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THE ROLE OF TRADITIONAL BIRTH ATTENDANTS IN PROMOTING MATERNAL AND CHILD HEALTH DELIVERY IN THE CENTRAL GONJA AND YENDI DISTRICTS.

BY
ZIBLIM SHAMSU-DEEN

THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF M.PHIL DEGREE IN GEOGRAPHY AND RESOURCE DEVELOPMENT.

JUNE, 2008

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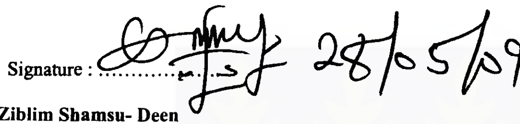
DECLARATION

I hereby declare that with the exception of references to work of others which have been duly acknowledged, this work is the result of my own research and that it has neither in part nor in whole been presented elsewhere for other degree.



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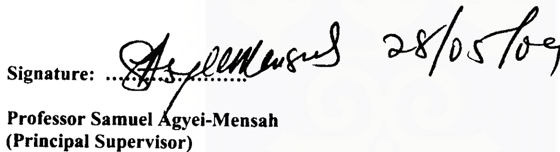
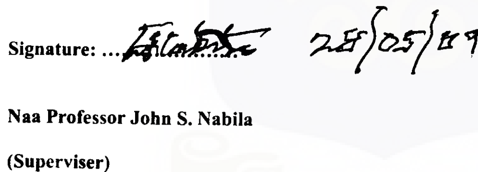


Signature: 28/05/09

Professor Samuel Agyei-Mensah
(Principal Supervisor)



Signature: 28/05/09

Naa Professor John S. Nabila

(Superviser)

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DEDICATION

I dedicate this work to my late mother, Awabu Abdullai.

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ABSTRACT

Maternal and Child Health Care (MCH) has been a challenge to government, Non-Governmental Organisations (NGOs,) service providers and beneficiaries in all developing countries. In fact, it is an area on which a lot of government resources are expended to with the ultimate goal of reducing maternal and child mortality. Majority of the people in developing countries live in rural communities, most of whom do not readily access proper health care. It was in the light of this that the study was designed to find out the contribution of Traditional Birth Attendants (TBAs) in promoting Maternal and Child Health most especially in rural settings aimed at contributing to the overall reduction of mortality among and their under five children.

Methodologically, the study was designed to collect information from service providers (TBAs) and beneficiaries (mothers). To effectively generate the data structured interviews and focus group discussion were employed.

The study revealed that TBAs played a very important role in MCH by assisting pregnant women to deliver and helping in the bathing of newly born babies as well as helping in the referring of cases in times of complications.

The study also showed that the TBAs were not motivated enough by community members and the government; as a result they demend the requisite training to broaden their knowledge and skills on better ways of facilitating safe and clean delivery.

It is recommended that the TBAs should be seen as important partners in the MCH and that efforts should be made by government and the District Health Management Team (DHMTs) to reach out to them and build their capacity to enable them deliver quality services in their

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communities and beyound. The TBAs can not perform effectively without the tools and logistics they require to work with. Government, the District Assembles, the Ministry of Health and NGOs should provive TBAs with the needed tools and facilities to work with, and training to make them more efficient.

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LIST OF ABREVIATIONS

CCFC	-	Christian Children Fund of Canada
CHIPS	-	Community Health Planning Service
CHW	-	Community Health Worker
DHMT	-	District Health Management Team
EHW	-	Environmental Health Workers
FGD	-	Focus Group Discussion
FMCP	-	Free maternal and Child Package
FPC	-	Family Planning Counseling
GDHS	-	Ghana Demographic and Health Survey
GHS	-	Ghana Health Service
GSS	-	Ghana Statistical Service
IMR	-	Infant Mortality Rate
JHS	-	Junior High School
LEF	-	Livelihood Empowerment Fund
MMR	-	Maternal Mortality
MCH	-	Maternal and Child Health
MDGs	-	Millennium Development Goals
MoH	-	Ministry of Health
MPS	-	Making Pregnancy Safer
MNH	-	Maternal and Neonatal Health
NHIS	-	National Health Insurance Scheme
NGOs	-	Non Governmental Organisation
NTBAP	-	National Traditional Birth Attendants Programme
NYES	-	National Youth Employment Scheme
PHC	-	Primary Health Care
RHE	-	Reproductive Health Education
SHS	-	Senior High School

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SMI	-	Safe Motherhood Initiative
TBAs	-	Traditional Birth Attendants
THC	-	Town Health Committee
UNICEF	-	United Nations International Children Emergency Fund
UNFPA	-	United Nation
UNESCO	-	United Nation Education Scientific and Cultural Organisation
USAID	-	United States Agency for International Development
WHO	-	World Health Organisation

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CHAPTER ONE

1.1 INTRODUCTION

Since the dawn of history, mankind has been actively experimenting with a variety of available means to safeguard its health and promote the quality of life. In most developing countries like Ghana, the two forms of health care that dominate the health care system are the modern/orthodox and the traditional. Due to the popularity of the first form, one may be tempted to conclude that the orthodox health care enjoys a higher patronage and supremacy over its traditional counterpart in most developing countries including Ghana. However, the fact remains that efforts to cope with the existing and enormous health problems in developing countries still lacks the necessary facilities required to cope with them.

In Ghana with an estimated population of about twenty – two million (22,000,000) the number of health professionals responsible for delivering orthodox health care is largely inadequate. Over 60% of the population in Ghana lives in rural areas yet over 90% of the Ghanaian orthodox medical and paramedical personnel are concentrated in the urban areas that have the large majority of modern health facility to the detriment of the teeming rural dwellers, (Ghana Stastistical Service,et.al,2004). Many rural Ghanaians, therefore, have not been exposed to the benefits of modern health care system. As a result traditional health care system is the principal system used in most rural communities in Ghana especially in the northern part of the country where there is a high illiteracy compounded with high poverty.

Globally, the health of women in the reproductive age group has engaged the attention of all governments especially in the developing countries where maternal mortality ranges from 200 to 800 deaths per 100.000 live births. Though women in the reproductive age group form about 22%

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of the population in most developing countries, they carry the burden of pregnancy, childbirth and child care and therefore form a special vulnerable group.(WHO,UNICEF,2005)

The problem of women in the reproductive group can be summarized by the level of Maternal Mortality rate (MMR), which covers deaths during pregnancy, child birth, and up to 42 days after delivery. In Ghana, the ratio is 540/ 100,000 live birth and is very high. (Ghana Statistical Service,et.al. 2004).The ratio differs across the regions and by localities.The Region in the northern part of the country where this study was undertaken place have high ratios and also women in the rural areas have higher ratios. There is a high correlation between the level of development of the region or the locality and the maternal mortality rate. Women in the northern part of the country or in rural areas have poor access to heath care in all descriptions of access, that is geographical, financial and cultural and women in these areas are relatively poorly educated and have poor nutritional status.

The high maternal mortality rate is unfortunate because majority of the factors associated with the deaths are preventable. It has a follow-up cost to the society and the health of the baby, should the baby survive.

It is clear from the above that new philosophies and appropriate approaches for conceiving the promotion of health care as an integral part of the overall national health and development are relevant. There is therefore the need to assess the nature and extent of the complementary and collaborative roles of Traditional Birth Attendants (TBAs) towards the promotion of maternal and child health care in two districts in the Northern Region of Ghana.

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in the late 40s.The study underlined the lack of adequate health services in the villages. This has cumulated the idea initiated by the then director general of WHO Dr Mahher in 1975 which was expressed later in the slogan 'Health for all by the year 2000'.

In Africa, Community Health Worker (CHW) includes village herbalists, bone setters and Traditional Birth Attendants (who existed before modern health care) .Most of these people are bearers of much traditional wisdom about people, custom, herbs and so on (Morley and Wallis, 1978).Their credibility to health care makes them serve as the base of the pyramid of referral, extending through a local health centre to district hospital and referral downward from the hospital to the Community Health Worker (CHW).

The role of the Traditional Birth Attendants (TBAs) is seen in the light of the above strategy and more importantly due to the specialized health care whose inability to contribute meaningfully to effective child delivery is the result of the horrible picture of maternal mortality and morbidity in the sub region.

Among the development challenges that the international community hopes to tackle in the next decade, reducing the health and suffering associated with pregnancy and childbirth in the world's poorest communities remains one of the most daunting. For instance, the World Health Organization (WHO) points out that, half of one million mothers die in childbirth every year and almost 10.6 million children under the age of five die from a handful of preventable and treatable conditions (.WHO 2002)

According to Martey et, al (1998) the health system in the Northern Region of Ghana as it operates in the rest of Ghana is made up of three sub-systems, namely, public, private and traditional. The public sub-system is made up of essentially what is referred to as orthodox medical services

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provided in government health facilities while the private sub-system refers to the orthodox medical services provided in private (including missionary hospitals, clinics, maternity homes, chemists shops, traditional medicine which refers to medical services provided by herbalists, traditional healers, traditional birth attendants, bone-setters, spiritual healers and many others. For example, in Northern region of Ghana, the public sectors provide 60% of health care followed by the traditional sector which provides 30% and the rest by the private sector (Martey et.al, 1998). By implication, a significant proportion of medical service is provided by the traditional sector including Traditional Birth Attendants (TBAs)

The knowledge and practice of traditional birth attendants need to be addressed by policy makers, researchers and planners. There is the need to make positive effort through research based on a firm understanding of what TBAs can and cannot do (WHO/UNFPA/ UNICEF, 2003). .

Of all health statistics mentioned, maternal mortality is the one showing the largest differences between developed and developing countries. Current estimates of maternal mortality ratios vary from more than 1000 per 100,000 live births in some African countries, to around 500 in many countries in Asia, 200-400 in several countries in South America and the less than 10 per 100,000 live births in some European countries. Though, there are great variations within the different regions

Traditional birth attendants existed long before the introduction of modern medicine. They are mostly old women and in some case few men and are found in most rural areas in Ghana and almost in the entire developing world. In northern Ghana, for instance, where this study has taking place almost every household in the rural area has a birth attendant.

The Traditional Birth Attendants (traditional midwives) focus their attention on pregnancy problems and they assist pregnant women at deliveries. They have a special role to play at child

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birth. In child birth, they are the midwives on who rest the responsibility for delivering the child and for seeing to the health of the mother. They are commonly known as specialists in child delivery in rural areas where health professional are lacking and health facilities are non existent. The range of their activities extends into the field of sex education, family planning and counseling.

Patients who seek the services of traditional birth attendants are usually members of the same community. Thus, traditional birth attendants tend to have an intimate knowledge of their clients. Most traditional birth attendants are usually middle-aged and elderly women. Most of them are illiterate or have very little formal education. To them midwifery practice is a part-time occupation. It is a female occupation. It is estimated that about 80% of deliveries which take place in the country and elsewhere in African countries south of the Sahara are performed by traditional birth attendants.(P A Twumasi 2005) They are everywhere in all Ghanaian communities. We do not have a shortage of TBAs in these areas.

The relationship between the traditional birth attendants and their clients is a supportive one. It takes place in an informal setting. This is due to the fact that they are also members of the same community as their clients. Thus during deliveries they deal with patients they intimately know.

Women who become traditional birth attendants learn their skills from relatives. They learn through observation and apprenticeship. The trainee learns in an informal atmosphere while performing other household duties. She acquires her skills by watching a trainer in action. Over a time period, sometimes of 5 years or more, she picks up the skills and knowledge of practice. She is trained in the preparation and administration of herbs needed for assisting deliveries.

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In Ghana, there are ongoing training programmes to "upgrade" the services of traditional birth attendants. In Ghana over 1600 traditional birth attendants, have been trained through refresher courses. (pp. 25, Medical systems in Ghana).

1.2 Statement of the Research Problem

Globally the health of women in the reproductive age group has engaged the attention of all governments especially in the developing countries where maternal mortality ratios range from 200 to 800 deaths per 100,000 live births. Women in the reproductive age group form about 22% of the population in most developing countries, they carry the burden of pregnancy; child birth and child care and therefore form a special vulnerable group.

As stated earlier, women in the northern part of Ghana, especially those in the hinterland have poor access to health care in all the descriptions of access, that is geographical financial and cultural. Women in these areas are also relatively poorly educated and have poor nutritional status for most of them can not access the modern health care as a result of proximity and poverty, the only source of maternity care to the rural woman is the TBAs who are always available and provide cheaper services, women in the rural part of Ghana therefore depend on the service of these TBAs.

Governments all over have put in measures to address the problem of maternal deaths through the enactment and implementation of policies, legislations and services. These include the recent introduction of the Free Maternal Health Care Package (FMHCP) in July, 2008, for pregnant women to have free medical care by the government of Ghana from pregnancy to one year after delivery. The health of the baby is also cared for. This in a way will help achieve the Millennium Development Goals (MDGs) three and four (3 and 4). This policy will help women who cannot afford the service of the modern health care as a result of poverty and even those who can not pay

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the premium to benefit from the current National Health Insurance Scheme (NHIS) to access modern health care.

The training of TBAs in rural Ghana where most pregnant women can not have access to modern health care as a result distance from the facility is another policy that was put in place to upgrade the skills of these TBAs.

In 1987, the World Health Organisation (WHO) and other United Nation agencies like UNICEF launched the safe motherhood initiative which was accepted in Ghana. Since then, several safe motherhood programmes have been and continue to be implemented in Ghana.

Maternal Mortality in the northern part of Ghana is said to be very high. It is estimated that the maternal mortality ratio in the Northern Region of Ghana is 640 deaths per 100,000 live births. (Biritwum, 2006). This is as a result of high illiteracy, inadequate health facilities and health personnel in the area.

The Millennium Development Goal four is to reduce maternal mortality by three-quarters by 2015 and it is necessary to assess the progress towards the achievement of the goal. The question that comes to mind is can this goal be achieved? in the mist of inadequate health facilities and professionals in the Northern part of Ghana? where traditional birth attendants are the major providers of antenatal care in rural Ghana.

It is estimated that, in Africa, 1 out of every 22 women die out of pregnancy related complications as against 1 out of 2,132 in Europe. And, for every woman who dies, between 50 and 100 other women suffer from illness or disabilities caused by childbearing (Arkutu 1995).

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According to Dr Elias Sorry, the then Northern Regional Director of Heath Service (GHS) announced that, during the last quarter of 2006, 258 pregnancies related deaths were recorded in the region of which the Yendi district alone recorded 79 of the total maternal deaths (Sory, 2005).

Roughly 500,000 women die every year of risks associated with pregnancy and childbirth, with some 95 percent of the deaths in the year 2000 occurring in Asia (253,000) and sub-Saharan Africa (251,000), four percent in Latin America and the Caribbean, with less than 1 percent in more developed countries.(WHO,2003)

It is estimated that each year approximately, 4.3 million newborn infants die during the first month of life, and an additional 4 million are stillborn.Many of these deaths are due to complications their mothers experienced during pregnancy or child birth. A million or more children are left motherless each year by the more than 500,000 women who die from pregnancy related causes and these children are likely to get less health care and education as they grow up. Daughters who survive are less likely than sons to receive quality health care and adequate nourishments in addition, girls are frequently forced to leave school to help at home, thereby restricting their own future (Save the Children 2001).Maternal death doubles or even triples the risks that children under age five will also die. A child whose mother dies in childbirth is 3 to 10 times more likely to die before his or her second birth day. (Safe the children, 2001)

Even though, Asia and Africa have almost equal number of these deaths, the risks are highest by far in Africa, which has a much smaller population than Asia. African countries struggle to provide health services for large, dispersed, mainly rural populations, and the average number of children per woman on the continent is close to six. An African woman has a 1 in 16 chance of dying in pregnancy or childbirth over her lifetime, compared with 1 in 94 in Asia. In Europe, where the

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average number of children per woman is less than two and medical care is readily available, only one in every 2,400 pregnant women dies of maternity-related causes.

This frightening picture calls for a serious protection for women during pregnancy, childbearing and post Partum period, but this effort is often marred by the inadequacy of doctors and other health personnel especially in the rural areas of the country due to factors such as low level of development and absence of service infrastructure compounded by the exodus of health personnel from developing countries. It is estimated that, Ghana lost in the year 2002 eighty-six (86) doctors, seventy-seven (77) pharmacist and two hundred and fifteen (215) nurses.

Prenatal mortality is highest when the previous pregnancy interval is less than 15 months (90 per 1,000 pregnancies). Prenatal mortality is also higher among women residing in rural areas than urban areas (51) and 37 per 1,000 pregnancies, respectively). A wide regional variation in prenatal mortality is also evident with women in the Western, Ashanti, Volta and Central Regions experiencing levels higher than the national average. (Daily graphip, 23rd 2003)

Surprisingly, women in the Upper East and Northern Regions reported the lowest rates (26 and 29 per 1,000 pregnancies, respectively). Contrary to expectations, there is no clear relationship between Perintal mortality and women's education or the wealth index.(GDHS 2003)

Every year, around 500,000 women die from complications of pregnancy and child birth, and more than 99% of these deaths occur in less developed regions. For each woman who dies of a pregnancy – related condition, it is estimated that 15-30 women suffer from serious damage and that in sub-Saharan Africa alone, between 50,000 and 100,000 women each year develop fistulas in birth in the birth canal that allow leakage of urine or faeces. (Gunnar Kvale 2005) As a consequence, many of them become social outcasts, rejected by their husbands and families.

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In some areas in east Africa the life time risks of maternal death reaches 1 in 11 in contrast to around 1 in 5000 in Sweden and Norway, representing an almost 500-fold difference.

The persistent high maternal mortality has for many years been a neglected tragedy, as pointed out by Rosenfield and Maine already in 1985.However,even today, 20 years after their article in the Lancet was published and after many years with high international awareness of the problem, little progress has been made. These deaths represent a larger tragedy than the death from many other diseases since they are very painful and potentially preventable. The causal factors are known, most of them being related to lack of provision of appropriate health care.

Approximately 250- out of 100,000 women die while giving birth or following complications after childbirth in Ghana. The figures are higher in some rural areas where health education is poor, inadequate facilities and traditional birth attendants provide the only healthcare services available to mothers and their children.(Plan Ghana 2005)

Traditional Birth Attendants (TBA's) have a role in supporting women during labour, but generally they are not trained to deal with complications. Because most trained TBAs have had one month or less of training, they are not defined as skilled attendants. Studies in Africa and Asia have found that, training TBAs in the absence of skilled back-up support did not decrease women's risks of dying in childbirth (Ronsmans 1997, Maine 1996). However, TBAs can contribute to reducing new born deaths and disabilities and play an important role in providing assistance to women during delivery. TBAs can offer pregnant women the much-needed emotional support. Evidence available suggested that many women turn to TBAs because doctors and midwives are not available or their services cost too much, or because TBAs are neighbors and family members or friends who know local customs and respect women's needs.

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The millennium development goal number four (4) states that by the year 2015 the maternal mortality ratio should be reduced by three quarters. In this study I pointed out some of the necessary precondition for achieving this goal, by describing the main causes of maternal mortality, the tools necessary to present maternal death and what could be done to make these tools available for the larger proportion of pregnant women in most rural Ghana. My focus was on the role of traditional birth attendants in promoting Maternal and Child Health in two Districts in Northern Ghana.

1.3 RESEARCH QUESTIONS

1. What are the background characteristics of the TBAs in the study areas?
2. What are the services rendered by these TBAs in maternal and child health care?
3. What are the challenges faced by these TBAs in the cause of their work?
4. What is the health policy focus with regards to TBAs in Maternal and Child Health?
5. Is there any way the TBAs can improve upon their work in safe motherhood and childhood?

1.4 OBJECTIVES OF THE STUDY:

The main objective of the study is to examine the contribution of Traditional Birth Attendants in maternal and child health delivery in Yendi and the Central Gonja Districts in the northern region of Ghana.

Specifically, the study addresses the following:

1. To describe the background characteristics of the TBAs in both the Central Gonja and Yendi districts.
2. To examine the preferred choice of place of delivery among pregnant women in the districts
3. To explain the reasons behind their preferred choice of place of delivery.
4. To examine the contributions of TBAs and the obstacles that they face in their work

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5. To come out with some recommendation that would enhance effective and efficient delivery of TBAs in maternal and child health service.

1.5.0 LITERATURE REVIEW

1.5.1 Introduction

After the Alma-Ata conference in 1978, several surveys and studies on the practices, roles and characteristics of Traditional Birth Attendants (TBAs) has influenced and attracted a lot of attention in several countries, especially those with low income economies such as Ghana. However, literature on the role of traditional birth attendants as a tool for promoting maternal and child health care shows that little has been researched on the institution of TBAs in Ghana. Thus, this section will survey literature on the position that is being occupied by TBAs in the delivery of health services in different cultures of the world. The sub-sections where literature will be reviewed on the broad title of traditional birth attendants in maternal and child health care will be in the means of: TBAs and the health delivery system in Ghana, the TBA innovation in ghana, support to TBAs, training of TBAs, trained TBAs, quality of TBAs training, changing role of TBAs, provision of locally developed kits, criteria for referral, knowledge of TBAs, Primary Health Care System, safe motherhood, TBAs and modern midwifery, health financing, and socio- cultural practice of TBAs

1.5.2 TBAs and Health Delivery in Ghana.

Traditional birth attendants (TBAs) are part of the birthing process throughout the developing world, assisting in the births of substantial proportion of the world's newborns. Usually self thought or informally trained. TBAs also provide advice and practical help in cleaning, caring for the households of pregnant women and new mothers. Because TBAs generally hold a position of respect and influence within the communities they are uniquely equipped to inform and to assist women and their families in preparing for deliveries.

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Although the Maternal and Neonatal Health (MNH) programme advocates that every pregnant woman seeks care from skilled provider it is also acknowledges the important role of TBAs in providing additional services such as: practical help, education and counseling to women. It is true that TBAs can not substitute for skilled provider; they can contribute to the survival of mothers and the newborns by facilitating access to needed information, clinical service and support. They also serve as a link between the women in the hinterland and the modern health delivery by referring complications to the modern facilities.

The role of TBAs started to be taking seriously in the early 1950s when high maternal mortality became a concern in many developing countries. A number of studies, surveys and reviews generated international interest in the traditional health care provider, and several countries started training TBAs in clean and safe home delivery and some other health care – related roles. For more than twenty years, bilateral and international donor agencies and nongovernmental and local organizations poured resources into TBAs training programmes, with the expectation that TBAs would contribute to the reductions in maternal mortality.

Studies of the effectiveness of these training programmes, however, showed that reductions in maternal mortality occurred only in area where the TBAs had skilled background support. The studies found that the majority of the programmes were ineffective because TBA did not have sufficient literacy or general knowledge when they started their training. Without supervision and background support, they tended to slide back into old ways and were not able to prevent death when life- threatening complications arose during childbirth. Although training programmes for TBAs have not contributed directly to the reduction in maternal mortality, they do appear to improve TBA's effectiveness in other areas. TBAs training programmes have contributed to TBA's

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effectiveness in reducing neonatal tetanus, increasing the use and provision of antenatal care, and enhanced timely referrals of complications.

1.5.3 The TBAs innovation in Ghana.

Resocialisation of TBAs in techniques of modern midwifery delivery was identified as the main national integrated and accessible maternal and child health care strategy in Ghana, pursued under the primary health care system (PHC). Under this strategy, TBAs were trained to improve their performance and to put into operation an effective maternal and child health system in the country.

The inclusion of TBAs in the strategies of Maternal and Child Health (MCH) services has a long historical development in Ghana. These community workers have long been recognized for their availability, steadfastness and cultural appropriateness in caring for mothers and newly born in rural areas in Ghana. Thus, numerous and determined efforts to upgrade their skills and improve the quality of the care they provide started in 1970s (Neumann, 1982).

The first of these was the Danfa Comprehensive Rural Health Care and Family Planning Project which was a joint endeavor between the University of Ghana and the University of California at Los Angeles and funded by USAID. It was initiated in the early 1970s as a demonstration, service, and teaching and research project in Danfa, a rural settlement in the Greater Accra Region. TBA training was an integral component of the Danfa project aimed at reducing maternal and infant mortality in the rural areas and evaluations of the project revealed initial success in this direction. (Neumann et-al, 1986).

The second major programme was the Brong- Ahafo Rural Integrated Development project, launched by the government of Ghana in the mid 1970s with assistance from World Health Organisation, (WHO). The objective of the programme was "to make health care delivery the

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responsibility of the community" (Buamah, 1977) and to "determine in a practical way the social processes that mould a community health centres project" (Twumasi, 1982). The most active participant in this activity was the TBAs and the use of existing traditional pathways in implementing the programme was considered a prime reason for its success. The last of these efforts to integrate traditional and modern systems of health care was the training of indigenous healer's project (Waren et-al., 1982).

Earlier projects were pilot programmes towards the integration of TBAs into modern maternal and child health delivery systems and the success of these programme led to proliferation of TBAs training programmes in Ghana in the 80s. In the northern region of Ghana, the Ministry of Health and UNICEF as well as other NGOs operating in the area were engaged in TBAs training programmes. Yendi and Damongo were some of the pilot districts for PHC, UNICEF sponsored projects in the region and as a result training programme for TBAs in the region were initiated in those areas by both the Ministry of Health and UNICEF.

An Operational Research Project to review the training programmes for TBAs in the country prior to National Traditional Birth Attendants (NTBA) programme revealed that pioneering TBAs programmes varied in content and orientation. The Operational Research called for a systematic National programme on TBAs based on experiences and lessons from earlier projects (Operational Project Report, 1990). It also drew attention to the impotance of a clear- cut national policy to address the role and responsibilities of TBAs in an integrated maternal and child health care system in Ghana. Such a policy was also believed to encourage and promote community involvement in matters of health care (Amonoo-Larson, 1981)

As follow up to the findings and recommendation of the Operational Research Project, the National TBAs programme work shop was organized in 1988. The workshop was charged among other

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things to work out the objectives for the implementation of a comprehensive national TBAs programme in the country to commence in April 1989. That is designing a midwifery programme for TBAs and institutional boundary resetting for an integrated child and maternal health care system. It is the constitution of these broad midwifery practices for TBAs and the concerted national effort towards an integrated maternal and child health care system with trained TBAs as the pivot of these integrated midwifery and family planning care that constitutes the innovation for adoption.

1.5.4 Supports to TBAs

UNFPA has supported Traditional Birth Attendants (TBAs) programmes since 1970 to improve maternal evaluation and child health and as part of the Safe Motherhood Initiative since it started in 1987. In the 1990s, UNFPA jointly with WHO and UNICEF, issued a statement on the training of TBAs in developing countries, this policy was put in place for TBAs to reflect common goals to contribute to the global effort aimed at improving reproductive health. The objectives of the support to TBAs in this statement are to: a) enhance the links between modern health care services and the community; b) increase the number of births attended by trained birth attendants and, c) improve skills, understanding and stature of TBAs.

The International Conference on Population and Development held in 1994 in Cairo further encouraged the agenda of the Safe Motherhood Initiative including the objective that all births should be assisted by trained persons.

A thematic evaluation was conducted in 1994-1995 to assess the effectiveness of UNFPA support to TBAs as a strategy to improve maternal and child health and family planning services. This evaluation was based on a sample of UNFPA supported projects in seven countries: Ghana, Burkina Faso, Nepal, Nigeria Malawi, and Uganda, which represent a wide range of country situations and

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experiences with programmes of support to TBAs. In all selected projects, training of TBAs was one of the strategies selected to achieve the objective of improving the quality and coverage of MCH/FP services.

The evaluation collected information from TBAs, women in communities served by TBAs, service providers at the first level of referral and trainers in TBA programmes. Information was also obtained from the staff of Ministries of Health at policy and programme management levels.

The TBAs interviewed were generally older women (in two case studies some TBAs were men) who were respected by their communities. Majority of the TBAs were illiterates and had learned their skills through working with other TBAs and inheritance. Most TBAs considered themselves as private practitioners who responded to requests for service and received some compensation, mostly in kind. The focus of their work was to assist women during delivery and immediately post-partum.

Most TBAs went to the woman's house to deliver although some had arranged a delivery area in their own house or compound. The majority of the TBAs interviewed resided in poor rural areas, very distant from health facilities. Good examples are those from Tijo and Jaramoapei in the Yendi and central Gonja respectively. They often served as a bridge with the formal health system, sometimes accompanying women to health facilities.

The training programmes reviewed reported that TBAs can learn new skills to provide safe and clean care to the mother and the newborn. Communities' members, TBAs and health providers at the first level of referral all drew attention to the changes in TBA practices after training.

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Trained TBAs practice clean delivery, advise mothers on basic pre-natal care, identify risk signs and make referrals. Also, trained TBAs have contributed to increasing the number of women going to health centres for examination of their pregnancy, family planning and immunization services.

Cases reviewed showed that TBAs can make the most impact in preventing maternal and neonatal infections. They can prevent post-partum sepsis by applying the "three cleans" during delivery and following placenta management procedures. They also can contribute to decreasing maternal and neonatal deaths due to tetanus by referring women for tetanus toxoid immunization and by conducting an aseptic delivery. In locations where referral is feasible,

TBAs can save lives through identifying risks and conducting required preventive measures before arrival at the referral site.

Therefore, through funding training programmes, UNFPA has contributed to achieving the defined objectives for supporting TBAs regarding MCH/FP care. For this reason, TBA Programmes should be supported particularly in those countries where a large proportion of deliveries are attended by TBAs and quality maternity care is not accessible to the majority of the population. At the same time, experience has also shown that the achievements of past interventions were seriously limited mainly by their narrow scope as well as vertical and thus, isolated approach.

The findings of the evaluation highlighted an important limitation to the effectiveness of the programmes:

An important factor contributing to the vertical approach is that external donors remain the exclusive source of funding of TBA programmes in most cases. An interview with madam Tani a mid wife in the Yendi hospital said that due to the lack of fund to support the training programme

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that was why it could not be sustained. National budgets for such programmes have not increased in the past decade due partly to the lack of conviction among policy makers of the value of TBA Programmes. Even though most policy makers interviewed expressed support of TBAs, some favored instead an emphasis on improving women's access to the formal health system. The strength of support was usually related to the extent of their exposure to TBAs. By the same token, the attitudes of the health staff at the first level of referral toward TBAs were more positive as compared to the health staff at the districts levels. It appears that at the local level, where they are closer to the health centre, TBAs are valued more for their work, resulting in more effective collaboration.

1.5.5 Training of Traditional Birth Attendants.

The training of Traditional Birth Attendants in clean delivery is important considering their role in maternal and child health care. The training of TBAs would foster practical life saving knowledge and skills involving problem solving, critical thinking, clean delivery and decision making with regard to referring complications to the modern health facilities.

The basic component of this training that promotes such knowledge, skills and attitudes includes: in service training and seminars organized by Non Governmental Organizations (NGO) in collaboration with Ghana Health Service to train TBAs in rural communities. These NGOs in the study area include: UNFPA, WHO, Christian Children Fund of Canada (CCFC), Plan Ghana, Action Aid Ghana and UNICEF. .Information from the study areas indicate that the training programmes were organized and conducted in the Yendi district and for that reason the district can boast of a number of trained TBAs. The table below shows the number of trained TBAs and the untrained ones.

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For the central Gonja district it was revealed that there has never been any training of TBAs in the area since it is a new district and for this reason most of the TBAs in that area are not trained and their method of operating is far different from those who are trained in the Yendi district.(field survey,2008).

1.5.6 Trained TBAs

The term "skill attendant" refers exclusively to people with midwifery skills (for example, doctors, midwifes and nurses) who have been trained to proficiency in the skills necessary to manage or refer complications. Ideally, the skilled attendants live in and are part of the community they serve. They must be able to manage normal labour and delivery, recognize the onset of complications, and perform essential interventions, start treatment and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in a particular setting. (WHO, 1999).

High-quality education and training of skilled attendants fosters practical lifesaving knowledge and skills involving problem solving, critical thinking, and decision making, rather than simply the recall of facts. According to the Jonas Hopkins programmer for International Education in Gynecology and Obstetrics' due to the lack of access to skilled providers, birth complications claim the life of an Afghan woman every 30 minutes- more frequently than malnutrition and war.

However, the production and competence of skilled birth attendants does not necessarily mean that they will be able to function effectively to save the life of women. For skilled attendants to be able to reduce the incidence of maternal deaths, they need an environment that facilitates their work. Critical factors in such an environment are supportive policies, laws and regulations; effective health system infrastructure, professional association and quality education supportive supervision systems (http://usmfo.state.gov/journals; 2007)

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In spite of the recognition given to Traditional Birth Attendants (TBAs) as part of the birthing process through out the developing world, a substantial proportion of them are self-thought or informally trained (http://www.pregnancy.com, 2007). The self-thought TBAs may not be able to provide solutions to serious delivery complications. This assertion was supported by the World Health Organization (WHO). According to the WHO, 98% of newborn deaths take place in developing countries and for the most part, these newborns die at home, in the absence of any skilled health care (WHO, 1996). Reflecting on the work of maimbolwa (2004) and Flemin (1994), the Traditional midwife lacks knowledge and thus, must be trained for their manpower needs to be effective because what ever they seem to know is a mere superstition that compounds the problem in maternal and child health.

1.5.7 Quality of TBA training

Most programmes did not undertake any needs assessment to derive an information base for developing an appropriate curriculum for TBAs. Curricula development was based only on what programme managers thought TBAs should know. A number of case studies reported curricula which were complex and too comprehensive for TBAs.

Training of trainers was often short and not well structured to prepare them adequately.
Often, expertise in the clinical content was considered sufficient without taking into consideration pedagogic skills. Most programmes lacked education materials (models) for demonstration in training.

The family planning component of TBA training programmes was found to be weak. In most programmes it was focused on a description of contraceptive methods only. Neither the health benefits of family planning nor the communities' perceptions and concerns with respect to family

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planning were adequately addressed. In some cases, in the northern part of Ghana the weak training was redressed to some extent by supervision of TBAs in their role of family planning promotion and distribution. As a result, TBAs in these parts showed greater confidence and were very active in these activities. TBAs who were not supervised, felt more uncomfortable discussing family planning. Most case studies stated that TBA's role in family planning was to promote and refer. Some programmes including contraceptive distribution was limited, however, to condoms use.

An assessment of the communities' health beliefs and practices should serve as the information base for the selection of appropriate topics and teaching methodologies of TBA programmes. Training of trainers in pedagogic techniques for illiterate adult learners should also be considered a critical element for the effectiveness of programmes.

Evaluation of TBA's performance immediately after the training was done by some programmes, often through observing the repetition of skills taught by simulation. Most training programmes, however, did not include follow up evaluation to assess behaviour change in trained TBAs. Some programmes assessed change through monitoring differences in the number of referrals after the training. In most receiving institutions, however, records/assessments of TBA referrals were not kept.

1.5.8 Supervision of Trained TBAs

Even though policy makers and managers stated emphatically that supervision is one of the most important factors for a successful TBA programme, findings showed that supervision was acutely limited in almost every part of Ghana, the more rural the TBA, the least frequent she reported to have been visited. Supervision was restricted by lack of funds, lack of transport and limited staff. One of the trained TBAs in the Yendi district said" they used to call us to come to Yendi to the tell

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them how far we have done and the problems we encounter, due to my inability to walk as a result of old age I used not to attend such meetings".

TBAs who were supervised regularly, reported a more positive attitude toward the health system, felt supported in their work and tended to refer more clients. Although, when supervision did take place, findings showed that it was focused mainly on checking supplies of kits and other logistics.

TBAs in the Yendi district in the Northern part of Ghana said that they promote family planning by distributing condoms only; however, they said that community members were "too shy to get condoms from them." To overcome these, some TBAs used "agents" (community health workers, usually young males) to distribute condoms. Other TBAs said that they preferred just to refer clients to health centres for family planning.

1.5.9 Changing TBA's role

Policy makers and programme managers favored adding primary health care tasks to TBAs. Some of these new tasks are: giving advice on health matters, promotion and distribution of family planning methods, distribution of oral rehydration solution and iron tablets, referral for pre and post-natal care and for vaccinations. The addition of new tasks has changed the focus of the TBA's role from its traditional one to that of a multi-purpose community health worker leading to the perception that they have become part of the government health network.

This has resulted in some cases in reluctance to pay TBAs for their services. It was observed that communities generally lacked understanding of the linkage between the formal health system and the trained TBA, although some TBA programmes in Ghana, included a component to promote understanding of the purpose of the training to gain support for the TBA's work. In such programmes, managers or trainers met with community groups to discuss the purpose of the TBA

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training, the TBA's link with the formal health sector to help in broaden the skills and knowledge of the TBAs in MCH service.

The TBA programme in the Upper East Region and Northern Region of Ghana, supported by UNFPA, tracked antenatal visits and deliveries conducted by trained TBAs during 1990 to 1993. Antenatal visits increased from 20,000 to 180,000. Deliveries reported by TBAs increased from less than 10,000 to 50,000. Nationally, the percentage of TBA deliveries as a percentage of supervised deliveries, increased from 16.4 percent to 22.2 percent between 1992 and 1993.

1.5.9.1. The View of Policy Makers and managers of TBAs activities

Policy makers and programme managers state that TBAs have contributed to:

- Improve pre-natal care,
- Increase contraceptive acceptance rate, and
- Decrease neonatal tetanus admissions.

Centre and the need for community support. It was found however, that when such orientation was conducted, it had not been sufficient. Interestingly, some communities, on their own initiative, were organized to provide food for the TBA's family while in training, and had arranged for a transportation system in case of obstetric complications.

Most programmes reviewed had not assessed beforehand the pertinence of the tasks to be added, nor their acceptability to TBAs. Evaluation findings show that TBAs are more receptive to skills improvement directly related to their traditional role in delivery and immediate post-partum care, for example regarding improved hygiene during delivery and post-partum infant and mother care.

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If TBAs are given additional tasks, these should be based on an assessment of the TBA's role in their community to ensure that both TBAs and communities perceive them as appropriate and partners in the health care delivery.(2006, stakeholders conference on the work of TBAs, Nairobi).

1.5.10 Provision of locally developed TBA Kits.

Most programmes had difficulty maintaining adequate supplies for TBAs to conduct clean deliveries. Replenishment of supplies was often planned in conjunction with supervision visits which were irregular. Some TBAs depended on the programme to restock supplies, others tried to replenish them themselves. Some clients replaced or paid for supplies used.

In a number of programmes, donors were the principal source of supplies contained in kits, which were generally large and durable. The use of the kit varied. For some TBAs it was a sign of prestige which showed that she had been trained. Other TBAs stated that kits were large, heavy and difficult to carry. Therefore some preferred locally manufactured kits, which were simple. Locally made home delivery kits had been developed with the aim to make them more appropriate, functional and inexpensive. The experience with producing and selling inexpensive clean home delivery kits to TBAs and/or families was beginning to be studied.

Locally produced kits seem to be more cost effective for ensuring availability of supplies for TBAs to conduct clean deliveries.

1.5.11 Criteria for referral differ significantly among managers and trained TBAs

The criteria for referral imparted in training programmes varied from those actually used by TBAs. Many managers used broad classifications to define risk and encourage TBAs to refer for most risk categories. The programmes in the Yendi district used the classifications of "too young, too old, too many pregnancies" as reasons to refer women to health facilities. TBAs, however, stated that they

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did not adhere exclusively to these criteria for referral. In addition, they also took into consideration cost, time and distance of travel, availability of transportation, and care of remaining children, days lost at work and views of husband and mother in- law in referral decision-making. The lack of adherence to criteria taught in training appeared especially true if the TBA lived in remote rural areas and had previous experience dealing with some risk factors.

As a result, in most case studies TBAs conducted deliveries considered by programme managers as high risk. Some managers interpreted this as a demonstration that TBAs were not aware of their own limitations. Others stated that it was an indication of the need to define a more realistic referral system, which takes into account logistics and the capacity of the health system to respond to obstetric complications.

To enhance community base care in Ghana, a number of initiatives with the aim to include TBAs in community base health service delivery have been undertaken by various governments. These include the Danfa Comprehensive Rural Health Care and family planning project, in which TBAs training was integral component aimed at reducing infant and maternal mortality. the second major initiative was the Brong-Ahafo Rural integrated Development Project, which was launched by the then government in the mid 1770s.the programme objectives was to make health care delivery the responsibility of communities(Boamah1977) and to determine practical ways for molding social process in community health care(Twumasi,1982), (Galaa Sylvester,2006).The National Traditional Birth Attendants (NTBA) programme launched in 1989 was the last of these efforts to integrate traditional and modern health system of health care. The NTBA was designed to improve the quality and expand the volume of the midwifery care of TBAs in an ordinary obstetrics and family planning. The objectives of the programme included the institutionalization of a two-tier referral system in complicated obstetrics and the provision of essential drugs and immunization (MOH, 1990, Galaa Sylvester, 2006)

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1.5.12 Innovation of TBAs

In general terms this study relates to the process of social change in promoting maternal and child health on the practice of Traditional Birth Attendants (TBAs) in Ghana. The research field of this study has been carried out within the discipline of health care pedagogies. The focus will however, be on how to bring about specific changes in traditional midwifery delivery without altering the subtle basis on which traditional obstetrics and maternal child health care are based. However, the redirection of attention on training and reorganization of TBAs under the NTBA (National Traditional Birth Attendants) program is a move towards the professionalisation of traditional midwifery practice.

The innovation theory, especially as it addresses the adoption of innovation, offers a perspective within which to study the process of change of TBAs practice initiated by specific stimulus: training TBAs on aspects of modern midwifery and the reorganization of the service of traditional midwifery within an integrated perspective of maternal and child health care. The innovation model is, perhaps, the most used model in the study of social change and development in the field of sociology and anthropology (Katz et.al 1963).

Studies that focus exclusively on the relationship between social structure and innovativeness have shown how socio-structural factors as opposed to adopter's personal characteristics hardly determine the orientation of adopters. Such studies focus on factors such as: the structural position of an adopter; level of integration (interpreted in terms of centrality and prestige), friendship relationships and so forth as determinants of innovativeness (Roger and Remarker; 1971).

Undoubtedly, medical Anthropology and actor-oriented research on prenatal health care systems have much in common with the fundamentals of anthropological research as well as with the study

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of knowledge, organization and culture within the domain of health care pedagogies. Research, including this particular one that is conducted within the discipline of health care pedagogies represents a variety of perspectives and approaches. Some of the studies have aligned to the interpretive ethnographic tradition (Friberg, 2001; Sandin, 1985).

Most relevant to this study is the development of the perspective of symbolic interactionism by Herbert Blumer (1969), which was borrowed from other scholar's works from interpretative tradition. Blumer|"s theoretical conviction was that the physical sciences are not only insufficient but also inadequate to capture and represent the complexity of human nature. This thinking made Blumer to devote and redirect his research works resulting into the development of the theory of symbolic interactionism. Lermenentics as well as the elaboration of linkages between the interactive tradition and ethnography (Prus, 1996).

The perspectives guiding this study equally influence the knowledge, treatments, conception and the role carried out by practitioners and providers of a health care system. As the scientific view of anthropology is anchored on the perception of man as a culture being whose actions and thoughts are both derived from and form part of a social system, so is the meaning of a health care system, and as "cultural system" – a system socially and culturally constructed by the different actors participating in that social reality. Kleinman (1980) describes the local health care system as composed of three (3) overlapping parts; the popular professional and folk sectors. Last (1996) suggests that national medical system may be a move appropriate concept than the universal or cosmopolitan medical system when comparing, competing or parallel systems.

The decision to seek whether service of the popular professional or the folk sector practitioners by the individuals is guided by needs, beliefs and cultural rules. The choice of any of the sectors equally determined the kind of role(s) the person will have to play in that sector (Sachs, 1991).

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1.5.13 The Knowledge of the Traditional Birth Attendant:

Mammo, 1990, explains that a tradition is something passed down from generation to generation, eventually becoming the customs and tradition of a given society. He states that indigenous knowledge comprises of such traditional practice that have prove to sustain local needs. According to Sillitoe (Sillitoe 2002), Indigenous knowledge relates to knowledge held more or less collectively by a population, informing understanding of the world. It may pertain to any domain, is community based, embedded in and conditioned by local traditions and culturally informed. He explains that it is mainly transmitted and through experience. Repetitive practice characterizes its leaning between generations this thesis will deal with the question of knowledge in its exploration of Traditional midwifery, one of a domain in indigenous knowledge system. If there are a variety of knowledge is traditional midwifery knowledge and does the midwife know? This definition gives possibility that traditional midwifery maybe knowledgeable and if so then the traditional midwife probably knows.

Berger et al (1966), points to the fact that knowledge is brought about by the relationship between human thought and social context which has specific located view points that are historically and socially relative. The theory of situated knowledge takes this kind of contextualization as a point of departure in discussing knowledge. Engels tad et al (2005) writing on this concept stated that it has become apparent that all aspect of the production of knowledge is situated and there is no such thing as universal knowledge. They argued that the acceptance of knowledge's situatedness is a prerequisite for connecting the different contexts in which all knowledge is produced. The concept opens space for communicating between different knowledge producers and ways of knowing. It serves to break down boundaries within the specific production of knowledge, not only within the physical, natural, social, cultural and human science but also the boundaries between specific and non-specific knowledge production. The concepts aim is to the boundaries porous, allowing for communication and understanding between knowledge which can only be achieved with respect

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and trust in the relations between knowledge producers. They point to the fact that the relationship between different knower's is crucial in situatedness. This point will be looked at in relation to any third research questions, which is on the ability of the integration to exchange ideas between the two different knower's (the western and traditional medicine).

1.5.14 Primary Health Care (PHC)

The declaration of "Health for all by the year 2000" made at the international conference on primary health care at Alma- Ata in September, 1978 drew attention to the wide spread lack of facilities for large numbers of people in the world (midgley et al 1989 ;45). With regards to the serious burden on the national budgets that makes it impossible to train doctors and other medical practitioners as well as providing health facilities; and a sharp contrast of overwhelming growth of the world populations which, call for effective measures for health related interventions. UNESCO, WHO, and UNICEF expressed the need for health services to be extended to the people in rural areas through the primary health care at a joint meeting at Alma Ata in Russia.

Primary Health Care (PHC) in Ghana operates on three tire systems: levels A, B and C. Level A constitute community clinics, level B consist of health centres and health post,

Level A constitute community clinics,

Level B consists of health centres and health post, and

Level C comprises the districts hospitals.

Level A (community clinics are meant for population between 200 to 500 people. this is to be man by the people themselves with the following staffing; a. community clinic attendant (community health worker)

b. Traditional Birth Attendant (TBA)

c. Environmental Health Worker (EHW)

d. Traditional Healers.

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The work of the above category of health workers are supposed to be coordinated by the Town Health Committee (THC) who are made up of opinion leaders in the town

In some direction of international health world health policy, PHC conjured up no images of self – reliant communities engaged with committed health workers and professionals in locally relevant health structures; rather it evoked images of empty clinics, lacking staff, drugs and equipments, and a public system riddled with corruption, abused and waste (Filmer,Hammer et,al,2000).

The following principles were adapted:

1. Equitable distribution of Health services
2. Community participation
3. Appropriate technology, i.e. the use of food stuff, herbs and vegetables for treatment and health education.
4. Multi-sectoral approach i.e. harmonizing all health related agencies e.g. Agricultural, Education, Environment and sanitation sectors etc.

Focus on prevention because it is known to better and cheaper than curative

The work of the above category of health workers are supposed to be coordinated by Town Health Committee (T H C) who are made up of opinion leaders in the town.

The above people are sent to level B and C for training and refresher courses to improve their diagnostic skills. The opinion leaders (THC) are responsible mobilizing community members for health development program.

1.5.15 Safe Motherhood

Motherhood is a stage of life, which is much cherished by families due to the emotional

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and social joy that it brings to families. It is therefore sad that many families are often eluded by this happiness through maternal and neonatal mortality, morbidity and disability. Motherhood related afflictions claim the lives of many mothers and /or babies annually. WHO/UNICE (1999) estimates that there are 585,000 maternal deaths each year globally from complications of pregnancy and childbirth. Another 15 million experience chronic problems resulting from childbirth while estimated 64 million women suffer dangerous complications of pregnancy. About 99% of these unpleasant cases occurred in developing countries where these complications account for at least 18% of the disease burden (DALYs) among women in their reproductive age (World Bank, 1993).

Having observed the hazards of unsafe motherhood in the world and especially in developing countries, there is now a global effort to increase maternal safety and reduce maternal and neonatal mortality and complications associated with pregnancy and childbirth. As part of this effort, the *Safe Motherhood Initiative* was launched at an international meeting in Kenya in 1987. The major focus was to reduce high maternal death rates and pregnancy related illness and complications especially in developing countries.

The importance of Safe Motherhood was again given impetus during the 1994

International Conference on Population and Development in Cairo and the 1995 World summit for Social development in Copenhagen as well as during the 1995 Fourth World Conference on Women in Beijing (Goliber, 1997). These global efforts have shaped maternal and child health care delivery in developing countries since the late 1980s and early 1990s.

Safe Motherhood is the prevention of maternal and infant death and disability through access to basic health care to ensure that all women have access to the information and care they need to go through pregnancy and childbirth safely and confidently. In Ghana,

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Making pregnancy Safer (MPS) is a component of National Reproductive Health Service Delivery, which is delivered through the Primary Health Care Programme (PHC).

1.5.16 Health Financing

The provision of effective and efficient maternal health care system is dependent on the policies and the amount of resources that are being committed. The government of Ghana has therefore put in place the Free Maternal and Child health Care Package (FMHCP) to enable pregnant women who can not afford to be able to access health care without paying for the service.

By the 1990s, the World Bank had become the leading funder of health sectors, and its view of the problems and prescriptions for solution dominated the field. The highly influential World Development Report 1993 entitled "Investing in Health", introduced new priority-setting techniques for public spending brought in new orthodoxy in health policy. The orthodoxy is on the premise that the private sectors most efficiently meet most health care needs and should be actively encouraged to do so.

In the opinon of Bloom and Standing, the insupportable view of discrete public and private health sectors may not pertain – perhaps in poor countries as their health systems can accurately be described as phiralistic, and more appropriately divided "organized" and "unorganized" categories.

The choice confronting people is not between a private health system that changes for a maximum choice of higher quality service, and a public health system providing essential service for free or at lower cost. On the contrary, all users are confronted with a bewildering array of sources for health care: from drug peddlers, traditional healers, to highly trained specialist physicians. The weakening of government supervision systems is "an important factor contributing to the defacto marketisation of health services" (Bloom and Standing, 2001).

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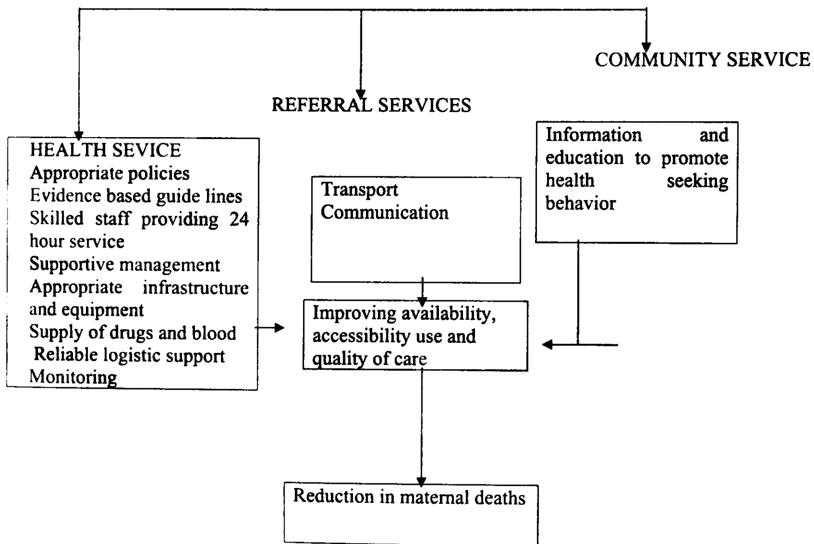
The issue of marketisation of health services had made traditional maternal and child health interventions, such as providing antenatal care and training traditional birth attendants, have failed. The availability, accessibility, use and quality of essential obstetrics care for life threatening conditions, including complications after abortion, need to be improved. What is less clear is how an environment can be created to enable interventions to be made in settings with few resources (Goodburn and Campbell, 2001). The views of Googburn and Campbell on resources needed to improve essential obstetrics care are diagrammatically illustrated below

Fig. 1.1 Resources needed to improve Essential obstetrics care.



(Source: Goodburn and Campbell, 2001)

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Even if Goodburn and Campbell wrote about other developing countries, their work is relevant to this study since they indicate that the availability use and quality of essential obstetrics services are influenced by the quantum of resources (in terms of finance, human and material resources) that is being directed to the health sector, particularly the maternal sub-sector.

1.5.17 Socio-cultural practices related to child birth in rural areas in developing countries.

Even though socio - cultural practices have positive effects on the health of the mother and the child in indigenous communities, some of them have unintentionally side effects; and help to explain the high infant mortality rate (IMR) in Ghana. Then, there is need for identification of forces behind them and incorporate in the health intervention programmes in order to reduce the high IMR. Currently estimates of IMR in Africa by average are 101 per 1000 births and in Ghana are 81 per 1000 births (WHO 2002). In developed countries, on the other hand, are less than 7 per 1000 births (WHO 2002). According to epidemiological studies the reasons for this wide gap are poverty, low education and poor sanitation (WHO 2002, UNICEF 2000). The identified factors truly explain the prevailing high IMR in Africa. However one factor which is not precisely spelt as a factor of IMR; and it is to be given special attention for intervention health programmes which aim to reduce IMR in Africa is the socio-cultural practices related to reproductive health.

Socio-cultural practices related to child birth and after birth vary from one community to another, but all have the same goal to ensure mother and child survival. They are developed through observations and experiences from time immemorial and how orderly things occur in daily life (Znaniecki 1963); and this in turn leads to the establishment of socio-cultural practices in a community to conform to that order. The theory of culture on the other hand, asserts culture as a set of beliefs, values, attitude and individual goals. These form standards and norms of the community (Znaniecki 1963); and modify the pattern of people's behavior. In sum, socio-cultural practices include set of beliefs and taboos as related to reproductive health and health in general, crop

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production, structural organisation, ecology and technology of a place in a given community (Znaniecki 1963, Swantz 1966).

To ensure that, socio-cultural practices of the community are maintained, the social structure (all leaders of the communities) has established social control mechanisms which are built in the set of beliefs and customs of a community. Some of them are geared to control people's behaviour which includes health seeking behaviour. The theory of culture views individuals as being constrained by their image of normative action composed by social control mechanisms, as they seek to conform to the values of the society; and hence are not freely to act any how to meet their expected goals.

Even though all socio-cultural practices are valued, there are some which are pillars of the community and are given special respect. Child delivery in African communities is one of them (Swantz 1966, Raum 1974, Molnos 1973). It has several procedures from pregnancy to child delivery, where the pregnant woman (and sometimes all women and men) has to observe to ensure safe child delivery and child survival after delivery (Swantz 1985, Raum 1974, Molnos 1973). Special practices are likely to more apparent to unusually births such as delivery of twins or breech presentation at delivery or emerge of the upper milk teeth before the lower teeth. Swantz (1966) terms them as 'abnormal births'. The ultimate goal of these procedures is safe delivery and good health well being of the child and the mother; and at the sametime to maintain the overall socio-cultural practices in the community. It has to be noted that any health side effect to the mother or the child derived from the socio-cultural practices is unintended outcome. Thus, besides the factors mentioned by researchers (Kayombo 1997a, Cosminsky 1983, WHO 1992) which make many women prefer to deliver their children at home, it might also be due to socio-cultural practices related to child births in their respective communities which cannot be performed in modern health facilities (Kayombo 1997a, 1998). But culture is dynamic with level of development; and hence socio-cultural practices are expected to change with level of development (Levinson et al 1995,

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Gooddall 1987, Foster 1973). However, there are some socio-cultural practices which resist change, depending how the technology or diffusion of ideas is perceived by receivers (Gooddall

1987), especially elderly people who form the social structures in the communities (Forster 1973). It is likely, some individuals, especially the young generation, notably those who have been exposed to other cultures and education, are being constrained by the image of normative action which prevails in their communities, specifically to practices related to child births. It is very possible to bring conflict with normative behaviour of their community. However, the fear of the believed outcome of the child and themselves is likely to put them in passive resistance to the normative behaviour in their respective communities. But how important is child delivery in a given community? In Ghana, child delivery is one of the social and demographic important events in a family and community as a whole (Swantz 1966, Kayombo 1996, Raum 1974).This is one of the occasions where members of family and close relatives congregate and offer presents to the child (Kayombo 1996, Raum 1974, Swantz 1985). In rural areas, the mother or the mother-in-law of the woman who has delivered may stay with her daughter or daugter-inlaw for weeks, and sometimes a month, until woman gains strength to perform household duties (Swantz 1966, 1985, Kayombo 1997b).

Before colonial times, child delivery was done at home with the assistance of co-wives, mother-in-laws, aunts or mothers or TBAs. The people who assisted the women to deliver at home in the past (and even today) were elderly women who had given births in their life time (Swantz 1966, Molnos 1973). Before colonial times, there were no other places where child delivery could take place. Soon after colonial times and mainly after independence a number of health units for both government and missionaries were opened in urban and rural areas. At present, on average 72% of Ghanaian population has access to health units but most people especially in the northern part of the country where people has to travel by bicycle to be able to access the facility as a result of an equal

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distribution of health facilities in the area In some regions, average population accessible to health units is higher than twenty –five kilometers distance. However, most of them do not have adequate health facilities, drugs and competent personnel (Kayombo 1997, (1996) and WHO (1998) show more 47% of women deliver at home with the assistance of close relatives, traditional birth attendants (GDHS 2003) (TBAs), medical aids and some cases the woman delivered without any assistance. Perhaps this accounts for reported high maternal mortality rate (770 per 100,000) (UNICEF 1996). Interestingly, antenatal care in medical services is high (97%) (GDH and 1993, WHO 1998). The questions arise as to why most women prefer to deliver their children at home with such high medical antenatal care? Is it because of inadequate health facilities and medical personnel in medical health units? As shown by (WHO, 1992, 1996)? Or is it because the motherly care or socio-cultural practices related to reproductive health? And what are the socio-cultural practices after child delivery and their importance to the mother and the child.

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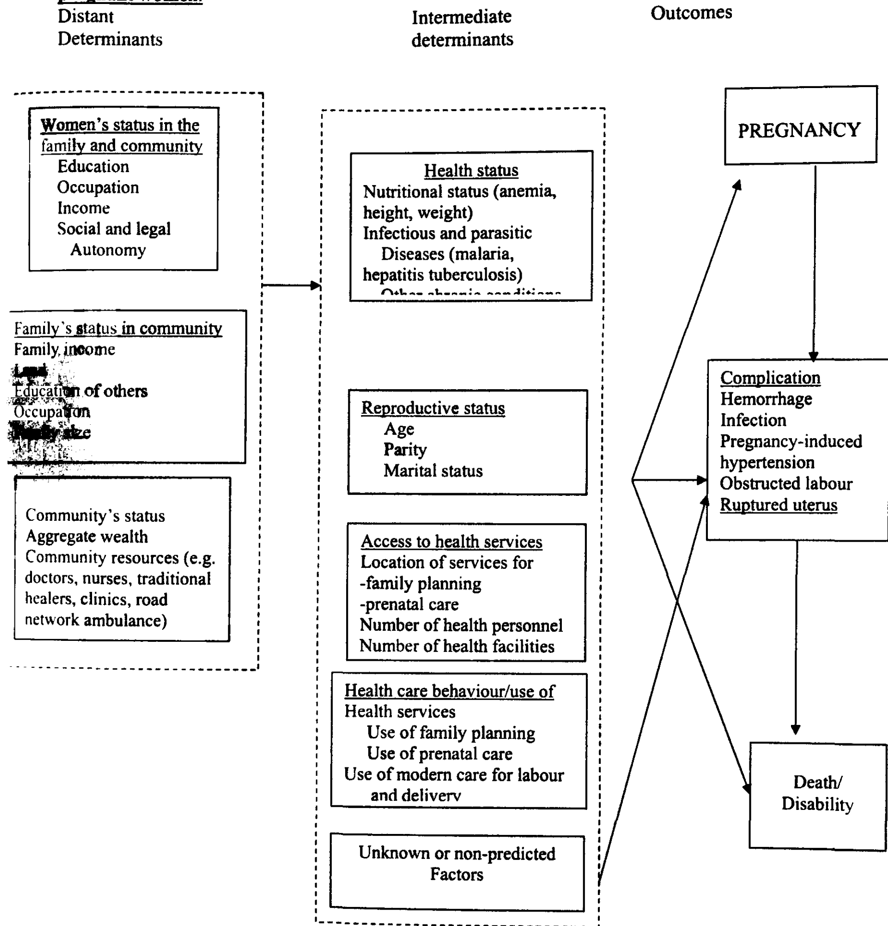
Fig:1.2 A detailed framework for analyzing the determinants of mortality and morbidity of pregnant women.



Source: Modified: from p. Gundor (2002)

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1.5.18 Research Proposition

These propositions have been put forward for testing based on the literature guiding the study

(a) Utilisation of MCH facilities is inversely related to the distance pregnant women travel to assess the facility

(b) Access to MCH service is directly related to family income.

(c) Educational status of the woman is directly related to health seeking behaviour.

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CHAPTER TWO

Study Areas and Research Methodology

2.1 Justification For the choice of Yendi and Central Gonja Districts.

As already indicated, the study was undertaken in the Central Gonja and the Yendi District in the Northern Region of Ghana. The two districts were chosen for the study because of the differences in their socio-cultural and spatial dimension with regard to health seeking behaviour.

Yendi is the capital of the Dagomba Traditional Area where most of the people are Dagombas and Konkombas.On the other hand, Buipe is the epitome of the Gonja Traditional Area and the people living there are mostly Gonjas. The study seeks to critically examine the role of TBAs in Maternal and Child Health (MCH) in both the Gonja and the Dagomba tradition as well as some aspects of the Konkomba culture about seeking maternal and child health care.

2.2 Background of the study areas

2.2.1 Location

Central Gonja District is located at the south western part of Tamale in the Northern Region of Ghana. It lies between longitude 1°5' and 2° 58' West and latitude 8°32' and 10°2' North.The Central Gonja District was carved out of the West Gonja District in 2004. It is therefore one of the newly created districts. It shares boundaries in the south with Kintampo North District in Brong Ahafo Region, West Gonja District in the West, Tamale metropolitan in the North and East Gonja District in the East.(Refer to map of the Central Gonja District).

The District covers about 8,353km2 which represent 12% of the total land area of the Region. The District however is strategically linked between the southern sector and the rest of the two Northern

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Regions. (Upper –East and Northern). This makes the capital very busy since it is on the main trunk road leading the south to the north.

The rivers and streams which drained the District have drainage pattern. The White Volta, South of Damongo District joins the Black Volta around Tuluwe and Mpaha area in the District. The confluence of the Black and White Volta Rivers is at Sheri which is a potential site for tourist attraction. Both the Black and White Volta Rivers which drain the district, have good potential for small-scale irrigation schemes along their valleys. They also provide good waterways from Buipe and Yapei respectively to Akosombo via the Volta Lake in Yeji. There is inland harbour at Buipe on the Black Volta. These rivers have good potential for fishing in the District and for this reason majority of the population in the area are engaged in aqua culture (fish farming).

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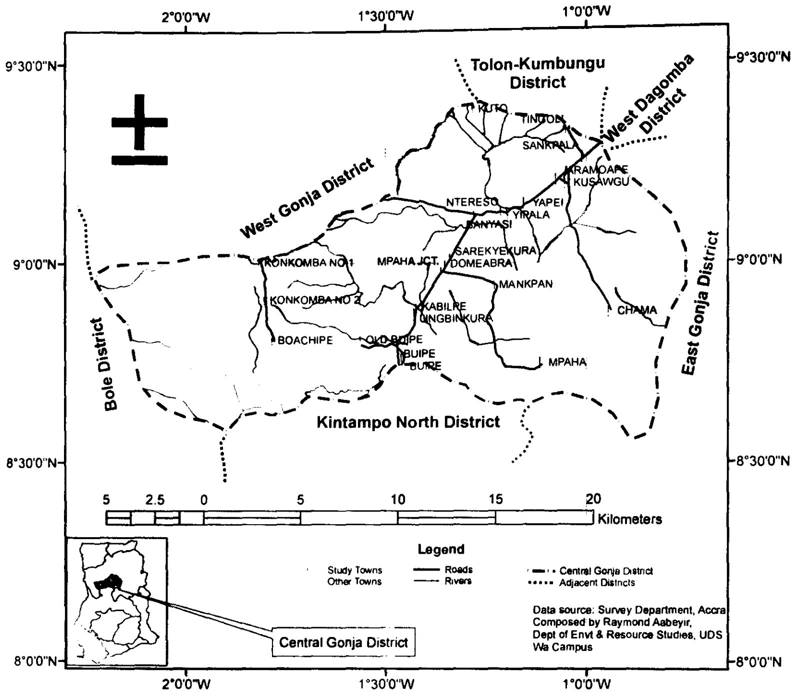
FIG:2.1

A Map of Central Gonga District showing the study communities



Also, Yendi District is located in the northern region of Ghana and shares boundaries with eight other districts namely; Gushegu and Karaga to the north, Nanumba north and East Gonja to the south. Saboba/Chereponi and Zabzugu/Tatale to the East and Tamale Metropolitan Assembly and Savelugu/Nanton to the West.(Map of the Yendi District).

It lies approximately between latitude $0^{0}\,32^{'\,W}$ - $0^{0\,25'}$ E and latitude 9^{0} 1' N - $9^{0\,36}$ N. The district covers approximately 350km2 and ranked 6th in terms of size among the eighteen districts of the

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main occupation. Over 80% of the people in the district depend on agriculture for their livelihood. The district is one of the leading producers of yam and maize in the northern region of Ghana. Out of the total land area of 535,000 hectares, arable land constitutes 481,000 hectares out of which only 15% is under cultivation. Other economic activities include weaving of traditional smocks, agro-processing (shea butter extraction), meat processing, fish mongering, wholesale and retail of general goods, transport and many others. These activities are on medium and small scale.

The potential of the district in agriculture is enormous. The land is suitable for the cultivation of cereals, tubers and the rearing of animals. Animals reared include cattle, sheep, goats, pigs, and poultry for domestic and commercial purposes.

A good number of the populace is engaged in small scale manufacturing businesses. These include smock weaving, blacksmiths, mechanics, shea butter extraction and groundnut oil extraction.

The centrality of the district within the eastern corridor puts it in a better position to drive some benefits from the surrounding districts. This is manifested by the concentration of major development projects in the district e.g. Hospital, communication facilities, pipe born water and banking services.

The advantage inherent in the centrality of the district notwithstanding, undue pressure is often brought to bear on the facilities mentioned above due to the large catchments area of the district.

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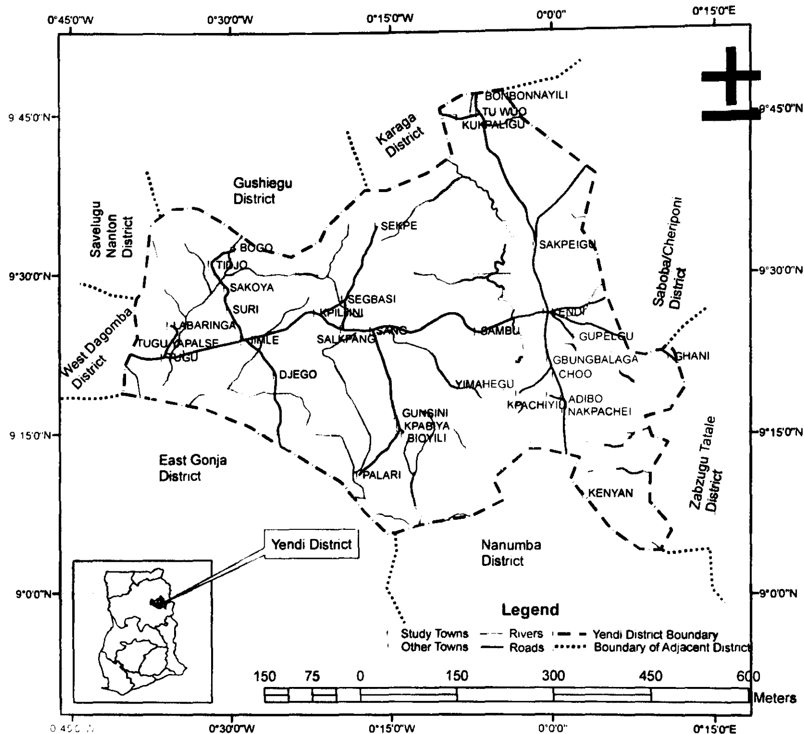
FIG:2.2

A Map of Yendi District showing the study communities



2.2 2. Administration

Buipe is the Administrative capital of the Central Gonja district. There are other sub-district centres located in other four administrative zones namely Mpaha sub-district, Tuluwe sub-district, Yapei sub-district. Kusawgu sub-district. Buipe is also in the Buipe sub-district making it five sub-districts.

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capital of the Dagombas makes it necessary for it to be chosen as a study area so that we can have a clear idea and understanding of the work of Traditional Birth Attendants (TBAs) in the Dagban Traditional area and the Gonja traditional area.

2.2.3 Population and demographic characteristics

Central Gonja District was recently carved out of the former West Gonja District in 2004. To this end all information on population of the district was not separated from that of West Gonja district. The information on the population of the district is scanty. The limited information on the population of the district is analyzed below.

The district has about 86,345 people according to 2000 population census (Projected). The population is not evenly distributed with large concentration of people in a few large settlements such as Buipe (8,692), Yapei (4,868), and Mpaha (4,674). The population density of the district is 8.3 persons per sq. km. The district population growth rate of 3.1% is higher than the national rate of (2.8%). There is therefore the need for public education of population growth in the area.

2.2.4 Age and sex composition

The sex ratio is 103 males to 100 females. This phenomenon is due to the fact that females are more mobile and migrate outside the district than their male counterparts. Another factor is that there is enough arable land therefore men who are mainly farmers and come from other districts to engage in farming.

Urban population decreased from 18% in 1984 to 14.5% in 2000 due mainly to the ethnic conflicts in 1990 and 1996 respectively. This has resulted in the devastation of several settlements and the exodus of thousands of people outside the district and region as a whole. The population is concentrated in a few accessible areas or settlements like Buipe, Yapei, and Mpaha etc. The age

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structure is typical of developing countries with over 50% between 15-60 years of age. Age –sex structure also follow the National and Regional patterns.

The population of the district is 130,504 (2000 population and Housing census) and is varied in terms of ethnicity with the Gonjas constituting the majority of about (74%). The other ethnic groups include Dagombas, Akan, Ewe, Moshie, and Hausa. The population is largely rural in that about 62.6% live in the rural areas while 37.4% are in the towns. The population growth rate is approximately 2.9% per annum. Out of the total, 64,728 and 65,776 are the population of males and female and respectively.

Additionally, 84,974 live in rural communities while 45,530 live in urban centres. The main religious groupings are Moslems, Christians and Traditionalist. Migration pattern is more pronounced among the youth and especially female girls who basically travel down south to engage in female porters (Kayaye)

2.2.5 Ethnicity and religion

There are about 13 ethnic groups in the district. The major groups, however, in terms of numbers are Gonja, Dagomba, Mamprusi and Dagarbas. Others including Ewes, Akans and Chokosi, Konkombas used to live in the District, but due to the 1994 ethnic conflict it has become risky for them to continue living there. The lack of ethnic homogeneity tends to constrain socio-cultural organization and development. There are however, inter-tribal marriages and peaceful co-existence, which enhanced unity in diversity in the area.

There are three major religious groups in the Central Gonja District. These are: Islam which constitutes about 70%. Christianity 18% while traditional religion also constitutes about 12%. There is relatively religious harmony which is a pre-requisite for development.

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The Yendi district has the same ethnic groups; the only difference is that the Yendi district is dominated by Dagombas, followed by konkombas, and the other tribes. The population of the district is 163,417 (2000 population and Housing census) and is varied in terms of ethnicity with the Dagomba constituting the majority. The other ethnic groups include Konkomba, Akan, Ewe, Basare, Moshie, Chokosi and Hausa. The population is largely rural. About 62% live in the rural areas while 37.4% are in towns. The population growth rate is approximately 2.9% per annum. Out of the total, 64,728 and 65,776 constitute the population of males and females respectively

Additionally, 84,974 live in rural communities while 45,530 live in urban centres. The main religious groupings in the Yendi district are Moslems, Christians and Traditionalists. The interesting thing is that majority of the Muslims and the Christians blend their religions with the traditional religion making it difficult to get the real Muslims and Christians in the district. Migration pattern is more pronounced among the youth and especially female girls who basically travel down south to engage in 'Kayaye'. Out migration by young girls exposes them to all forms of sexual abuse and low enrolment of females in schools.

2.2.6 Health infrastructure

Generally, Central Gonja district has limited health infrastructure. It lacks hospital. The highest health institution in the district is health posts which are located at Kusawgu, Mpaha, Yapei and Buipe. Apart from the health posts the district also has Rural Community Planning Services

(CHIPS) at Sankpala and Chama respectively. Health facilities are, therefore, inadequate and unevenly distributed in the district. The District Health Management Team (DHMT) is responsible for health delivery in the district. In the district TBAs are mostly the main providers of maternal and

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child health care. In almost every village there are these TBAs who assist in the delivery of pregnant women and also take care of the newly born babies .Some even go as far as giving the women health education especially the trained TBAs but these trained ones are very few in the district. In the year 2006, one thousand one hundred and twenty-five (1,125) TBAs were trained this have reduced in 2007 to nine hundred and twenty –two (922) TBAs as a result of the introduction of the youth employment scheme which has resulted in the employment of young ladies (Zoom nurses) to assist in the maternity ward and other health care delivery in the district, after they have been given some training in the Tamale Nursing Training College. The district assembly focused more attention on the training of the youth employment nurses because they are young and have at least secondary education as compare to the TBAs who are mostly old women and without any basic education. But then since most of the settlements in the district lack health facilities, the women in the hinterland are calling for the training of the traditional birth attendants (TBAs) who are easily accessible and understand the local custom.

On the issue of health status in the Yendi district, the indicators are that the health conditions of the people have been improving in the last three years. Coverage of DPT between 2003 and 2004 was 90%, 2004 and 2005 was 103% showing an increase of 13% coverage over the past years. The district has a government hospital located in Yendi and six (6) clinics located at Bunbonnayili, Gnaani, Adiboo, Sang, Jimle and Yendi. The District has three (3) other Community Health and Planning Services (CHPS) at Sunson, Dagban and Kuni.

The Yendi district hospital serves as a referral for the whole of the eastern corridor. As a result mortality rate in the district is very high for example the number of deaths in the year 2003 has increase from 428 to 875 in 2005. (Yendi hospital). Demand of the services of the hospital is very high.

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Infant and maternal mortality in the district has remained a major problem. This can be attributed to the use of local herbs during labour that eventually ruptures the uterus of the pregnant woman and endangers the life of the unborn child.

Another important trend is the doctor to the population ratio which was about, (1:28,400) in 2003, has increased to (1:48,650) in 2004.as a result of this lack of medical professionals most of the people in the area patronize traditional medicine which includes the TBAs.

2.2.7 Availability of health Facilities

Yendi and Central Gonja districts cannot be pegged at the same level in terms of availability of health facilities. The Yendi district has a government hospital located in the district capital and six (6) clinics and eight (8) health posts. This has made the Yendi district to be far developed in terms of health facilities as compare to that of the Central Gonja district which has no hospital and the only big health facility in the area is the Bupei and the Yapei clinics which are not also strategically located because they are both located along the trunk road from Kintampo to Tamale. Putting the people who are not residents along the trunk road to a disadvantage. Accessibility to health facility tremendously affects a person's patronage of the health care being offered. On the issue of health information regarding the important role the facilities play in reaching to the clients at the deprived areas, the Yendi district has an advantage over that of the Central Gonja. The staff of the Yendi district health normally goes on their regular outreach programmes but in the Central Gonja district the staffs are inadequate and the logistics to assist the few health staff too are not adequate. This was reveled when I interviewed both District Directors of Health Services in their respective districts

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2.2.8 Transport and communication

The availability of good road network plays a vital role in the accessibility and utilization of publi facilities. Bad road network might impose spatial constraints on the use of facilities in several way including travel time, risks associated with motor transport, absence of transport and impassabilit of the road during the rainy season which might seriously affect movements of people and goods.

The importance of good road network has been emphasized in the both the Yendi and the Centra Gonja Districts Development Plans(2005) which state that immunization coverage against the six childhood killer diseases is unevenly covered in the districts. This they stated is partly as a result of poor roads coupled with inadequate transportation.

Central Gonja District has a road network which consists of primary, secondary and feeder roads Except the Kumasi – Tamale trunk road that runs through the district, most roads in the district are in very poor condition and un-mortable during the rainy season. Most parts of the district especially the overseas (Tuluwe and Sheri) are cut off from the marketing centre and district capital during the rainy seasons, this makes it difficult for the people in the area to access modern health care facilities which results in the high rate of maternal and child mortality in the area. Footpath, in this regard, plays a major role in the movement of foods and service in the district. Passenger transport service is inadequate and unreliable. Taxi services are available in Buipe Township and other neighboring communities like Lito. Improvement in the road transport will go a long way to promote socio-economic development of the district most especially in the health delivery.

Water transportation is limited to the Black and White Volta Rivers in the district. Boast and canoes ate also used to carry goods and passengers to other of the district.

There exists an inland port at Buipe, which is used to transport bulky goods down south to Akosombo. Major cargos include cement, petroleum, lubricants, cotton, cattle, iron rods etc.

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Telecommunication system is, generally, a problem in the district. There are only two towns that can boast of such facility, thus Buipe – the district capital and Yapei- respectively. Post office is not in existence in the district. This in a way has made communication very difficult and the people in the area are forced to rely on traditional medicine if the is a problem that needs an immediate attention.

Road network in the Yendi district is very poor the only good road that can be describe as first class road is the road from Tamale the regional capital to Yendi the district capital. The nature of the road network has made it very difficult for people in the rural areas in the district to access health care especially when the situation is critical. People in the hinterland have to carry pregnant women in labour on motor bike to the Yendi government hospital. Some even deliver on the way. For this reason most people resort to the service of the TBAs.

2.3 Research methodology

2.3.1 Research design

The principal focus of this study is to critically examine the contribution of Traditional Birth Attendants in promoting maternal and child health in rural settings. Qualitative interview techniques and questionnaires were used to collect data from two different settings. The essence of this was to do comparative analysis of the data to find out any significant differences that was emerge as a result of diverse culture and life style as influenced by different geographical and economic conditions.

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2.3.2 Participants

The key informants in this research were Traditional Birth Attendants, mothers whose labour have been supervised by Traditional Birth Attendants, trained allopathic health care worker such as nurses and midwives and traditional healers. Other participants included some members of communities in the study areas who were selected through random sampling.

2.3.3 Sources of data.

The research was built basically considering primary as well as secondary data sources.

2.3.4: Primary data.

Primary Data was obtained from the following categories of people as respondents in the research areas (target population).

- Representatives of Women of Childbearing age. These categories of women were important to be contacted for information on the adequacy or otherwise of Traditional Birth Attendants and the perception of their level of skills and knowledge in the execution of their duties.
- Representation of Traditional Birth Attendants to get their input on resource constraints and other challenges they faced, and the possible ways of making them more functional.
- Health worker in the districts health facilities were also contacted to ascertain the level of mandate of Traditional Birth Attendants and the co-ordination between the skilled attendants and their unskilled counterparts and the possible integration of the orthodox and the traditional medical practiceners.
- Traditional Healers: People with traditional knowledge on health care were contacted to ascertain whether they have been treating pregnancy complicated cases and/or postnatal health conditions.
- Women in their menopause who have encountered Traditional Birth Attendants before were also be contacted to find out their views about TBAs.

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Sources of various primary data, unit of data collection type of data and methods of data collection are tabulated in Table 2.1

Table 2.1 Sources of data and methods of data collection,etc

Source of Data	Categories	Type of Data	Methods of Data collection
TBAs	TBAs	Both qualitative and quantitative	Interview guide,FGD and questionnaires
Service users	Mothers who have been given birth before or assisted by TBAs during delivery,etc	Both qualitative and quantitative	.questionnaires, FGD,observation,interview guide.
Health professionals (Trained).	1. Doctors 2. Midwives 3. Nurses	Both qualitative and quantitative	Participant observation, questionnaires
Traditional healers	Traditional healers in the study areas.	Qualitative	Interview guide, questionnaires

2.3.5 Secondary data:

Several sources of secondary materials were consulted to gain an insight into the current practice, theories, definitions and conclusions of similar researches that could be used to affirm or dismiss some of the assertions about Traditional Birth Attendants, and Maternal Child Health. These materials include text books, magazines, newspapers, journals, bulletins and materials from the inter net

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2.3.6 Sample size.

Because it was not possible to interview each and every woman of child bearing age, all TBAs, and all health practitioners both modern and traditional in the study areas, a sample procedure to select the sample that represent the population was adopted. This is shown in the table below (Yendi district)

Table 2.2 Sampled communities and persons interviewed in Yendi district.

Sub-District	Health professionals	Service users (mothers)	TBAs	Traditional healers
Adiboo	2	25	20	5
Bunbonnayili	1	25	20	6
Kpabya	-	25	25	5
Jimle	2	30	20	5
Tijo	-	35	20	5
Yendi	10	20	15	2
Totals	15	150	100	30

Source: Field Survey, 2008.

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Table 2.3 Sampled communities and persons interviewed in Central Gonja District

Sub –district	Health personnel	Service users (mothers)	TBAs	Traditional healers.
Buipe	3	25	10	5
Chama	-	30	20	5
Jaramoapei	-	30	20	6
Kusawgu	2	30	15	4
Mpaha	3	25	15	2
Sankpala	2	30	10	3
Yapei	3	20	06	2
Totals	13	190	96	17

Source: Field survey, 2008

2.3.7 Sampling techniques.

Given that the key informants were selected on the basis of their characteristics convenient sampling techniques were employed to select them to take part in the research. These include purposive sampling and snow balling.

For the other participants in the general population; systematic sampling techniques were used to select the sample.

Cluster the communities in zones. Select representative' zones or clusters through random techniques, select male and female adults' participants from each cluster or zone through simple random sampling.

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2.4 Rationale for the study:

This study would serve as a useful tool to various stakeholders of health planning and delivery.

The provision of adequate data for effective planning and implementation of maternal and Child Health Programmes, that will integrate the effort of skilled attendants and Traditional Birth Attendants in the two Districts in particular and Ghana in general.

The study would ensure that the most effective and cost-effective intervention strategies for safe mother-hood and child- hood service packages are incorporated into health planning in the study districts and beyond.

The findings of this research would guide policy makers to give Traditional Birth Attendants the needed supervision to gain social recognition, which will improve the quality of their delivery.

Equally, the data would guide other researchers into the activities of Traditional birth Attendants in the future to enhance Maternal and Child Health. This would also add to the existing body of knowledge on the contribution of Traditional Birth Attendants in Maternal Child Health in the study area and Ghana as a whole.

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CHAPTER THREE

MATERNAL AND CHILD HEALTH SERVICES IN GHANA

3.0 Introduction

Maternal and Child Health Services in Ghana is made up one of the 18 divisions of the Ghana Health Service. Their activities include all the Safe Motherhood and Childhood interventions. The Maternal and Child Health (MCH) services include the following programmes:

1. Child Care
2. Health Education
3. Maternal Health
4. Breast Feeding
5. Expanded programme on Immunization (POLIO)
6. Nutrition (including growth monitoring and Maternal nutrition)
7. Control of diarrhea
8. Environmental Health
9. Family Planning

The MCH services such as the antenatal and post natal services are put in place to promote the health of the pregnant woman through safe delivery and the health of the baby.

Therefore, MCH services can play a vital role in achieving improved reproductive outcome in various societies, particularly in rural settings (Bhatia and Cleland, 1999: Coeytaux, Leonard and Bloomer, 1998). However, the use of available MCH services continue to be low throughout the world (Paul, 1999: Holian, 1998), and sub Saharan Africa is no exception .This has being particularly evident in the rural areas.

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3.1 Safe motherhood

The joy and the hazards of reproduction have been inextricably linked since the beginning of humankind. Virtually all civilisationa and cultures place reproductive issues in the centre of their lives, by having deep-rooted and extensive rituals and regulation forming a basis for their societies. Although mortality and morbidity linked to pregnancy and child birth have been drastically reduced in many affluent countries, the reality of motherhood for many women in low-income countries is often grim most especially the northern part of Ghana where illiteracy rate among women is very high and poverty rate is also very high in the area. For these women, motherhood may frequently be marred by unforeseen complications of pregnancy and child birth. Some die in the prime of their lives and in great distress. Presently lower income countries are experiencing the hazards associated with motherhood at levels that at times seem difficult to grasp.

The concept of "safe motherhood" is concerned with a woman's ability to have safe and healthy pregnancy and delivery, addressing both morbidity and mortality. The cornerstone of safe motherhood is;

1. Community education on safe motherhood,
2. Prenatal care and counseling, including the promotion of maternal nutrition
3. Skill assistance during child birth,
4. Care for obstetric complication, including emergencies,
5. Post partum care,
6. Management of abortion complications, post abortion care and, where abortion is not against the law, safe services for the termination of pregnancy,
7. Family planning counseling (FPC), information and services
8. Reproductive health education (RHE) and service for adolescents.

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Culture, logistic, nutritional, education, legislative, economical and operational factor, health policy and health systems all are important factors when addressing safe motherhood. The connecting road to adverse events in pregnancy and delivery may be portrayed in a conceptual framework below, where socio-economic and cultural factors are distant determinant. These lead to intermediate determinants such as health status, reproductive status, access to health services, health care behaviour\ use of health services and unknown or unpredicted factors. Subsequently, the path goes on towards the outcome of pregnancy and delivery and complications which may lead to death or disability. AbouZahr describes a chain of care which starts in individual homes and families and links them to a health care system. A break at any point in this chain may prevent them from receiving the care they need, and may mean the difference between life and death. The chain of care has to be created by the health sector but with the involvement of other sectors and of the families and communities.

A holistic approach is required when considering the concept of safe motherhood. Therefore, this chapter would focus on safe motherhood in a global and historic context, causes, contributing factors, aspects of care in relation to maternal death, the work of TBAs and strategies in promoting safe motherhood.

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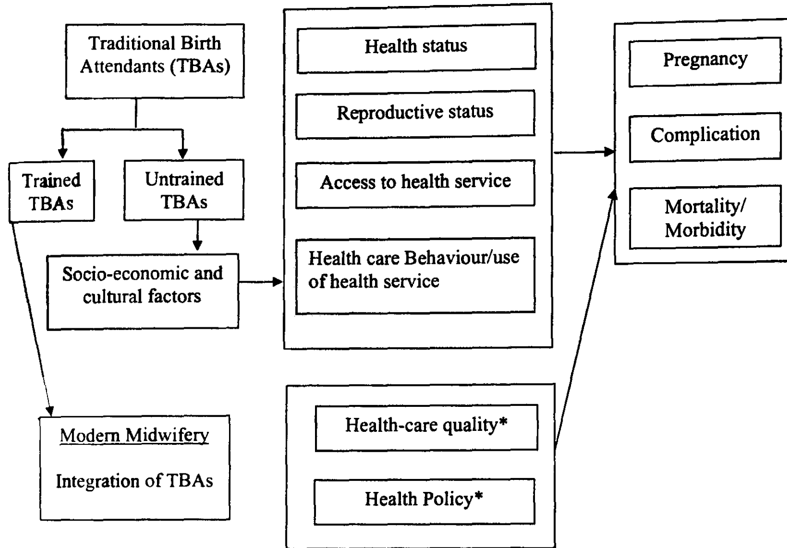
Figure 3.1 Safe Motherhood Conceptual Frame work



3.2 Background to safe motherhood.

Motherhood is a stage of life, which is much cherished by families due to the emotional and social joy that it brings to families. It is therefore sad that many families are often eluded by this happiness through maternal and neonatal mortality, morbidity and disability. Motherhood related afflictions claim the lives of many mothers and /or babies annually.

WHO/UNICEF (1999) estimates that there are 585,000 maternal deaths each year globally from complications of pregnancy and childbirth. Another 15 million experience chronic problems resulting from childbirth while estimated 64 million women suffer dangerous complications of pregnancy. About 99% of these unpleasant cases occurred in developing countries where these

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complications account for at least 18% of the disease burden (DALYs) among women in their reproductive age (World Bank, 2003).

Having observed the hazards of unsafe motherhood in the world and especially in developing countries, there is now a global effort to increase maternal safety and reduce maternal and neonatal mortality and complications associated with pregnancy and childbirth. As part of this effort, the *Safe Motherhood Initiative* was launched at an international meeting in Kenya in 1987. The major focus was to reduce high maternal death rates and pregnancy related illness and complications especially in developing countries.

The importance of Safe Motherhood was again given impetus during the 1994
International Conference on Population and Development in Cairo and the 1995 World summit for Social development in Copenhagen as well as during the 1995 Fourth World Conference on Women in Beijing (Goliber, 1997). These global efforts have shaped maternal and child health care delivery in developing countries since the late 1980s and early 1990s.

Safe Motherhood is the prevention of maternal and infant death and disability through access to basic health care to ensure that all women have access to the information and care they need to go through pregnancy and childbirth safely and confidently

3.3 Safe Motherhood Initiative

In Ghana, Safe Motherhood programme of which Making Pregnancy Safer (MPS) is a major component is part of the National Reproductive Health Service delivery, which is delivered through the Primary Health Care Programme. The Maternal and Child Health
(MCH) was launched in Ghana as a major component of the Primary Health Care (PHC) system in 1978. Among other things, the MCH initiative is mandated to promote and maintain the health of

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women and children in Ghana. This has become necessary given the high rate of maternal and infant mortality rates in the country. The maternal death estimation based on institutional data (MoH) placed the figure at 250/100,000 live births
(GHS, 2003) while a United Nations estimate put it at 540/100,000
(*http://millenniumindicators.un.org*) but it is believed that the best estimate will be between 1400 – 3900 / 100 000 live births
(*http://www.policyproject.com/pubs/MNPI/Ghana_MNPI.pdf*) since not all cases are reported.

In 1992, the Ministry of Health, having observed the numerous health problems affecting women and children in particular, set a number of priorities for itself. Among other things, there was the need to intensify maternal and child health services and family planning activities as part of the strategies within the framework of the national population policy (GSS, 1995). The idea of giving special attention to MCH/FP as part of the PHC was again justified in 1992 because of the fact that women and children are seen as the most vulnerable to ill-heath and death in Ghana (MoH, 1992). Consequently specific actions were taken to achieve Safe Motherhood including the process of instituting a Life-Saving skills programme and forming the National Safe Motherhood Task Force in 1993 (Levin, et al. 1999). In line with this, a number of health care centres were empowered to provide MCH/FP services through out the country.

Since 1998, the focus of the MoH/GHS has shifted from MCH/FP to Reproductive and Child Health (RCH). The Safe Motherhood initiative however continues to receive much attention. The major components of the Safe Motherhood programme include the following interventions;

- Antenatal Care
- Labour and Delivery Care
- Postnatal Care
- Family Planning

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- Prevention and Management of unsafe abortions
- Health education

These major interventions are mostly carried out within the context of the PHC system.

Services are taken closer to the communities while at the same time encouraging community participation. The interventions for making pregnancy safer in Ghana are mostly provided at the grassroots level by the various district hospitals, clinics, health centres and posts

3.4 Safe motherhood in a global context

The global efforts to reduce the difficulties of reproductive life have led to new insight and the development of new policies, strategies and intervention programmes. Reproductive health has been broadly defined by the World Health Organisation (WHO) as a set of four goals in which people should be able to exercise their sexual and reproductive rights in order to:

1. Experience healthy sexual development and maturation and have capacity for equitable responsibility and fulfillment,
2. Achieve their desire number of children safely and healthily, when and if they decide to have them,
3. Avoid illness, disease and disability related to sexuality and reproduction and appropriate care when needed and
4. Be free from violence and other harmful practices related to sexuality and reproduction.

3.5 Safe motherhood and aspect of care

In order to have a holistic perception of the concept of safe motherhood, it is important to consider various aspects of care as well. The lack of care may contribute to maternal deaths. Care in relation to safe motherhood ranges from preconception care through antenatal, pre-delivery, delivery and post partum care. Preventive measures and actions during all these period may contribute to the reduction of maternal deaths.

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3.6 Pre-conception care

Prevention of unwanted or unsafe pregnancy is one of the main pillars of safe motherhood. From the time a girl is able to conceive at menarche, she is at risks of experiencing unwanted pregnancy. In many societies she has little or no protection from coercive sexual action. Thus, this time period is of great importance in order to reduce maternal death. In developing countries where health personnel are lacking and TBAs are the main providers of maternal and child health care, education and training in this direction should be given so as to reduce maternal mortality.

3.7 Family planning

Family planning has been one of the pillars of safe motherhood care. In Ghana, the use of contraception has increased from 16% in 1996 to 42% in 1999. Historically for both age and parity the risks of dyeing per pregnancy follow a U- or J-shaped curve; women fewer than 20 or above 35 years of age, women having first pregnancy and high parity women all have elevated risks of dyeing from maternal causes. The response has been to advocate family planning in order to concentrate births in the safer age- parity group-in the range 20 -25 and at parities under 4-6. However the greatest proportional contributions to births and deaths are in fact made by the 20-35 year age group. In addition, some studies from Sweden and the United States observed that the J-shape curve of risks is disappearing. This means that older women may be less at risks of maternal mortality than previously thought in high – income societies.

Thus, the policy of focusing attention on the avoidance of births in high-risks groups has some difficulties. Firstly, it may not be able to prevent between half and three-quarters of all maternal deaths and secondly, it is not "efficient" since a substantial number of births must be avoided for each maternal death averted. A common notion has been that, short birth intervals increase the risks of maternal mortality. Family planning is the effort to lengthen birth intervals. However a report

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from Bangladesh has observed that short birth intervals do not increased the risks of maternal mortality. An aspect, which is present but often not mentioned, is the mortality from contraceptive method. Winikoff and Sullivan discuss this aspect and refer to a study by Sachs et al.which show that in the United State, pregnancy prevention was the cause of many deaths as pregnancy itself. Approximately 95% of those deaths were associated with oral contraceptives. The quality of these contraceptives is improving, most probably resulting in fewer deaths now.

The current strategies have turned from focusing on family planning for the "high-risks" groups, to the provision of safe obstetric care for the 15- 20 % of pregnancy where complications are likely to occurred and where risks assessment may not have been able to detect them at an early stage.

3.8 Antenatal Care

One of the main pillars of the WHO strategy for reducing maternal mortality has been the promotion of antenatal care. The rationale for antenatal care is that it is essential to screen a predominantly healthy population to detect early signs, or risks factors for diseases, followed by timely intervention. The care of the woman has three important functions these include: (1) selection of women at risk for subsequent referral to a level with better competence and facilities,

(2) Prevention, detection and treatment of severe maternal morbidity and (3) maternal health education (how to recognize problems if they occur, when they should have to seek help from wherever they are, and where they should go to receive proper attention) this education should focus on the TBAs and community health workers. Turning the potential benefits of this system into real health gains depends on the technical quality of implementation, user compliance and the functioning of corresponding parts of the health system such as the referral systems.

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3.9: Antenatal Care and the use of Health Facilities at Delivery

Antenatal services may contribute to lowering the barriers between pregnant women and the health services. In their study from India, Bloom and colleagues found that women receiving a high level of care during antenatal visits had estimated odds of using trained assistance at delivery that was almost four times higher than women with a low level of care. (Saif and Measham DM.,1992). The strong positive association between level of care obtained during pregnancy and use of safe delivery is important when considering the role of antenatal care in reducing maternal motility. In a study from Nepal, antenatal coverage was four to six times higher in the catchments areas of high quality health posts than for low quality posts. Immunization coverage was three to four times higher among families whose nearest health post was high quality than among those who had a poor quality post. Identifying risks and consequent referral of women to higher level facilities will not help if the quality of treatment such as blood transmission, surgery, or professional care is deficient or not available, or if there is deficient or non existing transport with which to reach the health facility. The compliance of women to come as a result of referral will be low, as shown in several studies from Africa. In northern Ghana a study by John and his colleagues found that even though antenatal coverage was high in the population (74%), (Starrs.A,2006). antenatal care had only a limited effect on extending obstricts services to high-risks mothers. this limited effect of extending services was also found in Yendi by A.K. Fosu, where the study identify a discrepancy among rural women between planned and actual delivery place, the most common reason being pre-term delivery, poverty and transport problems. (Fosu, A.K,1999).

3.10 Pre-delivery Care

Pre-delivery care is in- patient antenatal care before birth, as opposed to the out patient antenatal care. Adequate pre-delivery care is important for women affected by complications or perceived as being of high risks of adverse outcome of pregnancy. Even when delivery (intra partum) care is

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adequate, the outcome of pregnancy may be poor if pre-delivery care has not functioned properly.Bergstrom defines three (3) levels of redelivery care. These includes:

Level 1 maternal waiting area, corresponding to maternity waiting homes.

Level 2 is designated for women with pregnancy complication, such as pre –eclampsia, preterm labour, or pre term pre labour rupture of membranes. These women require rest and daily supervision by a nurse or midwife, but not necessarily by a doctor.

Level 3 is required for women with serious complication such as haemorrhage, threatening preterm birth, cervical insufficiency, intrauterine growth retardation, and severe cases of pre-eclampsia. These three levels of care should collaborate closely.

In many developing countries including Ghana, the barriers to health care may be so great that many women will not benefit from the health-care system, especially in times of emergency. Ensuring access to emergency obstetric services is one of the priorities of the Safe Motherhood Initiative (SMI).There are three ways of improving access to obstetrical services when complications arise, these includes the following:

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1. Bringing medical services to women in need-“flying squads”
2. Bringing women who need them to medical services- emergency transport
3. Decentralization of care so that women have easy access to skill attendants: this would require provision of obstetric facilities close to every community.

Currently, the third solution is not feasible in lower income countries. Thus, alternatives have to be sort. One of these is the concept of maternity waiting homes. These facilities have been developed in various way in several countries, but the common denominator is the idea of “bringing the geographical gap” between obstetric facilities and remote areas. Women who are defined as being at risks, and other women who would like to deliver in a health facility, may live in these residential homes until delivery, and preferably also post partum, as majority of maternal death occur in the

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post partum period. For women who do not have relatives close to a modern facility, paying for accommodation may be impossible. These homes may offer an alternative.

However, the concept of maternity waiting rooms thus poses some difficult questions. Financial considerations such as who should pay for the service, practical management, who is referred, what services are offered, what constitutes a maternity waiting homes and collaboration with the obstetric unit are all questions that need to be solved in each case. The acknowledgement that all pregnant women are at risks of complications, and the over bearding of health facilities due to the lack of capacity to accommodate all deliveries in a population, add to the questions that need to be address. There are cultural and social aspects unique to each area, which need to be resolved. Many mothers prefer to deliver at home, and may not be willing or may not have the possibility to leave home until complications arise, due to family and work load constrains. If maternity waiting homes are established, one should ensure that they are a link in larger chain of comprehensive maternity care, and be aware that they can not function effectively in a vacuum.

The effectiveness of maternity waiting home depends largely on the ability to recognize and refer women at risks, the utilization of the homes by such women, the availability of efficient emergency obstetric services. The evaluation of their effectiveness may be summarized by two (2) questions:

1. What difference does the maternity waiting home make to the health of the community: and (2) at what cost is this benefit achieved?

   A study from Zimbabwe found that when comparing women staying at a maternity waiting home and those reporting directly to the obstetric ward, the women with the obstetric risk who stayed at the home reduce their risk of a prenatal death by nearly 50% compared to the controls. Among the women without antenatal risk factors, staying at the maternity home had no effect on prenatal mortality. In the same study, when analyzing adverse maternal outcomes, the risk of

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obstructed labour was 16 times higher for those not attending a waiting home compared with those who did attend. In a study from Ethiopia, there were 13 maternal deaths among those admitted directly to hospital, but non among women who first entered a maternity waiting home.

3.11 Delivery Care

The majority of maternal deaths and much of the chronic morbidity resulting from childbirth are the result of failure to get appropriate help for complications of delivery. As the majority of women in sub-Saharan Africa still deliver at home and traditional birth attendants are responsible for most deliveries. They should be capable of simple first aid and referral to the nearest health facility. TBAs and modern midwives can function on all levels, be it in the community, health post clinics, health centres and hospital should be a link between the community and TBAs and the referral level. In a delivery ward each patient should have her own patient records this was included in the training of the TBAs by given them the tally card. The records should be operational oriented towards patient care and optimal for scrutiny which is oriented towards the collection of relevant data for each individuals, mothers and newly born babies.

The World Health Organisation (WHO) patogramme has been modified specially for conditions in lower- income countries. The maternal health card should have one part for antenatal recording, one part for delivery events, and ideally, the record should also contain information on the post partum\puerperal period. It should summarized information of each pregnancy outcome, with any maternal or infant complication. In Tanzania there is a patogram on the back side of the antenatal card.

It can also be a source for regular audit on the quality of care in a ward.

Recording of events is one aspect of good delivery care. However the quality of staff, availability of equipment, and emergency obstetric facilities such as anesthesia, blood transfusion laboratory and

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surgical services are necessary as well. These are inadequate in rural Ghana most especially in the Northern part where this study is took place. TBAs are the major attendants to women in labour in most rural part of Ghana.

Currently, essential obstetric care and emergency obstetric care as a sub-group are among the safe motherhood strategies with highest priority. This is a consequence of the realization that every pregnant woman is at risk of developing complication. with the first priority for delivery care been that it should be safe and clean, the deterioration of the health services in many developing countries, not in the least in the most resent years, is causing grave concern. Many public hospitals do not have even the most basic equipment such as gloves, syringes, lines for intravenous fluids, lining and other essential equipment and medicines.

Resent reports from the northern regional health directorate indicate that public health facilities in the Northern Region are in very poor condition especially in the rural areas. Hospitals services are falling apart and people are dying because of the severe shortage of resources and staff. Less than half of the delivery facilities have a medical doctor or clinical officer available at night. More than half of the government health facilities can not handle obstetric complications, which is one of the major causes for the high incidence of maternal deaths. Most doctors are looking for jobs in other countries and some prefer to open their own private clinics where they can earn more income especially now that the government has instituted the National Health Insurance Scheme (NHIS) to replace the cash and carry system in the country. Conditions such as these are what many lower-income countries are struggling with.

3.12 Safe Motherhood policies, strategies and challenges

As a foundation on which to base the global strategies of reducing maternal mortality, lies on the issue of human dignity and human rights. The fact that most maternal deaths are avoidable is one of

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the reasons why maternal mortality is an issue of human rights. Health in general is driven by the political, social and cultural contexts in which it exists. Hence it is essential to introduce the concept of human dignity and human rights at all levels: the international policy strategies, health sector policy planning and the clinical setting. The issue of women status and economic dependency are examples of the human rights strategies to reduce maternal mortality. Other examples are access to help care, de-penalization of induce abortion in order to help those with complication, and efforts to address gender-based violence in pregnancy and postpartum. Involvement of men in maternal and reproductive health programmes and research is also viewed as being increasingly important.

Presently, there is a growing hope that progress may be made in reducing maternal mortality. Firstly, the practical solutions required improving the availability; access, quality, and use of maternal health services are known and affordable. Secondly, there is a greater awareness of the importance of an integrated approach to development. Multi sectorial strategies are essential, involving action in the field of education, legislation and media communication as well as in the health sector. Thirdly, the idea of equal rights to health, education and other social services are becoming more accepted by law makers in many countries including Ghana. The essential elements of safe motherhood programmes contain a broad perspective. The path way to safe motherhood begins with women status and education, the level of socio economic development in the family and community, and political commitment to maternal health and family planning. Women's health and nutritional status of pregnant women and children, reproductive and health behaviour as well as access to the quality of family planning and maternal care services further influence motherhood. The immediate determinants of maternal mortality are exposure to pregnancy, and development of management of complications associated with pregnancy, labour and delivery, there are three main pathways to reduce maternal death: 1 reducing the number of pregnancies and births, 2 Reducing obstetric complication and 3 Preventing deaths among women who have developed serious obstetric complications

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CHAPTER FOUR

MATERNAL AND CHILD HEALTH CARE IN THE CENTRAL GONJA AND THE YENDI DISTICTS.

4.0 Introduction

Maternal and Child Health Services in the Yendi and the Central Gonja districts in the northern region of Ghana is consisting of the following services. Their activities include safe delivery, the welfare of the child after delivery and other activities that will help in promoting the health of the mother and the child.

1. Maternal Health
2. Health Education
3. Family Planning
4. Immunization
5. Weighing of children under one year
6. Nutrition (including growth monitoring and Maternal nutrition)
7. Environmental Hygiene
8. provision of bed nets

All the services mentioned above are provided by health personnel in both districts but the Yendi district has other services that they offer to their clients which are lacking in the Central Gonja district. An interview with the mothers in both districts with regards to antenatal care revealed the following as shown in the Tables 4.1 and 4.2.

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Table 4.1

Percentage distribution of women who had live births in the years preceding the survey by antenatal care providers during pregnancy for most recent birth, according to the background characteristics, Yendi District, 2008.

Background characteristics	Doctor	Nurse/midwife/ Auxiliary midwife	TBAs	No one	Total	Number of women
Age at birth						
> 20	15.5	34.8	42.6	3.5	100.0	7
20 – 34	14.3	27.4	50.2	8.1	100.0	85
35 – 49	10.7	21.5	58.6	9.2	100.0	58
Birth order						
1	9.6	28.3	57.1	5.0	100.0	
2 – 3	18.2	30.6	42.2	9.0	100.0	
4 – 5	20.0	35.4	40.6	4.0	100.0	
Residence						
Urban	18.2	30.6	42.2	9.0	100.0	20
Rural	10.6	31.0	48.6	9.8	100.0	130
Education						
None	11.0	33.2	47.6	8.2	100.0	115
Primary	16.6	28.3	50.1	5.0	100.0	26
Middle/JSS	18.2	30.6	42.2	9.0	100.0	7
Secondary +	20.0	35.4	40.6	4.0	100.0	2

Source: Field survey, 2008

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Table 4.2

Percentage distribution 0f women who had live births in the years preceding the survey by antenatal care providers during pregnancy for most recent birth, according to the background characteristics, Central Gonja district 2008.

Background characteristics	Doctor	Nurse/midwife/ Auxiliary midwife	TBAs	No one	Total	Number of women
Age at birth						
> 20	5.7	12.1	72.2	10.0	100.0	11
20 – 34	4.3	18.4	69.2	8.1	100.0	106
35 – 49	0.7	11.5	78.6	9.2	100.0	73
Birth order						
1	2.6	17.3	68.6	11.5	100.0	17
2 – 3	4.4	18.3	69.0	8.3	100.0	332
4 – 5	4.7	13.1	70.2	12.0	100.0	905
Residence						
Urban	-	-	-	-	-	-
Rural	0.6	11.0	78.6	9.8	100.0	190
Education						
None	3.0	21.2	67.6	8.2	100.0	154
Primary	9.6	28.3	57.1	5.0	100.0	23
Middle/JSS	18.2	30.6	42.2	9.0	100.0	10
Secondary +	20.0	35.4	40.6	4.0	100.0	3

Source: Field Survey, 2008

From table 4.1 it is clear that about 78% of the women interviewed in the Central Gonja District delivered their babies at home with the assistance of TBAs. This is as a result of the inadequacy of medical staff and the high illiteracy rate among women of child bearing age in the districts. In terms of spatial variation among the two districts with regard to antenatal care, the women in the Yendi district are more accessible to health personnel than those in the Central Gonja district. This has to do with factors such as women education, availability of health personnel and health facilities as well as the belief system of the people. From table 4.1 and table 4.2 the Yendi district has recorded about 15% of the women who delivered with the assistance of a medical doctor because of the present of the Yendi district hospital and the doctor in the Hospital do assist pregnant women in times of difficulties and complications but for the Central Gonja district there is no hospital let alone to talk of a medical doctor and for this reason all deliveries are assisted by TBAs or the

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midwives in the various health centres and clinic. TBAs in both districts are therefore contributing greatly in promoting maternal and child health as illustrated above (table 4.1 and table 4.2).

In the Yendi district, the DHMT has put in place weekly outreach programme of which some the staff in the maternal and child health units and the child welfare unit in the hospital and clinics move to the communities to examine health of children under five (5) years and pregnant women and to give them health education. The staff therefore sees to it that Maternal and Child Health (MCH) services are brought to the door steps of the people in the area. This has given the pregnant women who in one way or the other fail to visit the health facilities for their health need the opportunity to be able to access the services. The staff also helps to educate the people in health issues like exclusive breast feeding, immunizing the children against the six killer diseases among others.

The Yendi District Health Management Team with the assistance of the Catholic Relief Services (CRS), a Christian Non Governmental Organisation helps in the provision of food stuffs to nursing mothers to enable them give their children a nutritious diet that will make them healthy and enable them to grow well.

On the other hand these services are lacking in the Central Gonja district and as a result, the malnutrition rate among children under five years is higher in the Central Gonja district than that of the Yendi district. This is shown in the figure 4.1.

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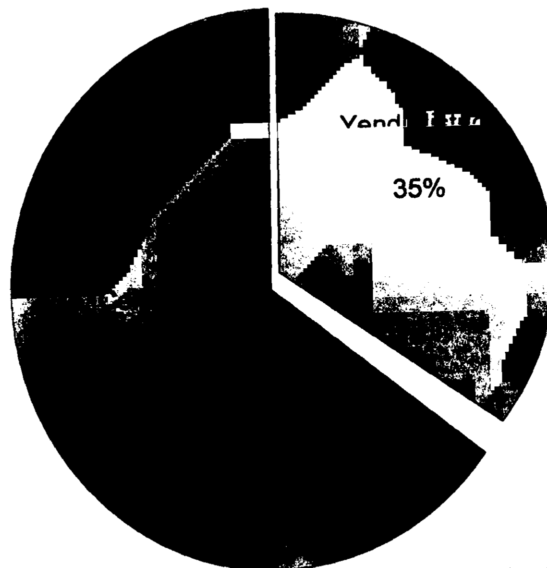
Fig 4.1 malnutrition rate in the two districts



Source: Field Survey, 2008

4.1 Maternal and pre – school child dietary habits

Pregnant women and children under five year in the study districts do not have a special diet. Maternal and child dietary habit did not diverge much from the routine household dietary pattern. Mother whether pregnant or lactating subsisted on what other member of the household ate. They did not eat a special diet. One thing that was significantly different was that in the child dietary pattern, children up to the age of three (3) month were fed almost exclusively on breast milk with the exception of about 14% who gave the children water to drink. The longest observed breast

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feeding period was one and half years. But from the third month onwards new babies were introduced to porridge. The age solid food like rice, yam and TZ were given to children varied. In normal cases, all from six month and above were fed on rice, yam and some even fed them on TZ.

4.2 Food Taboo among Pregnant Women and Under Five Children in the Yendi and Central Gonja Districts

The people (Dagombas) in the Yendi district hold the belief that pregnant women and children under five should not be given eggs or meat to eat. The reason being that if pregnant women are given eggs to eat, their babies would become thieves one day. Then also children should not be given eggs or meat as well as fish, this was done to prevent them from becoming thieves. This notion also applies to the Gonja traditional area. An interview with Mba Yahaya, a resident at Jaramoapei in the Central Gonja district revealed that he only provide meat for the wives to cook on festive days and that even if his cow or goat is about dyeing he prefer selling it to the butchers than using it for the family to consume. He lamented that meat is not for children but rather is for the old men and women.

When I interviewed Tijo Naa, the chief of Tijo he said that it was the wisdom of old people as a social control measure so that the people who could not afford meat or eggs to feel comfortable. That the elders realized that as a result of poverty, majority of the people can not afford meat for their pregnant women and children and for that reason they came out with that social control measure. But at the individual level those who can afford provide meat or eggs to their pregnant women and children.

Therefore, MCH services in the Yendi district has played a vital role in achieving improved reproductive outcome and child health in various communities in the district, particularly those in

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the hinterland, through the door to door visits by the health personnel where MCH services are brought to the door step of the people.

In the communities where health facilities are not in existence, TBAs and other community health workers are given the basic MCH skills so that they can attend to women in labour in times when the health personnel are not around especially in the night. In this case traditional Birth Attendances (TBAs) in the districts are contributing immensely in promoting Maternal and Child Health care.

4.3 Family planning (FP)

On the issue of family planning the Yendi district Health Management Team was doing very well through their door to door service delivery to the people in their catchments area and for this reason most of the people have understood why they should plan their family. However, those people living far away from the district capital like those in Gunsi and Kpabia could not understand why they should plan their family. They hold the belief that, children are their social security and also serve as their farm hands. This belief is more pronounced in the polygamous homes where there is competition among co-wives on the number of children they could bear.

An elder in Gunsi during an interview said that they have a traditional method of family planning and that when a women deliver her first or second child, she is allowed to go and stay with her parents for at least three (3) to four (4) years by which time the child will grow before she return to her husband's house. This is done for two main reasons. These are: one (1) for the woman to stay away from the husband and two (2) to learn the traditional way of child care practice from her mother. This belief is also practiced by the people of the Central Gonja District.

And that there existed a traditional system of family planning among the two ethnic groups before the introduction of the modern system of family planning.

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CHAPTER FIVE

THE ROLE OF TRADITIONAL BIRTH ATTENDANTS IN PROMOTING MATERNAL AND CHILD HEALTH CARE IN THE CENTRAL GONJA AND YENDI DISTRICTS.

5.0 Introduction

This chapter examines the role of TBA's in Maternal and Child Care Delivery in the Yendi and the Central Gonja Districts. First, I will like to describe the background characteristics of the TBA's.

5.1 Who are the TBA's in the Central Gonja and Yendi Districts?

. The study revealed that the TBAs in general have the following characteristics:

- They are mostly women
- Most of them are widows.
- They have long working knowledge and experience (passed on to them by mothers or grandmothers)
- They have very low levels of formal education or none at all in most cases.
- Low income level as they are not paid for the work they do
- They are predominantly Muslims in Central Gonja.
- In the case of the Konkomba communities in the Yendi district the TBAs are predominantly Christians.

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Plate 5.1 Sample of TBAs interviewed in Kpabya in the Yendi district

Source: Field Survey, 2008

A survey of hundred (100) TBAs in six (6) communities in the Yendi district revealed the followir

Table 5.1: Age Group of TBAs in Yendi District

Age Group	Number of Respondents	Percentages (%)
35-44	15	15
45-54	25	25
55- 64	38	38
65-74	12	12
75+	8	8
No Response	2	2
Total	100	100

Source: Field survey April, 2008

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Plate 5.2 The researcher having a discussion with a TBA in Sankpala in the Central Gonja District.

Source: Field Survey,2008.

A survey of ninety six (96) TBAs in seven (7) communities in the Central Gonja district revealed the following:

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Table 5.2: Age group of TBAs in Central Gonja

Age Group	Number of Respondents	Percentage (%)
34-45	9	9.40
45-54	17	17.76
55-64	21	21.80
65-74	42	43.75
75+	6	6.25
No Response	1	1.04
Total	96	100.00

Source: Field survey, April, 2008

With respect to the age of the TBA's Table 5.1 and Table 5.2 show that 22% and 51% of TBAs in the Yendi and the Central Gonja districts respectively are old. The aged bracket is 65 years and above. The low numbers of aged TBAs in the Yendi district (22%) as compared to that of Central Gonja district (51%) is due to the fact that the training of TBAs in the eastern corridor of the northern region was conducted in Yendi; as a result many young women in the Yendi district took part in the training and subsequently became TBAs. The training of the TBAs broadened their world view of facilitating child deliveries at home. The Central Gonja district has a greater number of aged TBAs (51%) because most of them acquired the skills through inheritance and the young ones did not get the opportunity to benefit from the TBA training to become TBAs as in the case of the Yendi district.

In an interview, 68% said they acquired their initial skills through inheritance and the remaining 32% acquired their skills through training.

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TBAs are women who have experience in child bearing themselves and are brave enough to stand the pains and suffering of others. The youth is often inexperienced in child birth and are not brave to withstand the pain of other women less alone to assist them deliver.

Table 5.3: Trained and Untrained TBAs in Yendi district

TBAs	Number	Percentage (%)
Trained	35	35
Untrained	65	65

Source: Field survey, April, 2008

Table 5.4: Trained and Untrained TBAs in Central Gonja district

TBAs	Number	Percentage (%)
Trained	12	12.5
Untrained	84	87.5

Source: Field survey, April, 2008

From the table 5.3 and table 5.4, it is clear that the Yendi District has the highest number of trained TBAs as against that of the Central Gonja District. This is due to the fact that the training of TBAs in the eastern corridor of the Northern Region was conducted in Yendi District. Yendi District being an old district has an advantage in the training of TBAs as against that of Central Gonja, which was created in 2004 as a result of the Ghana government policy of decentralization and the encouragement of grassroots participation in the decision making process. For this reason the Central Gonja District could not benefit from the training of TBAs. And there has not been any training of TBAs organized by Ghana Health Service (GHS) or any governmental and non governmental body in the area. As at the time of the research, a Non Governmental Organisation

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by name Christian Children Fund of Canada was in the Yendi District to train TBAs; this was done in collaboration with the District Health Management Team (DHMT), In Yendi. I asked the country director of CCFC, madam Sanatu Nantogmah why the training of the TBAs by her organisation was not taken place in the Central Gonja District? She said that her organisation had a contract with the Yendi district and the Nanumba district to train TBAs in those areas as far back in 1998 by which time the Central Gonja district was not even created, however she promised that her outfit would consider the Central Gonja district any time they got funding to train TBAs. The Yendi government hospital also played a major role in the training of TBAs in their outreach programmes as compared to central Gonja which has no hospital and the only big health facility in the Central Gonja district is the Buipe clinic. The District Health Management Team (DHMT) is still facing a number of challenges such as inadequate health staff accommodation for offices and to accommodate the health staff.

Table 5.5: Marital Status of TBAs

Marital Status	Total number of Respondents	Respondents for each district	
		Yendi	Central Gonja
Single	8 (4.09%)	5 (2.55%)	3 (1.53%)
Married	74 (37.75%)	21 (10.71%)	53 (27.04%)
Divorced	28 (14.28%)	16 (8.16%)	12 (6.12%)
Widowed	86 (43.88%)	58 (29.60%)	28 (14.29%)
Total	196 (100%)	100(51.02%)	96 (48.98%)

Source: Field Survey, April, 2008.

On marital status, it was established that 53 of the TBAs forming 27.4 % in the Central Gonja District were still with their husbands as against 21 (10.71%) of TBAs in the Yendi district. This is

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as a result of the 1993-1994 Konkomba –Dagomba ethnic conflict in the Yendi district and the 2002 Andani and Abudu conflict among the Dagombas in the Yendi district of which most women lost their husbands. The numerous ethnic conflicts in the Yendi district have led to the high number of widows in the area as against that of Central Gonja district that has not experienced any major conflict. This is illustrated in Table 5.5. From Table 5.5, it is also evident that widows constitute a greater number in both districts due to the fact that TBAs are mostly old women whose husbands have died because females have a higher live expectancy rate than that of their male counterparts. Also about 28 women constituting 14.28% of TBAs interviewed were divorced with the simple fact that some community member branded them as witches.

Table 5.6: Religious Composition of TBAs by District.

RELIGION	Total Number of Respondents	Respondents by District	
		Yendi	Central Gonja
Christians	56 (28.57%)	32 (16.33%)	24 (12.24%)
Moslems	137 (69.90%)	67 (34.18%)	70 (35.71%)
Traditionalists	3 (1.53%)	1 (0.51%)	2 (1.02%)
TOTAL	196 (100%)	100 (51.02%)	96 (48.98%)

Source: Field survey, April, 2008

On the issue of religion, it was established that Moslems formed the majority in both district, this can be clearly seen on the table 5.6 above. The Moslems dominance is as a result of the early introduction of Islam in the Northern part of Ghana by the Arabs traders in the northern territories before the coming of the Christian missionaries in the area. In the Yendi district Moslems formed 34.18% as against 35.71% in the central Gonja district. From the table above it was revealed that Christians in the Yendi district are more than that of the central Gonja this is due to the dominance

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of konkombas who are mostly Christians in the district whiles the central Gonja is occupied by only Gonjas and some few minority tribes

Table 5.7: Level of Education of TBAs

Level	Number of Response and percentage (%)	Respondents for each district	
		Yendi	Central Gonja
None	179 (91.33%)	87 (44.39%)	92 (46.94%)
Primary	12 (6.12%)	8 (4.08%)	4 (2.04%)
Middle\ JHS	5 (2.55%)	5 (2.55%)	0 (0%)
SHS	-	-	-
Tertiary	-	-	-
Total	196 (100%)	100 (51.02%)	96 (48.98%)

Source: Field Survey April, 2008

Questions on levels of education of the TBAs revealed that almost 179 respondents constituting about 91.33% out of a total of 196 interviewed did not attend school and this may not offer a fine opportunity for learning new skills expected of a contemporary TBA. The illiteracy rate among the TBAs in the Central Gonja district is higher than that of the Yendi district due to the fact that the Christian missionaries were accepted by the Konkombas and they could not study the gospel without first of all leaning how to read and speak the language of the white man which is English. Another reason for the high illiteracy rate among the TBAs in the Gonja District was that Yendi is an old district and being the capital of the Dagbon traditional area most people from the royal families were sent to school. This situation is different in the Central Gonja district. An interview with one of the TBAs in Sankpala revealed that her inability to attend school has affected her greatly in discharging her duty as a TBA. She lamented that those who participated in the training at

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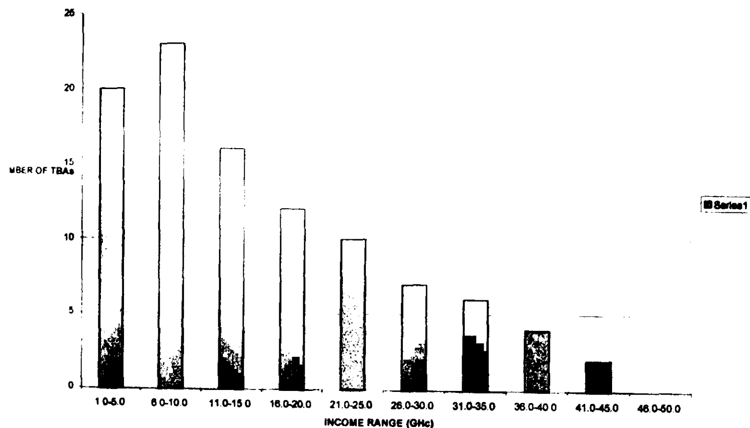
Yendi were admonished to keep record of number of deliveries but she is unable to keep proper records since she can neither read nor write and that she still uses a primitive method of keeping data by picking stones to represent the number of deliveries. She however bemoaned that the method was unreliable because she had a personal experience in which all the stones she used as a symbol for records got missing and she was confused when she got to know that the stones were no where to be found. This is as a result of her inability to go through formal education.

Another characteristic feature of TBAs as revealed by the survey is their low level of income. The graph below reveals the level of earning per month of TBAs that were contacted.

FIG.5.1: MONTHLY INCOME LEVELS OF TBAs IN YENDI DISTRICT



Source: Field Survey, 2008

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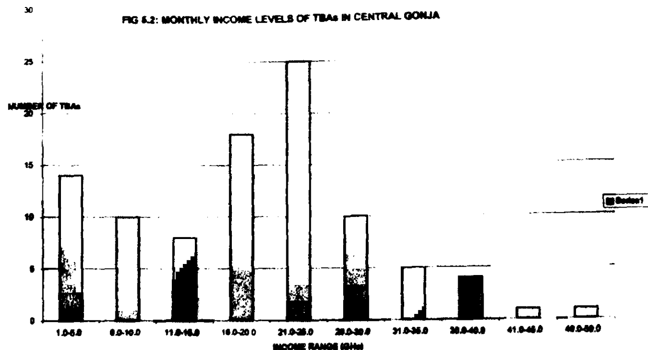

Source: Field Survey, 2008

It is clear that the income of the TBAs is very low since most of them are aged and 94% of them in both Districts are fifty years and above, their old age has served as a disincentive to them to work hard to acquire sustainable income for a living. All the same there exists income disparity among the TBAs in the two districts. From the two graphs above, 25 of the TBAs interviewed in the central Gonja district earned between 21 to 25 Ghana cidis a month whiles only 10 of the TBAs interviewed in the Yendi district earns the same amount. The disparities are due to the fact that most of the women in the central Gonja district are engaged in fish monging as due to the presence of the White and Black Volta Rivers which is one of the major fishing sites in Ghana. The second reason is that the central Gonja district is the epitome of charcoal burning in the northern region and these TBAs engaged themselves in the burning and selling of charcoal.

The Fig 5.2 above reveals that TBA's income is very low since about 33% of the respondents earns less than GH¢16 per month. Some of the TBAs were not ready to reveal their income status for the fear of being taxed and others would have liked to portray themselves as being poor, so that they

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could obtain support from the interviewer or benefit from the government social intervention policies such as Livelihood Empowerment Fund (L E F) and NGOs activities.

The table 5.8 confirms the type f occupation engaged in by the TBAs for a living.

Table 5.8 Occupation of TBAs

Occupation	Total no. of respondents	Various district respondents	
		Yendi	Central Gonja
Farming	162 (44.63%)	92 (25.34%)	70 (19.28%)
Shea butter processing	58 (15.98%)	36 (9.92%)	22 (6.06%)
Cotton spinning	46 (12.67%)	22 (6.06%)	24 (6.61%)
Local soap production	35 (9.64%)	18 (4.96%)	17 (4.68%)
Charcoal burning/fire wood	32 (8.82%)	12 (3.31%)	20 (5.51%)
Fish mongering	30 (8.26%)	4 (1.10%)	26 (7.16%)
Total	363 (100%)	184 (50.69%)	179 (49.31)

Source: Field survey, April 2008.

The data shows 48.64% of TBAs engaged in farming at the most subsistent level due to low income levels and old age. Some of these TBAs combine farming with other activities such as weaning of cotton, shea butter processing, local soap production, fish monging, charcoal burning/ fire wood among others. Some of the activities especially farming and the shea butter processing are not sustainable since they are seasonal because the northern part of the country has an unreliable single maximaum rain fall pattern.

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5.2 Traditional Birth Attendants in Central Gonja and Yendi Districts

Traditional birth attendants in the Central Gonja and the Yendi districts are responsible for delivering pregnant women in the localities in which they find themselves and beyond. The traditional role of this group of people 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. (Household interviews, 2008).

The contemporary TBAs are required to serve as health intermediaries between their community members and the orthodox health sector with the 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 The study points to the fact that TBAs play three basic roles in the health delivery system. These include antipartum, partum and post partum.

Traditionally, TBAs are noted for assisting women in child delivery and bathing of the child for about three weeks after delivery especially in circumstances where there is no elderly child bearing woman in the house of the woman who delivered. In some cases the trained TBAs help in educating nursing mothers on exclusive breast feeding and some times give family planning education to mostly women in their localities. The activities of TBAs in the northern part of Ghana are illustrated in the graph below. In FIG.5.3 the most dominant role as reported by TBAs is child delivery followed by visit to clients to bath the newly born baby and advisory role constitutes the least role TBAs played.

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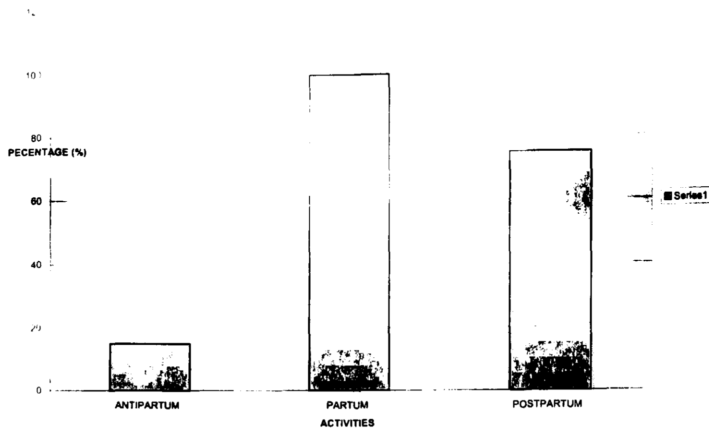

Field survey April 2008

Child delivery to the TBAs is the act of helping women in labour to bring forth to babies and cutting of the umbilical cord, and subsequently bathing the baby. Advice as mentioned entailed educating pregnant women on the need to visit health facilities regularly for antenatal check ups. They also visit the new nursing mothers for the purpose of bathing the baby for some period so that the mother will learn and continue bathing the child after the TBA has stopped.

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Plate 5.3 TBA bathing a four days old baby boy in Gunsi in the Yendi district

Source: Field Survey, 2008.

In a best case scenario, the TBAs are community health workers who are supposed to serve as a link between the community members and the health workers on issues of maternal and child health. They are supposed to educate and give first aid to women. Not only that, the trained TBAs have an additional role of record keeping on babies they delivered and their mothers in the communities.

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Case One (1)

An interview with Mma Sayibu Samata

"I have been a TBA for the past thirty (30) years. I can boast of delivering over six hundred children and I am known all over the Northern Region as a result of my activity as a TBA. As some one who is specialized in the work of delivering pregnant women, people from other parts of the District do refer their cases to me most especially when it has to do with a spiritual management. I thank God that any referral that come to me, the women deliver without problem. When asked where she acquire the skills? She has this to say' I inherited the skills from my mother. It is an indigenous knowledge handed over to me by my mother. Also, when people got to know about me the modern health staff came and picked me for training. That is why I can boast of being a trained TBA. At the trainin,g I was given a tool that would help me determine the position of the baby in the mother's stomach (foetal stethoscope) and also I have" neili" a spiritual eye which I use to see the sex of the unborn baby.

What do you do when a woman is over- bleeding during delivery? She sighed: Hmm! You want to know my secret! But said I first of all consult the oracles to indicate to me if I can assist the woman. If the result is that I can deliver he,r it will show and I give "Kagligu Tim"(kaligu tim is a black medicine that helps in delivering)) as a first aid to drink and then use 'takara" mixed it with tobacco leaves to smear on the abdomen. God willing the bleeding will stop immediately. But if it fails to stop I will refer her to the clinic.

When asked where she acquired the "Kagligu Tim" and the "Takara"? She said my late father who was a herbalist handed them over to me to assist me in my activities as a TBA.

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He also handed over some secret to treat infertility which I combine with my work as a TBA but for the fear of being called a witch I asked my brother to be treating the infertility so I now work hand in hand with my brother.

When asked about the problem she encounters she said "I have a lot of problems because I am not paid for the job and I do not get time to do other work to get additional income. Also, because of the patronage of my activity as a TBA I put up two (2) rooms purposely for delivering pregnant women, but there is no money for the renovation and maintenance of the rooms. Also I lack beds in the rooms for examination and for delivering of pregnant women. Some NGO came and gave me one bed that is what I am using currently but when I am to attend to more than one person at the same time, some are force to lie on the floor which the nurses who trained me said that is not good and that it could lead to sickness, but where can I get the beds?

I thank my community members because they mobilized funds last year and roofed my rooms for me.

I also lack gloves for my activities because the clients only come with washing soap and dettol which I use to wash my hands and the rooms. But for the gloves I buy them. It was the assemblyman who some times helps but now he is no more helping with the gloves.

For the problems, the earlier I stop the better, because you are not the first person to ask of my problems but nothing comes out of that.

Plate 5.4 Mma Sayibu Samata, the contributor.

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Table 5.9: Sample child bearing women by age and parity

Age group	Total no. of women	Parity					
		0	1	2	3	4	5+
15-19	18 (5.2%)	-	7 (2.1%)	11 (3.2%)	-	-	-
20-24	51 (15.0%)	-	10 (2.9%)	19 (5.6%)	22 (6.5%)	-	-
25-29	64 (18.8%)	-	-	14 (4.1%)	30 (8.8%)	20 (5.9%)	-
30-34	76 (22.4%)	-	-	-	20 (5.9%)	20 (5.9%)	36 (10.6%)
35-39	82 (24.1%)	-	-	-	10 (2.9%)	22 (6.5%)	50 (14.7%)
40-44	28 (8.2%)	-	-	-	-	12 (3.5%)	16 (4.7%)
45-49	21 (6.2%)	-	-	-	-	6 (1.8%)	15 (4.4%)
Total	340 (100%)	-	17 (5.0%)	44 (12.9%)	82 (24.1%)	80 (23.6%)	117 (34.4%)

Source: Field Survey, April 2008.

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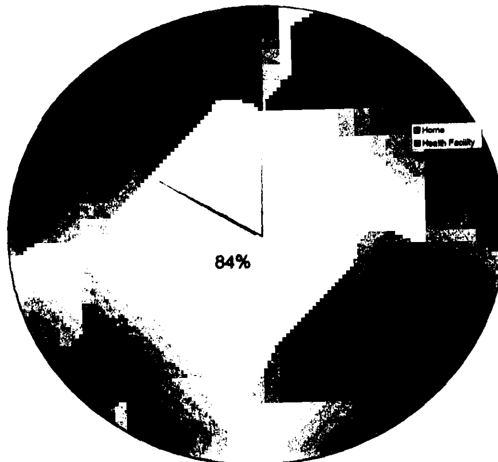
From table 5.8, it is clear that the family planning is not well understood or practiced by the people in the rural areas since women who delivered more than five children constitute about 46% of the women interviewed.

FIG 5.4: PIE CHART SHOWING PLACES OF DELIVERY



Source: Field Survey, 2008

5.3 Reasons Why Pregnant Women Preferred TBAs to the Modern health care

Figure 5.4 shows that out of a total number of four hundred and sixty four (464) deliveries, 84% were delivered at home and supervised by TBAs and only 16% were delivered at health facilities. The three main reasons that accounted for the choice of seeking maternal and child health care services at home, that is with TBAs or health facility are: accessibility, affordability and acceptability.

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Acceptability, is the health care model acceptable to the people in the locality? During a community forum organized by the researcher, it was revealed that both husbands and wives in the study area did not want to deliver at a health facility because some of the health personnel were men. It is not traditionally acceptable for men to see the "womanhood" or sex organ of women who are not their wives.

Also polygamy is common among the people in both the Central Gonja and the Yendi district as in both the Dagomba and the Gonja tradition a man is respected in a society based on the number of wives he has which to the local men in the study area is a prestige to possess more than one wife. Women who happen to be married to men who have more than one wife begin to rivalry among each other. They therefore have a feeling of jealousy, animosity and hatred among themselves. For this reason women want to deliver at home in order to avoid insults from their colleagues which they some times express in the form of songs. In such circumstances every wife wants to portray her self as being superior to others and will not like to damage her image or status. In their estimation delivering at the modern health facility will place them on a weaker pedestal.

An interview with mothers indicates that they prefer delivering at home supervised by TBAs to delivering at health facilities for the following reasons:

- Women in the traditional home hold the belief that a woman who is said to be strong and healthy deliver her children at home and they believe that weak women deliver at health facilities.
- TBAs are more accessible in terms of proximity and cost and that every community in the rural setting has TBA(s).
- TBAs know the customs and tradition of the place in relation to child birth.
- TBAs understand the local language of the people and women in labour can express themselves when the need arises.

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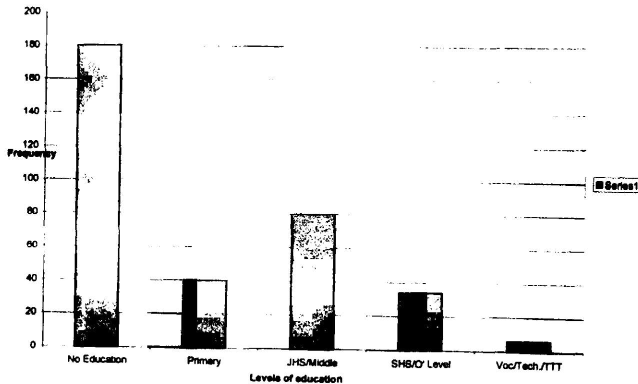
- Women who cheat on their husbands by sleeping with other men prefer to deliver at a health facility. Those who want to demonstrate their uprightness and faithfulness to their husbands also prefer to deliver at home under the supervision of a TBA. To them they belief that, the greatest taboo in the traditional area is married women sleeping with other men outside their matrimonial home.
- The mothers also claimed that if they go to the health facility to deliver the nurses some times do not treat them with dignity as they insult them for being filthy.

The research also revealed that the level of education had a great influence on the choice of the place of delivery. Thus almost all the women who delivered at the various health facilities were those who had at least a basic education.

Fig. 5.5 Level of mothers Education



Source: Field Survey, 2008.

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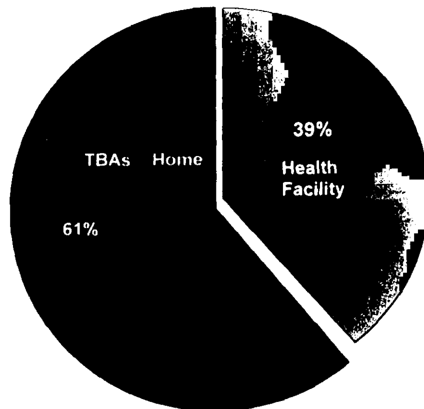
Fig.5.6 Choice of health facility by mothers



Source: Field Survey, 2008.

From Figure 5.5 and Figure 5.6 it is clear that mother's education has a strong relation with their choice of maternal health care. About 53% of the mothers interviewed were illiterates and the remaining 47% had at least Primary education. On the choice of health facilities, it was found that those with some level of education were consistently patronizing the modern health care delivery facilities. It was also clear from the focus group discussion (FGD) that those women whose husbands were educated patronized the modern health care delivery system.

The distance women travel to access Maternal and Child Health care also affects their patronage of the modern health care facility. One hundred and twenty (120) representing (35.3%) out of the three hundred and forty (340) women interviewed, who stayed five kilometers (5Km) and above awy from the health facility do not patronized the modern health care system.

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Information gathered from community fora indicated that women with low incomes could not access the modern health care delivery. Despite the introduction of the National Health Insurance Scheme (NHIS), many people especially women have still not registered with the scheme so as to benefit from it

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CHAPTER SIX

CHALLENGES FACED BY TRADITIONAL BIRTH ATTENDANTS IN THE CENTRAL GONJA AND THE YENDI DISTRICTS

6.1 Introduction

Having discussed the contribution of TBAs in the two Districts in the Northern Region this chapter will focus on the challenges these TBAs face in carrying out their activities.

In trying to inculcate and encourage TBAs to undertake clean delivery in rural communities and beyond the study revealed some challenges faced by these TBAs.

6.2 Resource Base of TBAs

It was observed that very few TBAs have delivery kits given to them by the Ghana Health Service and some Non Governmental Organizations (NGOs) during their earlier workshops. At the time of the research most of these kits were empty as the initial equipment in them was used up and no replacements have been made due to lack of funds. About 90% of the TBAs interviewed were very old and were not gainfully employed. TBAs do not charge fees for the management of labour and post- natal care. These services the TBAs said were not monetized and were delivered free though, gifts were accepted. This is due to the belief that a child born to a community belongs to the entire community and not to the immediate parents of the child alone. Since the entire community stands to benefit from such a child, it is not proper for TBAs to demand remuneration for services associated with birth. They enjoy support from family members such as in-laws and other relatives. Some TBAs may some times be lucky to attract the sympathy of some members of the community who some times organize friends to help these TBAs on their farms. An interview with the TBAs revealed that husbands of pregnant women they delivered helped by giving them pomade, kerosene, fire wood, groundnut paste and soap. In the Dagomba traditional area TBAs are given the head, skin and legs of the sheep or goat used for the out dooring and in the Gonja traditional area they add "zabla" to what is mentioned above Zabla is special grass used by Muslim women in the northern

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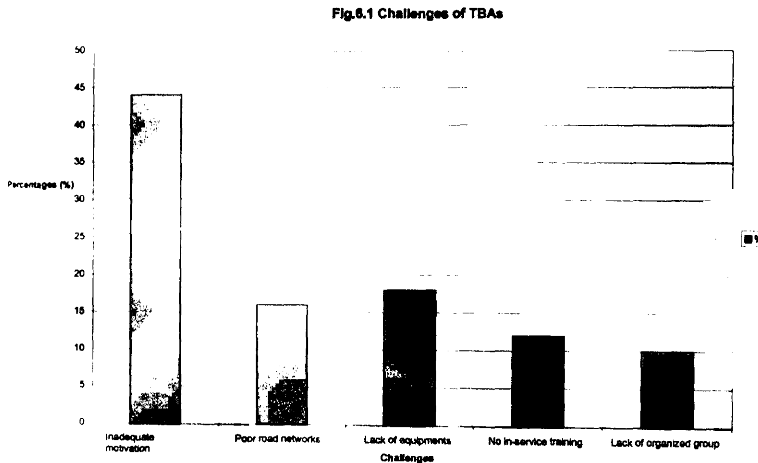
part of the country and beyond to beautify their legs. It is mostly applied on the legs of women to make it black.

Constraints are unavoidable challenges that people face when trying to pursue any ambition. Despite the ability of TBAs to do as much as is observed in the preceding discussions, further discussions with them revealed that their major constraints are: financial, lack of recognition, inadequate in-service training, lack of delivery equipment and old age. The frequencies of response to these challenges were brought to the fore as shown in figure 6.1.

Fig.6.1 Challenges of TBAs



Source: Field Survey, 2008.

From 6.1 it is clear that motivation of TBAs is seriously lacking and this does not encourage the people to put up their best in the discharge of their duties. This motivation according to the TBAs comprises: financial as well as social, which can take the form of social recognition.

The TBAs lack logistics such as scissors, hand gloves, antiseptics, towels, pain killers, blades, washing soap among others to effectively and efficiently carry out serve deliveries. To many of the

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TBAs, delivery kits are what they require and this constitutes about 18% when it was ranked among other challenges as shown in FIG 6.1

Poor road networks as indicated in the figure 6.1 was a big challenge to the TBAs especially those in the hinter land where health facilities are not available. According to one TBA by name "Limpo Tamanja" a TBA from Bunbonnayili in the Yendi District said that "I was to deliver a pregnant woman but during the course she was bleeding profusely, I asked her husband to take her to the Yendi hospital but on their way to the hospital the woman passed away due the delay in reaching the hospital. This delay was as a result of the bad nature of the road linking our community and Yendi, also the only means of transport is either bicycle or motor bike".

Lack oft training constitutes about 12% of the challenges that confront TBAs in both districts because as per the findings of the survey the last time some of them received training was in 1997. According to the respondents it is essential to upgrade their skills so that they can handle a lot of the cases of which they have no knowledge. A TBA by name Mma Samata, resident at Chama in the Central Gonja district, a very old woman in her seventies had this to say:

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Case number Two (2)

"We do the same work with other traditional healers like the bone setters, snake bite healers among others who often are sent to Mampong Ashanti for training for several days.They return better equipped with skills, certificates, money and new ways of doing their work. We do not have the opportunity of receiving comprehensive training. The most painful aspect of it is that some members of the communities called us witches. Because we are women and attend to pregnant women they think we are juju people, and that it is the juju we use to help women deliver. A case in point was just last week, one of my collegues went to bath a newly born baby. On her way to the house a young man met her and said,' the witches have finished their meeting and are returning to prepare for their night duties". The TBA was very upset and so the case was reported to the chief. What the chief and his elders could do was to ask the young man not to repeat it again. We could stop the work if we could do so, but posterity wouldl judge us wrong and our dead parents would also not forgive us for not doing what they left for us. Inspite of the fact that we are doing our best to help our respective communities and above all humanity, people are quick in referring to us as witches. Those who are fortunate among us to be sent for the training always go to attend to pregnant women with their kit boxes, but we the unfortunate ones who are not trained do not have the kit boxes lets alone the materials in them. You people should send us too for training and tell people to respect us. So that we togetherwith the already trained would share the idea and adequate knowledge about how to conduct safe deliveries in our various communities"

Mma Samata,Chama,12th June 2008)

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Mma Samata the TBA quoted above is said to have handled over four hundred (400) labour cases in the past two years. She is often called by other TBAs in other villages to assist in case of complications due to her experience as a TBA. This was confirmed by the number times the researcher visited her before he was able to meet her for the interview. She was always busy attending to delivery cases.

Notwithstanding the challenges enumerated above TBAs continue to play their role as health intermediaries' indicative of the fact that these are women who are committed to their work to save victims because of some socio-cultural commitment attached to their work. Any little motivation will enhance their performance tremendously.

6.3 Needs of TBAs for Effective Performance

Whiles TBAs do not seem to have any idea about what to do themselves to overcome the constraints, they have called for the following interventions from government, NGOs and other stakeholders in the health delivery system; financial assistance, provision of ambulance service to areas where there are no availability of health services, regular training programmes for the TBAs, provision of tools, encouraging the young ones to take into MCH care, especially now that the government has introduced the youth employment scheme with the option for and young girls to go into the health aid. These they say would in a way help them improve upon their activities.

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CHAPTER SEVEN

7.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This study sought to examine the role of Traditional Birth Attendants (TBAs) in promoting maternal and child health care in two districts in the northern region of Ghana. In line with the study objectives, a wide range of methods were employed encompassing both the qualitative and quantitative method. Thus this chapter deals with the summary and conclusion of findings as well as possible suggestions to help resolve the challenges faced by traditional birth attendants in rural Ghana most especially in the northern part of the country.

7.2 SUMMARY

7.3 Characteritiecs of TBAs

The survey has revealed that TBAs are old women who are mostly in their sixties (60s) and above and are mostly found in rural communities where modern health facilities are lacking. The TBAs are solely responsible for providing maternal health needs of the people in the hinterland where they are members of the communities.

The TBAs in the study areas are mostly women of which 30% of them in the Yendi district are widows as compared with 14% of them in the Central Gonja district. The high number of widows among the TBAs in the Yendi district as against that of the Central Gonja district is as a result of the ethnic and intra-tribal conflict in that district.

The study had also revealed that most women preferred to deliver at home supervise by a TBA to delivering at a modern health facility. The reason has been that they want to prove that they do not

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cheat on their husbands by sleeping with other men beside their husbands and also to prove to the community members that they are strong and healthy women.

Others hold the view that the staffs in the modern health facility are unfriendly rain insults on them saying they are dirty and do not wash their cloth well. Some nurses even say they smell and in order to avoid this embrasement they prefer to be attended to by a TBA who knows much about their custom and traditions.

In other areas like Tijo and Chama in the Yendi and Central Gonja Districts respectively, the distance one need to travel before accessing a modern health care is more than 35Km. This has made pregnant women in the areas unable to access modern heatl care.

7.4 Resource Base of Traditional Birth Attendants:

Resources of TBAs can be put into three (3) main categories, namely:

- Basic skills for handling cases of child delivery and pregnancy management which are acquired from long period of practice and training which are occasionally organised and from which the TBAs in the study areas are lacking ecept those few trained ones.
- Confidence and trust of the people and communities in which they work which are won through hardwork and much sacrifice and care which they some times get from family members as they are mostly weak enough to cater for themselves.
- Association of TBAs which is suffering from teething problem because it has has not got the basic establishment structures such as written constitution, substantive executive committee.

TBAs are beset with many challenges which are mainly financial, lack of logistics, old age, inadequate in-service training, lack of motivation, lack of transport facilities including ambulances

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for effective referral system etc. For instance 65% and 87% of the TBAs in the Yendi district and the Central Gonja respectively are not trained and do not have the requisite skill for clean delivery for safe mother hood and child hood. The high proportion of untrained TBAs in the Central Gonja district is as a result of its being a new district and its geographical location where about 78% of the population in the district are to travel more than 45Km before they can access modern health facility. This serve as a hindrance in achieving the Millennium Development Goals (MDG) four and five (4 and 5)

For effective performance, TBAs seek the help and support of stakeholders in the health delivery such as the Ministry of Health and the Ghana Health Service, District assemblies, Government and Non governmental organisations in terms of finance, logistics, in-service training and other forms of motivations in order also to entice the youth to take to TBAs activities.

The Government of Ghana introduced the National TBA Training in the year 2000 as a policy of upgrading the skills and knowledge of TBAs in order to facilitate clean and safe delivery. Information from the TBAs indicates that they have no training since that time. The TBAs in the Central Gonja disclosed that they never had that training but that some time in 1993 three (3) of them were called to Damongo for such training.

The policy of free maternal care recently introduced by the government will help pregnant women who due to lack of finance will now be able to access the modern health care. This in a way will help in achieving the Millennium Development Goal. But as at now , about 78% of the people in the study area who live in the hinterland do not know any thing about this policy. They will still continue to depend on TBAs for their services

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7.5 Conclusions

There are still many communities in the northern part of Ghana where a large proportion of the population does not have access to modern health services, relying on TBAs (and traditional healers) to meet their maternal and child health care needs. In these communities, TBAs who have been trained can contribute to improving maternal and child health, as they offer the only means by which women in rural communities have access to a clean delivery.

Valuation findings identified critical aspects where TBA programmes need to be improved. To increase their effectiveness, programmes should be part of the broader national strategy to improve reproductive health. They should not focus solely on a training component and should include adequate supervision, transportation and provision of supplies.

TBA programmes should increase efforts to ensure the availability of supplies to conduct a clean delivery since this is essential for TBA's to follow aseptic procedures. In this regard, locally produced TBA kits seem more practical and sustainable.

The quality of TBA training can be improved through an assessment of the communities' health beliefs and practices so as to ensure the following:

- ensure appropriateness of the training content
- ensure TBA and community acceptance if new tasks are to be added

Training of trainers in pedagogic techniques for illiterate adult learners should also be considered as a critical element of the programme

The family planning component of TBA training also needs to be improved by acquiring a better understanding of the communities' beliefs and concerns. Findings of socio-cultural research should

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serve as an important information base for designing the training content. The family planning component should also be part of reproductive/family health promotion and not focused only on contraceptive methods.

Although the importance of the TBA's role in referral is universally acknowledged, most programmes have not developed an effective referral system. Programme managers need to review the current classification of risk to take into account the criteria for referral used by TBAs, which includes conditions for referral (time, cost, transportation, etc). Criteria for referral should also reflect the capability of health services and hospitals to provide services for obstetric complications and emergencies.

Finally, where TBA programmes are undertaken as part of the strategy to improve reproductive health, special attention should be given to the quality of care provided at the referral site. Policy makers need to assess the attitudes and behaviour of health staff toward clients and identify strategies to improve the appropriateness of the services provided. In an effort to improve quality of care, TBAs should be considered a key partner since they can provide information on the communities' health perceptions and needs.

7.6 Recommendations:

From the findings of the study the following recommendations are made:

- **Partnership and Co-operation**

  There is the need to sharpening and intensifying the partnership of traditional midwives and the personnel of the orthodox health delivery sector, also each must recognise the other as playing complementary role. It is interesting to note that much as the orthodox health workers have information to share with the traditional midwives such as education on nutrition, on signs and symptoms of common ailment during pregnancy, on when to refer cases how to prevent tetanus

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etc; the traditional midwife have experiences and insights from many years of attending to child births, how to respond to common questions on concerns of pregnant women in terms of the local culture and language, knowledge of local beliefs and traditions relating to childbirth, absence of which makes rural women feel uncomfortable each time they visit health facilities. Discussions on topics of this nature can only be achieved through co-operation.

Traditional maternity rooms should be created in the health facilities so that women can freely go there for consultation without fear of being ridiculed. These maternity rooms would be manned by TBAs.

❖ **Community Mobilisation**:

In meeting the requirements of PHC to the letter, community members for whose benefits TBAs work should be mobilized and conscientised to work together towards sacrificing for the crucial needs of Community Health Workers (CHWs) including the TBAs. This will enable them to give of their best in times of needs. Members of the community could come together to suggest how much to pay for any delivery a TBA handles. They could establish community farms as well as build structures in various localities for the purpose of child delivery.

❖ **Free Maternal health care package**

Health personnel should go into the hinterland to educate people on the Free Maternal Health care package so that those who are not aware of it will get the chance of knowing of it there by benefiting from it.

❖ **Recognition and Support**

To ensure effective role of TBAs, it is important to put measures in place for their support financially, psychologically and materially. Members of rural communities should mobilised and committees be formed to oversee the extent to which financial support could be made

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through some form of revolving fund either by contribution or proceeds from community owned resources such as community farm products or animals. At best the National Health Insurance should be discussed at length to incorporate financial support for TBAs and other Community Health Workers who are notably doing effective work in health delivery.

Throughout discussion with TBAs and mothers, it is noted that the TBAs need recognition and that the orthodox health workers should see them as partners in the health delivery system and not just local practitioners as they viewed them. The community members should recognize their role and respect them and avoid branding them as witches.

❖ **Provision of Logistics**

Equipment such as scissors, gloves, antiseptics and detergents should be in regular supply. In a similar vain it is recommended that an ambulance service should be provided in the hinterland for easy referral of cases. Some of the TBAs offer their services at the risk of their life as they handling unknown HIV/ AIDS cases. The provision of the gloves may protect them from mishaps, such as handling HIV/ AIDS cases.

The National Food and Drugs Board should find out the health implication of the herbs TBAs use inpreventing over bleeding of women during delivery and the material used in cutting the umblical cord of tne new born baby.

❖ **Training:**

Regular training is very important to enhance the work of TBAs. This is in view of the fact that new diseases whether general or specific to child bearing continue to unfold in several ways. Regular in-service training will keep TBAs inform about the types and nature of such diseases and thy will be in the position to address them when the need arises.

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Sustaining the work of TBAs will mean to train young ones to go into the field as the old TBAs give way. Judging from the survey, it is realized that about 91% of the TBAs are old with only 9% who are in their late forties (40s). The young girls who are engaged in the National Youth Employment Scheme should therefore be encouraged to go into maternal health care and be motivated to go into the rural areas.

❖ **Training TBAs in their basic functions and in how simple first aid drug are administed**

Training the TBAs on in how to carry out simple first aid and the dangers of certain drugs will help lower the negative effects of drug related complications in pregnant women that continue to take lives of women and their babies as well as those that deformed a lot of babies in many societies.

❖ **Capacity Building of TBAs**

TBAs in all societies are mostly women who by their nature are recessive in bringing about the fast needed change in developing their area of activity especially those in the rural areas. In this regard, district assemblies and NGOs should help build the capacities of TBAs to enable them work in association with health authority and other organizations to enhance their performance. With their capacities built, TBAs will be in the position to channel grievances about their needs to the appropriate authorities for redress.

From Mma Abiba's contribution, it is observed that, TBAs being mostly female do not get the proper response to their plights. Even though health personnel and officials of ministry of health and the Ghana Health Service know how they worth, they do little to help them because the TBAs claimed they are women. TBAs should be seen as important people, unique in the society and should be involve in the decision making process despite their feminine status.

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7.6.1 Areas of future research

The study has identified some areas that require further research consideration in the near future:

- The health implication of the herbs traditional birth attendants use during complications and its efficacy.

- A comprehensive study of the methods TBAs employed in identifying the position of the baby in the mothers womb.

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APPENDICES

APPENDIX :(A)

Department of Geography and Resource Development, University Of Ghana.

This Study is a research on the role of traditional birth attendants (TBAs) in promoting maternal and child health care.

Utmost confidentiality of information is assured. Your cooperation is very much appreciated.

QUESTIONNAIRE FOR TBA'S

SECTION (A)

BACKGROUND CHARACTERISTICS OF TBAs

1. Community name .... 1b. Name of compound (No.) ....

2 Age of respondent ....

(1) 15-19 (2) 20-24 (3) 25-29 (4) 30-34 (5) 35-39 (6) 40+

2b. Sex: male (1) female (2)

3. Ethnicity

(1) Gonja (2) Dagomba

(3) Mamprusi (4) Hausa

(5) Dagabas (6) others specify.

4. Religious backgrounds.

(1) Christianity (2) Islam (3) Traditional (4) Others, specify

5 Marital statuses:

(1) Married

(2) Single

(3) Widowed

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(4) Divorced

6 Have you attended school before? Yes (1) No (2)

7 What was your highest level of education?

(1) Primary (2) J.S.S

(3) O-Levels\ SSS (4) A-Level\Voc\Tech\ TTC.

(5) Tertiary

8. What work do you do for a living? ....

SECTION (B)

MODE OF OPERATION OF TBAs

9. How much money do you earn in a month? ....

10. How long have you worked as a TBA? (No. of years) ....

11 Which of the following categories of TBAs do you belong to?

(a) Spiritualist

(b) herbalist

(c) attendant

(d) fetishprist

(e) Heller

12. How did you acquire the skills for working as a TBA? ....

(a) Training (b) Inheritance (c) Other

13. Where do you normally undertake the delivery exercise?

(a) Home (b) Clinic (c) Shrine (d) Others, specify

14. How many pregnancies have you delivered in the past one year?..................... 15.

15. How many deliveries were difficult for you? ....

16. How do you prevent bleeding during child delivery?

17 what do you do when there is difficulty in delivery?

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(a) Refer to clinic or health post (b) Consult oracles (c) Others, specify

18 What equipment do you use in cutting the placenta?

(a) Knife (b) Blade (c) Others, specify

19. Do you sometimes refer cases to health facilities? Yes (1) No (2)

20 Which health facility do you normally refer cases? ....

(a) Clinic (b) Hospital (c) Health Post (d) Others, specify

21. What are the processes you undergo when referring a case?

i...

ii...

iii...

iv...

22. What are your roles during?

i. Antenatal period...

ii. Child delivery period...

iii. Post natal period..

23. Apart from child delivery, what other health delivery services do you undertake?

i .Health education

ii. Family planning services

iii. Antenatal services

iv. Others (specify)...

SECTION(C)

CHALLENGES \ PROBLEMS AND TRAINING OF TBAs

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24. What problem(s) do you encounter during referrals?

i...

ii...

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iii...

25 What is needed to be done in order to have easy referral of cases?

i...

ii...

iii...

iv...

v...

26 Do you have any other problem in discharging your duty as a TBA? If yes what are

....

....

27. Have you ever had any training in your career? Yes (1) No (2)

28. What type of training have ever had?..

....

29 How often does training take place?

(a) Monthly (b) Yearly

(c) Every 4 month (d) others, specify ....

30 Who conducts the training (state).......................................

(a) Nurses in the district hospital

(b) Nurses in the community

(c) Trained TBAs

(d) Health professionals from other communities

(e) Others, specify

31 When was the last time you underwent a training?..

32 Do you need any other training to help perform your work better? Yes (1) No (2)

33. Do you have a kit for child delivery? Yes ( ) No ( )

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34. What equipments do you lack? Mention ....

35 Are you paid for the services you offer? Yes ( ) No ( )

36About how much are you paid? ....

37. Who pays you?..

38 What other support do you get for your work? (Mention them)

i...

ii..

iii...

39 What do you observe about the training of the national youth employment nurses in the maternal and child health delivery in the district? ....

....

....

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APPENDIX: (B)

QUESTIONNAIRE FOR SERVICE USERS

Department of Geography and Resource Development, University Of Ghana, Legon.

This study is a research on the role of traditional birth attendants in promotion maternal and child health.

All information is to be kept confidential by interviewer and any one who is involved in the project.

Your cooperation is very much appreciated.

SECTION A:

BACKGROUND CHARACTERISTICS OF RESPONDANT

1 Age

(1) 15-19

(2) 20-24

(3)25-29

(4) 30-34

(5) 35-39

(6) 40+

2. Education (1) primary\ JSS

(2) O-Level/ SSS

(3) Voc\ Tech\ TTT

(4) Tertiary

3 Ethnicity (1) Gonja

(2) Dagomba

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(3) Hausa

(4) Dagabas

(5) Others, specify

4. Religious denomination.................

(1) Christianity

(2) Islam

(3) Traditional

(4) Others, specify

5 What work do you do for a living? ....

6. No. of children...

7. In all, how many of your children did you born at

(a) Health facility (b) Home

8. What factors influence your choice of accessing maternal health services

i...

ii..

iii...

9. Who help to undertake child delivery at home?

(a) TBAs (b) Mother (c) Others, specify ....

10 Are you satisfied with home deliveries by traditional midwifery?

(a) Yes (b) No

11 Which of the following is safer to have child delivery?

(a) TBAs (b) Modern midwifery (c) Indifferent

12 Give reason(s) for your choice ....

....

13 Why don't you prefer the other services?..

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14. Do you have organized TBAs in your community? Yes ( ) No ( )

15. If yes, how do you rate the performance of TBAs in this community?

(a). Doing very well (best)

(b). Doing very well (better)

(c) They are trying doing well

17 Can further training enhance the performance of TBAs? Yes ( ) No ( )

18 What do you think prevents TBAs from performing their duties the best way?

....

19. Is it necessary to integrate the modern midwifery and TBAs Yes ( ) No ( )

20. Which of the following forms should the integration of TBAs and modern midwifery takes?

i. employment of TBAs into clinics □

ii. Admission into midwifery schools □

iii. Special training of TBAs □

21. Aside child delivery, what other health problem(s) do you seek from TBAs?

....

22 Do you offer anything for the services of TBAs? Yes □ No □

23. If yes, what kind of service/reward?

i. Cash payment □ ii. In kind payment □ iii. Others (specify) ....

24a. Do the TBAs charge for their service? Yes ( ) No ( )

24b. If yes, how much do they normally charge?

a. GH¢1.00 - GH¢14.00 b. GH20- 25GH

25. What are the importances of TBAs in the society? ....

....

26. In all, are you satisfied with the services provided by TBAs? Yes □ No □

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27 .If yes, what are your reasons?

i..

ii..

iii..

28. If no, what suggestions can you give?

i..

ii..

iii..

29 What do have to say about the youth employment nurses in the community?

30 Would you say they are performing better than the TBAs or other wise?

31 Give reason(s) for your answer

THANK YOU FOR YOUR RESPONSE

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APPENDIX: (C)

QUESTIONNAIRE FOR HEALTH WORKERS

Department of Geography and Resource Development, University of Ghana, Legon

This study is a research on the role of traditional birth attendants in promoting maternal and child health care.

All information is to be kept confidential by the interviewer and anyone who is involved in the study. Utmost confidentiality of data collected is assured. Your cooperation is very much appreciated.

1 Gender: (1) Male

(2) Female

2 Which department do you work? ……………………………………………………………..

3 What is your schedule of work? ……………………………………………………………..

4 What type of services offered by this health facility?

……………………………………………………………………………………………

5. For how long have you worked as a health worker? ………………………………..

6. which of the following maternal health services does the users patronize most and why?

i Antipartum ( ) ii. Partum ( ) iii Postpartum ( )

7. Do you receive child delivery complications from TBAs? Yes □ No □

8. Do you involve TBAs in treatment of child delivery complications? Yes □ No □

10. How often do you involve the TBAs? ……………………………………………….

11. How many maternal mortalities have you recorded in the past;

i. One year……………………..

ii. Two years…………………

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iii. Three/ more years............

12. Do you know of any recognized association of Traditional Midwives in this community?

Yes □ No □

13. How do you rate the skills of TBAs in maternal and child health delivery?

i. Very good ii. Good

iii. Not good iv. No knowledge

14. What other aspect of health delivery do you expect TBAs to offer apart from child delivery?..

15. Are you aware of any government policy aim at integrating the modern midwifery and TBAs?

Yes □ No □

16. If yes, what form of integration is in place?...

....

17. What is the collaboration between this health facility and the TBAs in the community?...

18. Would you describe TBAs as good alternative for child delivery in this community?

Yes □ No □

19. If yes why, and if no why not?..

....

20. In your view, what can be done to make TBAs take their proper role in maternal and child health care delivery?

i..

ii..

iii..

21 Is there any training giving to the TBAs by this health facility or any other body(s)

THANK YOU FOR YOUR RESPONSE

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APPENDIX: (D)

Department of Geography and Resource Development, University Of Ghana.

This Study is a research on the role of traditional birth attendants (TBAs) in promoting maternal and child health care.

Utmost confidentiality of information is assured. Your cooperation is very much appreciated. This survey is conducted mainly as an academic exercise with the aim of contributing to knowledge. Information gathered from this survey would be treated with all confidentiality and used for the utmost benefit of the people of the community.

FOCUS GROUP DISCUSSION-COMMUNITY FORUM

1. In times of sickness which health facilities do you rely on most?
2. Apart from the modern health facilities, where else do members of the community rely? to get solution to health problems?
3. Do some people rely on traditional healers and TBAs?
4. Which of the two systems is more reliable as far as our health problems is concerned?
5. Why do you prefer to go traditional healers (TBAs) first?
6. Why do you prefer to go the modern facility first?
7. Are the traditional Birth attendants able to give up their best?
8. What are the problems faced by TBAs in their work?
9. In your opinion, what should be done by the following category to enhance the Performance of the TBAs

a. community members

b. Individuals

c. Modern health system

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FOCUS GROUP GUIDE-TBAS

1. How long have you been working as TBAs in your various comities?
2. What is the procedure involved in getting TBA come to the aide of a woman who is in Labour?
3. After a woman safe delivery, do you charge anything either as customary requirement or For economic reasons
4. What are some of the thing you charge?
5. What is the equipment you used during delivery process?
6. Apart from child delivery what are other roles do you perform?
7. When do you decide to refer case to the health facility?
8. What processes are involved in referral?
9. What are the difficulties you face in referring case to health facilities?
10. Have you had training in your field before?
11. Who organizes the training programmed?

11a where did the training take place?

12. When was the last time you ever has such training?
13. Is the training beneficial to your work, why?
14. Is there any association you belong to?
15. How does the association operate?
16. How often do members of the association meet?
17. What are some of the issue you discuss?

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APPENDIX: (E)

SWOT ANALYSIS OF THE ROLE OF TBAS IN PROMOTING MATERNAL AND CHILD HEALTH CARE IN THE CENTRAL AND YENDI DISTRICTS OF NORTHERN REGION OF GHANA

TBAs Issue	Strengths	Weaknesses	Opportunities	Threats
TBAs provide antipartum, partum and postpartum services	* The present of a TBA in almost every family * TBAs good knowledge in local customs and respect women's needs	* TBAs lack adequate training to handle/deal with complications * TBAs are skillful in only partum services of maternal health care	* International and local support for Primary Health Care (PHC) since 1975	* Institutionalization of specialized health care * The desire for orthodox midwifery over that of traditional midwifery
Integrate the orthodox	* A policy document recognizing the traditional component of midwifery * TBAs serve as the base of the	* High concentration of traditional practitioners with fragmented front * Low literacy	* The existence of back-up support * The recognition by WHO to make positive effort	* Unbalance development and service infrastructure for both the modern and traditional midwives

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health care and TBAs	pyramid of referral	among the traditional midwifery for proper training and integration	through research based on a firm understanding of what TBAs can and cannot do	
Choice of assessing maternal health services	* The existence of the modern and the traditional midwifery serve the two category of users (urban/rich and rural/poor) of maternal health services	* The dominance of modern midwifery for the politically articulate urban dwellers against TBAs in the rural settings weakens equity in maternal health care	* The shift towards the development of primary health care (PHC) programme, especially in rural areas	* Fierce competition for resources between the health sector and other areas of government activities.

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