Initiation of Traditional Birth Attendants and Traditional Religious Practices Performed during Pregnancy and Childbirth among the Baganda in Uganda

Hassan Tugume Lubowa
Department of Religion and Peace Studies, Makerere University, Uganda

Abstract. Since time immemorial, traditional birth attendants (TBAs) in Buganda have offered pre- and post-natal services. Although it is anticipated that women in modern societies give birth in hospitals and clinics, some women still utilize the services of TBAs. The study aimed at an in-depth understanding of the initiation of TBAs and traditional religious practices employed during pregnancy and childbirth in Buganda. Thirty-two in-depth using individual interviews were conducted with a semi-structured interview guide; questionnaires were given to respondents purposely selected. Relevant literature was reviewed. Content analysis was thematically employed to generate findings. The findings revealed that TBAs were initiated through apprenticeship from family members who were TBAs and other non-family TBAs as well as through dreams and revelations. They practiced using both spiritual and physical methods and their work was founded on spiritual directions, use of spiritual artifacts, herbs and physical examination. TBAs delay the process of child birth and disposal of the placenta associating with beliefs which indicate that when not properly disposed, it will have adverse consequences on the child and family. Although TBAs like maternal health professionals operate to improve maternal health care, some religious practices and beliefs may pose threats to the mothers. Nonetheless, with appropriate initiation and training, they can become more useful.

Key words: birth attendant, initiation, umbilical-cord, herbs, placenta

Introduction

Despite efforts to reduce maternal and infant mortality-, low- and middle-income countries Uganda inclusive continue to report sizeable mortality rates, with some of the reasons being poor access to or low quality of professional care (Sullivan & Hirst, 2011). In Africa, traditional birth attendants (TBAs) have historically been the major caregivers for women during childbirth. Like many low and middle-income countries, pregnant women in Uganda continue to either give birth at home or with TBAs (Nyakaisiki, 2012). A traditional birth attendant (TBA), according to WHO is "a person who assists a mother during childbirth and who initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants (WHO, 1992). She is referred to as *'mulerwa'* in *Luganda*.

In Uganda, traditional midwifery is a part-time work for unskilled persons who mediate pregnancy and birth with some traditional religious practices (Roscoe, 1934). Many TBAs rely on herbal medicines which are culturally inherited to assist women before, during and after labor (Hamill et al., 2000). Meanwhile, research suggests that these TBAs have had very little training and education that might integrate them into the larger health care system and even those with training need the support of skilled back up services (Turinawe, 2016).

In 2010, there was a bun of traditional birth attendants; introduction and adoption of safe motherhood programs in Uganda which drew attention to the need for women to patronize professional healthcare services during pregnancy and childbirth (Nyakaisiki, 2012). However, these services are limited and not easily accessible or of low quality. In rural communities, over 50% of pregnant women do not have access to skilled birth attendants. Therefore, some of these women endure to access the services of TBAs. According to the Uganda Maternal Health Survey of 2014, 50% of deliveries were administered by TBAs (Turinawe, 2016).

TBA care has been known to cut across pregnancy, labor, postnatal and care of the newborn (Mbiti, 1911). Preference for TBAs has also been attributed to the fact that they provide reasonable and reachable services as well as conduct delivery at home- an environment familiar to the woman (Gao et al., 2010). In a country like Uganda where health services are insufficient, the amenities of TBAs continue to be in demand (Bulamu Healthcare, 2020). It is thus, observed that health policies that neglect the impact of TBAs would not be effective because some women still prefer home delivery and TBA services (Homsy, 2020). Hence, an in-depth understanding of the initiation, traditional religious practices of TBAs is pertinent for policy making.

Preceding authors report that initiation into TBA practice includes formal training by traditional medicine men, sacred calling through dreams or visions and inheriting or internship from close relatives such as grandmothers, mothers and aunts (Ssekamwa, 1992). The traineeship has the duration of two to five years under a family member but one to two years when the trainer of the TBA is not a family affiliate (Wasswa & Murima, 2006). This is probably because of commitment and remunerated training for those who are not family members. The findings also pre-suppose that TBAs learn on the job and hence may not benefit from technical and standard procedures of childbirth. The literature reports that TBAs keep the pregnancy status of a woman top-secret until signs of gestation are obvious in order to protect both mother and baby (Roscoe, 1934). They also assess the vagina for cervical dilatation during labor and some listen to fetal heart-beats (Rudrum, 2016). Some TBAs caution women when labor unduly delays, they are accused of hiding secrets such as unfaithfulness to the husband and that labor will only progress after confession (Kaggwa, 1971). Traditional birth attendants also use herbal medicine to accomplish prolonged labor and retained placenta but when overwhelmed by complications they refer to a magician. (Roscoe, 1934).

Some TBAs complement traditional religious practices to their care with the belief that pregnant women are vulnerable to spiritual attacks that can hinder successful outcome (Wasswa & Murima, 2006). In view of this, before childbirth, TBAs offer traditional prayers and execute rituals for effortless and safe birth (TBA32F). For the *Baganda*, the placenta and other birth products are connected with rituals. For instance, they believe that the placenta should be buried. However, there is fear that when the placenta is disposed of inappropriately, evil people can use it to harm the baby or may not be prosperous (Roscoe, 1934).

Although, the literature presented some knowledge on the initiation and practices of TBAs from various contexts including Uganda, the author of this study observed a prerequisite for supplementary insight as most of the studies have inadequately explored the topic. It is noted that most authors emphasized the need for the training of TBAs to promote maternal and neonatal wellbeing (Al-Busaidi, 2008). Improved care could reduce maternal and neonatal deaths (Adegode & Jegede, 2016). The author of this study anticipated that understanding the practices of TBAs will inform future training programs that could boost maternal care and wellbeing. Hence, this qualitative study was designed to explore the initiation of TBAs and the religious practices they employ during pregnancy and childbirth in Uganda.

Methods

Design

The study adopted an exploratory qualitative design to gain in-depth understanding of the initiation and practices of TBAs as well as traditional religious influences of their initiation and practice. The qualitative design allows probing and further exploration of

emerging findings and was deemed appropriate for the study (Broom, 2015). This design was useful because the study did not use an existing theory or framework but rather used probes to follow-up on participants' responses. This process afforded a deeper understanding of emerging themes.

Setting

The study was conducted in a rural community in Kalungu district with the participants drawn from an organized group which includes traditional healers. Kalungu district was created in 2010. It has 4 sub-counties, 33 parishes, 2 town councils and 284 villages. Its population was estimated to be 183,232 by 2020.It is boarded by Gomba in the North, Butambala in Northeast, Masaka in the South, and Bukomansimbi in the west. With the above population, it has one government hospital, at Kalungu established by Buganda government in 1927 and later taken over by Uganda government in 1967. It has one private hospital at Villa Maria run by the Catholic community, 12 grade 4 health centers; 12 grade 3 health centers and 11grade 2 health centers. It is thus imperative to understand the basis for the unexpected outcome by examining quality of care provided to women in this district which comprises of TBAs services Although Kalungu district receives reliable rainfall, poverty is widespread. Majority of the indigenous people are subsistence farmers using non-mechanized rain fed agriculture and the minority being petty traders. They are also highly religious with the majority of the population being Christians.

This setting was chosen because its communities were mainly emerging developments with limited access to health facilities that provide pregnancy and delivery care. It was also deemed as the appropriate place to get the targeted participants as there is also an organized group of TBAs. The group includes TBAs from rural communities within the district who were believed to have adequate experience in traditional practices during childbirth. It is called "Association of Traditional Healers". The group was formed as a means of bringing together all TBAs, Herbalists and Spiritual Healers in the community to network and share ideas. Members of the association meet periodically to discuss progress, shortfalls and other relevant issues pertaining to their practices.

Sampling and Data Collection Procedure

The study employed Participatory Rural Appraisal (PRA) (Punch, 2005) traditional healers, birth-attendants, local council officers and executives of Uganda *neddagala lyaayo*, an association that unites all traditional healers in Uganda. Using a purposive sampling technique, both males and females were recruited. To be included in the study, TBAs should have practiced for five years. Permission was obtained from the leaders of the associations to enable the researcher book appointments according to the meeting days of the groups. All interviews were held in *Luganda and* English. The interviews lasted between 40 and 50 minutes. The interviews started with a general question: *'Please tell me how you became a TBA'* and responses were probed. Follow-up questions such as: *'what do you do for pregnant women when they come to you'*? In-depth understanding was achieved in this study and concurrent analysis helped in full exploration of emerging themes. Privacy was ensured during interviews and permission was obtained to record the interviews. The interviews were conducted in an enclosed place. Participation in the study was also voluntary.

Data Management and Analysis

Interviews were recorded in English and *Luganda*. An expert in *Luganda* language who conducted the interviews checked the transcripts for accuracy. The research assistants read the transcripts several times to fully understand the perspectives of the participants. Concurrent scrutiny was undertaken using the techniques of content examination. Inductive

analysis processes were followed to develop themes and sub-themes since no theoretical framework informed the formulation of themes. The researcher independently coded the transcripts, grouped the codes and generated themes and sub-themes (Gale et al., 2013). The themes and sub-themes were analyzed to ensure the data were faithfully captured. The data were subsequently managed using the NVivo software version 11. Relevant data were sifted to support themes and sub-themes and the findings were presented with supporting verbatim quotes from participants.

Rigor

Rigor or trustworthiness of the study was achieved using a number of procedures. Emerging themes were further investigated in subsequent interviews (member checking) until saturation was achieved. The researcher undertook prolonged engagement with 32 participants and this ensured that the phenomenon under examination was fully understood. Also, field notes were taken to record non-verbal observations and decision trails during the study. Again, independent coding and checking of transcripts ensured that the data and analysis were credible. Identification codes were used to present verbatim quotes. The ID numbers were assigned chronologically as participants were recruited, for example TBA1M – TBA4M.

Ethical Considerations

Informed consent was attained from all participants and the data was anonym zed. Participants consented to the use of data for teaching and publication. Participants were also made aware of their right to withdraw from the study at any given time.

Results

Demographic Characteristics of Participants

An over-all number of 32 TBAs participated in the study, eight males and twenty -four females. Few males are engaged in midwifery; therefore, the number of males in this study depicts what exists in the general Ugandan context (Turinawe et al., 2016). They were aged between 30 and 90 years and had been TBAs between five and over fifty years. All participants were either Muslims or Christians since these are the predominant religions in Uganda. Out of the 32 participants, twenty were married, ten were widowed and two were divorced. The number of children they had ranged from 2 to 13. All respondents were *Baganda* by tribe. They conducted ten deliveries per month on average. None of the study participants had any formal education similar to all members in the group at the time of data collection. Within the socio-cultural context, it is rare for educated individuals to be TBAs unlike what the literature has shown in Zambia where the district health office sometimes trains TBAs (Choguya, 2014).

Initiation of Traditional Birth Attendants

Twenty-six of the Traditional Birth Attendants (TBA) acquired skills of managing pregnancy and labor through training from a family member and apprenticeship from experienced TBAs whereas the others had spiritual revelations.

My elder sister delivers women in the house so when he is going to deliver somebody, she calls me to come and I observe. (TBA20F); *...I was taught by my paternal aunt; so, as she did it, I learnt*. (TBA32F)

A participant claimed she received the revelation to be a TBA from her late paternal aunt after several encounters with her through dreams.

...my aunt operated as a TBA before she passed on. ...One day I slept and visualized that my aunt and I were going to deliver someone. These kinds of visions continued for

approximately one year. So, I enquired from a TBA who interpreted the dream. She told me that my aunt wants the work she left for me to endure. (TBA18M)

One TBA who was a hunter first, compensated for the killing of pregnant animals by assisting pregnant women during childbirth.

I was a hunter... I was asleep one day when God revealed to me that I should not hunt for wildlife again but deliver women. This is for the reason that at times I killed some pregnant beasts that I never identified were pregnant. (TBA6M)

Two participants believed they received the calling whilst in their sleep and later they were confronted with the reality of assisting women to give birth and continued to do so. One later underwent some basic training and became a qualified TBA.

I had three visions that women came to me and I delivered them; on the fourth instance, it happened substantially; so, I followed what I saw in the visions and delivered them successfully. After that then we had some education so now I am a TBA. (TBA10F).

I did not learn it anywhere; it came to me in a vision… (TBA8F)

Spiritual and Physical Practices of TBAs

Numerous TBAs in this study believed to have spiritual revelations that directed them to manage women during pregnancy and labor. The participants used relics and different herbs during their work.

Some claimed they had spiritual directions to guide their management of women through *hearing voices*. They were clearly shown how to go about the delivery.

A TBA believed that prolonged labor was a warning that the baby was spiritually *locked* up in the womb.

Most TBAs alleged that obstructed and prolonged labor was a sign of infidelity or adultery which was considered a taboo or was a result of relationship problems with other people.

... I told her "You have been unfaithful to your husband?" and she spoke the truth by letting me know what she did …after the concession, I perfumed a ritual.

When child birth delays, it could mean that the womb is locked by a spirit; after prayers everything is cleared and the child would come out quickly. (TBA12F)

One TBA asserted that she had *"visions"* of pregnant women coming to give birth with her before she was physically brought.

I see the women in a vision ready to give birth. …then when someone is brought in, she will look perfectly like the one I saw in the vision. (TBA30F)

I performed rituals and I used the "herbal medicine" on the expectant woman before she had safe delivery. (TBA6M)

Apart from the visions and revelations that some TBAs received, they also performed certain religious rituals for a safe delivery concentrating on removing effects of evil spirits.

I pray for her that deities should help her deliver peacefully…. (TBA24F)

…it is not all the time that it is physical, sometimes too it is spiritual. My wife's father had to do some rituals before she could deliver. (TBA2M)

Twenty six out of the thirty-two TBAs used a number of artifacts (substances or items that have been prayed over or blessed) in their practices with the belief that it lessened pain or enhanced delivery.

Some TBAs whispered over herbs and gave it to the pregnant women for chewing.

…I pray over the herb and the baby turns or positions well then, the mother kneels and she delivers easily. (TBA20F)

Also, the dissolved *mmumbwa* was used to perform some rituals which were believed to enhance easy delivery.

…my father just brings some herbs whispers some words on the dissolved mmumbwa; I don't know what he says but before he finishes his rituals, the woman just delivers. (TBA2M)

...when you give birth and I observe that your condition is not stable; I pray over herbs and emmumbwa and ask you to drink it. (TBA11M).

The TBAs gave the pregnant woman a mixture of *emmumbwa* and herbs to drink.

When they are in pain, I make them drink emmumbwa and chew herbal medicine. The pain means there is something like kernel that must burst. After this ritual, the pain stops. (TBA8F)

A TBA prepared special herbs that have been prayed over for the pregnant women for bathing to revert any challenges they faced.

...sometimes when women come, I prepare special herbs and pray over it for them to use to bath….. (TBA5F)

Other TBAs gave a mixture herbs boiled in water in order to revive distressed babies and give them strength.

...In instances where the babies do not turn and weaken, I make them take herbs boiled in water for them to drink; when they drink the baby gains strength and get revived. (TBA7F)

Use of Herbs/Material Objects

The *Baganda* know that life begins in the womb (Roscoe, 1911). If a married or cohabiting woman misses two menstrual periods, she confirms that she is pregnant (TBA3F). If she is a young wife, she tells the TBA her condition. The TBAs confirms pregnancy by vaginal examination to feel for a lump.

If she is confirmed, the TBA begins to treat (*okujjanjaba)* both the mother and the pregnancy. Pregnancy is considered an ailment in that, if not properly cared for it can go wrong, and miscarriage may happen.

Whichever TBA becomes responsible for the expectant mother; she treats her with four main types of medicine, used either separately or simultaneously. The first of these is *emmumbwa*. This is a lump of hardened clay, some six or more inches long and about five inches in circumference, into which has been pounded roots, leaves and the bark of various trees and shrubs, which are dried and then used in preparation of *emmumbwa.* The *emmumbwa* is dissolved periodically in water, commencing from on, and the medicated water is drunk by the mother. The precipitate left at the bottom of the medicinal container is smeared on the stomach or on any part of the body which is giving pain. The *emmumbwa* is in fact, used to cure a multiplicity of ailments, not all of which need be connected with pregnancy. However, since it is essentially a medicine for women's ailments connected with fertility, menstrual problems and pregnancy it is almost always present.

In many parts of Buganda, particularly in urban areas, and market centers, the *mmumbwa* is increasingly becoming commercial (one might even call it patent medicine). It is sold in almost any public place and even outside the gates of city hospitals. Each *mmumbwa* is said to cure between ten to twenty diseases, most of which are African diseases, some said to be incurable by bio-medicine. The proper use of *emmumbwa* involves the use of a pot-shed (*oluggyo)* in which the *emmumbwa* is dissolved by rubbing it against the shred until the water is thick with clay. This is a sign that the medicine has been adequately prepared and that it is ready for drinking and to rubbing on the body as described above (TBA 7F).

Traditional Drugs for Pregnant Women

These are very many in Buganda and go under the general name of *eddagala*, which is derived from the noun *olulagala, leaf*. However, these medicines may be obtained from

leaves of various trees and shrubs as well as other sources. For example, the TBA (*mulerwa)* may prepare these medicines for her, but on occasion she may also prepare them by herself.

These medicinal leaves are squeezed out in water, and like the *emmumbwa,* the mixture is drunk by the mother and some of it is rubbed on the stomach. These medicines include those derived from the bark of trees and certain roots, which can be cooked in water to prepare a mixture, or dried and pounded to a powder that is licked – up or dissolved in water. These preparations are thought to be effective both in the treatment and care of the mother and the fetus. A pregnant woman must be protected against all diseases, several of which are thought to attack particularly expectant mothers.

One of the most difficult and intractable problems of health in modern Uganda are general diseases. Women feel the effects of syphilitic infection by what is commonly known as heat in the womb (*nabuggumu).* It is recognized that this is a frequent cause of miscarriage and death of the expectant mother. Babies born under such circumstances are described as having the skin torn off their bodies (*banubuseeko oluliba).*

Given these possible disasters, the *mulerwa* collects a variety of medicines (*okwaya eddagala*) to protect the lives of the mother and the child. Among these are *omukakala (*a particular kind of leaf), *akayinamuti* (a kind of bean plant), *akagammansaakatono* (tiny leaves), and *ekigamansa* (whose roots which are boiled and drank). There are other medicines to ensure that the expectant mother keeps her bowels open, and hence doesn't suffer greatly from one of the universal afflictions of pregnancy.

Some of the more fearful diseases are attributed to the breach of enjoined behavior. For example, a woman may suffer from *amakkiro* or *ebigere* (feet) which implies that the mother has committed adultery. An unmarried girl who becomes pregnant or a girl who has many lovers may also have the same signals. A surprising point is that a girl who fornicates with an odd number of men (say three, five, seven etc.) is thought to suffer severe consequences as the result of her actions. She may after sometime become wild, eat up her baby and behave in a generally harmful manner (TBA15F).

Contrary to the situation in many parts of Eastern Africa, the genitor of the child of an unmarried girl goes to extreme length to justify his paternity. Therefore a number of competing lovers, who have failed to establish themselves as father of the child, may try to do harm to the girl. It is said that such young men could go and lie on their stomachs in the pit where bananas for making beer are stored, so that the expectant mother would die. The symbolism here is quite explicit. The act of lying down by the Youngman implies burial in a grave *(entana*) and lying on his stomach symbolizes the pressure upon the child in the womb and the difficulties of the labor of child-birth (Roscoe, 1934).

The medicine to treat this problem involves the participation of the girl concerned. She has to get two different banana leaves, one from the female banana tree (*nakittembe),* and the other from the black male, banana tree *(embidde*). She takes these to cross-roads (*masanganzira*), after placing them there, she gets two or four leaves of the shrub *kirarankuba* (literary: that which goes to sleep when it rains) and the *ekiwondowondo* shrub. She squeezes them out into water which is held within this banana leaves. Before she drinks some of this, she pours a libation upon the ground, drinks some of this and anoints her body with the remainder. She then takes the remaining medicines and places them under the flotsam of rain water in the gutter.

In the same evening she goes to the well, fetches water and washes her body. If these injunctions are carried out carefully, it is believed that a pregnant woman will not suffer any major illness or ill-health (TBA 11 F).

Other Medicines for Bathing

An expectant mother is further taught by the *mulerwa* to gather leaves of various plants, like *ekiwondowondo* (maesa, lanceolata, forks' succulent shrub), *ekiralankuba* (another shrub already mentioned) and *muwogo* (cassava leaves). These leaves are crushed before they are soaked in water, and pregnant woman is instructed to bath her body with them in the early morning, and late evening. If she feels very warm during the day, she can bath in them as required. This bathing is intended to keep her temperature normal and to make her feel strong and clean, and to sleep in the evening, after having been cooled by the cold bath (TBA 7M).

The medicinal bath is also thought to provide a cure or prevention of skin diseases. Before the mother bathes in it, she drinks a little of it and this is thought to strengthen the good effects that the medicines have upon the baby in the womb. The terms to cool (*okunyogoga*) and to cleanse (*okukansira*), also imply a super natural avoidance of heat, which is associated with ritual danger. It also to purifies both mother and baby, hence, protects them from physical and super natural attackTBA11F).

When the pregnancy reaches about seven months, the mother is advised to use special medicine with which to rub her abdomen. She pounds the leaves of the *mucuula* tree and mixes them with butter. In this, she is helped by the *mulerwa* .Early in the morning, before the expectant mother has eaten anything, the birth-attendant assists her to anoint and massage her abdomen.

This treatment, okutenga is given two or three times a week, and its purpose is to soften the skin of the abdomen and to position the baby in the womb to facilitate delivery. The *mulerwa* can examine a woman in late pregnancy, and tell whether the womb and the position of the baby are in good condition.

In the eighth month, an expectant mother begins to use other medicines to tolerate the pelvis to expand freely (*okummenya amagumba* literary to break the bones), widen the passage and hence make delivery easy. This treatment includes sitting in medicated water twice a week, increasing to three times a week in the ninth month. She must sit in this medicine for a limited period, say five to ten minutes (TBA 13M). It is thought that if she sits in it for more than the prescribed period her bones will become very soft, her muscles very tender, and the passage too slack for normal delivery.

Secondary, she must take either the leaves of the sweet potato plant (*amalagala ga lumonde),* or the leaves of the *olunyereketo* plant, or those of the *endotoki* shrub, crush them and mix with butter. She uses this ointment to rub on her virginal again to ensure the softening of the birth passage. The same purpose may also be served by the *endoto* leaves being crushed and soaked in water, the resulting mixture being drunk by the expectant woman. All of these medicines are thought to have successful results upon the health of the fetus, making it strong in itself and improving the health of the mother (TBA17 F).

Bodily Examination and Practices during Gestation, Labor Pains and Delivery

When the pregnant mother knows that her time is due, she tells her *mulerwa* or midwife '; that she feels unwell *(attandise okulumwa*) as opposed to the unusual term *omulwadde* (a sick person). The *mulerwa* will then come to help with the delivery. Most of the TBAs use their fingers to estimate the cervical dilatation during labor and predicted time of delivery based on their findings.

…when I check and get 3 fingers then I have to give food meaning that the time for delivery is almost close (TBA28F).

They also assessed the amniotic membranes or flesh of the baby if the membranes are ruptured with their fingers and asserted that the closer the membrane or flesh to vaginal opening the earlier the woman would give birth.

...when I check and the flesh around the womb is near the vagina, it means she can give birth right away (TBA30F).A TBA reported that she checked and felt the umbilical cord for pulsations. If pulsations were felt, the cord would not be cut until the pulsations diminished. This is to allow the return of the '*spirit*', believed to be in the cord, into the baby.

...when the child is born, I hold the cord and check if it is pulsating strongly; that means the child's spirit has reduced and the spirit is in the cord and if the beating of the cord stops, the child will be screaming and crying then it means the cord is now dead and can be cut… (TBA28F)

The midwife gives quickening medicine to the woman for example *ejjobyo* (the root of the medicinal plant, Penta Philla). The expectant mother must chew this after it has been heated in the ash of the fire place. After such treatment, a baby is expected to arrive without delay (TBA 23M). It is normally expected that, once labor pains have started, a baby will be delivered within a few hours.

Some TBAs believed that they never encountered issues of retained placenta because they offered pregnant women herbs before the start of labor.

Since I started this delivering, I have never delivered any child where the placenta delayed …this is because when the woman comes, before the delivery process, I give them herbs which prevents all these problems. (TBA6M).

If the mother shows signs of weakness or abnormality in the process of delivery, other measures must be taken.

When normal delivery has not been achieved, the following measures can be taken. First, the medicine woman gives the mother medicines which may be chewed or drunk. These medicines may be administered either by the husband or other close relatives. If this is the case, this person stands behind the patient while the latter takes the medicine (TBA27M). This precaution is meant to 'avoid shame' (*obutasonyiwaza*).

Second, if these medicines do not improve the mother's health, her husband or his sister or his parent goes to a medium or diviner (*omulaguzi*) to establish the cause for the delay in delivery (TBA6M). Usually, an ancestral spirit (*omuzimu*) of either the woman herself or her paternal aunt or a*lubaale* (deity) or *eddogo* (witchcraft) may be identified as the cause of the misfortune.

The medium instructs the client in what they must do. A *muzimu* or *lubaale* may be comparatively easily appeased. It is thought that these spirits wish the mother to have the child, but they make the delivery difficult to express their unhappiness at being neglected or because of disobedience of their descendants (TBA29F).

If, however, witchcraft is identified as the cause of difficult in delivery, it is much more complex to treat. It is considered to be very difficult to identify the person using witchcraft against the expectant mother and even harder to establish the motivation behind the use of such dangerous power. Two respondents told the researcher that despite every measure to save the lives of both the mother and child, the patient usually dies in such circumstances (TBA29F and TBA21F). In such severe cases when the mother becomes very weak, the midwife may insert her hand into the uterus in order to assist delivery (*okugoberera),* (literary: 'to follow). Such extreme measures are very rare since they usually result from neglect of the mother's health during pregnancy.

Religious Beliefs and Practices Regarding Umbilical Cord and Placenta

On delivery, the *Baganda* refer to 'two babies. The first is the actual baby, when it is born the midwife removes the mucus from its mouth and ears and blows up the nostrils to make it sneeze, which is a sign of good health and successful delivery. The second 'child' referred to is the placenta or after birth (*omwana owennyuma*, literary: 'the child behind'). The whole placenta must be completely brought forth for the safety of the mother's health.

Failure to do so can lead to the mother's death. The umbilical cord (*olulira or ekilira*) is cut with a sharp reed by the midwife. It is then placed on a piece of fiber near the mother's bed (*akaali*) for two days in the case of a boy or four days in the case of a girl (TBA2M). After this period, the cord is wrapped in leaves of both the Castrol tree (*omusogasoga*) and of a thorny tree called *omuyirikiti*. After the preparation of the placenta; it was buried according to the custom of the clan.

We don't just bury placenta. We perform rituals for burying placenta since it determines the destiny of the child. (TBA2M)

At this point, clans differ in the way in which the umbilical cord is handled. However, three procedures are common to all clans. The first is that the umbilical cord of a boy is buried near a male banana tree (*embidde*) and that of a girl near a female banana tree (*nakitembe*). It is believed that if the ritual procedures for the 'good treatment' *(okubyalira*) of the umbilical cord are not carried out, the life and health of the baby can be affected (TBA9F).

A baby boy is kept in doors for two days and a girl for four days; if they are twins, both male are kept in complete darkness for three days. If the twins are identical, their seclusion in for four days; twins of mixed sex remain in doors for three days. It is believed that a baby would be endangered by disease if it is taken out of house sooner than the periods stipulated. All TBAs maintained that all babies are particularly weak and susceptible to disease and witchcraft attack during the first four weeks of life.

After the stipulated time of seclusion, a baby is shown to the public. From this point, its health becomes the concern of all the members of the family and the community at large. Both the midwife and the mother are concerned in obtaining and administering the medicines which ensure the continuing health and growth of the child. The baby is regularly bathed in a bowl (*ekyogero*) in which medicines have been collected, cooked and given to the baby to drink in small quantities before it is bathed. These medicines are intended to prevent or cure internal diseases as well as skin infections or rashes. They are also thought to bring good fortune and happiness to the baby and hence to the family as well.

Discussion

The finding that TBAs were initiated into their work through apprenticeship from family members or other experienced TBAs, spiritual revelation and dreams or visions corroborated other findings regarding initiation of TBAs or their acquisition of skills (Wash, 2006; Kaingu, Oduma, & Kanui, 2011). Given that most of the respondents had little formal education, it is crucial that TBAs are formally trained since such knowledge will enable them to recognize early signs of complications and refer early so that lives can be preserved (Kagwa, 1971). Training programs should also be made simpler in order to facilitate easy understanding. Training of TBAs will also promote the use of standard procedures during pregnancy and labor and prevent infections and other related intrapartum and postnatal problems (Nyirenda & Maliwichi, 2016).

Furthermore, the finding that spiritual directions or revelations guide practices of most TBAs resonated that of Adegoke and Jegede (2016) where the roles of TBAs and their spiritual practices during childbirth were linked. The belief by some TBAs that voices originated from the "Holy Spirit" through prayers and directed them in their practice and in the use of herbs was attributed to the fact that some respondents were Christians. Such beliefs were not held by non-Christian participants. Revelations of evil acts that cause a baby's inability to turn in the womb are rooted in the predominant African belief that occurrences do not only have physical but also spiritual causes. The finding also confirmed the belief that pregnant women are susceptible to spiritual attacks targeting pregnancy destruction and poor delivery outcomes (Abrigo et al., 2015). Majority of TBAs reported praying, and performing

certain rituals to counteract evil spirits or activities intending to cause negative results of pregnancy or delivery (Mbiti, 1975). This finding was reasonable given that most respondents had received no formal training to enable them attend to obstetric emergencies. Also, since some pregnant women in Uganda believe in spiritual influences in pregnancy and childbirth, incorporation of spiritual activities could continue to attract pregnant women for their services. Hence, the need for training of TBAs to do proper assessment of women in labor is necessary so that the life of a woman and her baby is not risked.

Findings on unfaithfulness are consistent with the literature where the occurrence is linked to prolonged labor, excessive pain during labor, caesarean section or even death (Hadley & Tuba, 2011). Women suspected of adultery were induced to confess (Roscoe, 1934) using traditional herbs for safe delivery. This was one of the reasons that women preferred symphysiotomy because they still had a vaginal delivery. When practices such as this persist, TBAs could miss the opportunity of timely referral of pregnant women to health facilities. Findings on referral to a traditional healer during delivery are consistent with the literature (Ministry of Health, Government of Ghana, 2011).

Use of artifacts by TBAs in this study is similar to that of Aziato et al., where Ghanaian women enumerated a number of artifacts used in pregnancy and labor (Ministry of Health, Government of Ghana, 2011). Traditional Religion and societal norms have some influence on the TBAs' belief systems as well as their practices and could possibly explain the concurrent utilization of religious artifacts in the TBAs' practices with respect to pregnancy and delivery.

The study confirmed that the use of herbs is embedded in the practices of TBAs. While some boiled trees bark and sap, others prepared herbs to excrete water and trigger fetal activity and others also ground *emmumbwa* and herbal medicine to excrete discharges and realign malpresentation and enema to enhance delivery.

During prolonged labor some of the herbs were chewed to improve the blood level of women (Kagwa, 1971). These herbs when not well treated could serve as a source of infection. Nonetheless, some *Baganda* prefer herbal medicine because of the belief that it is effective and has no side effect (Kagwa, 1971). Pregnant women may patronize TBAs to obtain herbs. However, health professionals do not use herbs routinely for fear that such herbs, for example *Cytisusscoparius*, may trigger preterm labor, rupture the uterus, and affect the unborn baby and mother (Chalo et al., 2005).

Most TBAs reportedly diagnosed pregnancy by feeling for an abdominal lump using their fingers as reported in other studies (Serizawa et al., 2014). TBAs used their fingers to assess cervical dilatation and the amniotic membranes. Nevertheless, this is a concern because until recently, TBAs scarcely used examination gloves during these assessments or delivery raising a high risk of transmission of infections and the introduction of bacteria from the vagina to the fetus (chorioamnionitis). The TBAs could also handle more than one pregnant woman routinely and could therefore transmit infections from client to (Ray & Salihu, 2004). The need for the provision of resources for TBAs emphasized.

Delayed cord clamping is considered an international best practice for improving maternal and neonatal outcomes (Rudrum, 2016). This shows that although TBAs may not have scientific explanations for some of their practices and try to explain things in metaphysical terms, their practices are not completely harmful as depicted by some professional health practitioners. However, problems could result from their failure to recognize danger signs, their inability to implement simple evidence-based interventions for complications, and delayed referral (Rudrum, 2016). It is also emphasized that the cord should be cut with sterile instruments; hence, TBAs should be educated on this to prevent infections. One challenge encountered by TBAs is birthing of the placenta and burial by the family or in their presence according to their customs. Hadwiger and Hadwiger (2011)

recorded similar beliefs where the spouse buried the placenta at the dripping spot of roof water so that the baby will grow to be intelligent and courteous. The *Baganda* buried the placenta of a baby boy on a banana plantain used for making beer so that he grows up skilled in brewing. On the other hand, that of a girl was buried on the most fruitful plantain, *nakitembe*, so that she grows up with luck. This suggests that TBAs understand and respect the traditional religious beliefs of their clients and adhere to their requests. In relation to this, the assertion can be made that some women would still continue to seek the services of TBAs since they perceive them as people who share in their values and beliefs.

From the study, it is revealed that most TBAs engaged in much trial and error which includes many traditional interventions during delivery. This suggests that services provided by some TBAs in Kalungu district do not have defined guidelines that determine when they cannot manage a complication and this may lead to late referral with fatal consequences (Reeve et al., 2016). The current research calls for training TBAs to consider early referral in order to save lives. As compared to other studies where most participants were females (Abdul-Mumin, 2015) the researcher engaged eight males indicating that a general socio-cultural preference for female TBAs in sub-Saharan Africa although this is not speedily but gradually changing.

Bias was minimized in this study through the use of the same research instrument and verification of transcripts using an expert in *Luganda* language. The author concedes that TBAs who have formal education could have different experiences. Thus, the findings from this study should be generalized with caution.

Conclusion

The study revealed different approaches of initiation of TBAs and it was realized that whatever the initiation process, training was necessary to incorporate standard procedures in the care of women. The concurrent use of spirituality, herbs and the opportunity of women to observe or practice their beliefs such as the disposal of placenta attracted women to TBAs' services. Within the socio-cultural context of Buganda where religiosity is a key component of the culture (Mbiti, 1971). TBA services will continue to flourish and the use of some spiritual approaches in tackling maternal health issues may never cease. It is therefore important to train TBAs and provide them with the necessary resources to deliver appropriate services during pregnancy and labor in a holistic way, with much emphasis on the areas they find challenging such as cutting of the umbilical cord. A stronger collaboration with health professionals is also necessary to enhance their work.

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Ethics Declarations

Ethics approval and consent to participate: Participants gave informed consent to participate in this study by signing the consent form.

Competing Interests

The author declare that he has no competing interests.

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