Social Science & Medicine 148 (2016) 8–17

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

"I was on the way to the hospital but delivered in the bush": Maternal health in Ghana's Upper West Region in the context of a traditional birth attendants' ban

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ARTICLE INFO

Article history:
Received 15 April 2014
Received in revised form
4 November 2015
Accepted 11 November 2015
Available online 19 November 2015

Keywords:
Ghana
Upper West Region
Maternal health
Traditional birth attendants
Rural
Access to care

ABSTRACT

This study examines perceptions and experiences of mothers, traditional birth attendants (TBA), and skilled birth attendants (SBA) regarding Ghana's recent policy that forbids TBAs from undertaking deliveries and restricts their role to referrals. In the larger context of Ghana's highly underdeveloped and geographically uneven health care system, this study draws on the political ecology of health framework to explore the ways global safe motherhood policy discourses intersect with local socio-cultural and political environments of Ghana's Upper West Region (UWR). This study reveals that futile improvements in maternal health and the continued reliance on TBAs illustrate the government's inability to understand local realities marked by poor access to SBAs or modern health care services. Using focus group discussions (FGDs) (n = 10) and in-depth interviews (IDIs) (n = 48) conducted in Ghana's UWR, the findings suggest that mothers generally perceive TBAs as better placed to conduct deliveries in rural isolated communities, where in most cases no SBAs are present or easily accessible. The results indicate that by adhering to the World Health Organization's guidelines, the local government may be imposing detrimental, unintended consequences on maternal and child health in remote rural locations. In addition, the findings suggest that the new policy has resulted in considerable confusion among TBAs, many of whom remain oblivious or have not been officially notified about the new policy. Furthermore, participant accounts suggest that the new policy is seen as contributing to worsening relations and tensions between TBAs and SBAs, a situation that undermines the delivery of maternal health services in the region. The study concludes by suggesting relevant policy recommendations.

1. Introduction

Each year 287,000 women globally die from obstetric complications, with over 99% occurring in low and middle income countries (WHO et al., 2014). This paints a stark reality as most of these deaths are avoidable with adequate medical care (WHO, 2013). Adequate medical care – including the use of skilled birth attendants (SBA, including doctors, midwives, nurses) during labour, delivery, and the early postpartum period – could prevent many of these deaths (WHO, 2003; Koblinsky et al., 2006). International policies emphasize the provision of SBAs and improved obstetric services in health facilities as key interventions to reduce neonatal and maternal mortality (Starrs, 1998; Bergstrom and Goodburn, 2001; WHO, 2009).

Despite these directives, many women in low and middle income countries deliver at home without the assistance of a SBA (Bell et al., 2003; Mrisho et al., 2007; Choguya, 2015). This is in large part linked to severe shortages of SBAs, which is often worsened by concentrations of health workers in urban centres, when most of the developing population still resides in the rural areas (Ana, 2011). Health centers in rural areas are often understaffed, underserviced, and far removed from sparse populations, increasing

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http://dx.doi.org/10.1016/j.socscimed.2015.11.018
0277-9536/

pregnant women's difficulties in obtaining SBA care.

The Upper West Region (UWR) of Ghana is one of the areas heavily impacted by shortages of SBAs. Many women in this area have no choice but to deliver with a traditional birth attendant (TBA) (Titaley et al., 2010), despite international recognition associated with the benefits of skilled attendants (Prata et al., 2011; Owolabi et al., 2014). Since TBAs are usually older and have vast experience, women in their respective communities regard TBAs highly and greatly depend on them for delivery services in developing countries due to the absence of SBAs (WHO, 1978; UNFPA, 1997; de Brouwere et al., 1998; de Brouwere & Win Van Leberghe, 2001; Grieco & Turner, 2005; Titaley et al., 2010; WHO, 2012). Generally acquiring skills from apprenticeship or training, TBAs usually originate from the communities they serve and are accessible at any time of the day and night (WHO, 1992; Paul and Rumsey, 2002; Ana, 2011).

Recognizing their value, the WHO supported TBA training throughout the 1980s (WHO, 1982, 1990), encouraging them to conduct antenatal care and improve intrapartum and postpartum practices in the communities. The expectation was that these programs would eventually lead to dramatic improvements in early detection and referral of complications during pregnancy and ultimately reduce mortality (Mutambirwa, 1985; see Kruske & Barclay, 2004; Choguya, 2015). For instance, as part of their training, TBAs were taught hygienic practices such as hand washing, the utilization of gloves, and cord care in order to reduce infection and lower rates of postpartum hemorrhage by reducing traction of the umbilical cord, and the ability to recognize dangerous situations such as retained placenta and postpartum hemorrhage (de Brouwere et al., 1998; Starrs, 1997; bij de Vaat et al., 2002). Despite international support for TBA training programs, maternal mortality rates have remained high and in some cases, even increased (GSS, 2009; MOH et al., 2011; WHO et al., 2014). Policy makers assumed practical difficulties, such as poor literacy and lack of medical knowledge were preventing trained TBAs from effectively lowering the maternal mortality rate. This assumption led to the 1992 joint WHO/UNFPA/MCH agreement that declared TBA training and use to be considered only as an interim measure until “all women and children have access to accessible, professional, modern health services” (WHO, 1992:30). This was reinforced by a WHO, 1996 directive that discouraged pregnant women from TBA delivery in favour of delivery by a skilled health provider at a health facility.

The WHO's policy change altered the language addressing safe motherhood practices from a ‘trained attendant’ to a ‘skilled attendant’, reinforcing the distinction that someone who has received training is not necessarily *skilled* (Starrs, 1997). Skilled attendants were classified as people with midwifery skills (doctors, midwives, nurses) qualified to proficiently manage normal deliveries, diagnose, manage and refer complications to specialists (WHO, 1992). This position culminated in the termination of global TBA training programs. Yet, what seemed to have been missing in this discourse was a consideration for women in remote and underserved locations who may be unable to access ‘skilled attendants’.

Consequently, the debate on the relevance of TBAs rages on (Ana, 2011; Harrison, 2011). Supporters of TBAs argue for strengthening the skills of those who live within communities, especially in locations where access to adequate health care is problematic or unattainable (Ana, 2011; Hodnett, 2012; Vieira et al., 2012). In such contexts, TBAs can also act as referral connections to emergency obstetric services while also educating families to recognize signs of complicated labour (Titaley et al., 2010; Wilson et al., 2011). Conversely, others point to a lack of evidence on their impact on maternal mortality (Koblinski, 2003; WHO: 2005; Sibley and Sipe, 2006) and have highlighted cases of TBA incompetence (Harrison, 2011).

In response to global policy changes, Ghana stopped its program of training TBAs shortly after the WHO policy modification and discouraged their use entirely (Allotey, 2000). In contrast, some countries such as Malawi, have rescinded past bans amidst worsening health indicators and the succeeding challenges caused by inadequacies in the health workforce (Masina, 2011). In other countries, such as Sierra Leone, TBAs have been officially recognized by the health care system and are permitted to practice, although with close supervision and support (Higgings-Steele et al., 2015).

There is no doubt that delivery with a skilled professional is the safest option for mothers and their babies, but in many deprived, remote rural areas, access to such conditions remains elusive, and at times unrealistic (Choguya, 2015; see Ronsmans et al., 2003). It is in these remote locations that the importance of TBAs remains in question. As Gill et al. (2011b) reason, many women will continue to give birth without the supervision of a SBA for the foreseeable future and the disjuncture between health care recommendations and the reality of implementing local skilled birth attendant coverage is therefore likely to persist. Recent policy changes within Ghana have prohibited TBAs from delivering babies outside of the facility. TBAs are only allowed to assist in the transportation of a woman in labour to a health facility to be attended by a skilled care provider. While considering TBA accompaniment and encouragement are important roles, their practice and scope of skills in the community are restricted. Such restrictions may inevitably elicit counterproductive health outcomes for women in rural remote settings in Ghana's UWR. As such, this paper explores the perceptions and impact of the TBA ban in Ghana's UWR, specifically examining the experiences of women, TBAs, and professional skilled health workers in the changing health policy environment. Accordingly, we ask “How has the policy change prohibiting TBA delivery affected birthing experiences in Ghana's UWR?”

1.1. Study context

Ghana is one of the few countries in Sub-Saharan Africa (SSA) which implemented a National Health Insurance Scheme (NHIS) in 2004 and began offering a maternal exemption policy in 2008 that grants free health services for all pregnant women (Dzakpasu et al., 2012). The scheme was consistent with Millennium Development Goal (MDG) 5's aim to reduce maternal mortality by 75% (UN, 2000) and continues to align with the newly implemented Sustainable Development Goal's third target which strives to reduce global maternal mortality to less than 70% by 2030 while aiming to achieve universal health coverage (UN, 2015). Despite this policy initiative, Ghana's maternal mortality rates remain persistently high and outside the MDG and SDG targets with recent statistics suggesting a maternal mortality ratio of 380 deaths per 100,000 live births (WHO et al., 2014). While the percentage of births attended by SBAs have increased from 47% to 68% in 2011 (GSS, 2012b), regional variation has widened (MoH et al., 2011), marking vast rural-urban disparities (i.e. 54% rural, 88% urban) (GSS, 2012b). Coupled with geographic disparities in access to SBA are issues of poor staff attitudes, unsatisfactory facilities sometimes involving long and expensive journey times, and cultural barriers which affect a women's choice to give birth in a facility (GSS, 2010; MoH et al., 2011; Gething et al., 2012).

The Upper West Region (UWR) is one of the poorest, least populated regions in Ghana (GSS, 2012a), with only 17.5% of the total population characterized as urban compared to the national average of 51% (GSS, 2010). The region has a total population of 702,110 citizens (GSS, 2012a) and high rates of illiteracy (69.8%),