Blum Initiative Service Learning Fellowship – Ishaka Health Plan, Uganda (Summer 2016)

Report by: Kara Miller, Ph.D. Candidate – Department of Anthropology

Image: Generations of women sit outside of a maternity ward waiting for family members and discussing health care during an organized focus group. ***Photo Credit - Kara Miller, 2016***

In the wake of a national ban on traditional midwifery services advised by Uganda's Ministry of Health, rural communities have found themselves in a shifting medical landscape. Local midwives, know as TBA's (traditional birth attendants), have continued to act as the primary provider of maternal and obstetrics care for women in Ugandan villages into contemporary times. This means that the work of the TBA overlaps with, and often supplements, clinical health services, which are frequently absent in remote regions of the country. Impoverished areas cannot sustain many of the facilities and infrastructures that have been either temporarily or fleetingly installed over the last several decades. Throughout and since Ugandan independence, the nation has seen all manner and all levels of aid and assistance from health-based interventions and political strategies. To varying degrees, local practitioners have played a role in informing, bolstering, and cooperating with such efforts as a culturally appropriate way of meeting ideological and logistical health challenges, or crises. Most prominent of these local health experts are TBA's whose work stands at the fore of community development both because of the wide-ranging family-based services that they provide as well as the fact that these women act as liaisons between village communities and district-level activity.

Global health power brokers, including the World Health Organization (WHO), have been involved in efforts to harness the skills and the local authority of the village TBA, through programs meant to facilitate cooperation between TBA's and government-funded health centers, or through the organization and training of TBA's, for example. But the latest focus on maternal health and mortality in Sub-Saharan Africa, largely informed by the United Nation's Millennium Development Goals, have moved the discourse as well as on-the-ground efforts, away from any indigenous means of medicine. The UN's Goal number five of "Improving Maternal Health," aimed at achieving by 2015, has a built-in indicator of raising the proportion of births attended by, "skilled health personnel," meaning formally trained midwives and practitioners. So when the Ugandan government, in 2011, made a public statement condemning the practices of traditional providers, namely TBA's, and enacted a law that made their practices illegal, they cited infectious disease and maternal mortality among the reasons for the ban. However, they did not immediately enact any particular programs to replace TBA practices in rural areas or to spur the training or placement of any public health workers around the country.

For some time, this policy was fairly untraceable in Ugandan communities. TBA's continued to practice regularly. Slowly, public health campaigns that denounce and reprimand (via radio and other news) TBA practices began to take effect along with various efforts to spur clinical participation for men and women. In my ethnographic research, I found TBA's who were at-once frustrated by the threats to themselves and their work (in the form of fines, mostly), and in high demand as their numbers began to decrease, due to the retirement of many TBA's and the absence of any training for the next generation of traditional midwives. In an instinctive move, many TBA's either self- formed or were privy to some kind of organized effort to move their work from that of health practitioner to one of community advocate. Namely, groups of Village Health Teams (VHT's) have formed which allow TBA's to conduct the mobilization, sensitization, and education components of their work without any hands-on medical services being offered. As part of the duties of the VHT, community members are told to encourage women to visit local health centers, which are government-funded. This potentially shifts community members back into a series of referrals, which often direct patients to facilities that are either unequipped or otherwise unprepared to meet the needs of the community, further propelling cycles of uncertainty and need. But instead of a country full of this no-result pattern, I have seen and explored two distinct types of services emerge in the latest phase following the ban on traditional practitioners

Image: Mother of five (5) attends community health event.
Photo Credit - Kara Miller, 2016

Focusing on two districts in the Southwest, my research looked at the newest versions of health operatives, formed out of necessity and the right combination of empowered, informed, or skilled local resources. I studied the medical ideologies that inform these practices and the agencies or initiatives that fund and fuel such efforts. The first trend that I have identified in terms of women's health in Uganda is a grassroots-type of health organization that utilizes a pluralistic approach to dealing with the immediate factors influencing health and access in rural communities. These facilities include low-cost birthing centers, community-based women's health collectives, and informal cooperatives *within* existing health centers or clinics. Such efforts often incorporate nurse midwives and other clinically trained practitioners alongside the TBA, who now, perhaps more than ever, is being sought out as a consultant of sorts on sustainable women's health issues and low-tech delivery options amidst the mass transition to clinics and hospitals. Many TBA's working in such hybridized settings are acting as cultural purveyors or experts on women's regional praxes and preferences.

The second type of facility I see emerging in this generation of health services in Uganda is the community-based private clinic. Privatized clinics and private health services are not new in the region. Such providers have been around, even in rural areas, since medicine has become commodified in this colonized nation. However, not until recently has there been such a presence of subsidized, low-cost, private care for Ugandans. Transitioning off of donor monies is a complicated challenge in a nation that has dealt with forced dependence on international assistance. Today, Kihefo Clinic in Kabale, Uganda provides low-cost treatments in a busy trading center. The payments for those services, along with other projects such as rabbit rearing and tourism, fund outreach projects and free ARV supplies for those most in-need. Part of my project this year was to coordinate between Kihefo Clinic and a similar community-based clinic in Bushenyi district, Ishaka Health Plan, which specializes in micro-insurance schemes. With the support from UCR's School of Public Policy[1], I oversaw a meeting of these two community-based clinics who now actively help other private clinics open up their businesses to incorporate sustainable and profitable solutions that also meet the needs of the most poor families. Some of the ways this is being done is through voucher programs, such as the Healthy Baby vouchers that at 4,000 Ugandan Shillings (less than two US dollars – something that most families can afford) cover an entire birth plan.

Image: Mothers of newborns wait for a nurse midwife to administer vaccinations. The mothers are holding the Health Baby vouchers that cover pre- and post-natal care as well as delivery, including complications costing up to 40,000 Ugandan Shillings. These women are also holding health record booklets for themselves and their new

Both private clinics as well as grassroots organizations are operating without governmental assistance, though many programs, such as the Healthy Baby vouchers are funded by private donors – in this case Marie Stopes International, albeit in a sound and durable way as this relies on no additional supplies or volunteer labor. So far, the results of the ban and the emerging services show some intended as well as

[1] Kara Miller's research was supported by the *Blum Initiative for Global and Regional Poverty Studies* and the *One Health Center of the UC Global Health Institute*; both centers are housed within UCR's School of Public Policy.

some presumably unintended consequences. For one, the sheer number of providers in rural areas is lower, but traditional practitioners continue to carry prestigious positions though many TBA's have responded by charging fees (at all or more than before) for services, which drives people away from those particular providers. Also, developments in the private sector spur more investments from outside donors. Unlike donations funneled through governmental agencies, private clinics typically have more intimate accountability and potentially more transparency due to the scale of the operation. Ironically, the ban has partially been responsible for some collaborative efforts between clinical and traditional health practices – a cooperation attempted many times over in the history of Ugandan medical pluralism. But with the threat of the practice of the TBA disappearing, certain efforts like the community-based grassroots birthing operations have worked to sustain this medical tradition while adding to the expertise as well as available labor hands.

In looking at other Sub-Saharan African nations that have undergone the same policy banning TBA services, Uganda has comparatively experienced positive effects from the law. Even if some of the outcomes are byproducts, the ban seems to have spurred efforts and allocation of resources from a community level, though often via outside funds. I visited two communities in Mozambique as a way of accounting for a parallel context with a similar timeline in terms of TBA policy. Though Mozambique has experienced many effects in tandem with Uganda, namely TBA's who either discontinue or begin charging for services, the positive effects that Uganda is experiencing are not shared with this nation only two countries away. Mozambique continues to recover from a civil war and is experiencing ongoing social and political unrest. Because of this, Mozambique hosts much less in terms of volunteerism, aid and advocacy programs, private donations, and tourism. Communities in Mozambique suffer much more from the effects of poverty and thusly cannot sustain even the small-scale programs that Uganda currently hosts. The risk and the sacrifice are too much, one TBA tells me, which are magnified by violence.

In sum, this ban, perhaps oddly, works to spark initiatives for locally sustained health efforts, but only in combination with development efforts and only if there are structures in place to support or replace indigenous medicine. Such a drastic policy should be presented as a response-based solution rather than a diminishment of services and available means. In Uganda, various health venues have met this challenge but only where empowered growth and robust community efforts are possible – without such support, such a decision has potentially harmful impacts.