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Documenting the Roles and Collaborations of Maternal Health Care Options in Northern Uganda via Personnel Transcript Analysis

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Abstract

Health care is a constantly evolving aspect of a country's culture. Being no different, Uganda's health care has been shaped by the plurality of health care choices present in a community at any given point in history. The health-seeking behaviors displayed by Ugandans is dependent upon the public's perceptions and opinions of these available choices. This research focuses on themes found through the methodological transcription of interviews of northern Ugandan traditional birth attendants (TBA) and midwives, detailing their experiences working in maternal and early childhood care. These interviews serve as documentation of health care personnel accounts, which may be used to understand the population's shifting health-seeking behaviors. Furthermore, the themes drawn from these interviews reflect the patient population's shifting opinions as well as the timeline of the popularization of the Dr. Ambrosoli Memorial Hospital in Kalongo, northern Uganda. These themes drawn from TBA and midwife experience also introduce a potential course of symbiotic existence between traditional and western medicine, the relationship of which is shown to have great impact on the care provided to a population.

Keywords: Health Education, Health Care, Uganda, Acholi, Midwives, Midwifery, Traditional Medicine, Traditional Birth Attendant (TBA)

Introduction

Kalongo

Kalongo, Uganda serves as the setting for this research. Both the Dr. Ambrosoli Memorial Hospital of Kalongo and the St. Mary's Midwifery School are based in Kalongo (Minority Rights Group International, 2018). The hospital specifically lies in Kalongo Town Council within Agago County. It is the only General Hospital within the Agago district, making it the epicenter of patient-hospital needs for the surrounding catchment area of Kalongo Town Council, which reaches to 11,077 persons, as well as the rest of the district, the population of which is 230,908 persons (Annual Report, 2017). That being said, travel to and from the hospital can be difficult for patients especially when one considers the country's relatively poor road system and the likelihood that many families possess little to no means of traveling. To do so can be very expensive, a notable disadvantage for the 35.2% of the Agago district population living in impoverished conditions and the 87% of people living rurally (Andrea et al., 2019). The majority of the Dr. Ambrosoli Memorial Hospital patient population is made up by the Acholi, a sub-group of the Nilotic ethnic group found in Northern Uganda. This research focuses on the health care behaviors of this patient population from around 1960 to present as this is when the interviewed personnel primarily trained and worked in the field of maternal and early childhood care. Today, the public uses a mixture of biomedicine in the form of hospitals and midwifery, as well as traditional medicine. Beliefs surrounding birth are rooted in the patriarchal structure of the group and the cultural significance of family (Cross-Cultural Foundations of Uganda, 2017). This gives context to common maternal and child health care procedures and practices.

Midwives

The Dr. Ambrosoli Memorial Hospital in Kalongo, Uganda, was established in 1957 (hope2onelife.org). The first midwifery school in Uganda, St. Mary's Midwifery School, was established shortly thereafter in 1959. Midwives spend several years completing three stages of training in maternal and child health care through both classroom and laboratory courses. Finally, they further their studies by observing and assisting professionals through supervised clinical instruction in the Dr. Ambrosoli Memorial Hospital. Both the school and hospital were founded on Catholic beliefs, and this remains an integral aspect of the school's philosophy and student experience (kalongomidwifery.org). Since its institution, the school has produced 1,312 midwives who have worked in varying locations around Uganda, collaborating with nurses, doctors, and other health officials to provide patient care (Annual Report, 2017). They care for pregnant mothers, preparing them both for deliveries and motherhood, and encouraging them to attend appointments at the hospital for antenatal and postnatal care. They also assist in clinics and have a strong focus on health education (kalongomidwifery.org). While the hospital and the healthcare it provides has grown more popular as the years progressed, it remains in competition with more traditional forms of medicine used in Uganda.

Traditional Birth Attendants

The role of traditional birth attendants (TBA) existed well before global health imposed this classification or before the institution and popularization of the hospital setting. TBAs fulfilled the role of maternal health care providers in rural settings (Chi & Urdal, 2018). Later on this became an official title handed out by hospitals to women who practiced traditional medicine and underwent hospital training conducted by midwives of a local health facility. These trainings taught local birth attendants the western perspectives of patient care and treatment, and they

covered appropriate procedures for referrals to the hospital (Sibley et al., 2004). Often staples of the community, TBAs functioned similarly to midwives, to bring health education and care to the residents within a community. They could provide advice to soon to be parents and even on occasion functioned as a source of sex education for local children. They originally based their practice on traditionally held beliefs discovered through trial and error and used local herbs and plant-based medicines to treat patients (Chi & Urdal, 2018). Some who do not look favorably upon this health care role reference these individuals as “witchdoctors” (Chi & Urdal, 2018). However, that term is largely used in reference to other types of healthcare professions. TBAs were a popular and viable health care option for many women in Uganda and will be referred to as such in this paper.

Purpose

This research seeks to analyze personal accounts of maternal health care options available to women in Northern Uganda. It aims to identify themes and trends in these accounts so the results may be used to further document the popularization of the hospital in Northern Uganda from the perspective of those who were a part of it. This research takes into account community perceptions, which are integral to the history of the hospital’s beginnings. Furthermore, the themes can be compared across health care professions to characterize their symbiotic relationship and how they jointly work to provide care to a population. Notably, these interviews provide insight into the process of shaping a modern health care system, mirroring any society, not just that of Northern Uganda.

Procedure:

Research was conducted by transcription and analysis of interviews conducted in Uganda by Dr. Vongsathorn from the History department of Southern Illinois University Edwardsville along with a skilled midwife translator affiliated with Kalongo Hospital. The interviews were conducted with medical professionals active in Uganda's health care system before 1980 as well as traditional birth attendants who once practiced in the Acholi region. While interview questions and duration varied, participants were questioned about the same topics including, but not limited to, their background, education, religious affiliation, and employment. Those who could not speak English spoke through an interpreter. First, three separate interviews were transcribed. This set of three belonged to Ugandan midwives, of varying ages, who studied at the Dr. Ambrosoli Memorial Hospital Hospital in Kalongo, Uganda. Upon the completion of these transcriptions, two more interviews were transcribed- these belonged to traditional birth attendants who worked in the Acholi region during roughly the same time period. Following the transcription process, hour-long weekly meetings were held in order to discuss the findings from each interview transcription. The meetings were held by Dr. Vongsathorn with a team of undergraduates studying similar maternal health history concepts. The themes drawn from these interviews were then contextualized with the health care climate in Uganda at the time of personnel activity and training. Their responses can be applied to the growing knowledge of patient-caretaker relationships to understand its impact on the plurality of Uganda's health care system.

Results:

Table 1: Midwifery Interview Response and Theme Summarization- Each midwife interview conducted has been filtered into the categories or themes shown on the left of the table.

Topic	Midwife 1	Midwife 2	Midwife 3
Background	-Born 1946 -Began training: St. Mary's Midwifery School 1962	-Born 1959 -Began training: St. Mary's Midwifery School 1978	-Born 1959 -Began training: St. Mary's Midwifery School 1979
Training	-Class Size: Less than 20 -Spoke highly of Italian Sisters and Doctors who lectured - Taught in English - Learned about 2 main types of midwifery: abnormal and normal	-Sisters mainly taught classes; Doctors occasionally lectured - Competitive application process - Strict schooling- good environment for studies - Not permitted outside unless given permission or supervision - Emphasis on 2 types of midwifery: normal and abnormal - No students dropped the program	-Dr. Ambrosoli viewed as a father-figure and Sister Catherine, head of the midwifery school, viewed as a mother-figure - Strict schooling to understand the importance of their roles - Doctors and Sisters observed students while helping patients - Some students dropped due to lack of academic achievement - Emphasis on being "God-fearing"
The Profession	- Worked in maternity ward and "theatre" - In maternity ward, educated mothers on hygiene and feeding - Why midwifery: Because the school sponsored her to go	- Worked in maternity ward, "theatre", and medical ward - Tested blood for infections and HIV - Why midwifery: sick with serious illness when young and was cared for by medical personnel; wanted to help as she was helped	- Worked in deliveries and patient education - Why midwifery: a deep love for humanity and those who need care
Health Education	- Persuaded patients away from "witchdoctors" by claiming they would not know the name of their infliction - Found younger and more educated women attended the hospital as well as those with educated husbands	- In antenatal clinics, taught pregnant mothers about air compressions, the benefits of in-hospital delivery, and personal hygiene to avoid infections and diseases	- People in the community had a love for the hospital - Slowly drew people away from local beliefs until today you do not find as many of the same traditional medicine practices once used so frequently

	- Number of women delivering in the hospital increased over the years; became more well-known - Found some women feared the hospital	- Patients understood and accepted advice; midwife was repetitive and questioned patients to test understanding - Found some traditional healing techniques in conflict with personal health - Thought all midwives respected equally regardless of age; patients trusted midwives	- Worked to persuade traditional birth attendants to attend training and cease practicing
Religion	- Catholic - Did not talk to patients about religion	- Catholic - Prayed daily rosaries - Attended mass during training - Patients were encouraged to indicate their religion upon admission - Midwife encouraged patients to attend masses and prayer	- Catholic - "The most important part" of her training - Read the word of God to patients and unborn babies - Attended masses during training - Listened to Dr. Ambrosoli sermons

There are several trends within the responses provided by the three midwives interviewed (Table 1). All attended the St. Mary's Midwifery School; however, Midwife 1 was born earlier than the other midwives interviewed, and therefore, underwent her training and began practicing at an earlier date. Although all the midwives trained and practiced at the same age, the date of activity varied and seemingly impacted some of their answers pertaining to their schooling experiences. Midwives 2 and 3 both depicted a school setting much stricter and much broader in their training, noting shadowing experiences and practice with patients. When questioned about their reasoning for their pursuit of midwifery as a career, the elder midwife spoke of funds provided for her education while the others spoke more of a deeper sense of purpose to serve others. On the matter of religion, the Midwife 1 did not note the religious component of their training and did not incorporate her religious beliefs into her care. However, Midwife 2 and 3 took particular notice of the religious influences in their training and noted varying degrees of

Catholic themes in their practice. Alternatively, all women noted the importance of health education in their work as midwives. It was an integral aspect of their patient care which aided in improving the patient return rate. On the same topic of return rate, Midwife 1 recognized the patient fears associated with the hospital in its early days, such as suffering abuse or unnecessary charges and procedures. These fears gradually dissipated by the end of her career and were replaced with a respectful rapport. The other two interviewees, who worked during later years, spoke less of these patient fears and more of the mutually respectful relationship with patients, which indicates that public perception had improved in later years. In regard to traditional medicine, the midwives noted a tendency to steer the patients away from those called "witchdoctors" who were practicing unfounded and harmful methods of treatment.

Table 2: Traditional Birth Attendant Interview Response and Theme Summarization- Both TBA interviews (1 or 2) conducted have been filtered into the categories or themes shown on the left of the table.

Topic	TBA 1	TBA 2
Background	- Protestant - Age: 1956	- Catholic - Born 1947
Training	- Stopped school in primary term for lack of funds - What she learned in primary school had no impact on care provided, Learned of hygiene from her mother who had more schooling than she - Began career as TBA when sister-in-law gave birth and required assistance- moment she received the "calling" - Learned by acting as a birth attendant to local deliveries	- Never attended school - Learned by helping her mother deliver babies - Learned about germs from her mother who would take her to the local "witchdoctor" when she was ill
The Profession	- Not paid - Women came to her when they were feeling pain due to pregnancy - Delivered the baby, handed the baby to the mother, and then delivered the placenta - Deliveries would occur in her home	- Began working after delivering two children in the area. - Held the mother and guided her through pain during births - Bathed women before birth and explained this necessity to them - Treated mothers through massage when they had pain - Some deliveries took place in her house, but some were nearby their home if they could not travel

	- When a pregnant woman was unable to travel, the husband or mother-in-law would call her and the delivery would take place in the family's home - After birth, mother was delivered to the hospital - Knowledge of her services spread by word of mouth - Believed patients came to her because of her "calling" and courage - No notable competition between TBAs working in the same area	- Called on by the husband or mother is the husband was deceased - Continued caring for the mother and child for varying durations after the birth: She stayed four days if the child was female, and avoided washing the baby for three days if male - Knowledge of her services spread by word of mouth - No competition amongst TBAs- respected the patient's decision - Believes TBAs were successful because they interacted well with the mothers telling them what to expect - "Bad" TBAs were those who do not have the calling but practice anyway because their friends or relatives do
Health Education	- Advised mothers on proper postnatal care: keep bed clothing clean and bathe the baby regularly - Some would follow the advice while others would not. Women were more likely to follow when advice brought about visibly good change as evidence.	- Advised women not to overwork - Taught the mothers how to bathe their babies - Instructed mothers to test the temperature of the bath water with their elbow prior to bathing the baby - People followed her instruction although experienced more respect when older - Some cultural beliefs benefitted the baby. Example- after a baby is born people do not go into the house for several days. This would prevent people from spreading germs
On Midwives	- Some patients preferred TBA to hospital because of fear of the hospital and the midwives - Some patients preferred the hospital if they had a complicated case (the baby was not lying properly) - Hospital training taught TBA to identify signs of complications and recommend women to the hospital - More woman than before deliver in the hospital	- Some patients deliver with a TBA if they feel no pain or have no illness - Some patients delivered at the hospital if there were known complications or illnesses. - Found hospital training useful; taught patient interaction - Believes the hospital has helped women; they have medications and tools the TBAs do not - Believed midwives could do more to connect with patients. She was concerned that they made unnecessary cuts and quarreled with patients, even talking about slapping - TBAs were given a "gift" or a "calling" but midwives had to study

The TBAs interviewed worked during similar time periods (Table 2). Both noted a lack of education for varying reasons. The commencement of their careers came about by witnessing or participating in a live birth. From there, they both spoke of a "calling" or "gift" which had been realized and consequently motivated their pursuit of the TBA profession. The majority of treatments took place in their homes, offering care to women seeking relief from pregnancy pains and discomfort. Patients who were unable to travel to the TBAs residence for labor were often cared for in their own home. For those in labor, it was often the husband who called upon the TBA to dispense their services. After the birth of the child they continued to serve the mother and child by offering health advice on cleaning and appropriate interaction with the baby. Both TBAs recognized the importance of referrals to hospitals. If a patient was experiencing an illness or unforeseen complications with their pregnancy, they were referred to the hospitals by the TBAs who spoke complimentary of the resources they had at their disposal.

Comparisons can be drawn between the responses of midwives (Table 1) and TBAs (Table 2) when asked questions pertaining to their health care practices. First, the resources available to each party were significantly different. All three midwives attended St. Mary's Midwifery School while the TBAs interviewed did not finish their schooling. Furthermore, midwives spoke of extensive academic training which ultimately concluded with a shadowing experience, while TBAs learned by doing, partaking in experiential, hands-on training by observing and assisting established traditional health care workers. The midwifery training administered at St. Mary's Midwifery School was heavily infused with Catholicism while the TBAs differed in religious affiliation and noted no such infusion of religion and practice. In terms of the care they provided, midwives had access to medications and technological tools that the rural TBAs did not. Regardless, both professions sought to educate as well as serve their

patients, offering guidance on maintaining cleanliness and preventing illness. Upon the institution of the hospital, midwives began training TBAs in referral protocols and sharing knowledge based in western medicine. The TBAs notably found these trainings to be helpful and practiced the referral recommendations when patients experienced pregnancy complications in a display of understanding and cooperation with other health care practices. This both strengthened the plurality of Uganda's health care options and broadened the scope of health-seeking behaviors.

Discussion:

This paper serves the purpose of stating information gathered from sources directly involved in the creation of the modern Ugandan health care system. This knowledge can be added to the vast collection of documented Ugandan history. However, the purpose of this paper reaches beyond that of documented information. There are conclusions and connections one can draw from the above documentation which can be useful in a multitude of manners.

As a disclaimer, it is necessary to recognize the above interview responses within their context. This research is unable to account for those interviewees whose memories are subject to change during the years between their activity in question and the interview. Also, not all of the interviews were conducted in English. The use of a midwife translator added a great deal to the interviews; however, some things may have been lost in translation due to the difficulties of instantaneous interpretation. Lastly, it is the intent of the group involved in this project to transcribe more interviews in the coming years so as to both add to the wealth of documented accounts and bolster the conclusions which can be drawn from these few interviews already completed.

Nonetheless, there are tentative inferences to be made about the varying roles played in the popularization of the Ugandan hospital. Particularly in this case, the Dr. Ambrosoli Memorial Hospital in Kalongo, has seen a continuous increase in maternity ward admissions and births, reporting a 5.8% increase in hospital births between 2014/2015 and 2015/2016 (Annual Report, 2017). This individual hospital's trend aligns with the national popularization of the hospital setting for maternal and child health evidenced by Uganda's 2016 Demographic and Health Survey which states, "More than 7 in 10 live births in the past 5 years were delivered in a health facility (73%) and with skilled birth attendance (74%)" (Uganda Bureau of Statistics, 2018). This statistic is in fact reflected in the documented accounts of the Ugandan midwives. Midwife 1 was trained and began working shortly after both the institution of the St. Mary's Midwifery School and the Dr. Ambrosoli Memorial Hospital. The training as well as the public opinion she describes varies significantly from the accounts recorded by Midwives 2 and 3 who completed their training years later (Table 1). Midwife 1 spoke of patient fears which initially kept them from visiting the hospital. She also spoke about competing with local "witchdoctors" who were practicing unsafe techniques. Midwives 2 and 3 spoke of both a stricter, faith-based schooling and a positive and respectful relationship with patients. This is in accordance with the perspective of Midwife 1 who noted improved patient relationships as time passed. This push towards hospital care was also reiterated in the TBA interviews. TBA 1 and 2 spoke of hospital trainings which taught them the importance of referrals, a practice which most likely increased the hospital's patient population (Table 2). It can also be assumed, that these referrals created opportunities for the hospital to gain a reputation for their medicinal resources and procedural capabilities past those found in the rural TBA homes. These statistics do not indicate a significantly decreased utilization of traditional medicine services. The road systems in Uganda

are poor and make travel to and from hospitals challenging and expensive (Annual Report, 2017). Moreover, treatment at a hospital requires fees some patients are unable to pay. The poverty rate is highest in the Agago district where the Dr. Ambrosoli Hospital is located (Annual Report, 2017). These difficulties rightfully produce fears and doubts for patients which may be avoided if they pursue more rural and traditional health care options. This plurality in options allows patients to confront travel and hospital challenges only when they are most in need of the hospital's more specialized resources. Going forward, more can be done to further investigate the factors contributing to the population's continued draw to traditional medicine practices, including accessibility, tradition, and health outcomes.

These relationships demonstrate the importance of relationships in the medical community. These trends and themes can be applied to a number of medical settings across the globe. It need not apply only to Northern Uganda. The struggle between traditional western medicine is a common storyline of the history of all modern societies. This format for research is a valuable tool which can be used to further document our own medical histories. Documentation points to useful modes of integration and modernization of a medical setting which can certainly be applied today. The midwives and TBAs detail a storyline which serves as an example of how to establish a symbiotic existence and dual care system to provide holistically better health care services for their population.

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