain their privacy and confidentiality. I also made it known that all interviewees were allowed to withdraw if they chose to do so.

Limitations

Throughout my research, I encountered a variety of challenges and limitations. First and foremost, oftentimes there was an issue of translation. When I was using a translator, at times there was information missing. My translator would often summarize what the interviewees were saying rather than give word for word translations. I also observed that my questions may have not been translated exactly I would have liked. Therefore, I will not say that the translations offer direct thoughts or observations of the interviewees and may only offer part of the picture. Another challenge that I faced was simply getting some individuals to be responsive to the study. While many of the interviewees were more than happy to sit down and talk with me, there were a few who did not give the study priority.

Working in health, this is inherent as most of the health workers had more important priorities to attend to. However, this sometimes limited the time I was able to spend with a health worker and even limited me from interviewing some health workers at all. The head of the maternity department at Mbale Regional Referral Hospital would not agree to talk with me at any point during the study. It was also difficult to simply locate TBAs. Very few people within Mbale Town knew where they could be found. Had I not been in contact with the Village Health Team member, I would have had very little success in finding TBAs.

Finally, I also realize that six weeks is not enough time to address all issues or complete a full study. For that reason, I recognize that all findings and claims that I make in my writing are only formed based on a limited sample. I also felt that it took me a while as a researcher to build rapport with the health centres I was working with and it wasn't really until my last week and a half that I was fully connected with many of the individuals that were important to speak to. That being said, I also wasn't fully aware of or integrated within the system of the main hospital until this time. Had I had more time, I would have continued to redesign some question and spend time with some different people.

I was unable to access succinct data regarding maternal mortality in MRRH due to the inability to communicate with the head of department. However, if I could complete this study again, I would have made this a greater priority. I also realized throughout the study the great importance that intern doctors, students, and volunteers play within the healthcare system as a whole and specifically within maternal healthcare. If I were to redesign my study I would also include these individuals in the study. I also learned that the rates of

cesarean sections are particularly high in MRRH. Once again if I was continuing this study, I would have studied the reason for this further.

However, despite these challenges and lessons learned, I was able to obtain a great wealth of information regarding my objective questions over this short amount of time. Overall, the methods that I used were successful in gathering the information I needed.

Data Analysis Methods

I completed my data analysis using a variety of methods. Due to the fact that most of the data I collected is qualitative; this contributed to the analysis methods that I used. Throughout my data collection, I recorded interviews when the participants gave me permission. After recording each interview I would transcribe the interview word by word. This is a time consuming process but it is important to transcribe accurately as taking notes from a recording allows for pre-analysis. After transcribing I utilized my objective questions to organize the data I collected. I grouped the data based on key words such as "counseling", "male involvement", or "love and comfort" and similarities and differences amongst responses. These types of words helped me to narrow down the reasons why mothers chose to give birth at a specific location. Using these key words I was able to locate specific responses to my objective questions in interviews, observations in meetings and text throughout the health centres or hospitals. I created a detailed list of all of the possible answers to each of my objective questions and then tallied the amount of times one of my respondents offered that response. This allowed me to grasp what issues of maternal health were most important in the eyes of the interviewees and the healthcare system as whole. As I began to analyze my data in this way, I came to the understanding

that all of the factors causing maternal mortality discussed by respondents fell under one of the three delays that will be addressed in my analysis.

Discussion and Analysis

Maternal Healthcare and Development

As suggested throughout this report, maternal health is a very important topic when considering development. In fact, maternal health has been recognized as an international concern in the world of development. In order to understand what causes maternal mortality in Uganda and when coming up with solutions to improving maternal healthcare, it is important to consider the development paradigms that may be in place when others are examining maternal health and when solutions are implemented. A paradigm is a framework of mind that makes individuals perceive and value development in different ways. For example, the neo-liberal development paradigm that was designed in the 1980's prioritizes growth in income wealth and is measured by GDP. In the contrary, the human-development paradigm prioritizes human capabilities, empowerment, and security by increasing life expectancy and improving education, health, literacy, quality of life, etc.… Each of these paradigms offer a different perspective on what is important when it comes to developing a nation. However, when it comes to improving maternal health, both paradigms are important.

Maternal health is clearly an issue of human development. Poor maternal healthcare can lead to maternal mortality, which undoubtedly reduces life expectancy. The ability to choose where one wants to give birth can lead to empowerment as depicted by the mothers I interviewed throughout this study. Having access to experienced and trained health workers can greatly increase one's feeling of safety and security. All in all, maternal health

is about human life so each of these factors can contribute to the development and growth, or lack there of, of Uganda.

Finding solutions to improving maternal healthcare also must consider the neo-liberal development paradigm. Provision of poor care usually occurs to a variety of factors and more often than not these are inevitably due to a lack of funding. Low staff numbers contribute to diminished motivation, which lead to many of the other factors including; poor monitoring of mothers, low supervision of students, doctors on call not answering phones, or an overall lack of responsiveness from other wards. Many staffs interviewed suggested that motivation was suffering due to low pay, a lack of accommodation and transport. However, in order to improve these issues an increase in funding would need to occur. A greater amount of wealth would need to be distributed in order to improve staff motivation. Therefore, it is impossible to ignore that wealth, income and overall GDP do not play a role in finding solutions to improve maternal healthcare and thus increase development.

Maternal healthcare is inherently important in promoting sustainable growth and development in Uganda. As WHO suggests in its report on maternal and child health in Uganda, "Spending on women's and children's health is an investment, not just a cost, contributing to the well-being of families and communities, and to a nation's socio-economic development." (WHO, 2015, p.4)

The Three Delays

In order to utilize funding in the right ways, an understanding of what is causing mothers to or not to give birth in a health facility and why or why not good care is being offered is necessary. In healthcare, and specifically maternal healthcare, scholars and organizations alike often talk about the three delays. Safe Mothers, Safe Babies defines these delays as the following; "First Delay: A delay is recognizing the need to seek care or making the decision to seek care. Second Delay: A delay in reaching the health facility. Third Delay: A delay in receiving appropriate, high quality health care once in the health facility." (Safe Mothers, Safe Babies) The diagram below, provided by Safe Mothers, Safe Babies, depicts these three delays.

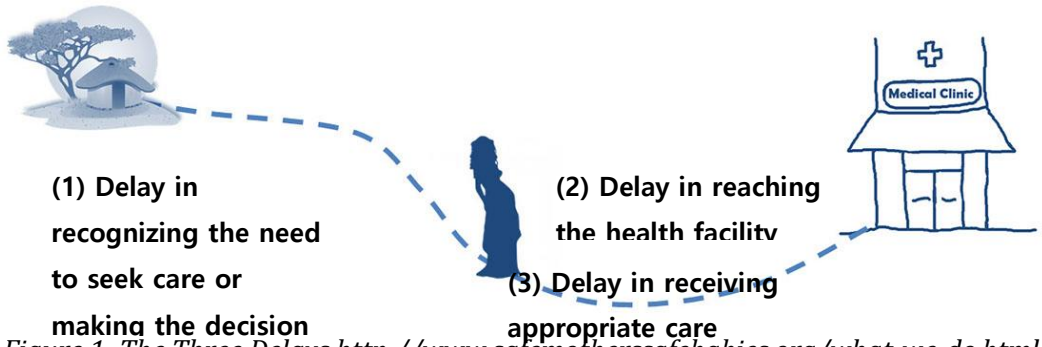

Figure 1: The Three Delays http://www.safemotherssafebabies.org/what-we-do.html

These delays have been accepted on an international level and as WHO says, this three-delay model illustrates that "maternal mortality is not due solely to a lack of economic and human resources but is a product of numerous interwoven factors." (Calvello, 2015) While there are a small number of physical conditions that actually cause maternal mortality, there are critical time points, represented by the three delays that could very well prevent the progression of these dangerous conditions. WHO notes the three critical time points as "seeking care", "reaching care" and "receiving appropriate care." During labor, both the ability to choose where to give birth as well as the ability to recognize an emergency on

part of the mothers and health workers are important when seeking care. The inability to do either can be devastating. When it comes to reaching care, identifying and reaching a health facility are of utmost importance. This stresses the importance of planning. Meaning one must know where the health facility is located, must have transport in place, and must set aside money to cover the transport at the time of an emergency during labor. However, bad roads, distance and general infrastructure also affect this delay greatly. Finally, in regards to receiving appropriate care, this delay focuses on the provision of appropriate care. There are many factors that influence this delay including the presence and motivation of staff, the general knowledge base of health care providers as well as communication between wards and the resources that are available. The recognition of each of these time points is critical in understanding why maternal mortality rates are high and even more importantly, in reducing them.

In Eastern Uganda, specifically in Mbale, Kween and Manafwa districts, each of these delays were present, contributing to maternal mortality in the region. In regards to delay one, the first important factor was recognizing that maternal mortality is an issue in Eastern Uganda and the country as a whole. However, most TBAs and some mothers interviewed in this study do not believe that maternal mortality is an issue. Out of 27 individuals interviewed, 10 did not see maternal mortality as a problem in their communities or at large. That being said, all biomedical health workers, one TBA, and just over half of the mothers interviewed do see maternal mortality as an issue even if they have not experienced it directly. As shown in Figure 2 below, when asked if they perceived maternal mortality to be an issue, 73% said yes, it is an issue, while 27% did not. Without possessing

the knowledge that maternal mortality is indeed an issue in their country, making an informed choice regarding where to give birth or how to tend to mothers is difficult.

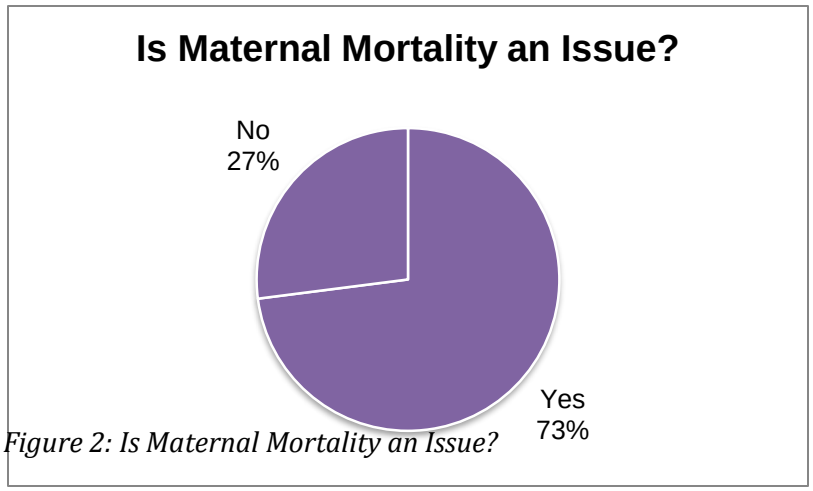

Figure 2: Is Maternal Mortality an Issue?

Other factors that were addressed by my interviewees in regards to delay one mostly had to do with a lack of knowledge or an attitudinal intention. Many interviewees claimed that mothers simply had the attitude that they "couldn't deliver in the hospital". This was due to a variety of factors including the fear of knowing their HIV status, the fear of operation, the fear of health workers being unkind or asking for money, the fear of congestion at the hospital and an overall community influence. The lack of knowledge also stemmed from a lack of antenatal care and sensitization about the importance of giving birth in a health facility. However, the biggest issue noted within delay one was referral delays due to these mindsets. Many health workers and mothers alike addressed the issue that when mothers are referred to a health centre or hospital, they refuse to go. Sometimes this is a personal decision and sometimes partners or relatives influence this. When the decision is finally made that a mother wants to go to a health facility, it is often too late. This also suggests the inability to recognize an emergency, which contributes to these delays. Interviewees

also suggested that the lack of support from a partner and the use of local herbs contribute to maternal mortality rates. The use of local herbs may also be due to a lack of knowledge but none the less contributes to delay one as women are making the choice to depend on these home remedies rather than going to a health facility. Figure 3, shown below, depicts the factors contributing to delay one and the frequency at which respondents mentioned those factors.

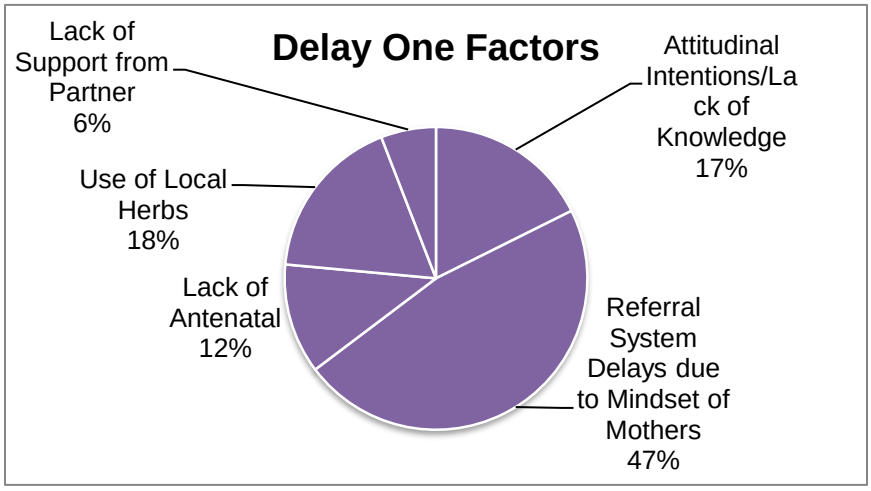

Figure 3: Delay One Factors

For example, out of all factors mentioned causing delay one, referral system delays due to mindset of the mother were mentioned the most at 47%. Lack of support from partner however was mentioned the least only accounting for 6% of given answers. That being said, each of these factors happen before a mother even leaves her home and contributes to the overall ability to make an informed choice to go to a health facility to give birth. This therefore contributes to maternal mortality rates.

In order to understand each of these factors in terms of development we must apply the development paradigms discussed above. As suggested human development discusses increasing human capability and empowerment by improving health. If maternal health

was improved and knowledge was dispersed so that women felt safe in getting to know their HIV status, or that they would only receive an operation if it were truly necessary, this would change the mindsets and attitudes of mothers. As noted, human development is about feeling secure and being able to make empowered decisions based off of knowledge. Therefore, delay one could be reduced by implementing solutions based on the human development theory.

As suggested, delay two refers to the ability to reach a health facility after the decision to go has been made. Throughout this study four factors within this delay were mentioned – distance, lack of transport, cost of transport and the presence of bad roads. Each of these factors limit women from reaching a health facility and encourage mothers to give birth from home. These factors can also cause mothers to deliver on the way to the health facility leaving them with little to no care, which can greatly contribute, to maternal mortality rates. This delay is inevitably one that must be viewed in terms of the neo-liberal paradigm of development. In order to improve infrastructure, economic growth is needed. In order to implement transport at all levels of the healthcare system, money is needed. That being said, without economic growth as suggested by the neo-liberal paradigm, this delay cannot be reduced. Figure 4, shown on the next page, depicts the factors contributing to delay two and the frequency at which respondents mentioned those factors.

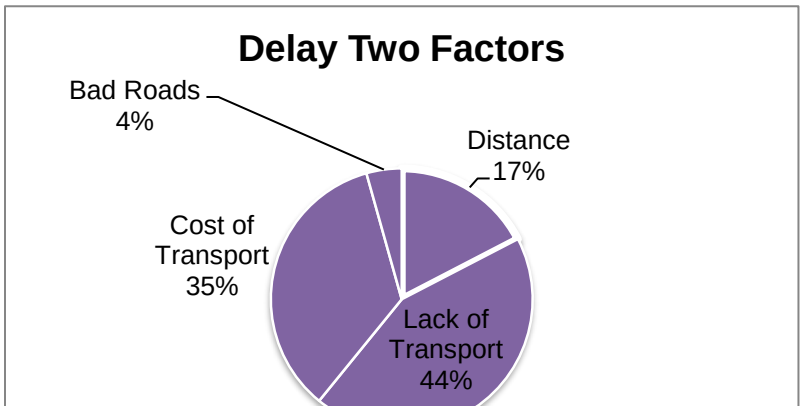

Figure 4: Delay Two Factors

While each of these factors are intertwined, it is important to note that the lack of and cost of transport held the greatest value for all interviewees as they were mentioned the most. As noted, Mbale Regional Referral Hospital serves 14 districts throughout Eastern Uganda. Therefore, some individuals who may be referred to this hospital are very far away. For example, if a mother is referred from Manafwa district to the referral hospital she must board a boda-boda for over an hour and pay approximately 10,000 UGX. This is inaccessible to most mothers in the area considering that many cannot afford 2,000 UGX to reach the nearest health centre that is 3-5 km away. That being said, if a mother is in labor at night, there may not be a single boda available, and taxis or other vehicles are far scarcer. A car cannot even access most homes in the mountainous village. This is another factor where the neo-liberal and human development paradigms are important. Economic empowerment is necessary to reduce this delay in that women must be able to access health facilities at ease when needed. Therefore, women must feel empowered and safe and secure in their economic status. They must be able to gain wealth for themselves without simply handing it over to their husbands and thus depending on them. This also calls for an overall increase in country wealth in the hopes of trickling down and benefiting each citizen. Delay two is ever present in Eastern Uganda.

Finally, when discussing delay three – receiving appropriate care – there are many factors that influence this delay as well. The most important factor that must be noted that was discussed by nearly all interviewees was that of lack of human resources and motivation of health workers. As shown in Figure 5 on the next page, lack of human resources and motivation accounted for 42% of all answers given within delay three. When mothers reach a health facility one of the biggest issues they will face is the presence of staff and the low motivation of those staff. Each midwife interviewed indicated that this was an issue. This contributes to a variety of other factors that affect the provision of appropriate care including; lack of accountability, doctors on call not answering their phones, mothers not being properly monitored and vitals not being checked or documented, poor record keeping, lack of responsiveness from other wards and low supervision of students. Each of these factors was present in all health facilities and ultimately contributes to poor provision of services and maternal mortality Other factors that diminish the ability to offer appropriate and good care include a small knowledge gap amongst health workers leading to unknown causes of death and wrong drugs administered, as well as a lack of resources including water, oxygen, electricity, blood, gloves, drugs and mama kits. Overall a lack of funding, appropriate training and low staff motivation contribute to delay three. . In order to improve these issues, the human development and neo-liberal paradigm must both be applied. Funding is necessary to increase human resources and offer greater pay to the staffs as well as provide more resources. Staff must also feel empowered with enough knowledge to provide good care to their patients. All in all, this delay also contributes to rates of maternal mortality. As suggested, Figure 5, shown below, depicts the factors contributing to delay three and the frequency at which respondents mentioned those factors.

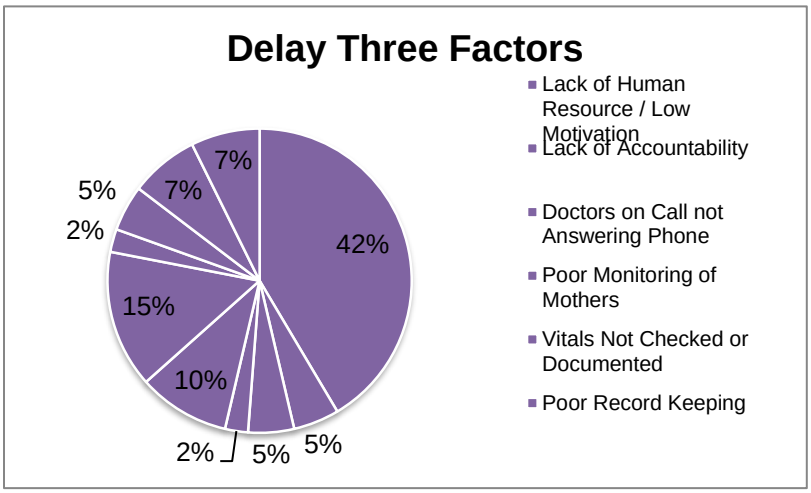

Figure 5: Delay Three Factors

When looking to develop Uganda, all of the factors causing each of these delays must be taken into account. Human development and economic growth alike are important in improving maternal healthcare and thus promoting positive and sustainable growth.

Making Empowered Decisions Despite Delays

Each of these delays greatly affects the ability that a mother has to make a choice about where she wants to give birth from. Despite each of these delays being present, the vast majority of the women that I spoke with through interviews as well as surveys were determined to and felt empowered to give birth from a health centre or hospital. Exploring the reasons why this is the case is just as important as exploring why women give birth from home with a TBA and these reasons were greatly contrasted. When speaking with mothers who wanted to give birth from a health centre or hospital, there was a resounding opinion that the hospital offered technically trained people with expertise who contributed to safety and security that if there was a problem, they would be okay. For these mothers, delay one was not present in that they had made the decision to deliver from a health centre or hospital. However, delay two and three were still present for most of the mothers.

Despite these delays, mothers were determined to overcome them in order to feel safe and secure. The belief that they would not die if they attended antenatal, received health education and ultimately delivered in the hospital under the care of bio medically trained midwives held greater importance than any delay. Each mother claimed that they made the decision by themselves for themselves suggesting a presence of empowerment in this decision. While mothers said they felt they would be safe in the hospital due to the expertise of health workers, they rarely spoke about positive relationships, love or great care. Midwives alike admitted that they faced many challenges in their practice and often felt tired and unmotivated due to understaffing and a lack of resources. However, they also all agreed that despite the challenges, they strived to offer the best care they could and worked to save the lives of mothers and babies, and the mothers they cared for recognized this. At the end of the day, mothers felt that delivering at the hospital was often "what they could do" to keep themselves and their baby safe and more importantly, alive.

Overall these mothers also had the perspective that mothers who give birth from home are uneducated, poor, and greatly influenced by either TBAs or other community members. One midwife even claimed that "TBAs confuse mothers" and that is why they give birth form home. However, when speaking with the few mothers who chose to give birth at home with a TBA, they also felt deeply empowered by their choice. They each claimed they also made the decision for themselves by themselves. While they suggested briefly that the cost of transport contributes to their decision, in great contrast to those who chose the hospital, they spoke of exceptional care, great experience, love, comfort and feeling like a priority. They felt that the presence of delay 3 – lack of staff motivation – was the most important. They often spoke of health workers being unkind and too busy for you. Therefore despite

that the TBA who tended to them did not have any formal education; the "emirembe" – comfort, and "okwagala" – love that they feel overrides the expertise present in health centres and hospitals. All in all while the three delays are inherently present and contribute to the quality of maternal healthcare one receives, most of the mothers that I spoke with felt that they were truly making the best decision for themselves and their baby.

What next?

So, how can maternal health care be improved in Uganda in order to promote sustainable development? Throughout this study the interviewees involved provided insight into what they thought would be the best ways to improve maternal healthcare and reduce maternal mortality rates in the Eastern region of Uganda as well as the country as a whole. The first and most prominent solution addressed by interviewees was the need for sensitization of mothers and outreach to communities. This solution would ultimately improve delay one; making an informed choice to deliver at a health facility. Most midwives felt that this was highly necessary to reduce maternal mortality rates. By conducting outreach, more mothers would deliver from the hospital or health centre allowing them to access health workers with expertise in their practice. The midwives interviewed also suggested that increasing early screening for at risk mothers through this outreach would reduce rates as well. At risk mothers include those with previous scars, those with multiple pregnancies, those who are suffering from other illnesses and those positive with HIV. By reaching out to these mothers, health workers are able to solve problems before they arise. Even most of the TBAs interviewed agreed that health workers should tend to at risk mothers and that they do not possess the ability to. Therefore sensitization of mothers – particularly at risk mothers – and the implementation of outreach to provide services in distant communities

are necessary to reduce maternal mortality rates. This solution is one of human development in that it is primarily based upon improving human capability by equipping them with the knowledge to make empowered, informed decisions. It is also one of economic growth in that community outreach inherently requires funding which is currently absent in the health facilities.

The second solution suggested was providing each and every health centre with means of transport. While many health centres have ambulances, they are not necessarily functional. Implementing functional transportation in health centres and at the village level alike would greatly improve delay two – ability to reach a health facility. That being said, an overall improvement of infrastructure would be necessary to reach particular areas in Manafwa District and other parts of Uganda. This solution is primarily one of the neo-liberal paradigm. In order to provide this solution, funding is necessary.

Finally, another solution that has already been addressed has to do with increasing staff motivation. Many maternal deaths are caused by a lack of responsiveness due to low numbers of staff being overworked. This can be done by increasing pay, offering transportation and accommodation, offering promotions and frequent free trainings to increase knowledge base, as well as hiring more staff. Each of these solutions is likely to improve quality of maternal healthcare and reduce maternal mortality rates overtime. These solutions will also lead to others that were mentioned including a greater supervision of students, improved record keeping and better attentiveness to mothers. One midwife interviewed also suggested that the government implement a plan in order to train promising students from rural districts to be health workers in their areas. This would allow each village to have a trained professional who could attend to mothers. Each of these

solutions must be viewed in terms of human development as well as economic growth. In order to introduce most of these plans, funding is necessary. However, the end goal is guided by the overall improvement of health and thus increased human capability, increased life expectancy and empowerment for all individuals involved. The implementation of these action plans would greatly reduce delay three – receiving appropriate care.

All in all, each of these solutions could be effective. However, it is also important that the presence of TBAs not be ignored. TBAs will inevitably practice as long as mothers still prefer them and communities in Uganda do not have easy access to health facilities. For that reason, TBAs cannot be ignored. A ban was placed on TBAs in Uganda in 2009. However, this ban was not greatly enforced and TBAs still practiced in hiding. At this time health workers were not aware of their presence, and TBAs were not able to receive any professional training. Since 2009 this ban has been lifted. However, some TBAs are still frightened to make themselves known. Ultimately, if TBAs stay hidden and unknown and are never encouraged to partake in professional training, the rates of maternal mortality are unlikely to be reduced greatly. All in all, it is important to recognize TBAs and utilize them to sensitize and mobilize mothers to go to the health centres when it is necessary.

Conclusions

All in all improved maternal and child healthcare are fundamental to promoting sustainable and positive growth and development in Uganda. Access to quality maternal healthcare highly depends on combatting factors that contribute to the three delays; the delay to seek healthcare, the delay to reach healthcare, and the delay to receive healthcare. In order to diminish these delays we must approach this issue with a human development view as well

as a neo-liberal view. More than anything, maternal healthcare must be about women's lives. Women must feel empowered to make a decision regarding where they want to give birth. They must feel safe and secure in this decision. However, in order to achieve this it is impossible to ignore the fact that economic growth is also important. In order to provide good quality maternal healthcare, staff must be motivated. In order to motivate staff they must have a full working team that can all be paid. Resources including machines and drugs must be available. Transportation must be available. All of these necessities require funding. Therefore, while maternal healthcare is first and foremost an issue of human development, economic growth is inevitably important in raising maternal healthcare to the standard it should be. Mothers and children alike must be alive and well to promote healthy growth and development and without access to high quality maternal healthcare, this cannot be done.

Recommendations

As suggested earlier, the individuals interviewed throughout this process are aware of the issues within maternal healthcare and have made a variety of excellent recommendations as to how it can be improved. First and foremost, women must feel empowered to make an informed choice to give birth where they want. This not only involves sensitization and education of women, but also educating the men involved in these women's lives. Empowering women involves not only providing them with the tools to make an informed choice by offering health education, but it also includes economic empowerment by generating income. Men are also inevitably part of the solution. In Uganda's patriarchal society men often are involved in making the decision where a woman may or may not receive healthcare. In many areas, men take control of economic resources. For that reason

it is just as important to educate and sensitize men about issues of maternal health including family planning, care during pregnancy and newborn care.

Second, an implementation of functioning transport in all health facilities throughout Uganda is of utmost importance. As of now, the referral system often fails due to this exact issue. Mothers often cannot reach the care they need due to a lack of transport or an exorbitant cost for transport. Providing functioning emergency transportation in health facilities and communities alike can combat this.

Finally, training and motivation of health workers and TBAs alike can contribute to improving maternal healthcare. Motivation of health workers is perhaps one of the most important solutions. Low motivation leads to poor provision of services, verbal abuse in health facilities, and a lack of accountability. Improving motivation can be done in a variety of ways. While increasing salaries may be difficult, providing more staff as well as trainings every quarter can greatly increase motivation. Providing accommodation for all staff would also increase motivation. Finally, further training TBAs and utilizing them to sensitize and mobilize mothers is also important in reducing delay three.

Most of these recommendations have been done elsewhere in Uganda or can be done through community funding. Education and thus empowerment of communities to know that they can make a difference in their lives can be very effective. All in all, I recommend that each of these recommendations be community based.

Appendices

Appendix 1A: Data Collection Tools: One-on-one Interview, Focus Group

Below I have provided questionnaires and a survey that I used throughout this study. However, these were simply used as a guideline. While I utilized most of the questions

here, the order changed when interviewing respondents. I also asked some questions not listed when I found that they were important to address or did not ask some questions when they did not apply to the situation.

Questionnaire 1: In-depth interviews with TBAs

1. What do you do in this community? Why is it important to you?
2. Why do people go to the health centre? Why do women chose to come to you for services?
3. How do you come in contact with your clients?
4. How long do you see them? Prenatal, natal and postnatal? What does this care entail?
5. How often do you see a woman? How does this frequency change as birth approaches?
6. How many women do you see per week? Per month? Per year?
7. How many births do you actually assist per week? Per month? Per year?
8. Do you have a good relationship with the health centre? Do you advise people to go to the health centre? Why or why not?
9. What are challenges that you face in your practice?
10. Are women taking advantage of multiple health care systems? What role do you play in this system?
11. How do people get to your home for services? How do women get to the health centre if they go?
12. How did you learn to be a TBA? Why did you decide to become a TBA?
13. Did you receive any biomedical training?
14. How long have you been a TBA? Does this impact how you interact with clients?
15. Is maternal and infant mortality a problem in this community? Why?
16. Have you ever experienced a death in your practice?
17. How do you work to reduce maternal mortality rates?
18. What do you do if there's an emergency?
19. What do you charge for your services? The health centre?

20. What herbal remedies do you provide? Why do you use those remedies? What are they called? What instructions do you give women to use the remedies? Do they treat particular symptoms?

Questionnaire 2: Key informant interviews with biomedical midwives

1. What do you do in this health centre? Why is it important to you?
2. Why do women choose to come to the health centre? Why do women choose to go to a TBA for care?
3. How do you come in contact with your clients? Do you educate clients outside of the health centre?
4. How long do you see them? Prenatal, natal and postnatal? What does this care entail?
5. How often do you see a woman? How does this frequency change as birth approaches?
6. How many women do you see per week? Per month? Per year?
7. How many births do you actually assist with per week? Per month? Per year?
8. Do you have a good relationship with TBAs in the surrounding communities? Do you think they are important in the community? What challenges do you face relating specifically to TBAs?
9. What challenges do you face more generally in your practice?
10. Are women taking advantage of multiple healthcare systems? What is your role in this system?
11. How do women get to the health centre?
12. Why did you decide to become a midwife? What training did you receive?
13. How long have you been a midwife? Does this effect your practice or interaction with clients in anyway?
14. Do you ever have challenges with language and communication in the health centre?
15. Is maternal and infant mortality a problem in your community? Why?
16. Have you ever experienced a death in your practice?
17. How do you work to reduce maternal mortality rates?

18. What steps are taken if there is an emergency? Do you ever receive women who are already in an emergency state? What do you in this case?
19. Who is held accountable when you experience emergencies or deaths? How does this affect the health centre?
20. What medications or remedies do you provide or recommend throughout each stage of care? Why do you use these medicines or remedies? What symptoms do they treat? What instructions do you give the women to use these medicines or remedies?

Questionnaire 3: In-depth interviews with mothers

1. How many children do you have?
2. Where did you give birth from? From home? From the health centre? Why not from the other location?
3. Who influenced your decision to give birth in that location? What influenced your decision to give birth in that location?
4. Who was present when you gave birth? Did you feel confident in them? Was your husband (boyfriend) involved? If so, in what capacity?
5. Did you receive care before or after birth? What kind of care and who from? What did this entail? Was your husband (boyfriend) present during this care? Who influenced you to receive this care?
6. Do you perceive maternal mortality to be an issue in your community? Why or why not?
7. What was your birthing experience like?
8. Why do you think women go or don't go to the health centre?
9. How did you get to the location where you gave birth? Did this cost money? Was that an issue? What did you pay for the birthing process?
10. Do you have confidence in the health care system? Why or why not?
11. What medications or herbal remedies did you use throughout your pregnancy? Why did you use these medicines or remedies? What symptoms did they treat? Were they helpful?

Questionnaire 4: Focus group interviews with mothers

1. How many children do you have?

2. Where did you give birth from? From home? From the health centre? Why not from the other location?
3. Who influenced your decision to give birth in that location? What influenced your decision to give birth in that location?
4. Who was present when you gave birth? Did you feel confident in them? Was your husband (boyfriend) involved? If so, in what capacity?
5. Did you receive care before or after birth? What kind of care and who from? What did this entail? Was your husband (boyfriend) present during this care? Who influenced you to receive this care?
6. Do you perceive maternal mortality to be an issue in your community? Why or why not?
7. What was your birthing experience like?
8. How did you get to the location where you gave birth? Did this cost money? Was that an issue? What did you pay for the birthing process?
9. Do you have confidence in the health care system? Why or why not?
10. What medications or herbal remedies did you use throughout your pregnancy? Why did you use these medicines or remedies? What symptoms did they treat? Were they helpful?

Appendix 1B: Data Collection Tools: Survey

1. How old are you? _____
2. How many children do you have? _____
3. Where did you choose to give birth and why?

   _____

   _____

   _____

4. On a scale of 1 to 5, rate how confident you are in the nearest health centre.
   1 2 3 4 5

Appendix 2: Consent Forms

INDEPENDENT STUDY PROJECT TOPIC: Maternal Healthcare
STUDENT NAME: Emma Gier
Thank you for taking the time to participate in this project.
My name is Emma Gier and I am a student with SIT Study Abroad Development Studies program. I would like to invite you to participate in a study I am conducting. However, before you agree to participate in this study, it is important you know enough about it to make an informed decision. If you have any questions, at any time, please ask me. You should be satisfied with the answers before you agree to be in the study.

Brief description of the purpose of this study

The purpose of this study is to learn about why women in Uganda choose to give birth with a TBA or a biomedical midwife and how this decision contributes to maternal mortality rates in Uganda. I will also be looking at what interventions you are using to prevent maternal mortality.
Your participation will consist of taking part in an interview with me and will require approximately 1-2 hours of your time.

If you see foreseeable risks in participating in this study there will be no penalties should you choose not to participate; participation is voluntary. During the interview you have the right to not answer any questions or discontinue participation at any time.

Rights Notice

This study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop participation. Please take some time to carefully read the statements provided below.

1. *Privacy* - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.
2. *Confidentiality* - all confidential information will be protected.
3. *Withdraw* – you are free to withdraw your participation in the project at any time and may refuse to respond to any part of the research. Participants who desire to withdraw shall be allowed to do so promptly and without prejudice to their interests 1

If you have any questions about your rights as a participant, you may visit the World Learning website and check its policies on Human Subjects Research at www.sit.edu or contact the Academic Director at +256 779 518 549.

If you have any questions or want to get more information about this study, please contact me at phone: _____ or email at: _____.

Please sign below if you agree to participate in this research study and acknowledge that you are 18 years of age or older.

Participants signature _____ Date_____

Researcher's signature _____ Date_____

INDEPENDENT STUDY PROJECT TOPIC: Maternal Healthcare

STUDENT NAME: Emma Gier

Thank you for taking the time to participate in this project.

My name is Emma Gier and I am a student with SIT Study Abroad Development Studies program. I would like to invite you to participate in a study I am conducting. However, before you agree to participate in this study, it is important you know enough about it to make an informed decision. If you have any questions, at any time, please ask me. You should be satisfied with the answers before you agree to be in the study.

Brief description of the purpose of this study

The purpose of this study is to learn you as a mother and woman Uganda, chose to give birth with a TBA or a biomedical midwife. Maternal mortality rates are still high in Uganda so I am looking at why this is occurring and what interventions are being used to reduce these rates.

Your participation will consist of taking part in an interview with me and will require approximately 1-2 hours of your time.

If you see foreseeable risks in participating in this study there will be no penalties should you choose not to participate; participation is voluntary. During the interview you have the right to not answer any questions or discontinue participation at any time.

Rights Notice

This study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop participation. Please take some time to carefully read the statements provided below.

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If you have any questions or want to get more information about this study, please contact me at phone: _____ or email at: _____.

Please sign below if you agree to participate in this research study and acknowledge that you are 18 years of age or older.

Participants signature _____ Date_____

Researcher's signature _____ Date_____

Glossary

Midwife: a person trained to assist someone in childbirth

TBA (Traditional Birth Attendant): pregnancy and childbirth care provider whom is not necessarily formally trained and often not recognized by the government

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