DO CULTURAL BELIEFS AND PRACTICES INFLUENCE PLACE OF DELIVERY AMONG WOMEN ? A CASE OF IBANDA DISTRICT, UGANDA

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Abstract

The paper investigates cultural beliefs and practices that influence women's choice of the place of delivery in Ibanda district of Uganda. Primary survey data on 144 women aged 20-49 years, 10 traditional birth attendants (TBAs) and 5 focus group discussions were used in the analysis. Results showed that fifty five percent of the women delivered from home. Cultural beliefs and practices in the area included use of herbs, burial of placenta, compression of womb, unexposed private parts and delivering alone, but were found not to determine place of delivery. Multivariate analysis of quantitative data found that level of education and type of housing were the most influential variables. Qualitative data identified several reasons for rural women preferring home as a place of delivery including home convenience, family support, rude behaviour by health workers, past positive experience with home delivery, quick labour progression and preference for TBAs.

Introduction

While motherhood is a positive and fulfilling experience, for many women in Africa, it is associated with suffering, ill health and even death brought by complications during pregnancy and childbirth (Urassa , Massawe, Lindmark & Nystrom,1997). In low and middle-income countries, deliveries still occur at home and without assistance of trained attendants. This has generated serious concern, since any births require an appropriate care. Women normally turn to TBAs because other health workers are not available, are too expensive or because TBAs

understand the culture and respect women‘s needs during delivery. However, it has been observed that even trained TBAs cannot in most cases, save women’s lives because they are unable to detect or treat complications and are often unwilling to refer these cases to modern health facilities for better management (Carlough & McCall, 2005). This has contributed to the slow decline of the world maternal mortality (Hogan, et.al. 2010).

In Uganda, maternal mortality is still high and declines slowly. In 2011, maternal mortality was estimated at 438/100000 live births which aproximates at 16 women dying every day from pregnancy and childbirth related causes. In southwest Uganda, only 40 percent of the deliveries took place at health facilities compared to 57 percent that took place at home (UBOS and ICF International Inc 2012).

There have been several attempts to increase institutional deliveries in Uganda. These include Training of midwives in safe motherhood and life saving skills; construction of level IV health centers (with operating theatres and at least a doctor to man it) in every county to offer emergency obstetric care; and training of comprehensive nurses who can offer both midwifery and nursing; However, in southwest Uganda, the proportion of mothers delivering in health facilities continued being low (22% in 1995, 22% in 2001, 31% in 2006 and 40% in 2011), but the rates are even lower in rural areas and among the poorest quintile of the population (UBOS and Macro International Inc 2007, UBOS and ICF International Inc 2012).

Since the factors influencing the place of delivery are many, this study focuses on traditional cultural beliefs and practices related to childbirth, that people believe in, and their significance to influence choice of place of delivery among rural women in Uganda, which are not well explored in the existing literature. This information should give a better understanding of the science behind these traditional beliefs and practices and if possible be incorporated into the

health intervention programs to increase utilization of maternal health services and reduce the high maternal mortality rate within Uganda.

The main objective of the study was to establish reasons why women opt for home delivery in rural Uganda. Specifically, the study was to identify various traditional beliefs and practices related to place of delivery, assess their contribution in influencing the place of delivery and examine the relationship between socio-economic and demographic variables and place of delivery.

Methodology

The study was conducted in all 11 villages of Nyarukiika parish, Rukiri sub-county, in Ibanda, a rural district situated in south western Uganda in 2009. The area of study was randomly selected from all parishes in Ibanda district. The study was cross-sectional, using both quantitative and qualitative approaches. A structured questionnaire with open ended and closed questions was used to probe randomly picked 144 women in the reproductive ages of 20 and 49 years. A qualitative study consisted of 10 Traditional Birth Attendants who were aged at least 45 years as key informants and 5 Focused Group Discussions of various age groups with six mothers in each group.

The outcome variable of this study, which was also the dependent variable, was the place of delivery, which is binary. This is directly or through cultural factors influenced by cultural, socio-economic and demographic factors, which include education, age of the mother, occupation, type of house and marital status.

The software programme, Epidata, was used to enter the data into the computer, thereafter; the data was imported into STATA (8.2) for further analysis, which was done at three levels: univariate, bivariate and multivariate. The binary logistic regression model was fitted to establish whether the independent variables could explain the influence of culture on the place of delivery. This model was used because the dependent variable in the study is dichotomous, that is, a woman delivers from a health facility=1 or from home = 0. Qualitative data was analyzed using a thematic approach whereby in collecting data, patterns of experience were listed from direct quotes and paraphrasing common ideas in the interview.

RESULTS

Table 1 shows the distribution of respondents by background characteristics. Of the 144 women, over a third were young aged 20-29, close to half were middle aged and less than a fifth were old. Almost all of them were married with a tiny proportion divorced/separated. Close to two thirds of the women were involved in farming activities, while less than a fifth were in business/trade and one in 12 were public servants. In terms of education, over 6 in 10 had stopped in primary school, while 2 in 10 had acquired at least some secondary level education and less than 1 in 6 did not go to school. Half of the women lived in semi-permanent houses, 3 in 10 stayed in permanent houses and 18% were living in temporary structures.

Table 1: Distribution of women by background characteristics

Characteristics	**Frequency**	**Percent**
Age		
20-29 years	52	36.1
30-39 years	67	46.5
40-49 years	25	17.4
Marital status		
Married	137	95.1
Divorced/ Separated	7	4.9
Occupation		
Agriculture/Farming	91	63.2
Business/trade	25	17.4

Public servant	12	8.3
Not working	16	11.1
Education		
No education	22	15.3
Primary	91	63.2
Secondary +	31	21.5
Type of the housing		
Temporary	25	17.4
Semi-permanent	75	52.1
Permanent	44	30.5
Total	144	100.0

Table 2 shows the distribution of women by place of delivery, traditional beliefs and practices and the type of delivery attendance. The table indicates that over half of the respondents delivered their last baby from their homes assisted by traditional birth attendants, mother-in-law, and other non-medically trained people, while only 45 percent delivered in a modern health facility being helped by medically trained personnel. Three in ten women practiced traditional rituals during the last birth. Most of the respondents were aware that beliefs and rituals existed but this did not necessarily mean that whoever knew the rituals practiced them and even a few that applied and respected them reported that beliefs and rituals could not stop them from delivering from the health facilities.

The reported traditional beliefs and practices included use of herbs, burial of placenta, womb compressing, not exposing the private parts and delivering alone. The most common practice was use of herbs. During labor, TBAs, women's mothers and relatives applied herbal medicine on the abdomen of the mother. The clay capsule *(emumba), were a mixture of clay soil with different herbs to soften the pelvis* and the woman would deliver sooner. Tea leaves to quicken labour progression were also given. Secondly, women compressed their wombs after delivery in order to keep them in shape and stay beautiful. In the health facilities, this would not be

allowed as it is dangerous and could dislocate women's bones. Thirdly, the respondents believed that it was not proper for a woman to expose her private parts to strangers, like health workers, some of whom were men. Fourthly, it was also believed that courageous and strong women delivered alone without any assistance, which is very risky to the health of the mother.

Table 2: Distribution of women by place of delivery, traditional beliefs and practices and the type of delivery attendance.

Place of delivery for the last birth	**Frequency, n=144**	**Percent**
TBA/Home	79	54.9
HC	65	45.1
Practice of traditional beliefs on last birth		
No	101	70.1
Yes	43	29.9
Beliefs and practices		
Use of herbs	66	45.8
Placenta burial	24	16.7
Compressing the womb	20	13.8
non exposure of private parts to strangers	15	10.5
Delivering alone	11	7.6
Don't know	8	5.6
Who attended to you?		
Health personnel	65	45.1
TBA	56	38.8
Mother-in-law	9	6.3
None	9	6.3
Husband	5	3.5
Total	144	100.0

Table 3 gives results from applying binary logistic regression on the data linking place of delivery and women's characteristics, in order to estimate predictors of place of delivery. In the table, there were two predictors, namely, women's education and economic status of the household. Women with at least secondary education had almost 8 times more chances of delivering in modern health facilities than uneducated women (OR = 7.6, p = 0.035). This is an expected finding in that women with high education had more information than others in appreciating the advantages of modern health facilities over home delivery. Similar results

were found by studies done in Turkey by Celik and Hotchkiss, (2000), in Enugu, Nigeria by Ikeako, Onah and Iloabachie, (2006) and in Lao by National Statistical Centre, (2007).

According to Table 3, the second predictor of place of delivery is type of house a woman lived in, which was used in this study as a proxy for economic status. The women who live in permanent houses were considered to be rich, while those who stayed in temporary building structure were poor and those in semi-permanent houses were medium rich. The results in the table show that respondents who lived in permanent houses had close to 9 times more chances of delivering from a modern health facility than those who stayed in temporary structures (OR=8.8, p = 0.003). This is because rich women could afford to transport themselves and the cost of delivering in modern health facility, compared to the poor women. Previous studies confirmed that women from low economic status find it difficult to use modern health facilities for delivery in rural Tanzania (Mrisho *et al*., 2007) and in Ethiopia (Warren *et al*., 2010). Also in Nepal, women with higher income levels gave birth in a hospital compared with those with lower income (Pradhan, 2005).

Table 3: Results of Binary Logistic Regression Model

Variable	Odds Ratio	Std. Err.	p>z	95% Confidence Interval	
Age					
20-29*	1.000	--	--	--	--
30-39	0.558	0.276	0.239	0.211	1.474
40-49	0.704	0.463	0.594	0.194	2.555
Marital status					
Married*	1.000	--	--	--	--
Divorced/ Separated	0.629	0.656	0.657	0.082	4.861
Education					
No education*	1.000				
Primary	2.382	1.822	0.256	0.532	10.665
Secondary +	7.641	7.373	0.035	1.153	50.639
Occupation					

Not working*	1.000				
Business/trade	2.724	2.675	0.308	0.397	18.670
Agriculture	2.787	2.357	0.226	0.531	14.626
Type of house					
Temporary*	1.000	--	--	--	--
Semi-permanent	0.633	0.362	0.424	0.207	1.939
Permanent	8.812	6.359	0.003	2.142	36.250
Practice of traditional beliefs					
Yes*	1.000	--	--	--	--
No	2.233	1.159	0.122	0.808	6.176

* Reference category.

It is important to note from Table 3 that the practice of traditional beliefs was not a predictor of place of delivery. This implies that these beliefs and practices have lost influence, may be as a result of education and modernization. In fact, the odd ratio of women not practicing the traditional beliefs and values using modern health facility was 2.2 times those practicing the beliefs.

Reasons for preferring home delivery to modern health facility.

To explain the continued preference of home to modern health facility, the study collected qualitative data from the community. The community responses on why they preferred giving birth at home to delivering at modern health facilities were severalfold**. First, the community reported that delivering at home was easy and convenient because the women did not have to move from one place to another. Delivering at home would ensure that the women would not give birth on the way to a modern facility, which was believed to be a taboo, making children born in such situation never to settle at home as they grow up. A focus group discussion 39 year member said:**

"I would like to deliver at home because it is easy and convenient. Engaging in unnecessary movements in the labour process may be dangerous and fatal, some women sit on their babies

while on the way to the hospital and the children die. In addition children born while on the journey are ever moving here and there".

Similar reasoning was found in a study conducted in Philippines by Schwartz et. al (1993), with a result that giving birth at home would avoid unnecessary movements of heavily pregnant women.

A second response was that women delivering at home get family support. The presence of family members such as the women's mother, mother-in-law, husband and other relatives provides the needed psychological support and physical touch like a back massage and gentle touching of the abdomen. A 25-year woman in a FGD stated:

"I would like to deliver at home because I want my husband to stay with me during labor so that I feel his warmth and love. My husband would hold my hands, and the TBA would stay with me all the time, but in the hospital, the midwife predicts the time for delivery and goes away".

A study by Moscucci (2002) similarly found that women in Britain delivered from their homes because they preferred their husbands and other close family members to take care of them and provide some psychological and emotional support.

In contrast to the family support, most women complained of being treated as strangers in the modern health facilities.

"*I prefer giving birth at home, assisted by TBA or relatives rather than in the unfamiliar setting of HC. We the uneducated have problems. Even before you talk, the midwife thinks automatically that you do not understand. I was abused at HC that I did not appear in good clothing and had no new clothes for the baby. Moreover, I had taken old clothing I used for the*

*older children although they were old, they were not torn. I was embarrassed! Health workers only like the rich" (*40- years- old woman respondent).

It was reported that women are made to feel powerless by the health workers. Sometimes midwives are overworked and too tired to listen to the patients and end up being rude and unfriendly. Although rural women admitted that they were poor, it was not the responsibility of a midwife to inform them of their poverty. In Ghana, women were discouraged from delivering at modern health facility, due to abusive language and lack of tolerance by health workers. (D'Ambruoso *et al*., 2005).

Furthermore, when women are having labour pains, some of them make noise and others become weird. In response, family members calm them down with sympathetic words and encouragement, unlike in health facilities where noise means that you are disturbing others and becoming unruly.

"When you go to deliver in a hospital, midwives cannot sympathize with you. When you feel pain and make noise, it is a crime. The midwives can decide to ignore you. In such a situation, I was about to lose my baby because I was ignored and when I called health workers for help, they started laughing at me, but God helped me and they came when they saw the baby had come out" (30-years-old woman).

This makes the women regret why they went to the modern health facilities for delivery. In Nigeria women too delivered from home because of unfriendly behavior of medical staff (Envuladu *et al*., 2003).

Another reason for preferring delivering birth at home to a modern health facility was to ensure privacy. Women in this society fear being naked and grew up knowing that their naked bodies belonged to their husbands only, but not strangers. When delivering their babies, women try to

maximize privacy and this was easier at home. In contrast, the environment in which women delivered at modern health facilities lacked privacy. Often the labour ward at the health facility was crowded by pregnant women and their relatives and there are no special rooms for delivering babies. A 44 year old woman lamented:

"Imagine a midwife fit to be your daughter directing you with pride. Can you imagine adding pain on an already existing pain? Exposing my private parts to my daughter is an abomination in my tribe".

Mrisho et. al. (2007) also found that women were **afraid to be seen delivering babies in public.** In addition, where some hospitals train midwives, some women who come to deliver become case studies for students, which women do not like.

Previous experience was taken into account when selecting the place of delivery. Most women in FGDs reported that they had some experiences delivering at home from their first child to their current pregnancies. If the previous place of delivery was good, it was more likely to use the same place in their next births. In addition, the childbirth experiences of their mothers, mothers-in-law, aunts and grandmothers influenced where their deliveries took place.

> *"If everyone in our family has been delivering here safely, then why waste time going to the hospital, what if something bad happens to me in the hospital? Most likely one can die because most of the maternal deaths have taken place there"* (23-years-old woman).

Similarly, in Ethiopia most women who gave birth from home regarded delivering from formal institutions as not necessary and even not cultural (Central Statistical Authority (CSA) [Ethiopia], and ORC Macro, 2006). Ignorance contributes to such perceptions, which require education to young future mothers and maternal health sensitization to the current illiterate women.

Women who experience quick progression to labour end up delivering at home. In case of emergency, when there is no warning that labours would start, women in the rural areas without immediate transport, they had no alternative, but to deliver at home.

"Labor was quick and easy, I could not go to the health facility on time. More so because I knew that pregnancy takes a period of nine months but I delivered at eight months, so I was not prepared at all" (20-years-old woman who had delivered).

A study done by Mrisho *et al*., (2007), in rural Tanzania found that sudden onset of labor forced women to deliver at their homes.

The last reason for preferring home to health facility delivery was preferring assistance from TBAs and being satisfied with their services to those of health workers. Most women in FDGs praised TBAs of being familiar with them, not expensive, being experienced, caring and friendly. Traditional Birth Attendants reported that they were preferred because of their experience. Others said that it is because women cannot afford health services, while others believed that women liked to be assisted by the people they knew and are familiar with. Cost and place of delivery were related as TBAs were mostly rewarded in kind by their clients through gifts and small amounts of money. The most treasured gift was a special meal locally referred to as "Ekihuuro". This was manageable and affordable to the women who were free to prepare what they afforded.

Similarly, in rural Tanzania, women from poor families hardly use health facilities for delivery. They lacked money for transport when the facility is located at a distant place and money to pay for delivery kit, hospital bills as well as food while at health facility and some hospitals could not discharge women with no money until their debts were paid in full (Mrisho *et al*., 2007).

Also, Kyomuhendo (2003) found that TBAs in Uganda assisted women to deliver, deal with pain and solve minor problems during delivery. They provide care that many women would otherwise not be able to access elsewhere, which increased women's preference for their delivery services. However, the herbs that women use were medically perceived to be harmful to the health of women because they were not recommended and tested, unlike what modern medicine went through before approval for use.

Conclusions

The study found that there were various cultural beliefs and practices related to childbirth. Although women respected and performed cultural beliefs and practices, the beliefs and practices did not influence their choices on place of delivery. Women's level of education and their economic status influenced their choices on where to deliver their babies. Besides, the qualitative data reported other factors that influenced women's choice of place of delivery and these were, home convenience, family support, rude behaviour by health workers, past positive experience with home delivery, quick labour progression and preference for TBAs.

Recommendations

To improve maternal healthcare requires that pregnancy and childbirth be conceived as health conditions with potential risks, which require the presence of modern health-care providers. However, TBAs will continue being used in delivery in rural Uganda since the majority of women are demanding their services. This is because most rural women do not have financial ability to deliver from the health facility and can only afford the services of TBAs. Therefore it is necessary to train and use the TBAs so that they can be able to recognize pregnancy complications and refer those with risky conditions, deliver positive messages on benefits of institutional delivery and also conduct deliveries in case of emergency and normal cases.

The only direct significant determinant of women's choice of place of delivery was education. Therefore, the government of Uganda should seriously continue promoting female education and women empowerment and provide regular health education to the current active reproductive women on the dangers of home delivery as a way of reducing maternal mortality in the country.

There is need to do a similar study at the national level to understand different causes of poor utilization of maternal health services particularly the place of delivery and ways of improving them.

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