Social Science & Medicine 133 (2015) 59–66

Contents lists available at ScienceDirect

Social Science & Medicine

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

The traditional healer in obstetric care: A persistent wasted opportunity in maternal health

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ARTICLE INFO

Article history:
Available online 27 March 2015

Keywords:
Ghana
Traditional practitioners
Traditional healers
Traditional birth attendants
Maternal morbidity
Obstetric care

ABSTRACT

Traditional medical systems in low income countries remain the first line service of choice, particularly for rural communities. Although the role of traditional birth attendants (TBAs) is recognised in many primary health care systems in low income countries, other types of traditional practitioners have had less traction. We explored the role played by traditional healers in northern Ghana in managing pregnancy-related complications and examined their relevance to current initiatives to reduce maternal morbidity and mortality. A grounded theory qualitative approach was employed. Twenty focus group discussions were conducted with TBAs and 19 in-depth interviews with traditional healers with expertise in managing obstetric complications. Traditional healers are extensively consulted to manage obstetric complications within their communities. Their clientele includes families who for either reasons of access or traditional beliefs, will not use modern health care providers, or those who shop across multiple health systems. The traditional practitioners claim expertise in a range of complications that are related to witchcraft and other culturally defined syndromes; conditions for which modern health care providers are believed to lack expertise. Most healers expressed a willingness to work with the formal health services because they had unique knowledge, skills and the trust of the community. However this would require a stronger acknowledgement and integration within safe motherhood programs.

1. Introduction

In 1987, the World Health Organisation launched the safe motherhood initiative (SMI). The purpose of the initiative was to ensure that all women receive a minimum basic standard of care needed to be safe and healthy throughout pregnancy and child birth (Berer and Ravindran, 1999). SMI programs were designed to increase the prevalence of contraceptive use, increase the number of births attended by a skilled birth attendant, improve access to emergency obstetric care and improve the monitoring of maternal morbidity and mortality. The initiative was welcomed by resource-poor countries because it had the potential to address the significant maternal mortality burden (United Nations, 2008). The guidelines established through SMI are the basis of the standard of obstetric care within health systems around the world (ICPD, 1994).

By 1992 it had become clear that the effectiveness of SMI, particularly in low income settings, was limited, largely as a result of poor access and utilisation (WHO et al., 1992). Extant traditional medical systems in low income countries in Africa and Asia remained the first line service of choice, particularly for rural communities (WHO, 2002). SMI programs however, had failed to adequately acknowledge the importance of the role played by traditional birth attendants (TBAs). The WHO therefore advocated for the integration, where appropriate, of TBAs in the primary health care system (WHO et al., 1992). TBAs were trained to improve their skills for the management of normal births and the recognition of potentially high risk cases that required referrals for emergency management in health facilities. The strategy formally recognised the importance of pluralism of health care systems for traditional societies and to some extent, the recognition has persisted through more recent 'task-shifting' strategies (WHO, 2012). However, the approach has been restricted to a shallow pool of practitioners and to a narrow field of practice (Allotey, 1999).

Reviews of progress towards meeting MDG targets show that in excess of 30% of women in rural communities do not have access to skilled attendants at birth (Ghana Statistical Service (GSS) et al.,

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http://dx.doi.org/10.1016/j.socscimed.2015.03.046
0277-9536/

2009; World Health Organisation, 2014). Furthermore, community based studies suggest that for some obstetric complications, including those that might be regarded as life-threatening, a broader range of traditional practitioners are consulted within the traditional health system (Goodburn et al., 1995; Mills and Bertrand, 2005). These traditional practitioners – diviners, spiritualists, herbalists – are not in the formal category of 'TBA' but are often the preferred care provider for some women for obstetric complications, even where there is access to obstetric care (Aborigo et al., 2014; Mills and Bertrand, 2005).

Without a clear knowledge and understanding of the range of practitioners involved in the management of pregnancy-related complications and the nature of their practices, maternal health services will continue to ignore what might be a significant entry point to the provision of 'skilled' attendants. In this study, we explored the role played by traditional practitioners, other than just TBAs, in managing obstetric complications. We also examined their relevance in current initiatives to reduce maternal morbidity and mortality. Specifically, the study explored questions on who they were, how they acquired their knowledge, the range of complications they managed and the nature of the management.

1.1. Background

Maternal deaths are rare but complications in pregnancy are common. Estimates suggest that for every maternal death, 15 to 30 women experience severe complications including obstetric fistula, ruptured uterus or pelvic inflammatory disease (Bang et al., 2004; Starrs, 2006). Furthermore, research in Ghana suggests that about 9.6% of women who have home births suffer severe maternal complications (Ghana Statistical Service (GSS) et al., 2009). Under the Ghana Health Service safe motherhood guidelines, these complications need to be referred to and managed within a health care facility equipped to manage emergency obstetric care (GHS, 2007).

However, preference for home deliveries and use of traditional medical systems continue to limit utilisation of health facilities for child birth and management of complications (Ngom et al., 2003; Ronsmans and Graham, 2006). Studies in Tanzania and Bangladesh show that women still trust TBAs to intervene when severe complications occur during child birth – and although TBAs were found to refer appropriately to other practitioners when the complications were beyond their capability to manage, mothers often did not follow upon the referral due to financial costs, transportation bottlenecks and fear of maltreatment from health care providers (Moyer et al., 2013b; Vyagusa et al., 2013).

In spite of several years of implementing referral systems for maternal health, reporting to health facilities with maternal complications in many low income countries occurs only as the final treatment option, when all others have been exhausted (Aborigo et al., 2014; Adisasmita et al., 2008). These other treatment options include herbal remedies based on general folk knowledge, or prescribed by local healers. Treatment in this context could also require the imposition of strict dietary changes or rituals that serve to restore a malcontent ailing spirit that may ultimately be responsible for the poor health outcome (Hevi, 1989). It is important to note that although there is widespread recognition of the role of a traditional health care system other than through TBAs, sanctioned practice does not extend to maternal health and pregnancy complications (GHS, 2007).

2. Study context

Safe motherhood was launched in Ghana in 1987 to make childbearing safer for all women and to improve infant health. The initiative coincided with other debates about the integration of other traditional practitioners into the health system within the broader context of comprehensive primary health care (Jarrett and Ofosu-Amaah, 1992). However, while the importance of a limited role of trained TBAs was recognised for maternal and child health programs (Odoi-Agyarko, 2003), there was significant resistance to the formal integration of other types of traditional medicine practitioners such as the traditional healers. A traditional healers (THs) association was established in the 1960s and more recently, a directorate for traditional and alternative medicines has also been established. All traditional healers who intend to practice are required to register with the Traditional Medical Council (Odoi-Agyarko, 2003). Although to some extent, these acknowledge the importance of the traditional medical system to the population, the veracity of their evidence base is still questioned by professional associations (Tsey, 1997).

Within this broader health system context, the study was carried out in the Kassena-Nankana East and West Districts (KND) in northern Ghana. The KND is a relatively poor rural and agrarian district with a population of about 153,263 people from the Kassena and Nankani tribal groups (Oduro et al., 2012).

Polytheism is common among the Kassena-Nankanis. Animism, the traditional religion, predates the arrival of Christianity and Islam and while there have been many converts, the different religions and deities are believed to serve different functions (Allotey, 1999; Mills and Bertrand, 2005). The traditional religion holds to a supreme being – consistent with conversion to Christianity or Islam – but also served by lesser gods or spirits that dwell in rivers, trees, stones, animals and other objects (Manoukian, 1951; Yoder, 1982). Ancestors live with these spirits and act as the link between the individual and the deities. Ancestors are revered deceased family members who are believed to intercede to alter the fortunes of individuals or the family. They are regularly called upon through the pouring of libation – a ritual that involves the spilling of animal blood and ritual foods and alcohol on an object that embodies the spirit. The pouring of libation averts misfortune from the family and brings prosperity. There is also a belief in reincarnation and soothsayers (*vuru)* are able to foretell during pregnancy for instance, which ancestor is to be reincarnated (Allotey, 1995). Converts to other religions continue to maintain their belief in the power and wisdom of the ancestors and the spirits (Yoder, 1982).

Households in the KND are made up of extended patriarchal family units in relatively isolated compounds. A compound is a group of households that are physically linked. They are headed by males who have absolute authority over the compound members. In addition to the role as provider, the compound head is a mediator and the link between the dead and the living – the ancestors and compound members.

The traditional medical system in the KND is based on a belief in spirits – including ancestors, practice of soothsaying and the healing abilities of herbs and other natural products and objects. Illnesses and other misfortunes are attributed to either spiritual forces or disgruntled ancestors. The ancestors impose misfortune where family members make decisions without seeking advice (Adongo et al., 1997). Soothsayers are believed to have the ability to communicate with the ancestors and an individual's personal gods to foretell the future and give advice. Soothsayers provide a preliminary diagnosis of an ailment and recommend the type of traditional practitioner that should be consulted. Key practitioners within the traditional medical system include herbalists, spiritualists and TBAs. These practitioners function alongside formal health care providers throughout the district.

2.1. Maternal health facilities

Government health facilities are strategically located