

**TO PRACTICE OR NOT TO PRACTICE: PERSPECTIVES OF
TRADITIONAL BIRTH ATTENDANTS AND LOCAL
COMMUNITIES IN THE GA-WEST MUNICIPALITY ON THE NEW
REPRODUCTIVE AND CHILD HEALTH (RCH) POLICY IN GHANA**

BY

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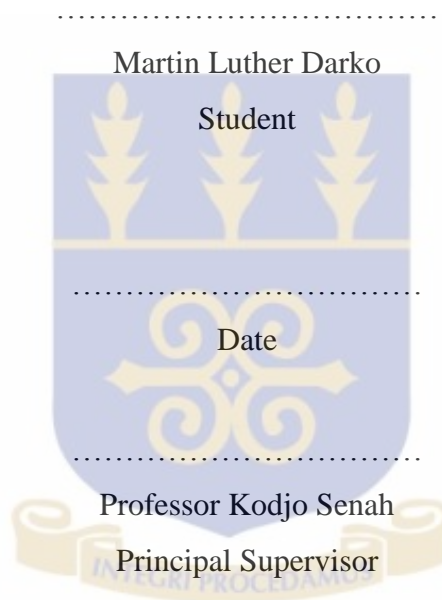


**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR
THE AWARD OF MPhil SOCIOLOGY DEGREE**

JUNE, 2015

DECLARATION

I hereby declare that besides the references cited in this work which have been duly acknowledged, this thesis is the product of my independent research work under the able supervision of Professor Kodjo Senah and Dr. Stephen Afranie. I also declare that as far as I am concerned, this thesis has not been submitted in part or in whole for the award of any degree in any other university elsewhere.



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Date

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Dr. Stephen Afranie
Supervisor

.....

Date

DEDICATION

I dedicate this thesis to Madam Afua Tweneboa Kodua of Ghana Blind Union.



ACKNOWLEDGEMENT

I thank the Almighty God for the strength, knowledge and protection I have enjoyed throughout the period of writing this thesis.

I would like to render my greatest appreciation to my principal supervisor, Professor Kodjo Senah who has not only being a father to me throughout the period of writing this thesis but has also been the greatest influence on my entire academic life in the University of Ghana. His corrections, critiques and eye for fine details have made it possible for this thesis to be completed. The open-door approach which made it possible for me to see him any day I had difficulty with my thesis cannot be wished away. I recount how on one such occasion we sat in the open air for corrections to be effected because there was power outage. What else can a student ask for from a supervisor?

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MLD



ABSTRACT

Maternal health remains a major issue in Ghana. Policies and programmes to address this phenomenon have been varied. The current policy by the Ministry of Health calls for skilled birth attendance for all and barring traditional birth attendants (TBAs) from conducting deliveries especially in communities with health facilities. No comprehensive studies have assessed the likely impact and response to the new maternal health policy in Ghana. The aim of this thesis therefore is to ascertain the views of local community members and TBAs on the new health policy. A total of 27 interviews were held with key stakeholders drawn from eight communities in the Ga-West Municipality of the Greater Accra Region in Ghana. The results reveal that community members, TBAs and rural health workers are generally unaware of any policy directive on the activities of TBAs. Community members were of the opinion that, barring TBAs from conducting deliveries will have serious implications for maternal health outcomes. It also came to light that the policy has come about because of the TBAs' inability to handle complications and the delays parturient experience under TBAs which predispose them to maternal deaths. Maternal health policies in Ghana need to take into consideration the socio-cultural setting of the people for its implementation to be effective. Policy formulation and implementation must involve all stake holders concerned.

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CHAPTER ONE

AN OVERVIEW OF THE INVOLVEMENT OF TRADITIONAL BIRTH ATTENDANTS (TBAs) IN HEALTH CARE DELIVERY

The major theme of this thesis is to study how health policies are made and implemented at the local level in Ghana. Within this context, the thesis focuses on the new Ghana Health Service directive regarding the use of the services of traditional birth attendants (TBAs) in rural communities. In order to put the discussion in its right perspective, the chapter begins with a discourse on health labour shortage and the role of traditional birth attendants in health care services delivery.

The world is experiencing a serious human resource shortage in the health sector; the World Health Organisation calls this "a crisis in health." The WHO has estimated a 7.2 million health worker shortage and a projected shortage of 12.9 million health-care workers by 2035. The WHO warns that the shortage – if not addressed now – will have serious implications for the health status of billions of people across all regions of the world (WHO, 2013).

The WHO estimates that 4.3 million more health workers are required to meet the health-related Millennium Development Goals (MDGs)—a global compact to reduce child mortality, improve maternal health, and combat AIDS, malaria, and other diseases by 2015 (O'Brien & Gostin, 2011). However, this alarmingly high figure suggestively underestimates the global need for human resources because the WHO only accounts for shortages in 57 countries that miss the minimalist target of 2.28 doctors, nurses, and midwives per 1,000 in the population. These 57 countries have "critical shortages," but the WHO estimate does not take into account the shortages of health workers experienced in

countries who provide services in excess of basic immunizations and childbirth attendance. The agency does not factor in the shortages that emerging and developed countries claim to be experiencing. Nor does it factor in the marked human resource disparities among countries and regions, which reveal that shortages in low-income countries are actually much worse (O'Brien & Gostin, 2011).

The global human resource shortage is certainly much greater than 4.3 million health workers. And the shortage includes more than physicians and nurses—extending to health workers across the spectrum, including pharmacists, dentists, laboratory technicians, emergency medical personnel, public health specialists, health sector management, and administrative staff. The human resource crisis affects developed and developing countries, but the global poor suffer disproportionately, not only because they have a much smaller workforce but also because their needs are so much greater. Of the 57 countries with critical shortages, 36 are in Africa. Africa has 25% of the world's disease burden, but only 3% of the world's health workers and 1% of the economic resources. In particular, there is an extreme imbalance in the distribution of the estimated 12 million working nurses worldwide: the nurse-to-population ratio is 10 times higher in Europe than in Africa or Southeast Asia, and 10 times higher in North America than in South America. These numbers mask the real human tragedy of health personnel shortages. Where there are vastly inadequate numbers of health workers trained and employed, people cannot enjoy the good health that will enable them to flourish. They have fewer opportunities to prevent and treat injuries and diseases or to relieve pain and suffering when they are sick or dying. According to the WHO, in many poor countries, the lack of health workers is a major factor in the deaths of large numbers of individuals who would survive if they had access to health care (WHO, 2006). The situation according to the WHO will get worse if nothing

was done to scale-up the production of health workers. The figures below show shortage of health workers across the world and by WHO regions.

Figure 1: Shortage of health workers across the world

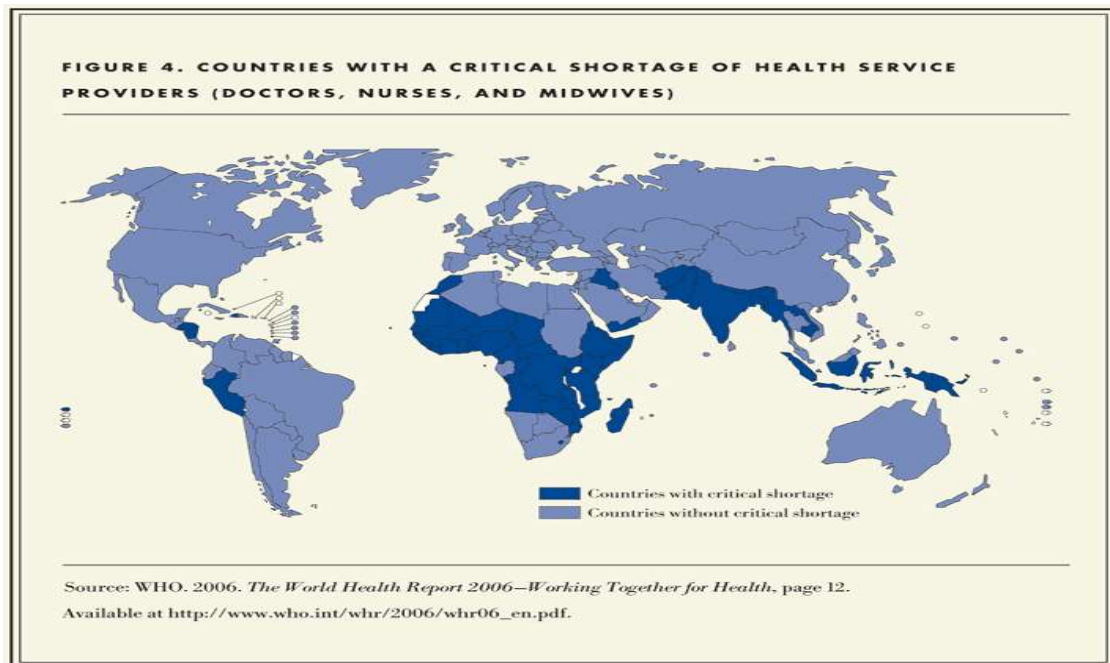


Figure 2: Shortage of health workers by WHO regions

TABLE 1. ESTIMATED CRITICAL SHORTAGES OF DOCTORS, NURSES, AND MIDWIVES BY WHO REGION

WHO region	Number of countries		In countries with shortages		
	Total	With shortages	Total stock	Estimated shortage	Percentage increase required
Africa	46	36	590,198	817,992	139
Americas	35	5	93,603	37,886	40
Southeast Asia	11	6	2,332,054	1,164,001	50
Europe	52	0	NA	NA	NA
Eastern Mediterranean	21	7	312,613	306,031	98
Western Pacific	27	3	27,260	32,560	119
World	192	57	3,355,728	2,358,470	70

NA, not applicable.

Source: WHO. 2006. *The World Health Report 2006—Working Together for Health*, page 13.
Available at http://www.who.int/whr/2006/whr06_en.pdf.

Africa's shortage of health workers is at a critical level. Forty-six countries comprise the African region of the WHO and as stated, thirty-six of these fail to meet the WHO standard of 2.3 doctors, nurses, and midwives per 1,000 people. In 2007, the WHO found that there were only 1.2 doctors, nurses, and midwives per 1,000 populations (WHO, 2006). It was revealed that some African countries are in a better or worse position than these averages. For example, in Malawi, there are 2 doctors per 100,000 people (WHO, 2006). The situation is very similar in Mozambique where there are 3 doctors for every 100,000 people (WHO, 2006), and 32 nurses per 100,000 people (WHO, 2006).

In Uganda, there are 71 nurses per 100,000 people (WHO, 2006). In Zambia, some district health centers have no medical staff at all (WHO, 2006). However, the situation in South Africa is much less serious, where there are, on average, 5 physicians and nurses to every 1,000 people (WHO, 2006). In Seychelles, there are 9 physicians and nurses to every 1,000 people (WHO, 2006). In Ghana however, we have seen improvements in the human resources practices in the health sector. The Ghana Health Service (2008) posits that there has been an improvement in the nurse-population ratio from 1,728 in 2001 to 1,458 in 2007. This figure is still woefully inadequate to meet the government's goal to improve access to quality health services. This challenge of inadequate workforce has been an obstacle to achieving the Millennium Development Goals (MDGs), especially MDGs 4&5- reducing child and maternal mortality. The World Health Organisation in 2013 estimated a worldwide health- worker shortage of 7.2 million including midwives and emphasised that the shortage is high in developing countries, especially in the hard-to-reach areas (WHO, 2013). The International Confederation of Midwives (ICM, 2009), indicated that there were 250,000 licensed midwives worldwide with only 13,000 in sub-Saharan Africa. The ICM further stated that the number of midwives worldwide would

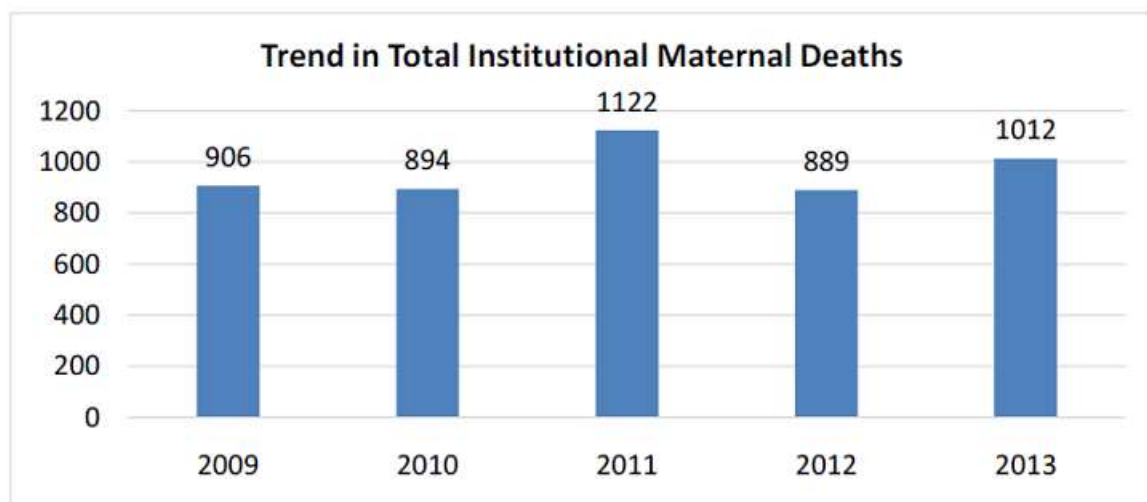
have to double to meet the MDGs 4&5. The WHO has also indicated that with the annual 160 million births worldwide it would take an additional 350,000 midwives to ensure that at least 95% of births were attended by a trained health worker thereby helping meet MDGs 4&5. The Ghana situation is not any different. In 2008, there were an estimated 3,780 midwives, nurse-midwives, and nurses with midwifery competences. In 2010, there were estimated 3,591 midwifery personnel, it was estimated that Ghana will need 1,459 more midwives in order to achieve 95% skilled birth attendance (SBA) coverage by the end of 2015 (www.mamaye.org.gh accessed on 17th Dec. 2014).

These health workforce shortages have serious implications for the realisation of the health-related MDGs, especially, MDG 5- (reducing maternal mortality by three quarters between 1990 and 2015). According to the WHO, maternal mortality is unacceptably high. The international body has indicated that approximately 800 women die from preventable causes related to pregnancy and childbirth every day. The WHO also posited that 99% of all maternal deaths occur in developing countries. The WHO further indicated that maternal mortality is higher among women living in rural poor communities. Again, the WHO has revealed that 289, 000 women died during and following pregnancy and childbirth in 2013, and almost all of these deaths occurred in low-resource settings, and most could have been prevented (WHO, 2014). Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted by the international community in 2000. Under MDG5, countries were committed to reducing maternal mortality by three quarters between 1990 and 2015. Since 1990, maternal deaths worldwide have dropped by 45% (WHO, 2014).

In sub-Saharan Africa, a number of countries have halved their levels of maternal mortality since 1990. In other regions, including Asia and North Africa, even greater headway has been made. However, between 1990 and 2013, the global maternal mortality ratio (i.e. the number of maternal deaths per 100 000 live births) declined by only 2.6% per year, which was far from the annual decline of 5.5% required to achieve MDG5 (WHO, 2014). The high number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Almost all maternal deaths (99%) occur in developing countries. More than half of these deaths occur in sub-Saharan Africa and almost one third occur in South Asia (WHO, 2014). The maternal mortality ratio in developing countries in 2013 was 230 per 100 000 live births versus 16 per 100 000 live births in developed countries. There are large disparities between countries, with few countries having extremely high maternal mortality ratios around 1000 per 100 000 live births. There are also large disparities within countries, between women with high and low income and between women living in rural and urban areas (WHO, 2014). The risk of maternal mortality is highest for adolescent girls under 15 years old and complications in pregnancy and childbirth are the leading cause of death among adolescent girls in developing countries (Conde-Agudelo et al., 2004 & Patton et al., 2009).

Women in developing countries have on average many more pregnancies than women in developed countries, and their lifetime risk of death due to pregnancy is higher. A woman's lifetime risk of maternal death – the probability that a 15 year old woman will eventually die from a maternal cause – is 1 in 3700 in developed countries, versus 1 in 160 in developing countries (WHO, 2014). The situation in Ghana is not any different, even though the country has made some strides towards achieving the MDG 5. Statistics from

the Ghana Health Services (GHS) showed some reduction in maternal mortality ratio from 740/100,000 live births in 1990 to 350/ 100,000 live births in 2010. The 2010 MDG report on Ghana revealed that the trends fell short of the 5.5% annual decline required to achieve the target of 185/100,000 live births by 2015 (www.mamaye.org.gh accessed on 17th Dec. 2014). Again, the 2013 Annual Report of the Reproductive and Child Health Department (RCH) of the Ministry of Health showed an irregular pattern for the trends in maternal mortality. The institutional maternal mortality ratio recorded for the year 2013 was 154/100,000 live births, with a total of 1012 maternal deaths. Total deaths recorded during the year 2013 with age disaggregation were as follows: 10-14yrs (2), 15-19yrs (77), 20-24yrs (166), 25-29yrs (231), 30-34yrs (299) and 35yrs and above (237). Source: (RCH, 2013).



Source: RCH Report 2013

Maternal mortality according to the WHO (2004) is defined as the death of a woman while 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. Medical causes of deaths can be divided into direct causes that are related to obstetric complications during pregnancy, labour or the post-partum period, and indirect

causes (WHO, 2004). Most studies are unable to link direct causality of maternal mortality to TBAs, however, it is perceived that their actions and inactions contribute to or reduce maternal mortality. Pyone (2014) as well as Sibley & Sipe (2006) have concluded that the training of TBAs has had no impact on maternal outcomes.

The quest to address the shortage of skilled birth attendants (SBAs) and the high incidence of maternal, infant and child mortality and morbidity by the International community led to the call for the training and integration of traditional birth attendants (TBAs) into the reproductive health care delivery system. TBAs provide care during pregnancy, childbirth, and the postpartum period; and are well established, living in close proximity to the women who require maternity care in the community. They have detailed knowledge of community norms and are often paid in kind. These characteristics are increasingly considered as strengths that the formal health sector has sought to leverage (Leedam, 1985).

Although TBAs have been trained since the late eighteenth hundreds, important milestones over the last century illustrate the shifting policies on TBA training as a global public-health strategy. The Inter-Governmental Conference of Far-Eastern countries, held in Bangkok in 1937, called for the integration of TBAs into rural health programmes. By 1952, the United Nations Children's Fund (UNICEF) began to supply trained TBAs with delivery-kits. The goal of these early programmes was to improve perinatal healthcare. Twenty years later, interest in Primary Health Care (PHC) and in traditional medicine in relation to PHC had grown to the extent that the UNICEF and the WHO sponsored a technical consultation on TBA training (Fleming, 1994). By the time of the 1978 Alma-Ata Declaration, the WHO was fully in support of training TBAs to extend the reach of

primary healthcare services. In September 1978, the International Conference on Primary Health Care was held in Alma-Ata, USSR (now Almaty, Kazakhstan). The ‘Declaration’ of Alma-Ata, which was the product of the conference co-sponsored by the WHO, was a brief document that expressed "the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world." It was the first international declaration stating the importance of primary health care and outlining the world governments' role and responsibilities to the health of the world's citizens. The Declaration of Alma-Ata began by stating that health, “which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal . . .” (WHO, 1978). Section seven, sub-section seven 7(7) Declaration of the 10 point communiqué was instructive and shed more light on TBA training and read as follows “PHC relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community". The communiqué tasked all governments, to work together toward global health. These are still some of the fundamental tenets that guide the work of the WHO today. The ratification of the Declaration of Alma-Ata anticipated that it would be the first step toward achieving health for all by the year 2000. Although that goal was not achieved, the Declaration of Alma-Ata still stands as an outline for the future of international healthcare (WHO, 1978).

For more than three decades the WHO and other agencies of the United Nations promoted training of traditional birth attendants (TBAs) as a global public-health strategy to reduce

the sad loss of life of women as a result of pregnancy and child bearing (Stanton, 2008). At that time, the WHO recommended that trained TBAs work side-by-side with the modern health system, so that the informal traditional and formal modern health systems could presumably co- exist without conflict, ((Sibley & Sipe, 2006). The success of the WHO's encouragement could be measured by the rapid increase in the number of countries which undertook TBA training. For example, in 1972, only 20 countries had TBA training programmes. It was estimated that by 1994, 85% of developing countries have had some form of TBA training, (Fleming, 1994).

Ghana joined the league of developing countries training TBAs in 1965 as part of its response to the calls for the training and integration of TBAs into the main health care delivery system. This was done by the establishment of The Danfa Comprehensive Rural Health Project, located 29 km north of Accra. In 1965 the Ghana Medical School's Department of Community Health designed a comprehensive rural health project to serve as a field laboratory for training students in community medicine (Neumann et al., 1974). The objectives of the project's family planning component were to provide family planning services to the people in the region and to conduct research into ways of making these services as effective and accessible as possible. The involvement of traditional midwives and the subsequent training of same was an integral component of the project. For example, 90 per cent of traditional midwives were trained to improve their obstetrical techniques and to screen for high-risk pregnancies and deliveries. In addition, they received training in family planning motivation and referral. They referred a number of women for family planning. The enthusiastic response of the TBAs made it possible for the research team to select and train some to be used in both introduction and resupply of

pills, foam, and condoms under the supervision of the family planning team (Ampofo, Nicholas, Amonoo-Acquah, Ofosu-Amaah, & Neumann, 1977).

It was in the pursuit of the Alma-Ata Declaration that Ghana began to expand its PHC delivery system in the 1980s. This expansion drive which anchored on the Rural Maternal and Child Health Programmes (RMCHP) was supported locally by Community Health Nurses and Nurse-Midwives, who played a central role. An integral component of RMCHP was the training and subsequent expansion of Traditional Birth Attendants training nationwide (McGinn et al, 1990). The major aims of TBA training programmes were to reduce maternal and child mortality and morbidity and to improve the reproductive health of women. The explicit responsibilities apportioned to trained TBAs were: to encourage women to seek prenatal care; to recognize women at high risk of complications and refer them for medical attention and/or delivery in a health facility; to encourage women to use family planning after delivery and to assist in normal, uncomplicated births and facilitate a clean, safe and culturally appropriate delivery. The assumption was that by performing these responsibilities, TBAs ideally could help reduce maternal mortality by encouraging healthy practices among pregnant women, improving screening and referral for high risk pregnancies, fast-moving emergency care for obstetrical complications, performing uncomplicated deliveries safely and decreasing fertility (Eades et al, 1993; Sibley & Sipe, 2006). The training programmes were varied, however, in addressing these objectives, for example, individuals, non-governmental organizations, and missions have trained TBAs through the private sector and also through local authority; state and national government and international agencies have trained them through the public sector. Training programmes may last from several days to several months and may include clinical practice at a health facility, follow-up

supervision, and continuing education (Fortney & Smith, 1997). The content of curricula of TBA training also varied. Most TBAs have been trained to upgrade their skills so as to be able to perform safe deliveries. Consistent with the emphasis on extending the reach of primary healthcare, many TBAs have also been trained to take on the expanded functions of prevention, screening, and referral (Fortney & Smith, 1997; Sibley & Sipe, 2004). However, by the late 1990s, the WHO and many Safe Motherhood advocates' interest in the 'wholesale' training of TBAs declined and were calling for skilled birth attendance for all (Flemming, 1994).

A study conducted in Malawi found that most of the people relied on traditional birth attendants although the quality of their services was poor due to illiteracy, their advanced ages, lack of supplies and equipment and general absence of supervision. The study further revealed that although the hospital attended to many pregnant women during antenatal care, very few women actually came back to the hospital for delivery (Bisika, 2008). A similar study conducted in Ethiopia revealed that trained traditional birth attendants were the backbone of the maternal and child health development in pastoralist communities. However, the numbers of TBAs were inadequate and could not meet the needs of the pastoralist communities including services like; antenatal care, delivery, postnatal care and family planning (Temesgen, Umer, Buda, & Haregu, 2012). It is believed that about 70-90% of Africa's population live in rural settings, the rate of births attended by TBAs may be much higher. For instance, in a rural area of The Gambia, where the 200 km trip to the nearest hospital included crossing a river on an unreliable ferry, maternal mortality was 2360 per 100,000 live births (Greenwood, 1990). Ghana is not an exception from the league of nations with health worker shortages as clearly indicated in pages 4 and 5.

Evidence suggests that, in settings characterized by high mortality and weak health systems, trained TBAs can contribute to the Millennium Development Goal 4 &5—through participation in key evidence-based interventions.

However, with the advent of the safe motherhood initiative and very little to show in terms of the training of TBAs and the correspondent reduction in maternal mortality, there has been a waning of enthusiasm for training TBAs (Flemming, 1994). Again, by 1997, the WHO and many safe motherhood advocates turned from TBA training to promote skilled birth attendance for all and calling for a ‘new’ and ‘expanded role’ for TBAs, where TBAs act as ‘link workers’ to skilled birth attendants rather than conducting deliveries (UNFPA, 2004, Tarnpol, 2005).

Problem Statement

The Ministry of Health in conjunction with the WHO has released a new policy directive on the activities of TBAs in relation to maternal health. The aim of this policy according to the joint communiqué is to help address MDG5. The import of the communiqué is the thrust of this research. To this end the researcher quotes in extenso reportage from a government-owned national dailies- ‘The Daily Graphic’ of March 27, 2010, (p.19). The title and the content of the article read as: *“New role for Traditional Birth Attendants. With effect from 2015, more than 10,000 traditional birth attendants (TBAs) will not be allowed to handle deliveries because of their inability to handle complications which lead to maternal mortality. Rather, they will be trained to provide information on proper antenatal care, support family planning initiatives and educate expectant mothers on the need to attend health facilities. The decision was taken jointly by the Ghana Health Service (GHS) and the World Health Organisation (WHO) as part of measures to ensure that Ghana meets targets 4 and 5 of the Millennium Development Goals (MDGs). The*

Reproductive Health Co-ordinator of the GHS,(name withheld) who made this known to the Daily Graphic, admitted that even though phasing out the TBAs remained a big challenge, it was necessary if the country was to meet the targets of the Millennium Development Goals (MDGs) 4 and 5. The MDG 4 is to reduce child mortality by two-thirds, between 1990 and 2015, while MDG 5 is to reduce maternal mortality by three-quarters between 1990 and 2015. The co-ordinator further explained that the policy was intended to ensure that only skilled healthcare personnel conducted deliveries throughout the country in safe hygienic and well- resourced health facilities. After many years of trials with the TBAs there was a realisation that the things that kill women during child birth were beyond the capability of the TBA. He was, however, quick to add that the TBAs would be re-oriented to provide services other than deliveries. According to him, the current policy is that GHS train and support TBAs but not in the whole country. Any district that has a lot of women delivering but the number of midwives are not adequate are at liberty to train and support the TBAs. He added that the focus now would be to increase the number of midwives in the system in addition to more health facilities.”

In the context of the above, the reviewed policy has reaffirmed that “TBAs are recognised as community-based service providers and shall offer supportive care, education, and lay counselling and referrals services but not conduct delivery. However, in communities that do not have access to skilled delivery care, they shall be supported to conduct deliveries” (RCH, 2010).

Conversely, an online version of the same Daily Graphic of March 30, 2010, also had this caption, “*Reconsider Policy on Traditional Birth Attendants*” which was attributed to The Hunger Project-Ghana (THP-Ghana), a Non-Governmental Organisation working in rural Ghana. It reports that Participants at a conference sponsored by THP-Ghana maintained

that considering the valuable delivery services rendered by TBAs to expectant mothers in rural areas, where accessibility to health facilities is difficult, they should be allowed to play the role "until such a time that we have enough health facilities and professionals in those areas".

These two positions are not new- debates in health policies, especially those on reproductive health- have their antecedent in history. In 13th century Europe there was a debate regarding who could perform a caesarean section (Althabe et al., 2005); in mid-18th century France, the discourse was centred on the royally mandated childbirth trainings for rural women (Gelbart, 1998); in the United States of America there is debate regarding the right to a home-based birth (Johnson & Daviss, 2005); and in the developing world there is argument regarding promotion of health facility-based births as opposed to births attended to by traditional birth attendants (Costello, Azad, & Barnett, 2006). These discussions will continue, until such a time that appropriate solutions would be found to resolving maternal mortality issues. It is in the midst of the forgoing arguments that this research was undertaken to ascertain the state of preparedness of rural health practitioners, local communities and TBAs for the implementation of the above policy.

Research questions/ Main Objective

The central question of the study is what are the views of rural health facility functionaries, local community members and TBAs regarding the new policy? How does this contribute to the discourse and policy direction on the role of TBAs in reproductive health in Ghana?

In order to address this broad question, the following specific questions would guide the study:

Specific Questions/ Specific Objectives

1. What factors have informed the new Ministry of Health policy on TBAs?
2. Do TBAs have knowledge on the MoH policy directive?
3. What is the attitude of rural communities (clients of TBA services) on the policy directive?
4. What is the attitude of Management of rural public health facilities regarding the policy directive and TBA training?

Significance of the study

The discussion on the role of TBAs in maternal health continues to engage the minds of academia, policy makers in health, and international bodies like, the WHO, the UNFPA, the UNESCO, the USAID, the UNICEF to mention but a few. The debate has been inconclusive, since there is a new call for community-based approaches to health care delivery. Besides, the debate will continue till such a time that the search for appropriate solution for addressing maternal mortality globally is arrived at.

The findings of this study would be useful to the Ministry of Health (MoH) and its allied bodies involved in health promotions to improve maternal and child health care services. Again, the findings would provide information for strategic planning by the Health Ministry as the end for the Millennium Development Goals approaches in 2015. The findings of the study will also be useful to the Government, Ministry of Health (MoH) and other organizations involved in formulating policies on improving maternal health care services specifically in the rural areas. The findings of this study will also provide information for better planning of maternal and child health care policies; which could lead to reduction in infant morbidity and maternal mortality in the Municipality.

Finally, the study findings will provide data on views of local health functionaries, TBAs' and local community members on policy formulation and implementation in relation to maternal health which will enrich the existing body of knowledge.

Organisation of thesis

This thesis is made up of eight chapters. Following closely after chapter one is chapter two which focuses on the literature review as well as the conceptual frame work. This chapter presents a detailed and critical analysis of policy formulation and implementation and a variety of studies on TBAs and their practices. Again, it discusses the frame work on which the work hinges. Chapter three is dedicated primarily to the Reproductive and Child Health (RCH) Policy in Ghana. It examines the trajectory the policy has undergone over the years. Chapter four explores the profile of the Ga-West Municipality as the study area of this thesis. The chapter describes the political organisation, health care delivery system, educational structures, security issues to mention but a few in the Municipality.

Chapter five concentrates on the research methods of the thesis. This chapter discusses the research design, study population, the sampling techniques, data collection procedure, data collection process, and ethical considerations. The chapter also addresses the field problems encountered during the study. The main issues in chapters six and seven are the analysis of the field data and the discussions of the results generated there from. Chapter eight provides a summary of the findings from the data and proffers recommendations based on the findings.

CHAPTER TWO

LITERATURE REVIEW

Literature review is important in all academic research. It affords the researcher the opportunity to acquaint himself or herself with research works which have been done in relation to the topic under research. It also affords the researcher the prospect of establishing the gaps in existing literature and the contribution the study can make to existing knowledge. This chapter focuses on two main issues; a) the activities of TBAs in relation to reproductive health and b) health policy formulation and implementation difficulties.

A traditional birth attendant (TBA), also known as a traditional midwife, community midwife or lay midwife, is a pregnancy and childbirth care provider. Traditional birth attendants provide the majority of primary maternity care in many developing countries, and may function within specific communities in developed countries. Traditional midwives provide basic health care, support and advice during and after pregnancy and childbirth, based primarily on experience and knowledge acquired informally through the traditions and practices of the communities where they originate (WHO, 2010).

Contributions of TBAs towards Maternal and Child Health Care

The contributions of TBAs to maternal and child health is contested. The view of respondents in a study in Ethiopia was that TBAs make significant contributions to maternal and child health care and reproductive health and that TBAs were so highly respected in their communities that women tell them all their secrets. A health service provider also intimated that TBAs decrease the workload of hospitals even though the

majority of pregnant women seek maternal care from the health centers (Temesgen et al., 2012).

Another study which corroborates the above was done by Bisika (2008) and revealed that the role of TBAs was to assist pregnant women during delivery. The roles that were mentioned by the TBAs themselves were corroborated by health staff from the District Health Officer's office who even spoke of a much broader roles played by TBAs and it included delivery service for women who are due, distribution of iron tablets, referral of pregnant women for ante-natal care (ANC), health education, screening of pregnant women for danger signs including advising women on neonatal care, taking care of pregnant women, ANC, giving advice to pregnant women, cooperating with the community, offering advice on nutrition and hygiene and stocking supplies like iron tablets and anti-malarial tablets for pregnant women as well as encouraging pregnant women to go for immunization at the hospital (Bisika, 2008).

Demographic and Health Surveys of many developing countries have also revealed that the majority of births in remote rural areas, take place at home or in the community and these births are usually assisted by relatives / friends or TBAs. In these communities, TBAs who have been trained contribute to improving MCH as they offer the only means by which women in these rural communities have access to assisted delivery (Prendiville, 1998).

A critical overview of the United Nations Population Fund (UNFPA) report on the support to TBAs (1996) noted that TBAs can be effective if their programmes were part of the broader national strategy to improve reproductive health. The report suggested that the

programmes should include adequate supervision, transportation and provision of supplies. The report endorsed that TBA programmes should increase efforts to ensure the accessibility of supplies so as to enable TBAs conduct a clean delivery and to follow disease-free procedures. It was in connection with this, that the report observed that locally produced TBA kits could be more practical and sustainable. The report concluded that having an effective referral system in the catchment areas where TBAs operate will ensure the success of TBA training (Prendiville, 1998).

Another study conducted in northern Ghana revealed that TBAs in Yendi are responsible for delivering pregnant women in the localities in which they find themselves and beyond. The traditional role of TBAs has mainly been child delivery. After child birth they are responsible for bathing the child for at least a month and thereafter the nursing mother takes over. The TBAs are required to serve as health intermediaries between their community members and the orthodox health sector with responsibility of educating women on breast feeding, family planning and maternal care and identification of mothers at risk during labour and arrangement for referral to health facilities (Shamsu-Deen, 2013).

Role of TBAs in Family Planning

The contribution of TBAs in family planning (FP) may be controversial. However, a study conducted in Pakistan, identified that after the introduction of community midwives (CMWs) in the health system, TBAs still had a pivotal role in health promotion activities such as breastfeeding promotion and vaccination. TBAs assisted CMWs in normal deliveries, and referred high-risk cases to the formal health system. The studies also revealed that TBAs were positive about CMWs' introduction and welcome their addition, even though their livelihood has suffered after CMWs' deployment. The study further

suggested that monetary incentives to TBAs in recognition of referrals to CMWs could be one solution of improving their livelihood. A TBA disclosed that she advised each woman that in order to remain strong and healthy, she has to deliver the children with enough space in between (Shaikh, Khan, Maab, & Amjad, 2014).

TBAs and Antenatal Care

On antenatal, the common advice given by TBAs to pregnant women center on nutrition, consumption of iron tablets, check up by a doctor, and receiving tetanus injection. Pregnant women were also encouraged to observe personal and environmental hygiene. Again, pregnant women were also referred to a health facility when the TBAs observed that they were overweight and too tired, and showed signs of abnormal oedema, hypertension, little foetal movement, blood loss, malaria, and when they still vomited after six months (Singh, et al., 2012; Temesgen, et al., 2012).

Another study conducted in Indonesia revealed that out of 200 married women who were interviewed on preferences about midwives and TBAs, the results showed that two-thirds preferred TBAs to midwives and their decisions were affected by traditional beliefs and their lower incomes (Agus & Horiuchi, 2012).

A study conducted in Tanzania, revealed that women in the urban area preferred delivering at a health facility because they wanted to avoid problems arising out of the delivery. Again, they believed that the health workers knew better and would be in better positions to help should complications arise. Above all, they believed that should one deliver at home and complications arose it would take time to reach the hospital in order for one to be saved. However, same could not be said of the women in the rural area. It

was also revealed that the primary factor influencing women's place of choice for delivery was how convenient they interpreted the place of delivery. The location of and distance to a single health facility supporting a catchment area as well as the poor transport system were push factors towards TBAs and home deliveries. In addition, the low rate of fatalities associated with home deliveries gave women a certain degree of confidence that they were safe. The study revealed that many women preferred delivering in a private and confidential environment with the assistance of someone from within their community, someone they trusted and know well (Pfeiffer & Mwaipopo, 2013).

Another study conducted in Ethiopia revealed that the hospital attended to about 15% of pregnant women during ANC, but only 3% of these eventually delivered in the hospital (Temesgen et al., 2012). A similar study in Ethiopia by AMREF revealed that trained traditional birth attendants (TTBAs) cleaned the new born babies after delivery and when the baby was awake and alert; they encouraged the mothers to breastfeed. TTBAs also educated mothers on how to care for their new babies. A District Health Officer in one of the districts of the study said, after the training, TTBAs improved child care infection prevention and advise mothers on proper cord-care. After delivery, the TTBA recognized the need to wash the mother with water and soap. They also taught their clients about the importance of personal hygiene and eating a healthy diet (Yousuf et al., 2010).

Trained TBAs and Harmful Practices

TTBAs were also reported to be useful in the fight against harmful traditional practices. After the training, they began promoting behaviour change among community members and other untrained birth attendants. The move to stop some harmful cultural practices like the use of herbs and ashes in the dressing of the cord which would have been impossible

without involvement of insiders was very instructive. TBAs have been very effective in this area since, to a large extent, women are the ones affected by harmful traditional practices (Temesgen et al. 2012).

Training and weaning interest in the Training of TBAs

Research has shown that training TBAs contribute to improve reproductive health. Training programmes may last from several days to several months and may include clinical practice at a health facility, follow-up supervision, and continuing education (Fortney & Smith, 1997). The content of curricula of TBA training also varies. Most TBAs have been trained to upgrade their skills so as to be able to perform safe deliveries. Consistent with the emphasis on extending the reach of primary healthcare, many TBAs have also been trained to take on the expanded functions of prevention, screening, and referral (Fortney & Smith, 1997; Sibley & Sipe, 2004).

The stated goal of TBA training was and is still to contribute to the reduction of maternal and child mortality and morbidity through improved delivery and child care practices by improving the skills, understanding and stature of TBAs; increasing the number of births conducted by trained TBAs; and improving links between modern health services and the community through TBAs (Cabral et al., 1992). Core training generally focuses on teaching TBAs to perform deliveries in a more hygienic and safer fashion, discouraging harmful practices, recognising danger signs and referring women with complications to facilities where essential obstetric care was available. Health education for pregnant women and antenatal and postnatal care were usually included. In some programmes TBA training has assumed a much wider agenda and included child health intervention, health promotion and family planning. It has even been proposed that training TBAs in

anthropometry could help in identification and improved management of pregnant women with malnutrition (Krasovek and Anderson, 1991) as quoted in (Bergström, 2000). Training arrangements usually consist of short (about 5 days) basic course followed by regular meetings with mainstream health staff for supervision and on-going education. TBAs may be asked to keep simple records with the intention of allowing the health system to monitor their activities. NGOs working at community level in resource poor countries frequently include TBA training in their activities. A number of governments, for example Bangladesh, have also adopted this approach, supported by massive donor funding. International agencies, including WHO, UNICEF and UNFPA have also supported TBA training.

However, in recent years the value of TBA training has been increasingly questioned (Bergström, 2000), although there are still many groups who remain enthusiastic (Greene 1995 as quoted in Bergström, 2000). There often appears to be little common ground between the proponents and opponents of TBA training. Often times the arguments of the proponents of TBA training has centered on the China experience. China is one of very few developing countries which have maintained reasonably accurate records of maternal mortality over a long period of time. From 1950 to 1980 delivery care in China was provided mainly by minimally trained village birth attendants backed up by a strong referral network for women with complications. Using this model China succeeded in reducing the national MMR from 1500 to 115 (Koblinsky et al. 1999).

However, the opponents of the effectiveness of the training of TBAs on maternal outcomes have cited TBAs' inability to handle complications as one of the main reasons for the lack of enthusiasm in the continuous training of TBAs. A study conducted in Tanzania

involving traditional birth attendants on emergency obstetric care (EmOC) revealed that TBAs' inadequate knowledge on EmOC issues seems to have contributed to the rising concerns about their competence to deliver the recommended maternal services (Vyagusa, et al., 2013).

Again, the extra confidence gained from the training experience by TBAs may lead to a higher incidence of dangerous procedures and sometimes delays in referral (Eades et al. 1993). There is also evidence that training does not substantially alter the belief systems of TBAs and will therefore have little impact on practices that are rooted in these beliefs (Goodburn et al. 1995).

Another study conducted in Nigeria revealed that, most childbirth occur at home and is not assisted by skilled attendants and it is believed that such a situation increases the risk of death for both mother and child and has severe maternal and neonatal health complications (Ebuehi, & Akintujoye, 2012).

Temesgen identified two types of training in his study in Ethiopia, namely; basic and refresher. Both were short term. There was no evidence of practical training or mentoring at the health facility level. The study also found that the training was mainly conducted by NGOs, with limited participation by the district health management team, which could have implications on sustainability of the operations. Another revelation from the study was the difficulty the District Health Office (DHO) experienced in supporting them because there was no relationship between TTBAAs and the District Health Office (Temesgen et al., 2012).

Referral by Trained TBAs

Access to essential obstetric care seems to be the crucial factor in reducing maternal mortality. In Bangladesh, the decreases in maternal mortality have been credited to the existence of a referral hospital and transport links that were available to all areas (Maine, 1996; Ronsmans 1997 as quoted in Sibley & Sipe, 2006). A common finding in many studies of the effect of TBA training is the importance of referral to essential obstetric care facilities (Sibley & Sipe, 2006).

Many programmes have had a specific focus on training TBAs to refer emergency cases appropriately and some have also had major inputs into improving obstetric services, mechanisms for transport and the links between TBAs and professional health staff (Bullough, 1989 as quoted Sibley and Sipe, 2006). In a peri-urban area in Brazil it has been shown that TBAs trained to recognise prenatal conditions and complications of pregnancy were successful in identifying them and in making referrals. TBAs were given a small maternity centre to work in and transport was available (Janovitz et al. 1988 as quoted in Sibley and Sipe, 2006). TBAs in Burkina Faso have been successfully trained to refer seriously ill mothers (Wollast et al. 1993 as quoted in Sibley and Sipe, 2006) and the Mother Care demonstration projects in Bolivia, Guatemala, Indonesia and Nigeria have shown that addressing issues of referral and emergency obstetric care improved quality of referrals and reduced perinatal mortality (Kwast, 1996).

On the issue of referral, TBAs indicated that when they have to refer cases the communication between them and the community was good. There were multiple channels and points of communication and referral which include referral from one TBA to another and/or to a nearby health facility. Some of them preferred to first refer a woman

to another TBA. In that way they could discuss the case and decide together if further referral to a health facility was needed. When it became too difficult to arrange for referral, some TBAs said that they tried to get a health service provider to the home of the woman in labour. Under such situation, relatives of the woman in labour would go to the health facility to ask for help. Most TBAs said that the first line referral points were health posts (HP) close to them, and if the case was beyond the capacity of a HP the women had to be referred to other health facilities (Temesgen et al., 2012).

The field data from the quantitative study in Ethiopia Temesgen et al., (2012) revealed that the first contact of 47% of the TBAs with the pregnant woman occurred more than one month before delivery, about a quarter (28%) within a month of delivery, and another quarter on the day of birth. The TBAs commonly reported delivering the baby (90%), placenta (84%), and cutting the cord (64%) in their most recent delivery. During antenatal visits, the TBAs provided advice on diet and nutrition (61%), immunizations (34%), and reducing the workload during pregnancy (21%). More than two-thirds (69%) of the TBAs reported advising on tetanus toxoid (TT) immunizations. Of those, 57% suggested three vaccinations during pregnancy, and 37% suggested two vaccinations. Given the scenario that a pregnancy was perceived to be a threat to the woman's health, almost three-fourths (73%) of the TBAs stated that they would refer her to a clinic, 9% would advise her to eat nutritious food, 8% would advise getting an abortion, and 8% would not do anything.

Post-natal Care by TBAs

According to Temesgen et al., (2012) eighty-five per cent of the TBAs provided postnatal care and advice. Of these, 57% returned within 24 hours after delivery to provide postnatal care to the mother and the baby. Oil massage of the baby (68%) or the mother (52%), and

bathing the baby (46%) were the most frequently-reported specific examples of care provided. Thirty-seven of the TBAs provided postpartum advice to the mother regarding nutrition. Information on immunizations, medical care, and/or family planning was more often provided by the TBAs (Temesgen et al. 2012).

Washing hands with soap prior to delivery was common (74%) among various ethnic groups, yet varied substantially by training status: 89% of trained TBAs versus 65% of untrained TBAs reported washing hands before delivery. The use of a new blade to cut the cord was reported in 89% of live births across training and ethnic groups while the remaining TBAs (11%) used scissors. Cutting the cord after delivery of the placenta was an almost universal practice (99%). The vast majority (88%) of the TBAs reported that the cord was cut more than five minutes after birth; 22% and 12% cut the cord more than 30 and 60 minutes after birth respectively. About 27% of the TBAs reported the immediate application of a substance to the umbilical cord. Of all substances, mustard oil (64%) was the most common topical application, followed by substances, such as saliva (16%) or antiseptics (12%). Almost half (47%) of the TBAs used a clean delivery-kit in their most recent delivery. The use of the kit was significantly higher for trained and literate TBAs. About half (52%) of kit-users described the correct use of all items in the kit in their most recent delivery, and this was similar across training status and ethnic group.

The post natal care given by TBAs is a prominent act. Temesgen et al. (2012) reported that immediately after delivery, 75% of the TBAs placed the baby on the floor. Only 16% reported that the baby was wiped and/or dried, and 28% wrapped the baby within the first three minutes after birth. Evidently, this delay was due to the practice of waiting until after delivery of the placenta to care directly for the baby, although some TBAs stated that the

baby was wiped (32%) and/or wrapped (43%) before the placenta was delivered. The TBAs' knowledge of immediate drying (28%) and wrapping (37%) was slightly higher than actual practice. Early bathing (within 1 hour after birth) was reported for the most recent delivery by more than half (53%) of the TBAs, and a similar proportion (56%) of the TBAs also recommended this practice. Only 19% of babies during previously-reported deliveries were washed 24 hours or later after birth. Although no difference was detected by training status, literate TBAs were more likely to delay bathing until after 24 hours (54%) compared to illiterate TBAs (7%).

On breast feeding, the study found variations in practice based on the trained versus untrained TBAs on one hand and ethnic groupings on another hand. The field data revealed that about 62% of the TBAs recommended initiating breastfeeding within one hour of birth. This was higher for literate TBAs (83% versus 55%) but similar by ethnicity and training status. However, in actual reported recent practice, the early initiation of breastfeeding (within 1 hour) was only 28% for the Madeshi and 54% for the Pahadi TBAs. Later initiation (24 or more hours postpartum) was reported by 22% of the Madeshi versus 3% of the Pahadi TBAs. Most (97%) Pahadi TBAs recommended feeding colostrum compared to three-fourths (75%) of the Madeshi TBAs. All trained and literate TBAs gave advice on feeding colostrum compared to 78% of untrained and 75% of illiterate TBAs. This advice was most commonly provided because the TBAs reported that colostrum benefited the overall health of the baby (70%) or boosts the immune system of the baby (37%). Those advising against colostrum (15%) suggested that colostrum was 'thick and unhealthy' (57%) or that it would cause diarrhoea (21%).

On the use of oil to massage babies after birth the study found it as paramount practice among the TBAs. Baby massage with mustard oil was a universal practice (99%) among recent deliveries. Mustard oil was considered to be superior to other oils because of its 'hot' properties (i.e. to keep the baby warm, 60%) and its perceived benefit to the health of the baby (55%). The priority given to mustard oil was not due to objectionable properties of other oils, e.g. stickiness, odour. In fact, more than half (52%) of the TBAs were open to using an alternative oil; those suggested by the TBAs included baby oil (26%), yellow mustard oil (13%), and sunflower oil (13%). Also, 17% of the TBAs who were accepting other oils suggested using any oil currently in the household. In general, the availability of different types of oils was not considered a limitation in their use.

Regarding complications for the new babies, Temesgen et al., (2012) in his study revealed that TBAs attributed it to various reasons. For example, babies not breathing after birth, traditional care practices, such as milking the cord to send the breath to the baby were still widely practised. The use of equipment, such as bag/tube and mask for resuscitation, was not reported. In study, most (90%) TBAs recognized poor nutrition as the primary risk factor associated with low-birth weight babies. Other factors mentioned were illness of the mother (20%), continued heavy work during pregnancy (12%), small size of the mother (10%), and prematurity (10%). Signs that a baby requires extra attention included 'weak' (67%), light weight, or appearing abnormally small (57%), and difficulty in suckling (27%). A 'weak' baby or one feeling/looking small was recognized as indicative of a baby at risk of dying; other reported signs included respiratory distress (37%) and prematurity (30%).

On referral for maternal complications, the findings of the study indicated that when a complication during delivery could not be managed, the TBAs reported that they would send the woman to a clinic/hospital (75%) and/or would call a doctor to the house (41%). In actual practice, however, only 53% of the TBAs reported ever having referred a woman with delivery-related complications to a health facility or a doctor. Whether or not the TBAs had ever referred did not depend on their training status, ethnic background, years of experience, or literacy. About 61% of trained TBAs cited excessive bleeding as a reason for referral compared to 39% of untrained TBAs. Excessive bleeding was defined subjectively by the TBAs—they generally ‘knew by seeing’ (83%). Also, 14% of the TBAs counted the number of pieces of blood-soaked cloth as an indicator of excessive bleeding, although the number of pieces ranged from 2 to 6 (Temesgen et al. 2012).

Challenges faced by TBAs

TBAs encountered several challenges while working. The training of TBAs is usually carried out by NGOs. Government agencies have not paid much attention to the activities of TBAs. Although coverage of the training is good, there has been little follow-up and support to the TBAs. In most cases, they lack essential supplies such as scissors, gloves, methylated spirit. In most cases, TBAs agreed that the trainings were not long enough to address all the important issues. In Ethiopia, Temesgen (2012) indicated the workshops lasted 15-21 days only. The TBAs mentioned that their services were not valued by the health facility workers. This was usually reflected by the way they were treated when they took mothers to the health facilities. Since the area is hot and arid, there is perennial scarcity of water. This has had a major impact on hygiene and sanitation. In addition, mothers to be referred to a health facility needed to travel long distances of up to 80 km in some cases. Most of the health centres were understaffed and ill-equipped and therefore it

was likely that on arrival at the health centre, the parturient would receive upward referral to another facility Temesgen et al, (2012).

Policy Formulation and Implementation Processes

The next section of the literature review focuses on policy implementation processes.

Policy implementation is the process of turning policy into practice. However, it is common to observe a gap between what was planned and what actually occurred as a result of a policy (Buse et al, 2005). A policy implementation barrier analysis by the USAID on three countries (Vietnam, Indonesia, and China) revealed that policy implementation is hampered by a set of variables including, conflicting or intersecting policies, low motivation and commitment, implementation at multiple levels, Stigma, discrimination, and gender, and Policy formulation versus implementation (Spratt, 2009). A study conducted by Ellen et al. revealed that the most frequently identified barriers to implementing policy were limited resources (that is, money or staff, or both), time constraints, and negative attitudes (or resistance) toward change (Ellen et al., 2014).

Another study conducted by Watt et al, revealed that policy implementation in any health care system relies upon provider commitment. Policies that do not address the organizational, professional and social contexts are unlikely to achieve successful implementation. Political objectives alone, however well intentioned, are inadequate to change practice. When barriers to policy implementation exist in any of these contexts, the policy may fail to meet its objectives (Watt, Sword, & Krueger, 2005).

A study conducted in Nigeria on health fees exemptions revealed that exemption policies are receiving increased political and social attention especially with the evolving

democratic atmosphere in Nigeria. However, the implementation of exemption policies is faced with numerous challenges which led to a failure of attainment of objectives of such social policies. These implementation challenges were political, financial, technical or organizational.

The said challenges made exemption policies ineffective, demanding a change in policy implementation practices (Onoka, Onwujekwe, & Uzochukwu, 2010). A study conducted in northern Ghana on the challenges and prospects of the school feeding programme revealed that, whilst the programme increased primary school enrolment, the major impediment to the implementation of the programme was cash flow constraints (Sulemana, Ngah, & Majid, 2013).

A study conducted to ascertain stakeholders' perceptions of the challenges facing Ghana's mental health care system revealed the major challenges as, inadequate implementation of mental health policy; legislative limbo; inadequate human and financial resource; widespread stigma; dominance of psychiatric hospitals; and insufficient human rights protections for the mentally ill (Doku et al., 2011).

A study conducted in northern Ghana on the implementation challenges of maternal health care revealed inadequate in-service training for health care providers especially midwives, limited knowledge of health policies by midwives, increased workload for midwives, risks of infection, low motivation for midwives, inadequate labour wards for parturient, transportation problems for referring emergency cases, and difficulties in following the procurement act, among others (Banchani & Tenkorang, 2014). A study on the regenerative health in Ghana revealed the following implementation challenges, financial

difficulties, and low awareness by citizens, inadequate staffing of the health ministry, and lack of partnership from other stakeholders, wrong orientation and inadequate facilities (GHS, 2013).

In conclusion, the literature review has shown that extensive research has been done on TBAs' and their practices; the arguments have been inconclusive on the contribution of training of TBAs to the maternal health discourse with regards to the reduction of maternal mortality. However, what are lacking in the review are studies which have focused on the 'new roles' of TBAs by the international community (WHO, UNDF, USAID, and UNICEF). It is this lacuna this study seeks to fill.

Theoretical Framework

There are quite a number of social theories which may explain this research work. For example, Communities of Practice by Wenger (1999), offers a comprehensive framework for understanding and analysing what people do in the context of their social milieu.

Again, contextual Interaction theory (CIT) by Owens & Bressers (2013) posits that policy actors' motivation, information needs, and level of collaboration are key variables influencing policy and programme implementation.

Furthermore, the theory of imprinting by (Marquis & Tilcsik, 2013) explains how initial environmental conditions leave a persistent mark (or imprint) on organizations and organizational collectives (such as industries and communities), thus continuing to shape organizational behaviours and outcomes in the long run, even as external environmental conditions change.

Paramount among others, path dependency theory which explains how the set of decisions one faces for any given circumstance is limited by the decisions one has made in the past, even though past circumstances may no longer be relevant (David, 1994). It is in the midst of the above proposed theories that the researcher settled on the path dependency theory. The theory was first developed by David (1985). In economic development, it was said by David (1985) that a standard that is first-to-market can become entrenched (like the QWERTY layout in typewriters still used in computer keyboards). Paul called this "path dependence", and said that inferior standards could persist simply because of the legacy they have built up. Path dependency theory was originally developed by economists to explain technology adoption processes and industry evolution. When one considers the example the videotape format; two mechanisms independent of product quality could explain how VHS achieved dominance over Betamax from a negligible early adoption lead. One of the key mechanisms was the network effect. Under this, videocassette rental stores observed more VHS rentals and stocked up on VHS tapes, leading renters to buy VHS players and rent more VHS tapes, until there was complete vendor lock-in. The second was a VCR manufacturer bandwagon effect of switching to VHS-production because they expected it to win the standards battle. Positive feedback mechanisms like bandwagon and network effects were at the origin of path-dependence. They lead to a reinforcing pattern, in which industries 'tip' towards one or another product design. That QWERTY versus Dvorak is an example of this phenomenon. Even though, an economic theory, it has been used widely in many disciplines to explain how policy changes are constrained by institutions and actors involved in the evolution of change. Methodological work in comparative politics and sociology has adapted the concept of path dependency into the analyses of political and social phenomena. Path dependency has primarily been

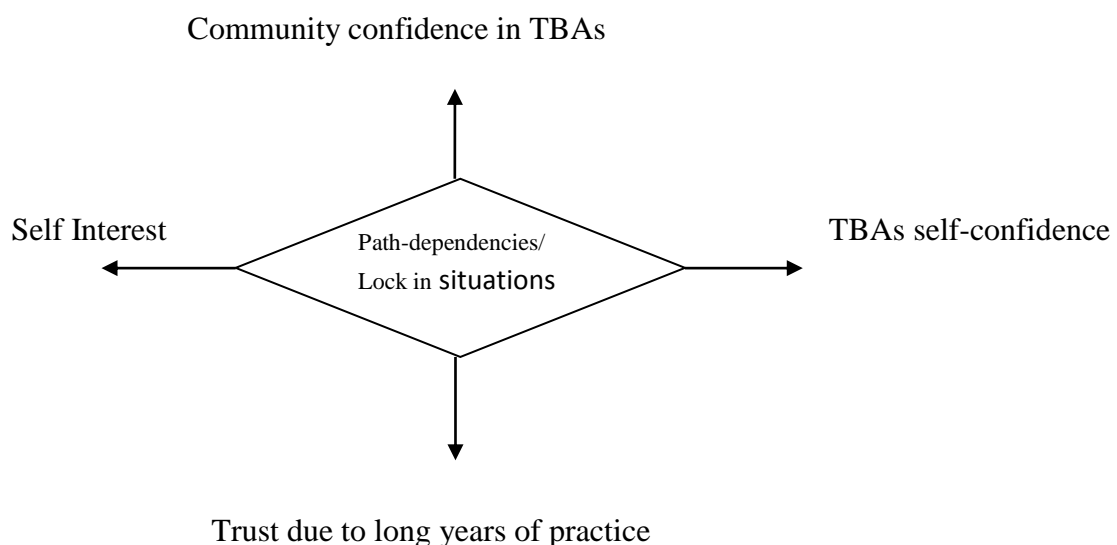
used in comparative-historical analyses of the development and persistence of institutions, whether they are social, political, or cultural.

In the social sciences, especially sociology and organizational theory, a distinct yet closely related concept to path dependency is the concept of "imprinting", which captures how initial environmental conditions leave a persistent mark (or imprint) on organizations and organizational collectives (such as industries and communities), thus continuing to shape organizational behaviours and outcomes in the long run, even as external environmental conditions change (Marquis and Tilcsik, 2013).

How the theory would be applied

This work draws on the inspiration of this theory to explain the perceived difficulty in the implementation of the RCH policy on the practices of TBAs, in that the TBAs (majority) had received and continue to receive training from the Municipal Directorate of Health. These continuous training has legitimised their operations which will make it difficult for the TBAs to adopt and adapt to their new defined roles as captured by the policy. Again, the confidence of the community members in the practices and services of the TBAs is another obstacle which is likely to hinder the policy implementation. Lastly and importantly, is the perceived self-interest of TBAs. The TBAs deliver pregnant women for a fee, either in cash or in kind and for them to lose their 'daily bread' through a policy will be resisted. The combinations of these factors create lock-in situations which are likely to obstruct the smooth implementation of this policy.

In the past, TBAs have discharged their duties as birth attendants in their own rights in the absence of medical doctors and midwives. Their practices were validated through tradition and other environmental conditions. These environmental conditions such as: confidence in TBAs by the community because of the training received, self-interest, trust due to long years of practice, self-confidence of TBAs in their practices have become contingently triggered paths which created lock-in situations. When such lock-in situations are subject to self-reinforcement, given enough time, the paths develop and become highly resistance to change and likely to endure for a long time (Antonelli, 1999). According to Arthur, 1994, since the paths benefit those who created them the same actors cannot unlock it. Only an exogenous shock (an event outside the path can radically change the incentives and enable the actors to break free from it. Applying these propositions from the path dependency theories, below is a diagrammatic representation of the paths created.



The thesis draw from this framework to show that there have been continuities of paths that have the tenacity to stand the passage of time even with considerable resistance

coming from the new TBA policy introduced. The theory is discussed in line with the thematic issues limiting their practice.

The literature review also revealed the challenges inherent in policy implementation programmes. This study sought to find out how this new roles for TBAs by the WHO and the Ministry of Health will be implemented. It may be the case that policies are made to, as it were; enhance the livelihood of the citizens. The broad consultative processes involved in making the policies working documents are often over looked by policy makers. The people about whom these policies are about are often times neglected and not consulted. Their opinions are not factored into the processes, the needed education to back the policy is often lacking. These are the issues the researcher would like to draw the attention of policy makers to.

The next chapter focuses on the reproductive policies Ghana has undertaken over the past decades to help address issues pertaining to reproductive health.

CHAPTER THREE

A REVIEW OF REPRODUCTIVE HEALTH POLICIES OF GHANA

This chapter discusses the evolution of policies and programmes related to reproductive health. This chapter is important because the policy of the Ministry of Health which is the subject matter of this thesis hinges on reproductive health. Again, it is important to situate the current policy in the context of international developments on reproductive health for a better understanding. These are the motivation for this chapter.

Evolution of Policies from maternal and child health (MCH) to Reproductive Health

Organised Maternal and Child Health (MCH) started in Ghana in the 1920s. By the end of 1972, there were 416 institutions comprising government hospitals, health centres, health posts, private midwives clinics and homes, private doctors' clinics and hospitals and mission hospitals and clinics offering services to mothers and children. In the 1960s, the idea of birth spacing was placed in the context of Maternal and Child Health (Odoi-Agyarko, 2003).

The history of Ghana's family planning movement, particularly the debates over and difficulties with the first family planning programme, sets the context for the nation's current structure of policymaking and implementation. Lessons learned from the National Family Planning Programme (NFPP) facilitated subsequent policy formulation and implementation, including the establishment of the National Population Council (NPC), the successor to the NFPP. Ghana has witnessed two major phases of population activities: early public and private activities that focused on family planning programmes in the 1960s to 1970s, followed by an interruption until the mid-1980s when renewed efforts brought about an expanded population programme. In the early 1960s, the Christian

Council of Ghana initiated the family planning movement by promoting Christian family living and addressing the problems of too many or too few children in families. In 1961, the council opened a family planning center in Accra (Nabila, 1986 as quoted in Odoi-Agyarko, 2003). In 1962–1963, the government of Ghana sponsored the United Nations resolution on “*Population Growth and Economic Development*,” and, in 1967, Ghana became the first sub-Saharan African country to sign the World Leaders’ Declaration on Population (Ampem, 1991, & Rawlings, 1985 as quoted in Odoi-Agyarko, 2003). Another milestone was also chalked in 1967; a group of physicians and demographers led the founding of the Planned Parenthood Association of Ghana (PPAG), an International Planned Parenthood Federation (IPPF) affiliate. The goal of the PPAG was to decrease infant and child mortality and abortion; at the time, the PPAG offered limited family planning services.

In 1968, the Ministry of Finance established the Manpower Board, which, along with the PPAG and the Christian Council, initiated the 1969 population policy, entitled *Population Planning for National Progress and Prosperity*. The National Population Council was set up by ACT 485 of Parliament as the highest statutory body to advise Government on population and related issues that included reproductive health. In 1969, the First Population Policy was formulated. It was comprehensive and holistic in nature and encompassed key areas such as education, productivity, gainful employment and wider non-domestic roles for women but it was not implemented in full (Odoi-Agyarko, 2003). The context in which these population policies were structured owes its antecedents to the economic depression of the 1960s.

When Ghana gained its independence from Britain in 1957, the economy appeared stable and prosperous. Ghana was the world's leading producer of cocoa, boasted a well-developed infrastructure to service trade, and enjoyed a relatively advanced education system. Using cocoa revenues as security, the head of state at the time (name withheld) took out loans to establish industries that would produce import substitutes as well as process many of Ghana's exports. These plans were grounded in the desire to reduce Ghana's vulnerability to world trade. Unfortunately, the price of cocoa collapsed in the mid-1960s, destroying the fundamental stability of the economy and making it nearly impossible for these plans to continue. Pervasive corruption exacerbated these problems and in 1966 a group of military officers overthrew the head of state and inherited a nearly bankrupt country. Since then, Ghana has been caught in a cycle of debt, weak commodity demand, and currency overvaluation, which has resulted in the decay of productive capacities and a crippling foreign debt. Once the price of cocoa fell in the mid-1960s, Ghana obtained less of the foreign currency necessary to repay loans, the value of which jumped almost ten times between 1960 and 1966 (www.modernghana.com accessed on 01/06/15). It was within this context that the population policies became inevitable.

The 1969 policy aimed to integrate demographic and development goals by introducing measures to reduce unemployment, regulate the rate of migration to cities, reduce the high rates of morbidity and mortality, and target malnutrition (Rawlings, 1985 as quoted in Odoi-Agyarko, 2003). Population policy leaders in Ghana viewed the 1974 World Conference on Population in Bucharest as an affirmation of the 1969 population policy (Kwafo, 1987). To implement the policy in 1970, the Manpower Board established the Ghana NFPP to offer services on a larger scale than the Christian Council and PPAG could sustain. The NFPP did not, however, fulfil its potential and ran into problems soon

after its establishment. To begin, it was instituted as a coordinating body for population activities and located under the Ministry of Finance and Economic Development (MoF). Moreover, the NFPP Plan of Implementation and Operation did not clarify the specific roles of key ministries. As a result, disputes ensued, especially with the main service delivery ministry, the Ministry of Health (MOH). In response to the lack of clearly defined ministry roles, the NFPP stepped beyond its coordination role and began to offer family planning services; it even opened its own clinics. Not surprisingly, the NFPP encountered problems that adversely affected its implementation activities: personality conflicts; poor institutional coordination, especially between the MoH and the NFPP; an in-effective family planning service delivery system; and competition among donor organizations working through different ministries (NPC, 1994; MoF, 1991; Kwafo, 1987). In addition, political and economic instability compromised implementation (Benneh et al., 1989). Launched with commendable objectives, the NFPP raised awareness of family planning, especially in urban areas; however, in terms of overall achievement, the programme made only “modest gains” (Ampem, 1991; Benneh, 1987). NFPP components other than family planning, particularly health education, and the role of women, were not considered priorities (MoF, 1991; Nabila, 1986). As a result, population and family planning advocates recognized the need to subject the 1969 population policy to a critical review within the context of the 1978 Alma-Ata Declaration on Primary Health Care (PHC), the 1987 Safe Motherhood Initiative (SMI) and the Rawlings’ government’s economic and administrative reconstruction programme. The Alma-Ata Declaration has its aim to be; "the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world" (WHO, 1978). The Safe Motherhood Initiative was to improve the health and well-being of mothers and new-borns through community-based approaches

(WHO, 1987). These programmes culminated in the introduction of the training of traditional birth attendants (TBAs) into the public-health delivery system.

In 1986, USAID funded the Ghana National Conference on *Population and National Reconstruction* to offer experienced professionals a forum for frank and objective discussions related to Ghana's population policy. In addition, the conference was intended to stimulate greater public awareness of population issues (Benneh, 1987 as quoted in (Odoi-Agyarko, 2003). The overall recommendations constituting the *1986 Legon Plan of Action on Population* included a call to establish a national population council and the Population Impact Project at the University of Ghana. As a result of the 1986 conference, the government formally acknowledged the submission of the *1986 Legon Plan of Action on Population*; however, it offered no reaction to the document (Ampem, 1991).

In 1989, UNFPA sponsored a second conference, *Ghana Population Policy: Future Challenges*, to commemorate the 20th anniversary of the 1969 policy. Conference delegates concluded that the tenets of the 1969 policy were still valid, but that the policy itself could be updated by adding emerging issues such as the environment and AIDS. In addition, delegates noted that policy implementation could be strengthened by, among other strategies, involving the newly established district assemblies, which were part of Ghana's decentralization process. The 1989 conference reiterated the recommendation to establish a national population council (Ampem, 1991; NPC, 1994 as quoted in Odoi-Agyarko, 2003).

In 1992, Ghana adopted a new constitution whose provisions stipulated that the government should maintain a population policy consistent with the aspirations, development needs, and objectives of Ghana and that population issues should receive prominence in National Development Plans (NPC, 1994 as quoted in Odoi-Agyarko, 2003). In response to calls for establishing of a national population council in the late 1980s, Parliament in 1992 ratified an act to institute the National Population Council (NPC). Given that the NFPP had not succeeded when housed under the Ministry of Finance and that population issues were recognized as multi-sectoral and in need of high-level political support, the parliamentary debate focused on where to house the NPC. For these reasons, the act placed the NPC in the Office of the President.

In 1994, the NPC led the process to revise the 1969 population policy. The 1994 (revised) National Population Policy expanded the reach of population beyond family planning to considerations such as reproductive health, the environment, and housing. In addition, for the first time, the policy formulation process included grassroots participation in population policymaking (NPC Secretariat). NPC advisory committees developed action plans for the main components of the policy, including a plan for maternal and child health (MCH) and family planning.

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focus on reproductive health policies and programmes. Many countries have worked to adopt the recommendations from the ICPD Programme of Action and to shift their population policies and programmes from an emphasis on achieving demographic targets for reduced population growth to improving the reproductive health of their population. Based on epidemiological significance and the

recommendations from the ICPD Programme of Action, reproductive health care is defined as including the following elements; thus the prevention of unintended pregnancy through family planning services, provision of safe pregnancy services to improve maternal morbidity and mortality, including services to improve perinatal and neonatal mortality as well as the provision of post abortion care services and abortion services as permitted by law. Others include the prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) and HIV/AIDS, provision of reproductive services to adolescents, improvement of maternal and infant nutrition, including promotion of breastfeeding programmes, screening and management of specific gynaecological problems (reproductive tract cancers, including breast cancer, and infertility) and finally addressing of social problems such as prevention and management of harmful practices, including female genital mutilation and gender-based violence. Even though the 1994 policy was drafted before the ICPD, it embodied similar recommendations, particularly those pertaining to MCH and family planning. While acknowledging that Ghana's 1994 policy addressed reproductive health issues, it was noted that the country also needed a separate operational policy to implement reproductive health activities in particular. In 1994, the MoH undertook a needs assessment of all levels of public health facilities to determine the information and services available for reproductive health. In reviewing existing guidelines, the MoH discovered parallel guidelines for STDs and MCH activities, noted that other guidelines contradicted each other. In addition, standards spelling out the responsibilities of health workers did not exist. The assessment determined the need for a comprehensive reproductive health policy and guidelines. Consequently, The Reproductive Health Policy and Standards were "carved" out of the MCH/FP component of the 1994 National Population Policy.

Accordingly, the MoH directed formulation of the National Reproductive Health Service Policy and Standards in 1996, specifically to address reproductive health in Ghana.

The policy has gone through a number of revisions with the current version (3rd edition) yet to be printed. The areas which border on the researcher's study have been reviewed in the subsequent discussions.

The Reproductive Health Service Policy & Standards

The Government of Ghana endorses the principle that Reproductive Health care is a constellation of preventive, curative and promotional services for the improvement of the health and well-being of the population, and especially mothers, children and adolescents. This implies that all couples and individuals have the basic right to decide freely and responsibly their reproductive goals and have the information and means to do so.

The Government of the Republic of Ghana adopts and adapts the reproductive health definition from the 1994 Cairo ICPD as follows; "Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide

couples with the best chance of having a healthy infant. It is in line with the above definition of reproductive health by the ICPD, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.” The components of Reproductive Health Care Services are: Safe Motherhood: antenatal, labour and delivery, post-natal care including breast-feeding and infant health , Family Planning ,Prevention and management of unsafe abortion and post-abortion care, Prevention and management of Reproductive Tract Infections (RTIs), including Sexually Transmitted Infections (STIs) and HIV/AIDS, Prevention and management of infertility ,Prevention and management of cancers/tumours of the female and male reproductive system, including the breast, Responding to concerns about menopause and andropause (male climacteric), discouragement of harmful practices and gender based violence that affect the reproductive health of women and men, information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, preconceptional care and sexual health, Reproductive Health Infrastructural development and Commodity Security. Under the current RCH policy, Safe Motherhood is concerned with maintaining the health of the woman/and her new-born throughout the process of pre-conception, pregnancy, childbirth and the post-delivery period. It means creating the circumstances within which a woman is enabled to choose whether she will become pregnant, and if she does, ensure she receives care for prevention and treatment of pregnancy complications, has access to trained birth assistance, emergency obstetric care if she needs it, and care after birth, so that death or disability from complications of pregnancy and childbirth can be avoided for both mother and baby. The goal of the safe

motherhood programme is to improve the health of women and their new-borns in general and specifically to contribute to the reduction in maternal and new-born morbidity and mortality. The strategies for achieving the goal of safe motherhood shall include promoting family planning and pre-conception counselling, providing essential obstetric and new-born care, providing emergency obstetric and new-born care, strengthening referral between communities, basic and comprehensive emergency care settings, equipping community health workers, including TBAs with skills and tools to support and provide quality services to mothers and their children within the context of Primary Health Care, strengthening community participation in maternal and new-born care among many other strategies. Antenatal care is the health care and education given during pregnancy. Antenatal care is an important part of preventive and promotive health care. To deliver antenatal care services, appropriate infrastructure and logistic support shall be provided as indicated in the standards. The provision of antenatal care shall be guided by the principles of comprehensive and individualized care. The objectives of antenatal care are to promote and maintain the physical, mental and social health of mother and baby by providing education to the pregnant mother and her family on nutrition. The main objective of labour and delivery care is to ensure safe delivery. The specific objectives of care are to ensure early identification, management, and/or early referral of complications, proper management of the four stages of labour, minimal stress or injury to mother and baby during the delivery. Labour and delivery care shall be provided at the hospital, clinics or by community-based interventions. The activities involved in labour and delivery shall be, management of normal labour, identification and management of complications and referrals as required. Another facet of the safe motherhood strategy is postnatal care. The postnatal period begins at the end of delivery and ends six weeks after delivery. The objectives of postnatal care include among many others, the maintenance of the physical

and psychological well-being of mother and baby, to perform comprehensive screening for detection, treatment and /or referral of complications of both mother and baby, to detect and treat complications in the mother and the baby, to provide health education on nutrition, danger signs, family planning, infant feeding/breastfeeding and immunization of the baby and to counsel and provide family planning services.

The providers of antenatal, delivery and postnatal care at each level of service delivery shall include, ***TBAs, CHOs, and Midwives.**

At the sub-district level the providers of the safe motherhood strategy shall include midwives, nurses and physician assistants with training in midwifery, health assistants. Medical doctors, Obstetricians (where available) shall be the providers of these services.

At the regional level, midwives, medical doctors and obstetricians will be the providers of the safe motherhood strategy. When it comes to the Teaching/Specialised centres; midwives, medical doctors and Obstetricians will be the main providers of these services.

It is in the provision of these services that the Reproductive and Child Health Department (RCH) has defined the roles of TBAs; *** TBAs are recognized as community - based service providers and shall offer supportive care, education, lay counselling and referral services but not conduct delivery. However in communities that do not have access to skilled delivery care, they shall be trained and supported to conduct deliveries** (RCH, 2010).

Conclusion

The reproductive health policies of Ghana have gone through an elaborate review from Maternal and Child Health (MCH) in the 1920s to Reproductive and Child Health (RCH) in the current discourse. What is instructive is that the current RCH policy has been broadened to capture a wide range of reproductive issues. However, the implementation of

many of the reforms had not been properly carried out to bring the desired results. The infrastructure, the human resource, the social context and financial resources which will create the enabling environment for the implementation of reproductive health reforms are often lacking. It is within this context that this study seeks to explore the views of affected peri-urban community members and other stake holders on the implementation of a reproductive health directive ostensibly asking TBAs not to conduct deliveries in communities where there are health facilities. The sociocultural factors which serve as pull and push factors towards TBAs and from the health facilities ought to be explored by policy implementers to enhance the smooth implementation of the policy. The failed lessons of the implementation of earlier policies must not be overlooked. The next chapter profiles the study area and discusses its importance to the study.

CHAPTER FOUR

PROFILE OF GA WEST MUNICIPALITY

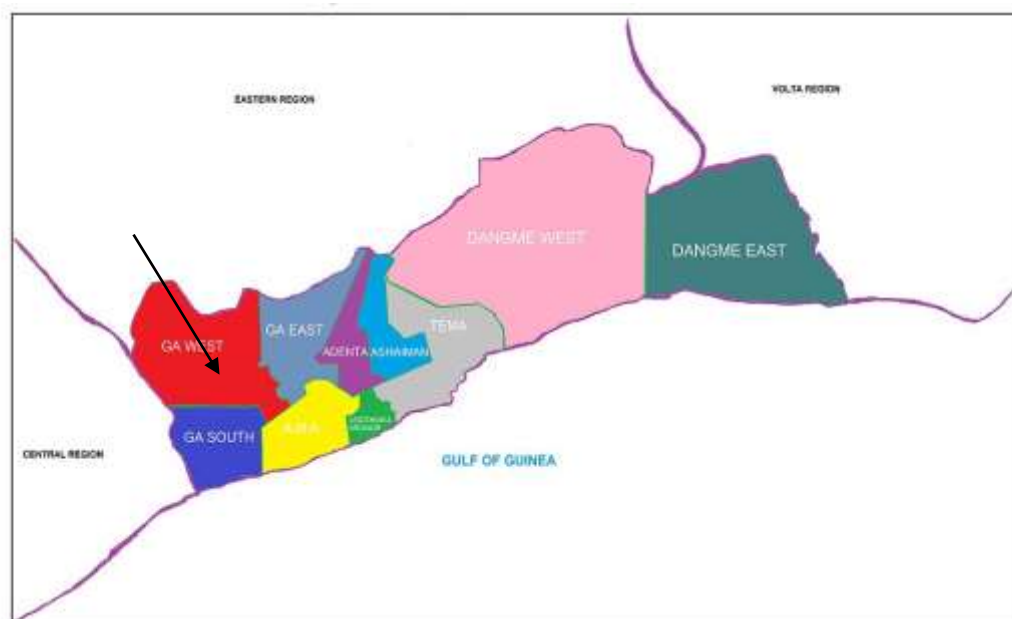
This chapter discusses the social structure of the study area. Understanding the social structure of a community gives an indication of the health-seeking behaviour and other aspects of the life of the people within the community. It is for this reason that this chapter focuses on the social structure of Ga-West Municipality. Although, the study focused on eight communities within the Municipality, the social structure of the entire community is discussed since the lives of the community members are influenced by the social structure of the area.

The Ga West Municipal Assembly was carved out of the erstwhile Ga municipal which was created in 1988 in pursuance of the government's decentralization and local government reform policy. In 2004, the Ga Municipality was divided into two with Amasaman remaining the capital for the newly created Ga West Municipal. The Municipality forms part of sixteen (16) Metropolis, Municipalities and Districts in the Greater Accra Region. The Municipality lies within latitude 5°35' North, 5°29' North and longitude 0°10' West and 0°24' West. It shares common boundaries with Ga East and Accra Metropolitan Assembly to the East, Akuapem South to the North and Ga South and Ga Central to the South. It occupies a land area of approximately 284.08 sq. km with about 412 communities.

The Ga-West Municipality was selected for this study because of the high incidence of the activities of TBAs within the Municipality. Besides, the prevalence of the activities of TBAs, the researcher also had conducted earlier studies within the Municipality on maternal health which brought to bear the collaboration between the formal health system

and the TBAs. It is within the above stated reasons and the current policy directive of the MoH that the researcher found the Ga-West Municipality and ideal location for the study. Out of the 412 communities within the Municipality, 8 were selected for the study. These communities are those with trained TBAs by the Municipal Health Directorate. Even though, there were other communities, they could not satisfy the above inclusion criteria.

Figure 3: Map of Greater Accra Region showing Ga West Municipality



Source: Ga West Municipal Assembly, 2014.

According to the 2010 National Population and Housing Census, the population of Ga West Municipality was estimated at 525,484, with intercesal growth rate of 3.4%. The growth rate was as a result of the Municipality's closeness to the capital city of Accra where there is a lot of inflow of migrant workers. The female population as at year 2010 was 268,030 representing 51% of the total population; Males make up the other 49% i.e. 257,454 (GSS, 2010). The population is mainly concentrated along the peri-urban areas of the Municipality, particularly on the border with the Accra Metropolitan Assembly and Ga East Municipal Assembly. The urban population of 361,533 inhabitants constitute 67.8% with the remaining 163,951 residing in the rural portion of the Municipality. The

population growth rate of the Greater Accra Region is 4.4 per cent as compared to the national which is 2.7 per cent. This growth rate may be understood because of the geographic location of the Municipality.

An important observation is the relatively fast growth in the size of some localities adjoining the Accra Metropolitan Area such as Pokuase, New Achimota, Ofankor, Amasaman and Omanjor which were rural areas in 1984, but have now attained urban status, mainly as a result of the spill over of the growth of the Accra Metropolitan Assembly (AMA), Ga-South Municipality, Ga- East Municipality and Akuapem South Assembly. The Municipality remains predominantly urban. The classification of localities as urban or rural was based on the size of the population. Hence, all localities with population of 5000 were classified as rural. The estimated population figure also yields a density of 711 persons per sq. km much higher than the national density (79.3) and a still greater than that of Greater Accra Regional figure of (89.5). This indicates great pressure of population on land resource or what the land can generate. It is also necessary to take locality differences into account. The most populous locality is Pokuase followed by New Achimota, Ofankor and Amasaman. What this means is that the population is largely concentrated in Pokuase, Amasaman, and New Achimota and towns developed around the Accra Metropolitan Area. This should not be surprising because these centres happened also to be the areas with many economic and social infrastructural facilities. Balance of spatial distribution of the population is not likely to be achieved unless the opportunities for improvement in the lives of the people are more evenly distributed. These locality differences have policy implications.

The age structure is typical of less developed economies, which are characterised by large proportion of children (under 15 yrs.) and a small proportion of elderly persons (over 64 yrs.). The proportion of the population under 15yrs in 2010 (34.8%) is a reflection of high fertility. The proportion of the elderly which is (3.0%) is also a reflection of low life expectancy. For instance the dependency level is lower for males; mainly because the younger dependency group (under 15 yrs.) is lower (34.0 as against 35.0 females). Males constitute 49 per cent of the population translating into a sex ratio of 98 males to 100 females.

The classifications of ethnic groups in Ghana, as used for the census, is that officially provided by the Bureau of Ghana Languages and are only generic descriptions to cover a broader spectrum of ethnic groupings. The predominant group is the Akan (44.3%), followed by the Ewe (25.7%) and the Ga-Dangme (19.1%).

Table 1: Ethnic groups in Ga West Municipality

Ethnic groups	Total	Male	Female
Total	167,625	83,640	83,985
Akan	74,046	37,260	36,786
Ewe	41,998	20,433	21,151
Ga- Dangme	37,684	18,410	19,274
Mole-Dagbani	4,994	2,478	2,501
Guan	3,579	1,816	1,763
Grushi	2,617	1,449	1,168
Mande	1,002	530	472
Gurma	775	392	383
Others	945	457	487

Source: 2000 Population and Housing Census, GSS

The population distribution by ethnic groups gives meaning to the rural- urban migration confronting the nation. Even though, a predominantly Ga area the population dynamics indicates that the Akan and Ewe ethnic groups are the major groups in the community. Another explanation to this phenomenon is the fact that Ga-West is bordered by an Akan speaking Municipality- Akuapem South so it is not far- fetched for Ga-West to be dominated by the Akan.

Official numbers of individual religious affiliations was derived from the direct responses of respondents or relatives and no attempt will be made to verify or question if respondents practice the faith they profess. The three main religious groupings are Christianity, Islam and the Traditional. In the Municipality, Christianity is dominant followed by Islam and traditionalist.

The average household size of the Municipality as at year 2000 is 5.2 persons even though female adolescent (15-19 years) here have much higher fertility than that of Accra Metropolitan Assembly, Ga West and East and Tema Municipal Assembly. This is supported by evidence based on life time fertility. The mean number of children born to adolescent (15-19) years in Dangme West (0.216) is higher than the regional average of (0.090). This larger average household size (44.9%) has implications for housing policy and housing development in the Municipality. In terms of maintenance of law and order, the Municipality has a Municipal Court to address judicial issues within its jurisdiction. The presence of the security services to ensure that people go about their normal duties in a free environment was also observed. The security agencies present in Municipality are the Police, Fire Service and National Disaster Management Authority (NADMO). There

are two Police Stations located at Pokuase and Amasaman. The Divisional Command is also located in Amasaman.

A peculiar characteristic of the education sector in the Ga West Municipality is that there are significant numbers of private educational institutions operating alongside the public institutions. Available statistics from the Municipal Educational Directorate show that, there are 407 private schools compared to 202 public institutions in the various levels of education.

Enrolment figures in the urban and peri-urban areas are very high. The same trend applies to staffing where fewer teachers are found in the deprived areas. It is therefore clear that whilst there is over-enrolment in the urban and peri-urban schools there is a disproportional under-enrolment in the rural and deprived schools. In addition to the afore-mentioned observations, it must be emphasized that most of the private educational institutions are located in the urban and peri-urban communities whilst very few of these private schools are found in the rural areas.

The pupil teacher ratio of the Municipality in the various levels is as follow:

Primary - 1:35

J.S.S - 1:24

S.S.S - 1:20

The figures fall within the national ration 1:35 for Primary, 1:24 for JSS and 1:20 for SSS. This situation is due to the fact that the over-enrolment in the urban schools coupled with the high number of staff counter the under-enrolment in the rural schools with fewer teachers. The ratio may therefore not be a true reflection on the situation on the ground.

There are six Senior High Secondary Schools in the Municipality, four being private and 2 being public. The Municipality has also 2 Technical and Vocational Institutions. There are 94 private Junior High Schools and 62 public ones. On primary education, the Municipality has hundred and fifty-two private schools and 72 public ones. The concept of pre-schooling which has become a new mine-field in Ghana is also being experienced in the Municipality. To this end, there are a hundred and fifty-five private pre-schools as compared to the 66 public ones. This distributional dynamics give a generic view of the educational structure of the Municipality. The literacy rate according to the 2000 Criterion Reference Test conduction for the Municipality is 55.99% Literacy and 54.01% Numeracy compared to the national figures of 60% Literacy and 45% Numeracy. The comparatively low literacy rate is largely consequent to the irregular attendance in the rural schools due to poverty. The physical structures of majority of the school infrastructure in the Municipality are in un-acceptable conditions with the exception of a few structures that require rehabilitation works. However, there is need to refurbish a number of J.S.S workshops both in the rural and urban communities. School furniture requirement for most of the urban schools has greatly improved. However, same cannot be said for the rural institutions. The security situation in most of the schools is also inadequate. This has led to the misuse of school facilities and theft of workshop tools equipment and furniture according to the Municipal Director of Education. The premises of the intuitions are often times used as places of convenience affecting the smooth running of academic activities. While literacy can be acquired through reading and private informal channels, the formal schooling system remains the best process for improving access to information and broadening the horizon of the people. The proportion of the population (3 years and over) in pre-school is encouraging and a reflection of the significant role these pre-school institutions play in providing child care services and giving the children a jump-start

towards the preparation for entry into primary level of basic education. As compared with the national average of 18.6 per cent, the Municipality has a smaller proportion (6.2%) of the population that attained primary education at the highest level. This is encouraging; however there should still be the challenge for the full implementation of the FCUBE programme, since the effects of education do not begin to manifest until beyond the basic level.

The Municipality is served by the three (3) utilities: water, electricity and telephone. Less than half of the population is served with pipe borne water from the GWCL whilst the remaining relies on a combination of borehole water and streams. About 40% of the population is served by electricity from the national grid, and 70% of the population has access to fix and mobile telephone. Water supply has always been a basic problem of the Municipality with a limited number of communities having access to potable water, notwithstanding the fact that the Weija water Reservoir and Treatment plant is located in the adjoining Municipality (Ga South). Pipe-borne water is periodically supplied to areas such as New Achimota, Tantra Hill, and Ofankor but the Municipal capital Amasaman lacks potable water. About a third of the over 300 rural communities in the Municipality have access to boreholes and hand-dug wells while as much as 35% of the settlements depend on dams and dugouts and streams for their water needs. Potable water supply in the urban/peri-urban areas of the Municipality has been a major challenge to the Assembly, especially since the Assembly has no direct control over urban water supply. To improve this situation the Municipal Assembly is supporting and facilitating government strategies to accelerate the provision of safe water in the urban areas, especially the inclusion of rain water harvesting facilities for buildings. In the rural areas and small towns however, the Municipal Assembly is responsible for water supply. The

Assembly is currently managing one small town piped scheme through a Water and Sanitation Committee (WATSAN) at Ashalaja. The Municipal Water and Sanitation Team (MWST) has been established and trained by the Community Water and Sanitation Agency. The Team represents the Assembly in its water and sanitation activities to achieve favourable health outcomes, economic growth and sustained poverty reduction. About 23.85% of the rural population has access to potable water either from a borehole, stand-pipe or a hand dug well. The focus of the Assembly with regards to rural water supply over the plan period is to maintain and expand the current facilities to cover the remaining 76.15% of the rural population. This will mean ensuring that boreholes and stand pipes serve not more than 300 persons and 600 persons respectively.

On the issue of sanitation in the Municipality, it appears that a number of people have access to some type of sanitation facilities either public or private. Others also resort to indiscriminate defecation in gutters, school compound and public refuse dumps. Total sanitation coverage is estimated at 47% for domestic and 65% for institutions. The types of facilities in use include WC toilets, Household KVIPs and public KVIPs. Pit latrine, even though not approved by the Assembly, is being used by some households even in the urban communities. The Assembly is in partnership with currently Community Water and Sanitation Programme to improve the provision of such facilities in the various institutions in the Municipality. Under the Community Based Rural Development Project, some sanitation facilities are also being constructed in selected communities.

In terms of road infrastructure, a large proportion of the road network is feeder roads. Their conditions are generally poor, majority are inaccessible especially during the rainy season.

The road condition statistics within the Municipality is as follows: 13% good; 21% fair and 66% poor. The main Accra-Kumasi railway line passes through the Municipality at Amasaman, Opah and Adzen Kotoku. There are two main railway stations at Amasaman and Adzen Kotoku. There is one major market in the Municipality, which is located at Amasaman. There are other satellite markets established in Pokuase and Ofankor areas. Poor and inadequate housing has been identified as one of the major problems confronting the people in the Municipality particularly the poor in rural settlements. A significant proportion of the people lack access to adequate housing and housing-related infrastructure including drainage, pavements, bridges, streets etc. The condition of housing for poor families is often deplorable and not conducive to healthy living. People living in these houses are frequently exposed to adverse climatic and environmental conditions that impact negatively on their health and standard of living generally.

Agriculture supports about 55 per cent of the economically active population in the Municipality directly or indirectly through farming, livestock development, fisheries, and distribution of farm produce and provision of services to the sector. About 95% of the farmers are small holders with 5% being large-scale holders. Approximately 70% of those in the rural areas depend on agriculture and agricultural related activities for their livelihood. Commercial holdings are mainly into non-traditional export crops such as pineapple, chilli peppers, pawpaw and some Asian vegetables such as tinda and marrow. Agriculture productivity in the Municipality is rather low due to several factors. These include high illiteracy rate, poor soil conservation and improvement management skills, low capital, high cost of inputs, high incidence of pests and diseases, high post-harvest losses (25-30%), the persistent use of traditional farming methods and over dependence on rain-fed agriculture. Rainfall is insufficient and erratic and irrigation infrastructure is

almost non-existent due to high cost. The agriculture sector has not seen growth within the past few years in spite of several government initiatives aimed at facilitating the growth of the sector. This has basically been caused by the loss of existing farmlands to sand winners as well as growth in estate development and acquisition of land for private housing projects. It has been observed that incomes accrued from lease of lands to private and estate developers are generally higher than for agricultural purposes hence, the preference of landowners to lease out lands for purposes other than agriculture.

The land issue notwithstanding, the Ga-West Municipality lies in the catchment area for the production of for cassava (Manihot esculantus) for industrial starch. The Roots and Tuber Improvement Programme which has tremendous government support and funding as well as the Export Development and Investment Fund that can be accessed by pineapple producers and exporters alike provide good opportunities for local farmers within the Municipality. The tremendous market opportunities for these agricultural products present a big challenge to the Assembly to focus on creating the enabling environment as well as supporting agriculture-based enterprises to create jobs for the unemployed and reduce poverty among the people. The poultry and livestock sub sector have suffered a decline in its growth rate. With respect to poultry production, high cost of inputs such as day old chicks, feed, drugs etc. has resulted in high production cost. The importation of selectively cheaper poultry products especially from Europe has further aggravated the situation. Farmers would require the support of government to considerably reduce the cost of production to enable them compete favourably on the market. The fisheries sub sector has also not seen any significant growth in spite of the fact that communities along the coastline depend on fishing and fish processing as their main source of income and livelihood. This is mostly due to the over exploitation of this resource through

unapproved fishing methods. Also, fishing activities carried out in the lakes and rivers have been on small-scale basis. There is therefore the need to increase investments in this sector especially in the area of fish farming to improve growth in the sector through maximising the use of the existing water sources.

Land as a factor for agricultural production is under siege from the estate development sector either for physical structures or for sand winning or stone quarrying. Land sizes for production are small and over exploited without any meaningful soil conservation and improvement practices. Chiefs are the custodians of land and hold them in trust for their subjects. However, direct ownership is in the hands of clan or family heads. Anyone in the lineage could inherit from the parent or grandparent. Land could be owned either by direct purchase or lease share cropping tenure arrangement for a period of one farming season. Land sale is one of the quickest ways of making money and the major cause of conflict is land ownership.

Even though there are ready markets for available farm produce, crop farmers, especially do not control the pricing of their goods. The highly perishable nature of most agricultural produce coupled with the glut at immediate harvest time's account for the low prices of produce, leading to low prices. Lack of information on prevailing market prices and the inability of farmers to freely enter established markets due to the presence of powerful market queens, continue to predispose farmers to the exploitation of market women and middle men.

Significant post-harvest losses particularly cassava; cowpea, maize and vegetables are recorded in the Ga West Municipality. The average annual post-harvest loss for maize is

estimated to be between 20 to 25%. The loss is even higher in cowpea, vegetables and cassava. Aside of a few traditional silos, warehouse with drying facilities are virtually absent. The implication of this sector to the study lies in the fact that the occupation of a person has direct relation to the individual's ability to access health care and the kind of health facility he or she can equally patronise. To this extent, since the predominant occupation of the majority of the people in the Ga-West municipality is agriculture, it explains why the activities of TBAs thrive and the inhabitants utilise the services of these TBAs.

Health is one of the basic inputs to human development and has a direct linkage to growth and poverty reduction. Health services delivery in the Ga West Municipality is provided principally by government health centres and a number of private clinics and family planning and maternity homes. A few others are established by foreign non-governmental organizations in collaboration with local counterparts.

The major health facility in the Municipality is the Amasaman General Hospital located in Amasaman. Besides the General hospital, there are 24 other health facilities scattered across the Municipality serving the over five hundred thousand inhabitants. These 24 health facilities are made up of 6 government clinics, 5 CHPS compounds, 5 private clinics, 4 private hospitals and 4 private maternity homes. The other health centres located in Oduman and Pokuase which serve a considerable portion of the rural population of the Municipality were provided by a French non-governmental organization, Entrained Medicals International (EMI), working in collaboration with a local counterpart.

These health facilities statistics have serious implications for better health care delivery. A common implication is the burden that the public health facilities will carry. Quality service delivery will definitely be compromised. Another major issue of the health service delivery in the Municipality is the problem of inadequate access to health care for the majority of the population. A significant number of the population lives in scattered rural settlements covering about 80% of the land area of about 568.2 square kilometres. In order to make up for the inadequate coverage of health facilities, the majority of the rural population depends on traditional healers, diviners and birth attendants for their health delivery and occasionally outreach services are organized for selected communities. By this means, basic preventive and curative services such as Immunization coverage are provided for various communities. Another issue of grave concern is the prevalence of several communicable diseases of public health magnitude. In addition to these diseases are others like Buruli Ulcer, Tuberculosis and HIV/AIDS, which although do not appear among the top ten diseases within the Municipality, yet cause severe suffering and death and have profound negative effect on the total development of the Municipality.

Other pertinent issues which directly or indirectly impact on the effective and efficient delivery of health services in the Municipality are inadequate laboratory facilities, inadequate cold storage facilities, lack of transport services, lack of telephones, water shortage at health institutions and lack of electricity supply to most part of the rural communities. The focus of health delivery system has been the implementation of the Community Based Health Planning and Service Programme (CHPS) in which mobilized communities and community groups work with and are supported by the formal health sector to plan and organize their own health services. The current strategy that has been adopted by the Ghana health Service entails the posting of re-trained nurses referred to as

Community Health Officers (CHO's) to live within communities to render services to population groups of between 3000-5000 with the full participation of the communities themselves. Where individual communities are less than this population group, they are re-grouped into units to make up the number. The GHS- Ga West Municipality has demarcated 30 such units that are termed Community Health Service Units (CHSU). Nearly all 30 CHSU's are rural. What skills are these CHOs equipped with, in a Municipality that has serious disease burden? Interestingly, these CHOs are not allowed by their orientation to carry out basic ante natal care for pregnant women. These are issues that impact negatively on the health seeking behaviours of the inhabitants. The GHS-Ga West has therefore planned to find ingenious ways of demarcating the peri-urban areas into Home Service Units (HSU) and work with each unit to develop effective ways of making health care accessible to the people. The objective is to help bridge the yawning but unrecognized access gap, more of the socio-economic rather than geographical accessibility found in the urban areas. The National Health Insurance Scheme is being implemented in the Municipality with a high registered population. However assessing the ID card is very difficult. Unfortunately most of the health facilities are not prepared to provide services to clients under the NHIS because of the erratic way claims from the NHIA are paid. The Municipal hospital which attends to most of the bearers of the NHIS cards is saddled with inadequate health personnel, inadequate space in the facilities, lack of laboratory facilities, and lack of sanitation facilities, inadequate logistics, and poor lighting system. The Municipality is endowed with a number of industries. Prominent among the industries located in the Municipality are; Agya Appiah Bitters, Voltic Industries (GH) Company Limited, BIVAC Vehicle Inspection and Technical Organisation, Ernimich Agro Processing Centre, Le Court Mineral Water Company

Limited, Accra Composite Recycling Plant, Rocksters Aluminium Company Limited, Instyle Aluminium Company Limited, ISADA Brick and Tile Company Limited.

The industrial sector has seen some remarkable growth in the past few years according to the Municipal Chief Executive Officer. The establishment of manufacturing companies such as Aburaaba Mineral water, Voltic Mineral water, a number of aluminium companies such as Rocksters and Instyle as well as the improved performance and reactivation of existing companies such as Isada Brick and Tile factory , just to mention a few, gives an ample indication of growth of the sector. The widespread mining and quarrying of large deposits of sand, stone, clay and laterite materials by both large and small scale operators such as Construction Pioneers and Sonitra as well as operatives of the Sand and Stone Winners association has also contributed to the growth of the construction industry. The commercial sector engages the largest working population of the Municipality. A wide range of commodities comprising mainly of agricultural produce and industrial goods dominate this sector. The major marketing centres are Amasaman and Achimota. Even though some modern infrastructure have been provided at these areas, a lot still needs to be done to decongest the areas. A number of economic and financial services and other infrastructure facilities exist whilst others are being developed to serve as catalyst for the rapid development of the Municipality. These include telecommunication, hospitality and banking facilities. There are a number of Hotels and Guest Houses in the Municipality. These ranges from three-stars to Guest Houses and include the following; Kingsby Hotel, Maple Leaf Hotel, Korkdam Hotel, Days Inn, Tadoma Hotel, Festus Hotel, Top Lodge, Regeorge Guest House, Joy Family Guest House, Topido Guest House, Markings Guest House. The springing up of these hotels may be understood in the context of some tourism attractions sites dotted in the Municipality. Tourism is gradually becoming a source of

revenue for the Assembly through the gradual increase of hotel facilities in the district. The district is endowed with a lot of basic natural tourist attractions such as the Guaokoo Sacred Grove- Pokuase, Samsam Cave, Samsam Water Falls, Okaikwei Shrine at Ayawaso Village, Medie Flower and fruit Gardens, Osofoman Presbyterian Cemetery, Dagari Music Centre, Medie, Africa Heritage Archives (Kofi Ghanaba)

The major festival which is celebrated among the Ga People of the District is Homowo. It is celebrated in the month of August each year. In addition to this are smaller festivals which are celebrated by the various clans, stools and houses.

A significant number of the growing number of fuel filling stations being established in the region can be found in the Municipality. The major fuel service stations or oil marketing companies which have their presence in the Municipality include Total, Shell, Excel, Goil, Glory Oil, etc.

The municipality has two constituencies, namely; Amasaman and Trobu. These constituencies are held each by the two major political parties in the country, that is, the National Democratic Congress (NDC) and the New Patriotic Party (NPP). In accordance with section 10 of Local Government Act, 1993 (Act 462) the Municipal Assembly is the highest administrative and political authority in the Municipality and is vested with deliberative and executive powers. The Municipality consists of 18 electoral areas which are represented in the Municipal Assembly by elected and appointed Assembly members. The composition of the Assembly is 18 Elected Members, 8 Appointed Members, 1 Member of Parliament and the Municipal Chief Executive. The Assembly is headed by an elected Presiding Member with the Municipal Co-ordinating Director as the Secretary.

The Municipal Chief Executive is the political and executive head of administration of the Municipality. The Legislative Instrument also establishes the Executive Committee and the following Sub-Committees: Finance and Administration, Development Planning, Social Services, Justices and Security, and Works/ Infrastructure. The Local Government (GAWM) Establishment Instrument, 2004 LI 1587 makes provision for the establishment of Area Councils and Town Councils. Thus, there are currently 6 Area Councils in the Municipality, namely; Ofankor, Pokuase, Mayera, Amasaman, Ayikai Doblo and Kotoku Area Councils. The Assembly is in the process of providing built office accommodation for the Area Councils. So far Pokuase and Amasaman have been provided with their own office structures, Kotoku and Ofankor are under construction. Mayera Zonal Council will be next in line according to the Municipal Chief Executive Officer. The situation above presents serious implications for the decentralisation programme. Since some of the Area Councils lack logistics to make them function effectively, it creates problems for the smooth administration of the decentralised system. This situation also reinforces the ill-preparedness of policy makers in rushing to formulate policies without the accompanying resources for implementation (Sourced from www.ghanadistricts.gov.gh).

The Ga-West Municipality has a lot of economic prospects and activities. However, the infrastructure development of the Municipality leaves much to be desired. The road networks are bad, rapid urbanisation and over population which have implication for the security of the Municipality, land disputes, inadequate health facilities and health staff, poor water supply, serious sanitation issues to mention but a few. All these have implication for the well-being of the inhabitants. The next chapter discusses the research methods of the thesis.

CHAPTER FIVE

RESEARCH METHODS

This chapter discusses the research methods of this study. Different research methods have different purposes and different levels of validity. Validity is one measure that helps to determine how accurate the results of a research method are. Validity refers to whether or not a study measures what it is supposed to measure. The results of a study provide stronger evidence if the research has a higher measure of validity. It is for these reasons that this chapter focused on the research methods. Historically, researchers using different methods have debated the quality and rationale for using a particular research method. In many disciplines, debates have arisen over the quality, usefulness, and legitimacy of the most effective research method of what has been broadly categorized as qualitative versus quantitative research (Sale, et al. 2002). Quantitative research approach sees knowledge as discoverable through objective research. It looks for facts such as cause and effect, and researchers try to measure and then theorise from this (Sale, et al. 2002). On the other hand, qualitative research approach to knowledge looks at it as constructed by the subjective meaning that people make of their world and their interpretations, perceptions, meanings and understandings, as the primary data sources' (Mason 2002: 56 as quoted in Sale, et al. 2002). It is within the foregoing arguments that this study settled on the qualitative approach because the researcher is interesting in constructing meanings and interpretations from some of the communities the new RCH policy is likely to affect.

Study design

An exploratory qualitative research method was adopted. This design was used because the researcher intended to explore an aspect of human behaviour which would be very difficult to quantify (Boodhoo & Purmessur, 2009). The larger scope covered by qualitative designs guarantees that some useful data are always generated, whereas an

unproved hypothesis in a quantitative experiment could mean that a lot of time has been wasted. Qualitative research methods are not as dependent upon sample sizes as quantitative methods; a case study, for example, could generate meaningful results with a small sample group (Boodhoo & Purmessur, 2009). It is for these reasons that this research design was adopted in exploring the behaviour of TBAs and their clients on the policy directive.

Targeted respondents

Traditional Birth Attendants (TBAs) were the main respondents for the study. This was the case because the Reproductive and Child Health policies in Ghana have a direct bearing on the activities of TBAs and other stake holders. Women who have and continue to patronise the services of TBAs were interviewed to explore the rationale behind the continuous utilisation of the services of TBAs. The Director of Reproductive and Child Health was also interviewed since the policy on TBAs was developed by that Department of the Ministry of Health (MoH).

At the Municipal level, the Deputy Director of Nursing (DDN) was interviewed. This interview was necessary because it afforded the researcher the opportunity to understand the flow of policy directives and the rationale behind the continuous use of TBAs within the Ga-West Municipality. Again, it was meant to help the researcher gain insight into the kind of collaboration that exists between the formal health system and the traditional practitioners within the Municipality. At the community level, the managers of the local health facilities were interviewed to ascertain not only the relationship between the TBAs and the health facility and their level of knowledge on the new policy but also to find out from them the extent to which the activities of TBAs complement or affect their own activities.

Table 2: Summary of Objectives, methods and respondents

Objectives	Method of data collection	Respondents
1. To gain insight into some of the factors that have informed the new Ministry of Health policy on TBAs	In-depth Interview	Director of Reproductive and Child Health
2. To explore the knowledge of TBAs on the Policy directive	In-depth Interview	Traditional birth attendants
3. To examine the attitude of rural communities (clients of TBA services) towards this new policy	In-depth Interview	Clients of TBA services
4. To find out the attitude of officials of rural public health facilities regarding the policy and training of TBAs in the GAWM	In-depth Interview	Deputy Director of Nursing, Community health Officers and midwives.

Number of respondents

For a qualitative method to meet rigour and trustworthiness, the researcher is required to obtain thick and rich data (Lucas, 2013). It is in line with this that Lucas (2013), has argued that 12 interviews will satisfy this requirement as long as the participants are the holders of knowledge in the area the researcher intends to investigate. Other considerations for the number of respondents for qualitative research is dependent on the type of sampling techniques employed (Patton, 2002). Resources for the study (finances and time) have also been found to place limitations on the sample size (Kvale, 1996 & Seidman, 2006 as quoted in Gill et al., 2008). It is in the midst of the above mentioned considerations that this current study settled on the number of respondents. In all, 27 respondents were interviewed - 8 trained TBAs, 11 clients of trained TBA services, 6

managers of the local health facilities, 1 Deputy Director of Nursing Services (DDN), and The Director of RH.

Selection of respondents

Purposive sampling technique was used to select respondents for the study based on the homogeneity of the respondents. The researcher obtained a list of trained TBAs from the Municipal Health Directorate. The list is made up of all trained TBAs operating within the Municipality. The researcher purposively selected all TBAs operating in communities where there are health facilities (hospitals, clinics, and maternity homes and CHPS compounds). The researcher's first port of contact in each of these communities was the health centre. After the initial felicitations, the names of the TBAs operating within the specific community were mentioned to the health officer who led the researcher to the TBA. Snow ball technique was used in selecting the clients of the services of the TBAs. After the interview session with the TBA, the clients of the services of the TBA were introduced to the researcher by the TBA upon request. This sampling technique was employed because it was not every member of the society who bore the characteristics to satisfy the inclusion criteria. The members who satisfied the inclusion criteria were trained TBAs, clients of trained TBA services, DDN, Director of RCH and managers of the local health facilities (Community-Based Health Planning and Services: CHPS, Clinics, and Health Post and Centres).

Instrument of Data collection

In-depth interview guide was used in conducting the interviews among the respondents. This tool of data collection does not only allow the researcher to define the areas to be explored but also allows the interviewer to probe further in order to pursue an idea or response in more detail. Again, the flexibility of this approach , particularly compared to

structured interviews , also allows for the discovery or elaboration of information that is important to participants but may not have previously been thought of as pertinent by the researcher (Britten, 2007).

Data collection Technique/Procedure

The interviews were done face-to-face with respondents. The interviews were audio-recorded so that researcher will not lose any of the information. This interview procedure helped the researcher to be able to elicit appropriate information on the subject under investigation. In-depth interviews are believed to provide a deeper understanding of social phenomena than would be obtained from questionnaires. It is also appropriate where detailed insights are required from participants by the researcher (Silverman, 2013). These were the considerations which informed the research approach.

Data management and Analysis

All qualitative interviews were audio recorded and transcribed verbatim. The researcher kept a note to record descriptive aspects of individuals at the IDI sessions which enhanced the course of data collection. This was incorporated into the analysis to enhance interpretation of findings. Transcripts were coded line by line and then later developed into themes (Auerbach and Silverstein, 2003). The researcher manually analysed all data from the fieldwork. The trends that emerged from the data were developed into major and sub themes. The objectives of the study ultimately guided the discussion of the themes. In generating the themes, the data were reviewed by two persons and a debriefing session was held to assess the degree of agreement. Data were summarised and presented as narratives with quotes to support the findings.

Field Experience and Ethical Considerations

Ethical clearance was obtained from the Humanities Ethics Committee, University of Ghana. Written and verbal informed consent was also obtained from all participants selected for the study. Participants were assured that data would be used for the intended purpose. Data collected from participants was not disclosed to others (anonymity). Protocol was observed during the community entry. In this regard, the researcher contacted one CHO who he used as the focal person to reach out to the other respondents. This was done by giving out cakes of soap to respondents after the interview sections were over. The field work was sometimes hampered by lack of transport to the research site. Again, the inaccessible nature of the communities sometimes forced the researcher to commute on foot or hire a motor-cycle to get to respondents. Interview sessions were often times interrupted by playing kids and other community members who were curious to know what was going on between the respondents and the researcher. The intended number of TBAs for the study was sixteen, unfortunately, the researcher tried without success to meet all of them. This was mainly due to the fact that the TBAs have travelled outside their communities to engage in their practice. Sometimes language became a barrier to effective communication as respondents were unable to understand the question being asked. The researcher also had a fair share of the communication gap syndrome, where he could not also understand the respondents sometimes. A major challenge encountered on the field was getting the police document from the Ministry of Health. It took the researcher almost a month to get a soft copy of the policy document. The interview session with the RCH director had to be rescheduled on a number of times because of the director's busy schedule. The same could also be said about the DDN. The bureaucratic process associated with accessing officialdom for information was at its best. Following closely after this chapter is the presentation of data and analysis.

CHAPTER SIX

FACTORS DRIVING THE NEW REPRODUCTIVE HEALTH POLICY

Introduction

This chapter is dedicated to analysing the data from the field. The data are analysed according to the objective of the study as indicated in chapter one. For comprehensive analysis of data, the objectives are analysed in two chapters. This chapter focus on gaining insight into some of the factors that informed the new Ministry of Health policy on TBAs and to explore the knowledge of TBAs on the Policy directive. In order to examine these issues, the researcher contacted the Director of RCH and TBAs.

However, the chapter begins with a description of the socio-demographic characteristics of the respondents involved in the study.

Socio-Demographic Characteristics of Respondents

Studies have shown that social background of people impact on their worldview. For instance, it has been shown in various scientific disciplines that opinions on a vast number of topics differ between different age groups. Again, more often than not there are clear differences in opinion between respondents with different educational levels. Moreover, educational level – generally asked as ‘the highest level of education completed’ – is also quite often used as a proxy for income. It is then argued that educational level gives an impression of the respondent’s income, or more generally his or her socio-economic status (SES) (Dobronte, 2013). It is in this regard that this study focused on the socio-demographic characteristics of respondents.

Age of Respondents:

The ages of TBAs who took part in the In-depth interviews ranged from 42 to 59. The ages of the TBAs were captured for the researcher to understand the social status of these respondents. Socially, these TBAs are seen as mothers in their various communities. They

have children whose ages are almost the same as those of their clients, and because of that, they are considered 'experienced' in the practices they undertake. The ages of the clients of the services of TBAs ranged from 23 to 36 years. Significantly, these people are young woman in the prime of their reproductive stages and birthing is one of the culturally important features of this age bracket. These young women would like to do that in an environment which is friendly and socially acceptable in their own estimations, thus the choice of the TBA's place.

Education and Occupational Background of Respondents

The field data revealed that all the TBAs except one had no formal education. This finding is consistent with findings of other research works. For example, results of a study conducted in Malawi found that most of the people rely on traditional birth attendants although the quality of their services was poor due to illiteracy, their ailing age ... (Bisika, 2008). These findings have implications for TBAs' appreciation for complications and prompt referral should that occur. Even though, the field data revealed that TBAs had other jobs they did besides their practice of delivering mothers; the social recognition and prestige attached to their craft of delivering mothers were great motivation for them.

Religion of Respondents

Religion is key to the understanding of people's behaviour. It defines people's attitudes, beliefs, and practices. Since birthing and the place of birthing is influenced by people's beliefs, this study sought to find out the religion of the respondents. For example, according to Opoku (1978:110) as quoted in (Nukunya, 2003), in all Ghanaian societies, twins are believed to have some kind of association with certain celestial spirits and upon their birth shrines are constructed for them. This belief and practice influences the place of birth as soon as the pregnant mother becomes aware that she is carrying twins. Other

studies on the practices of TBAs have shown that some of them (TBAs) have turned their places into prayer centres. However, the field data from this study did not find such a practice among the respondents, even though, unanimously, all TBAs say a prayer before the commencement of their practice.

Number of Children Delivered with the TBA

It was important for the researcher to understand the extent to which the practices of TBAs were wide spread in the communities they operated. To do this, the researcher was interested in the number of children the clients of TBA services had delivered with them. Data from the IDIs revealed that almost all the respondents delivered all their children with the TBAs. Proximity, easy access and cultural competence were some of the reasons assigned for delivering with the TBAs.

Length of Residence in the Community

This socio-demographic characteristic was important to the researcher because societal norms, beliefs, and practices are shaped over time. People's beliefs and practices tend to become norms and acceptable way of doing things over time. These practices and norms are passed on from one generation to the other as the older folks transit from the land of the living to join their ancestors. To this end, it was reasonable to find out how long people have stayed in the community so as to ascertain how the norms of the society have impacted on their world view.

Factors that Informed the New Ministry of Health Policy on TBAs

For more than three decades the WHO and other agencies of the United Nations promoted training of TBAs as a global public-health strategy to reduce maternal and neonatal mortality (Stanton, 2008). However, with the advent of the safe motherhood initiative and very little to show in terms of the training of TBAs and the correspondent reduction in

maternal mortality, there has been a waning of enthusiasm for training TBAs (Flemming, 1994). Again, by 1997, the WHO and many safe motherhood advocates turned from TBA training to promote skilled birth attendance for all and calling for a ‘new’ and ‘expanded role’ for TBAs, where TBAs act as ‘link workers’ to skilled birth attendants rather than conducting deliveries (UNFPA , 2004, Tarnpol, 2005). In the context of the above, the reviewed policy of the Reproductive and Child Health Department (2010), third edition, has affirmed its stance on the practices of TBAs as captured in the policy- “TBAs are recognised as community-based service providers and shall offer supportive care, education, and lay counselling and referral services but not conduct delivery. However, in communities that do not have access to skilled delivery care, they shall be supported to conduct deliveries” (RCH, 2010).

It is therefore important to know and analyse the factors that informed the formulation of the new policy directive on TBAs by the RCH. To make sense of these factors, the researcher employs the path dependency theory of David (1985) to discuss issues such as delays, complications, impacts of TBA training on maternal out-comes.

Delays

Research has shown that factors such as extension of primary health care, addressing global maternal issues, and co-existence of the traditional and modern health system have been influential in the formulation of policies about TBAs and their activities (Stanton, 2008 & WHO, 1987). The situation is not different in Ghana. Results from this study show that the national policy directive asking TBAs not to deliver is premised on the fact that TBAs who conduct delivery in the various communities, delay in referring cases that are beyond them to the appropriate health facilities.

This is illustrated in the response below;

We were having delays, parturient were coming late because instead of coming to the health centre, they go to the TBA so by the time they discover complications and refer, it will be too late and the women arrive in a very bad state”(IDI with Director RCH, Accra)

Furthermore, the data show that, TBAs delay women so that they can receive the money and other benefits that come with the delivery. This is to serve the interest of the TBAs because as it were, they are supposed to conduct delivery without monetary compensation. This is one of the reasons informing the policy to stop them from conducting deliveries. The Director of RCH during an IDI session threw more light on this as shown in the response below.

We realised also that, a lot of the TBAs have become commercialized, so they are also deliberately delaying cases for them to be paid” (IDI with Director RCH, Accra)

From the above responses, the researcher employs the path dependency theory to explain the self-interest concerns of TBAs. Self- interest has been established as one of the paths which are usually triggered. From the discussion above it is obvious that the TBAs are not ready to lose the benefits they accrue from delivering babies. So far as the monetary and other self- induced-interests persist, the attempt by a policy from the Ministry of Health to restrict them to activities other than delivery will be counter-productive. This is because the TBAs are the agents of this path (self-interest) and like Arthur (1994) posited, they are the major beneficiaries of this path and can therefore not unlock it.

The issue of commercialization of the services of TBAs was confirmed by a TBA and a client of TBA services. This is what a client of TBA service had to say during an IDI session.

After the delivery, the TBA takes GHC 100, two bottles of malt and four cakes of Geisha soap but the amount could be bargained and paid in instalment” (IDI with a client of TBA services, Amasaman).

Most of the TBAs shed light on this issue, validating the above findings. The quotation below however gives a clearer picture of the situation:

I take two bottles of malt, four cakes of soap, and GHC20 but some can afford while others are not able to pay; even some come empty handed” (IDI with TBA, Akramaman)

Undoubtedly, while prompt intervention is critical in the management of obstetric dangers, the ability of the health system to effect swift intervention is mediated by socio-cultural factors which have come to be known as the DELAYS. According to Senah (2003), there are four of such delays. These are; Delay in the Recognition of a Problem- Medical anthropologists have stressed that the concepts of 'health', 'sickness' and 'problem' are all cultural constructs and consequently they may be reinterpreted to disguise the element of medical danger. Consequently, there are instances when grossly oedematous pregnant women are said to be expecting twins or a baby boy when medically they may be on the path to death as a result of pregnancy- induced hypertension. Again, there is a second form of the delay-Delay in the decision to take appropriate action; even when the emergency situation has been appreciated there is considerable delay in taking appropriate action. This may be due to lack of knowledge about where to locate the appropriate facility or the lack of money to access the services of the health facility. There is the third delay, Delay in arriving at a health facility; when the decision to access the services of a health facility

has been taken, there is a further delay in arriving at the facility, which may be several kilometres away. The distance factor is complicated by lack of vehicles, bad roads and high transport fares. In the study area of this research, it came to light that at such crucial times, parturient are carried on motor-bikes to referral health facilities. The last delay occurs within the health facility, the health facility finally accessed from the village may be a private maternity home, an MCH clinic, a district or a regional hospital. However each of these facilities has its own problems which may delay quick intervention. For instance, upon arrival in the facility, instead of the prompt attention, health workers will be demanding the parturient folder, NHIS card and other non-essentials before she could be attended to. From the above discussion should the TBA be blamed when a complication arise?

It also is important to note that, TBAs do not intentionally delay pregnant women, who are in labour, simply because they want to take money. In any case, what is wrong with the commercialisation of the activities of TBAs? Do maternity homes and the hospitals not take money for the services they render to pregnant women? In this context, TBAs rather offer support to women, who otherwise will not be able to deliver at the health facility as prescribed. This is because these TBAs operate in communities where the referral health facilities are not adequately equipped with human and logistical resources to conduct deliveries. When the CHPS compounds and community clinics are managed by CHOs how will pregnant women entrust their lives and that of the unborn child in the hands of these 'unqualified' health staff? Also, the roads linking the communities to the referral facilities are unmotorable especially, during the raining season. Pregnant women therefore resort to the services of TBAs since there are no cars plying the roads on regular basis. During emergency, some pregnant women are transported on motorbikes to health

facilities to deliver. In as much as some TBAs may encourage women to deliver at their places because of the monetary reasons, some also go there voluntary because of the challenges mentioned above.

In effect, the items and money collected by TBAs are not charges since women who are unable to provide are not forced to do so. Some of these items are the same things collected at the health facilities and women are considerably compelled to provide them. What happens to a parturient when she is unable to settle her medical bills at the health facility? More often than not, she is detained by the authorities at health facility, and in these communities that everyone is known almost by everyone, which one is a greater shame? To be detained at a health facility and become a laughing stock in the community or to deliver with a TBA where one could negotiate the payment terms? Notwithstanding, the immediate question that arises is, must TBAs not survive? If the answer to this question is yes, then why should they be seen as opportunist if they collect money often given to them by their clients as a form of appreciation?

Complications

Another factor that emerged from the study to have informed the policy directive asking TBAs to stop delivering is the TBAs' inability to handle complications. As the Director of RCH pointed out

“....As you know we have five main causes of maternal deaths. For example bleeding, when a woman is bleeding, she will need blood transfusion but the TBA cannot do anything about that. When a woman's blood pressure goes up (pre-eclampsia), when there are complications arising out of abortion, or obstructed labour, infection, there is nothing a TBA can do about that” (IDI with Director RCH, Accra).

But is the TBA entirely to be blamed? The answer is obviously no because there are other socio-cultural factors that cause complication. For instance, in many societies in this country, it is culturally regarded immodest to show early signs of pregnancy until it is visible (Arhin, 2001 as cited in Senah, 2003). Thus, often the prenatal screening for complications is missed. Again, complications could be as a result of poor dietary regimen for pregnant women within a sociocultural arrangement. That is, in some societies in Ghana, pregnant women are not expected to eat snail lest the child may be born drooling; they must not eat eggs lest the child grows to become a thief, pregnant women are restricted to vegetarian diet; they must not eat meat and groundnut lest they give birth to 'spirit children' (Senah, 2003). These may cause malnutrition for both the mother and the unborn foetus leading to complication during delivery whether at the TBAs place or the health facility. There are also delays as a result of the inability of pregnant women to recognise danger signs concerning their pregnancies in order to seek immediate care. For instance, pregnant women who spot 'small' quantity of blood may regard this as normal and may not report it to even the TBA until it gets out of hands.

Furthermore, the director of RCH explicitly outlined some of the reasons why there is the need to refer pregnant women in labour to deliver at health facilities. As encapsulated in the response below, usually complication cannot be medically predicted:

“Majority of the complications cannot be predicted, no one will know which woman is going to bleed after delivery or is going to get hypertension in pregnancy, so we treat all pregnant women as risk cases even though we know that about eighty five to ninety per cent of women who get pregnant could deliver without complications. These are some of the factors that influenced the current policy on TBAs” (IDI with Director RCH, Accra).

If complications cannot be predicted why should the TBA be the only one to be blamed? TBAs are not able to handle complications; local health facilities lack the requisite logistics to handle complications, who bears the blame? The truth is that the training given to TBAs is to equip them to identify complications and refer timely. If the TBA is not doing so who should be blamed? Where is the supervisory role the formal health system is supposed to exert over the activities of these TBAs? Whose interest is the MoH serving in the rolling out of the policy? Is it the citizens of Ghana or their ‘pay masters’ the WHO and its allied bodies?

Impact of TBA Training on Maternal Outcomes

Some scholars have argued that for more than three decades, the training of TBAs has not contributed to the reduction of maternal deaths (Pyone, 2014, Replogle, 2007, Sibley and Sipe, 2006, WHO, Vyagusa, 2013). Field data from this study showed that, TBAs are being stopped from assisting with delivery because there is no clear evidence that their activities have reduced maternal mortality as envisaged. This was explicit in the words of the respondent as captured below.

“...There was also a meta-analysis across the world that also showed that trained TBAs have not made any significant contributions to the reduction of maternal mortality but have rather contributed to the reduction of neonatal death because of the training” (IDI with Director RCH, Accra).

It is worthy to note that the assumption that a meta-analysis routinely represents the final and accurate viewpoint in an area of research is not warranted. Meta-analyses are by no means perfect. A meta-analysis is particularly subject to biased conclusions when it is created by advocates of a controversial opinion regarding the same topic the meta-analysis is addressing.

Similarly, a meta-analysis written by employees or representatives of a pharmaceutical company, for example, will have an inherent and expected favourable bias towards the product of that company. This type of meta-analysis will always be an advocacy meta-analysis (Darrell, 1954). The policy by the MoH lacks contextual relevance. Where are the empirical studies on the activities of TBAs in Ghana that suggest that they are contributing to the high incidence of maternal mortality? Did the meta-analyses upon which the policy hinges include Ghana? What can we say and learn about the China Model? Where traditional practitioners were trained with delivery skills and with a well-structured referral system reduced the maternal mortality ratio from 1500 in 1960 to 61 in 1990.

Again, the meta-analyses findings are not the holistic representation of studies relating to the TBA training on outcomes of pregnancies elsewhere. There is evidence showing positive relationship between TBA training and maternal outcomes. More recently, Lassi, Haider, & Bhutta (2010) reviewed 18 cluster-randomised and quasi-randomised trials and found significant reductions, maternal morbidity (25%), stillbirths (16%), perinatal mortality (20%) and neonatal mortality (24%), along with increases in referral for complications (40%) and early breastfeeding (94%) as a consequence of implementing a broad range of community-level maternal and new born care packages, many of which included a relationship with TBAs. As Osrin (2010 quoted in Lassi et al., 2010) noted TBAs have been largely abandoned as a cadre who could take useful health actions to reduce perinatal maternal ratio (PMR). This abandonment is at the level of international policy rather than the realities on ground. The relationships among poverty, women's health status and access to quality health care are especially important. Each is relevant to any discussion and practical decision regarding the feasibility and potential of TBA

training to contribute to improved pregnancy outcomes in a given setting (Lassi et al., 2010).

TBAs and Policy Directives

Information flow is crucial in every set-up as far as policy implementation is concerned. Policy Implementation is the process of turning policy into practice. However, it is common to observe a gap between what was planned and what actually occur as a result of a policy (Buse et al, 2005). In this regard, the people for whom the policy is meant for must be adequately involved to ensure that they accept the policy when it is rolled out. Without this, the policy is likely to be rejected. It is therefore important to know whether the people who are likely to be affected by the policy are aware of the new RCH policy on TBAs and whether they played a role in its formulation.

Ideally, in Ghana, policies formulated by the Ministry of Health are disseminated through the Ghana Health Service to all the regional health directorates. The regional directorates in turn get the policy to the local level through the district directorates to the sub-districts and finally to the community. Similarly, same channel is supposed to be followed in the formulation of any policy such as the RCH policy. However, it appears that, this channel was not followed in the formulation of the RCH policy on TBAs.

In view of this, the data showed that, TBAs in the study area are generally unaware of any policy directive which prevents them from conducting deliveries in their various communities. The response below captures most of the views of the TBAs:

“We do not know of any such policies. Ah!!! But how can such a policy be rolled out without our knowledge since it affects our livelihood?” (IDIs with TBAs at the study area)

Quite interestingly, it was also revealed that health administrators and workers at the district level were also oblivious of this policy directive. This is clearly encapsulated in a response by a Deputy Director of Nursing in the Municipality;

“To tell you the truth until you are telling me, I am not aware about that one (referring to the new policy Directive). I know that a survey has been done and they found a few gaps in the existing policy so they were going to review it but as we speak now, I cannot really tell you emphatically whether the review has been completed or whether the policy is still under consideration, whether they have deducted or added anything, I cannot really tell you. I don't have that information”.

Similarly, the clients of the services of TBAs were also oblivious of the policy directive barring TBAs from conducting deliveries at home. The quote below captures the sentiments of majority of the clients of the TBAs:

“Eeeii! I don't know about that. Then it will be difficult for me. I delivered all my three kids with the TBA in this community and currently the pregnancy I carry, I will also deliver at the same place” (IDI with a patron TBA of services, Kojo Ashong).

When the apparent lack of knowledge on the new policy by local health workers was made known to the Director of Reproductive and Child Health, he had a rather unpleasant commentary about such health workers, as captured below;

“When I was in school, my Academic Adviser told me that it was his duty to teach me, but it was my responsibility to educate myself. So if you are a health worker you must make every conscious effort to know current changes in your profession” (IDI with Director of RCH).

The above result gives a clear indication of major shortfall in the policy formulation. Other major stakeholders (TBAs, community health administrators and workers, and clients of TBA services) who will directly be affected by this policy were not engaged during the policy formulation. This is as results of the top-down approach used by the Ministry of Health in the formulation of the policy. This approach sees policy formation and policy execution as distinct activities. To this end, policies are set at higher levels in a political process and are then communicated to subordinate levels which are then charged with the technical, managerial, and administrative tasks of putting policy into practice (Buse et al, 2005).

Drawing inspiration from the above discussions, the fact that TBAs are not aware of the new policy, is clearly due to implementation gap between the establishment of the policy and the consequences of the policy for the people whom it affects (Edwards, 1980) as quoted in (Makinde, 2005). This is the foreseeable problem the researcher believes the new policy will encounter. Besides, the attitudes of policy formulators should not be seen to be against the work of the TBA but rather to shape and improve maternal health else, phasing out TBAs is going to be a herculean task (Daily Graphic, March 27, 2010, p.19). What is the meaning of decentralisation in all these discussions? How effective is the monitory and evaluation department of the MoH? Who monitors the implementation of health policies?

Even though, the policy has already been formulated, alternative implementation approach that could ensure smooth implementation of the new policy is the Bottom-up approach. This approach recognizes that individuals at subordinate levels play an active part in implementation and may have some discretion to reshape objectives of the policy and change the way it was formulated. This will ensure interactive implementation process involving policy makers, implementers from various levels of government, and other stakeholders (TBAs and their clients).

CHAPTER SEVEN

ATTITUDE OF RURAL COMMUNITIES TOWARDS THE NEW POLICY

This chapter discusses the attitude of rural communities towards the new policy as well as the attitude of officials of rural public health facilities regarding the policy and training of TBAs at the study site.

Attitude of rural communities towards the new policy

Policies are generally made for people to enhance their lives. However, policies cannot be made in isolation; that is to say, the people for whom these policies are made should have a say. It is in that regard that the above objective was explored. The attitude of community members can be categorized into three: economic, quality of care and geographical proximity.

Economic

The economic divisions within societies and lack of social security system make the poor more vulnerable in terms of affordability and choice of health provider. Poverty does not only exclude people from the benefits of health care system but also restricts them from participating in decisions that affect their health, resulting in greater health inequalities (Asenso-Okyere et al. 1998; & Nyamongo, 2002 as quoted in Frimpong, 2013). Also, cost has been a major barrier in seeking appropriate health care in developing countries. Not only the consultation fee or the expenditure incurred on medicines count but also the fare spent to reach the facility and hence the total amount spent for treatment turns out to be cumbersome. Consequently, household economics limit the choice and opportunity of health seeking (Shaikh & Hatcher, 2004).

Though community members are not aware of the policy directive asking TBAs not to conduct delivery, their responses indicated that the impending policy will pose a challenge

to them if implemented. This assertion is also evident in reasons enumerated for patronizing the services of TBAs. This can be seen in the responses captured below:

“Eii! Then it will be difficult for me. I don’t have money neither do I have insurance so it will be very difficult. I don’t work; I may be detained at the hospital because I don’t have money to pay. So I think many women like me in this community will suffer if TBAs stop delivering pregnant women.....” (IDI with a client of TBA services, Oduman).

Another respondent confirmed this finding when she explained the vital role the TBA plays in assisting with the financial difficulties pregnant women face when they have to deliver. This is what the respondent had to say:

“The TBA is very important because if you don’t have money to go to the hospital, she is there to help you. Sometimes, if the women don’t have insurance to cater for their expenses at the hospital, the TBA is there to help” (IDI with a patron TBA of services, Nsakina).

This finding was corroborated by a TBA who further elaborated on the economic reasons why pregnant women patronizes her services.

“In practicing as TBA for all these while, I have identified two reasons why pregnant women come to me: some because of fear, and others because of financial difficulties. They are unaware of what the situation would be like at the hospital but if you come to me and you don’t even have money, I don’t consider your financial situation, because your health and that of the unborn baby is important to me” (IDI with a TBA, Kojo Ashong).

In view of these economic challenges, some respondents strongly advocate for reintroduction of the maternal health exemption policy. In September 2003, the Ministry of Health of Ghana introduced an exemption policy directed at making delivery free. The thrust of this policy was to improve uptake, quality and financial and geographic access to delivery care services. The services covered by the exemption policy are normal deliveries, assisted deliveries including Caesarean section and management of medical and surgical complications arising out of deliveries, including the repair of vesico-vaginal and recto-vaginal fistulae. The policy covered delivery services in public, private and faith-based health facilities (Ofori-Adjei, 2007). Unfortunately, the policy has been absorbed by the National Health Insurance Scheme (NHIS) and with the challenges the scheme is saddled with, parturient are being made to pay some of their medical bills upfront before services are rendered to them. It is within this context that the call is being made for the reintroduction of the free delivery policy. This will encourage more women to utilize the formal health facilities as suggested by a midwife in the response below.

“My opinion is that they should bring back the maternal exemption policy, that will allow and encourage pregnant women because they know when they come to antenatal they will not pay anything and when they deliver too they will not pay anything” (IDI with a Midwife, Akramaman).

This finding is consistent with the results of the study done by Agus and Horiuchi (2012) in Indonesia which revealed that out of 200 women interviewed on preferences for midwives and TBAs, the results showed that two-thirds preferred TBA to midwives and their decisions were affected by traditional beliefs and their lower incomes (Agus and Horiuchi, 2012).

Quality of care

The quality of care has to do with the good human relation between TBAs and pregnant women on one hand and the unfriendly relation between midwives and pregnant women on the other hand. The human relation between TBAs and pregnant women has always been good, cordial and friendly because they may be family relations and live in one community; above all, they have detailed knowledge of community norms. This was explained in the comment captured below:

“Some of them are related to the TBA; maybe their grandmother, their auntie, their in-laws or their children so they feel that if they deliver there, they are more comfortable than going to the hospital” (IDI with a CHN, Domesampaman).

This finding is in tandem with the observation made by Leedam (1985) that, TBAs provide care during pregnancy, childbirth, and the postpartum period and are well established, living in close proximity to the women who require maternity care in the community. They have detailed knowledge of community norms and are paid in kind. These characteristics are increasingly considered as strengths that the formal health sector has sought to leverage (Leedam, 1985).

On the contrary, respondent preferred to deliver with TBA as opposed to the facility because of the attitude of midwives at the hospitals. Pregnant women therefore consider delivering at the hospital very uncomfortable to experience. A respondent had this experience to share;

“When I went to the clinic, I left my health insurance card so the nurse asked of it and I told her I didn’t bring it. So she asked why I left it at home and I told her that I thought there was no need to bring it again since I brought it in my previous visit. Upon hearing this, she started shouting at me and started calling me names and all that, so I told myself I will never go there again” (IDI with a patron of TBA service, Nsakina).

This finding is consistent with studies that argue that, long waiting hours, bureaucracy in hospitals, and impoliteness of nursing personnel are the most pressing problems patients seeking health care in public hospital face (Ejiro, 2015). Also, this finding was given a further credence by the health worker in one of the CHPS compounds. She made this comment in support of the poor attitude of some midwives to pregnant women who are in labour.

“You know, they say ‘efie bia Mensah wom’ (meaning in every social group there is a bad nut). Sometimes the pregnant women think that they cannot go and deliver at the health facility because of the attitude of midwives. The shouting and all those things; they will find a comfortable place like the TBAs’ place who can be very caring in conducting the deliveries for them” (IDI with a CHN, Oduman).

Furthermore, the attitude of community members towards the new policy asking TBAs not to conduct deliveries can also be seen in their responses about the need for privacy. This is captured below.

“The women talk about privacy during delivery. They say at the labour ward, there could be about three women who are due and everybody will be in the room but at the TBAs place, there is privacy and the TBA takes good care of them” (IDI with a CHO, Pokuase)

The public health facilities lack privacy because of the numbers it attends to. Besides, the economic status of people predisposes them to the kind of health care they can access. A person's economic status will determine where she delivers.

Closely related to the above, is the preferred position for delivery. The women argued that, they are not comfortable with the conventional position of lying supine to deliver. However, they have no choice but to do as instructed. At the TBAs place, however, one could chose to deliver in any position of convenience under the guidance and supervision of the TBA. The response of a pregnant woman tells it all;

“.....at the TBAs' place, during labour, whichever position the woman wants to deliver, she is allowed, but when you go to the hospital, they have to put you on a bed to deliver which I don't find comfortable. For me I want to squat.....” (IDI with a patron of TBA services, Mayera)

This finding reveals that birthing position is one of the major factors that influence women's choice of place of delivery. This is because, scientifically, movement and positioning in birthing produce good results. Movement enhances comfort by stimulating the receptors in the brain that decrease pain perception. The result is that parturient are able to tolerate increasingly strong contractions. When contractions become severe, endorphins are released and pain perception decreases even more. Eventually, your movement in response to your contractions reduces pain and facilitates labour. Movement also helps the baby move through the pelvis, and some positions enlarge pelvic diameters. As indicated in the response, women at the study site prefer the squatting position which is allowed at the TBAs place. The advantages of the squatting positions are that, it encourages rapid descent because of gravity. It also increases rotation of baby and gives

the freedom to shift ones weight for comfort (www.fitpregnancy.com accessed on 05/06/15).

These findings are coherent with what Pfeiffer and Mwaipopo (2013) found in Tanzania in their study. They showed that the primary factor influencing women's place of choice for delivery was 'convenience'. In addition, the low rate of fatalities associated with home deliveries gave women a certain degree of confidence that they were safe. The saying, 'but I delivered the first baby safely at home!' reflect the belief that it is safe and therefore culturally acceptable to deliver at home. It was further revealed that many women preferred delivering in a private and confidential environment with the assistance of someone from within their community, someone they trusted and know well. Although they have been advised during MCH visits to avoid doing so, they often preferred using the quick services of a community-based TBA (Pfeiffer and Mwaipopo, 2013).

It is in line with the above discussion that the Path Dependency theory explains how the set of decisions one faces for any given circumstance is limited by the decisions one has made in the past, even though past circumstances may no longer be relevant (David, 1985). The primary duty of the TBA is to conduct deliveries. They have become used to this practice and community members have built trust and confidence in them over the years. Any attempt to dislodge them of this primary activity of delivering babies will be counterproductive. Even though, facility-based delivery is considered the best, a lock-in situation has occurred and hence the likely difficulty in the implementation of the new RCH policy.

Proximity and transportation

Access to healthcare services is critical for rural residents. Rural residents often experience barriers to healthcare that limit their ability to get the care they need. In order for rural residents to have sufficient healthcare access, necessary and appropriate services must be available which can be accessed in a timely manner.

Geographical proximity and transportation challenges are some of the likely predictors of the lack of interest among community member's towards the policy directives that instructs TBAs not to conduct deliveries. Community members prefer to deliver at the TBAs place because the health facilities are not close to them as pointed out in the response below;

“For instance, here in Kojo Ashong we have a community clinic but we don't have a midwife. If you are in labour and you want to deliver at the health facility, you have to travel all the way to Amasaman or Obom. Even if you decide to go, there is no means of transport; pregnant women are carried on motorbikes so why won't I deliver with a TBA” (IDI, patron of TBA services, Kojo Ashong).

In support of this finding, a health worker gave further explanation on the proximity and transportation challenges as captured in the response below.

“.....the facilities are far away from where the women live, so when a woman is in labour and has to get transport to travel to a distance to deliver, it becomes a challenge; and if there is a TBA around, they just go there to deliver” (IDI with a CHO, Akramaman)

Transportation is an important issue when people are dependent on public transport to access health care. This is particularly the case in rural areas. Distance has been shown to limit access to health care (Goddard & Smith, 2001). In a Municipality where about sixty per cent of the road networks are untarred and unmotorable this will definitely have implications for health care access and delivery. What are the options available to pregnant women under such situations? How close are the health facilities to the people? These are the issues which have predisposed community members to TBA services. This situation has created a dependency syndrome. It is in this regard that the path dependency theory explains both the behaviour of the TBAs and their clients as a lock-in situation. The community members have become used to the services of the TBAs and the TBAs have also become entrenched in their services they render to the community people. Any attempt to dislodge the social structure of the community without recourse to the norms and values of the people will be counter-productive.

The results of the study in Tanzania by Pfeiffer and Mwaipopo (2013) is in harmony with the findings above that proximity and transportation were major setbacks for pregnant women's utilisation of the health facility as compared to TBA services. The revelation was that the primary factor influencing women's place of choice for delivery was 'convenience'. The location of and distance to a single health facility supporting a catchment area as well as the poor transport system were push factors towards TBAs and home deliveries (Pfeiffer and Mwaipopo, 2013).

Attitude of Management of Rural Public Health Facilities Regarding the Policy and Training of TBAs in the GAWM

Health workers in rural health facilities support the training of TBAs to be able to conduct deliveries in rural communities. According to the health workers, trained TBAs

complement the health system in its efforts to reduce maternal mortality. The Health workers perceive TBAs as assets to the community because of the inadequate number of health workers and health facilities. Even where there are health facilities, there are no midwives to conduct deliveries. The training of TBAs in the Ga-West municipality is motivated by shortage of health staff and scattered health facilities within the Municipality. This finding is illustrated in the response below.

“Sometimes geographical location is also a setback for pregnant women. They cannot access care, and our clinics are not in every community so they will definitely find their ways into the TBAs place” (IDI with DDN, Amasaman).

They (health workers) also support the training of the TBAs because some community members would always prefer to be delivered by a TBA because of socio-cultural reasons. As the District Director of Nursing pointed out;

“Whether you like it or not, some pregnant women will not want to come to us because they have traditional values. My mother told me that, no woman in our family has ever been to the hospital to deliver; when you are pregnant this woman (TBA) takes care of you. So they have these perception and beliefs and trust in these women (TBA) that are difficult to disabuse” (IDI, DDN, Amasaman).

The above discussions are not different from what other studies have found. In a study conducted in Indonesia, out of 200 married women who were interviewed on preferences about midwives and TBAs, the results showed that two-thirds preferred TBAs to midwives and their decisions were affected by traditional beliefs and their lower incomes (Agus & Horiuchi, 2012).

The path dependency theory can be used to explain the above discussions. The theory stipulates that both traditional and environmental conditions (paths) serve as reinforcements for lock-in situations. Where geography inhibits access to health care it reinforces the path and creates lock-in situation thereby making change difficult. Also, long held beliefs as captured above in the response make change (implementation of the RCH policy) a herculean task.

Respondents however suggested that the TBAs should be properly trained so that they will be able handle to deliveries and refer complications. This comes in the wake of the fact that some community members cannot be separated from the services of TBAs. This finding can be seen in the response of this CHO,

“We don’t conduct deliveries because there are no midwives here. So if that is the case, then the TBAs should be trained well to conduct deliveries and handle complications” (IDI with a CHO, Akramaman)

Speaking to the issue related to staffing of health personnel within the Municipality, the DDN lamented on the staff strength and called for a scale up to help address maternal related issues. The response below captures the frustration of the DDN;

“You see, we don’t have enough health personnel with midwifery competences manning all the health facilities in the Municipality. The CHPS compounds are supposed to be manned by midwives but unfortunately, that is not the case. Regrettably, it is only Community Health Nurses you will find at the CHPS Zones. This is a very worrying situation but what can we do? It is for these reasons that it has become imperative to collaborate with the Anglican Dioceses of Accra and Westminster University of England to train TBAs” (IDI with DDN, Amasaman)

However, when the Director of RCH was asked about how the Ministry of Health is dealing with the shortage of health personnel vis-à-vis the policy directive, this was his response;

“Between 2003 and 2004, we were doing about 100 admissions into the midwifery schools. As at 2010, the number has gone up to 1200. We are churning out about an average of 700 midwives yearly. So we have scaled up the production of midwives in the country so that every health facility will have a midwife” (IDI with Director of RCH, Accra).

The question which quickly comes to mind is where do these midwives serve? How many are posted to the rural communities? How many of the midwives accept postings to the rural communities? What sort of motivation packages exist for those who accept posting to the rural communities? How many of them stay in the country after their training? From the foregoing, it is clear that the decision to ask TBAs to stop delivering lacked the grass-root involvement of key actors in the reproductive health discourse. The mere churning out of health workers does not translate into improving pregnancy outcomes. How functional are the CHPS compounds? How resourceful are these CHPS compounds in terms of equipment and human resource? These are the issues confronting health care delivery in the country and rural communities in particular. The above discourse is in harmony with the study by Sibley, Sipe, & Barry (2012) which indicated that, in settings where there are an insufficient number of skilled birth attendants or limited access to health facilities and women prefer TBAs, TBA training may be the only means to optimise the use of community-level health workers for maternal and new born health. Where skilled birth attendants and health facilities exist and are accessible, and women prefer TBAs, TBA training coupled with strategies to effectively engage them with the health system may be considered (Sibley, Sipe, & Barry, 2012).

CONCLUSION

From the field data and the analysis and discussions above, it has become obvious that the policy by the Ministry of Health on TBAs not to deliver has a likely tendency to suffer a setback in its implementation. This assumption is premised on the fact that, the grass root consultations of other stake holders (TBAs, Community members and community health workers) were not taken into account. Again, in as much as issues of access, proximity, economic and socio cultural factors which were the pull factors for the utilisation of TBA services linger, community members will continue to patronise the services of TBAs. Clearly, universal skilled attendance at delivery is a worthy objective. However, in many communities, where professional birth attendants are simply not available to rural populations or the urban poor, this ideal remains a distant goal. Worldwide, about one third of all births take place without the assistance of skilled health personnel. In 2014 alone, this translated into more than 40 million unattended births in low and middle income countries and about 90 per cent were in South Asia and sub-Saharan Africa www.data.unicef.org/maternal-health/delivery-care accessed on 20/05/15. Of these, midwives, or other professionals, conduct only a small proportion. The majority, around 60 million deliveries per annum, are currently attended by a traditional birth attendant, a relative, or, in some settings, no one. Achieving skilled attendance at delivery for all is going to be a huge challenge. It has been calculated that, with an assumed load of 150 deliveries annually per midwife, plus associated prenatal and postnatal care, around 400,000 midwives will have to be trained (WHO, 2006). These estimates can be expected to increase as rising numbers of young women enter the reproductive age group. Significant costs, which include salaries, housing and rural posting allowances, are inevitable. In addition to these direct costs there may be additional costs related to supervision and support. It is against this background that training of traditional birth

attendants should be promoted on the basis that they are available, are already engaged in maternity care and appear to present a lower cost alternative. The researcher could not agree more with Sibley, Sipe, & Barry (2012) that, in settings where there are an insufficient number of skilled birth attendants or limited access to health facilities and women prefer TBAs, TBA training may be the only means to optimise the use of community-level health workers for maternal and new born health. Again, where skilled birth attendants and health facilities exist and are even accessible, and women prefer TBAs, TBA training coupled with strategies to effectively engage them with the health system must be considered.

CHAPTER EIGHT

FINDINGS AND RECOMMENDATIONS

Introduction

Maternal mortality assumed global attention in 1985 when Rosenfield and Maine (1985) alerted the world of the fact that many developing countries were neglecting this important problem and that existing programmes were unlikely to reduce the high maternal mortality rates. According to WHO report (2006), one of the key reasons for the high rate of maternal mortality is health worker shortage particularly in the remote areas of developing countries. The situation according to the WHO will get worse if nothing is done to scale-up the production of health workers. The quest to address the shortage of health workers and the high incidence of maternal, infant and child mortality and morbidity by the governments in developing countries led to the training and integration of traditional birth attendants (TBAs) in to the reproductive health care delivery system.

In Ghana, the first practical step toward the use of TBAs by the health system was on the Danfa project in 1970s. As part of extending PHC to rural communities as a result of the 1978 Alma-Ata Declaration the training of TBAs assumed a national character. These earlier TBA training programme was to improve perinatal care. By 1997, the WHO and many safe motherhood advocates turned their attention from the training of TBAs to skilled birth attendants for all and calling for new roles for TBAs rather than conducting deliveries. In 2010, the Ministry of Health in conjunction with the WHO released a joint communiqué to as it were ban TBAs from conducting deliveries in communities that have health facilities. It was to explore the feasibility of the implementation of this policy that this research was carried out based on the following specific objectives;

1. To gain insight into some of the factors that has informed the new Ministry of Health policy on TBAs

2. To explore the knowledge of TBAs on the Policy directive
3. To examine the attitude of rural communities (clients of TBA services) towards this new policy
4. To find out the attitude of Management of rural public health facilities regarding the policy and training of TBAs in the GAWM

Key findings

Results from this study show that the national policy directive bars TBAs from conducting deliveries because TBAs who conduct delivery in the various communities delay in referring cases that are beyond them to the appropriate health facilities. To this end, it was revealed that, TBAs delay women so that they can receive the money and other benefits that come with the delivery. This is to a greater extent unethical because as it were, they are supposed to conduct delivery without monetary compensation. TBAs are therefore seen as a commercialized group who take some fixed amount of money for conducting deliveries. This is one of the reasons informing the policy to stop them from conducting deliveries. However, it is instructive to note that, women who are not able to pay, are not detained and forced to pay the money contrary to what pertains at the health facility.

It was also found that, the inability of TBAs to handle complications were another factor which informed the policy directive asking TBAs to stop conducting delivering. It was noted that, TBAs could not be blamed entirely because, apart from sociocultural factors, some of the women delay at home before arriving at the TBAs place. In this regards, the TBAs are seen to be providing stop gap services to averse any unfortunate incidence.

Furthermore, it was found that, TBAs are being stopped from delivering because there is no clear evidence that their activities have reduced maternal mortality as envisaged.

TBAs in the study area are generally uninformed of any policy directive which prevents them from conducting deliveries in their various communities. Quite interestingly, it was also revealed that health administrators and workers at the district level were also oblivious of this policy directive and are indeed supportive of the continuous training of TBAs.

Though community members are not aware of the policy directive asking TBAs not to conduct delivery, their responses indicate that the impending policy will pose a challenge to them if implemented. The challenge mainly hinges on economic reasons. Respondents explained that they lack the financial ability to attend health facility for delivery. In view of this, respondents called for the reintroduction of the free maternal policy to encourage more women to utilize the formal health facilities.

Furthermore, clients of TBA services emphasized that, they still prefer to deliver at the TBAs place because of their good human relation. It was found that, there is a good, cordial, and friendly relationship between TBAs and their clients because they may be family relations and above all they live together in one community. This is suggestive that, the community as well as clients of TBAs are not likely to welcome the new policy if it is implemented.

It was also established that, geographical proximity and transportation challenges are some of the likely predictors of the lack of interest among community member's towards the

policy directives that instructs TBAs not to conduct deliveries. This is because not all communities have health facilities and where there is one, it is not equipped enough to handle delivery cases. Women in labour will therefore have to travel some relatively long distance to attend health facilities. In circumstances like this, women resort to TBAs particularly during emergency.

It was established that, health workers recognize TBAs as complementary staff in support of the health system in its efforts to reduce maternal mortality. In view of this, health workers perceive TBAs as an asset to the communities because, there are inadequate number of health workers and health facilities. To this end, health workers suggested that TBAs should be properly trained so that they will be able to handle deliveries and refer complications timely, instead of asking them not to deliver at all. This comes in the wake of the fact that some community members cannot be separated from the services of TBAs. It was observed that the Municipal Health Directorate organises a public forum for pregnant women and their spouses fortnightly called the 'pregnancy school'. This concept holds that pregnancy is no longer the business of women and a well-informed spouse is a game changer throughout the gestation period. It has therefore become imperative for all concerned to be brought on board to help address issues of pregnancy.

Recommendations

- Policy formulation and implementation should involve all known stake holders. For example, the policy by the MoH that TBAs should not conduct deliveries in communities which have health facilities should have involved all parties concerned. When this is done, it will engender community participation. The policy will not be seen as top-down approach to policy formulation and implementation which has characterised most policies.

- Also, in policy formulation process, community assessment studies must be carried out to by the Health Ministry to find out the impact of TBA training on maternal outcomes. By so doing, policy formulators will be better informed about the realities of the contribution of trained TBAs to the maternal health discourse.
- Furthermore, the activities of TBAs are couched in the socio-cultural milieu of the community. Any policy directive to dislodge them from their practices without recourse to this basic fact is likely to face implementation challenges. In view of this, TBAs must be properly trained by the Ministry of Health and incorporated into the formal health system so that they can continuously fill in the gap, till such a time that every community has access to functional and resourceful health facility. To this end, TBAs should be frequently supervised to ensure that their activities conform to best practices.
- Fourthly, to ensure drastic reduction of the patronage of TBA services by community members, the health system should be equipped and be user friendly. Health workers should treat patients with decorum and respect. By so doing, community members will be re-oriented to begin to patronise facility-based deliveries. Birthing positions at the health facilities should be amenable to the needs of parturient by the Ministry of Health. The Ministry of Health must ensure that maternity wards are equipped to create the needed privacy for parturient.
- Lastly, the concept of ‘pregnancy school’ should be intensified by the Municipal Health Directorate. The school should be organised in all the communities by the Municipal Health Directorate to create the needed awareness towards facility-based delivery. This can be done by the health promotions unit of the Municipal Directorate.

Agenda for future research

Future research should focus on other Municipalities in the Greater Accra Region where there are health facilities yet the activities of TBAs are predominating. Again, future research should employ a mixed method approach to compliment the weakness of the qualitative approach.

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APPENDICES

Appendix 1: Interview guide for key informant

UNIVERSITY OF GHANA

INTERVIEW GUIDE FOR KEY INFORMANT

(DIRECTOR OF REPRODUCTIVE HEALTH, MoH)

TOPIC: TO PRACTICE OR NOT PRACTICE: PERSPECTIVES OF TRADITIONAL BIRTH ATTENDANTS ON THE NEW REPRODUCTIVE AND CHILD HEALTH POLICY.

I am an M.Phil. student from the Department of Sociology, University of Ghana conducting a research on the above topic. I will like to assure you that all the information I will collect from you through this interview will be treated with strict confidentiality and for academic purposes only. Kindly respond as truthfully as possible. Thank you for your cooperation.

1. What did the old policy say about TBAs and their practices?
2. What is the new policy saying on TBAs and their practices?
3. How different are the two policies?
4. What necessitated the modifications?
5. Is the policy monitored?
6. How is the policy monitored?
7. What are the results of the monitoring?

8. Kindly explain the concepts 'skills' and 'tools' as captured in the new policy.
9. How does the ministry equip TBAs with skills?
10. How does the ministry equip TBAs with tools?
11. Does the ministry monitor and supervise the practices of TBAs?
12. What is the operational definition of 'supportive care' as captured by the new policy?
13. How are TBAs supported in communities where pregnant women do not have access to skilled delivery care?
14. How are TBAs trained in communities where pregnant women do not have access to skilled delivery care?
15. How is the training monitored and supervised?
16. What are the results of the monitoring and supervision?
17. What is the take of the RCH on calls by NGOs (THE HUNGER PROJECT-GHANA) to reconsider the policy on TBAs?
18. What is the response of the Dept. on the view that the policy is a TOP- DOWN approach to policy change as opposed to the BOTTOM-UP approach?
19. How likely is Ghana to achieve the MDGs 4&5?
20. Any comments.....

Appendix 2: Interview guide Deputy Director of Nursing

UNIVERSITY OF GHANA

INTERVIEW GUIDE FOR KEY INFORMANT

(DEPUTY DIRECTOR OF NURSING)

MUNICIPAL LEVEL

TOPIC: TO PRACTICE OR NOT PRACTICE: PERSPECTIVES OF TRADITIONAL BIRTH ATTENDANTS ON THE NEW REPRODUCTIVE AND CHILD HEALTH POLICY.

I am an M.Phil. student from the Department of Sociology, University of Ghana conducting a research on the above topic. I will like to assure you that all the information I will collect from you through this interview will be treated with strict confidentiality and for academic purposes only. Kindly respond as truthfully as possible. Thank you for your cooperation.

1. How is the state of health care delivery in the Municipality?
2. What are the common health problems facing the inhabitants in the Municipality?
3. What is the state of maternal health delivery in the Municipality?
4. What role do TBAs play in the delivery of maternal health in the Municipality?
5. What is your opinion on the new Reproductive Health (RH) policy on the practices of TBAs?
6. What role do TBAs play under the new policy?
7. Are there any training schedules for TBAs in the Municipality?

8. What is the content of the training schedule?
9. How often are the training schedules organised?
10. Why does the Municipality continuously organise training for TBAs?
11. Who are the main sponsors of the training schedules?
12. Are there any tools TBAs are equipped with in the carriage of their duties? (If yes, probe further for the kind of tools)
13. Are there mechanisms in place for the monitoring and supervision of the practices of TBAs in this Municipality? (Probe further for type of mechanisms)
14. What are your final comments?

Appendix 3: Interview guide for clients of TBA services

UNIVERSITY OF GHANA

INTERVIEW GUIDE FOR CLIENTS OF TBA SERVICES

TOPIC: TO PRACTICE OR NOT PRACTICE: PERSPECTIVES OF TRADITIONAL BIRTH ATTENDANTS ON THE NEW REPRODUCTIVE AND CHILD HEALTH POLICY.

I am an M.Phil. student from the Department of Sociology, University of Ghana conducting a research on the above topic. I would like to assure you that all the information I will collect from you through this interview will be treated with strict confidentiality and for academic purposes only. Kindly respond as truthfully as possible. Thank you for your cooperation.

PART ONE

SOCIAL-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS.

AGE

OCCUPATION

RELIGION

LEVEL OF EDUCATION

NO. OF CHILDREN DELIVERED BY TBA

LENGTH OF STAY IN THE COMMUNITY

PART TWO

ATTITUDE OF RURAL FOLKS TOWARDS THE NEW POLICY

1. What are the commonly known health problems of the inhabitants of this community?
2. What are the commonly known health challenges confronting women in this community?
3. Where do the inhabitants seek solution to their health care needs in this community?
4. How do women prepare for pregnancy in this community? (Probe for nutrition, health care practices both traditional and biomedical)
5. Where do women seek advice concerning pregnancy in this community? (Probe for traditional, religious, and biomedical sources)
6. Are there any prohibitions (dietary and religious) to be observed by women during pregnancy, delivery, and post- delivery periods in this community? (If any probe for the type of prohibitions)
7. Where do pregnant women deliver in this community?
8. Why do pregnant women deliver at the places they deliver?
9. What role do TBAs play in the delivery of maternal health in this community? (Probe for their role during pregnancy, delivery, and post-delivery periods)
10. The MOH has banned TBAs from conducting deliveries in communities that have health facilities. What is your reaction to this policy?
11. How is the policy going to affect women who patronise TBA services?
12. Do you pay for the services you enjoy from the TBAs? (Probe for the mode of payment)
13. What are your final comments.....

Appendix 4: Interview guide for TBAsUNIVERSITY OF GHANA
INTERVIEW GUIDE FOR TBAs

TOPIC: TO PRACTICE OR NOT TO PRACTICE: PERSPECTIVES OF TRADITIONAL BIRTH ATTENDANTS ON THE NEW REPRODUCTIVE AND CHILD HEALTH POLICY

I am an M.Phil. student from the Department of Sociology, University of Ghana conducting a research on the above topic. I would like to assure you that all the information I will collect from you through this interview will be treated with strict confidentiality and for academic purposes only. Kindly respond as truthfully as possible. Thank you for your cooperation.

PART ONE

SOCIAL DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS.

AGE

SEX

OTHER OCCUPATION

RELIGION

LEVEL OF EDUCATION

NO. OF CHILDREN

LENGTH OF STAY IN THE COMMUNITY

PART TWO

KNOWLEDGE, BELIEFS, AND PRACTICES OF TBAs ON THE NEW POLICY

1. How did you become a TBA?
2. How long have you been practicing as a TBA?
3. What do you do as a TBA? (Probe: during pregnancy, delivery, and post-delivery practices)
4. On the average how many deliveries do you conduct monthly?
5. Do you add herbs or spirituality to your practices? (Probe further for how and why)
6. Are there any dietary or religious prohibitions women are to observe during pregnancy, childbirth, and post-delivery periods? (Probe for the kind of prohibitions)
7. Why those prohibitions if any?
8. Is there any relationship between the health center and your practices? (Probe for the kind of relationship)
9. How often do you get trained by the MOH staff? (Probe for regularity)
10. What is the content of the training?
11. What kind of tools do you get from the MOH to support your work?
12. Are your activities monitored and supervised by the MOH?
13. How often do you refer pregnant women to the health facility? (Probe for when? how? and why?)
14. Do you take any payment for the services you render to pregnant women? (Probe further: kind of payment)
15. The MOH has banned TBAs from conducting deliveries in communities that have health facilities. Are you aware of this ban?

16. What is your reaction to the ban?
17. How do you think the ban is going to affect maternal health delivery in this municipality?
18. How is the ban going to affect your practices?
19. What are your final comments?

Appendix 5: Interview guide for CHOs

UNIVERSITY OF GHANA

INTERVIEW GUIDE CHOs

COMMUNITY LEVEL

TOPIC: TO PRACTICE OR NOT TO PRACTICE: PERSPECTIVES OF TRADITIONAL BIRTH ATTENDANTS ON THE NEW REPRODUCTIVE AND CHILD HEALTH POLICY

I am an M.Phil. student from the Department of Sociology, University of Ghana conducting a research on the above topic. I will like to assure you that all the information I will collect from you through this interview will be treated with strict confidentiality and for academic purposes only. Kindly respond as truthfully as possible. Thank you for your cooperation.

1. How is health care delivery in this community?
2. What are the common health problems facing the inhabitants of this community?
3. What is the state of maternal health delivery in this community?
4. What role do TBAs play in the delivery of maternal health in this community?
5. What relationship exists between the TBAs and the health facility?
6. Are there any mechanisms in place to monitor and supervise the activities of TBAs in this community? (If yes, probe for the kind of mechanisms and level of supervision)
7. Are you aware of the policy directive from the MOH on the practices of TBAs?(Probe further for level of knowledge on the new policy)
8. Where do pregnant women deliver in this community?
9. Why do pregnant women deliver where they do?
10. Your final comments