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Understanding the Preference for Traditional Birth Attendants Over Health Care Centers Among Mothers in Budondo Sub- County, Jinja District Uganda: A Qualitative Inquiry

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Abstract

Background

Maternal mortality remains a significant public health challenge in Uganda, where only 58% of deliveries occur in health facilities despite high antenatal care attendance exceeding 90%. Persistent reliance on Traditional Birth Attendants (TBAs) in rural communities contributes to preventable maternal and neonatal deaths, yet the underlying drivers of this preference in Budondo Sub-County, Jinja District remain inadequately understood at the local level.

Methods

A qualitative, cross-sectional exploratory-descriptive study was conducted, rooted in the interpretivist paradigm and guided by an ecological conceptual framework examining influences at the individual, interpersonal, and community levels. Thirteen participants were purposively recruited: nine mothers (aged 20–28 years) who participated in in-depth interviews and four key informants (two TBAs and two midwives) who participated in key informant interviews. Data were collected using semi-structured interview guides administered in Lusoga and Luganda, and analysed using Braun and Clarke's six-phase reflexive thematic analysis framework supported by NVivo software. Methodological triangulation strengthened the credibility of findings.

Results

Nine themes emerged across three analytical domains. At the individual level, fear of caesarean sections, emotional safety provided by TBAs, structural access barriers, and conditional trust in health facilities drove TBA preference. At the interpersonal level, husbands and mothers-in-law exercised decisive authority over delivery decisions, while peer narratives functioned as powerful social proof. At the community level, exclusion of cultural birthing practices from health facilities, TBAs' deep social embeddedness, and an almost complete absence of TBA–facility referral collaboration collectively sustained reliance on TBAs.

Conclusions

Maternal preference for TBAs is a rational, contextually situated response to healthcare system failures and unmet emotional and cultural needs, rather than ignorance. Key recommendations include TBA registration and structured integration into the formal referral system, mandatory respectful maternity care training for health workers, culturally inclusive facility protocols, strengthened Village Health Teams, and targeted household engagement programmes for male partners and mothers-in-law.

Background

Maternal mortality is a significant global public health problem, especially in low- and middle-income countries (LMICs). The World Health Organization estimated that 260,000 maternal deaths will occur worldwide in 2023, with 92% of these occurring in LMICs and Sub-Saharan Africa (SSA) bearing approximately 70% of the burden [1]. Although global antenatal care (ANC) coverage has risen above 80% and the coverage of skilled birth attendance has increased to around 86%, these global aggregate statistics hide wide disparities, especially in rural areas where access to facility-based care remains a challenge [2, 3]. In fragile and rural settings, inaccessibility and distrust of health facilities speak volumes about the growing disconnect between the formal frameworks of health systems and the realities of populations [4]. A basic framework for the analysis of determinants of maternal mortality has been proposed by McCarthy and Maine [5], and remains central to understanding the interaction between distal and proximal factors that leads to poor maternal outcomes in such settings.

In SSA, care-seeking behavior during childbirth is determined not only by the availability of the service but also by cultural values, trust in caregivers, and previous interactions with the formal health system [6]. Traditional Birth Attendants (TBAs), community-based women who help mothers give birth by drawing upon traditional knowledge, remain an important fixture in rural communities. TBAs offer culturally congruent, compassionate and emotionally responsive care, which is in marked contrast to reported experiences of neglect and mistreatment in formal health facilities [7, 8]. Acceptability of evidence-based neonatal and maternal care practices in Uganda and elsewhere has been shown to be strongly linked to trust and cultural compatibility within the community [9]. Informal and concealed payment practices in the context of ostensibly free maternal services have the additional effect of eroding trust in formal facilities [10]. As a result, many rural women continue to opt for TBAs despite policy frameworks stressing on skilled birth attendance.

Uganda is an example of this paradox. Despite the fact that ANC attendance is over 90% nationally, health facility deliveries are disproportionately low, especially in rural areas and the country has one of the highest maternal mortality ratios in the region [11]. Adolescent and low-income women in rural Uganda are faced with compounded barriers to maternal care, including financial constraints, geographic distance and institutional insensitivity [12]. In Budondo Sub-County, Jinja District, geographical distance, fear of unnecessary medical procedures, cost factors and the sympathetic care of TBAs are often cited by mothers as some of the primary reasons why they bypass institutional deliveries [13]. These preferences are further perpetuated by systemic weaknesses such as frequent drug shortages, understaffing, and long waiting times [14]. TBA practice in Budondo has historical origins going back decades, with documentation on evaluation of TBA training programs in Jinja District dating to as early as 1998 [15]. Studies in similar settings have shown that the proportion of mothers who are influenced by cultural norms in their delivery decisions is up to 77% and 47% report being restricted by their partners from delivering in hospitals [16].

Despite efforts by the government to promote skilled birth attendance and the 2010 prohibition by the government on the practice of TBAs, dependence on TBAs remains rife in rural communities. Factors and structural determinants affecting maternal mortality in rural Uganda, including fragmentation of health systems and community trust deficits continue to be documented [17]. Barriers to maternal healthcare among adolescent mothers are still especially high, including social stigma, lack of male partner support and institutional insensitivity [18]. Male partner perceptions on reproductive health services and community level dynamics of trust and institutional responsiveness are additional reflections of the drivers of TBA preference [19]. Understanding the multilevel drivers of this preference is key to designing culturally responsive interventions that are consistent with Uganda's RMNCAH Sharpened Plan 2022/23-2026/27 [20] and the overall Ministry of Health Strategic Plan 2020/21-2024/25 [21].

This study therefore set out to find out factors that influence the preference of mothers to TBAs instead of health care centers in Budondo Sub-County, Jinja District. The specific objectives were: (i) to explore how mothers describe their beliefs, fears, and personal experiences in choosing TBAs; (ii) to explore the role of the community in influencing the mother's decision of choosing TBAs; and (iii) to understand how cultural norms contribute to TBA preference over formal health care centers. The study addresses a critical lack of evidence at the local level and provides context-responsive results to inform national and global efforts to reduce the burden of maternal mortality in accordance with the Sustainable Development Goals.

Methods

Study Design

This study employed a qualitative, cross-sectional exploratory-descriptive design rooted in the interpretivist paradigm [22]. This approach was appropriate given the study’s aim of understanding the subjective meanings, lived experiences, and contextual realities that shape maternal delivery decisions dimensions that are difficult to capture through quantitative methods alone [22]. Data analysis was guided by Braun and Clarke’s [23] six-phase reflexive thematic analysis framework, which has been extensively applied in qualitative health research [24]. The ecological conceptual framework structured the analysis across three levels: individual (beliefs, fears, and personal experiences), interpersonal (family and peer influences), and community (cultural norms and structural health system factors). This framework aligns with Andersen’s Behavioral Model of health service utilization [25] and the social determinants of health perspective.

The study was conducted in Budondo Sub-County, Jinja North City Division, Uganda. Budondo comprises five parishes Buwagi, Ivunamba, Kibibi, Namizi, and Nawangoma with approximately 70 villages. Key health providers in the catchment area include Budondo Health Centre IV and Kyabirwa Health Centre. This setting was selected because of persistently low rates of facility-based delivery despite documented high ANC attendance and the presence of active TBAs operating within the community.

Study Population and Sampling

The study population comprised mothers living in Budondo Sub-County who had delivered a child within the preceding one to three years. Purposive sampling was employed to recruit information-rich participants meeting the inclusion criteria and well positioned to provide meaningful responses to the research questions. Mothers were selected to represent diversity in age, parity, and place of last delivery, while key informants were selected to represent community and professional perspectives.

Inclusion criteria for mothers were: aged 18 years or above, resident in Budondo Sub-County, recent delivery experience with a TBA, and provision of informed consent. Mothers who had delivered only in a health facility, could not consent, or had severe communication barriers were excluded.

Participants

A total of thirteen participants were recruited: nine mothers and four key informants. The nine mothers ranged in age from 20 to 28 years. Eight had delivered with a TBA as their last delivery; one mother (Mother 2) used a TBA due to transport unavailability during heavy rain but expressed a preference for facility care under normal circumstances, and one mother (Mother 6) had delivered in a health facility. Four key informants were interviewed: TBA 1 (age 50, practicing since 1984, documenting over 200 deliveries monthly), TBA 2 (age 40, active TBA in Budondo), and two midwives serving at maternal health facilities within the sub-county catchment area.

Sample size was determined by thematic saturation rather than statistical representativeness. Saturation was reached when no new themes emerged during further interviews, consistent with evidence that saturation is achievable in small purposive samples of information-rich participants [26].

Data Collection

Prior to fieldwork, the research team held community entry meetings with local leaders and health authorities to gain approval, build trust, and facilitate recruitment. Each participant was individually approached, informed of the study purpose, and provided with written or verbal informed consent in their preferred language. Interviews were conducted in private settings of the participant's choice and lasted 30–45 minutes. With participant consent, interviews were audio-recorded, transcribed verbatim, and translated into English for analysis.

Data were collected using semi-structured interview guides for both in-depth interviews (IDIs) with mothers and key informant interviews (KIIs) with TBAs and midwives. The guides covered open-ended questions on personal beliefs, fears, and experiences; partner and family influences; and community norms and perceptions of health services. The guides were translated into Lusoga and Luganda by bilingual experts and back-translated to verify accuracy, and pre-tested with mothers and key informants from an adjacent sub-county to ensure clarity and cultural appropriateness. Methodological triangulation

was achieved through the combination of IDIs and KIIs, enabling comparison of mothers' perspectives with those of TBAs and midwives [23]. Participant codes were assigned to maintain confidentiality: mothers were identified as Mother 1 through Mother 9, and key informants as TBA 1, TBA 2, Midwife 1, and Midwife 2.

Data Analysis

Data were analyzed using Braun and Clarke's [23] six-phase reflexive thematic analysis framework. The phases comprised: (1) familiarization with data through repeated reading of transcripts and integration of field notes; (2) generating initial codes using in-vivo and interpretive coding; (3) searching for themes by collating codes into broader categories reflecting emerging patterns across ecological levels; (4) reviewing themes to ensure coherence and accuracy; (5) defining and naming themes within domains corresponding to individual-, interpersonal-, and community-level factors; and (6) producing a narrative report integrating thematic findings within the ecological framework. Analysis was reflexive and inductive, consistent with the approach described by Vinitha [27] for applied qualitative health research. Data were organized and coded in NVivo software.

Research assistants participated in a two-day training workshop covering study objectives, ethics, and interviewing techniques, including role-playing and mock interviews. Frequent debriefing sessions during data collection supported consistency. Memo writing enhanced reflexivity and transparency throughout analysis. These steps collectively ensured the trustworthiness and rigor of the qualitative findings.

Results

Participant Characteristics

A total of thirteen participants were included: nine mothers who participated in in-depth interviews and four key informants (two TBAs and two midwives) who participated in key informant interviews. Table 1 presents the socio-demographic characteristics of the mothers and Table 2 presents the profiles of the key informants.

Table 1
Socio-demographic Characteristics of Participating Mothers

Code	Age (Yrs)	Parity	Last Delivery	Marital Status	Education
Mother 1	28	Multipara	TBA	Widowed	Primary
Mother 2	27	Multipara	TBA (situational)	Married	Primary
Mother 3	27	Multipara	TBA	Married	Primary
Mother 4	25	Primapara	TBA	Married	Primary
Mother 5	20	Multipara	TBA	Married	Primary
Mother 6	Not disclosed	Primapara	Health Facility	Not disclosed	Primary
Mother 7	20	Primapara	TBA	Married	Primary
Mother 8	23	Multipara	TBA	Widowed	Primary
Mother 9	25	Multipara	TBA	Married	Primary

Table 2
Characteristics of Key Informants

Code	Role	Age (Yrs)	Background
TBA 1	Traditional Birth Attendant	50	Practising since 1984; >200 deliveries documented monthly
TBA 2	Traditional Birth Attendant	40	Active TBA in Budondo Sub-County
Midwife 1	Midwife / Health Worker	Undisclosed	Serving at a maternal health facility in the Budondo catchment area
Midwife 2	Midwife / Health Worker	Undisclosed	Serving at a maternal health facility in the Budondo catchment area

The nine mothers ranged in age from 20 to 28 years, reflecting a predominantly young reproductive-age group consistent with the demographic profile of Budondo Sub-County. The majority were married and had delivered more than one child. Most reported their last delivery as being attended by a TBA, with the exception of Mother 2 who used a TBA due to transport unavailability on the night of delivery but expressed a preference for health facility care under normal circumstances and Mother 6, who delivered in a health facility. This diversity within the sample is analytically significant, as it permits comparison of experiences across both TBA and facility delivery contexts.

The key informants brought complementary perspectives. TBA 1 was a particularly information-rich participant, having practiced since 1984 and maintaining a logbook documenting over 200 deliveries monthly, making her one of the most experienced and recognized TBAs in Budondo. Both midwives

served at formal maternal health facilities within the sub-county and offered professional insights into the structural and relational factors that influence maternal health-seeking behavior.

Individual-Level Factors: Mothers' Beliefs, Fears, and Personal Experiences

The first objective explored why mothers choose TBAs over formal health facilities. Four themes emerged: fear of surgical intervention, TBAs as emotional and relational safe spaces, structural barriers to facility-based delivery, and conditional trust in health facilities.

Fear of Surgical Intervention

Most mothers feared caesarean sections, viewing them as unnatural, dangerous, and symbolic of loss of control. This fear was reinforced through community narratives rather than personal experience. Mother 4 stated that a TBA guaranteed there would be no surgery:

With a TBA, no matter what she does, she is unable to push. She pushes the child. There is no C-section.

Mother 5 had heard stories of women who did not return from operations and linked this to her fear. Midwife 1 confirmed that mothers believe facilities take them straight to theatre without allowing vaginal labour to progress:

Mothers always say that whenever they come to health facilities, they just take them to the theater. They do not give you a chance to push and produce.

Although most mothers feared surgery, variation existed. Mother 1 regarded surgical capacity as a safety net rather than a threat, and trusted facilities' ability to perform operations if something went wrong.

TBAs as Emotional and Relational Safe Spaces

Mothers described TBAs as nurturing figures who provide material and emotional support absent in health facilities. Mother 3 described being with a TBA as being with a mother:

When she is with a TBA, she is like she is with her mother. The TBA provides everything, especially now that she does not have food, she does not have enough money for food for breakfast. The TBA provides breakfast, the food and everything.

Other mothers highlighted patience, gentle communication, and the ability for family members to be present. Mother 7 said the TBA stayed close, talked gently, and allowed relatives around her. Mother 8 noted that the TBA was someone known and trusted, close to home and supportive of family involvement. TBA 1 described her approach:

When a mother comes, they handle her with care. They offer emotional support—the psychological bit of it. They also give them some food and drinks, and they feel really that they are at home, like they are with their mother.

Midwife 1 observed that TBAs assure mothers they will deliver vaginally: “TBAs can really express to the mothers that you are going to produce. They assure them. There is that assurance that they are going to produce. Come what may, they are going to produce.” By comparison, health facilities were depicted as impersonal and sometimes neglectful, with reports of women delivering on the floor and staff absences at night.

Structural Barriers to Facility-Based Delivery

Many mothers turned to TBAs when distance, transport, or cost made facility care infeasible. Mother 2 did not prefer the TBA but delivered there because heavy rain prevented the motorcycle taxi from arriving:

On that day when she gave birth to that child, it was a rainy day, and they called the border person to come and pick her up. But unfortunately, the border person did not come in time, hence the TBA helping her to give birth.

Mother 9 similarly explained: “I delivered my baby with a Traditional Birth Attendant because I could not easily reach the health facility. The health center is far from my home, and transportation at night is difficult.” Other deterrents included long waiting times, the absence of midwives overnight, and poor facility conditions. Mother 5 remarked that she disliked seeing women deliver on floors in lower-level centers. Midwives noted that health centers are self-centered and lack community interaction. These findings indicate that some TBA use reflects circumstantial necessity rather than intrinsic preference.

Conditional Trust in Health Facilities

Mothers acknowledged the technical advantages of health facilities while criticizing their interpersonal practices. Mother 1 articulated this conditional trust:

She mostly trusts health facilities or health workers, because in case anything fails, they can always decide to take her for an operation or to do something about it. For the TBAs, there is nothing like an operation there. Yeah, so it can be risky and can lead to other consequences.

Some mothers, like Mother 6, described facilities as a safe place for childbirth, and Mother 9 said: “I prefer delivering in a health facility because I feel my baby and I are safer there.” However, many women disliked post-delivery observation requirements. Midwife 2 explained that mothers want to leave immediately after delivery to return to their household responsibilities, whereas TBAs permit early discharge, a practice that health facilities do not allow. This tension illustrates that trust in facilities is moderated by perceptions of respect, autonomy, and cultural congruence.

Interpersonal Influences: Community Influence on Maternal Decisions

The second objective examined how interpersonal dynamics shape decisions to use TBAs. Two themes were identified: the husband–mother-in-law alliance as decisional authority, and peer narratives as social proof.

Husband–Mother-in-Law Alliance as Decisional Authority

Household power structures heavily influence where women give birth. Mother 4 said her husband and mother-in-law decide together on delivery location:

Mostly her husband and her mother-in-law are the ones who influence her decision because they discuss where to give birth and how the way forward.

Family members recommended specific TBAs based on successful past deliveries, reinforcing multigenerational trust. Midwife 1 stated:

The most influential person who has an influence on a woman's decision about where to give birth is the mother-in-law, then secondary is the husband. Most family members are the ones who encourage mothers, mostly, to use TBAs.

Partner influence was not uniform. Mother 2 noted that her husband strongly encourages facility delivery, and Mother 1 reported that no one influenced her choice. These counterexamples demonstrate that family dynamics can also support facility births.

Peer Narratives and Community Testimonials as Social Proof

Stories about other women's birth experiences circulate widely and constitute a form of social proof. Mother 4 explained that positive stories about safe deliveries encourage women to seek certain TBAs:

They have heard stories of TBAs delivering very well, having a safe birth, so of course they encourage them to go there, especially to the TBAs who give birth very well.

Women place trust in specific TBAs they know personally. As Mother 8 said: "She is someone we know and trust." TBAs participate in community life, attending ceremonies, funerals, and other events. Midwife 1 contrasted this with health workers: "TBAs go for burials. They go to ceremonies in the community, which is not the case for most health workers in the health facility." TBA 1 noted that her record of over 200 deliveries is documented and widely known: "People like this known TBA, they know her because they talk about her, how many babies she has helped deliver, because she has given birth to over 200 people, which is proven in her records." Negative stories about health facilities also circulate and deter

use. Midwives observed that a single poor outcome can have ripple effects on community perceptions. These interpersonal narratives often outweigh formal health education in shaping choices.

Community-Level Factors: Cultural Norms and Structural Health System Factors

The third objective explored community-level influences on TBA preference. Three themes were identified: cultural practices and institutional rejection of biomedical norms, TBA social embeddedness and community trust, and the TBA–facility collaboration deficit.

Cultural Practices and Institutional Rejection of Biomedical Norms

Childbirth in Budondo is embedded in traditional rituals, including the use of herbal medicines, ritual bathing, removal of curses, preferred labor positions, and post-delivery ceremonies. Mother 3 described the cultural customs:

The hubs showering with those herbal medicines, sharing the baby with those herbal remedies, showering the bed with herbal medicines to remove curses. In our community, TBAs are respected and trusted because of the safe deliveries that they have been doing.

She noted that facilities prohibit these rituals: “They do not allow them to practice them at the hospital, and it is against the health professionalism.” Midwife 1 affirmed: “All those rituals or customs are ignored by the health facilities because they are not in line with what the health facility needs, or with health professionalism.” Traditional practices persist even among mothers who attend facilities. Midwife 1 observed that women secretly use herbal medicines, share chocolate for blessings, and use lunar rituals to break curses. Health facilities’ refusal to accommodate these rituals is experienced as disrespect and deepens cultural estrangement. Midwife 2 added that facilities require post-delivery observation, conflicting with cultural expectations to return home quickly for family duties and rituals.

TBA Social Embeddedness and Community Trust

TBAs are not merely service providers; they are longstanding community members. TBA 1 has practiced since 1984 and keeps detailed records of over 200 births per month, which community members cite as evidence of competence. Women select TBAs based on reputation, choosing individuals who ‘deliver mothers very well’ rather than any TBA. Midwife 1 explained that TBAs’ participation in everyday community life generates sustained relational familiarity that health workers cannot replicate.

Field notes indicated that only approximately ten TBAs are active in Budondo, maintaining low profiles because they “do not want to be known by outsiders” owing to Uganda’s 2010 ban on TBA practice. This regulatory environment paradoxically reinforces loyalty to known TBAs by making networks more exclusive.

The TBA–Facility Collaboration Deficit

The final theme exposed a breakdown in referral and collaboration between TBAs and health facilities. TBA 2 recounted a tragic case:

A mother came while she was helping her give birth. The baby came out when the intestines were out. She got scared. The mother had stolen the referral letter from the hospital. They went to Jinja Hospital. They went to emergency and tried to help her, but the baby died, but the mother survived.

TBA 2 stated she needs health education to recognize high-risk conditions such as hypertension, diabetes, and HIV. Midwife 1 bluntly described the situation: “Referral mechanism systems are dead, no collaboration with TBAs.” Midwife 2 proposed: “How they can collaborate with TBAs is through health education. They should start health education on the ground. Let the government empower VHTs through payment so that they are able to focus attention on those mothers that go to the TBA.” TBA 2 echoed the desire for partnership: “She wants health education so that she can work hand in hand with the community.” Without functional referral pathways, manageable complications can become fatal.

Summary of Findings

Across three objectives and nine themes, the findings explain why many mothers in Budondo Sub-County prefer TBAs. Individual-level fears and needs, interpersonal dynamics, and community-level cultural and structural factors converge to shape choices. Many mothers fear C-sections and value the emotional care and home-like environment TBAs provide. Others choose TBAs because facilities are distant, expensive, or inadequately staffed. Some mothers trust health facilities for their clinical competence but criticise their interpersonal and cultural insensitivity. Household decision-making often rests with husbands and mothers-in-law, and peer narratives function as informal social proof. At the community level, TBAs align with cultural practices and are embedded in social networks that generate durable trust. The near-absence of collaboration between TBAs and health facilities represents a systemic failure that places mothers at risk.

Discussion

Reflection on the Methodological Approach

The study employed a qualitative exploratory-descriptive design within an interpretivist paradigm, appropriate for understanding meanings, experiences, and context surrounding maternal preference for TBAs dimensions difficult to capture quantitatively [22]. Nine in-depth interviews with mothers and four key informant interviews with TBAs and midwives generated multiple perspectives and strengthened credibility through triangulation. Braun and Clarke’s [23] six-phase reflexive thematic analysis guided analysis, with data quality further supported by approaches described by Campbell et al. [24] and Vinitha [27]. The nine themes generated across three analytical domains demonstrated theoretical saturation, consistent with Hennink and Kaiser [26], who note that saturation may be achieved in small purposive samples when participants are information-rich. NVivo enhanced coding transparency and auditability.

The ecological framework enabled analysis at individual, interpersonal, and community levels, consistent with Teshale et al. [4]. Interview guides were translated into Lusoga and Luganda, back-translated for accuracy, and research assistants trained in ethical interviewing and reflexivity. Memo writing supported reflexive interpretation. However, limited generalisability and possible social desirability bias remain acknowledged limitations.

Individual-Level Beliefs, Fears, and Personal Experiences

Fear of Surgical Intervention

Fear of cesarean section emerged as one of the strongest themes. Many mothers described surgery as unnatural, dangerous, and associated with loss of control during childbirth. These fears were largely shaped by community narratives of women who allegedly died or suffered complications after surgery rather than direct personal experience. Participants often viewed TBAs as protectors of normal vaginal delivery, with Mother 4 explicitly stating that TBAs prevent surgery.

This agrees with Atukunda et al. [11], whose rural south-western Uganda study identified fear of caesarean section as a major barrier to facility delivery. Chi and Urdal [13] similarly found that women in northern Uganda preferred providers believed to avoid unnecessary interventions. Dektar et al. [7] in Busoga-Jinja also found fear of surgical procedures strongly influenced younger and primiparous mothers toward TBAs. Fear was not universal. Mother 1 viewed surgical services as an emergency safety measure rather than a threat. Midwife 1 reported that mothers believe facilities rush women to theatre before labour progresses naturally, echoing Mukuru et al. [14], who linked institutional practices to perceptions of unnecessary intervention. This aligns with Andersen's Behavioural Model [25], where predisposing beliefs shape health-seeking behaviour. Within the ecological framework, fear of surgery is an individual perception reinforced through community narratives.

TBAs as Emotional and Relational Safe Spaces

TBAs were consistently described as nurturing, patient, and emotionally supportive. Mothers portrayed TBAs as familiar figures who offered food, comfort, reassurance, and continuous labour support. Mother 3 described the TBA as a mother figure, reflecting findings by Bwirire et al. [28] and Dektar et al. [7], where relational support strongly influenced maternal preference. TBAs allowed family presence, gentle communication, and uninterrupted companionship, unlike health facilities, which participants described as hurried and impersonal. Adatara et al. [6] also showed that continuous emotional support is rarely replicated in formal facilities.

Negative facility experiences described by participants, including neglect, absence of staff, and poor treatment, align with Anastasi et al. [8] and Roed et al. [29] on disrespectful maternity care. Chandler et al. [30] and Roed et al. [29] showed interpersonal quality strongly influences delivery choices. Teshale et al. [4] argue maternal healthcare barriers extend beyond access to include trust, perceived quality, and cultural safety, all strongly reflected in this study.

Structural Barriers to Facility-Based Delivery

Distance, transport difficulties, cost, and poor facility conditions strongly influenced TBA use. Mother 2 reported using a TBA because transport failed during heavy rain, while Mother 9 described long distances and dangerous night travel. Wong et al. [31] identified distance and transport as major barriers to skilled childbirth care across sub-Saharan Africa. Flake [32] similarly documented geographic barriers, while Debie et al. [33] and Dantas et al. [34] highlighted hidden costs in supposedly free Ugandan maternal services, consistent with Schaaf and Topp [10], who documented the pervasiveness of informal payments in maternal care. A key distinction emerged: some mothers used TBAs not because of cultural preference but because of unavoidable structural barriers. This adds nuance beyond studies such as Ntoimo et al. [35], which often categorise all TBA use as cultural preference.

Conditional Trust in Health Facilities

Mothers acknowledged health facilities as clinically safer, especially for emergencies, but criticised interpersonal treatment, cultural insensitivity, and prolonged post-delivery observation. Mother 1 recognised facility benefits while still expressing reservations. Chi and Urdal [13] similarly found women choosing TBAs despite understanding facility advantages. Atukunda et al. [11] showed women valued surgical capacity but disliked reduced autonomy in facilities. Midwife 2 noted mothers often leave facilities early because of household responsibilities, consistent with Kagoya et al. [36], who documented conflict between biomedical post-delivery requirements and cultural expectations. Apolot et al. [37] similarly documented how adolescent mothers' specific vulnerabilities compound institutional distrust.

Interpersonal and Community Influences on Maternal Decision-Making

The Husband and Mother-in-Law Alliance as Decisional Authority

Childbirth decisions were rarely made independently by mothers. Husbands and mothers-in-law often held decisive authority. Midwife 1 identified mothers-in-law as especially influential. Rutindangyezia and Nakasolo [16] found similar patterns in Mbarara, where male partners discouraged facility delivery. Muheirwe and Nuhu [38] showed male decision-making often limited skilled birth attendance, while Gopal et al. [39] reported weak male involvement despite policy emphasis on reproductive health. Rujumba et al. [19] also documented how male partner perceptions of health services shape women's healthcare decisions at the household level. However, some counterexamples emerged. Mother 2 described husband support for facility delivery, and Mother 1 reported personal autonomy. Turinawe et al. [40] proposed TBAs may promote male involvement because of their trusted household role.

Peer Narratives and Community Testimonials as Social Proof

Peer stories strongly shaped delivery decisions. Positive TBA stories encouraged other women, while negative facility stories reinforced avoidance. Dektar et al. [7] documented similar peer-driven influence in Busoga. Bwirire et al. [28] also found collective memory of facility failures persists despite health education. TBA 1's reported 200 monthly deliveries strengthened her reputation. TBAs build trust through community participation in ceremonies and local events, unlike most health workers. This supports Chandler et al. [30], who argued that information alone rarely changes behaviour where trust and collective narratives dominate decisions.

Community-Level Cultural Norms and Structural Health System Factors

Cultural Practices and Institutional Rejection of Biomedical Norms

Cultural childbirth practices remained central to maternal preference for TBAs. Mothers described herbal medicines, ritual bathing, placenta burial, preferred birthing positions, and spiritual rituals as essential. Health facilities were described as prohibiting these practices. Midwife 1 confirmed such rituals are routinely suppressed, consistent with Chi and Urdal [13] and Kagoya et al. [36], who found cultural accommodation strongly influenced TBA preference. Importantly, cultural practices continued secretly even among facility users. Adatara et al. [6] and Teshale et al. [4] argue cultural safety should form part of maternity care quality. Childbirth in Busoga remains a social and spiritual process, not merely a biomedical event.

TBA Social Embeddedness and Community Trust

TBAs were deeply embedded in community life as neighbours, elders, and relatives. TBA 1's long practice and high delivery volume demonstrated strong reputational trust, echoing Lukwago et al.'s [15] historical findings on TBA practice and community trust in Jinja District. Turinawe et al. [40] and Bwirire et al. [28] similarly described TBAs as trusted social actors. The 2010 Ugandan ban appears to have strengthened discreet trust-based TBA networks rather than eliminating them, supporting arguments by Gopal et al. [39] and Ntoimo et al. [35] that punitive regulation limits accountability without removing demand. Factors and structural determinants of maternal mortality in rural Uganda more broadly reinforce the need for community-centred rather than purely prohibitive policy responses [17].

The TBA–Facility Collaboration Deficit

The near absence of TBA–facility collaboration was the most clinically significant finding. Midwife 1 stated referral systems were effectively absent. TBA 2 described delayed referral leading to neonatal death. Mukuru et al. [14] linked referral delays to maternal mortality. Anastasi et al. [8] also identified referral gaps between antenatal attendance and skilled delivery. Nambile Cumber et al. [18] documented that strengthening referral pathways and training community-based providers are among the key strategies needed to improve maternal services. TBA 2 expressed willingness to learn danger signs such as pre-eclampsia, diabetes, and HIV. Midwives proposed mobile outreach, TBA education, and Village Health Team support. These align with Waiswa et al. [9] and Rutledge et al. [41], which support integration of TBAs as first responders within referral systems and validation of evidence-based practices at the community level.

Synthesis of Findings and Theoretical Contributions

The findings show that maternal preference for TBAs is not a simple cultural choice but a rational response to fears, emotional needs, family influence, community trust, cultural identity, and health system failures. A key theoretical contribution is the concept of culturally constituted risk: mothers' perceptions of safety are shaped through social meaning, community narratives, and cultural values rather than biomedical evidence alone. Fear of surgery and trust in TBAs are socially reproduced, suggesting conventional factual risk communication alone is insufficient. This extends Andersen's Behavioural Model [25] and the social determinants framework [5] by embedding them within a community-specific ecological analysis.

Implications of the Findings

Policy Implications

The findings suggest Uganda's 2010 TBA ban has reduced visibility but not use. A regulatory integration model is recommended, especially in remote areas similar to Budondo Sub-County. The recommended integration should include registration, training, and referral linkage, consistent with Rutledge et al. [41], Kagoya et al. [36], and the Ministry of Health RMNCAH Sharpened Plan [20]. Respectful maternity care training should be mandatory. Patient feedback systems should strengthen accountability [30]. Facilities should accommodate medically safe cultural practices, including flexible birthing positions and respectful family presence [36]. Referral systems need strengthening through communication channels, emergency transport, and active Village Health Teams, and the Alkhawaldeh et al. [42] systematic review of Andersen's model confirms that enabling factors including infrastructure and policy must be addressed alongside predisposing beliefs.

Implications for Health Service Practice

Facilities should adopt community outreach approaches, with midwives visiting communities and building trust. TBAs require structured training in danger sign recognition, infection prevention, safe

delivery, and referral. Mobile midwifery outreach could bridge facility and community care, as supported by Adatara et al. [6] and Anastasi et al. [8].

Implications for Research

Future research should compare TBA and facility delivery outcomes longitudinally, examine fear-based narratives around surgery, explore adolescent and economic vulnerabilities [12, 37], and test TBA–facility collaboration models in Uganda and similar LMIC contexts [41].

Limitations of the Study

The purposive sample was limited to Budondo Sub-County, reducing transferability. Self-reported data may contain social desirability bias, especially given TBA illegality. Only two TBAs participated because of regulatory sensitivity. Researcher interpretation may also have influenced analysis despite reflexive measures. Single-time-point data limited understanding of changing maternal preferences over time.

Conclusions

This study demonstrates that maternal preference for TBAs in Budondo Sub-County is ecologically shaped by fear, emotional care needs, household authority, community trust, cultural practice, and health system limitations. The study's findings have important implications across three areas.

At the individual level, fear of caesarean sections, the desire for emotional and relational support, structural access barriers, and conditional trust in health facilities are major drivers of TBA preference. Fear of surgical intervention emerged as the strongest individual driver, shaped mainly by community narratives rather than direct experience. TBAs are perceived as providers of emotionally safe, continuous, home-like care that formal health facilities cannot fully provide under current conditions of understaffing, overcrowding, and institutional culture. TBA use is not uniform: some mothers have genuine cultural preferences, while others use TBAs because distance, transport problems, and cost make facility delivery difficult.

At the interpersonal level, childbirth decisions in Budondo Sub-County are strongly shaped by household authority, especially mothers-in-law and husbands, whose influence often determines delivery location. Family recommendations of trusted TBAs act as major referral pathways that formal health systems have not effectively penetrated. Maternal health interventions focusing only on individual mothers are therefore incomplete without household engagement. Peer narratives about safe TBA deliveries and negative facility experiences form a powerful informal information system that often shapes maternal behavior more strongly than formal health education.

At the community level, traditional childbirth practices including herbal medicines, ritual bathing, birthing positions, placenta ceremonies, and post-delivery spiritual practices remain central expressions of cultural identity and safety. Their exclusion from formal health facilities is experienced as cultural

disrespect. The study's most urgent structural finding is the breakdown of referral and collaboration systems between TBAs and health facilities. The absence of communication channels, transport arrangements, and structured liaison creates direct risks for maternal and neonatal survival.

Overall, maternal preference for TBAs in Budondo Sub-County is a rational and culturally coherent response to individual fears, relational needs, household authority, community norms, and health system failures. Improving maternal health outcomes therefore requires building clinically strong, emotionally responsive, culturally inclusive, and community-embedded services.

The Ministry of Health and Jinja District Health Office should establish a formal TBA registration and integration programme, including competency-based training in danger sign recognition, infection prevention, safe delivery, and referral protocols, with each TBA linked to a designated health facility. Functional community-to-facility referral pathways should be introduced through referral forms, mobile communication with on-call midwives, and emergency transport support. Mandatory respectful maternity care training for all health workers should be implemented. Culturally inclusive maternity care protocols should be developed, allowing medically neutral traditional practices such as flexible birthing positions and family presence where safe. Village Health Teams should be strengthened as maternal health liaison networks. Targeted engagement programmes for husbands and mothers-in-law should be introduced, and community-based peer health champions should be recruited to leverage positive facility experiences as influence.

Abbreviations

Abbreviation	Meaning
ANC	Antenatal Care
C/S	Caesarean Section
IDI	In-Depth Interview
KII	Key Informant Interview
LMIC	Low- and Middle-Income Country
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SDG	Sustainable Development Goal
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
VHT	Village Health Team
WHO	World Health Organization

Declarations

Ethics Approval and Consent to Participate

This study was conducted in accordance with the Declaration of Helsinki and received ethical clearance from Clarke International University's Institutional Review Board (IRB) CLARKE-2025-1723. Informed consent was obtained from all participants prior to their involvement in the study. Participants were informed of the purpose of the study, their right to withdraw at any time without penalty, and the confidentiality measures in place. Interviews were conducted in Lusoga or Luganda to ensure full comprehension. All data were anonymized and stored securely with access restricted to the research team.

Consent for Publication

Not applicable. This study does not contain any individual person’s identifying data in any form.

Availability of Data and Materials

The datasets generated and analyzed during the current study are not publicly available due to the sensitive nature of the data and the commitment to participant confidentiality, but are available from the corresponding author on reasonable request.

Competing Interests

The authors declare that they have no competing interests.

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Authors' Contributions

KS conceptualized the study, conducted the thematic analysis, and drafted and substantially revised the manuscript. KTJ collected the data and provided critical input during manuscript editing.

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