Field Notes

Chasing out traditional birth attendants in Ghana – implications for maternal and newborn health

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This paper reflects on a growing shift away from the training and use of traditional birth attendants (TBAS) to provide maternity care services in Ghana and calls for greater collaboration between TBAs and the health system in Ghana. The paper communicates personal reflections based on experiences working with communities to address barriers to maternal and newborn health care services in Ghana. It also draws on evidence from a larger research study examining the effects of Ghana's free maternal healthcare policy on women's maternity care seeking experience, equity of access and barriers to accessibility and utilization of maternal and newborn healthcare services. The design of this larger study involved analysis of nationally representative, retrospective household survey data in combination with qualitative exploration using focus group discussions, in-depth interviews, case studies and structured field observations in a total of six communities between November 2011 and May 2012. The study was comprised of 185 expectant and lactating mothers, 15 traditional birth attendants and 20 healthcare providers (i.e. community health nurses, midwives, doctors, health facility managers, district and regional directors of health, district and regional public health nurses, policy makers at the Ministry of health and Ghana Health Services).

Background

Like many countries in Africa, Ghana is a country where deaths from pregnancy and childbirth are very high. In 2007, maternal mortality accounted for 14% of all female deaths and continues to be the second largest cause of female mortality in Ghana.[1] In 2010, the WHO estimated that Ghana's maternal mortality ratio (MMR) was 350 per 100,000 live births.[2] Despite the fact that since 2003 Ghana has implemented a new maternal healthcare policy that provides free maternity care services in all public and mission healthcare facilities, recent survey data suggest that only 55% of women receive skilled assistance during delivery or postnatal care following delivery.[3] The survey also suggests that more than 30% of births still occur at home with traditional birth attendants (TBAs). This poor maternal health situation is compounded by widespread access inequalities among different socio-demographic groups across the country, with the rates of skilled attendance either stagnant or declining for poorer women.[2] This situation has partly been caused by limited access to skilled birthing services, especially in rural Ghana.[4]

Despite the low levels of maternal and newborn care access and the significant role TBAs continue to play in maternity care, the Ghana Health Service has largely failed to engage TBAs in the provision of maternal health services. TBAs, who are often illiterate elderly women and who usually learn their midwifery craft from personal experience and from older women in their community, have historically operated throughout Africa and Asia. During the 1970s-1990s the WHO, UN and donor agencies mooted the idea of formally recognizing and training TBAs to complement efforts aimed at improving maternal and perinatal health in low and middle-income countries.[5] Since then, the roles of TBAs have been the subject of fierce debate among maternal health professionals worldwide and several repeated assessments have been conducted to ascertain whether the strategy works.[5, 6-8] The recent 'Head to Head' debate "Are traditional birth attendants good for improving maternal and perinatal health?" highlights the attention TBAs and their practice continue to attract. In said debate, Kelsey Harrison, a retired obstetrician and gynecologist argues on one side that TBAs do more harm than good partly because of their lack of education and the unhygienic environment in which they operate8. Harrison's arguments are further grounded in a growing body of evidence that suggest that delivery in a health care institution or with skilled birth attendant (SBA) significantly reduces the chances of maternal and neonatal death compared to delivery by unskilled birth attendants.[9, 10]

Joseph Ana, a former Commissioner for Health, Cross River State, Nigeria, on the other hand believes that the shortage of skilled health workers in most developing countries means that TBAs have a valuable place in the delivery of maternal health care. Ana therefore argues that TBAs need to be trained and incorporated into the formal health care system to help improve women's access to skilled birthing services.[5] Ana's arguments are based on personal experiences in Nigeria as well as several studies that have indicated that TBA training and inclusion in maternal health service provision has the potential to improve maternal and perinatal health.

While the debate on TBAs remains unsettled, many developing countries including Ghana – with acute shortage of health resources and health care personnel – are discouraging the training and use of TBAs to provide maternity care services.[9,10] A closer, more personal look, however, reveals that increasing the training of TBAs to provide safe and effective access to life-saving maternal health services, particularly in rural areas where health care facilities are lacking and SBAs unavailable can be effective.

Findings – the case for TBAs training

Effective training, engagement, monitoring and supervision of TBAs could improve maternal and newborn health. From a six-

month observation of women and healthcare providers in Ghana, it was clear that TBAs still occupy an important position in maternal healthcare provisioning in Ghana. Qualitative interviews and regular interaction and conversation with community members, women, and TBAs suggested that TBAs are often seen as easily accessible, culturally competent and acceptable providers of maternity care services, particularly births at home in rural Ghana. One lactating mother says:

> In this community all pregnant women go to see Mma (Mother) Ramatu [referring to the community TBA]. She is very good. She delivered my son in my own home. She has delivered many pregnant women from this community and other neighboring communities without any problems. So we the women trust her more. She even knows our culture better than the health people at the hospital so when you go to her, she knows how to treat you well. That is why I will always go to her.

It was also clear that TBAs can attend to some of the longstanding barriers preventing skilled care seeking in health facilities, which are rooted in the beliefs and cultures of expectant mothers, such as burying the placenta around a home or in a warm place. These findings are in agreement with other recent studies elsewhere, which reported that some women preferred the services of TBAs because of their cultural sensitivity, easy accessibility and cheaper services.[11-13]

While several women expressed their satisfaction with, and desire for, the services of TBAs, health workers criticized TBAs for their lack of education, their limited understanding of the anatomic and physiological complexity of pregnancy and birth and their engagement in very dangerous practices during labor. For instance, TBAs were accused of not wearing hand gloves during delivery. Using bare hands to deliver women can easily spread infection from the TBA to the woman or her newborn. Health workers also criticized TBAs for failing to use clean cutting instruments such as blades to sever the umbilical cords of newborns; the use of unclean instruments has the potential to spread infection. More importantly, some health care workers argued that the conditions under which TBAs deliver pregnant women are such that the management of post-partum hemorrhage – one of the leading causes of maternal deaths – becomes difficult. In particular, some of the health care providers that were interviewed in the course of the research in Ghana said that TBAs do not have the technical know how and the basic equipment to provide live-saving blood transfusion services in cases where excessive bleeding and blood lost occurs. Others even blamed women's preferences for TBA services on the lack of education of such women. Such local criticisms resonate with some opinions in the literature, which argue that TBAs are the source of many risks that could be avoided with proper training.[8]

In Ghana, these criticisms of TBAs and their practices have divided the formal health system and the activities of TBAs. Even in regions such as the Northern region, where the formal health system continues to unofficially acknowledge TBAs as partners in maternity care, the relationship is neither clearly delineated nor cordial. Yet, face to face interactions with TBAs and women from the Upper West Region of Ghana reveal the potential value that TBAs could have in promoting effective access to maternal and child health care. This perspective comes from a pilot community-based health promotion project in several communities in the Nadowli District of the Upper West Region between 2005 and 2007.

The TBAs Training Project in the Nadowli District

This project was a partnership between Ghana Health Services and World Vision Ghana. The project involved the training of community-based surveillance volunteers (CBSVs) and TBAs in various aspects of community health including but not limited to reporting the outbreak of any disease and recording births and deaths in their community. As part of the project, several TBAs across 30 communities were trained to recognize the danger signs of pregnancy and to quickly refer pregnant women to the nearest health facility. All TBAs were also equipped with hand gloves, hand sanitizers, kerosene lanterns (for use in the night due to lack of electricity), new packs of cutting blades and other basic delivery and maternity care tools. The main purpose of the research was to both enhance the skills of TBAs and ensure that TBAs were relatively well resourced to handle uncomplicated deliveries, especially in remote rural communities where access to health care facilities is difficult.

The project also included a material reward package for TBAs who referred and/or encouraged pregnant women to attend antenatal care in a health facility setting. To ensure women's attainment of antenatal care, TBAs were encouraged to keep monthly records of all pregnant women they have referred or encouraged to seek care in a health facility. Local health care workers were also encouraged to ask and to keep records of all pregnant women who reported to the local health facility because of the advice from or referral by a TBA. Depending on the number of women that each TBA referred to the local health facility, appropriate monetary and other material rewards were given to the TBA. TBAs who physically accompanied pregnant women to the hospital to deliver were also given some instant monetary and material compensation.

It was clear that traditional birth attendants (TBAs) still occupy an important position in maternal healthcare provisioning in Ghana.

Impact of the TBAs Training Project

By the middle of 2007 when a preliminary evaluative survey was conducted, the number of women attending ANC in some communities had doubled – from 41% in 2005 to 85% in 2007. Qualitative discussions and interactions with both women and TBAs suggested that many women were encouraged by TBAs to seek health facility-based maternity care. Also, several TBAs reported that the training they had undertaken had enabled them to quickly refer women to health care facilities in emergency situations. For those TBAs who conducted home deliveries during the period, it was reported that infections due to TBAs' use of their bear hands and other unhygienic practices (e.g. using the same blades to cut the umbilical cords of two different babies) during labor, had also been reduced. This decrease was largely attributed to the TBAs' new supply of hand gloves, hand sanitizers and new blades (for severing off the umbilical cords after delivery). The TBAs' enhanced knowledge of pregnancy and labor management practices also contributed to the decrease in infection. Although the gains from this pilot project were relatively modest, the experience suggested that positive results in maternal and newborn health outcomes could be attained if TBAs and the health care system worked together.

The author's research in Piase—a rural community in the Bosomtwe district of the Ashanti region—where a trained government midwife trained and worked with TBAs on the issue of safe deliver—demonstrates the benefits of training and cooperating with TBAs.

Testimony of the Midwife in Piase

According to the midwife in Piase, before she was posted to work in the community in 2005, attendance at antenatal care (ANC) clinics was low. Women were delivering their babies at home despite the fact that maternal and newborn care services were provided free-of-charge at the health facility. According to the midwife the women were not delivering in the health facility because they were using the services of TBAs despite the fact that they charged a delivery fee of between 2-5 Ghana cedi (US$1 - 2.5). The TBAs were also actively discouraging pregnant women from seeking care at the health facility.

From this state of despair, the midwife discusses how she gradually and successfully engaged and worked with TBAs to increase demand for skilled maternity care services among women.

> One thing I did was to reach out to the TBAs…I visited each of the TBAs in the community to first introduce myself to them as the new midwife. During these intro-

ductory meetings, I asked each of them about what they thought the problems of maternal healthcare were and how we could come together to work to make things better…you know the TBAs were very surprised that I was asking for their opinions because I was the midwife and I was suppose to know everything. But I said that, well I might not know everything and given that I am new in the community, I believe they [TBAs] could be of immense help…in fact, I later organized a meeting and invited all the TBAs to discuss how best we could ensure that no woman suffer or die as a result of pregnancy and childbirth. During the meeting I made it clear that they should see the problem of maternal health as belonging to all of us. I reassured all the TBAs that I did not come into their community to take their jobs, but to work with them so that together we could make things better. After this meeting, I worked closely with the TBAs and even went to help one of the TBAs conduct a delivery at home. It was through this that the TBAs came to realize that I had some skills that they didn't have. So they came to me and asked me to teach them how best to deliver women…I was really surprised. So (I) trained them and gradually, the TBAs started to encourage pregnant women to come to me for ANC and delivery. Now, the TBAs themselves will even bring the women to the clinic to deliver except when I am not around. We are all now working like a team, and I can say that it has contributed a lot to all the progress we are making.

Since the midwife (who is a trained skilled birth attendant) and TBAs (who are unskilled birth attendants) have become partners in promoting access and improvement in maternal and newborn, no maternal or neonatal death has occurred in the community since 2007. This sharp decrease contrasts with the district's average figure of four maternal deaths per year.

Since 2007 there have been no reported incidences of the common various debilitating consequences of pregnancy and childbirth such as chronic anemia, obstetric fistulae with urinary and or fecal incontinence, foot drop or palsy, urine prolapse or pelvic inflammatory disease. Indeed, anecdotal data extracted from records of the Piase health center show a steady improvement in the percentages of women who are able to access and use antenatal, delivery, postnatal, family planning and tetanus toxoid immunization services (see Figure 1). Both the midwife and TBAs attributed this improvement to increases in the proportion of women who now deliver at health facilities as well as to the training that the midwife gave to all TBAs.

Evidence from other TBAs Training Programs in Ghana

Various evaluations of programs, which promoted trained TBAs, have also indicated that TBAs' services could increase women's use of antenatal care and emergency obstetric care and decrease perinatal and neonatal mortality.[6, 14] Oxfam's work and research with 150 TBAs in six communities in Bolgatanga, Kassena Nankana and Bawku West districts of the Upper East Region of Ghana have demonstrated remarkable success.[15] According to the organization's monthly research report in each of the six communities, twice the number of women are now being referred by TBAs to clinics and hospitals for potentially life-saving care and support.[15] Maternal mortality has also reduced by 7%. These findings raise questions regarding why a stronger partnership has not been forged between the Ghana Health Service and TBAs.

Discussion and Reflection

Based on the observations above and the midwife's testimony it seems that criticisms and objections to the practices of TBAs emanate from a maternal health system that is increasingly haunted by, and intolerant of, fears of the 'old ways'. Ghana is progressively aiming to be a modern state, so the power of modernity consequently shapes ideas and practices relating to reproductive health policy and planning. For instance, Ghana's Reproductive Health Strategic Plan (2007-2011) emphasizes the reduction of maternal and neonatal mortality and morbidity through the modernization of obstetric care.

Encouraging all women to seek care from skilled health personnel is certainly critical for improving maternal and newborn health outcomes. Access to skilled ANC at health facilities can facilitate the detection and treatment of problems during pregnancy and provides an opportunity for health workers to inform women about their health and the danger signs associated with a pregnancy. It is during an antenatal care visit that screening for complications and advice on a range of maternity-related issues take place including counseling about healthy lifestyles. Studies have even suggested that early and regular contact with a formal healthcare system during pregnancy may also contribute to timely and effective use of services during and after delivery or in the event of an obstetric complication.[16,17] Similarly, it has been observed that a considerable number of problems that lead to maternal and newborn deaths occur during the postpartum period.[11] The first 48 hours following delivery are therefore critical for detecting and monitoring potential complications that, if unattended, could result in the death of mothers and newborns. Access to and use of post-delivery care services in government health facilities where skilled birth attendants are likely to be available can therefore enable health professionals to identify post-delivery problems including potential complications and to provide treatments promptly.

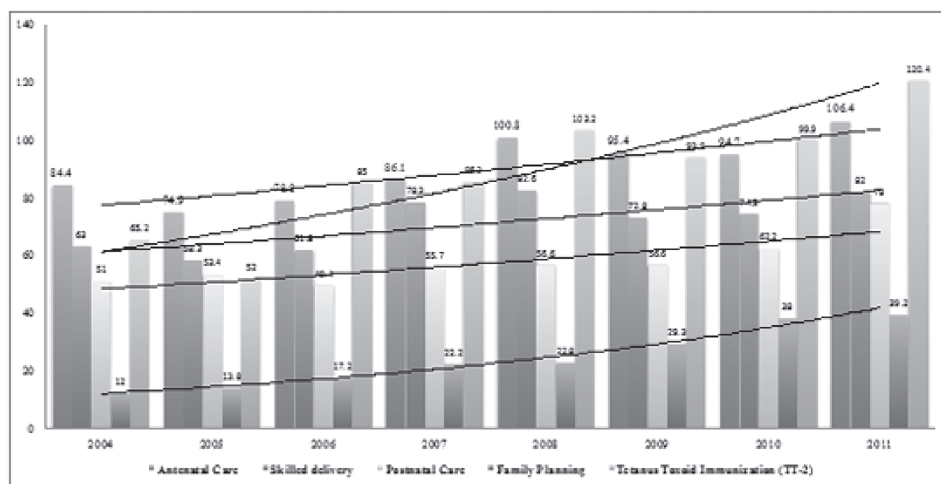
> The power of modernity consequently shapes ideas and practices relating to reproductive health policy and planning.

Given the shortage of skilled birth attendants (SBAs) in Ghana and across Sub-Saharan Africa as indicated by the latest WHO report on the 'state of the world's midwifery,'[18] it is clear that ensuring skilled attendance at all births is neither feasible nor achievable in the short term. In this context reasonably acceptable equity and efficiency arguments can be made for building working partnerships with and incorporating TBAs into the maternal healthcare system in contexts such as Ghana where skilled maternal healthcare provisioning is acutely limited. This is further supported by the observations of the pilot community-based health promotion project. Indeed, TBAs typically work in remote settings where women lack access to healthcare facilities despite the fact that such care is necessary and without cost. Furthermore, women often prefer TBAs for their cultural sensitivity, caused in part by their status as trusted members of the community, the fact that they speak the birthing woman's language and their understanding her tribal culture. The TBAs' close relationship with their clientele allows the practices of TBAs to persist.

Of course there can be real challenges in attempting to recognize, train, supervise and incorporate TBAs into the maternal healthcare delivery system. For instance, the midwife in Piase emphasized that she was able to work with TBAs by convincing them that she did not come into their community to take their jobs away but came to work with them to improve maternal health. Whether or not such an approach would succeed on a large scale is uncertain. Reaching all TBAs and integrating them into an already bureaucratic health service was also a major challenge in the community health project described above. This difficulty in integrating TBAs is worsened by the resentment of some trained health care workers towards TBAs. Similarly, the receptiveness of TBAs to training and modernization could also pose a challenge. This research with TBAs and midwives in communities such as Abono, Piase, Buipe, Mpaha, Sakpala and Tidrope, however, suggests that most TBAs are actually very receptive to training in modern ways of maternity care.

The issue is not that we the TBAs don't want to receive training. As a woman who has experienced pregnancy and child-

Figure 1 Trends in Maternal Healthcare Access in Piase (2004 – 2011)



birth myself, I am always concerned about the safety of all women who come to me for help. So I am always looking for ways to improve how I help the women to deliver or care for their pregnancy. Therefore, we the TBAs are happy to be trained by the midwives. The only problem is that sometimes the midwives and nurses think that because they have studied book, they know how to deliver women better than us…you know they feel that we are too traditional. When they treat us like this then some of us feel reluctant to go for training. But if they treat us well, I am sure every TBA will like to go for training (TBA, In-depth Interview, Piase).

Interviews and interactions with TBAs suggest that in many cases tension and disunity between TBAs and the formal health system only arise when health care professionals or the formal health care system look down upon TBAs. In some cases, the TBAs' fear that the healthcare system will deprive them of their source of livelihood leads to mistrust and lack of cooperation.

In attempting to train and work with TBAs, it is essential that systems be instituted to assure TBAs of their job security. It is also important that mechanisms are constructed to reward TBAs, especially those who accept to be trained. Indeed, in Piase TBAs who accept the training and encourage pregnant women to visit the health center or accompany pregnant women to the health center when they deliver are given small cash rewards. The scheme has proved to be cost-effective and efficient. This scheme could potentially be used in other contexts to engage TBAs as an effective complementary alternative solution for many women, because of the unavailability of many SBAs in rural settings and the long stretch of time before sufficient numbers of SBAs are trained to populate the entire health care system.

Before the cash rewards and incentive scheme can work effectively, the health system will need to first restructure itself to be more welcoming to TBAs. The healthcare system's lack of an underlying positive sentiment towards TBAs has caused mistrust between TBAs and health care personnel. It might also be useful to train health care workers to be more culturally competent. Since TBAs can already provide culturally competent birthing services to women, they [TBAs] can thus train the formal health care workers to be more engaged in, and to take account of, the cultural and local practices of childbearing women. Changing the attitude of health care workers towards TBAs is certainly a difficult task, and may not happen any time soon. However, the success that past TBA training programs have had, and the fact that SBAs are woefully inadequate and underrepresented in Ghana highlights the need to continue training both TBAs and SBAs and encouraging them to be more tolerant of each other.

Conclusion

Despite the potential dangers associated with the practice of TBAs, access to and use of maternal and newborn care services in Ghana is better promoted when TBAs are trained and integrated within the modern health system. The experiences of the midwife in Piase - how she reached out to local TBAs,and succeeded in collaborating with them to increase demand for skilled maternal and newborn care services – demonstrate the importance of cooperating with TBAs. The experience also suggests that if all midwives can approach TBAs in similar ways, successful maternal and child health related MDGs could be attained.

Given the shortage of SBAs in Ghana and high regard for their services in many communities, the formal health care system should ally themselves more with TBAs. The Ghana Health Services, for example, could use innovative incentive mechanisms such as public recognition or cash rewards to encourage TBAs to promptly refer mothers to healthcare facilities especially during labor. Indeed collaboration will also enable the health care system to identify, train and enhance the skill set of TBAs. Partnerships between TBAs and SBAs would also help health care workers to become culturally sensitive to the needs and concerns of childbearing women. Even if the Ghanaian health system were to train and deploy sufficient numbers of SBAs to all parts of the country in the future, TBAs could still play important roles in helping health care workers to provide culturally competent care. In particular, TBAs could still mobilize and persuade women at the community level to seek skilled care services in health care facilities. However, Before an effective collaboration and the associated benefits can occur, TBAs and the healthcare system in Ghana must see each other as partners in maternal health rather than competitors.

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