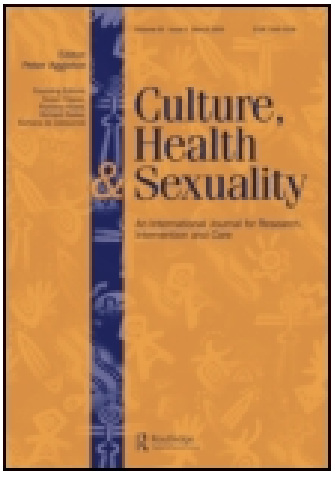

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Birthing choices among the Sabiny of Uganda

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The paper examines maternal health-seeking behaviour among the Sabiny people of Eastern Uganda in relation to health policy ideals. It is based on a study of maternal health conducted between 2011 and 2012. Data were collected using in-depth interviews with mothers, focus group discussions with mothers and fathers and key informant interviews. The paper addresses what factors influence choice of place of delivery among the Sabiny. Findings reveal that the majority of Sabiny women opt for homebirths, with around one quarter delivering at health facilities. Some women would prefer to deliver at a health facility but do not manage to do so. Sabiny cultural beliefs and practices are a key factor influencing choice of place of birth. Comprehension of and accommodation to Sabiny concerns in available maternal health services is limited, highlighting the need to develop cultural competence among health workers and methods of accommodating (health-promoting) local practices. This should be accompanied by improved patient care and a narrowing of the gap between health workers and Sabiny communities by promoting outreach and community-based health interventions. The paper highlights how the implementation of policy might be tailored to specific local contexts.

Keywords: culture; birthing choices; Sabiny; Uganda

Introduction

This paper is based on findings of a study conducted in 2011–2012 that explored cultural beliefs, practices and experiences associated with pregnancy, birth and the post-partum period in relation to the utilisation of health services among the Sabiny people in Kapchorwa district, Uganda. It seeks to identify the factors that influence choice of place of delivery among the Sabiny. Culturally embedded pregnancy and birth beliefs and practices, decision-making arrangements, issues of social support and the strengths and weaknesses of various delivery and post-delivery care options were all analysed, resulting in recommendations for improving maternal health.

Maternal morbidity and mortality remain unacceptably high in sub-Saharan Africa where, for instance, a woman's maternal mortality risk is 1-in-30, compared to 1-in-5600 in richer parts of the world. The decline in maternal mortality rate is also slow, although the majority of deaths could be prevented (Goodburn and Campbell 2001; United Nations 2010). Improving maternal health in Uganda poses a challenge. Perinatal and maternal health problems account for 20.4% of the total disease burden. Limited progress has been made in ensuring universal access to reproductive health (Ministry of Health 2010). Notably, the maternal mortality ratio remains high at 438 per 100,000, while the perinatal mortality ratio is 40 deaths per 1000 live births and pregnancies (Uganda Bureau of

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Statistics and ICF International 2012). In Uganda, the utilisation of maternal health services remains low. While antenatal care (ANC) attendance is almost universal (95%), only 48% attend four or more times (UBOS and ICF International 2012). According to Amooti and Nuwaha (2000), most women's intention in attending ANC is acquisition of the ANC card, which is required for delivering at health facilities. Only 41% of births are assisted by skilled attendants, which is low compared with less developed countries generally, where 63% of births are assisted by skilled personnel. Routine postnatal care coverage is also low, at 26% (United Nations 2010). Poor maternal and child health has been associated with the nature of birth attendance and the risk of maternal death is higher amongst unassisted births or those attended by unskilled birth attendants, which usually occur in home settings (Prata et al. 2005). Such births are associated with the inability to handle complications, unhygienic conditions and the use of unsterilised instruments, which expose mothers and babies to infections (Ministry of Health 2010).

Health indicators of indigenous/minority populations are usually worse than amongst the general population. For example, the infant mortality rate among the Batwa people was 21% compared with 5% among the non-Batwa in South Western Uganda. This is attributed to geographical isolation, displacement (in some cases) and the persistence of socio-economic marginalisation, compounded by cultural barriers, inappropriate health services and cultural insensitivity and discrimination by health workers (Stephens et al. 2005, 2006; Ohenjo et al. 2006).

Birthing choices in Uganda

The shortcomings of health service delivery in the public sector in Uganda are widely documented (Munene et al. 1997; Kyomuhendo 2003). Apart from access and affordability challenges, public health facilities are often under-staffed and may lack basic equipment and supplies. The treatment of patients seeking delivery services is often of low quality and culturally insensitive (Kyomuhendo 2003; Waiswa et al. 2010; Oosterhoff et al. 2011; Ruiz et al. 2013). The situation is worse for indigenous communities (Ohenjo et al. 2006). Interventions that have enhanced utilisation of health facilities include the provision of community-based transportation and communication means and the establishment of waiting rooms (Amooti and Nuwaha 2000; Andemicheal et al. 2010; Ruiz et al. 2013).

Adherence to traditional birth practices influences the choice of place of delivery amongst numerous ethnic groups in Uganda. Among the Banyankole, for example, childbirth is regarded as a normal process that should take place at home, while among the Banyoro and Baganda, pregnancy and childbirth are viewed as risky and equated to a battle or a 'thorn-strewn path' that the woman has to tread. Maternal death among the Banyoro is regarded as a sad but normal event. Nevertheless, homebirths are admired. Women who deliver by Caesarean section (C/section) are deemed lazy and are therefore not congratulated (Kyomuhendo 2003). Indeed, amongst certain cultural groups, particular value is placed on unassisted births and women in labour are discouraged from communicating about their condition (Sargent 1984; Bradby 1999). Home-based, unassisted deliveries have an element of self-efficacy that is founded on cultural institutional values and experiences (Amooti and Nuwaha 2000).

Despite their frequent lack of technical skills, traditional birth attendants (TBAs) are deemed a culturally appropriate and acceptable presence during delivery by many ethnic groups in Uganda. Advantages locally associated with TBAs include their accessibility and in some cases the belief that these women possess 'magical' abilities to change the sex of the baby and treat infertility (Waiswa et al. 2010). However, TBA practices remain

controversial since they are associated with late referrals and the poor management of various medical obstetric conditions (Ministry of Health 2010).

In Uganda, the use of herbs, non-supine delivery positions and placenta disposal are all cultural preferences that are more easily put into practice in the home setting, and hence influence the choice of delivery location (Kasolo and Ampaire 2000; Kyomuhendo 2003). The practice of Female Genital Mutilation/Cutting (FGM/C), which in Uganda is practised by the Sabiny and Pokot people, can also influence birthing choices. It has been observed elsewhere that circumcised women may resist using biomedical services (particularly outside their own cultural setting) for fear of embarrassment (Lundberg and Gerezgiher 2008; Odemerho and Baier 2012). Traditional practices aimed at tending to the new-born, such as the seclusion of mother and child (staying inside the home for periods ranging from days to months), may have social and health benefits but are also potential deterrents to women and newborns receiving timely postnatal care (Waiswa et al. 2008).

Gender relations are also instrumental in determining the place of delivery. Men, as household heads and controllers of economic resources, are instrumental in making decisions concerning place of birth and modes of care, even though their decisions may usually be informed by mothers-in-law, TBAs and other senior female relatives, who also provide social support to delivering women (Neema 1994; Amooti and Nuwaha 2000).

The Sabiny

The Sabiny are a Nilo-Hamitic ethnic group in Eastern Uganda whose livelihood is based on mixed farming (Benintendi 2004). There are disagreements in defining indigeneity in Uganda since all ethnic groups were colonised (African Commission on and Peoples' Rights 2009). The Sabiny are not classified as being among the indigenous peoples of Uganda. However, they share descent with the Benet (Himmelfarb 2005) and some characteristics with indigenous people in general.

The Sabiny have a distinct language and culture relative to the larger ethnic groups of Uganda, with a strong sense of separate cultural identity and need for its preservation (Stephens et al. 2006). The Sebei sub-region is geographically isolated and largely mountainous, with one all-weather road to the district town of Kapchorwa. Attracting and retaining skilled service personnel is a challenge. The distinctiveness of their culture relative to the rest of the country and possible marginalisation at health facilities is likely to impact upon Sabiny access and utilisation of health services (see, e.g., Ohenjo et al. 2006).

In Uganda, some (though limited) ethnic specific health data exist, but only for the Batwa and Karamojong peoples (Stephens et al. 2005; Ohenjo et al. 2006; ACHPR 2009). Apart from their practice of type II FGM/C (removal of the clitoris and labia) as a rite of passage to female adulthood (Jones et al. 2004) little data exist about Sabiny women's health. The fulfilment of productive and reproductive roles is known to be important for a woman's perceived marital worth. If a wife dies during the birth of her first child, her bride-price is returned or another woman is given to the husband. A man can divorce his wife for (among other reasons) having 'children three times and each time she "kills" them' (Benintendi 2004). Kapchorwa is among the districts in Uganda with the highest maternal mortality ratios at about 600 per 100,000 (Mwesigye 2011). Given the national-level maternal mortality ratio of 435 per 100,000, this evidence reveals the gross intra-country health inequalities that can occur even within a developing country (Stephens et al. 2006).

The United Nations declaration on the rights of indigenous people, to which Uganda is a signatory, and the African (Banjul) charter on human and peoples' rights-both make provision for a culturally sensitive participatory rights based approach to healthcare delivery. Articles 21, 23 and 24 of the former, state that indigenous peoples have the right to the improvement of their economic and social conditions, including their health, the right to be actively involved in developing and determining health, the right to traditional medicines and health practices and the right to access, without any discrimination all social and health services (IFG and Tebtebba Foundation 2009).

Methodology

The study was part of wider research on birth experiences of women from four cultures of Uganda, conducted under the supervision of the Uganda Population Secretariat and the United Nations Population Fund. The study was designed and conducted by the Centre for Population and Applied Statistics (CPAS) at Makerere University, with the author as team leader. It was conducted in Kapchorwa district (named after Kapchorwa town), Chema/Munaria Sub County, Sipi and Chebonet villages, Eastern Uganda, between April 2011 and March 2012, with additional interviews conducted up to June 2012. The locations were purposively selected owing to the availability of health facilities. Qualitative methods were used for data collection. Research activities were carried out by the lead researcher (the author) and Sabiny research assistants. Interviews at the community level were conducted in Kuksabiny. English was used at the district level.

Participants were purposively selected for their knowledge and experience of maternal practices among the Sabiny. A total of 10 key-informant interviews were conducted with health personnel, TBAs and local leaders, 9 in-depth interviews were carried out with selected mothers of varying age and parity and 4 focus-group discussions (FGDs) were held with 10–12 participants each, with young (15–24 years), middle-aged (25–35 years) and older (36 + years) women and fathers (29–46 years), respectively. Pair-wise ranking and problem cause-effect tree analysis were used in the FGDs to analyse preferred birthing options and explore perceived causes of maternal and perinatal deaths, respectively. Themes explored in the primary data collection included cultural understanding of childbirth, decision-making on the place of delivery, and women's experiences with the various delivery options. The data were recorded, transcribed, translated, captured in Excel and analysed according to the main and sub-themes of the study.

The study was approved by the Uganda Population Secretariat, a government institution that, according to the National Council for Science and Technology, does not require ethical clearance since the research was conducted in a programming context. Permission to conduct the research was, however, obtained from district and local authorities. Voluntary informed consent was obtained from all respondents. For purposes of maintenance of anonymity, pseudonyms are used for quotations in this paper. The Centre for Population and Applied Statistics, which owns the study data, provided clearance for them to be used in this paper. The possibility of bias where some responses may reflect what respondents feel is appropriate was checked through triangulation.

Findings

Motherhood among the Sabiny

Motherhood is one of the most important attributes that defines a Sabiny married woman. Among the Sabiny, a woman's worth is pegged to her performance of culturally defined

reproductive and productive roles. Payment of bride-price is effected mindful of these expectations. Women are held responsible for ensuring live births (Benintendi 2004). Conception within marriage is welcomed. However, hard work and endurance are synonymous with pregnancy and childbirth. This contrasts with the Baganda and Basoga, for instance, where a display of pain during labour is expected. Pregnant women are not expected to neglect their domestic and productive work. Given the value attached to children, protective measures are taken to ensure the health and safety of the baby. Extended sexual abstinence is expected at the realisation that a woman is pregnant and up to six months after delivery. The *vernix caseosa* on babies' skins is believed to provide evidence of sexual activity during pregnancy and is therefore scorned.

Consultation of and care by the TBA is synonymous with motherhood. The TBAs' services apply throughout the antenatal, birth and postnatal period. Services are integrated in nature ranging from what are believed to be magical abilities in aiding conception, correction of mal-positions, change of the baby's sex, to practical aspects of delivery, care and management of post-delivery complications in a culturally appropriate manner. The TBAs are regularly visited during pregnancy for belly massages, and administration of herbs.

Motherhood is a central aspect of womanhood; Uncircumcised women are girls and a mother is expected to be circumcised and uncircumcised women, who deliver with TBAs are often circumcised afterwards. Failure to adhere to cultural expectations of motherhood in the delivery process and failure to comply with FGM/C affects a woman's role in child rearing and her status as a mother throughout the children's lives.

Delivery options

The majority of women who participated in the study were acquainted with both the biomedical and traditional health systems and it was found that ANC and delivery services are sought out as deemed necessary. Study findings revealed that ANC usually takes place alongside regular care by TBAs and the results of ANC check-ups inform interventions by TBAs. As observed elsewhere in Uganda, qualitative data revealed that some women attend ANC merely to obtain the ANC card to give them access to services in case of major complications during delivery.

Beliefs and practices regarding pregnancy, delivery and the post-partum period inevitably influence delivery choices. Three scenarios were identified relating to childbirth choices: (1) a strong cultural preference for homebirths, which in this context refer to any delivery in the domestic informal setting, including women's and TBAs' homes, (2) women who would prefer but do not succeed in using health facilities and (3) those that select health facility births.

Homebirth preference

Results from an analysis of the Uganda Demographic and Health Survey data (Uganda Bureau of Statistics and Macro International 2007) revealed that only 26.7% (8/30) of Sabiny women interviewed deliver at health facilities. In the current study, the choice of homebirth was found to be influenced by several cultural ideas, namely the ideal of an unassisted birth, preference for TBA-assisted deliveries (where necessary) and the desire/need to follow local birthing and post-delivery practices.

Interview respondents and FGD participants reported that among the Sabiny although pregnancy increases a woman's status, she is expected to work hard throughout that time.

This is believed to both make the baby healthy and the woman physically fit for delivery. According to one in-depth interview respondent:

> A woman is expected to move, carry luggage (but not on her head) to give her strength, dig to make the waist flexible. She is not expected to rest anyhow. (Angela, 47)

Aspirations for unassisted birth

Female study respondents reported that, according to the Sabiny ideal, women should deliver alone at home. This is based on an origin myth that the mother of the 10 Nilo-Hamitic groups that migrated from Ethiopia (including the Sabiny) had unassisted births, which her daughters should emulate.

In Chebonet village, it was reported that one woman had delivered 11 children by herself and was consequently well-known and highly respected. One in-depth interview respondent described her own experiences:

> I had all my 10 children at home. I used a mat or a sack because I did not have polythene sheet from the hospital. Sometimes I used a razor blade or even a knife to cut the cord. I would use a string to clamp the cord. I always had a basin with some water to clean myself after delivery. (Patronella, 35)

Women's reports concerning unassisted births were confirmed by a key informant interview with a male health professional:

> Women are expected to squat, struggle, and deliver without TBAs poking fingers. They have to do it alone. (Meshach, 54)

Study participants highlighted how unassisted births are promoted through the belief that such births are an endurance test and the marker of a real woman. Childbirth is generally portrayed as a battle – the phrase *mi barite*, meaning 'going to war', is used. Key informants and women FGD participants reported that women in labour are expected to show resilience by bearing pain without crying. In contrast, a health facility delivery is believed to be a sign of weakness because it usually entails the use of drugs and equipment that ease the process. Seeking care at health facilities was presented by many study participants as a last resort. Caesarean sections, in particular, are avoided as far as possible. A key informant revealed that among the Sabiny, a man whose wife delivers by C-Section could be denied the right to speak in certain fora because he did not ensure his wife exercised her body sufficiently for a homebirth. Men are supposed to ensure that their wives work hard during pregnancy. Women FGD participants reported that children born by C-section are believed to be dull.

Further, one key informant reported that the pain experienced in homebirths is believed to enhance bonding between mother and child, which is deemed essential for child rearing. Overall, therefore, failure to deliver at home can mean that a Sabiny woman's desired identity as a strong woman (as well as their spouse's dignity) is compromised.

Role of TBAs and social support

With respect to assisted births, women who participated in the study described how they preferred to be aided by those they trusted. The popularity of TBAs was found to cut across socio-economic status. A key health professional reported how:

> An educated prominent civil servant's wife in this town who attended ANC was told that the baby was in a transverse position. She believed more in delivery with a TBA since the TBA

> could change the position of the baby. She literally walked right past the hospital and went to deliver at famous TBA's. (Meshach, 54)

The TBAs are appreciated for providing comprehensive and consistent care during pregnancy, birth and the postnatal period, while also understanding and facilitating cherished cultural practices. Indeed, they are trusted to the extent that it was reported that advice given by a health workers is often subject to a TBA's approval. This creates tension, particularly where owing to the TBAs' advice, women who need skilled care fail to access the services and arrive at health facilities when it is too late.

The TBAs were reported to have excellent interpersonal relations and were characterised as polite and comforting, providing warm water for bathing, tea, food and even clothing when necessary. It was reported that TBAs accept clients irrespective of clients' poverty or poor hygiene. This was confirmed by a health professional in an informant interview:

> TBAs have good public relations; they are better than our staff. They welcome and greet patients, share food including sour milk which is a delicacy. (Meshach, 54)

The overall physical, emotional and social support provided by TBAs was highlighted by one female FGD participant:

> At the TBA's, somebody holds your hand and gives you strength to push. They even hold your waist to help increase the frequency of the contractions. Food and tea are served and many people come to see you; generally the care is good. (Margaret, 28)

Women also reported valuing the additional social support provided by other members of the family and wider community during delivery. Mothers, mothers-in-law, other female relatives, neighbours and sometimes spouses also provide advice and sometimes assistance during delivery, which is not authorised during facility deliveries. At the same time, gender relations and interactions between husband and wife were reported as being more fraught and complex. One female FGD participant observed how:

> If the mother fails to push, even the men come and they force her to push by beating, slapping, pinching, and biting her head. The husband also tells her not to kill his baby. (Anisa, 52)

Importance of traditional practices during and following delivery

Cultural practices such as the use of herbs and the mobility of the woman in labour to facilitate the descent of the baby are all more feasible at home than in health facilities and are also likely to contribute to the current homebirth preference. It was reported that the Sabiny traditionally squat, kneel or sit to ease delivery – indeed, some who adhere to the traditional birth positions believe that lying prone could kill the baby and, as such, homebirths are preferred as the safest option. In contrast, women indicated that they are compelled to accept the supine position at health facilities.

The preference for traditional birthing positions is also linked to circumcised women's desire to limit the exposure of their bodies. As described by one FGD participant:

> At the health unit the nurse may over-expose my private parts, which is not good for me. (Rose, 21)

The fact that FGM/C is prohibited by the national government increases women's apprehension. It was also reported that homebirths are also preferred because women do not wish to be seen by non-Sabiny health workers who are strangers to their culture. According to a key informant:

> Women do not want people who may not be part of the Sabiny culture to see how they suffer. (Florence, 62)

Preferred postnatal cultural practices were also reported as contributing to some families opting for homebirths. Traditionally, after clamping the baby's umbilical cord, charcoal powder and herbal extracts are applied to the cord stump. The baby is given boiled water with sugar and salt to cleanse its stomach and ease digestion and herbal mixtures to boost its immunity. The TBA plays an important role and the close, ritualistic care provided to baby and mother also generates an important sense of belonging to the community.

The Sabiny regard the placenta as a baby in another form, which requires proper disposal, otherwise the new-born can become ill (indeed, the placenta is called *letut,* meaning 'deadly'). Traditionally, the placenta is either buried in a banana plantation or outside the house, or thrown into a pit latrine facing upwards by a trusted person. It is important to ensure that the placenta is not eaten by animals or accessed by persons with ill intentions. The placenta of a breech delivery is pinned on a stick and fixed to the roof until it decomposes. As such a birth is associated with a curse, the placenta is hanged in prayer to the ancestors for forgiveness and the wind is believed to blow the curse away. The placentas of twins are kept in the house for the period the mother remains in seclusion.

Seclusion for the mother and baby lasts at least a week after delivery. For twins it can last up to three months (depending on when ritual requirements can be met). Traditionally, new-born babies are not permitted outside the house to avoid people with the 'evil eye'. Whereas TBAs follow-up their clients for extended periods depending on their health conditions, home visits by health workers were not reported, with the exception of a few cases of mothers who delivered at health facilities.

While seclusion has the value of disease prevention and allowing the mother time to recover from delivery, it prevents women and their new-borns receiving early postnatal care. Babies are usually taken for immunisation after one week (longer in the case of twins). It was reported that institutional postnatal care is usually associated with illness or complications after birth and therefore only sought in case of serious complications.

Unsuccessful homebirths

Despite a cultural preference for delivering in the home setting, study respondents acknowledged that not all homebirths have a successful outcome. Reported complications that result in recourse to health services include obstructed labour, placenta retention and severe haemorrhage. Further, many interview respondents and FGC participants reported cases of perinatal and maternal deaths in their communities during the past two years. A male FGD participant described

> The wife of my brother-in-law was in labour but did not tell the husband. She told an old woman who helped her to deliver. The baby was placed on the bed. The placenta was retained and she bled severely. The husband was later informed and she was taken to hospital but died upon arrival. The body was brought home. … The baby was found under the blanket; it survived. (Stephano, 58)

It was noted that maternal deaths are often attributed to witchcraft and sometimes spousal violence.

Obstacles to the use of health facilities

Interviews with some women revealed cases where they preferred to seek maternal care at a formal health setting but were not able to do so due to decision-making processes associated with gender roles, the aforementioned cultural ideals associated with enduring pain and the challenges of access to and affordability of services.

Sabiny wives have limited decision-making power, hence husbands are the main decision-makers concerning the place of delivery, sometimes in consultation with experienced female relatives and TBAs. Husbands are also responsible for paying for any services provided. A husband's decision is likely to include his opinion on what a (culturally-speaking) 'ideal birth' is, coupled with the availability of funds and his willingness to pay, and whether complications are anticipated. Male FGD participants noted that homebirths were cheaper, although it was also observed by one local leader that an economic rationale could be used as an excuse for husbands pursuing their preference of maintaining their dignity within Sabiny culture by means of conforming to homebirth tradition.

At least one case was reported of women being compelled to homebirth contrary to their own (implied) desires. The individual in question described matters thus:

> The labour was very difficult until relatives present thought I should be taken to hospital but when we reached the road my husband refused and I was brought back home. The TBA was rough, she told me to push when the time was not appropriate. My husband no longer cared because he had other women. (Florence, 45)

Both male and female FGD participants reported how alcohol consumption by husbands led to negligence due to absence or inability to assist when needed and lack of finances, which resulted in delays in (or non-) attendance of services by women in need. Women whose spouses worked outside the district often made decisions alone.

Prescribed gender roles also inhibit health service attendance. For example, the desire to work until delivery, compounded by concealing labour pains as part of showing endurance, and also a lack of responsible persons with whom they can entrust existing children were all reported as contributing to the current inability of many women who might be interested in attending health facilities to actually do so. Furthermore, the current management of health facilities can also serve as a deterrent to attendance. Miscalculation of delivery date and lack of a waiting space for women in labour were cited as barriers. One of the women interviewed recounted visiting a health facility during labour but being told it was too early, so returned home where she delivered upon arrival. Some women reported that they were unable to access services due to transportation challenges, given the mountainous terrain and poor roads.

Women who deliver at health facilities

In Kapchorwa, public facilities are the main source of formal maternal healthcare. All nine in-depth interviewees indicated that they would prefer to have their next baby at health facilities. Although it is possible that some women reported what they thought was the government's expectation of them, it appeared that some women genuinely appreciated institutional services, stressing the fact that when other options fail, the hospital is the final solution. Aspects that women expressly valued included health workers' technical expertise in handling complications such as: severe bleeding, breech presentations, retained placenta and managing second and third degree tears. The availability of drugs for induction of labour, incubators, HIV prevention and a hygienic environment were also particularly appreciated. An in-depth respondent and a FGD participant noted, respectively:

> TBAs use dirty hands … a TBA carries your new-born child with dirty hands! At least health workers use gloves. (Agnes, 19)

> The disease of HIV came; now hospitals are safer. (Hamida, 47)

The same women, however, had major concerns about patient treatment. It was reported that the significant divide between health workers' and Sabiny service users' culture and

language, the 'professional' distance maintained by health workers and the lack of rapport combined to complicate the delivery process and deterred many women from attending health facilities. Cases of negligence and unethical behaviour amongst health workers, including physical abuse, were reported by several participants. One female FGD participant reported:

> I had gone to deliver and the time reached to push at night. The nurse was called, but she refused to wake up. Later she came and examined me and said it was not yet time so she went back. By the time she came back, I had already delivered with help of my relatives. She came and cut the umbilical cord and left saying that the second baby was still far (I had twins). I also gave birth to the second one with help of my relatives. She again came and cut the cord and then left to assist another woman who had just arrived before my placenta came out. I asked my relatives to help me kneel. I was given tea and within a short time it came out. The nurse instead got angry and asked for money for assisting me and I had to pay her. Another nurse attended to me and gave me an injection. (Theckla, 23)

Poorer women may be discriminated against. Another FGD participant noted:

> Some mothers are poor; they cannot afford fancy clothes. A mother may go with a clean cloth but old and torn to carry the baby; the nurses will slap and even beat such a mother. (Olivia, 32)

Women desirous of delivering at a health facility at the same time expressed interest in the presence of a familiar person during delivery and the possibility of using traditional birth positions, which are not currently accommodated in health facilities. Ideally, women expressed a preference for mature, female health workers from their own culture or at least those familiar with Sabiny culture, who would be willing to follow-up patients in the community. According to the women and health professionals, most health facilities currently had few health workers of Sabiny origin. Indeed, the Sebei sub-region more generally suffers from a shortage of health workers. Kapchorwa district has just one doctor based at Kapchorwa hospital, who is also district health officer as well as hospital superintendent.

Health professional key informants' accounts revealed that understaffing leads to heavy workloads for health workers who are also demotivated due to poor remuneration. Health workers have to juggle several income-generating activities, mainly in form of micro enterprises and offering medical services outside health facilities, and lack of accommodation within or near health facilities reinforces absenteeism.

A key informant noted problems in communication and collaboration:

> Let's be partners and not rivals in healthcare delivery. Health workers usually say 'who are these stupid TBAs?' while TBAs say 'who are these young girls who were born yesterday. She has even never given birth'. (Meshach 54)

Indeed, other health worker key informants raised the possibility of complementary roles whereby women could be accompanied to health facilities by their TBAs.

Discussion

While homebirths among the Sabiny appear to be significantly high compared with national-level data, a preference for homebirths is not peculiar to Sabiny culture (Magoma et al. 2010; Waiswa et al. 2010). Furthermore, the perception of childbirth as a normal process where births should be unassisted has also been observed among the Banyankole (Uganda) and in rural Tanzania (Neema 1994; Magoma et al. 2010). Sabiny culture is unique, however, in that the responsibility for ensuring a live birth (in compliance with cultural ideals) is placed on the woman. Similar to the Banyoro of

Uganda (Kyomuhendo 2003), childbirth amongst the Sabiny is equated with a 'war' that should ideally be fought outside of a medical setting (unless major complications are anticipated) where the community retain control over the process and women can retain their traditional identity and status (Magoma et al. 2010). However, for women with risky pregnancies or problematic birth histories to be compelled to opt for homebirths, and then be blamed in case of negative outcomes irrespective of the cause (Benintendi 2004), has an element of victimisation. It is therefore important that women and communities are made aware that, in some cases, the battle does not have to be fought alone (Kyomuhendo 2003) or limited to the home setting and that the wellbeing of mother and child is of central concern.

As observed elsewhere (Bradby 1999; Kasolo and Ampaire 2000; Ruiz et al. 2013), Sabiny women and their communities attach importance to the use of herbs, upright delivery positions, the presence of close relatives during labour, placenta disposal and seclusion after delivery (widely practiced in the developing world), while FGM/C is associated with a desire for 'cultural privacy'. In addition, the Sabiny's need to display resilience, which exhibits elements of self-efficacy and cultural identity, restricts the utilisation of postnatal services. Lack of understanding and the failure to accommodate such practice shows a lack of cultural competence among health workers.

As reported by Waiswa et al. (2008), the Sabiny preference for homebirths is also linked to the value attached to TBAs and their culturally relevant approach whereby women preserve their identity and dignity. Traditional birth attendants can be considered the custodians of maternity tradition among the Sabiny, and carefully devised interventions that recognise their cultural importance are required. For example, the practice of women being escorted to health facilities by TBAs could be encouraged. Prolonged sexual abstinence in the Ugandan context is unique to the Sabiny. It has protective health benefits but also has potential for promoting extra-marital sex and possible exposure to sexually transmitted diseases.

Decision-making concerning place of delivery, although dominated by husbands, is rarely an individual undertaking among the Sabiny (see, for example, Neema 1994). The Sabiny differ from other ethnic groups in that husbands face cultural pressures and can bear the brunt of stigma in case of non-compliance with cultural expectations. In many cases, women's failure to access services may be detrimental to their health and that of their unborn/newborn child, or even fatal. However, in many cases it may often be in their best interest to maintain harmony and respect within marriage and the community.

Many of women's reservations concerning public health services were linked to health workers' limited cultural competence, a finding observed elsewhere (Odemerho and Baier 2012). This is evidenced by the fact that some women were not comfortable at health facilities, perceived such settings as foreign and found communication with health workers challenging. Reports of discrimination and abuse echo the more general marginalisation of minority indigenous people (Stephens et al. 2006) that requires urgent attention.

Unlike women's relationship with TBAs, the interaction between Sabiny women and health workers hinders the nurturing of the trusting relationship that women believed was essential to maternal health. Service users often have to deal with different health workers at the various stages of pregnancy, delivery and post-delivery and community follow-up is rare. This contrasts with the home setting, where there is a traditional service provider that is already known to the woman, shares her culture, speaks her language and provides the required care throughout the various stages of maternity.

At the same time, some women's parallel engagement with both traditional and formal maternal health services indicates some flexibility and accommodation of change. An in-depth interviewee who had used both services observed:

> For the last two children delivered at hospital, I got delivery kits for attending ANC more than four times. I was assisted unlike the first time. When you deliver at home it is more expensive. At the hospital sometimes there are free supplies. (Dora, 26)

Encouraging women to use the services provided by skilled providers must be accompanied with improving the quality of services, especially at public health facilities. Health workers' apparent negligence and unethical practices could be associated with their heavy workloads, poor working conditions and lack of motivation.

Concluding comments

The safeguarding and promotion of maternal and newborn health requires collaborative, multi-faceted strategies. The suitability of homebirths should be assessed on a case-by-case basis, whereby women who could safely opt for them are accommodated and medical care is sought where necessary. This requires regular ANC. Women who opt for homebirths and their birth assistants should be sensitised to the importance of a hygienic delivery environment and taught how to recognise high-risk pregnancies and delivery complications and when to seek external assistance. To the extent feasible, services should provide outreach to women who remain in communities for delivery through community outreach programmes.

Communities and men in particular should be sensitised to critical maternal health issues. Particular attention should be paid to spousal equitable partnerships in decision-making, the importance of ANC attendance by the couple, material and emotional support and the need to save lives and preserve health as a higher priority than the maintenance of cultural integrity and dignity. Health-promoting cultural practices should be affirmed and negative practices addressed using sensitive approaches nurtured and spearheaded by the Sabiny people themselves.

Providing room at health facilities (where feasible) or establishing homes close to health units where high-risk women/mothers and caretakers can stay could be instrumental in addressing current challenges in accessing services. The professional training of health workers should emphasise cultural competence and sensitivity as well as professional ethics. The proactive accommodation of cultural practices that are harmless or beneficial at health facilities is vital. The root causes of health workers' absenteeism and unethical behaviour also need to be addressed. Special measures to attract and retain staff are necessary given the poor maternal indicators and evidence of marginalisation.

Skilled and traditional service providers need to appreciate each other's merits and limitations in order for positive adaptation and, in some cases, mutual accommodation to take place, with the ultimate aim of promoting maternal and child health. Encouraging women to use available public health facilities should take place in tandem with an improvement in the quality of services provided.

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Résumé

Cet article examine l'adéquation entre les comportements de recherche de soins en santé maternelle chez les Sabiny (population localisée à l'Est de l'Ouganda) et les idéaux en matière de santé publique. Il se base sur une étude sur la santé maternelle conduite entre 2011 et 2012. Les données ont été collectées grâce à des entretiens en profondeur avec des mères ; des groupes de discussion thématique avec des mères et des pères ; et des entretiens avec des informateurs clé. L'article traite des facteurs qui influencent le choix du lieu de l'accouchement chez les Sabiny. Les résultats révèlent que la majorité des femmes Sabiny optent pour l'accouchement à domicile, même si environ un quart d'entre elles accouchent dans des établissements de santé. Certaines femmes préféreraient accoucher dans une structure de soins mais n'y parviennent pas. Chez les Sabiny, les croyances et les pratiques culturelles sont un facteur d'influence crucial en ce qui concerne le lieu de l'accouchement. La compréhension et la prise en compte des préoccupations spécifiques aux Sabiny dans les services de santé maternelle disponibles sont limitées, ce qui met en avant la nécessité de développer des compétences prenant en compte la culture des Sabiny parmi les professionnels de santé et des méthodes d'adaptation (de promotion de la santé) aux pratiques locales. Cette approche doit être accompagnée d'une amélioration des soins pour les patients et d'une réduction de l'écart existant entre les professionnels de santé et les communautés sabiny, pouvant être obtenue grâce à la promotion des interventions de proximité et de santé communautaire. L'article souligne comment la mise en œuvre d'une politique pourrait être ajustée à des contextes locaux spécifiques.

Resumen

En este artículo se analizan los patrones de atención sanitaria maternal del pueblo sabiny en el este de Uganda con relación a los ideales de la política sanitaria. Se basa en un estudio de salud maternal llevado a cabo entre 2011 y 2012. Los datos se recabaron a partir de entrevistas exhaustivas con madres, charlas en grupo con madres y padres y entrevistas con informantes clave. En el artículo se examina qué factores son importantes para el pueblo sabiny a la hora de elegir el lugar del parto. Los resultados indican que la mayoría de las mujeres sabiny optan por alumbrar en casa, y aproximadamente una cuarta parte da a luz en centros sanitarios. Algunas mujeres preferirían parir en un centro sanitario pero no pueden. Las creencias y prácticas culturales del pueblo sabiny tienen una gran influencia en la decisión de elegir el lugar donde parir. Los servicios sanitarios disponibles para cubrir las necesidades maternales tienen conocimientos limitados de los aspectos que preocupan al pueblo sabiny para poder adaptarse a ellos y sería necesario capacitar a los profesionales sanitarios en cuestiones culturales y desarrollar métodos para introducir prácticas locales que fomenten la salud. Esto debería venir acompañado de una mejor asistencia a los pacientes y estrechar la brecha entre los profesionales sanitarios y las comunidades sabiny mediante el fomento de programas de salud para la comunidad y la sociedad. En este artículo se pone de relieve cómo se podría personalizar la aplicación de políticas en contextos locales específicos.