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Comparative Research Network, 2008

The Influence of Cultural Practices and Gender Dynamics in Maternal Mortality in Uganda

Annotated Bibliography

CODICE, 2009

Table of Contents

Introduction

The Council for the Development of Social Science Research in Africa (CODESRIA) held from 14 to 16 October 2008 in Addis Ababa, Ethiopia, a methodological workshop gathering the Comparative Research Networks selected in 2008.

As a support to the researchers involved in the Comparative Research Networks, the CODESRIA Documentation and Information Centre (CODICE) has produced bibliographies on the various research themes. This bibliography has been generated for the Comparative Research Networks whose project proposal is **"The Influence of Cultural Practices and Gender Dynamics in Maternal Mortality in Uganda"**

Classified alphabetically by author or by title, the selected references are in English on the topics of the Influence of Cultural Practices and Gender Dynamics in Maternal Mortality in Uganda and are grouped in two sections:

- Hard Copy Documents;
- Electronic Documents ;

The background Document is in the annex of this bibliography.

Specific bibliographic searches may also be done upon request from each participant of the Comparative Research Network.

We hope that this bibliography will be useful for the members of the Comparative Research Network, and suggestions for its improvement are welcome.

Part I – Hard Copy Documents

1. SIIMWE, Florence Akiiki

Gender Dynamics in Home Ownership in Kampala, Uganda
Cape Town: University of Cape Town, February 2008.- xvi-327p.
Thesis, PhD, University of Cape Town, Graduate School of Humanities, Department of Sociology, 2008

/HOME OWNERSHIP/ /MARRIED WOMEN/ /UNMARRIED PERSONS/ /INHERITANCE/ /PROPERTY RIGHTS/ /UGANDA//KAMPALA/

2. SSEWAKIRYANGA, Richard

Sexual Identities and Sex Work: Interrogating the Interface: A Study on Constructed Identities Among Female Sex Workers in Kampala. – p. 11-
In: Gender, Economies and Entitlements in Africa / ANNAN-YAO, Elizabeth; BASHAW, Zenebe N. ; ISHENGOMA, Christine G.; MOOKODI, Godisang; ONGILE, Grace; PEREIRA, Charmaine; PHALANE, Manthiba; SSEWAKIRYANGA, Richard; TAMALE, Sylvia; UROH, Chris Okechukwu
Dakar: CODESRIA, 2004.- ix-179p.

/GENDER RELATIONS/ /FAMILY/ /HEALTH/ /EDUCATION/ /WOMEN/ /ENVIRONMENTAL DEGRADATION/ /WOMEN WORKERS/ /GLOBALIZATION/ /TRADE/ /POVERTY//AFRICA/ /TANZANIA/ /ETHIOPIA/ /NIGERIA/ /UGANDA//DOMESTICITY/ /RESOURCES SCARCITY/ /CITIZENSHIP/ /SEXUAL IDENTITY/ /ACCESSIBILITY OF RESOURCES/ /SEX WORK/

Part II : Electronic Documents

1. AHN, Namkee; SHARIFF, Abusaleh

A Comparative Study of Socioeconomic and Demographic Determinants of Fertility in Togo and Uganda
International Family Planning Perspectives. Vol. 20, No. 1, Mar., 1994, p. 14-22

2. BANTEBYA-KYOMUHENDO, Grace

Cultural and Resource Determinants of Severe Maternal Morbidity: Lessons from Some `Near Miss' Experiences..
African Sociological Review. Vol. 8, Issue 1, 2004, p. 67-82

Abstract: The article discusses the women's near to death experiences due to complications from pregnancy and childbirth, based on a study conducted in Kiboga, Hoima and Kampala districts, Uganda between 1999 and 2000. The study inter alia sought to describe women's severe morbidity experiences highlighting factors that constrain their ability to seek and obtain timely and appropriate obstetric care at formal health facilities when faced with life-threatening situations. In Uganda, as in a great part of Sub-Saharan Africa, maternal mortality and maternally related severe morbidity still pose a serious health problem. In fact Uganda has some of the worst maternal health indicators globally. In 2000, Uganda had a total fertility rate of 6.9 and contraceptive prevalence rate of only 23 percent. In the past, high maternal mortality and severe morbidity rates were largely and justifiably attributed to the country's socio-economic and political instability, characterized by destruction of health infrastructure, chronic shortfalls in staffing and material supplies/equipment, poor remuneration of health workers and erosion of medical ethics.

3. **BLACKER, John; OPIYO, Collins; JASSEH, Momodou; SLOGGETT, Andy; SSEKAMATTE-SSEBULIBA, John**

Fertility in Kenya and Uganda: A Comparative Study of Trends and Determinants
Population Studies. Vol. 59, No. 3, Nov., 2005, p. 355-373

4. **BLANC, Ann Klimas; WOLFF, Brent**

Gender and Decision-Making over Condom Use in Two Districts in Uganda
African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. Vol. 5, No. 3, Dec., 2001, p. 15-28

Abstract: Based on a survey of couples in long-term unions in Masaka and Lira districts in Uganda, we critically examine the role of gender inequality in the domain of decision-making about fertility and sex in the discussion and use of condoms. First, we document the sexual context and process of condom negotiation from the perspectives of women and men. Next, we test the hypothesis that increases in the relative influence of women, compared to their male partners, in decision-making about sex and fertility should enhance the likelihood of discussion and use of condoms. The results point to barriers that exist for both men and women but show a clear disadvantage for women. They also suggest that, for both partners, a sense of control over fertility has a positive effect on condom use, and that the effect of women's empowerment does not seem to diminish the effect of men's empowerment.
Source : Jstor

5. **BOHMER, Lisa; KIRUMIRA, Edward K.**

Socio-Economic Context and the Sexual Behaviour of Ugandan out of School Youth
Culture, Health & Sexuality. Vol. 2, No. 3, Jul. - Sep., 2000, p. 269-285

Abstract: This article provides a descriptive analysis of the cultural and socio-economic contexts that shape young people's sexual perceptions and behaviour. Qualitative research was conducted within two Ugandan communities with out of school females and males ages 12-19 years. An innovative methodology placed young people themselves in control of the research agenda to explore sexuality and reproductive health. Nine groups of varying age/sex compositions met weekly over three months. One hundred and thirteen group meetings were recorded, tran- scribed and analysed by content analysis. This article focuses on linkages between sexual meanings and practices and the contexts of economics, environmental influences, and gender dynamics. Participants expressed intense interest in sex and are influenced by the sexual behaviour of other community members. While both males and females accept that sex involves some exchange of money or gifts, each gender experiences different pressures and motivations within the negotiation process. Financial pressures play a large role in influencing out of school girls to begin engaging in sex in order to meet basic needs. By increasing understanding of young people's perceptions and sexual meanings as well as the contexts in which they occur, programmes have the opportunity to more meaningfully address their sexu- ality and reproductive health.
Source: Jstor

6. **BOLLINGER, Lori; BASAZA, Robert; MUGARURA, Chris; ROSS, John; AGARWAL, Koki**

Estimating the Impact of Maternal Health Services on Maternal Mortality in Uganda
. - March 1, 2004. – 20 p.
Source: http://paa2004.princeton.edu/download.asp?submissionId=41231

7. **BOYD, Rosalind E.**

Empowerment of Women in Uganda: Real or Symbolic
Review of African Political Economy. No. 45/46, 1989, p. 106-117

8. BRESLIN, M.

Almost One in Three Ugandan Births are Unwanted or Mistimed, But Few Women Practice Contraception
International Family Planning Perspectives. Vol. 24, No. 1, Mar., 1998, p. 46-47

9. DONOVAN, P.

Rates of Pregnancy and Birth in Rural Uganda are Lower Among HIV-Infected Women
International Family Planning Perspectives. Vol. 24, N°. 3, Sep., 1998, p. 146-147

10. GOETZ, Anne Marie

Women in Politics & Gender Equity in Policy: South Africa & Uganda
Review of African Political Economy. Vol. 25, No. 76, 1998, p. 241-262

Abstract: There are more women in politics in Uganda and South Africa today than in many more developed democracies. This significant achievement owes to explicit affirmative action interventions in political institutions and processes to favour women's participation. This article analyses these measures for their effectiveness in bringing more women into government, and for their impact on the perceived legitimacy of women in power. It goes on to stress that there is a difference between a numerical increase in women representatives, and the representation of women's interests in government decision-making. The one does not automatically lead to the other, not just because individual women politicians cannot all be assumed to be concerned with gender equity, but because of institutionalised resistance to gender equity within the apparatus of governance. This problem is exacerbated in the context of structural adjustment, which rules out social welfare measures to subsidise women's reproductive contributions to the economy and thereby level the economic playing field between women and men. In spite of these obstacles, women in power in Uganda and South Africa have taken significant steps to articulate women's interests in politics, with a particular focus on problems of violence against women.
Source: Jstor

11. GUPTA, Neeru; KATENDE, Charles; BESSINGER, Ruth

Associations of Mass Media Exposure with Family Planning Attitudes and Practices in Uganda
Studies in Family Planning. Vol. 34, No. 1, Mar., 2003, p. 19-31

Abstract: This study examines the associations between multimedia behavior change communication (BCC) campaigns and women's and men's use of and intention to use modern contraceptive methods in target areas of Uganda. Data are drawn primarily from the 1997 and 1999 Delivery of Improved Services for Health (DISH) evaluation surveys, which collected information from representative samples of women and men of reproductive age in the districts served by the DISH project. Additional time-trend analyses rely on data from the 1995 Uganda Demographic and Health Survey. Logistic regressions are used to assess the associations between BCC exposure andfamily planning attitudes and practices, controllingfor individuals' background characteristics. To minimize the biases of self-reported exposure, the analyses also explore cluster-level indexes of the penetration of BCC messages in the community. Results indicate that exposure to BCC messages was associated with increased contraceptive use and intention to use. Some evidence of self-reported bias isfound, and the pathways tofertility-related behavioral change appear differentfor women and men. (STUDIES IN FAMILY PLANNING 2003: 34[1]: 19-31)
Source: Jstor

12. HULTON Louise A., ; CULLEN, Rachel; KHALOKHO, Symons Wamala

Perceptions of the Risks of Sexual Activity and Their Consequences among Ugandan Adolescents
Studies in Family Planning. Vol. 31, No. 1, Mar., 2000, p. 35-46

Abstract: The principal aim of this study of adolescents in Mbale District, Uganda, is to provide program-related information about their behavior, motivations, and perceptions of risk with regard to pregnancy and HIV transmission. Twelve single-sex focus-group discussions were conducted, six with young people aged 17-18 who were still attending school, and six with people of the same age who were not. The most important findings to emerge are that knowledge of safe-sex behavior and reported behavior have little in common and that the fundamental barriers to behavioral change lie within the economic and sociocultural context that molds the sexual politics of youth. Young males' lack of responsibilityfor the outcomes of their behavior is identified as an important barrier to improved sexual health. The imperative to explore ways by which young women might achieve status and identity and acquire material resources by means not related to their sexuality is highlighted. (STUDIES IN FAMILY PLANNING 2000; 31[1]: 35-46)
Source: Jstor

13. JAGWE-WADDA, Gabriel; MOORE, Ann M.; WOOG, Vanessa

Abortion Morbidity in Uganda: Evidence from Two Communities
New York: Guttmacher Institute, 2006. – 58 p.
Occasional Report No. 26
Source: http://www.guttmacher.org/pubs/or26.pdf

14. KASOLO, Josephine Kasolo; OPIT, Chris; ISIKO, Joyce

Maternal Death Audit in Jinja District: Audit Report
February 2002. – 40 p.
Source: http://www.ugandadish.org/MaternalAuditReport.doc

15. KETENDE, Charles; GUPTA, Neeru; BESSINGER, Ruth

Facility-Level Reproductive Health Interventions and Contraceptive Use in Uganda
International Family Planning Perspectives. Vol. 29, No. 3, Sep., 2003, p. 130-137

CONTEXT: In Uganda, modern contraceptive use has recently increased in areas served by the Delivery of Improved Ser- vices for Health (DISH) project. Whether these increases are associated with facility-level factors is unknown, however. METHODS: Data from the 1999 DISH Evaluation Surveys were used in multivariate logistic regressions to assess the in- dependent relationships of five indicators of the family planning service environment with individual-level use ofa modern contraceptive in rural and urban areas. The surveys consisted of a household questionnaire of 1,766 women of reproductive age and a facility module implemented in all health facilities that serve the sampled population. RESULTS: After women's social and demographic characteristics were controlled for, none of the service environment factors was independently associated with current use of a modern method in rural areas. By contrast, in urban areas, the proximity of a private health facility (which likely reflects an increased availability of methods) was positively associated with current use (odds ratio, 2. 1), as was the presence of a higher number (three or more) of DISH-trained ser- vice providers (1.7). CONCLUSIONS: The presence of private health facilities was the factor most strongly associated with contraceptive use in urban areas, perhaps because they improved the availability of methods. Few other facility-level program in- puts had significant effects.
Source: Jstor

16. KINSMAN, John; NYANZI, Stella; POOL, Robert

Socializing Influences and the Value of Sex: The Experience of Adolescent School Girls in Rural Masaka, Uganda
Culture, Health & Sexuality. Vol. 2, No. 2, Apr. - Jun., 2000, p. 151-166

Abstract: In order to explore the socializing influences which have shaped rural adolescent schoolgirls' views and values about sex in a high HIV prevalence area of Uganda, detailed qualitative data was obtained over a one year period from 15 schoolgirls (aged 14-17), chosen for their willingness to participate actively in a series of role plays, focus group discussions (FGD) and one-to-one interviews. Findings suggest that the girls have been subjected to a wide range of influences, including parents, social functions, other young

children, nature, their ssengas, peers, school, and various media, such as pornography. There was disagreement about the relative values of sex and virginity. Some were determined to retain their virginity, but the majority felt that sex benefits them socially and personally. Peer pressure was a major factor shaping many girls' opinions, while traditional influences are in decline. Because of the small sample size, care should be taken in generalizing from the findings. However, the data suggest that sex has a high value for at least a substantial minority of adolescent girls in rural Masaka, Uganda. Policy makers and health educators should therefore consider how best to devise safe sex messages that are both relevant and applicable to this especially vulnerable group.
Source : Jstor

17. KISEKKA, Mere Nakateregga

Sexual Attitudes and Behavior among Students in Uganda
The Journal of Sex Research. Vol. 12, No. 2, May, 1976, p. 104-116

Abstract: This report is concerned with sexual attitudes and behaviors among students in secondary schools in Uganda who are highly exposed to and influenced by non-indigenous factors of western education and religions as well as the popular youth culture. The study shows an increasing acceptance and incidents of premaritial coitus and abortion. When it is not a career contingency, premaritial parenthood is preferred to abortion and a forced marriage. These attitudes are partly explainable by the increased opportunity for heterosexual contacts, lack of information and availability of up-to-date contraceptive techniques and a stigma-free cultural attitude towards nonmarital children. There is support for traditional sexual practices especially by males.
Source: Jstor

18. KNUDSEN, Lara

Limited Choices: A Look at Women's Access to Health Care in Kiboga, Uganda
Women's Studies Quarterly. Vol. 31, No. 3/4, Fall - Winter, 2003, p. 253-260
Source: Jstor

19. KOENIG, Michael A; ZABLOTSKA, Iryna; LUTALO, Tom; NALUGODA, Fred; WAGMAN, Jennifer; GRAY, Ron

Coerced First Intercourse and Reproductive Health among Adolescent Women in Rakai, Uganda
International Family Planning Perspectives. Vol. 30, No. 4, Dec., 2004, p. 156-163

Abstract: CONTEXT: Although there is increasing recognition of the scope and significance of sexual coercion experienced by adolescent women in developing countries, evidence on its consequences for reproductive health remains limited. METHODS: A sample of 575 sexually experienced 15-19-year-old women were interviewed in 2001-2002 as part of the ongoing Rakai surveillance project in rural Uganda. Chi-square tests and logistic regressions were used to investigate associations between coerced first intercourse and selected reproductive health behaviors and outcomes. RESULTS: Fourteen percent of young women reported that their first sexual intercourse had been coerced. After the effects of respondents' demographic characteristics were accounted for, young women who reported coerced first intercourse were significantly less likely than those who did not to be currently using modern contraceptives, to have used condoms at last intercourse and to have used them consistently during the preceding six months; they were more likely to report their current or most recent pregnancy as unintended (among ever-pregnant women) and to report one or more genital tract symptoms. CONCLUSIONS: Coerced first intercourse is an important social and public health problem that has potentially serious repercussions for young women's reproductive health and well-being. Interventions to improve adolescent women's reproductive health should directly address the issue of sexual coercion.
Source : Jstor

20. KWAGALA, Betty

Integrating Women's Reproductive Roles with Productive Activities in Commerce: The Case of....
Urban Studies. Vol. 36, Issue 9, Aug 99, p. 15-35

Abstract: Summary. Uganda has registered significant improvement regarding economic growth and the raising of women's status at the macro level. Commerce is one of the sectors that attracts women of varying social status. The paper is based on an exploratory and cross-sectional study that focused on Kampala businesswomen's experiences in coping with productive and reproductive roles. Quantitative and qualitative methods of data collection were utilised. The survey involved a total of 224 women. Results reveal an increasingly asymmetric gender division of roles, to women's disadvantage, especially as their incomes increase. Women's experiences in integrating reproductive roles and productive activities in commerce, which have a strong bearing on their economic performance, are discussed.
Source: Ebscohost

21. KYOMUHENDO, Grace Bantebya

Low Use of Rural Maternity Services in Uganda: Impact of Women's Status, Traditional Beliefs and Limited Resources
Reproductive Health Matters. Vol. 11, No. 21, May, 2003, p. 16-26

Abstract: In Uganda, lack of resources and skilled staff to improve quality and delivery of maternity services, despite good policies and concerted efforts, have not yielded an increase in utilisation of those services by women or a reduction in the high ratio of maternal deaths. This paper reports a study conducted from November 2000 to October 2001 in Hoima, a rural district in western Uganda, whose aim was to enhance understanding of why, when faced with complications of pregnancy or delivery, women continue to choose high risk options leading to severe morbidity and even their own deaths. The findings demonstrate that adherence to traditional birthing practices and beliefs that pregnancy is a test of endurance and maternal death a sad but normal event, are important factors. The use of primary health units and the referral hospital, including when complications occur, was considered only as a last resort. Lack of skilled staff at primary health care level, complaints of abuse, neglect and poor treatment in hospital and poorly understood reasons for procedures, plus health workers' views that women were ignorant, also explain the unwillingness of women to deliver in health facilities and seek care for complications. Appropriate interventions are needed to address the barriers between rural mothers and the formal health care system, including community education on all aspects of essential obstetric care and sensitisation of service providers to the situation of rural mothers.
Source : Jstor

22. LAUKARAN, Virginia Hight; BHATTACHARYYA, Adity ; WINIKOFF, Beverly

Delivering Women-Centred Maternity Care with Limited Resources: Grenada
Reproductive Health Matters. Vol. 2, No. 4, Nov., 1994, p. 11-19

Abstract: Maternity care in the Caribbean island nation of Grenada is organised and provided largely by trained nurse-midwives and maternal mortality is relatively low. This paper discusses how the various elements of this care - emphasis on third trimester coverage, health education for women, clear protocols for managing serious complications, round-the-clock coverage, effective referral, good communication and record-keeping, and limited use of physicians and technology - can be used as a model by other countries to reduce maternal deaths.
Source : Jstor

23. MBONYE, A. K.

Abortion in Uganda: Magnitude and Implications

African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. Vol. 4, No. 2, Oct., 2000, p. 104-108

Abstract : This study was conducted to assess the status of safe motherhood in Uganda. A total of 97 health units, 30 hospitals, and 67 lower health units were included in the sample. Altogether, 335,682 deliveries, 302 maternal deaths, and 2,978 abortions were documented over a period of one year, with a computed abortion ratio of 8,346 per 100,000 live births and maternal mortality ratio of 846 per 100,000 live births. As high as 340 (11.4%) abortions had occurred in one of the health centres in that year. A total of 1,638 (55%) of the abortions occurred in adolescent girls aged 17-20 years; and 1,575 (52.9%) of mothers who had abortions were not married. Six hundred and eighty five (23%) of all abortion cases resulted into complications - haemorrhage 378 (52.2%), localised infections 238 (34.8%), uterine perforation 60 (8.7%) and cervical injury 9 (4.3%). Capacity to manage abortion complications was found to be limited; 39 (40.2%) of health units were able to manage abortion complications. Of those 39 health units, 31 (79.5%) had a vacuum extractor. Only 2 (2%) had a committee to review abortion cases.
Source : Jstor

24. MBONYE, Anthony K.

Risk Factors Associated with Maternal Deaths in Health Units in Uganda

African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. Vol. 5, No. 3, Dec., 2001, p. 47-53

Abstract: This study was conducted to assess the magnitude of maternal deaths in health units in Uganda, and the risk factors associated with such deaths. A retrospective study of maternal deaths in 20 hospitals and 54 randomly selected health centres was conducted in 12 randomly selected districts of Uganda. The reference period for documenting maternal deaths was September 1992 to September 1993. The International Classification of Discases 10 was used to define a maternal death. Data on maternal deaths and associated risk factors was obtained from admission and patient case notes. SPSS/PC statistical package was used to carry out advanced statistical analysis. Log linear analysis was used to rank risk factors for maternal deaths. A total of 418 maternal deaths and 75,000 live births were recorded, giving a maternal mortality ratio of 557 per 100,000 live births. Three hundred and sixty (86.1%) mothers died within one hour of admission. The risk factors identified were inadequate antibiotic supply, intravenous drug fluids and blood for transfusion in health units; non-use of family planning, use of traditional medicine; mothers aged 15-19 and 30-50 years. Others included those who had a history of two or more abortions and stillbirths; parity of five and above; and living within a distance of more than 10km to the nearest health unit. We conclude that the focus on risk factors for maternal deaths have policy implications.
Source : Jstor

25. MBONYEA, A. K.; MUTABAZIA, M. G.; ASIMWEB, J. B.; SENTUMBWEC, O.; KABARANGIRAD, J.; NANDAE, G.; ORINDAD, V.

Declining maternal mortality ratio in Uganda: Priority interventions to achieve the Millennium Development Goal

Abstract Purpose: We conducted a survey to determine availability of emergency obstetric care (EmOC) and to provide data for advocating for improved maternal and newborn health in Uganda.
Methods
The survey, covering 54 districts and 553 health facilities, assessed availability of EmOC signal functions, documented maternal deaths and the related causes. Three levels of health facilities were covered.
Findings
Few health units had running water; electricity or a functional operating theater. Yet having these items had a protective effect on maternal deaths as follows: theater (OR 0.56, P<0.0001); electricity (OR 0.39,

P<0.0001); laboratory (OR 0.71, P<0.0001) and staffing levels (midwives) OR 0.20, P<0.0001. The availability of midwives had the highest protective effect on maternal deaths, reducing the case fatality rate by 80%. Further, most (97.2%) health facilities expected to offer basic EmOC, were not doing so. This is the likely explanation for the high health facility-based maternal death rate of 671/100,000 live births in Uganda.
Source: http://www.ijgo.org/article/PIIS0020729207003074/fulltext#abstract

26. MUSEVENI, Yoweri Kaguta

Speech by the President of the Republic of Uganda Yoweri Kaguta Museveni on the Occasion of the Closing of the 1st Africa Regional Conference on Women and Health on 27th October 1989
Agenda. No. 6, 1990, p. 53-61

27. MWAKA, Victoria Miriam

Women's Studies in Uganda
Women's Studies Quarterly. Vol. 24, No. 1/2, Spring - Summer, 1996, p. 449-464

28. NDYANABANGI, Bannet; KIPP, Walter; DIESFELD, Hans-Jochen

Reproductive Health Behaviour among In-School and Out-of-School Youth in Kabarole District, Uganda
African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. Vol. 8, No. 3, Dec., 2004, p. 55-67

Abstract: This study was conducted to elucidate whether in-school adolescents have sexual behavioural patterns that differ from those of out-of-school adolescents. A total of 300 in-school and 256 out-of-school adolescents were interviewed. Condom use was significantly higher among in-school than out-of-school adolescents. In-school adolescents had fewer sexual partners in the previous year and had started sexual activities at a later age than out-of-school adolescents. In-school adolescents were more likely to have used modern contraceptive in the past than out-of-school adolescents. We conclude that out-of-school adolescents are less likely to practice safe sex and to use modern family planning methods than in-school adolescents. This indicates the need to provide more information to this group of adolescents. They are traditionally neglected in favour of in-school adolescents, who have greater access to information.
Source : Jstor

29. NEEMA, Stella ; MUSISI, Nakanyike; KIBOMBO, Richard

Adolescent Sexual and Reproductive Health in Uganda: A Synthesis of Research Evidence
New York: Outtmacher Institute, December 2004. – 46 p.
Occasional Report No. 14
Source: http://www.guttmacher.org/pubs/2004/12/20/or14.pdf

30. NUWAHA, F.; AMOOTI-KAGUNA, B.

Predictors of Home Deliveries in Rakai District, Uganda
African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. Vol. 3, N°. 2, Oct., 1999, p. 79-86

Abstract: In order to identify independent predictors for home delivery, 211 women from 21 clusters, who had a delivery in the previous one year, were interviewed in Rakai District, Uganda, from June 2 to 30, 1997. Mothers answered questions regarding socio-economic, local, reproductive and self-efficacy variables and whether they delivered at home or not Ninety-four (44.5%) of the women delivered at home.

On univariate analysis, the factors that favoured home delivery were: not being from Kyotera County, mother not having at least primary education, not being a Muganda, not being a Catholic, father not having secondary education, mother being a peasant or housewife, father being a peasant, living more than 5 kilometres from a maternity centre, living within more than one hour walking distance to a maternity centre, not attending antenatal clinic, saying that choice of delivery site is dependent on the mother, saying that safe delivery depends on God, previous delivery at home, and not being of high social status. On stepwise multivariate analysis, the independent factors that favoured home delivery were: not being from Kyotera County, father being a peasant, previous delivery at home, and not being from a high social class. The highest risk for current home delivery was previous home delivery with an adjusted odds ratio of 16.52. These data suggest that in addition to improving access to maternity services, educating fathers about safer delivery may discourage home deliveries.
Source : Jstor

31. NYANZI, Stella; NYANZI, Barbara; BESSIE, Kalina

"Abortion? That's for Women!" Narratives and Experiences of Commercial Motorbike Riders in South-Western Uganda
African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. Vol. 9, No. 1, Apr., 2005, p. 142-161

Abstract: Although constitutionally illegal, induced abortion is a vital reproductive health option in Uganda. This paper analyses men's narratives about meanings of, and experiences with, abortion. Men play significant roles in abortion as instigators, facilitators, collaborators, transporters, advisors, informers, supporters or punishment givers. Many participants were knowledgeable about abortion. Attitudes were ambivalent, with initial reactions of denial and relegation of abortion to women's private domains. Further exploration, however, revealed active support and involvement of men. Interpretations of abortion ranged from 'dependable saviour' to 'deceptive sin'. Though a private action, abortion is socially scripted and often collectively determined by wider social networks of kinsmen, the community, peers, law and religion. A disjuncture exists between dominant public health discourse and the reality of local men who interact with women and girls as wives, lovers, sex sellers, mothers, daughters and sisters. Interventions targeting men about abortion should include safe sex education, provide safe abortion services and create stronger social support mechanisms. Policy and law should incorporate local knowledge and practice.
Source : Jstor

32. OKUONZI, Sam Agatre

Learning From Failed Health Reform In Uganda
BMJ: British Medical Journal. Vol. 329, No. 7475, Nov. 13, 2004, p. 1173-1175

33. ORACH, Christopher Garimoi; DE BROUWERE, Vincent

Postemergency health services for refugee and host populations in Uganda, 1999-2002.
Lancet. Vol. 364, Issue 9434, 2004, p. 611-612

Abstract: Since 1990, Uganda has hosted an estimated 200 000 refugees in postemergency settlements interspersed within host communities. We investigated the extent to which obstetric needs were met in the refugee and host populations during 1999-2002. Between September and December, 2000, we retrospectively collected data from 1999 and 2000 on major obstetric interventions for absolute maternal indications from all five hospitals in Arua, Adjumani, and Moyo districts, Uganda. The same data were collected prospectively for 2001. We did community-based maternal mortality surveys on refugee and host populations in Adjumani district in 2002. Rates of major obstetric interventions were significantly higher for refugees than for the host population who live in the same rural areas as refugees (1.01% [95% CI 0.77-1.25] vs 0.45% [0.38-0.52]; p 0.0001).

Rates of major obstetric interventions were also significantly higher for refugees than for the host population who live in rural areas without refugees (1.01% [0.77-1.25] vs 0.40% [0.36-0.44]; p<0.00001). Maternal mortality was 2.5 times higher in the host population than in refugees in the Adjumani district (322 per 100 000 births [247-396] vs 130 [81-179]. Refugees had better access to health services than did the rural host population in the northern Ugandan communities that we surveyed.
Source: Ebscohost

34. OTTEMOELLER, Dan

The Politics of Gender in Uganda: Symbolism in the Service of Pragmatism
African Studies Review. Vol. 42, No. 2, Sep., 1999, p. 87-104

Abstract: This essay outlines a realist explanation for an increase in women's participation in formal political processes in Uganda. The essay notes that a variety of factors influence women's participation in formal politics, such as demands for increased participation from women and women's organizations, the influence of the worldwide feminist movement, and Uganda's turbulent political and economic history which has created openings for novel political initiatives. However, the paper's central argument asserts that women's role in formal politics in Uganda is expanding principally because women constitute a potentially influential voting bloc in an era in which the liberalization of African economic and political systems limits politicians' abilities to build electoral support based on patronage. The essay suggests that in this context, politicians will seek to build support around issues that can be addressed with symbolic solutions. In sum, this essay asserts that women's increased role in formal politics in Uganda has been brought about by power-seeking politicians who are sympathetic to feminist issues because (1) electoral strategies are severely limited by liberal political and economic values and (2) politicians can secure support from women with relatively low-cost symbolic political initiatives. The paper concludes with a brief examination of the implications of an expansion of women's influence in formal politics in Uganda, especially concerning the potential for women's political support to "cross-cut" historical Ugandan political allegiances defined by ethnicity, religion, region, and political party affiliation.
Source: Jstor

35. PRADA, Elena; MIREMBE, Florence; AHMED, Fatima H.; NALWADDA, Rose; KIGGUNDU, Charles

Abortion and Postabortion Care in Uganda: A Report from Health Care Professionals and Health Facilities
New York: Outtmacher Institute, December 2005. – 66 p.
Occasional Report No. 17
Source: http://www.guttmacher.org/pubs/2005/05/28/or17.pdf

36. SINGH, Susheela; PRADA, Elena; MIREMBE, Florence; KIGGUNDU, Charles

The Incidence of Induced Abortion in Uganda
International Family Planning Perspectives. Vol. 31, N°. 4, Dec., 2005, p. 183-191

CONTEXT:Although Uganda's law permits induced abortion only to save a woman's life, many women obtain abor- tions, often under unhygienic conditions. Small-scale studies suggest that unsafe abortion is an important health problem in Uganda, but no national quantitative studies of abortion exist. METHODS: A nationally representative survey of 313 health facilities that treat women who have postabortion com- plications and a survey ofS3 professionals who are knowledgeable about the conditions of abortion provision in Uganda were conducted in 2003. Indirect estimation techniques were applied to the data to calculate the number of induced abortions performed annually. Abortion rates, abortion ratios and unintendedpregnancy rates were calcu- lated for the nation and its four major regions. Data on contraceptive use and unmet need were obtained from Demo- graphic and Health Surveys.

RESULTS: Each year, an estimated297,000 induced abortions are performed in Uganda, and nearly 85,000 women are treated for complications. Abortions occur ata rate of 54 per 1,000 women aged 15-49 and account for one in five pregnancies. The abortion rate is higher than average in the Central region (62 per 1,000 women), the country's most urban and economically developed region. It is also very high in the Northern region (70 per 1,000). Nationally, about half of pregnancies are unintended; 51% of married women aged 15-49 and 12% of their unmarried counterparts have an unmet need for effective contraceptives.

CONCLUSIONS: Unsafe abortion exacts a heavy toll on women in Uganda. To reduce unplanned pregnancy and un- safe abortion, and to improve women's health, increased access to contraceptive services is needed for all women. International Family Planning Perspectives, 2005,31(4):183-191
Source: Jstor

37. SINGH, Susheela; MOORE, Ann M.; BANKOLE, Akinrinola; MIREMBE, Florence; WULF, Deirdre; PRADA, Elena

Unintended Pregnancy and Induced Abortion In Uganda: Causes and Consequences
New York: Outtmacher Institute, 2006. – 38 p.
Source: http://www.guttmacher.org/pubs/2006/11/27/UgandaUPIA.pdf

38. STEWART, Kearsley A.

Toward a Historical Perspective on Sexuality in Uganda: The Reproductive Lifeline Technique for Grandmothers and Their Daughters
Africa Today. Vol. 47, N°. 3/4, Summer - Autumn, 2000, p. 123-148

Abstract: Current health research on HIV-AIDS in Uganda is predominantly ahistorical and acultural. This is an inadequate analysis of a profoundly social epidemic, especially as the burden of disease shifts from adults to adolescents. As well, many Uganda adults hold unexamined attitudes about adolescent sexuality, often declaring that today's youth are recklessly sexually active at a much younger age than in the past. This paper presents new data on sexuality reaching across three generations of Ugandans. These data were collected with an original qualitative social scientific research method-the reproductive lifeline technique. Building on the focus group method, this exercise is designed to produce fertility data with historical depth of several generations of women, and to encourage parents to speak more openly with their own children about reproduction and sexuality. This paper analyzes one particular demographic variable, age at first live birth, in an effort to theorize about change over time in another important variable, age at sexual debut. The results were surprising: age at first live birth has not changed significantly over the past forty years in western Uganda and some evidence suggests that age at sexual debut has not changed much either. Several explanations are offered to explain the discrepancy between the demographic evidence and the cultural norms held by adults about adolescent sexual behaviors.
Source: Jstor

39. Uganda, Ministry of Finance, Planning and Economic Development, Kampala

Uganda's Progress in Attaining the PEAP Targets - in the Context of the Millennium Development Goals Background Paper for The Consultative Group Meeting
Kampala, 14-16 May 2003
Kampala: Ministry of Finance, Planning and Economic Development, 2003. – 45 p.
Source: http://siteresources.worldbank.org/UGANDAEXTN/Resources/CG_2003_GoU_PEAP_targets.pdf

40. Uganda. Ministry of Health, Kampala

Proceedings of the National Reproductive Health Symposium
Kampala: Ministry of Health, 2003. – 80 p.
Source: http://www.aidsuganda.org/pdf/Symposium_final_report_05-Sep.pdf

41. Uganda 1995: Results from the Demographic and Health Survey
Studies in Family Planning. Vol. 28, No. 2, Jun., 1997, p. 156-160

42. Uganda 2000-2001: Results from the Demographic and Health Survey
Studies in Family Planning. Vol. 35, No. 1, Mar., 2004, p. 70-74

43. VAVRUS, Frances ; LARSEN, Ulla
Girls' Education and Fertility Transitions: An Analysis of Recent Trends in Tanzania and Uganda
Economic Development & Cultural Change. Vol. 51, Issue 4, Jul2003, p. 945, 31p.

Abstract: Examines the impact of education of girls on the fertility rates in Tanzania and Uganda. Revelation of a negative relationship between the number of years a girl spends in school and her fertility; Information on economic development of Uganda between 1986 to 1996; Comparison of political, economic and educational conditions of Tanzania and Uganda; Revelation of fertility rates observed in Tanzania and Uganda.
Source: Ebscohost

44. WASSBERG, Susanna
Misoprostol: Obstetric Care in Uganda And a Missing Drug: A Minor Field Study Report
Stockholm: Karolinska Institutet, 2004. – 47 p.
Source: http://ki.se/content/1/c6/03/62/52/Susanna%20Wassberg.pdf

45. WEEKS, Andrew; LAVENDER, Tina; NAZZIWA, Enid; MIREMBE, Florence
Personal accounts of 'near-miss' maternal mortalities in Kampala, Uganda.
BJOG: An International Journal of Obstetrics & Gynaecology. Vol. 112, Issue 9, Sep. 2005, p. 1302-1307

Abstract: To explore the socio-economic determinants of maternal mortality in Uganda through interviews with women who had 'near-misses'. Observational study using qualitative research methods. The postnatal and gynaecology wards of a large government hospital in Kampala, Uganda. Thirty women who had narrowly avoided maternal deaths with diagnoses of obstructed labour (7), severe pre-eclampsia/eclampsia (3), post caesarean infection (6), haemorrhage (5), ectopic pregnancy (5) and septic abortion (4). The semi-structured interviews were conducted in the local language by a woman unconnected to the hospital, and were recorded before being translated and transcribed. Analysis was conducted in duplicate using commercial software. The predominant theme was powerlessness, which occurred both within and outside the hospital. It was evident in the women's attempts to get both practical and financial help from those around them as well as in their failure to gain rapid access to care. Financial barriers and problems with transport primarily governed health-seeking behaviour. Medical mistakes and delays in referral were evident in many interviews, especially in rural health centres. Women were appreciative of the care they received from the central government hospital, although there were reports of overcrowding, long delays, shortages and inhumane care. There were no reports of bribery. Women with near-miss maternal mortalities experience institutional and social powerlessness: these factors may be a major contributor to maternal mortality.
Source: Ebscohost

46. WEEKS, Andrew D.; ALIA, Godfrey; ONONGE, Samuel; MUTUNGI, Alice; OTOLORIN, Emmanuel O.; MIREMBE, Florence M.
Introducing Criteria Based Audit Into Ugandan Maternity Units
BMJ: British Medical Journal. Vol. 327, No. 7427, Dec. 6, 2003, p. 1329-1331

Abstract: Problem Maternal mortality in Uganda has remained unchanged at 500/100 000 over the past 10 years despite concerted efforts to improve the standard of maternity care. It is especially difficult to improve standards in rural areas, where there is little money for improvements. Furthermore, staff may be isolated, poorly paid, disempowered, lacking in morale, and have few skills to bring about change. Design Training programme to introduce criteria based audit into rural Uganda. Setting Makerere University Medical School, Mulago Hospital (large government teaching hospital in Kampala), and Mpigi District (rural area with 10 small health centres around a district hospital). Strategies for change Didactic teaching about criteria based audit followed by practical work in own units, with ongoing support and follow up workshops. Effects of change Improvements were seen in many standards of care. Staff showed universal enthusiasm for the training; many staff produced simple, cost-free improvements in their standard of care. Lessons learnt Teaching of criteria based audit to those providing health care in developing countries can produce low cost improvements in the standards of care. Because the method is simple and can be used to provide improvements even without new funding, it has the potential to produce sustainable and cost effective changes in the standard of health care. Follow up is needed to prevent a waning of enthusiasm with time.
Source: Jstor

47. WOLFF, Brent; BLANC, Ann K.; GAGE, Anastasia J.

Who Decides? Women's Status and Negotiation of Sex in Uganda
Culture, Health & Sexuality. Vol. 2, No. 3, Jul. - Sep., 2000, p. 303-322

Abstract: Women's ability to negotiate the timing and conditions of sex with their partners is central to their ability to control a variety of reproductive health outcomes. Focus group discussions and survey data from 1356 women and their regular male partners in two districts in Uganda were analysed to explore the nature of sexual negotiation and to test hypotheses about the influence of women's work and marriage institutions on norms and behaviour regarding sexual decision making. Sexual negotiation is characterized by four stages starting with normative precedent for decision making about sex and progressing to communication, disagreement, and conflict resolution. Men are generally reported to have more influence over sex in these settings, but women can and do refuse sex under a variety of circumstances. Education and urban resi- dence consistently enhance women's ability to negotiate sex. The effect of marriage and women's work characteristics depends strongly on district context. We speculate that certain types of bridewealth agreement inhibit a woman's ability to influence timing and conditions of sex independently of other 'bargaining' resources she may control.
Source: Jstor

Part III : Background Document

Background Document

THE INFLUENCE OF CULTURAL PRACTICES AND GENDER DYNAMICS IN MATERNAL MORTALITY IN UGANDA

1.1 Background to the problem

Culture is a system of shared ideas, concepts, rules and meanings that underlie all aspects of human life including health (Kisubi and Mugaju 2002). Culture also refers to common beliefs and practices of a group of people. Culture also depicts the integrated pattern of human knowledge, belief and behaviour that depends upon man's capacity for learning and transmitting knowledge to succeeding generations (Harrison 1998). Culture can also be defined as the accumulated habits, attitudes and beliefs of a group of people that define for them their general behavior and way of life; the total set of learned activities of a people (Dennis and Brian 1998). It is important to note that the way people respond to illness and health reflects their cultural systems (Kisubi and Mugaju 2002).

Among health statistics, the term mortality means the number of persons per given population who die in a given period of time. Maternal mortality refers to the number of mothers who die per 100,000 live births for a certain period (WHO 2000). According to WHO (1999), maternal mortality is the death of a woman pregnant or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management (WHO 2001).

Mulumba D. (2005), defines gender as the socially constructed relationship between men and women.

The first estimates of the extent of maternal mortality around the world were made in the late 1980s (WHO 1999). They indicate that globally, some 500,000 women die each year from pregnancy related causes. In 1996, WHO and UNICEF revised the estimates for 1990 on the basis of the growing volume of information that has become available in recent years. These new estimates showed that the scale of the problem was significantly greater than had originally been suspected and that close to 600,000 maternal deaths occur each year, with the overwhelming majority of them in developing countries. In developing countries, the ratio is nearly 20 times higher at 480 deaths per 100,000 live births and may be as high as 1000 deaths per 100,000 live births in some regions (WHO 1999).

According to Hawkins, Newman, et al (2005), although improving maternal health is one of the Millennium Development Goals, actual progress in reduction of maternal mortality remains limited. Too few countries have seen any noticeable reductions over the last 20 years. Unacceptably high maternal mortality rates prevail, despite 15 years of the global Safe Motherhood initiative. There are very few signs of progress. This lack of progress can be attributed to the status of women, the systematic violation of their basic human rights, and also to failing health systems that deny many women access to emergency obstetric care (EmOC). These dynamics are inextricably linked. Unless the underlying factors relating to women's human rights are addressed, the necessary conditions for ensuring significant investment in maternal care is never assured.

Maternal mortality rates are highest in Africa, with community rates of up to 1000 per 100,000 live births reported in some rural areas. The risk of dying from maternal causes is somewhat lower in urban areas of Africa, though rates of over 500 per 100,000 live births have been reported in several cities. A recent study in Addis Ababa, for example, revealed a rate of 566 per 100,000 live births (WHO 1999). In general, maternal mortality rates in Northern and Southern Africa are a little lower than in Western, Central and Eastern Africa (Royston and Armstrong1989).

Medical causes of maternal mortality are similar throughout the world but some may be precipitated by cultural factors. For example, prolonged or obstructed labour that accounts for about 8% of maternal deaths is common in populations with traditions and taboos regarding the diets of girls and women. It is worse where girls marry young and are expected to prove their fertility, often before they are fully grown (WHO 1999;Turyasingura 1996; UNFPA 1998).

In many patriarchal societies, a woman's only path to social status and personal achievement is through motherhood. A woman's status and her health are intricately intertwined. Any serious attempt to improve the health of women must deal with those ways in which a woman's health is harmed by social customs and cultural traditions simply because she was born female (Royston and Armstrong 1989; Gordon 1996).

According to WHO (2003) Report, the Millennium Development Goals (MDGs) place health at the heart of development. The report observes that every year millions of children are left motherless and an estimated one million children die as a result of the death of their mothers. This situation makes maternal mortality an area that needs to be given priority. In order to tackle it well, the causes have to be identified first.

The United Nations (2007), particularly UNPFA, has supported the government of Uganda in promoting safe motherhood initiatives since 1975. The main aim is to ensure that every woman has access to four reproductive health services that save women's lives, namely, voluntary family planning, skilled attendance at birth, emergency obstetric care if complications arise during delivery and post partum care (that is care given to mothers after delivery). Yet the cultural practices are not identified here and their influence to maternal mortality is to be identified in this research.

The Uganda Demographic Health Survey 2000-2001 shows that maternal mortality in Uganda has remained at 509 deaths per 100,000 live births. According to UNICEF (2008), Uganda's maternal mortality ratio of 2000-2006 has been at 510 per 100,000 live births. Culture is one of the factors among others, which need to be explored. Therefore this research is meant to find out the cultural practices that contribute to maternal mortality.

1.2 PROBLEM STATEMENT

Uganda's economy depends mainly on agriculture and women contribute 60-80 percent of the labour. Women's health, therefore, has vital social and economic implications for national development. However, among Ugandan women of reproductive age, maternal health issues are a major problem. Cultural influence to maternal mortality is not

recognized as an important factor. Very few researchers have written about this important aspect. According to Bantebya's paper (2003), clinical causes to maternal mortality and the causes inherent in the health care system are well known in Uganda but less is known about the cultural beliefs that may contribute to women's deaths. A participant at a Safe Motherhood conference (25-27 June1998, Dar es Salaam, Tanzania) emphasized the social dimensions of safe motherhood programmes and pointed to the importance of the often neglected "software" such as cultural beliefs and explanatory models which influence maternal mortality. Therefore there is a need to explore the influence of cultural practices and the gender dynamics to maternal mortality in Uganda.

1.3 STUDY OBJECTIVES

- To establish the major causes of maternal mortality in Uganda
- To identify the cultural practices that lead to maternal mortality in Uganda.
- To find out perceptions of men and women regarding cultural practices that lead to maternal mortality.
- To assess the gender dynamics in the cultural practices that lead to maternal mortality.

1.4 STUDY SIGNIFICANCE

This being a comparative study, it will bring out the different cultural practices in South, Central and Eastern Uganda that influence maternal mortality.

The findings of the study will contribute information from different regions of Uganda which will help policy makers' to design appropriate interventions to address maternal mortality, which is likely to form a basis for improving maternal health conditions.

The study will avail data on cultural practices that lead to maternal mortality, which the medical personnel and other researchers have always marginalized. This data is essential to researchers, planners, non-governmental organizations and agencies like WHO, UNICEF whose aim is to improve the health conditions world wide.

The findings will also contribute to the academic advancement by providing more literature on cultural issues in maternal health.

1.5 SCOPE

The study will cover men and women who are 18 years and above because they are expected to have more information and may have experience in reproduction. The study will be carried out in Kabale District in Western Uganda, Mukono District in Central Uganda and Mbale District in Eastern Uganda.

LITERATURE REVIEW

2.1 Introduction

Related studies given below are divided into four parts: the major causes of maternal mortality; the cultural practices that can lead to maternal mortality; perceptions of men and women regarding cultural practices that can lead to maternal mortality and the gender dynamics in cultural practices that can lead to maternal mortality.

2.2 The major causes of maternal mortality

According to WHO (1999), it is possible to estimate that at least half a million women die from causes related to pregnancy and childbirth each year. 99% of these deaths occur in developing countries, which account for 88% of the world's births. WHO has it that the highest numbers of maternal deaths occur in Asia with the countries of southern Asia being the worst affected. The second worst affected continent is Africa, where around 150,000 women die each year. These numbers make maternal mortality an area of concern and priority to many African countries, as it is a threat to human race globally.

According to UNICEF (1996), of all the major health indicators, such as life expectancy, infant mortality, and so on, only maternal mortality has not improved since 1960. UNICEF mentions haemorrhage, sepsis, eclampsia, obstructed labour and unsafe abortion as some of the major causes of maternal mortality. UNICEF's study is based on medical causes of maternal mortality but this research is based on the cultural practices that contribute to maternal mortality.

According to Dr. Mbonye A. (2007), a survey that was conducted in 54 districts of Uganda to determine the availability of emergency obstetric care so as to provide baseline data for monitoring provision of obstetric care services identified a number of maternal mortality causes. Some of the direct obstetric causes included hemorrhage, 42.2%, which was leading, and malaria accounted for 65.5% of the indirect causes. Among the obstetric complications, abortion accounted for 38.9% of direct causes and malaria 87.4% of indirect causes. Other direct causes include infection, obstructed labour and hypertension. The other indirect cause included anaemia, which aggravated the situation during pregnancy.

The survey further identified complications like ectopic pregnancies (where the fertilized egg implants into the fallopian tube instead of the uterus) as well as socio-economic constraints also worsened the problem. Poverty was also identified as a factor that explains more grave statistics of maternal mortality in developing countries like Uganda as compared to those of developed world, while access to information determined whether and where one should seek assistance. However the survey didn't indulge in cultural practices as a contributing factor to maternal mortality, which this research is meant to find out.

According to MOH Uganda Survey 2004, each year, more than 500,000 women die in the world from pregnancy and childbirth-related complications, and at least 10 million

suffer serious injuries or disabilities. More than 80% of these deaths occur in sub-Saharan Africa and South Asia. HIV/AIDS has significantly increased maternal mortality ratios. Evidence suggests that suppressed immunity causes higher risks of prenatal and childbirth complications including miscarriage, anaemia, postpartum, hemorrhage and puerperal sepsis, in addition to increasing chances of dying from indirect causes during and after pregnancy, such as malaria or pneumonia. Thus, maternal mortality ratios for women who are HIV positive can be substantially higher than for those who do not have HIV.

WHO (1998) also mentions unsafe abortion, which accounts for about 13% of all the maternal deaths each year. Abortion is as well a major problem in Uganda according to Bitangaro (1999); New Vision paper (April (1999); Ross et al (2000); DISH Project (2000); MOH (1999) although it is illegal. Kirumira (1993) also observes HIV infections and increased risk taking sexual behavior as factors that lead to maternal mortality. He further observes that the low social status that traditions assigned to women, their lack of voice in family decision making as well as formation of policies, further impede their chances to stay healthy and productive. However, cultural practices and their contribution to maternal mortality are not tackled by the mentioned researcher, which makes this research necessary.

WHO (1997); Kisembo (2001) identified some of the factors that prevent women in developing countries from getting the life saving health care they need. These include: distance from health services, cost (direct fees as well as the cost of transportation, drugs and supplies), multiple demands on women's time, women's lack of decision-making power within the family, the poor quality of services including poor treatment by health providers also make some women reluctant to use services.

Kisubi and Mugaju (2002) observe that lack of relevant information was a major problem. His study in Western Uganda revealed that young women were particularly unaware of the dangers of early sexuality, early pregnancy and early childbirth whereas older women did not understand the risk of giving birth at later ages. However, Kisubi did not indulge in cultural practices of the area, which makes this research distinct.

According to Hawkins, Newman et al (2005), also supports women's lack of access to health care services due to inaccessibility, cost, or perceived poor quality as causes of maternal mortality. They argue that poorly functioning health system and a lack of skilled personnel, supplies, equipment, and adequate referral systems, lack of a supportive and protective legal and policy environment, or where it exists poor enforcement of its provisions worsens maternal mortality rates in developing countries. However, this research is meant to find out the influence of cultural practices to maternal mortality.

Uganda has one of the highest maternal mortality rates in Africa (Bantebya 2003). According to her paper, Bantebya shows that Uganda's maternal mortality estimates of 2000 and 2001 are 500-600 deaths per 100,000 live births. She further observes that these figures are from hospital based studies while majority Ugandan women live in rural areas and do not deliver in health facilities. Her paper was based on a study carried out in

Hoima, which investigated socio- cultural factors on reproductive health and maternal mortality in particular. It found out that women preferred to deliver unassisted which makes them respected culturally. This research is to find out the cultural practices that contribute to maternal mortality Kabale, Mukono and Mbale in Uganda.

2.3 Cultural causes to maternal mortality

The factors underlying the direct causes of maternal mortality operate at several levels. The low social status of women in developing countries limits their access to economic resources and basic education and thus their ability to make decisions related to their health and nutrition. Patriarchy as it currently exists in Africa has made women face more disadvantages and exploitation than men. Some women are denied access to care when it is needed either because of cultural practices of seclusion or because decision-making is the responsibility of other family members (WHO 1999; Gordon 1996).

While maternal mortality rates remain unacceptably high the actual determinants of maternal mortality are well known according to Hawkins, Newman et al (2005). They also argue that women's status starting with lack of education, which is linked to early marriage and childbearing; inability to take decisions regarding health care; low valuation of girls and women, particularly in the peak reproductive years, and poorer access to nutrition. Family and community beliefs which prevent early identification of problems related to pregnancy, or lack of awareness of pregnant women's needs. This study will clearly bring out the exact cultural practices that influence maternal mortality and the gender dynamics there in.

According to WHO (2000), in every culture important practices exist which celebrate life - cycle transitions, perpetuate community cohesion, or transmit traditional values to subsequent generations. These traditions reflect norms of care and behaviour based on age, life stage, gender and social class. Harmful traditions exist in many different forms, but they share origins in the historically unequal, social and economic relationship between men and women. Female genital cutting, early marriages and child bearing, and gender bias have received global attention due to their severe negative impact on the health and well- being of females.

According to WHO (2001), traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations. Every social grouping in the world has specific traditional cultural practices and beliefs some of which are beneficial to all members while others are harmful to a specific group, such as women.

National Research Council (1997) observes that female genital mutilation has been reported in more than thirty countries on the African continent. Seven countries are mentioned in the Middle East, four in Asia and other areas to which certain ethnic groups from these countries have migrated. The immediate health consequences of female genital mutilation (FGM) can include infections, like tetanus and HIV, septicemia, hemorrhage, injuries to adjacent tissues, urinary retention, shock and death. In Uganda, female genital mutilation is practiced among the Sabiny of Kapchorwa. It is believed that girls who undergo female genital mutilation are provided with rewards including public recognition and celebrations, gifts, potential for marriage, respect and the ability to

participate in adult social functions (WHO 1999; UNFPA 1999; Chekweko 1994). Among the Hausa people of Nigeria, "*gishiri* cuts" a traditional surgical operation, are commonly performed on uneducated women, while educated women rarely allow themselves to be subjected to this practice (Royston *et al* 1998). The "*gishiri* cut" is a treatment for obstructed childbirth, and involves the cutting of the vagina by an elderly woman using an unsterilized blade. These cultural practices can lead to maternal mortality but they are practiced in some parts in Uganda. This research is meant to find out the cultural practices in Kabale, Mukono and Mbale which will give us a general picture for Uganda.

According to WHO fact sheet 23 (2000), in the countries where the practice of female genital mutilation exists, most women believe that, as good Muslims for example, they have to undergo the operation. In order to be clean and proper, fit for marriage, female circumcision is a precondition. Among the Bambara in Mali, it is believed that, if the clitoris touches the head of a baby being born, the child will die. The clitoris is seen as a male characteristic of the women. In order to enhance her femininity, this male part has to be removed. Among women in Djibouti, Ethiopia, Somalia and the Sudan, circumcision is performed to reduce sexual desire and also to maintain virginity until marriage. A circumcised woman is considered to be clean.

Ayisi (1992) shows that Among the Kipsigis of Kenya, sexual intercourse before initiation for girls resulting in pregnancy is regarded as sacrilegious. So it is not surprising that among the Kipsigis of Kenya, the offence of making an uninitiated girl pregnant is one of the most heinous that can be committed, and the girl and her child in the past used to be cast out in the community.

Proverbs and sayings from many cultures indicate the long-standing of son preference. Royston and Armstrong (1989) give an old proverb from China, which says: 'Eighteen goddess-like daughters are no equal to one son with a hump'. He further observes that among the Iteso of Uganda a newborn baby boy is described as 'the central pole,' indicating the central support of a spreading family, while a baby girl is described as 'only a prostitute' because her destiny is to be 'sold' into marriage in exchange for cattle. This means that culturally if a woman produces girls, she will be forced to continue producing until she gets a boy. This is dangerous to a woman's health in that it makes the uterus weak and might lead to rapture, which might cause maternal death. However Royston and Armstrong do not indulge in cultural practices in depth, which makes this research necessary.

Jjemba (1994) observes that among the Iteso traditions, observance and nominating pregnant mothers, treatment by drumming, dancing '*etida' quod* shaking '*akayeni;*' use of cowrie shells for foretelling fortune or misfortune is a cultural practice that may lead to maternal mortality. While doing all this, a woman can take long in labor and may die. Jjemba examined this among the Iteso but the cultural practices in Kabale, Mukono and Mbale and how they contribute to maternal mortality has not been done.

"A woman giving birth has her one foot in the grave." – A Filipino saying. Poor nutrition can increase the risks of the baby being born with low birth weight and the mother dying". Akpe (2001) has it that despite societal advances of the 21st century women and children are barred from eating chicken and eggs in some societies in Adamawa state in Nigeria, a senior Nursing officer, Mrs. Justine Murey said. Murey disclosed this in Yola at a seminar on harmful traditional practices against women organized by the state's Ministry of Women Affairs. She further talked about food taboos, such as the prohibition of women from eating goat meat, groundnuts and Okra soup during breast-feeding, and grossly affect the nutritional status of women in such societies.

According to Kumar's paper (1998), son preference discriminated the family allocation of food and the access to health care services for girls in Bangladesh. Reasons given for families preferring sons to daughters include: sons maintain and extend lineage; inherit property; act as a hedge against financial disaster; provide support for parents in old age and farm the family land. Daughters on the other hand are considered as a liability for the family because they marry early and outside the family, any investment in them is lost to the other family, contribute little to household expenses, require dowries and expensive weddings and provide no support to the family of origin after marriage. For these reasons, families preferred to have sons and to maintain them in good health since sons are considered as an asset for the family. In Bangladesh, women on average continue to bear children for 23-25 years between first and last birth of their child and "strong son preference" plays a significant role for this. Kasonde (1990) has it that some cultural practices are detrimental to reproductive health. For example, in some societies, pregnant women are prohibited from eating certain foods thus contributing to poor nutritional status and anemia. It is well known that anemia is a risk factor for maternal morbidity and mortality.

Karwemera (1994) observes that girls, who conceived before marriage, would be taken and thrown in Kisiizi waterfalls or on any steep hill in Kabale where they would die. Others would be sent away from home and culturally they had to go to a different clan or else the girl would be beaten until she mentioned one who impregnated her. In that process some would die. He further noted that in marriage, when the placenta would delay to come out, the husband would go on top of a house with a mortar and would let the mortar fall while mentioning his mother-in-law's name. Mentioning mother-in-law's name among the Bakiga is a taboo so when it is mentioned, it is believed to make the placenta come out. Karwemera's study was meant to explore the norms and values of the Bakiga but cultural practices that lead to maternal mortality are not tackled which this research is expected to cover.

WHO (1999) observed that delayed referrals, a significant cause of maternal mortality, may be due to cultural beliefs causing TBA's (Traditional birth attendants) to dismiss warning signs. For example, TBAs in Cambodia believe that bleeding after delivery releases "bad blood" which the attendant may not recognize as haemorrhaging. Referral postponements may also occur when TBAs dismiss emergencies because the women did not fall into the definition of a group "at risk". Ultimately, a delayed referral further

compromises the health of the women because it limits the ability of the medical staff to cope with the emergency.

According to WHO (2001), among the most bizarre treatments for obstructed labor are the psychological ones. In many societies, difficulty in labor or delay in delivery is believed to be punishment for marital infidelity. The woman is pressured to confess her misdeed so that labor may continue without complications. This practice, which inflicts great mental cruelty on a woman already in agony due to obstructed labor, is prevalent in several African countries. In addition to the psychological trauma suffered by the woman, the practice further delays her being taken to hospital. Treatment of obstructed labor by ineffective and harmful traditional methods can also cause uterus rapture. Rapture of the uterus still constitutes one of the major causes of maternal mortality in obstetric practice in developing countries. Death rates as high as 37 percent have been reported in studies of hospitalized women with ruptured uteruses.

WHO (1999) has it that in two African countries, a practice known as "*zur zur*" is performed on women between the 34th and 35th weeks of their first pregnancy. A deep cut is made in the anterior wall of the vagina, sometimes on the posterior wall. The wound is allowed to bleed, and then the woman rests for a while to nurse the wound. The purpose of this operation is to prepare the woman for an easy delivery. However, the consequences can be death through excessive bleeding, shock and infection of the birth canal.

UNFPA (2000) has it that TBAs have been found to use traditional practices that can lead to post- partum infection and sepsis. A woman's health is threatened when the TBA conducts examinations with unclean hands or when herbal mixtures are applied " which may result in genital infections if left untreated, pelvic sepsis may result and may lead to chronic pelvic inflammatory disease which is the underlying cause of many cases of infertility, menstrual disorders and ectopic pregnancies. When these practices are rooted in cultural beliefs, it is particularly difficult to train attendants to use alternative methods.

Turyasingura (1996:16) argues that pre-marriage cultures, which punish the unmarried women, explain why some maternal deaths occur. Parents often culturally arrange marriage. In nearly all the indigenous customs in Uganda the groom usually pays bride price. The parents of the girl therefore earn apparent "wealth" and these practices have often compelled girls to be married off at a tender age and are also not given the opportunity for further education. The median age at first marriage is 17 years for females. Early marriage interferes with the girls' education, which reduces opportunities for their career development and exposes them to the health risks commonly associated with early child bearing. Turyasingura's study shows how culture contributes to maternal mortality but it does not exhaust the cultural practices that lead to maternal mortality.

Bantebya (2003) observed that women continue to choose high-risk options leading to severe morbidity and even their own death. Her findings demonstrate that adherence to traditional birth practices and beliefs that pregnancy is a test of endurance and maternal death is a sad but normal event, are important factors. She shows that culture contributes

a big percentage to maternal mortality especially in rural areas in Uganda but she mentions that little is known about cultural beliefs that contribute to maternal mortality which this research is meant to explore.

UDHS (Uganda Demographic Health Survey 1995) pointed out that, although utilization of antenatal care services is very high, very few mothers normally go back after delivery. Despite the fact that some of them are abrupt deliveries, it was mentioned in Arua District that only 'coward' women would seek hospital services. Similarly, in Western Ankole, Neema (1994) found out that pregnancy is not regarded as illness, which can require medical care by a professional doctor. This is because culturally women are expected to be brave and strong during childbirth.

According to Babirye (2000), in a cultural setting, childbirth is a private affair attended to by close relatives with the furthest person being a TBA, who is a village-mate. Modern medicine on the other hand makes delivery a public affair, where the attendants are at best indifferent. It was as well pointed out that at home and with TBAs women deliver their babies while squatting or kneeling while at health centres, they are told to lie on their backs, which they are not used to.

Royston and Armstrong (1989) identify that most of the causes are medical although they observe that in rural Africa it is quite common for a woman to have given birth to eight live babies and to have been pregnant several more times. Such a woman has a chance of dying from pregnancy. Though this is a cultural practice especially in Africa where many children are valued, Royston and Armstrong do not indulge in cultural practices and how they contribute to maternal mortality, which this research is meant to find out.

Babirye's study (2000) reveals that competition among co-wives to have as many children as possible so as to win the husbands favor is a common practice in Kiboga district. This is not good for a woman's health because the number of times a woman produces can affect her health or even lead to death especially if the numbers are so many. In communities where polygamy is common the problem might affect women seriously.

Ssemogerere et al (1995) found out that some women preferred self medication because they were unwilling to expose their private parts to the male gynecological doctors, and even to the midwives and nurses who were considered as young girls fit to be their daughters. Women therefore preferred to have their deliveries at home with the assistance of a TBA.

In addition to this, Babirye's study revealed that the placenta was another factor that was culturally very important. Women disclosed that when they deliver at the TBA's home they are given possession of the placenta. The placenta is seen as a second child and if it is not given a proper burial then they believe that this will affect their ability to have

more children. In health facilities, the placenta is simply discarded without respect to traditional beliefs and women's anxieties. This issue could hinder women to visit health facilities and in case of any complications a maternal death could occur.

Wall (1998) observes that among the most important factors contributing to this tragic situation is an Islamic culture that undervalues women; a perceived social need for women's reproductive capacities to be under strict male control; the practice of *purdah* (wife seclusion), which restricts women's access to medical care, almost universal female illiteracy, marriage at an early age and pregnancy often occurring before maternal pelvic growth is complete. Wall did not look at the other cultural practices that are not religious which makes this research necessary.

2.4 Perceptions of men and women

According to Koblinsky (2003) assistance at birth by a skilled birth attendant in the home or any health facility supported by a functioning referral system can reduce maternal mortality. She argues that deliveries conducted in the home can be successful if the health system beginning with the referral hospital, provides outreach support to home birth attendants whether they are traditional birth attendants, community workers or skilled midwives.

According to Mohtashami UNFPA (2007) TBA's are not considered as skilled birth attendants and several studies have shown that they cannot contribute in reduction of maternal mortality. In a joint statement in 1999, WHO, World Bank, UNICEF and UNFPA stated "Training of TBAs, in the essence of back-up from a functioning referral system and support from professionally trained health workers (skilled attendants at birth), is not effective in reducing maternal mortality.

Bantebya (2003) argues that, the conceptualization of childbirth as "the woman's battle" was also found to be prevalent in West Africa, where maternal mortality was explained as "she fell on the battlefield in the lien of duty". However, the view that birthing wields immense power, attributed to the unique nature of childbearing, is especially noticeable in societies where women command much less power than men in the public domain.

Bantebya noted that, in Uganda, the literature on the socio-cultural aspects of maternity care is scanty. In the FIGO Save the Mothers Initiative needs assessment in Kiboga district, Uganda, which investigated socio-cultural factors in reproductive health and maternal mortality, community perceptions and cultural expectations were found to have a significant bearing on reproductive health and on maternal mortality in particular. In the Kiboga community, as in most ethnic communities in Uganda, where continuation of the lineage is central dynamic and the individual is subordinated to the group, the importance of a woman still lies in her ability to produce children. It was evident that pregnancy and childbirth were one of the major areas where women still command power and status, which they would strive to keep enhancing their status within the household and community. The scarcity of information like this made this research necessary.

2.5 Gender dynamics in maternal mortality

According to Sweetman C, (2001), reproductive tasks - ranging from the work of child bearing and rearing to the care of the home create particular health needs for women. Men's role in reproductive work is minimal in comparison to that of women. Many women have little or no choice over when, where, and how they have sex and hence no control over possible pregnancy or disease transmission. Women's experience of pregnancy, birth and post-natal recuperation is likely to be shaped by the expectation of their families in respect to their cultural practices.

In recent years, there has been a growing understanding of how people's gender identity determines the nature of their ill health, vulnerability to disease, their ability to prevent diseases, and their access to health care. This is supported by Kisubi and Mujaju (2002) who argue that women are liable to more ill health problems in relation to their productive duties compared to men's. Lack of control over resources by women might hinder them to seek health care services.

According to Helman, in almost every culture most primary health care takes place within the family, and in the popular sector the main providers of health care are usually women - often mothers and grandmothers. Also within the popular sector women have often organized themselves into healing cults, circles or churches which act as either self-help groups for their members or sharing of sorrow groups. Women have played a central role from the village 'wise women' and the several types of female medium or spiritual healer in Britain, to the man female folk healers in the non-industrialized world and the Traditional Birth Attendants (TBAs) that still provides the majority of the obstetric care in those countries.

Hutchinson P. et al (1999) The health situation of women in Uganda has been one of the worst in the world. The maternal mortality rate is currently estimated at 506 deaths per 100,000 live births, accounting for roughly 17 percent of all deaths that occur among women aged 15-49 years. Only 13.7 percent of pregnant women receive prenatal care in the first trimester, and only 35.4 percent of births occur in a medical facility. Of all births, 65.9 percent are considered high risk. The total fertility rate remains high, at almost seven births per women. Further, no change has been noted in the age at first birth, and in fact fertility rates among teenagers may be increasing.

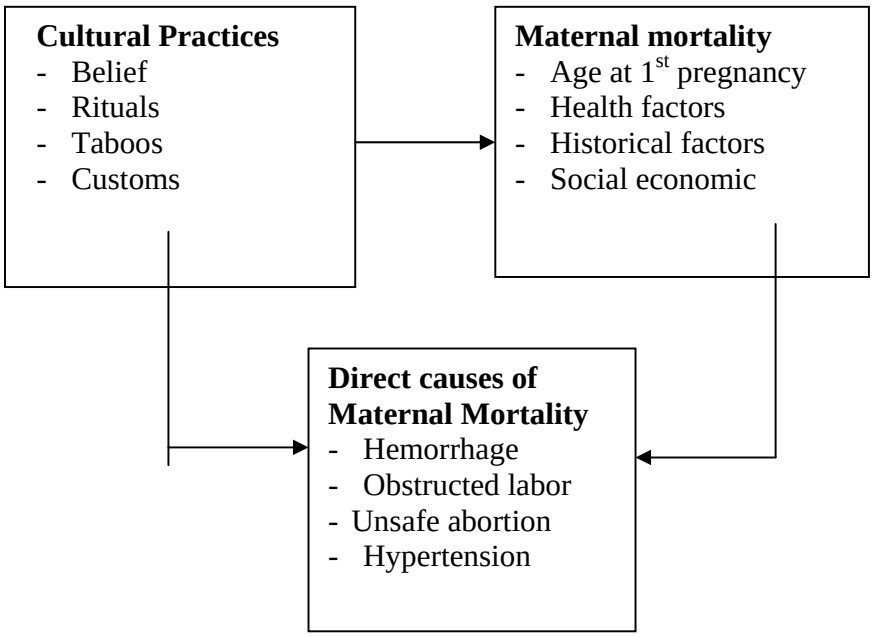
According to Deborah (2005) women refugees in Ugandan camps are experiencing a wide range of reproductive health problems. This is because these camps are put up in isolated areas where access to health facilities is a big problem. In addition to this, men are in control of the very little resource that they have yet their ill health is not as diverse as that of women in reproductive age. Many problems in camps affect pregnant women greatly, which include lack of transport to health facilities, lack of enough food, lack of water and many others, which can cause maternal death in the areas. Very few people in camps can access education, which makes them get married at an early age. This has a very negative impact on their health especially girls whose pelvises are usually not well developed to carry babies. Deborah's study was based in camps while this research is meant for usual communities in Kabale, Mukono and Mbale which makes it distinct.

Women form more than 50% of the population in Uganda and they contribute more than 70% (MOH 2000) of the labour force and if their reproductive health is neglected it is fatal and it has implications for the overall national development.

CONCEPTUAL FRAMEWORK

The study will be conceptualized on people's perceptions on cultural practices that might lead to maternal mortality and attitudes towards antenatal check up. This is in relation to gender and the causes that lead to maternal mortality. This is elaborated in Figure 1.

Figure 1: Conceptual framework



From the conceptual framework above, some cultural practices that include beliefs, rituals, taboos and customs are expected to lead to maternal mortality but in an indirect way. This is because they precipitate the direct causes and hence will have led to maternal mortality.

(h) METHODOLOGY

Introduction

This section describes the research design, study area, study population, sample size, sampling procedure, and methods of data collection, and data analysis.

Research Design

The research design used will be an exploratory survey design.

Study area

The study will be carried out in Uganda,in three Districts that is Kabale, Mukono and Mbale.

Study population
The research will focus on TBAs, medical personnel, old women who have helped others to deliver, men and women in the community who are 18 years and above.

Sample Size
The sample will include men and women who are 18 years and above. The key informants will be 20 elderly mothers from each district who have ever helped some people to deliver, 15 TBA's from each district, 10 medical personnel from each district. 6 focus group discussions of 12 people from each District will be selected as respondents. 100 people from each district will be selected to answer questionnaires.

Sampling procedure
The respondents will be drawn from various types of households. These will include married male or female-headed households. Local council chairpersons will be identified from each District. The chairpersons will be helped by the local committees to identify some women who might have helped others to deliver or those who have delivered. The men identified will be those who have produced, apart from the medical personnel.

Methods of Data Collection/Research Instruments
The study will employ both qualitative and quantitative methods because the two are considered to be complementary. Quantitative methods will be used to backup qualitative data.

Semi-structured questionnaires will be used which will have both closed and open ended questions. The questionnaire will be structured according to the objectives of the study and it will require multiple responses. It will have questions which can be answered with pre-determined responses like 'yes /no', 'agree/disagree'. It will also have open-ended questions to allow respondents freedom to express their feelings and opinions about the issues of maternal mortality and cultural practices.

In depth interviews will be used as well, by use of the interview guide consisting of open-ended questions. In here, there will be personal contact between the researcher and the respondent, which will generate detailed information. Each respondent will be interviewed away from the spouse with consent from either spouse because it could make the respondents more free. In-depth interviews will be used for key informants.

Two focus group discussions of twelve people from each District will be conducted. Focus group discussion guide will be used and the discussions held will help to clarify the ideas expressed by respondents in the questionnaire. Focus groups will be used to collect qualitative data. The data will be recorded in notebooks.

Documentary review will also be used which will give secondary data and information that will be collected for example from books, government policies, reports, journals, newspapers and action plans. These sources will be used before the fieldwork and after in order identify the gaps and to clarify the data that will be collected.

Data Analysis

Quantitative data

Data will be analysed by use of descriptive statistics for the socio-economic and demographic characteristics like sex, marital status, age, educational level, occupation and religion. These will be coded thereafter.

Qualitative data

This will be analyzed thematically according to what will be on the checklist. The themes will be done manually by use of useful quotations and literature that will be useful in the discussion of findings. The patterns established in this category of themes will then be analyzed by use of descriptive statistics. Direct quotations from participants will be included.

(i) REFERENCES

Babirye (2000) *Factors influencing the Utilization of maternal Health services in Kiboga District* (Not Published).

Bantebya G. (2003) *Low Use of Rural Maternity Services in Uganda: Impact of* Women's *status, Traditional Beliefs and Limited Resources. Kampala, Fountain Publishers.*

Chekweko J. (1995) *A Report of a workshop on Female Circumcision in Kapchorwa.*

DISH (2000) *Research on Adolescent Sexual and Reproductive Health in the Districts of Uganda..* http://www.ugandadish.org/resources/aa/aa4.shtml 24 August 2003.

Hecht R, Alban A et al (2005) *Aids and Millenium Development Goals :* http://www.globalenvision.org/library 16th May, 2007.

Hawkins, Newman et al (2005), *Developing a Human Rights-Based Approach to Addressing Maternal Mortality*, DFID Health Resource Centre

Jjemba (1994) *A report of a two day sensitization workshop organized by Inter Africa Committee (A.E.C.) Uganda chapter- Fighting harmful cultural Practices affecting the health of women and children with particular emphasis to early Marriages.*

Kamatenesi-Mugisha, M. (2004) *Medicinal Plants used in Reproductive Health Care in Western Uganda: Documentation, Phytochemical and Bioactivity Evaluation.* Ph.D. Thesis in Botany, Makerere University, Kampala, Uganda.

Karwemera,F (1994) *Emicwe n'Emigyenzo y'Abakiga* Kampala: Fountain Publishers ltd Uganda.

Kisembo A (2001) *Accessibility and utilization of Reproductive Health information and services by Women with disabilities in Mbarara*. (Not Published).

Kisubi M. and Mugaju J. ed (2002) *Rural Health Providers in South-West Uganda*: Kampala; Fountain Publishers.

MOH (2001*) Maternity Statistics for District; District Monthly Reports.*

National Research Council (1997) *Reproductive Health in Developing Countries* Washington: National academy Press.

Neema (1994), *Mothers and Midwives: Maternity Care Options in Ankoke South Western Uganda.* Ph.D Thesis. University of Copenhagen.

Okong *et al* (1997) *Country Report; Risk factors associated with Maternal Mortality in three Kampala Hospitals; Mulabo, Nsambya and Lubaga..*

Olupot, M (2003) The New Vision 23rd Aug *Culture Responsible for High Mortality Rate* http://allafrica.com/stories/200308250155.html 25th August 2003.

Ross J. Stover J., and Willard A. (2000) P*rofiles for Family Planning and Reproductive Health Programs*. Newington: Paladin Commercial Printers.

Royston E. & Armstrong S. Ed (1989) *Preventing Maternal Deaths*: Geveva WHO.

Turyasingura G. (1996), *A Review of Research on Maternal Mortality in Uganda.* Kampala; Makerere University.

UNFPA (1990) *Report on the Regional Conference on Traditional Practices Affecting the Health of Women and Children in Africa..*

UNFPA (1998) A Journal on r*eproductive Health Services in Crisis situations*.

UNFPA (1999) *Report on Reproductive Health Rights and Legislation Workshop for Parliamentarians from Eastern and southern Africa..*

UNICEF (1996) *Society of Obstetricians and Gynecologists of Canada (SOGS): International Women's Health Program.*
UNICEF (1999) *A Situation Analysis of Women Adolescents and Children in Uganda: An Analysis of the Health Program.*

UNICEF (2008) *Humanitarian Action Uganda*.

Wall, L. (1998) *Dead Mothers and Injured Wives: The social context of Maternal Morbidity and Mortality among Hausa of Northern Nigeria*.

http://www.sogc.org/SOGCnet/sogc_docs/intl/pregn_e.shtml Friday 10-2000.

WHO (1990-91) *Reproductive Health: A Key to a Brighter Future*. Biennial Report special 20th anniversary issue.

WHO (1991) *Maternal Mortality: A Global Fact book.*

WHO (1996) Revised 1990 *Estimates of Maternal Mortality: A New approach by WHO and UNICEF*.

WHO (1997) *Safe Motherhood: Why Are Women dying?* http://www.safemotherhood.org/factsandfigures/maternal_mortaility.htm.

WHO (1999*) Female Genital Mutilation to Date: What Works and What does not.*

WHO (2002) *Reduction of Maternal Mortality: A Joint WHO/UNFPA/UNICEF /World Bank Statement*: Geneva: Printed in Switzerland.

WHO (2001) *Maternal Mortality in 1995: Estimates Developed by WHO, UNICEF, UNFPA.* http://www.ncbi.nlm.nih.gov/entrez/query.fcgi? Cmd = Retrieve ^db= Pub Med $ list-vids = 99919629 & dopt = Abstract 23rd August 2003.

WHO (2003) *Health Report.*

World Bank (2002), *Maternal Health Care in Rural Uganda*, Leveraging Traditional and Modern Knowledge Systems.

Ayisis Eric. O (1992) *An introduction to the study African culture.* Nairobi East African Educational Publishers Ltd.

Sam Akpe (2001) *Harmful cultural practices and maternal mortality in Nigeria* HTTP.// LISTS.Kabissa.org/list.archives/public/womenwrighs watch-nigeria.msg 00071.litml

UNICEF (1999) *Maternal nutrition and birth weight* http://www.unicef org nutrition/ index – low birth weigh. Html

Kumar.D (1998) *Factors influencing maternal mortality in Bangladesh from a gender perspective*. http//www.qweb.Kvinnoforum.se/papers/bangladesh.html 2/6/04

WHO (1996) *A joint WHO/UNICEF / UNFPA Statement Giving up Harmful Practices Not Culture*. http://www.advocatesforyahh.org/publications/oag/harmprac.htm. 7/6/04.

Taylor .K and Pan (1999). *The maternal and child Health Community leadership Institute. Understanding the Health culture of Recent Immigrants to the United States:* http://www.aph.org/ppp/red/summary.htm2/6/04.

WHO (1999) *TBAs are a threat to women's health s/controversies/ paper 01/TBAS/Traditional % 20 Birth % 20 Attendants.* Doc 7/6/04.
WHO (1998*) Harmful Traditional practices affecting the Health of Women and Children* http://www.vnlichr. Ch/html/menu 6/2/fs23.htm.

Sweetman C. (2001), *Gender Development & Health, Ministry of Health (Uganda) Uganda Health Bulletin. A Journal on Health and Poverty* Vol. 7, Number 1.

Women's Dignity: (2003): *Faces of dignity*: Seven stories of girls and women with fistula.

Mulumba D. (2005): *Gender relations, likelihood security and reproductive health among women refugees in Uganda***.**

Koblinksy M. (2003): *Reducing maternal mortality*. Washington, World Bank office of the Publisher.

Green (2004): *An introduction to Health Planning in Developing Countries,* New York, Oxford University Press.

Bantebya G. (Ed.) 2005: *Women's Health: African and Global Perspectives Kampala.*

The World Bank (2005) *Improving Health Outcomes for the poor in Uganda: Current status and implication for health sector development.*