UNIVERSITY OF CAPE COAST

A HISTORY OF TRADITIONAL BIRTH ATTENDANTS AND MATERNAL HEALTH IN GHANA, 1931 – 1992

BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature …… Date …….

Name: …….

Supervisors Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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ABSTRACT

Before the introduction of conventional midwifery, Traditional Birth Attendants (TBAs) or indigenous midwives were the only maternal healthcare providers. With the introduction of conventional midwifery came the introduction of policies to scrutinize the practices of TBAs. These policies depicted efforts to ban TBAs and eradicate the reliance of pregnant women on TBAs. No research has explored policies affecting TBAs and how they affected their status as the original providers of maternal healthcare. This thesis historicized the policies affecting TBA practices from 1931 when the Midwives Ordinance was passed, to 1992, when the National Reorientation project for TBAs ended. Using archival documents including official government documents such as legislative debates, annual reports and policy briefs amongst others, this research has shown that the policy that affected indigenous midwives or TBAs during the colonial and postcolonial period mainly sought to gradually remove them from the system, to allow a dependence on conventional healthcare. These policies affected the roles that TBAs played over the years, and also caused certain undesirable perceptions about TBA practices. However, TBAs could not be removed from the system due to the inability of the government to provide conventional healthcare to all areas in Ghana. TBA reorientation and inclusion into the formal healthcare system became necessary for the government to use already available resource. In rolling out these reorientation programmes however, the government and policy makers failed to consider the social and cultural dispositions of TBAs.

KEYWORDS

Traditional Birth Attendants

Indigenous Midwives

Maternal Health

Conventional Maternal Healthcare

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DEDICATION

This work is dedicated to my parents,

Mr. Timothy A. Akansor and Mrs. Comfort Akansor,

And my advisor and friend,

Dr. Jim Weiler.

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LIST OF ACRONYMS

CHN:	Community Health Nurses
CHN:	Community Health Nurses
CHPS:	Community-based Health Planning and Services
FMH:	Free Maternal Healthcare
GOG:	Government of Ghana
MDG:	Millennium Development Goal
MMR:	Maternal Mortality Ratio
MOH:	Ministry of Health
NRC:	National Redemption Council
NRCD:	National Redemption Council Decree
NTBA:	National Traditional Birth Attendant training programme
PHC:	Primary Healthcare
PRAAD:	Public Records and Archives Administration Department
PROP:	Project Paper
SBA:	Skilled Birth Attendant
TBA:	Traditional Birth Attendant
THP:	Traditional Health Practitioners
TMP:	Traditional Medical Practitioners
ToT:	Training of Trainers
UCLA:	University of California at Los Angeles, School of Public Health
UGMS:	University of Ghana Medical School
UK:	United Kingdom
UN:	United Nations

UNFPA:	United Nations Population Fund
UNICEF:	United Nations International Children's Emergency Fund
USAID:	United States Agency for International Development
VHV:	Village Health Volunteer
WHO:	World Health Organization

CHAPTER ONE

GENERAL INTRODUCTION AND BACKGROUND

1.0 Background to the Study

According to the World Health Organization (WHO), a Traditional Birth Attendant (TBA) is a person who assists an expectant mother during childbirth and who initially acquired her skills by delivering babies herself and by working with other Traditional Birth Attendants (TBAs).[1] Traditional Birth Attendants refer to indigenous midwives, and in Ghana and most parts of the world, were in the past the only providers of maternal healthcare.[2] TBAs maintained an indisputable and exclusive control of their specialty of medicine until conventional healthcare providers, including midwives, doctors and nurses, steadily took this away from them, especially through policy implementations.

The focus of the research is to historicize the policies concerning TBA practice in Ghana, and how these affected the practices of TBAs as original providers of maternal healthcare in Ghana. It investigates how and why TBAs were excluded from the formal healthcare delivery system and later included. Also, the factors that necessitated the inclusion of TBAs in the formal

[1] 'Amref Health Africa's Position on the Role and Services of Traditional Birth Attendants', Amref Health Africa, assessed 23 May 2016, http://www.amref.org/amref-position-health-africa's; this online article contains the World Health Organization's definition of Traditional Birth Attendants.

[2] In this thesis the terms 'Traditional Birth Attendants' and 'Indigenous Midwives' are used interchangeably to refer to the same group of people. The author subscribes to the use of Indigenous midwives, however, because of the different names that indigenous midwives acquired in subsequent years, the terms are used interchangeable during certain periods to reduce any form of confusion.

healthcare system are examined. Additionally, the factors that made them an essential resource in maternal healthcare delivery in Ghana are discussed.

The genesis of the gradual infiltration of conventional maternal healthcare into the maternal healthcare system in Ghana can be traced to the early 20th century during the colonial period. In 1915, a private African medical practitioner, Dr. F. V. Nanka-Bruce, had reported on the devastating maternal and child mortalities in Ghana.[3] To remedy the situation, he had suggested that African midwives be properly trained while maternity hospitals be built to reduce the rate of maternal and child mortalities.[4] This suggestion was to bear fruit later on in 1921 when the colonial government set up welfare and maternity centres in the Gold Coast. By 1932, welfare centres were established in various parts of the Gold Coast colony, and their work was considered a success with a reduction in mortality rates. From 1928, midwifery training began to be offered and the necessary auxiliary staff was also trained to support this work.[5]

During this crusade, TBAs were sidelined and seen to have formed a major part of the maternal health problems. In Geneva in 1931, at the Save the Children International Union, participants listed the causes of child and maternal mortalities to include social diseases, poverty, native midwives, mother's carelessness, and irrational feeding of infants, superstition and a lack

[3] Stephen Addae, *History of Western Medicine in Ghana, 1880 – 1960* (Durham, 1996), 148.
[4] *Ibid.*
[5] *Ibid*., 148 – 150.

of sufficient medical aid.[6] In that same year, the Midwives Ordinance of 1931 was passed in the Gold Coast. Through this ordinance the colonial government discouraged the use of TBAs and assented to the use of conventional healthcare. In other British colonies, TBAs were completely prevented from practicing.[7] Therefore, Europeans interfered in the healthcare system of locals, displaying themselves as extraordinarily knowledgeable in the art of childbirth and mothering, whereas traditional methods were rejected and portrayed as dangerous. This continued in the postcolonial era.

This thesis is set within the context of colonial policy, which sidelined African institutions and knowledge in an effort to promote western ideas and gain control of Africans and how these policies were transferred into the postcolonial period. At the dawn of the colonial period, African institutions like chieftaincy, marriage, forms of education, and healthcare amongst others were downgraded. Also the colonial period saw the exclusion of Africans from the public service, an obvious unwillingness to give Africans the opportunity to serve in the public service. No training institutes and scholarships schemes existed to expose Africans to the possibility of serving in the public service.[8] Thus Africans, along with their ideas were degraded.

The rejection of TBAs and the passing of the Midwives Ordinance of 1931 that banned TBAs from practicing is a clear example that this thesis has analysed. Nana Akua Amponsah has argued that the introduction of maternal

[6] Nana Akua Amponsah, 'Colonizing the Womb: Women, Midwifery and Colonial Ghana', (PhD Dissertation, University of Texas at Austin, 2011), 9; Jean Allman, 'Making Mothers; Missionaries Medical Officers and Women's Work in Colonial Asante, 1924 – 1945', *History Workshop*, no. 38 (1994), 23.
[7] Allman, 'Making Mothers', 29 & 31.
[8] David Kimble, *A Political History of Ghana: the Rise of Gold Coast Nationalism, 1850 – 1928* (London, 1963), 98 – 105.

and child welfare institutions was a clear attempt to medicalize pregnancy and control women's reproductive life.[9] Traditional Birth Attendants represent an African institution that was sidelined in the face of growing sense of superiority on the part of Europeans, and the need to control Africans and the insistence on the acceptance of European ideas. The neglect of TBAs by the government, until the introduction of TBA reorientation programmes, during the postcolonial period also illustrates how colonial policy was transferred to Ghana.

During the postcolonial period, the Government of Ghana (GOG) introduced interventions to make the conventional maternal healthcare system work more efficiently and provide services to all areas of Ghana. These interventions revealed a neglect of the traditional maternal healthcare that still existed despite the ban by the colonial government. However, the continuous dependence on conventional maternal healthcare did not yield the expected results, as gaps in assessing conventional healthcare continue to persist.

In the 1970s, the GOG considered the use of TBAs alongside conventional healthcare provision. Having concluded that the practices of TBAs were unsafe and unhygienic, reorientation and training was, therefore, to induce more hygienic and safer methods of delivery by TBAs. As a result, the Danfa Rural Health Project, which started training programmes for TBAs, was started in Accra in the 1970s. These training programmes continued into the 1990s and were replicated in all ten regions of the country.

[9] Amponsah, 'Colonizing the womb', 7.

1.1 Statement of the Problem

The problem that this research examined is the policies that have driven Traditional Birth Attendant's (TBAs) status and practice in Ghana between 1931 and 1992. The Midwives Ordinance of 1931 depicted Traditional Birth Attendants (TBAs) as the primary cause of maternal and child mortalities and other related problems, and therefore questions the usefulness of TBAs. Despite efforts to sideline TBAs, the colonial government was unable to cover the entire country with conventional maternal healthcare, leading to a continuous reliance on TBAs.

In the early postcolonial period, policies on maternal healthcare had little or nothing to do with TBAs. Primarily in dealing with maternal and infant welfare, the government relied on conventional maternal healthcare and sought to increase the number of conventional healthcare providers, and accessibility to them.[10] Despite these policies, continuously, conventional maternal healthcare was unable to cover the entire country and several women relied on the services of TBAs. This necessitated the reorientation of TBAs in the country to augment conventional midwifery, while attempting to make them adopt the skills and roles expected of western trained midwives.

Despite the roles that TBAs played in filling the gap that conventional healthcare providers created, they continued to be scrutinized. After the Midwives Ordinance of 1931, several maternal healthcare policies were introduced and adopted to increase reliance of conventional healthcare. Some of these policies included the Nurses and Midwives Council Act of 1966, the

[10] Gloria Ampim, 'An Historical Analysis of Maternal and Infant Welfare in Ghana, 1957 – 1980', (Masters Thesis, University of Ghana, 2013), 25.

Nurses and Midwives Degree of 1972, the Community-based Health Planning and Services (CHPS) and the Millennium Development Goal (MDG) 5 introduced in 1990s, and the Free Maternal Healthcare, also introduced in the 2000s. Additionally, in 2010, the government initiated a policy to exclude all TBAs from deliveries by 2015, and in 2012 TBAs roles were specified as delivery babies of 2nd and 4th pregnancies in cases where delivery could not be avoided, or otherwise refer those deliveries to the clinic.[11]

The policies concerning maternal healthcare in Ghana, affected the roles that TBAs played since the colonial period and after their reorientation programmes. Gradually, the exclusive rights over their work and practices were taken away from them and yet, it could not be proven that TBAs were responsible for maternal and child mortalities in Ghana. Despite the introduction of conventional healthcare and several policies to improve maternal healthcare in the country, TBAs remained an indispensable resource. Therefore any efforts to phase out TBAs would have been disastrous to the health of majority of mothers in Ghana, who continued to rely on TBAs.

During the reorientation programmes, more than 10,000 TBAs were reoriented, and their role was to assist in health promotion, and indulge in the basics of safe delivery and also refer high-risk pregnancies to the hospital and health centres. Before this, the roles of TBAs were not specified and depended mostly on the knowledge passed down to them, their own experiences in the course of assisting in birth delivery and from their predecessors and based on a

[11] Seth J. Bokpe, 'New Role for Traditional Birth Attendants', *Daily Graphic*, March 27, 2010, 19; Socioserve-Ghana and District Health Administration of the Lower Manya Krobo District Assembly, 'Towards an Effective Collaboration for Quality Maternal and Neonatal Health Delivery: the Role of Traditional Birth Attendants & the Ghana Health Service', 2012, 4.

culture of medicine that made use of herbs.[12] The policies, which gradually reduced TBA roles to referring mothers to the hospitals, suggested a lingering wish to oust TBAs from the system, and an inconsistency with exactly what roles TBAs should play in maternal healthcare delivery in the country. The key question that this research asks is how did government and policy makers conceptualize the role TBAs can play that consequently led to their reorientation and use?

1.2 Literature Review

This section seeks to review some related literature concerning Traditional Birth Attendants (TBAs) practice in Ghana. Even though several literatures have analysed Traditional Birth Attendants (TBAs) practices in Ghana, these have been done as a general study of maternal welfare in Ghana. That is, none of the literature has done an in-depth historical study on the policies affecting Traditional Birth Attendants (TBA) practice and their relative social and professional position, after the introduction of conventional healthcare. This study draws mainly from three main bodies of historiography in Africa and Ghana; conventional healthcare in the Gold Coast and Ghana, Maternal health in the Gold Coast and Ghana, and Traditional Birth Attendants in Ghana and Africa.

The body of work on conventional healthcare in Ghana helps significantly to understand how and why conventional healthcare was introduced in Ghana to the detriment of TBA practice. Also it gives an idea of how locals reacted to the introduction of conventional healthcare in Ghana.

[12] Emily Kennedy, 'Traditional Birth Attendants in Modern Ghana: A Discussion of Maternal Healthcare', *African Diaspora,* ISPs, 40.

They also indicate that the colonial government along with prior work of missionaries did not only criticize the work of existing traditional healthcare systems but took measures in the form of introducing conventional maternal healthcare. Stephen Addae in his work, History of Western Medicine in Ghana, 1880 – 1960, has examined how and when western medicine was introduced into Ghana and its operation till 1960. The kinds of diseases that plagued Ghana during the colonial period and how they were dealt with are all analysed.

Addae's work also covers maternal and child welfare on the coast and has talked about infant and maternal welfare work during the colonial period. He suggests that the colonial government and other non-governmental agencies like the British Red Cross Society played major roles in creating a conventional maternal and child welfare system for the colony. The colonial period therefore saw the institution of welfare and maternity centres and the introduction of women medical officers. However, all these became necessary due to their belief that the traditional maternal healthcare system that existed was a major cause of maternal and child mortalities and its associated problems.[13] Thus mother and child mortality rates were explained as a result of TBA practices. The accusation against TBA as the cause of maternal mortalities helps to establish why TBAs were excluded from the colonial governments formal healthcare system. To understand how TBAs exclusion from maternal healthcare was rolled out, and the effect that it had on TBAs, this thesis examines what specific policies were introduced during and after the colonial period.

[13] Addae, *Western Medicine*, 148.

In examining conventional healthcare in Ghana, K. David Paterson and Gabriel B. Fosu in their works, 'Health in Urban Ghana: the Case of Accra 1900 – 1940' and 'Access to Healthcare in Urban Areas of Developing Societies' respectively, have shown how the introduction of conventional healthcare shaped the health seeking strategies of Ghanaians. They both argued that the changing socio-economic conditions in Ghana, and the changes in the socio-economic status of Ghanaians did not significantly shift the reliance on traditional healthcare to conventional healthcare.[14] Though Addae's work shows that locals accepted and relied on conventional healthcare on the Gold Coast and demanded that the colonial government put measures in place to widen the scope and effectiveness of conventional healthcare provision,[15] Fosu and Patterson have showed that the health seeking strategy of Ghanaians continued to be pluralistic. Fosu and Patterson both agree that changes in economic status did not change the views of women with regards to resorting to traditional healthcare. This thesis explores the economic and socio-cultural factors that informed the continuous reliance on TBAs.

The second body of literature examines maternal healthcare in the Gold Coast and Ghana, and analyses how conventional healthcare was introduced. The common theme in the literature examined is that the colonial government in introducing conventional healthcare sidelined traditional maternal healthcare and presented it as dangerous. It is also argued that the introduction of maternal healthcare in the Gold Coast and Ghana was not as a result of a

[14] Gabriel B. Fosu, 'Access to Healthcare in Urban Areas of Developing Societies', *Journal of Health and Social Behaviour*, Vol. 30, December (1989), 398 – 411; K. David Patterson, 'Health in Urban Ghana: the Case of Accra 1900 – 1940', *Social Science and Medicine*, Vol. 13b, (1979).
[15] Addae, *Western Medicine*, 153.

genuine concern for women and children but a means of reaffirming British control on the Gold Coast. Jean Allman in her article, 'Making Mothers: Missionaries, Medical Officers and Women's Work in Colonial Asante, 1924 – 1945' has also explored the interest in maternal welfare in Ghana during the colonial period. Allman investigated the work of the colonial government and missionaries in Asante. She, like Addae, indicates a great distaste for the traditional methods of maternal healthcare on the Gold Coast and efforts by the colonial government to remove the traditional birthing and maternal welfare practices on the coast.

Even though Allman mentions that TBAs were to be removed as a result of their practices which were seen as a major cause of maternal and child mortality, she argues that interest in maternal welfare during the colonial period had both social and political dimensions.[16] The political interest is depicted by the institution of laws and meting out of punishment to induce women to marry and also desist from relying on traditional methods of healthcare. The social interest is also depicted through the introduction of welfare centres. Allman shows that despite collaboration between the colonial government and welfare organizations and traditional rulers to control of the reproductive health system of women, African women, and precisely women in Kumasi influenced the situation to an extent. Thus the women in Kumasi did not oppose the idea of being educated with foreign ideals in mothering and childcare, but transformed these centres into places to handle complications that they could not handle only and for treating all sort of diseases.

[16] Allman, 'Making Mothers'.

Allman's view suggests that despite the introduction of conventional healthcare, women still greatly relied on TBAs for their maternal healthcare needs. Allman has shown that Asante women took their own initiatives to subvert colonial policy and Asante male-centred policy of controlling women's progress and mobility. This thesis emulates Allman by examining the agency of TBAs when they were banned during the colonial period, and during the period of neglect of their existence in the postcolonial period.

Allman's argument on the social and economic dimensions on the interest in maternal health on the coast is comparable to the argument by Nana Akua Amponsah. In her work, 'Colonizing the Womb: Women, Midwifery, and the State in Colonial Ghana'. Amponsah also examined the interest in maternal welfare in Ghana and argued that the colonial government's interest in maternal healthcare on the Gold Coast was a means to 'colonize the womb', a means of controlling the reproductive choices of African women. According to Amponsah, Gordon Guggisberg insinuated through a narration that Europeans knew how to handle children and womanhood better than Ghanaians, therefore leading to the colonial government's interest in reconstructing womanhood. However, Amponsah mentions that in Europe and in the New World, women were at times used as beats of burden, enslaved even when they were due to give birth. Therefore, there was a clear attempt to impose the superiority of the European culture and not a genuine attempt to help African women on the Gold Coast.

Nonetheless, interest in the maternal health of Africans culminated into certain health activities like the institution of welfare centres and the banning

of traditional midwives that economically benefited Europeans more than Africans.[17] Thus, in instituting conventional healthcare and belittling the practice of TBAs, Europeans benefited through employment and TBAs, a majority of who were women were to lose their source of livelihood.

The above clearly agrees with Allman's argument on the political dimension of maternal welfare and indicates an effort to push women to the background in society. Subsequently, Amponsah focuses on women's perspectives during the effort by the colonial government to control their reproduction and historicizes the experiences of these women. In fact, both a critique of Allman's work and Amponsah's theorizing are relevant in rewriting the history of women's welfare, by listening to the feminine side; hearing it from the women themselves and showing how women had also contributed to the making of their history, which many history books do not project. This thesis like Allman and Amponsah brings out the experiences of TBAs focusing on their practices and how they dealt with pregnancy and delivery despite the projection of their practices as unprofessional and wrong, and the main cause of maternal mortalities.

Gloria Ampim also examines the changing policies and practices concerning maternal and infant welfare in postcolonial Ghana in her work, 'An Historical Analysis of Maternal and Infant Welfare in Ghana'. From 1957 to 1980, the period in which she conducted her research, she argues that maternal and infant welfare policies were "defined by political, traditional and gendered factors."[18] That is, maternal and infant welfare polices were not truly

[17] Amponsah, 'Colonizing the Womb'.
[18] Ampim, 'Maternal and Infant Welfare', 21.

based on a concern for the welfare of infants or mothers. To support this argument she examines the maternal welfare policies instituted by the governments. She shows that policies made concerning maternal health were driven by the focus of the government in power. This could be either the need for population growth or a decrease in population growth as was the focus of the Conventions Peoples' Party government of Kwame Nkrumah and the Progress Party government of Dr. Busia respectively. She also mentions that the policies concerning maternal health shifted to TBAs and therefore brought about the reorientation of TBAs in the 1970s to augment the existing maternal healthcare provision. This thesis differs from Ampim's by specifically examining those policies that affected the role and practice of TBAs, how government conceptualized the reorientation of TBAs, and the effect that these reorientation programmes had on TBA status in Ghana.

Another body of literature examines Traditional Birth Attendants, their practices, and why they remained indispensable in Ghana and other parts of Africa despite the introduction of conventional healthcare. Nah Dove, in examining 'A Return to Traditional Health Practices; a Ghanaian Study', studied the continuous reliance on traditional medicine despite several years of policies to implement western medical practices.[19] She argues that the policy of implementing western medical practices had led to the continuous reliance on traditional medical practices. Using Ghana as a case study, Dove argues that several people in the rural areas of Africa could not have survived if traditional medicine was totally eliminated. Dove explains that rural dwellers had little or no access to conventional healthcare and could therefore not have

[19] Nah Dove, ' A Return to Traditional Health Care Practices: a Ghanaian Study', *Journal of Black Studies*, Vol. 40, No. 5 (2010), retrieved from http://jbs.sagepub.com.

survived if traditional healthcare was banned. This thesis is in line with Dove's work that, TBAs were a major source of healthcare provision for women in Ghana, and a need to explore how they were treated, and their contribution to maternal healthcare in Ghana must be critically analysed.

Kodjo Senah in, 'Maternal Mortality in Ghana: the Other Side', stressed the fact that in approaching maternal welfare, causes of maternal and child mortality should be addressed holistically. Significantly, causes of maternal mortality have been linked to, and identified from the medical perspective. However, Senah points out that medical conditions and socio-cultural practices are a combined factor in causing maternal mortality. He argues that the socio-cultural factors are overlooked because it concerns women. Therefore Senah believes that maternal welfare in Ghana is gendered, primarily because the women involved are "politically voiceless and financially weak."[20]

Taking a cue from Kodjo Senah, this thesis investigates the extent to which the socio-cultural practices were considered in introducing policies that sidelined TBAs. Senah explains that TBAs continued to be relied upon due to their knowledge of the cultural beliefs of the communities in which they operated and the reverence they showed towards these beliefs in their practice. This thesis further examines which socio-cultural aspects of the Ghanaian were considered in conceptualizing the reorientation of TBAs as a means of dealing with maternal welfare.

[20] Kodjo Senah, 'Maternal Mortality in Ghana: the Other Side', *Research Review*, NS 19. 1 (2003), 54.

Apart from the above-mentioned literature that deals with traditional birth attendants in Ghana, others have examined the impact of TBAs in other parts of Africa. Jane Turrittin in her work, 'Colonial Midwives and Modernizing Childbirth in French West Africa', has examined the work of African midwives during the colonial period and the effect on maternal health using mainly, the autobiography of an African midwife.[21] Turrittin's work helps establish the differences in impact on maternal health in French West Africa and British West Africa. Due to French colonial policy of creating évolués, they educated several African women to complement the conventional maternal healthcare introduced. In the British West African colonies however, missionary institutions initially trained the British African medical auxiliaries in small numbers. The colonial government later subsidized the training of Africans as medical auxiliaries. The delay in training African medical auxiliaries explains why in British West African colonies like the Gold Coast, the number of health personnel was low, and further explains the continuous reliance on traditional methods. Turrittin's work also provides primary data to understand the practices and beliefs of TBAs before the introduction of conventional healthcare.

I. T. Kamal's work on 'the Traditional Birth Attendants: a Reality and a Challenge', has also studied the impact of trained TBAs on maternal health in Africa. He argues that TBA training and utilization has not been very successful because TBAs tend to practice their traditional roles and neglect the new roles assigned them, as well as the practices expected of them. This he blames on the lack of supervision. Kamal therefore suggests that despite the

[21] Jane Turrittin, 'Colonial Midwives and Modernizing Childbirth in French West Africa, in *Women in African Colonial Histories*, ed. Jean Allman et al. (Bloomington, 2002), 17 – 72.

fact that TBAs are being utilized by the government, countries and agencies must at the same time plan and implement other strategies to deal with maternal healthcare.[22] However, the argument that is made in this thesis is that TBA reorientations did not capitalize on the knowledge already possessed by TBAs; rather, much of the focus was on conventional healthcare indoctrination. This indicates a conflict between the knowledge and skills TBAs possessed over the years, and western maternal healthcare knowledge and skills that were acquired over a short period of reorientation.

Edmund J. Kayombo in 'Impact of Traditional Birth Attendants on Maternal and Morbidity in Sub-Saharan African Countries', has also examined the impact of training TBAs in sub-Saharan African countries. He makes a case for the relevance of TBAs despite the fact that it has been denied by western health practitioners. He reiterates that TBAs can help to deal with the socio-cultural practices that serve as barriers to the improvement of maternal health.[23] This thesis argues that the reorientation of TBAs led to and reinforced the practice of a combination of traditional medicine and western medicine which practice had its own effects on maternal health. This is done by analysing the impact of the training programmes on the medicine culture of TBAs.

Additionally, Staffan Bergstorm and Elizabeth Goodburn in 'The Role of Traditional Birth Attendants in the Reduction of Maternal Mortality' also argues that the training and use of TBAs should not be ignored but rather,

[22] I. T. Kamal, 'the Traditional Birth Attendants: a Reality and a Challenge', *International Journal of Gynaecology and Obstetrics*, s63 Suppl. 1(1998), 43 – 52.
[23] Edmund J. Kayombo in 'Impact of Traditional Birth Attendants on Maternal and Morbidity in Sub-Saharan African Countries', *Tanzania Journal of Health Research*, Vol. 15, No. 2 (2013), 7.

given a low priority, and the focus should be on other programme options.[24] This argument stems from the idea that it cannot be proven that TBAs can prevent maternal and child mortality and so concentration should be directed to those areas or health professionals who have shown evidence of effectiveness at preventing maternal and child mortality.

Aparna Kumar in his work, 'The Examination of Traditional Birth Attendant's Practices and their Role in Maternal Health Services in Mwandama Village Cluster', has argued in the same direction as Bergstorm and Goodburn. He explains that TBAs potentials are ignored despite the fact that they are already skilled. Using the Mwandama Village as a case study, Aparna Kumar has investigated the neglect of TBA potential and use despite the fact that they performed majority of births. He argues that the focus has been tuned towards the use of western healthcare facilities and western midwives because TBAs are not regarded as skilled birth attendants.[25]

Yet, a majority of women in Nwandama did not have access to and could not afford conventional healthcare. Based on this analysis, this thesis examines what status TBAs in Ghana assumed after their reorientation programme. If the reorientation programme was to train them to adopt certain skills, then why were they not considered midwives and referred to as TBAs or trained TBAs? Clearly it was wrong to assume that TBAs were not already

[24] Staffan Bergstorm and Elizabeth Goodburn, 'the Role of Traditional Birth Attendants in the Reduction of Maternal Mortality', assessed on 31 July, 2017, retrieved from http://jsieurope.org/safem/collect/safem/pdf/s2933e/s2933e.pdf.
[25] Aparna Kumar, 'The Examination of Traditional Birth Attendant Practices and their Role in Maternal Health Services in Mwandama Village Cluster', (Masters Thesis, University of Malawi, 2007).

skilled, because they received some form of training prior to the practice of obstetrics.

Margaret Owen in 'The Traditional Birth Attendants and the Law' has discussed the potential of the training and use of TBAs by most countries. However, she identifies the reluctance by most countries to legalize their practice. She asks, "who is liable should anything go wrong?"[26] However, the same question can be asked of conventional healthcare workers. Yet, the legal standing of TBAs will determine who should be held responsible in the case of deaths or severe complications leading to death. Fouzieyha Togwi also in assessing policies concerning traditional midwives in Pakistan stressed that health policies are determined to a large extent by "international trends and donor priorities".

This shows that little or no priority was given to the culture of the Pakistani and the perspectives of Pakistani women in creating laws concerning maternal welfare. This thesis asks whether the perspectives of Ghanaian women and TBAs were enquired in introducing conventional midwifery and also including TBAs in the formal healthcare system through reorientation. This thesis investigates the status of TBAs prior to the 1930s and how that changed over the years. This research is relevant in addressing these issues and more because despite several measures, including the reorientation of TBAs, Ghana continued to record high maternal and child mortalities.

[26] Margaret Owen, 'The Traditional Birth Attendants and the Law', *World Health Forum*, Vol. 4, 291 – 312 (1983), 295.

1.3 Purpose of the Study

The purpose of this study is to examine the policies concerning TBAs since the introduction of conventional maternal healthcare in Ghana, and how the government conceptualized the reorientation of Traditional Birth Attendants. It argues that the reorientation of TBAs, apart from augmenting the conventional healthcare system, served two other purposes. First, there was the institutionalization and control of TBAs. Secondly, it served the purpose of dealing with the inability of conventional healthcare to cover the entire country.

1.4 Research Questions

In exploring polices concerning TBA practice, and the impact on the operations of TBAs, the research investigates these sub-questions: what roles did TBAs play prior to the introduction of conventional midwifery and how did that change? What policy directions governed the practice of TBAs and how did these policies affect the roles TBAs played? What policy conceptions led to the reorientation of TBAs? And what prevailing conditions led to the continuous reliance on TBAs by Ghanaian women?

1.5 Significance of the Study

- The study indicates how policies concerning maternal healthcare, affected the practices and roles of TBAs in Ghana.
- The study shows how governments conceptualized the reorientation of TBAs, and how that affected the status of TBAs in Ghana.

- The study aids in understanding the recognized status of TBAs before the introduction of conventional healthcare and how that changed.

- The study establishes the roles TBAs have played in maternal health in Ghana.

- The study provides information useful for overcoming notions that become obstacles to the use of TBAs.

- It adds to studies into the History of TBAs and the History of Medicine in Ghana.

1.6 Organization of the Work

The study has been organized into six main chapters, with a summary and conclusion. The Introduction and Background to the study forms the first chapter and indicates the problem that the work has investigated, the significance of the study, the methodology and the literature review, and clearly identifies the gap that this study was filled.

The second chapter examines the Traditional Birth Attendant's role, operation and functions before the introduction of conventional healthcare. This chapter examines TBA practices, taking into consideration some of the clinical roles they performed. It argues that TBAs had their own methods of providing antenatal care, postnatal care and performing surgeries amongst others, which debunks any contrary views that the introduction of conventional maternal healthcare suggested. For instance, the notion was that TBAs did not perform some clinical roles.

The third chapter examines Policy Directions Affecting Traditional Birth Attendants in Ghana, 1931 – 1970s. This chapter has examined the policies initiated by the governments concerning maternal healthcare and how they affected and shaped the status and roles of TBAs in Ghana. It starts from 1931 with the introduction of the Midwives Ordinance and ends in the 1970s, with the introduction of the Alma Mata Declaration on Primary Healthcare in Ghana.

The fourth chapter is the Reorientation of Traditional Birth Attendants, 1970 – 1992. It examines how the process of reorientation began, what guidelines were adopted and what necessitated it at the time that it was started. This chapter also investigates how the government intended to train and use TBAs in the 1970s for improving maternal healthcare and if that was achieved. Also what became the legal status of TBAs after their training? It is argued that the inability of the government to improve maternal health, or solve maternal health issues and especially with the use of TBAs is discriminatory against women.

Gaps in Conventional Healthcare forms the fifth chapter. In order to understand the lingering wish to do away with TBAs, an exploration of governments training of healthcare providers, thus TBAs and conventional healthcare providers is done in order to establish whether the training of TBAs negatively affected the training of conventional healthcare providers. It also analyses what gaps persisted in the practice of conventional healthcare which positioned TBAs as an indispensable resource. Does the government find itself

in a situation where it had adequate professional healthcare providers and therefore saw no need for TBAs?

A concluding analysis of the study on policies affecting TBAs, and the role of TBAs in maternal healthcare in Ghana before and after the introduction of conventional healthcare is also done in the sixth chapter.

1.7 Research Design and Available Sources

This study adopted a qualitative paradigm. That is, answers to the research questions were sought by examining various data on TBA practices and policies on maternal healthcare provision in Ghana. Data was collected through face-to-face interviews with TBAs, mothers and conventional healthcare providers. Potential informants were sampled using the snowball sampling technique, where those sampled aided in gathering more informants in order that a detailed and wide data was collected. The interviews with the aforementioned groups helped to establish how roles and practices of TBAs have changed over the years, and also indicate some gaps in conventional healthcare that made TBAs indispensable in Ghana.

Interviews were supplemented with official government documents including annual reports, legislative debates and policy briefs. *The Gold Coast Annual Reports* give a fine description of general conditions of health on the Gold Coast. This greatly helped to follow up and justify the exclusion of TBAs from the formal health system during the colonial period and which form it took. In addition, data from the Annual Reports was used to analyse the introduction of conventional midwifery as a way of establishing government agency after banning indigenous midwives. Also the *Legislative*

Debates gave a description of developments on maternal health conditions in especially rural Ghana. The legislative debates also assisted in understanding government's position on the use of TBAs to supplement the conventional healthcare delivery system in Ghana.

Government policy documents that were examined include the First Seven Year Development Plan, 1963, by the CPP. The First Seven Year Development Plan indicates government's plan to train by 1970 medical practitioners. This document was significant in establishing the gaps in conventional healthcare prior to the TBA reorientation programmes in the 1970. The National Redemption Council (NRC) Proclamation Decree of 1972 also indicates who can be qualified to practice midwifery. The 1972 decree along with other polices indicate how the Government of Ghana (GOG) continued colonial policy of neglecting the practice of TBAs as indigenous midwives.

These policy documents, along with the Gold Coast Annual Reports and Legislative Debates are available at the Public Records and Archives Administration Department (PRAAD), Accra, and the Africana and Balme Libraries of the University of Ghana, Legon.

Also letters written by Chiefs in the Gold Coast to the Governor complaining of a need for midwives are available at the PRAAD in Cape Coast and Kumasi. These letters were used to show how traditional rulers showed little enthusiasm about obtaining midwives on the Gold Coast. In addition, these letters helped to establish the insufficient number of midwives

during the colonial period, and suggests why there was a continuous reliance on TBAs despite the introduction of conventional maternal healthcare.

Reports on the assessment of TBA training at the Danfa Health Clinic in Accra and other reports on TBA reorientation and training programmes were also assessed at the Ministry of Health Research Centre, Accra and the Department of Community Health at the University of Ghana Medical School (UGMS) at Korle Bu. These reports were useful in understanding why and when TBA reorientation programmes were started, and how the government conceptualized these training programmes and the use of TBAs to augment conventional healthcare provision. They were also useful in examining the impact of TBA training on the roles and practices of TBAs, and the impact on maternal health in Ghana.

CHAPTER TWO

THE TRADITIONAL BIRTH ATTENDANT

2.0 Introduction

This chapter discusses Traditional Birth Attendants (TBAs) operation and practice before the introduction of conventional midwifery in Ghana. Before the introduction of conventional midwifery, TBAs were referred to as local midwives by the colonial government.[27] However the suitable reference would be indigenous midwives because they existed long before the introduction of western conventional healthcare. In contemporary times, they were referred to as TBAs, and sometimes called trained TBAs for those who had gone through a reorientation programme. In the various communities where they reside, TBAs assumed different names unique to the languages used in their communities, which literally meant 'child deliverers'.[28]

An analysis of the operation and practice of TBAs before they received any form of reorientation is done to provide a background to understanding the roles that they played before the introduction of conventional healthcare and what changes have occurred since their contact with conventional healthcare.

By examining these roles, an understanding of what necessitated the reorientation and training of TBAs before their inclusion into the formal healthcare system will also be accomplished. This chapter is necessary to

[27] Allman, 'Making Mothers', 31.
[28] Interview with Aba Edua, Chief Priestess and Traditional Birth Attendant, Esuekyir, Winneba on 24 August, 2016, and Sarah Agymeman, Traditional Birth Attendant, Akpoma, Accra, 14 January, 2017.

provide knowledge on traditional midwifery as an indigenous practice, which was once the only way of providing maternal healthcare in the country.

The introduction of conventional healthcare in Ghana created the impression that TBAs did not play any vital roles or were unable to deal with several of maternal healthcare related practices or complications. Some of these pregnancy related practices and complications included prenatal care, postpartum care, bleeding, still birth, and breech birth amongst others. This research shows that TBAs played diverse roles including the provision of prenatal and postpartum care. They also had remedies to deal with complications such as breech birth, delayed birth, hemorrhage, and stillbirth, just as conventional healthcare. Thus this chapter shall primarily deal with the practices and functions TBAs played, and what management skills they employed in dealing with maternal healthcare, independent of foreign influence.

2.1 Training of Traditional Birth Attendants

The Traditional Birth Attendant (TBA) entered this profession through two outstanding means; one, as a result of training with a relative or acquaintance and the other, through spiritual gifting. Talking about traditional medical practice in general, Nah Dove has mentioned that qualification was based on interest in the profession, choice of a shrine or spiritual institution, and inheritance of knowledge from family.[29] Despite this, the final decision to become a TBA is dependent on one's own conviction. A male Traditional Midwife narrates how he entered into midwifery.

[29] Dove, 'Return to Traditional Health', 824.

> I was a spiritualist before I started midwifery. I had prayed that I wanted to do more than just being a spiritualist. One time I was sitting here and I saw someone in white cloth standing under the big tree in my father's house and the person said, 'if you want he would add it to what you are doing so take. Do it that way and that way, but during this time they would bring someone, look after the person, she would deliver and look after her'.[30]

Another traditional midwife interviewed mentions that,

> Nobody taught me. Rather, I had a dream that two white people came to me that they were bringing someone for delivery and the person came and delivered the baby. After I delivered the child, I woke up and someone came in reality to deliver and I did it and it got stuck.[31]

Though there are several instances of people becoming TBAs through spiritual gifting or choice of a shrine, an appreciable number of these, especially women, learnt this as a trade from their mothers. This came naturally as learning to cook, sell, or fetch water from a stream. A TBA interviewed mentioned that, when young girls reached adolescence and were considered to be women, informally they helped their mothers who were Traditional Birth Attendants during delivery and when they showed interest, they were given the opportunity to learn. In addition, TBA trainees were given all the skills and knowledge about how to do this.[32] Initially, these young women acted as apprentices to their mothers or family members with whom they learnt the practice, and when their master, or in this case their mother died, they automatically inherited the profession.

Because of the nature of the profession, which was viewed as difficult,

[30] Interview with Osofo Kakraba Stephen Nartey, Traditional Healer and Birth Attendant, on August 23, 2016 at Esuekyir, Winneba.
[31] Interview with Afua Mansa, Traditional Birth Attendant, Winneba, 29 May 2017.
[32] Interview with Sarah Agyeman.

and the spirituality associated with it, there were not many TBAs in several villages. It was possible to find one TBA serving a whole village or even several villages. Therefore, TBAs felt the inclination to teach their own children to take over when they were not available.

Even though she still practiced midwifery, Afua Mansa, a traditional midwife interviewed, mentioned that anytime she was away to trade or in the market, her daughter whom she had trained through observation and coaching could deliver babies on her behalf. She mentioned that one time, when she got back from the market, her daughter had delivered twins.[33] This goes to show that traditional midwifery practice was easily passed onto other family members.

That said, despite the existence of male traditional midwives, majority of these midwives were female and started their profession at an advanced age. The explanation to why they started this profession at an advanced stage was that, apprentices only started their independent midwifery practice when their trainers were no longer present (died or had moved away). However, there were instances where TBAs were younger than usual.[34] For a majority of them, their profession started when they were around 40 years old or over, and had reached a menopausal state. At this point the TBAs, in the case of females, were no longer menstruating, and could therefore dedicate ample time and concentration to care for the pregnant women and babies. Jane Turrittin has depicted the connection between age and the midwifery profession by TBAs through a primary document.

[33] Interview with Afua Mansa.
[34] Interview with Akua Nyinsin, Traditional Birth Attendant, 23 August 2016 at Esuekyir, Winneba.

> One day when we were alone . . . Sokona said to me, "Aoua Gaffoure, you know that my mother is a midwife like you?" "No, Sokona, I didn't know that" "Ah, well, she is the one who assists all the women at Goumbou . . . Like her grandmother and her mother, she began as a magnamagan and became a midwife later. In my maternal family, all the women exercise that profession, if God gives them a long life and strength. After the age of forty, they teach the profession of magnamagan to their daughters and they exercise the profession of midwife starting about the age of forty-five or fifty, after the menopause." "What is the relationship between menopause and the profession of midwife?" "It is when a woman no longer menstruates and is normally no longer obliged to be occupied during the night, so that she has plenty of time to conscientiously occupy herself with childbirth, women giving birth, and babies. In a few years, I will have to go live in Goumbou so that I will be able to accompany my mother to the villages where she always goes to help women in labor. Thus, I will undergo my apprenticeship and be able to effectively replace her on the day of her disappearance, which I hope will be as far in the future as possible."[35]

As the conversation went on the TBA also showed the sacredness and spiritual aspect of the profession and how African women trained others to become midwives.

> "But why don't you do your apprenticeship with me, here?" I said to her. "I have trained and equipped numerous midwives in Kita, Tougan, and Gao." "No, Gaffoure, among us Soninkes this profession is only taught by mothers to daughters. And that's not all. In order to do this work, there are magic, beneficent words to be used while massaging women's stomachs that you others, toubabs, are able neither to understand nor to teach . . . I prefer to be initiated by my mother, who will at the same time convey all the secrets and necessary talismans to me, as she did when she initiated me to my present profession, which I now exercise to my clients' satisfaction".[36]

Thus, the midwifery profession, which TBAs learnt from their relatives or acquaintances involved not only knowing how to deliver, but a combination of some spiritual and or religious manifestations, without which the profession and practices was not complete.

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[35] Aoua Kéita, *Femme d'Afrique* (Paris: Presence Africaine, 1975), pp. 276 – 79. Translated by Jane Turrittin, in Jane Turrittin, Colonial Midwives, 84 – 85; in this work Jane Turrittin uses the autobiography of a western trained African midwife, Aoua Kéita – Femme d'Africque to examine how childbirth was modernized in French West Africa. According to Turrittin, Aoua Kéita shows her experiences throughout her training days to the work that she did with African women in femme d'Afrique. The conversation used in this work expresses her experience with one such African woman, which without doubt provides an excellent description of TBAs and their indigenous practices.

[36] *Ibid.*

After having delivered a baby, the client is expected to pay some sort of compensation or fee depending on the arrangement between the client and the TBA. A TBA interviewed mentioned that the payment for their services had continued to change from time to time, but was usually very low and had flexible terms of payment. This was because as mentioned earlier, TBAs were most likely related to their clients and therefore tended to charge them a lower fee. Secondly, in cases where they did not know the client, they saw their job more as a moral and religious responsibility to help their fellow human beings and would take any cash or kindness their client presented after providing the service. In some cases the TBAs did not take anything and would not ask or take any payments unless offered. They charged between 5 Cedis and 10 Cedis depending on how closely they were related to the client or how difficult the delivery was.[37] When asked how much she charged for her services, a TBA interviewed mentioned that,

> Eiii...sometimes I had to use my own soaps to cater for my clients. The maximum I ever got was 20 Cedis. Some will even tell you that they will pay later, but would never show up. But it is a gift from God and so I had to work because God will ask me one day what I did with my gift, and so I did it even when I got nothing.[38]

This disposition illuminates the point that, traditional midwives did not solely practice midwifery as a profession but were inclined to take on other professions. Their jobs as midwives and the remuneration that they received from their clients was not enough to fend for their needs. Therefore, apart from being midwives, a majority of them were traders; generally, most women were traders. The informal nature of trading in Ghana helped them to combine

[37] Interview with Afua Mansa.
[38] Interview with Sarah Agyeman.

both professions. Deborah Pellow has mentioned that as early as the 1960s, as many as 90 percent of women in Accra alone were traders and trading actually helped them to deal with their domestic requirements such as taking care of their children, and husbands (for those married).[39] This was because trading was usually a form of self-employment and meant that traders could take on several other activities. For the traditional midwives this gave them the freedom to also actively continue practicing midwifery as a co-job to trading. Usually, due to proximity to the home where they practiced midwifery, the TBAs would put up stalls close to their homes where they sold their wares. This meant that they could be available anytime their clients needed their attention.

2.2 Delivery

All TBAs interviewed mentioned that before delivery, they would find out if the pregnant woman had eaten anything. If not, they had to feed the pregnant woman. Feeding the pregnant women before delivery gave them the strength to deliver. Due to changes that occurred in the ensuing years, TBAs began to do deliveries on mattresses they kept in their homes or on mats. However, when the numbers are too much, just a piece of cloth on the floor did the job. R. S. Rattray describes a scene during delivery in Asante.

> Dried plantain fiber is strewn upon the floor and upon this the woman sits with her back to the wall and is further supported by one of the midwives, who stands behind her, placing her arms under the arm-pits of the recumbent woman and placing her hands against her breast. Two other women each hold an arm. The fourth woman sits in front with her left foot under the patient's posterior and with her toe pressed against her anus. As soon as the child begins to make its appearance, the old women adjure the mother saying: 'mia w'ani (lit. press your eyes, i. e. strain). The woman squatting in front also assists in drawing

[39] Deborah Pellow, 'Work and Autonomy: Women in Accra', *American Ethnologist*, Vol. 5, No. 4, 770 – 785 (1978), 775.

forth the child.[40]

A TBA interviewed mentioned that,

> When the pregnant woman came, I let her sleep on the mattress, wear my gloves and look at you critically to see how you are faring. I check to see if you can deliver and if you can, I leave you there for some time until you call out that you want to deliver. When I show up to perform the delivery and the baby is coming out of the woman, and then I let her push and then the baby comes out.[41]

Even though some TBAs claimed to have resolved to deliver on mattresses, the fact is that these were rare and many continued to deliver on a piece of cloth placed on the floor. Thus, the cloth replaced fibers of leaves and palm branches that were originally used during delivery. When the baby was delivered, the TBAs cleaned the baby and checked the nose, ears and other openings to make sure to remove any blood or impurities that might be there. This allowed the baby breathe freely.[42]

After the baby came out in a successful delivery, the TBA dealt with the umbilical cord. Whiles many TBAs used threads and blades; others mentioned that they had used scissors before.

> Most of them [TBAs] used new blades and then they used thread, the one used to plait hair. When they were using that one [thread], what they did was, they put the thread in a bottle or plastic can and poured akpeteshie to kill bacteria. Or the sewing machine thread; when they bought the thread they removed the first three layers on the roll, assuming that the first three layers were not clean and so the one beneath these was what they used to cut the cord.[43]

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[40] R. S. Rattray, *Religion and Art in Asante* (Oxford, 1969), 56.
[41] Interview with Afua Mansa.
[42] Interview with Sarah Agyeman.
[43] Interview with Mr. Braint, Environmental Health Officer at the Danfa Health Centre, Accra, 17 December 2016.

A TBA interviewed also mentioned that, when the child came out, the umbilical cord is cut with a blade, and they used akpeteshie to wash their hands and clean the area where the baby was delivered.[44] The akpeteshie or local gin, served as a sanitizer. The use of new blades and sterilized thread and the efforts to kill bacteria on their instruments and the area where they delivered indicated that TBAs were aware of the existence of bacteria and the damage it could do to the mother and newly born baby. These instruments including the blade and thread came to replace sharp objects such as a sharp shell and a special knife for cutting the umbilical cord.[45] Apparently, replacing this special knife after every delivery made the cost of delivery expensive. After the cord was cut however, the mother decided if the TBA should dispose it off, or disposed it off herself. The cord was either buried or flushed down a toilet.[46]

2.3 Risk Management and Skills

Traditional midwives had various ways of dealing with pregnancy complications and managing risks that led to death of the mother or child. These complications could be before, during or after delivery. During this risk management periods, the TBAs exhibited a lot of patience with their clients. This is because they realized that women went through a lot of pain during pregnancy and close to delivery.

> Pregnancy is painful so if you take a look and realize that the baby is not showing properly, you can massage the stomach gently to help the mother, so

[44] Interview with Sarah Agyeman.
[45] O. Tmogene, 'Current Information on the Practice, Training and Supervision of Traditional Birth Attendants in the African Region' in *Report of a Study Group, Training and Supervision of TBAs*, Brazzaville 9-12 (1975), 15.
[46] Kennedy, 'Traditional Birth Attendants', 18 & 32.

that she can relax and deliver.[47]

Thus, the TBAs had a way of indulging mothers to ensure that they went through delivery with less pain and this included patiently massaging the mother's belly. In the process of delivery, traditional midwives also had a way of managing cases of breech births.

> God showed me; if the child comes out with the leg, I keep praying and the shoulder would come out, when the shoulders come out, then I take hand out one after the other and when the head starts coming out, I put my fingers in the mouth and the head comes out. Then finally the womb comes out.[48]

This TBA could not explain how putting her fingers in the mouth of the baby, helped her get the baby out. Her demeanor when she described the act, indicated that she just pulled the baby out of the mother's womb with her fingers by holding onto the baby's mouth. Another TBA interviewed mentioned a similar procedure in dealing with breech birth.

> Delivering babies is not easy; some babies come with their legs, or buttocks but you have to slowly pull the baby out to make sure they survive. You can also give the mother medicines so that she delivers.[49]

These TBAs indicated that their ability to do this was due to a spiritual gifting. The connection between midwifery and spirituality is also depicted in the narration below. TBAs viewed pregnancy-related complications as the work of spirits. A baby was also viewed as a spirit, and was therefore

[47] Interview with Sarah Agyeman.
[48] Interview with Afua Mansa.
[49] Interview with Sarah Agyeman.

perceived as been capable of causing the mothers' demise.

> "Voila! As soon as the midwives of my region are confronted with a breech presentation, a shoulder or a face, they make a somber prognosis. . . .Unfortunately, it is often the death of the two [mother and infant]. . . .Loss of blood before childbirth and the prolapse of the umbilical cord are both considered signs of mourning. For us, all infants who come by the posterior, the arm, or the mouth, all those who show their cords early, are not called to life. Often they drag their mothers toward death. It is said in town that you manage to keep mother and child in good health when faced with these sorts of presentations. The praise-singer from Boumba, Faragaba, whom you saved and whose daughter is named after you, speaks about it wherever she goes. . . . In the name of our close friendship, I would like you to give me the secrets the whites have given you about these things..."[50]

That said, it is unclear if there are some TBAs who have done surgery or operated on their clients before. All TBAs interviewed mentioned that they are unable to do operations and have never seen or done that before. Rather they relied on the medicines that they prescribed to deal with complications that, which in the conventional healthcare system, an operation would have been used to deal with. A TBA interviewed mentioned that,

> One time they told a pregnant girl that they [conventional healthcare providers] would operate on her and I told her that it would not happen. True to my word too, she gave birth without an operation. I gave her medicines. When you pray to God it would happen. ... Some come and they are bleeding; you have to give them medicine to drink and they sleep and wake up fine.[51]

The above narration indicates that TBAs relied on herbal medicines for almost every complication or problems that they faced. Also TBAs could identify a still baby, by observing the stomach of the mother. To deal with a complication such as a still baby, they used medicines to ensure that the still

[50] Turrittin, 'Colonial Midwives', 85.
[51] Interview with Sarah Agyeman.

baby came out of the mother easily without the mother being harmed. In fact many of the TBAs interviewed agreed that these herbal medicines were created for Africans because it helped them more than the conventional medicine.

Also after delivery when the mother was unable to produce breast milk to feed their babies, TBAs provided a remedy. In Navrongo the TBA made a concoction by mixing ingredients known as kaligongo [local medicine] and yara mum [flour from guinea corn] acquired locally to be drunk by the mother in order to help produce breast milk.[52]

2.4 Prenatal and Postpartum Care

Prenatal and postpartum care generally refers to care for pregnancy during pregnancy, and care of mother and child few weeks after delivery respectively. Per an analysis of TBA practices, it was inferred that TBAs performed prenatal and postpartum care even though there were no distinct names to call these.

> Pregnant woman, eat fruits and peanuts, fish and eggs, snails and crabs, it will give you blood, and you unborn baby will grow up well.[53]

The above is a lyric to a Fante song, which has been translated into English. The song was sang to, and taught women in Simpa, Winneba, by TBAs during pregnancy. Literally, the song advised pregnant women to eat vegetables, fruits and protein foods to enable them gain more blood and also aid in the growth of their babies. Thus TBAs provided antenatal care in the

[52] Elizabeth Hill et al, '"I don't Know Anything about their Culture": the Disconnect between Allopathic and Traditional Maternity Care Providers in Rural Northern Ghana', *African Journal of Reproductive Health*, 18 (2): (June 2014) 36.
[53] Interview with Afua Mansa.

form of advising their clients on what meals to take during and related to their pregnancy. Another TBA mentioned that,

> When some people are pregnant, they cannot eat certain things like onions, tomatoes, pepper and so on. So when they came for the herbal medicine I also advised them on what to eat including kontonmire and so on.[54]

Also, the daily growth of the mother and child before and during delivery was checked. In some communities the wearing of beads on the wrists of babies, helped them to determine whether the baby was growing or not. However, in other communities TBAs just observed the baby regularly to ascertain the growth of the baby.[55] This indicates that TBAs had a way of checking the weight of the baby, and also the growth of the baby. This was necessary to ensure that the baby was receiving the best care, starting with eating the right food and also in dealing with any illnesses that might have befallen the baby.

When the TBAs noticed that the growth of the baby was stagnated, they advised the mother to improve on the foods and medicines they took. At other times, the TBAs tried to ascertain the reason (s) behind such developments, with the aim of finding a lasting solution to the growth problem.

2.5 Medications and Healing

As already mentioned, TBAs like other traditional medicinal practitioners also used herbs in dealing with pregnancy related issues, and as medication to heal certain illnesses that the mother or child experienced before, during and after

[54] Interview with Sarah Agyeman.
[55] Interview with Afua Mansa.

pregnancy. It was commonplace therefore to find TBAs who were also spiritualists, or who were dedicated to certain shrines. They used herbs and spiritual knowledge to dictate to their clients what was expected of them before, during and after pregnancy. This also explains the wearing of amulets and beads by mothers and children after birth in some communities or among some ethnic groups. This served as a form of protection against evil spirits.[56] The wearing of amulets in this regard was to prevent any spiritual illnesses. This practice of wearing amulets at birth has been carried on to modern times, but its spiritual basis is lost. In contemporary times, most Ghanaians use beads for fashion or as part of sustaining their culture.

Other remedies involved the use of herbal medicine, and often used to solve several illnesses that the mother or child may contract after pregnancy. For instance, in the Bawku East and Builsa districts, herbal remedies for the mother and child after delivery included the following:

Table 1: Herbal Remedies from Bawku East and Builsa

Herb	**Processing**	**Usage**	**Sickness**	**Person**	**Area**
Pawpaw leaf, mango leaf, guava leaf	Boiled together	Drink	Malaria	Mothers, Children	Bawku East
Ashes, akpeteshie	Mixed	Smeared on body	Measles	Children	Bawku East
Early Millet, fiber seeds	Burned to ashes	Drink	Severe cough	Children	Bawku East
Millipede	Burned to	Insert into	Piles	Children	Bawku

[56] Rattray, *Religion and Art*, 54.

	black powder	anus		(1-8 years old)	East
Egg, sigirin	Boil egg, pound herb to powder mist	Eat	Jaundice	Children (1-15 years old)	Bawku East
Neem tree leaves	Boil	Drink, inhale	Fever	Children, mothers	Builsa
Neem tree, ginger, pepper, lansuik	Grind, mix with water, sieve	Drink, enema	Diarrhea, appetite	Children, mothers	Builsa
Shea butter, papaawo	Mixed	Smeared, massaged	Hotness	Infants, children	Builsa

Source[57]

Looking at Table 1 above, one can tell that the sicknesses indicated were general and could be experienced by anyone. Yet they also indicated specific directions for use of herbal medicine for each type of person and year group. This indicates that these TBAs had profound knowledge in herbal medicines. However, this differed from community to community and from TBA to TBA. They could also tell the differences between medicines; no matter how similar they looked. Sarah Agyeman, a TBA, mentioned that,

> Each medicine has three kinds and performed different roles. Some are good and some are bad and so if you don't really know them, you might mistake the bad ones for good. Last time, I gave medicine to a girl and she told me that there was some close to her house. However when I went to take a look, it was different.[58]

She prescribed herbal medicines like *Obranatsiata* when the woman had

[57] Dove, 'A Return to Traditional Health Care', 827 - 829. Collated from tables produced by Nah Dove on the remedies used by traditional healers to treat women and children in Builsa and Bawku East.
[58] Interview with Sarah Agyeman.

difficulty during labour and the baby is taking too much time to come out. She explained that this medicine felt slimy like okra when blended and could be drank to be effective. Also, when the mother was bleeding, she used medicines like *Nanyina*. This was boiled in water and the liquid injected into the woman and this stopped bleeding almost instantly.

2.6 Belief Systems and Taboos

In the traditional setting, taboos for expectant mothers were commonplace. There were food taboos, family taboos, and community taboos that pregnant women were supposed to observe. Some food taboos included but was not limited to the consumption of moderate amounts of honey, which caused respiratory problems at childbirth, Bambara beans which caused respiratory and skin problems for the infant at birth, and corn flour, which caused heavy bleeding at delivery. It was also believed that excess consumption of eggs, fresh meat, fresh milk, and cold and sugary foods made the unborn baby large, contributing to difficulty during delivery and possible death of mother.[59] When monitored by the TBA, these things could be checked and during the prenatal sessions, as already mentioned, TBAs advised on the diet of the mother.

Again, pregnant women were to desist from going to the market to avoid attracting evil spirits. Also such places caused too much noise, which was not good for the baby. Funerals, shrines, forests, rivers and the in-law's house too were believed to hold certain negative spirits.[60] Though these taboos did not have scientific basis, they largely depicted the culture and belief systems of

[59] Dove, 'A Return to Traditional Health Care', 825.
[60] *Ibid*., 825.

the African people. Even though when it came to spirituality or faith, these things could not be proven, these had been established from decades of experiences and so the people were privy to it and abided by them.

These taboos were necessary to be spelt out to the mother by the TBA to avoid any complications from pregnancy, such as death of the mother or child after delivery or a miscarriage. However, in some societies like the Akan, a miscarriage could also mean that, the mother committed adultery, the mother offended a god, or a snake or a particular type of spider bit the mother. It could also be understood to be the evil work of a co-wife who did not want her husband's other wife to deliver, as well as the doings of witches or evil spirits, among others.[61] Despite the fact that these precautions induced some kind of fear when spelt out, one can also picture that pregnancy was viewed with sacredness and a genuine inclination to protect expectant women with much care.

After delivery both mother and child, and sometimes other pregnant women in the community observed other traditional remedies. These remedies often depended on the outcome of the pregnancy, stillbirth, healthy child or death of the mother and often differed from community to community. For instance in Osu, Accra, all pregnant women were required to have a ritual bath in the sea following the death of another pregnant woman who died as a result of a pregnancy-related complication. They did this immediately the woman was buried.[62]

Also in the Volta Region women who died whiles they were pregnant

[61] Rattary, *Religion and Art*, 54.
[62] Senah, 'Maternal Mortality in Ghana', 47.

were buried as soon as possible and at midnight as maternal death was seen to be from an evil or unclean spirit.[63] As a result of the belief that maternal deaths were evil, the sooner they dealt with them, the less chance any evil spirit had to attract other pregnant women or cause more maternal or child deaths.

2.7 Conclusion

Looking at some of the characteristics of TBAs mentioned, one can tell that the TBA offered services beyond the delivery of children or taking care of pregnant women. TBAs took care of women throughout their life cycle, as well as infants. TBAs were health providers who found a remedy to issues with pregnancy, gave medical assistance to women and children and therefore did the work of three different western trained professionals; that is, the medical doctor, the obstetrician and the western trained midwife.

TBAs exhibited knowledge in prenatal and postnatal care, and medication and healing of their clients. Their deep knowledge in herbal medicine also helped them to deal with pregnancy-related complication. Also indigenous midwives provided for an institution where would-be midwives were trained formally to gain the skills and knowledge of midwifery that allowed them to practice the profession.[64]

Even more, their relationship with their clients which was cordial put them in a position to better take care of pregnant women and pregnancy- a condition often referred to as difficult. Even though it differed from

[63] *Ibid.*
[64] Patrick A. Twumasi, *Medical Systems in Ghana: A Study in Medial Sociology* (Tema, 1975), 26.

community to community, their knowledge of the cultural beliefs of their clients, made them more trusted and accepted, a prerequisite for success in their line of job.

Looking at the primary document used by Turrittin, one can tell that African women appreciated the work done by western trained midwives, not mainly because they could not do what they did or knew better how to deal with complications that led to child and maternal mortality than the TBAs.[65] Rather this narration suggests that they were delighted by the new methods that were used and were prepared to learn them to improve on their skills.

This chapter has shown that, the existence of the TBAs meant that the services of western trained medical practitioners were not needed. This is to say that the job security of western trained doctors and their auxiliary staff were threatened and probably did not have a future in Ghana. However, the limited number of TBAs, which is explained by the sacredness of the profession and the unwillingness of people to learn it, also gave room to conventional health workers to also operate. This also indicates that the job security of conventional healthcare providers was not threatened to an extent because there was room for them to operate with the limited number of TBAs.

[65] Turrittin, 'Colonial Midwives', 84 - 85.

CHAPTER THREE

POLICY DIRECTIONS AFFECTING TRADITIONAL BIRTH ATTENDANTS IN GHANA

(1931 – 1970S)

3.0 Introduction

In Ghana, Traditional Birth Attendants (TBAs) enjoyed exclusive rights to their profession and its practices until the coming of western midwifery, which saw their gradual neglect. TBAs provided maternal healthcare services until the early twentieth century, when the colonial state took up that mandate. Since then policies regarding maternal health have been shaped and scrutinized largely by the Government in power. This chapter seeks to examine the actions taken concerning maternal health in Ghana and how it affected the practice of TBAs during and after the colonial experience, focusing on the policies of the government on one hand, and global agencies on the other.

The various governments of Ghana introduced conventional midwives and health providers, maternal education, and western antenatal care, western medicalization of childbirth, western scientific infant feeding and western

childrearing practices. [66] Other global agencies like the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and the United Nations International Children's Emergency Fund (UNICEF) played diverse roles in the institution of health policies. These agencies have been visible from the colonial to the postcolonial period, providing support for government policies.

During the colonial period, the provision of maternal care and child health services in the colony formed a part of the state's social policy, where the policies instituted in the metropolitan country of the colonial masters were transferred unto the colonies.[67] There were of course, the missions, the Gold Coast League for Maternal and Child Welfare, the Red Cross, and some private practitioners available, whose support for maternal health preceded that of the WHO, UNFPA and UNICEP, and who had their own justifications for aiding the state in providing maternal care on the Gold Coast. Some of these policies were transferred into the postcolonial period. These policies have affected TBAs, who as indicated earlier, operated independent of foreign ideologies, and relied on the customs of the African society.

As far as the government was concerned, TBAs were not to be considered for use by mothers and expectant mothers. According to the standard of the government's maternal healthcare system, TBAs were woefully incompetent in the arts of mothering and nursing babies. This is evident in the policies taken by various governments to curb maternal and

[66] Deanne van Toll, 'Mothers, Babies and the Colonial State: the Introduction of Maternal and Infant Welfare Service in Nigeria, 1925 – 1945', *Spontaneous Generations*, 1.1 (2007), 111 – 131.
[67] Ulrike Lindner, 'The Transfer of European Social Policy Concepts to Tropical Africa 1900-50: the example of Maternal and Child Welfare', *Journal of Global History*, 9, (2014), 209.

child mortalities in Ghana, which saw amongst other things the introduction of measures to sideline TBAs and consequently render them unwanted.

Despite these policies, TBAs continued to operate, largely relying on their traditional methods, and later, they were included in the formal healthcare system. In Ghana, the colonial government at a point considered the inclusion of TBAs through training. The most outstanding contributory factor was the inability of the formal healthcare system to cover the entire colony and reach several rural areas. In the postcolonial period, the inclusion of TBAs was done based largely on recommendations by the WHO, UNFPA and UNICEF who had pushed the agenda to train and use TBAs in the face of growing infant and maternal mortality ratios in developing countries and the fact that these TBAs over the years continued to perform the majority of births in Ghana and other African countries. Prior to and after the suggestion to include TBAs, there had been other policies on maternal health, introduced in Ghana that suggested a lingering wish to phase out TBAs.

3.1 The introduction of Conventional Midwifery

In 1916, Governor Sir Hugh Clifford appointed a committee of enquiry to look into the issue of high infant and maternal mortality rates in the colony. The committee blamed the problem of high infant and maternal mortality rates on three main factors. The first was the bad treatment of mothers by midwives and the ignorance of midwives. The second was reported to be the faulty treatment of infants by ignorant parents with regards to feeding. The final factor was the bad sanitary and dwelling conditions, which was responsible for

diseases such as malaria, and chest and intestinal complaints,[68] which caused complications during pregnancy.

To curb the situation, the committee had suggested that the government provide maternity clinics and the training of midwives. Frederick Gordon Guggisberg, who became the next governor in 1919, took up this suggestion. Guggisberg had had a personal encounter with Africans on the Gold Coast and how they handled children. For instance, during one of his tours in the colony, he was astonished on seeing the way that a mother fed her baby. The mother swung the baby towards her hip, secured the baby with a piece of cloth, tucked it under her arm and allowed the baby to feed while she performed her chores. In another episode, a woman had her baby at her back supported by a piece of cloth, with the baby asleep in a condition that looked as if the baby's neck was going to break as it 'wobbled back and forth'.[69] Guggisberg's account of the way African mothers handled children, seemed to suggest that he was enthusiastic to help mothers and also depicted a genuine concern for African mothers by constructing maternity hospitals and training midwives.

Yet his utterances and actions contradicted his concern for African mothers. Guggisberg considered the provision of maternal and child health services on condition that public subscription of the services would be used in funding them. Thus the public had to pay for receiving such services. Despite his resolve for African mothers to pay for conventional medical services to be provided, the committee that suggested the institution of conventional healthcare made a strong recommendation that the colonial government should

[68] Maternity and Infant Welfare Movement – Statistics relating to, CSO/11/4/9, PRAAD, Accra.
[69] Amponsah, 'Colonizing the Womb', 81 - 82.

take up the financial responsibility of providing maternal and childcare services. As a result of the committee's suggestion that the colonial government pay for health services, Guggisberg accepted the proposal and started the establishment of infant and maternity welfare centres.[70]

The initiative to interfere with the health of the indigenous people, however, fell beyond the personal whims and caprices of Guggisberg, but rather formed a part of the greater developments of colonial imperial social policy. Ulrike Lindner has mentioned that, health services including maternal and child health were used as a means of safeguarding a healthy colonial labour, controlling the body of the colonized, gaining confidence of the indigenous people by providing some social services, and importing European biomedicine to a lower race.[71] Thus the colonial government saw their interference in African maternal and child health as a way of achieving the greater imperialistic goals of extending their authority in the colonies and establishing economic and political dominance over them. In order to achieve this, indigenous institutions that were already providing these services had to be eliminated.

Aside from colonial imperial social policy, there was the alarming number of pregnancy related mortalities recorded from 1920 to 1921 periods in Accra alone. Out of 1000 babies born alive, about 400 of them died before reaching a year old.[72] As a result by 1920, maternity and child welfare centres were opened in various parts of the colony and their work considered successful. By 1925, there was one Infant Welfare Hospital in the colony

[70] Addae, *Western Medicine*, 148.
[71] Lindner, 'European Social Policy', 210.
[72] Maternity and Infant Welfare Movement – Statistics relating to, CSO/11/4/9.

while work was ongoing for an Infant Welfare dispensary.[73] In 1928, a new maternity hospital was opened in Accra, the first of its kind in the colony. This maternity hospital was also used as a teaching centre for training midwives, African Medical Assistants and Medical Officers. From 1930, proposals were also drawn by the colonial government and educated Africans to improve healthcare provision. One example was that of the ex-Principal of Achimota College who suggested the need to offer scholarships to Africans to study medicine in the United Kingdom (UK). However, the numbers were only few; one to two per year.[74]

Despite these efforts, due to the customs of Africans including the necessity of a woman to deliver in her own kitchen, the maternity hospital was unpopular for some time.[75] However, after its gradual acceptance by Africans, the maternity hospital in Accra achieved enormous heights in maternal health. Between 1929 and 1930, the Maternal Mortality Ratio (MMR) in Accra had decreased from 17 per 1000 to 6.1 per 1000, whiles there were only 7 per 1000 in 1931.[76] Between 1925 and 1930 the number of children in the infant welfare centres numbered over 20,000 and over 130,000 respectively, whiles the numbers of women attending the welfare centres were overwhelming.[77] Table 2 below also describes admissions in the maternity hospital at Accra.

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[73] Gold Coast Annual General Report, 1st April 1925 – 31st March 1926, Dp/DT 507.5G5 An 7, Africana Library, UG, p. 50.
[74] Medical Training for Africans – Scholarship for, CSO/11/7/1, PRAAD, Accra.
[75] Gold Coast Annual General Report, 1st April 1928 – 31st March 1929, Dp/DT507.5G5An7, Africana Library, UG, p. 34.
[76] Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1931 – 1932, Dp/DT 507.5G5An7, Africana Library, p. 14.
[77] Addae, Western Medicine, 150.

Table 2: Admissions at the Maternity Hospital opened in Accra by 1928.

	1928–29	1929–30	1930–31	1931–32	1932 April-December
Admission	183	418	678	672	1023
Births	107	260	452	553	529
Maternal Deaths	11	25	13	13	22
Infant deaths	9	23	15	32	33

SOURCE: CSO/11/4/9, Maternity and Infant Welfare Movement – Statistics relating to, PRAAD, Accra.

From Table 2, one can see the gradual increase in seeking conventional midwifery especially in Accra where it was first introduced. However, with Accra being a major city, it could be explained as the effect of accepting western knowledge as superior to traditional knowledge.

The Missions, the Gold Coast Maternity and Child Welfare League, and later the Red Cross, and private practitioners supported efforts by the colonial government at improving the health of locals. Unlike French West Africa, medical auxiliaries in the British colonies were, from the very beginning trained in missionary institutions, and their training programmes were later

subsidized by the colonial government.[78] In several rural areas, the only conventional healthcare facility available was that provided by the missions.[79] The Red Cross started its work on the Gold Coast in 1929 as the League of Maternal and Child Welfare and in 1932 became the Gold Coast Branch of the British Red Cross.[80] In 1931, the Gold Coast League of Voluntary Workers for maternity and child Welfare were also reported to have contributed to maternal and child welfare services.[81]

The focus of the colonial government in the provision of maternal and child welfare centres and services had been in the principal towns of the colony. In these principal towns where midwives used scientific European methods, and where deaths and births were registered, the records depicted still, alarming maternal and infant mortality ratios. The mortality ratio in children under one year was 165 per thousand deaths by 1929. In children between the ages of one and five years, the mortality ratio was 153 per thousand births.[82] Also the mortality in women at childbirth was presumed to be more than four times the ratio in England and Wales.[83] These were independent of the situation in the rural areas where the majority of births and pregnancy related issues were attended to by TBAs.

However, continually the maternal mortality cases in the colony,

[78] Turrittin, 'Colonial Midwives', 1
[79] United Nations Children's Fund, 'UNICEF in Africa, South of the Sahara: a Historical Perspective', *UNICEF History Series*, Monograph VI, CF/HST/MON/1986-006, p. 4; see also Charles M. Good, 'Pioneer Medical Missions in Colonial Africa', *Social Science Med*., Vol. 32. No. 1, 1 – 10, (1991).
[80] Ghana News Agency, 'Ghana Marks World Red Cross Day', *Modern Ghana*, 8 May 2010, assessed on 2nd February 2017, at 20: 17 GMT, http://ghananewsagency.org/social/ghana-marks-world-red-cross-day-15318.
[81] Gold Coast Annual General Report for the period 1st April, 1930 to 31st March, 1931, 42.
[82] Gold Coast Annual General Report, 1st April 1928 – 31st March 1929, 33.
[83] *Ibid.*

including the major towns were blamed on the 'mismanaged pregnancies and labours before admission' and the 'cases of obstructed labour seen after they had been in the hands of TBAs'.[84] TBAs were also often blamed for their inexpert skills at delivery and attending to pregnancy related issues even though sometimes, medical officers admitted that high maternal and infant mortality were caused by several factors. TBAs were also accused of causing umbilical hernia amongst newborn infants. They were blamed for leaving the cord so long that it reached the infants knee.[85] In fact the unhygienic care of the umbilical cord led to neonatal tetanus and consequently the death of the child or mother.

3.2 The Midwives Ordinance of 1931

The harm that TBAs were reported to have been causing, along with colonial policy of introducing conventional healthcare on the Gold Coast necessitated the elimination of traditional midwives. Therefore the colonial government passed the Midwives Ordinance of 1931. According to this ordinance, indigenous midwives could enroll on a list of unqualified midwives on condition that they had some prior experience in midwifery, had been in practice for not less than two years and exhibited among other things, good character. Apparently the government could not ban TBAs from practicing, at least not yet, as it had done in other colonies.

This was primarily because, despite the government's effort at providing midwifery services in the colony, these services were inadequate. In many rural areas, access to general conventional healthcare provision was non-

[84] Amponsah, 'Colonizing the Womb', 136.
[85] *Ibid.* 111 – 112.

existent. Even by 1947 in Axim-Nzima for instance, the people saw a doctor once in three months.[86] The colonial government itself had raised concerns about its inability to cover the entire colony with healthcare provision, whiles there was a continuous reliance by African women on TBAs.[87]

However, per the provision of the Midwives Ordinance, the training of midwives was conducted at the Accra Maternity Clinic but for a limited number each year. The enrollment of TBAs on a list of unqualified midwives raises the issue of complete distrust for TBAs and disregard for their knowledge in midwifery and ingenuity of their culture of medicine. Nana Akua Amponsah has reiterated severally how the colonial authority despised the practices of TBAs and blamed them repeatedly for the high maternal and infant mortality rates.[88] The enrollment of TBAs on the list of unqualified midwives for training did not change how they were viewed by the colonial government, as unskilled and unwanted.

This can be linked to the vigorous training that local nurses had to endure to become Nursing Sisters, which differed from the training gained by British nurses on the Gold Coast. This is evident in the fact that trained nurses on the Gold Coast were not qualified as Nursing Sisters until they had had some training in the United Kingdom. In 1947, during a Legislative Council session, Mr. Nii Amaa Ollennu, a nominated member of the council had lamented that:

> The Red Cross Society of the Gold Coast Branch has thought it expedient to

[86] Legislative Council Debates, Session 1947, Issue No. 1, Gold Coast Colony, African Studies Library, 202.
[87] Allman, 'Making Mothers', 31.
[88] Amponsah, 'Colonizing the Womb', 111 – 113.

> give scholarships to girls to train in the United Kingdom as Nursing Sisters and to take charge of some of the Red Cross Hospitals and Clinics in the Gold Coast. If Red Cross authorities have thought nursing in the United Kingdom absolutely necessary to qualify girls for these responsible positions, I think, Sir, the analogy can be good, as far as Government hospitals are concerned, that to qualify our nurses for the position of a Nursing Sister it may be necessary probably to select some suitable girls with secondary education and already trained as nurses locally to be given the opportunity to qualify in the United Kingdom.[89]

Thus after training as nurses in the colony, local nurses were still not recognized as Nursing Sisters until they had traveled for further training in the United Kingdom. One could conclude that there were no facilities available to train locals, however, from Ollennu's narrative, one can tell that efforts were not made to train and upgrade local nurses. In 1950, the Director of Medical Services, had mentioned in a broadcast that, owing to the fact that training of nurses at the Nurses Training College at Korle Bu was suited to local conditions, midwifery training at Korle Bu was better off than the training offered in the United Kingdom. Yet the General Nursing Council in the United Kingdom did not accept the local qualification and expatriate nurses were hired at the expense of the Gold Coast nurses.[90]

The argument is that if expatriate nurses were favoured in terms of gaining employment and gaining high positions in the health sector, at the expense of western trained African nurses, then TBAs were worse off because of their indigenous ways of nursing, which was not recognized by the conventional health sector. This depicts the general atmosphere in the colonies; a situation where the careers of Africans were hindered due to rising

[89] Legislative Council Debates, Session 1947, Issue No. 1, Dp/J741.G6.G5 afr C. 1, African Studies Library, 248.
[90] Legislative Council Debates, Session 1950, Issue No. 2, Vol. II, Dp/5.744.H2G5, 351.

racism[91] so that Europeans monopolized top positions, whiles Africans who had had the same levels of education were marginalized.

The continuous reliance on TBAs by African mothers during this period could also be credited to the prioritization of infant healthcare services over maternal healthcare services. In the colony, there were more infant welfare centres than maternal welfare centres, as well as services respectively. Even the training and mother craft education introduced by the government and other non- governmental organizations, were more focused on how to take care of the children, than women taking care of themselves.

This is seen in the first Infant Welfare Centre put up in 1921 at Christiansborg in Accra. In 1926 the Princess Marie Louise Hospital was opened and prioritized the treatment of infants. The Korle Bu Hospital was opened in 1923 and the isolation ward was turned into accommodation for children. After much financial difficulty, only one maternity centre had been built by 1928.[92] Even though the alarming number of child mortalities might explain the increased number of Infant Welfare Centres, this also suggests that there was a lower concentration on maternal healthcare and consequently the continuous reliance on TBAs with the limited number of Maternity Centres. This raises the question of how the locals would have fared if traditional midwifery had failed completely as a result of colonial policy to stop their operation.

The government's inability to cover the entire colony with midwifery

[91] Adell Patton, Jr., 'Dr. John Farrel Easmon: Medical Professionalism and Colonial Racism in the Gold Coast, 1856 – 1900', *The International Journal of African Historical Studies*, Vol. 22, No. 4, Boston University African Studies Centre (1989), 601.
[92] Maternity and Infant Welfare Movement – Statistics relating to.

and childcare services, which necessitated the inclusion of TBAs on a list of unqualified midwives and not their outright elimination, was also as a result of the government's worsening economic situation. The fall in revenue during the 1930 – 1931 period had caused the colonial government to reduce its staff.[93] For instance, during this period, the clinic at Christiansborg had to be closed down owing to lack of staff. It had to take the effort of a temporary lady medical officer, to operate the facility in a private capacity, without government support. This lady medical officer had had her contract terminated due to lack of funds.[94]

As a result of these shortfalls, in 1932, in Cape Coast, Steven Addae has mentioned that the local people, now reliant on the colonial welfare system, had requested that women medical officers be maintained. The request for women medical officers to be maintained was also due to the fact that, the operations of the women medical officers had reduced infant mortality rates in the town by 50%.[95] In that same year, in Kumasi, the Kumasihene, writing to the Governor petitioned the colonial government not to close down the Infant Welfare Clinic in Kumasi as a result of financial difficulties because the African people now depended on it, having realized that the conventional methods were better than the traditional methods.[96]

What this meant was that more people who relied on the western midwifery had increased, and the colonial government did not have the

[93] Annual Report on the Social and Economic Progress of the People of the Gold Coast, 1931 – 1932.

[94] Gold Coast Annual General Report for the period 1st April, 1930 to 31st March, 1931, Dp/DT 507.5G5 An7, Africana Library, 41/42.

[95] Addae, *Western Medicine*, 153.

[96] Infant Welfare Work 1931, ARG 3/14/12, PRAAD, Kumasi.

capacity to cater for them. Also, the inability to provide services to the locals meant that they had to now fall back on the TBAs due to the colonial government, and the local peoples inability to afford the services of western trained midwives.

During the colonial period, other issues with the provision of conventional healthcare in the country included the delay in drugs, inappropriate schedule of services provided by welfare clinics and the inclusion of untrained personnel amongst others. In several welfare clinics there were complaints of delay in drugs. In Kumasi too, by 1948, a report had been made about the schedule of the Welfare Clinic, which was done in a way that mothers could only report at certain times in the week, whiles children could also report at certain times in the week. The result of this was that, a child died in the hands of the mother because the mother refused to take the child to the hospital with the excuse that, that day was meant for the treatment of women and not children.[97]

In 1946 too, looking at the acute shortage of staff, the Head of the Medical Department in Accra instructed the Medical Officer in Kumasi to take on five untrained girls as candidates-under-test to be assigned Pupil Nurses after three months if found suitable to work.[98] This sharply contradicted the policies of the Central Midwives Board, which had by 1938 indicated that nurses who were already on the State Register for general training, should take a twelve months maternity course to become certified Midwives.[99] Thus the

[97] Child Welfare Clinic and Quarters, ARG 1/14/1/24, PRAAD, Kumasi.
[98] *Ibid.*
[99] Central Midwives Board – Rules regarding the training & Examination of candidates for admission to the roll of midwives (March 1938), CSO 11/6/15, PRAAD, Accra.

conventional healthcare provision, despite been displayed as the ultimate solution to maternal healthcare issues, also had some serious problems.

In June 1948, the Chief Commissioner at Cape Coast had written to all District Commissioners and Assistant District Commissioners on the Coast concerning the employment of conventional midwives. There was the need to inform the traditional authorities (Chiefs) about a letter received from the Midwives Board to employ midwives in their districts at a salary through the midwives Board. Already, in some towns like Winneba and Swedru, there were two and one midwives respectively.

While some Chiefs agreed to employ the services of the midwives, others mentioned that they could not, arguing that the suggested salaries were too high. Quite apart from that, of the sixteen towns, twelve were in favour of employing midwives to aid in maternal care. Of this twelve, only five pointed out that they could afford to provide the drugs for their operation.[100] This account shows a certain level of interest by the local authorities in keeping midwives, but very little effort at acquiring them and using their services. Though the numbers of midwives were few, and the midwives board was prepared to post midwives to certain areas, there were unenthusiastic responses from the chiefs. These discouraging responses did not only show the inability of the locals to afford the services of conventional midwives but also indicated that women still largely relied on TBAs during this period.

However, despite the inability of the government to provide adequate maternal healthcare services and depicting other shortfalls, the colonial

[100] *Ibid.*

government regulated and controlled the roles that TBAs played in maternal health through the Midwives Ordinance. This was done by the use of the superintendents of health visitors to check the activities of TBAs. These health visitors subjected these TBAs to scrutiny and inspection. As a result, health visitor training had being firmly established on the Gold Coast by the 1950s. [101] The government also indulged in inspecting private, mission maternity centres with Health Visitors, aside the governmental ones. These inspections checked whether the midwives had the right resources for their jobs, and recorded all cases of birth, death, or complications during delivery.[102]

The effectiveness of the colonial government's inclusion and training of TBAs, as well as inspecting and supervising their practices is yet to be assessed. Owing to the limited number of indigenous midwives the maternity hospital could train, it is right to suggest that majority of these indigenous midwives were not trained in western scientific medicine and foreign medical culture, and continued to rely on their traditional medical culture. Also, since the government had economic problems it raises the question of how many of health visitors were available to supervise these indigenous midwives and other private practitioners.

Despite the lengths that the colonial government had reached in instituting the Midwives Ordinance of 1931 and the introduction of health visitors to regulate the practices of trained midwives, women still made the major decisions concerning their health. This included when they wanted to

[101] Addae, *Western Medicine*, 154.
[102] District Sisters Report, ARG 13/3/7, PRAAD, Kumasi.

use traditional methods or herbal medicines and when they wanted to use western scientific methods. They also controlled largely how these welfare centres catered for their needs. For instance in Kumasi, the Child Welfare Centre was constructed to provide antenatal and child care. However, the services were opened up to issues beyond welfare services such as delivery of babies.

By 1936, 84 women had delivered at the centre, and 109 deliveries by 1937. [103] African women, and in this case, Asante women, therefore transformed the European modeled welfare centre meant for education on maternal and child welfare to medical services that suited their needs, including deliveries. This is also an indication that African women welcomed colonial midwives ability to reduce infant and maternal mortality, but were not so keen on throwing away their indigenous knowledge in birthing and mothering.

3.3 Nurses and Midwives Act of 1966

It has already been indicated that after independence, the government had focused on improving conventional healthcare, and had largely neglected the inclusion of TBAs. This was reinforced with the introduction of a Nurses and Midwives Act. In September 1966 a Nurses and Midwives Act was introduced to indicate the procedures to institute a nurses and midwives council and also to define the functions of such a council amongst other things.

Without doubt, this Act was silent on the existence of Traditional Birth Attendants and the role they played as far as offering services to the majority

[103] Allman, 'Making Mothers', 31.

of women in the country. Even so, the Act also limited their practice and seemed to suggest that TBAs were illegal health practitioners. According to the Act,

> "Midwife" means a person who having been, admitted to a midwifery education programme authorized and duly recognized by the appropriate regulation has successfully completed the prescribed programme of studies, has acquired the necessary qualifications and is registered and licensed to practice midwifery.[104]

Thus by virtue of the fact that TBAs had not been enrolled on a midwifery education programme that was recognized by the government, TBAs were not midwives. Therefore practicing midwifery constituted an offense. In any case, any person who was not registered under the 1966 Act was not qualified to practice midwifery. Practicing midwifery without being registered under the Act, was an offense, and one could only register if one had received a midwifery education as stated above.

3.4 Nurses and Midwives Decree of 1972

Also despite the inception of the 1970 reorientation of TBAs and inclusion of TBAs into the formal healthcare system, by 1972 another decree was constituted that suggests an exclusion of TBAs from midwifery practice in Ghana. In 1972 the government under the National Redemption Council (NRC) introduced the Nurses and Midwives Decree of 1972. This decree, like that of the 1966 Nurses and Midwives Act indicated amongst other things the establishment of a nurses and midwives board, and what qualified a person as a midwife. Like the Act of 1966, the neglect of TBAs existence and a deliberate attempt to show that government did not subscribe to their practices

[104] Nurses and Midwives Act, 8th September, 1966.

is evident. Section 15 subsections 1 of the National Redemption Council Degree (N.R.C.D) 117, which indicated qualification for registration as a midwife stated that,

> "15. (1) Subject to the provisions of this Decree, any person who shows the satisfaction of the Registrar that ---- (a) he holds a qualifying certificate issued by the Council under this Decree or some other qualification recognized by the Council as furnishing a sufficient guarantee that he has the knowledge and skill requisite for the efficient practice of nursing or midwifery and which is approved by the Ministry of Health; and (b) he is of good character; and
>
> (c) he is by law entitled to practice nursing or, as the case may be, midwifery in the country where the qualification was granted, or would, if he were a national of that country, be so entitled, Shall upon payment of the prescribed fee for registration, be entitled to be registered as a nurse or midwife, as the case may be."[105]

According to subsection 15. (1), since indigenous midwives did to receive any training with the council, they could not receive certificates or any certificate at all, which therefore disqualified the indigenous midwife to practice midwifery. The N.R.C.D 117 indicating the registration conduct of nurses and midwives therefore totally neglected the existence of TBAs, even those who had received some form of orientation.

In that same year, the introduction of Post-Basic Midwifery in the nursing institutions by the government suggests that the N.R.C.D 117 was a deliberate action to oust TBAs from the country. Nurses who graduated from the Post-Basic Midwifery programme gained a diploma in midwifery, which allowed them to attend to pregnancy related issues and delivery after training for a shorter period. Post-Basic Midwives were therefore to increase the reliance on conventional healthcare, rather than resorting to the use of TBAs.

[105] NRC (Establishment) Proclamation (Amendment) Decree, (1972 Vol. IX, NRC Decree, T – 193), PRAAD, Accra.

3.5 Policy on Primary Health Care

In 1978, the Alma Mata Declaration was adopted at the International Conference on Primary Health Care provision. The Alma Mata Declaration stressed on 'preventive, rural, peripheral and appropriate services, integration and inter-sectorial collaboration, and participation of local communities.[106] In accordance with the Alma Mata Declaration, Ghana's Ministry of Health (MOH) recognized TBAs as significant stakeholders in the provision of primary healthcare services especially in rural areas. According to the MOH,

> Primary Healthcare is a strategy to provide basic healthcare with a scientific basis to the entire population and all ethnic groups, which is appropriate for actual needs and acceptable to all the people. Primary Health Care expands the health network to remote areas based upon the principles of self-reliance and self-sufficiency.[107]

That said TBAs who had received some level of reorientation were recognized as primary healthcare providers to assist in the villages in the rural areas. And their main responsibilities were to assist with deliveries and provide advice on safe delivery. Also they were required to work with Village Health Volunteers (VHVs) to promote health and hygienic living in the villages where they found themselves.

Also TBAs were to be supervised by the Health Centres in their

[106] Barbara McPake, 'The story of Primary Health Care: from Alma Mata to the present day,' Id21 Health [online]. (2008), accessed from: http://eresearch.qmu.ac.uk/374/.
[107] Ministry of Health, Ghana, Policy on Primary Health Care, Ministry of Health, January 2000, 88.

communities. At the district level too, the District Health Service and District Hospitals were responsible for the selection, training and supervision of TBAs and other subsidiary healthcare providers.[108] As a result, TBAs interviewed recall frequent visits by nurses and doctors in their communities, who also encouraged them to continue performing safe deliveries.

3.5 Conclusion

It is clear that the colonial government had considered the training and use of indigenous midwives due to the inability of conventional healthcare to cover the entire country. These efforts were, however, started by the missionary bodies. Earlier the colonial government's intolerance of TBAs led to their neglect. Through the Midwives Ordinance of 1931, the colonial government sought to eliminate TBAs. However this chapter has shown that the colonial government, through the Midwives Ordinance resorted to the use of indigenous midwives in a policy of training and use. This, therefore, allowed indigenous midwives to practice after receiving some form of training and worked under the supervision and scrutiny of the colonial system.

The colonial government was largely unsuccessful in ousting indigenous midwives due mainly to economic hardships. Also Ghanaian women's continuous reliance on TBAs had hindered the expansion of colonial health policy. Despite the colonial policy on inducing Ghanaian women to rely on conventional healthcare, Ghanaian women took initiatives at subverting colonial policy and made the decisions concerning which methods and cultures were appropriate for them.

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[108] *Ibid.,* 11.

In the postcolonial period, policies concerning midwifery largely neglected the existence of TBAs. The Nurses and Midwives Act of 1966 and the Decree of 1972 are examples of the neglect of TBAs in Ghana, which also depicted them as unqualified. The Policy on Primary Healthcare introduced in 1978, included TBAs as primary healthcare providers. Even though the policy recognized TBAs as primary healthcare providers and therefore recognized the role they could play in maternal healthcare delivery, it suggests that the roles of TBAs were much more reduced to providing 'primary' services. That is, unless the situation was urgent and needed immediate and basic attention, women had to rely on conventional healthcare.

Despite this declaration, the continuous introduction of diverse maternal healthcare policies indicates the move by the government to make all women rely more on conventional healthcare. The introduction of policies like the Millennium Development Goal (MDG) 5 and Community-based Health Planning and Services (CHPS) in the 1990s, and Free Maternal Healthcare Initiative in the 2000s were done to steadily remove TBAs from the system and replace them with conventional healthcare providers.

The CHPS Compound for instance was implemented with the aim of reducing barriers to geographical access to healthcare. It focused on deprived and remote areas of rural areas. The main idea was to have a resident nurse in the community who would also provide mobile services to clients.[109] The CHPS Compound nurses provided public sector healthcare services to the communities were they were located. Additionally CHPS were expected to

[109] Frank K. Nyonator et al, 'The Ghana Community-based Health Planning and Services Initiative for Scaling up service delivery innovation', *Health Policy and Planning*, 20 (1), 25 – 34, Oxford University Press (2005), 26.

oversee the work of TBAs. Yet, their roles restrained them from providing obstetrics, delivery (except during emergencies), management and complications (except those not requiring blood transfusion), blood transfusion and caesarian operations or any other operations.[110]

The MDG 5 was also introduced by the United Nations to improve maternal health in developing countries that recorded high mortality rates.[111] To achieve this the United Nations (UN) insisted on the use of Skilled Birth Attendants (SBAs). According to the UN, a skilled birth attendant was one who had had some form of conventional training. This implied that TBAs who went through reorientation by conventional healthcare system were SBAs.[112] However to implement MDG 5, the government relied more on conventional healthcare by training conventional midwives. The introduction of midwifery training by the Sekondi Nursing Training College and the Cape Coast Nursing Training College in 2001 and 2003 respectively were to cater for training more midwives to achieve MDG 5.

Another initiative was the Free Maternal Healthcare (FMH) introduced in 1997. The FMH exempted pregnant women from paying for some maternal healthcare services. In 2003 fee exemptions for delivery services started for four regions and was expanded to the whole country by 2015.[113] Exemptions from paying for delivery by pregnant women reduced the burden to pay for

[110] HERA, 'Evaluation of the Free Maternal Healthcare Initiative in Ghana', *Summit Report*, May 18, 2013.
[111] Ghana Statistical Service, 'Millennium Development Goals in Ghana', 2010 Population and Housing Census Report, 2013, 71.
[112] World Health Organization, *Making Pregnancy Safer: the Critical Role of Skilled Attendant: a joint statement by the International Confederation of Midwives, International Confederation of Gynecology and Obstetric & the World Health Organization* (Geneva: World Health Organization, 2004).
[113] Ghana Statistical Service, 'Ghana Maternal Health Survey 2007', *Ghana Health Service*, Macro International Inc., May 2009.

maternal healthcare services. What this meant was that, TBAs were to lose the patronage of pregnant women. However, reduction in TBA patronage pertained to areas where hospitals and health facility were non-existent. The issue of access to conventional healthcare was still prevalent. The lack of transportation and lack of ambulance services prevented many women from accessing this benevolence. In addition, a TBA interviewed mentioned that the reception given to her clients as a factor determining the decision not to choose free maternal healthcare. She mentioned that,

> Even with the introduction of free maternal healthcare, they (pregnant women) still did not go to the hospital and came to me to deliver…. It is because of how I treated them.[114]

By introducing these measures, the government sought to increase the availability of conventional maternal healthcare, and also induce women to rely on it. Thus, whiles earlier policies indirectly projected TBAs as the main cause of increasing maternal mortality ratios in the country, subsequent ones sort to reduce reliance on TBAs by pregnant women. However, these measures did not entirely deal with the problems to accessing conventional healthcare. The issues that induced women to rely on indigenous midwives were still evident from the colonial to the postcolonial period.

[114] Interview with Afua Mansa

CHAPTER FOUR

REORIENTATION OF TRADITIONAL BIRTH ATTENDANTS

(1970 – 1992)

4.0 Introduction

Just like the colonial administration, the Government of Ghana (GOG) neglected the potential of Traditional Birth Attendants (TBAs) and excluded them from the formal healthcare system when it took power in 1957. This trend however changed when in 1970, the reorientation of Traditional Birth Attendants (TBAs) was conceived with the institution of the Danfa Rural Health and Family Planning Project in the Accra Region.[115] The Project initiated the process of government's inclusion of TBAs in the formal healthcare system of Ghana.

This chapter seeks to examine the motivation behind TBA reorientation in Ghana since the 1970s. What were the motivations behind the reorientation and inclusion of TBAs in the formal healthcare system? Also, the structures and guidelines introduced to ensure the running of the project shall be addressed. The curriculum and study structure of the TBA reorientation projects would help to understand how the goals of the reorientation projects were achieved. It also answers the question of how the government deployed its trained Traditional Birth Attendants after the reorientation programme and how that was sustained. Also, the question of what became the legal status of

[115] Ampim, 'Historical Analysis', 4.

TBAs would be answered.

The orientation exercise fell into the WHO agenda to eliminate maternal and child mortalities in Sub-Saharan Africa through the use of African midwives who were readily available in all areas of Africa. Several examples of TBA reorientation and use also existed internationally in Asian countries like India, Pakistan, Indonesia, Malaysia, the Philippines and Thailand. In these countries, since the early 1950s Traditional Birth Attendants had been trained to be included in the formal healthcare system.[116]

By 1970, the general medical service provision in the entire country was described as 'inadequate' and the siting of hospitals was also unfavorable as several people could not access them.[117] Undoubtedly, issues like the woefully inadequate number of facilities available for maternal healthcare and the absence of adequate numbers of healthcare providers necessitated the training and inclusion of TBAs in the formal healthcare system. Aside from the introduction of TBA reorientation programmes, other services and initiatives were introduced, that suggested that the problem of high maternal mortality ratios persisted.

After reorienting and training several TBAs in the 1970 Danfa Project, an "Evaluation of a Programme to Train Traditional Birth Attendants in Ghana" was conducted on the Danfa Rural health Project in 1986. This evaluation commended the training of TBAs as having had a positive impact

[116] Everett M. Rogers and Douglas S. Solomon, 'Traditional Midwives and Family Planning in Asia', *Studies in Family Planning*, Vol. 6, No. 5 (May 1975), 126 – 133.
[117] Parliamentary Debates, Second Series – Vol. 3, National Assembly Official Report, Session 1969 – 70, Ghana Publishing Corporation, Accra, Balme Library, UG, 452 - 453.

on maternal health, as TBAs were described as effective.[118] As a result, the study recommended that other training programmes be conducted. In 1989, the results from the Danfa Rural Health Project and other TBA training programmes led to the nation-wide training of TBAs.

It is argued in this work that the reorientation and use of TBAs was not done due to a genuine concern for the work of the TBAs, such as enhancing their status. The reorientation and use of TBAs became an alternative to the unavailability of conventional health personnel to engage in the family planning education and the provision of other healthcare services. This chapter will show that even after the reorientation programme, several of the TBAs reverted to their former practices with little changes in the way they did their work.

By the 1970s TBAs continued to practice their culture of medicine as was passed unto them by their predecessors. The obvious changes included changes in technique with regards to tools used. The razor blade for instance replaced a penknife and sharp shell for cutting the umbilical cord.[119] Therefore, the accusation of uncleanliness, which was used as justification for ousting them since the colonial period, still existed. Also the religious and supernatural aspect of their practices existed, most of which could not be scientifically tested, at least during the period under study. There is the need, therefore, to address how the TBAs reconciled the habits imparted to them by the reorientation programme with the African values to which they were

[118] Alfred K. Neumann et all, 'Evaluation of a Programme to Train Traditional Birth Attendants in Ghana' in A. Mangay Maglacas and John Simons, *The Potential of the Traditional Birth Attendant*, (Geneva: WHO, 1986), 51.
[119] Tmogene, 'Current Information on the Practice', 15.

socialized.

4.1 The Role of International Agencies in the Reorientation of TBAs in Ghana

Maternal health on the Gold Coast saw attempts by the colonial government to instill in the colony the policies from their metropolitan country, and in so doing disregarded the existence, skills and knowledge of TBAs. Global health agencies like the World Health Organization (WHO), United Nationals International Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) did not have direct contacts with TBAs and could not directly influence what happened to them, but however, they supported the policies of the governments. For instance in 1949/50, UNESCO supported the colonial government's efforts through the Mass Education Team in the Gold Coast to train women who represented about 100 villages, in Child Care and Nutrition.[120]

In fact, the colonial powers wanted these international agencies to integrate their efforts into the projects of the colonial powers rather than start new projects.[121] Therefore, where colonial policy largely sidelined the role Africans played in maternal health, these international agencies concurred by supporting the health policies instituted by the government, such as the expansion of basic rural health services. However, that is not to imply that these international agencies did not have their own policies independent of colonial government's policy.

[120] Welfare and Mass Education in the Gold Coast, 1946 – 1951, ADM 5/4/62, pp. 59, PRAAD, Accra.
[121] United Nations Children's Fund, UNICEF in Africa, 2.

This practice of supporting governmental policies on maternal and child health continued into the postcolonial period.[122] Government policy on training, courses and seminars on food and nutrition organized by national nutrition councils, committees and boards for the improvement of maternal and child health, were supervised often by the WHO and as a result, the government had to reshape its Food and Nutrition Board to suit the agenda of the WHO. Whiles WHO provided advice and consultancy on health, the UNICEF and other international agencies aided in training personnel and organizing mother craft lessons.[123]

These international agencies, however, did not play any role in the training of TBAs until the 1970s. Despite the support of these international agencies for government policies on maternal health, it was not until the 1970s, in the postcolonial era that the World Health Organization advocated for the use of Traditional Health Practitioners (THPs) or Traditional Medical Practitioners (TMP), who included TBAs, as Primary Healthcare (PHC) providers, and the inclusion of their culture of medicine into national healthcare systems in Ghana.[124] This was done primarily to use TBAs and herbal medicine practitioners to augment the formal healthcare provision.

The WHO had, however, in the late 1950s and 1960s debated on several occasions as to where and with whom women should deliver. As a result, the emphasis had been on training TBAs. This evolved to the recommendation that TBAs should work with the formal healthcare system and in the 1970s,

[122] First Seven Year Development Plan, 1963, BG 8/2/863, PRAAD, Accra, 5.
[123] Ampim, 'Historical Analysis', 38 – 50.
[124] Kofi Busia and Ossy M. J. Kasilo, 'Collaboration between Traditional Health Practitioners and Conventional Health Practitioners: Some Country Experiences', *Decade of African Traditional Medicine*, Special Issue 14, (2001 – 2010), 40.

their integration into the formal healthcare system through training, supervision and technical support.[125] This shows that issues of maternal and child health provision which manifested in the colonial period had persisted through to the postcolonial era, and WHO as an international health agency, sought to address these problems independent of the actions various governments took. Addressing maternal and child healthcare problems by the WHO included considering the use of TBAs.

The issues with maternal and child healthcare provision included but were not limited to lack of basic necessities such as sufficient hospitals, means of transportation, and formal education amongst others. In the colonial period, neonatal tetanus caused by unhygienic care of the umbilical cord was one of the main causes of maternal mortality. Other causes of maternal mortality included hemorrhage, sepsis, unsafe abortion, eclampsia, and obstructed labour.[126] Since a majority of women were still attended to by TBAs, WHO saw the need to train these TBAs to handle these complications instead of continuously relying on the insufficient conventional midwives.

In Ghana, the governments continued to indulge in these mother craft lessons, nutrition lessons, day nurseries, the building of more maternity centres, the training of community nurses, and family planning lessons. They also involved these international agencies. The Socialist government of Kwame Nkrumah introduced maternity and infant welfare services as a relevant prerequisite for the future generations and also encouraged the

[125] Cynthia Stanton, 'Steps towards Achieving Skilled Attendance at Birth', *Bulletin of the World Health Organization'*, retrieved from http://www.who.int/bulletin/vollumes/86/4/08-052928/en/ on 10/23/16.
[126] Judith R. Bale, Barbara J. Stoll, and Adetokunbo O. Lucas, *Improving Birth Outcomes; Meeting the Challenges in the Developing World* (Washington, 2001), 8.

making of more babies. The Busia government on the other hand, encouraged family planning as a way of reducing and spacing births to improve the livelihoods of Ghanaians. In achieving these health policies, the government worked jointly with the international agencies.[127] These services were provided, no doubt, to improve maternal and child healthcare in Ghana. Yet the socio- economic conditions and cultural belief systems of the majority of Ghanaians, which informed their decision on which maternal healthcare service they should choose, were totally neglected.

According to WHO as stated in its agenda, maternal care should include premeditated measures to boost the health of prospective parents, to develop the right moves towards family life, and also help these prospective parents to fit their family rightly into society. These preceded the care of the pregnant woman, her safe delivery, postnatal care, and care for her new baby. This concept was produced in 1966,[128] but upon the realization that developing countries were not sufficiently resourced to start and maintain this activity, it was perceived as a potential of TBAs, especially because they attended the greater number of deliveries in developing countries.

The 1970 recommendations to train and integrate TBAs into the formal healthcare system in Ghana had originated from a WHO-sponsored interregional seminar on 'The Role of the Midwife in Maternal and Child Health Care.' This seminar was held in Malaysia. Participants concluded that research should be done to improve the quality of data used for planning maternal and child health programmes involving the use of TBAs. This

[127] Ampim, 'Historical Analysis', 3 & 28.
[128] A. Mangay Maglacas & John Simons (Eds.), *Potential of Traditional Birth Attendant, World Health Organization* (Geneva, 1986), 1.

conclusion was drawn based on the considerations that, midwives, including TBAs played a definite role in developing countries with regards to family health. Also it was realized that information on TBAs was not adequate for planning programmes to train them.[129] Therefore in order to achieve this, much research was to be conducted on TBAs.

Apart from making these recommendation, WHO took active steps to realize this agendum of including TBAs in the healthcare system. The initiatives taken by the WHO, especially in collecting enough accurate information on TBAs for their use, suggests an attempt to make a case for their value after decades of their rejection and blacklisting. In 1972, WHO sponsored an international survey on TBAs. This culminated into the release of a document for a consultation on the "Role of the TBA in Maternal and Child Health and Family Planning". This consultation session was held in Geneva in March 1973, by which time the GOG had already piloted the TBA reorientation programme. The main objectives of the consultative session were:

1. To continue the review of data on Traditional Birth Attendants; of survey and research findings; of studies of birth practices in traditional cultures; and of training programmes for Traditional Birth Attendants.

2. To describe the characteristics of the Traditional Birth Attendants, especially with regard to her role and position in the community, traditional birth practices and attitudes and beliefs inherent in them, as a

[129] Maria de Lourdes Verderese & Lily M., Turnbull, *The Traditional Birth Attendant in Maternal and Child Health and Family Planning: A Guide to her Training and Utilization*, (Geneva: WHO, 1975), 5.

background for understanding her response to modern methods of maternal and child health and family planning and care.

3. To define the role the Traditional Birth Attendant may play in maternal and child health and family planning programmes and to formulate strategies for her training and utilization in these programmes, according to the type of community in which she operates.

4. To prepare guidelines for planning, implementing and evaluating training programmes and for supervising Traditional Birth Attendants and

5. To identify problems for future research.[130]

The outcome was the recommendation that guidelines should be prepared to assist countries in determining strategies for the training and use of TBAs. The GOG, therefore, based on WHO agenda conceptualized the training and use of TBAs in the 1970s and through the Ministry of Health and the University of Ghana Medical School piloted the training of TBAs through the Danfa Rural Health Project in Greater Accra, the nation's capital. *The Traditional Birth Attendant in Maternal and Child Health and Family Planning: a Guide to Her Training and Utilization* by M. L. Verderese and L. M. Turnbull was also published in 1975, as a WHO initiative. The publication did not only provide guidelines to developing strategies for the training and utilization of TBAs but also described how strategies could be formulated to involve TBAs in maternal and child healthcare provision,[131] as recommended

[130] *Ibid.*, p. 5.
[131] *Ibid.*, p. 1.

through the consultative sessions. All these helped to facilitate the nation-wide reorientation and use of TBAs.

UNICEF support to sub-Sahara Africa started in 1952, mainly, to support various disease control projects. Having given support through maternal and child welfare education on the Gold Coast, UNICEF's aim specifically changed to both formal and non-formal education and consequently to child welfare. It established the role of children in nation building and promoted the idea of planning for children as part of a process of national planning, by collaborating with governments.[132] This did not, however, impede their support for the inclusion of TBAs into the formal healthcare system for maternal health.

UNFPA support for TBAs in Ghana and other countries to improve maternal and child health started with the Safe Motherhood Initiative, started in 1987. Apart from that, UNFPA has collaborated with the WHO and UNICEF in subsequent years to include TBAs in the formal healthcare system through the agenda of training, supervision and use.[133]

In 1989, a collaboration of UNICEF, USAID, and UNFPA supported a National Traditional Birth Attendant training programme (NTBA) through funding.[134] This was done based on the recommendations from the Danfa project and other TBA reorientation programmes, and as a result TBA training programmes were commenced in all ten regions of the country.

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[132] United Nations Children's Fund, UNICEF in Africa, preface.
[133] Findings Office of Oversight and Evaluation, Support to Traditional Birth Attendants, United Nations Population Fund, Issue 7 (1996), 1.
[134] Jason B. Smith et al., 'the Impact of Traditional Birth Attendant Training on Delivery Complications in Ghana', *Health Policy and Planning*, 15(3), 326-331, (2000), 327.

4.2 The Danfa Comprehensive Rural Health and Family Planning Project

In 1970 the Danfa Comprehensive Rural Health and Family Planning Project was established at Danfa, a community in Accra. As the name suggests the project sought to improve rural health and implement the objectives of the National Family Planning Programme, introduced by the GOG in 1970. The University of Ghana Medical School (UGMS) initiated the Danfa project in 1964 as part of its responsibilities to train general medical officers to supervise rural teams and assist in the provision of rural health services.

The Danfa community was chosen on the basis of its nearness to the University of Ghana Medical School (UGMS) so that it could serve as a training site in rural health for medical students.[135] Nonetheless, it is commendable that the project was able to serve several other rural areas besides the Danfa community. For instance the area that the Danfa project covered was divided into four and in Area 1 alone the Danfa Health Centre served 28 communities.

The GOG funded the Danfa Project, with external funding assistance for the research component coming from the United States Agency for International Development (USAID). As a result of this external funding, the UGMS had to collaborate with the University of California at Los Angeles, School of Public Health (UCLA) to pursue this project. In April 1970, a Memorandum of Understanding was signed between the UGMS and the USAID's mission to Ghana. The first Project Paper (PROP) was also signed in

[135] The Danfa Comprehensive Rural Health and Family Planning Project, Ghana. Final Report, September 30 1979.

May 1970.[136] Amongst other things, the UGMS was responsible for the provision of the service aspects of the project, whiles the UCLA team was to assist in conducting research, and the planning and teaching aspects of the project. This was a nine-year research, service and teaching project.[137] The first phase of the project, which is of significance to this research, covered the years 1970 to 1975. The second phase was considered after an evaluation of the first phase and prioritized the development of the institutions that handled the project, as well as transfer of information amongst these institutions. The main objectives for the first phase of the project were;

1. "To investigate the state of the rural community and the factors associated with effective participation in health programs."

2. "To undertake research into the most efficient means of utilizing available manpower and other resources in the operation of health post-centered comprehensive rural health services."

3. "To train doctors, sanitarians, midwives, community health nurses and other health personnel, both separately and in teams, for their role in rural health work."

4. "To improve manpower oriented and equipped to handle the problems of the community". [138]

These four core objectives implied that the rural areas lacked the

[136] *Ibid.*
[137] D. A. Ampofo et al, 'The Training of Traditional Birth Attendants in Ghana: Experience of the Danfa Rural Health Project', *Trop. Geographical Medicine*, Vol. 29, 197 – 203 (1977).
[138] The Danfa Comprehensive Rural Health and Family Planning Project, Ghana. Final Report, September 30 1979.

necessary facilities and personnel following the direction that health had taken in Ghana. This was a direction that embraced western scientific healthcare. The Danfa project therefore made provision to fill this gap, by first investigating the needs of the rural communities. In this regard it must be remembered that by 1970, the nearest hospital to Danfa and its surrounding communities was the Korle Bu Teaching Hospital. The implication is that members of the Danfa and surrounding communities, continued to rely on traditional methods, practiced a pluralistic healthcare, or had to travel long journeys to seek medical care.

During the first phase of the project and in line with the second objective, the project included as part of its core mandate, the training of Traditional Birth Attendants (TBAs). TBAs were recognized as available manpower that could be used to roll out the project. Health education, nutrition and sanitation were other programmes that the project set out to achieve during the first phase. Under each programme, objectives were set. For the TBA reorientation the objectives included,

1. To motivate and train the TBAs to monitor women during the antepartum period.
2. To motivate and train the TBAs to recognize and refer high-risk women or those with serious complications of pregnancy and delivery.
3. To train the TBAs to perform safer deliveries. To train the TBAs in proper care of the cord. To enlist the aid of the TBA in the promotion of improved maternal and child health practices and family

planning in their villages.[139]

These objectives indicate roles that the project wanted TBAs to perform as a prerequisite to include them in the formal healthcare system. Also, among other things these objectives suggested that the TBAs did not perform safe deliveries and did not take proper care of the umbilical cord.

Even though the objectives indicate an upgrade of TBA skills and knowledge, it cannot be denied that the reorientation of TBAs became necessary to utilize resources that were already available in the community to achieve the overall goal of the Danfa project, which was to improve rural health and enhance family planning.

The training programme was divided into two main parts. The first part was a training period that comprised eight sessions of training with the TBAs. These eight sessions covered general discussions of TBAs experiences, antenatal care, recognition of high risk pregnancies, personal hygiene and nutrition, disorders and complications with pregnancy as well as preparation for confinement and use of midwifery kit, stages of labour, complications, and position of delivery, care of cord, dangers of cord sepsis, bleeding during pregnancy, child nutrition and immunizations. The TBAs were also taught about family planning, its benefits, methods, location of services and motivational techniques. The second part comprised a period of continuing education and follow-ups, which started in 1976.[140]

In order to meet the requirements of the curriculum and activities, there

[139] Ampofo et al, 'Training of Traditional Birth Attendants', 197 – 203.
[140] *Ibid.*

needed to be trainers who had the capacity to teach the courses mentioned above. Therefore, there was a Training of Trainers (ToT) session that required the training of medical personnel who in turn trained TBAs. The selection of ToT participants for the TBA training programme had to meet certain criteria. The criteria stated that a trainer must be a midwife or, in the case of Community Health Nurses (CHN), medical assistant or public nurse, have a midwifery background; have at least two years of midwifery experience; be stationed at a health post; and be interested in working with TBAs.[141] This criterion suggested that TBAs were not recognized as midwives and could only be included on this project if they had some form of training with a conventional midwife; further suggesting that conventional midwives were the qualified crop of practitioners. The transfer of knowledge and skills was one-sided from, conventional midwives to TBAs, and as a result, the TBAs became acquainted with some western healthcare practices.

Despite the fact that the involvement of TBAs in the Danfa Project was projected as a training programming for TBAs, the project was more of reorienting them than training them. As one would come to comprehend, these TBAs were already trained and these sessions were meant to help these TBAs to familiarize themselves with the trend of western scientific healthcare provision that the government had embraced since the colonial period. This explains the attempt to discuss at these sessions the practices of TBAs, exchange of ideas and the introduction of new techniques rather than train them, which presupposes teaching them a new craft entirely. As Nii Afutu Brempong III mentioned,

[141] Final Report Operations Research Project, Family Planning and Primary Health Care by Traditional Birth Attendants (1990), 10.

> The doctors told them [TBAs] because you are in the rural area we just want to assist you to do something that is cleaner; something that is clinical and clean in nature, which is different from the dirty environment where they normally practice. Someone was going to deliver and they put the person on the mat or on the floor and the blood will be oozing out... put them in a clean environment.[142]

This implies that the conditions of the TBAs in their rural settings informed the need to reorient them and indicate to them safer and cleaner methods of practice.

> But sometimes with regards to the herbs that they use, how to prepare them so that they are not contaminated that is what our people must know. ... So there is something positive but just how to prepare the thing so that bacteria load would be absent so that when they apply it, it wouldn't cause any problems. For them [TBAs], wherever they can grind it and whether the hand is washed or not, they do not care.[143]

The quote above also indicates that some of the practices of TBAs raised concerns about the fact that they caused other illnesses, knowingly or unknowingly, in their attempt to aid their clients. Therefore, the TBA reorientation programme was informed by their practices and the conditions of their environment, which was seen as not conducive for safe births. As already mentioned, a great majority of women relied on TBAs and therefore, the need to reorient them to indulge in safe births. By 1970, even though a majority of women (92%) attended antenatal clinics, only an estimated 25% delivered at the clinic.[144]

The reorientation and use of TBAs as a means of achieving the objectives of the Danfa project had some advantages. As recognized by the team, the TBA services were less expensive, did not depend much on

[142] Interview with Nii Afutu Brempong III, Chief of Danfa, Medical Records Officer at the Danfa Health Centre from 1969 – 1976, 5 December 2016.
[143] Interview with Mr. Briant, Environmental Health Officer at the Danfa Health Centre, 17 December 2016.
[144] Ampofo et al, 'Training of Traditional Birth Attendants', 198.

transportation, and offered a natural setting for child delivery and the TBA became a resident agent for health education in the community.[145] This suggests that the TBA filled the gap created by the unavailability of formal healthcare in the rural areas at a relatively low cost.

By 1972, 263 TBAs were registered by the Project. Not all the TBAs that registered went through the programme. For instance in Area I of the Danfa project, 57 TBAs were reoriented out of the 67 that registered.[146] This indicates that not all the TBAs committed to being acquainted with western scientific methods, and therefore the existence of TBAs that continued to rely on their traditional knowledge and methods of maternal healthcare.

4.3 The National Reorientation of TBAs.

In 1987 there was a Safe Motherhood Programme initiated by the World Health Organization to research on TBAs, train them and include them in aiding community maternal care. This programme was conducted in 12 selected districts in the country.[147] Thus in terms of reorienting Traditional Birth Attendants, the Danfa Comprehensive Rural Health and Family Planning Project was not the only project that the GOG had offered its support and collaboration.

In 1989 again, a collaboration of UNICEF, USAID and UNFPA offered funding to support a National Traditional Birth Attendant (NTBA) training programme. The NTBA training programme grant covered three years, 1989 –

[145] The Danfa Comprehensive Rural Health and Family Planning Project, Ghana. Final Report, September 30 1979.
[146] Ampofo et al, 'Training of Traditional Birth Attendants', 200.
[147] Henrietta Odoi-Agyarko, 'Profile of Reproductive Health Situation in Ghana', *World Health Organization*, 2003; Henrietta Odoi-Agyarko was at the time the Deputy Director, Public Health/Family Planning, Ministry of Health, Ghana.

1992. Unlike the Danfa Project that included TBAs as part of a family planning project, the NTBA project from the onset intended to reorient TBAs in order to establish a conventional form of training TBAs in all regions of Ghana. The NTBA sought to provide assistance to the Ministry of Health to expand primary healthcare services to all rural areas. It was to be done on a region-by-region basis, with the first region to implement its NTBA training activities being the Volta Region.[148]

This fell into the agenda of the GOG to use Community Health Workers called Community Clinic Attendants, and Traditional Birth Attendants in health service delivery at the community level.[149] This was spelt out in the MOH 1978 policy paper that recognized TBAs as fundamental providers of maternal and child health services in rural areas.

Like that established by the Danfa project, the NTBA was to assist in training and supporting TBAs to provide antenatal, delivery, postnatal and family planning services in the rural areas, thereby improving healthcare there. Also the grant provided for NTBA office to coordinate, monitor, support and evaluate the NTBA programme in five regions of the country.[150] The curriculum designed for the NTBA programme was quite different from that designed for the Danfa project. It was a 2-week programme that spelt out the following,

1. Instruction in care/management of normal pregnancy

[148] Final Report Operations Research Project, 'Family Planning and Primary Health Care by Traditional Birth Attendants', June 1990.
[149] National Community-Based Health Planning and Services (CHPS) Policy, 'Accelerating Attainment of Universal Health Coverage and Bridging the Access Inequity Gap', *Ministry of Health, Ghana*, March 2016, 8.
[150] Smith et al, 'Impact of Traditional Birth Attendant', 327.

2. Recognition of complications and referral, care of the newborn

3. Five non-obstetric primary healthcare topics; family planning, infant feeding, growth monitoring, immunization and control of diarrheal diseases.[151]

Even though the curriculum had three main topics, these indicated the confidence placed in TBAs in providing healthcare to pregnant mothers. More responsibilities were bestowed on the TBAs in the form of providing primary healthcare and control of other diseases that were not obstetrically related, in line with the 1978 policy paper. This indicates that the project recognized the ability of the TBAs to help in improving rural healthcare beyond the delivery and care of mothers and infants. The decision to allow TBAs to handle other health problems that were not obstetrically related shows that the TBAs proved themselves during their training sessions. A TBA who enrolled during the NTBA programme explained that,

> Even before the training we knew we had to use Dettol and wear gloves. At that time they were very expensive but we tried to use them. ... There were so many things that they told us that we already knew in terms of delay in delivery ... and how to handle the cutting of the placenta. ... before the training we had a special knife to cut it and we threw them away after use and when we realized that it was costly, we used new blades and disposed them off after use because we didn't want to transfer sicknesses from one person to the other.[152]

The above quote indicates that the TBAs were privy to certain technicalities that the conventional healthcare system sought to introduce. For example TBAs made sure that they did not use the same blade for several patients. This was to avoid the transfer of bacteria or diseases from one patient

[151] *Ibid.*, 327.
[152] Interview with Sarah Agyeman.

to the other. The account above indicates that the TBA was aware of such technicalities before enrolling on the NTBA reorientation programme. This could mean that evolving TBAs educated themselves independently on what their competition (that is the conventional healthcare providers) knew, and therefore aimed at enhancing their practices.

Again, the decision to allow TBAs to handle more medical conditions could be as a result of the processes and criteria used in selecting TBAs during the expanded project of NTBA. The selection was done with the help of the Chiefs, community elders and whole communities. The criteria included: the TBA should be a permanent resident of the community, should be committed to continuing work as a TBA and be willing to be trained, should be someone the community trusted and respected, and volume of work, age, and location should also be considered.

Thus, the TBAs finally chosen should be those who did many deliveries, who were themselves healthy, and who served different parts of the village. Also, any person they wished to work with as an assistant could be selected for training.[153] This presupposes that, the TBAs registered on the reorientation programme were confirmed as capable, and trusted by the communities where they found themselves and could therefore practice without any hindrance. The confidence placed in TBAs as a result of this criterion for selection explains why their roles were expanded.

Upon graduation from both the Danfa and the NTBA projects programmes, a ceremony was held, where the TBAs were offered certificates,

[153] Final Report Operations Research Project, "Family Planning and Primary Health Care by Traditional Birth Attendants", June 1990, 12.

identification cards and midwifery kits. In the kits, one could find a medium sized bowl, a small bowl, a plastic mackintosh, a nail brush, a soap dish, toilet soap, and packets of blades, hand towel, cord ligatures, plastic bag of cotton wool, contraceptives (condoms and foaming tablets), sachets of ORS (Oral Hydration Therapy), record books and referral cards.[154] These items were supposed to be replaced by the TBA after they were all consumed.

Even though the TBAs had been reoriented with government resources like any other health personnel, they were free to operate, and therefore charge their clients any fee they desired for their services. However, N.R.C.D 117 of 1972 seemed to suggest otherwise. According to section 22, subsection 2 of the decree,

> ...every midwife registered under this Decree not being a person employed by the Government and paid out of public funds, shall be entitled to recover in any court, with full costs of suit, reasonable charges for professional aid, advise and visits and the value of any medicine or any medical or surgical appliances rendered or supplied by him to his patients.[155]

The above subsection of the decree implied that despite these reoriented TBAs were free to operate and demand fees, this right was not protected by any law or guaranteed since they were not registered under the Nurses and Midwives Council. Therefore if a client decided not to pay for services rendered by the TBA, the TBA could not do anything specified by the law about it.

[154] *Ibid.*, 14.
[155] NRC (Establishment) Proclamation (Amendment) Decree, 1972.

4.4 Supervision and Monitoring of TBAs

As mentioned earlier, the curriculum of the TBA reorientation programme catered for continuous monitoring and follow-up of TBAs. The trainers also supervised the TBAs. During the supervision, the supervisors reinforced what had been discussed and taught during the training programme.[156] Although the supervision and monitoring was a great idea for helping the TBAs achieve the goals of the project and monitor their activities and progress, there were many loopholes that indicated that nation-wide, the supervision did not achieve much.

This is to say that the supervision and monitoring exercise only worked in some areas. For instance since most TBAs were illiterate, they depended on the supervisors to record their activities in their records book. Therefore in instances where the supervisors were not able to go for supervision, this information was lost forever. This was the lamentation of a TBA interviewed.[157]

4.5 TBAs Reaction to the Reorientation Projects

In all areas where the TBAs were identified and reoriented, they reacted differently to the project. However, one thing that was common was that, a majority of them willingly accepted to join the project and work with the Ministry of Health in enhancing rural health. This however came after much convincing that the project was not meant to ban them from practicing but rather to support and use them efficiently in rural healthcare.

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[156] *Ibid.*
[157] Interview with Akua Ninsin.

> ... I remember, the midwife, Mrs. Franklyn was asked by the Chief of Party, Dr. Lawryn to go to the surrounding villages and search for the TBAs so that they could start training them... So when Mrs. Franklyn Aidoo was going, she was dressed in 'white' and went into the villages. When she went through out the whole day she couldn't get one person to register although we have many TBAs in the communities; because the people were afraid. First she was in 'white' and from her appearance the villagers thought she was coming to deceive them and arrest them because they were practicing medicine. ... So I was called, 'Ashia, you are the relative of the Chief of Danfa, go round and see if you can get some of the TBAs'. So I left and on that day fortunately, I had 22 TBAs. When I went they said to me that they were afraid, she was in 'white' and we villagers we don't dress like that. But when I came to them, I introduced myself and they normally refer to me as Oko Ashia, I am the nephew of the Danfa Chief and my mother comes directly after the Chief... So they received me and then told me that; first and foremost I remember the Chief of Amanfrom called Attah Ala; he was also a TBA and he said I will let you get the names of the TBAs but 'if anyone is arrested in the community you will see; now that you have revealed your own identity to us, it will be easy to get you.'[158]

The quote above explains the reaction of some TBAs when they were first sought after by the team at Danfa. The decision of the TBAs not to make themselves known out of fear of being arrested indicates their knowledge or perception that, the Government did not recognize their practice. Nonetheless, they practiced and to some, the super-natural basis of their practice mandated them to continue practicing.

After the programme, some TBAs did not entirely forgo their previous knowledge and practices, but found a way to merge their practices with that received from the project. For instance, the use of herbs continued alongside medicine recommended by the hospital. Also some continued to use their bare hands to deliver and they delivered babies by placing clothes on the floor.

Because a majority of TBAs were also herbalists, they continued to use herbs to treat their clients despite the fact that they had agreed to refer them for antenatal care in the hospital. Some of them claimed that the drugs prescribed at the hospitals did not help their clients and in order to ease their

[158] Interview with Nii Afutu Brempong III.

pain, they had to help them by prescribing herbal medicines.[159] An Environmental Health Officer interviewed agreed that some of the herbs that TBAs used helped mothers deal with complications during pregnancy. Referring to an instance, the Environmental Health Officer mentioned that, a pregnant woman had been eased from a pregnancy complication due to the timely intervention of a TBA who prescribed herbs for the woman,[160] after western medicine had failed completely.

Despite the effort, through the project, to abolish unhygienic practices such as the use of bare hands and delivering in an unclean environment, some TBAs did otherwise. Three of the TBAs interviewed mentioned the fact that after they used the set of materials in the kit provided by the government, they could not afford to purchase more. Their justification was that they did not make much profit from their work and could therefore not afford to purchase these items. Despite their excuse, it seems that they did not give much importance to the use of these items. One could tell that these are things they felt were useful, but not necessary. Also it suggests that they only accepted to use these equipment out of fear of being banned from practicing. Again, despite been accused of been unhygienic, most compounds of TBAs remained untidy.

A review of the referral cards and record books given to the TBAs showed that most TBAs did not give a true account of their activities. Apart from issues with relying on their supervisors to record their activities, some of them could not comprehend the requirements in the record books and

[159] Interviews with Sarah Agyeman and Akua Ninsin.
[160] Interview with Mr. Briant.

therefore left them blank. For instance, even though a TBA interviewed claims she had referred several of her clients to the hospital, her records showed that none of her clients were referred to the hospital.[161] This could mean either that she did not record it or she never sent her clients to the hospital. Nonetheless, there needed to be a clear understanding of the use of the records book to give a true reflection of how the TBAs achieved the objectives of the programme.

The conducts of the TBAs in relation to forgoing much of what was taught during the reorientation programme, does not prove that the reorientation programme failed. There were many instances that showed that the TBAs appreciated the programme and used it in enhancing maternal health in their rural communities. First of all, the TBAs recognized that, they could not deal with all pregnancy related complications and could therefore refer these to the hospital without hesitation or fear of being chastised. As a TBA mentioned,

> We have sicknesses that are treated by the hospitals and those to be treated by herbs. I normally do referrals if I realize doctors can only cure the sickness.[162]

Also the TBAs became confident to share with the medical practitioners who visited them, the herbs they used in curing their clients. There was therefore no need to continue mixing herbal medicine with medicines prescribed by medical practitioners as that could cause complications. A TBA interviewed also mentioned that, a bond was formed between her and the nurses that helped them to discuss the best ways of doing things. Due to this bond, she again mentions that, she was sometimes called upon to help to

[161] Interview with Aba Edua.
[162] Interview with Akua Ninsin.

deliver babies in the health centre, manned by nurses in her community.[163]

4.6 Conclusion

Despite the Danfa Comprehensive Rural Health and Family Planning Project set the pace in including TBAs in the formal healthcare system of Ghana, the initial design of the Project was not to include TBAs in the formal healthcare system. The reorientation of TBAs formed a part of a wider project that along the way realized that TBAs could be a valuable resource in attaining the goals of the project. The idea was towards involving TBAs to improve maternal health and child health in rural areas in Ghana and not aimed necessarily at improving the social position of the TBA. Therefore the reorientation programme was initiated without taking into consideration the socio-economic or cultural inclination of the TBAs or women. This chapter has shown that their poor socio-economic status and their cultural beliefs, especially pertaining to the use of herbal medicines affected the aims of the reorientation programme.

The training of TBAs by conventional midwives suggests that TBAs were not recognized as midwives. Having graduated therefore, one would think that the prestige of TBAs with regards to their professional position would increase in the formal healthcare system. Yet the only thing that changed was the consent through certificates that they could practice freely without being viewed as illegal. TBAs who graduated from the programme were now referred to as 'Trained TBAs', suggesting that they were not trained before. However, this notion is wrong because they received some form of

[163] Interview with Sarah Agyeman.

training before they practiced their profession passed on to them by their predecessors.

The receipt of certificates meant that, the government and other health institutions recognized TBAs as authentic. The same applied to traditional medicine practitioners who received some sort of reorientation and were handed certificates. In view of this, TBAs who had not gone through the programme were encouraged to go through the training, but no stringent laws existed against their not attending the programme.

CHAPTER FIVE

GAPS IN CONVENTIONAL MATERNAL HEALTHCARE

5.0 Introduction

This chapter seeks to analyze the barriers in accessing conventional healthcare that existed and therefore influenced the continuous reliance of pregnant women on Traditional Birth Attendants (TBAs) especially after the colonial experience. In what seemed to be a lingering wish to eradicate Traditional Birth Attendants (TBAs) through policy implementations, the research asks, how conventional healthcare sought to provide efficient services and provide equal maternal healthcare services to women in all areas of Ghana. Also, it indicates those benefits derived from seeking traditional birth assistance that the conventional healthcare system had failed to provide.

Even though this research has mentioned several factors, such as the limited number of personnel and facility, which indicated the gaps in conventional healthcare provision, this chapter further elaborates these gaps. To do this, this chapter assesses the effect of socio-economic conditions of women, the attitudes of conventional maternal healthcare providers, education, the cultural and belief systems of some Ghanaian women, coverage of conventional healthcare, as well as how accessible conventional healthcare is. It is argued in this chapter that, these factors and many more are gaps that have informed the low patronage of conventional healthcare.

In the early 20th Century, conventional healthcare was introduced by the colonial administration, after TBAs were accused of causing high maternal and child mortalities and were banned from practicing. In the ensuing years,

several other policies were rolled out to check TBAs and their practices. However, this failed because a majority of women continued to rely on TBAs. Other factors included the inability of conventional healthcare to cover the entire country. However, since the 1970s, the inclusion of TBAs, the Policy on Primary Healthcare, the Community-based Health Planning and Services (CHPS) Compound, and the Free Maternal Healthcare Initiative were all introduced to improve maternal health and increase the number of women who sought healthcare in the formal healthcare system. Despite these efforts, by 2003, out of the over 90% of pregnant women who attended antenatal care in conventional healthcare institutions, only 43% of these delivered in the health institutions.[164] Data available showed a majority of women still relied on TBAs for maternal healthcare.

This, without doubt, also indicated the plurality of the provision of maternal healthcare in Ghana. A majority of pregnant women relied both on the traditional and conventional healthcare providers. Thus the conventional healthcare and traditional healthcare were used interchangeably.[165] What therefore informed the decision to choose one of these two services at a point and the other at another point in time?

5.1 Effects of Women's Socio-Economic Conditions

In Ghana, the economic experiences of women differed largely from men's economic experiences. Culturally, women were pushed to the background in

[164] Richard M. K. Adamu, 'Utilization of Obstetric Services in Ghana between 1999 and 2003', *African Journal of Reproductive Health*, (Regular Issue): 14 (3), (September 2010), 153.
[165] Elizabeth Hill et al, 'I don't know anything about their Culture', 36 & Kennedy, 'Traditional Birth Attendants'.

most aspects of the economy. In the banking, industrial and even agricultural sectors, men dominated.[166] During the 1960 – 1970 period for instance self-employed women in agriculture reduced significantly and this was as a result of the majority of landowners leaving their lands in the control of men rather than women.[167] A majority of women in the agricultural sector, Ghana's largest economic sector, did not even own the means of production and were mere employees. Therefore men, rather than women were more empowered financially. This low participation of women in the agricultural sector also reflected in 1984. What this meant was that the cheapest maternal healthcare provision would be resorted to. All four TBAs interviewed, mentioned poverty as a significant reason why women in both rural and urban areas patronized their services.

> The reality is that when they go to the hospital they take soap, cot sheet, rubber and some other things. Some people do not have that. Some do not even have a chamber pot. But when they come I have some and I give them some of these things. When they go out they commend me to other people. So all the time I buy some of these things and I receive some as gifts from others. So when people help me I have to help others.[168]

The TBAs were able to provide their needy clients with resources that they did not have during their delivery. This was not done in the hospitals and often women shied away women from the hospitals as a result. Even with the introduction of Free Maternal Healthcare, other costs like transportation and ambulance services were also outstanding factors militating against seeking

[166] Ghana Statistical Service, Analysis of Demographic Data, Vol. 2, Accra, 1995, GHA/89904, p. 27.
[167] Gwendolyn Mikell, 'Filiation, Economic Crisis, and the status of Women in Rural Ghana', *Canadian Journal of African Studies*, Vol. 18, No. 1, 195 – 218, 213; an AID/GHANA report published in 1975, this publications mentions the statistical decrease in agriculturally self-employed females during the period 1960 and 1970 and Mikels data, uses the case of the Sunyani District to illuminate the problem.
[168] Interview with Stephen Nartey.

conventional healthcare. Also, whereas TBAs accepted any form of payment to render maternal services, the situation in the formal healthcare system was different. Prior to the introduction of the free maternal healthcare initiative in 2008, pregnant women had to pay for their services at the hospitals.

Table 3: Percentage Distribution of Employed Persons by Major Industries (1960, 1970 and 1984)

All Industries		**1960**	**1970**	**1984**
Agriculture	T (Total)	61.8	57.0	61.1
Hunting, Forestry	M (Male)	39.2	32.4	32.3
And Fishing	F (Female)	22.6	24.6	28.8
Mining and	T	1.9	1.0	0.5
Quarrying	M	1.8	0.9	0.5
	F	0.1	0.1	0.5
Manufacturing	T	9.1	12.1	10.9
	M	5.3	5.3	3.7
	F	3.8	6.8	7.2
Electricity, Gas	T	0.6	0.4	0.3
And Water	M	0.6	0.4	0.3
	F	0.0	0.0	0.0
Construction	T	3.5	2.3	1.2
	M	3.4	2.2	1.1
	F	0.1	0.1	0.1
Wholesale and	T	14.4*	13.9	14.6
Retail Trade,	M	3.7	2.1	2.1
Restaurants &	F	10.7	11.6	12.5
Hotels				
Transport	T	2.6	2.7	2.3
Storage and	M	2.6	2.6	2.2
Communication	F	0.0	0.1	0.1
Service (Finance,	T	6.0	10.5	9.2
Insurance	M	4.9	8.8	6.7
And Real Estates	F	1.2	1.7	2.5
Inclusive)				

*The figure for 1960 pertains to wholesale and Retail Trade only. **Source: Ghana Statistical Service, Analysis of Demographic Data, Vol. 2, Accra, 1995, GHA/89904 p. 27**

For the TBAs, the main influence for their low charges was the fact that

majority of their clients were family or community members. Even in cases where they did not know the client, they saw their job more as a moral and religious responsibility to help their fellow human being.

Contrary to the situation in the agricultural sector, in the trading industry, women rather than men dominated. As Table 3 above indicates, the second most flourishing sector was the Trading sector, the only sector in which women dominated. The trading sector was also largely informal. This was not only witnessed in the rural areas but also in the urban areas. For the case of women in Accra Robertson mentions that,

> By virtue of being the indigenous inhabitants of Accra and dominant numerically, and because of their long-standing contacts with the European firms on the coast, they [Accra women] control the fish, imported goods, and locally-prepared food sales. Their participation in these trades goes back to at least the sixteenth Century, so that they have had hundreds of years to develop a complex fund of common experience to refine their business techniques. This accumulation of knowledge has been passed from generation to generation through an apprenticeship system, and is constantly enriched by informal exchange of information between traders.[169]

By 1960, as many as 90 percent of women in Accra were traders, and trading actually helped them to deal with their domestic requirements such as taking care of their children, and husbands (for those married).[170] The informal economic disposition meant that, there were no stringent expectations of them to resort to formal medical care as was the case of people who worked in the industries and the formal sectors. Therefore, women and mothers involved in the trading sector were free to resort to traditional medicinal practice including the use of TBAs.

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[169] Claire Robertson, 'Economic Women in Africa: Profit-Making Techniques of Accra Market Women', *the Journal of Modern African Studies*, Vol. 12, No. 4, 657 – 664, (1974), 657.
[170] Pellow, *Work and Autonomy*, 775.

Marian E. Smith et al mentioned that, seeking institutional delivery was highly influenced by women's status. Therefore women with high status sought more institutional delivery than women with low status.[171] Apparently, high status was accompanied by the need to seek comfort, which was also informed by the ability to afford it.

5.2 Training of Conventional Maternal Healthcare Practitioners

In 1963 the government mentioned in its Seven Year Development Plan that the number of health personnel at all levels including maternal health, available in the country was not adequate. It stated that,

> The shortage of personnel at all levels has been a restricting influence on the expansion of health work in this country. If rapid progress is to be made then the workers must be trained.[172]

As a result of the low numbers of personnel, training of all cadres of health personnel was started. The training of Community Health Nurses (CHNs) was introduced in 1960 and maintained, and this sought to expand rural health services. The increasing cases of infant mortality and the need to cater for maternal and infant welfare greatly informed this decision.[173] In 1961/1962 too, 265 nurses and midwives graduated from six nursing schools, while 114 new doctors were also registered in Ghana.

Table 4 below indicates an increasing trend of trained health personnel between 1961 and 1970. However, as will be discussed in the effect of

[171] Marian E. Smith et al, 'Why some women deliver in Health Institutions and others do not: a Cross Sectional Study of Married Women in Ghana, 2008', *African Journal of Reproductive Health*, Vol. 16, pp. 36 – 47, No. 3 (2012), 37.
[172] First Seven Year Development Plan, 1963, PRAAD, BG 8/2/863.
[173] Ampim, 'Historical Analysis', 49.

population growth on maternal health, the figures for the number of doctors produced each year did not match the maternal health needs of the country, as the population increased each year. Also, the issue of brain drain which affected the 'reservoir of skilled labour, including professionals', aggravated the situation.[174] This presupposes that many people still relied on traditional methods for their maternal health needs.

Table 4: Medical and Para-medical Personnel (For maternal Health only) in Government and Non-Government Service, 1961 – 1970.

Type of Personnel	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970
Doctors	434	516	525	560	567	573	497	539	575	667
Midwives	1,008	1,104	1,235	1,489	1,601	1894	1,981	2,334	2,610	2,808
Trained Nurses	2,023	2,191	2,290	2,378	2,660	3,078	3,173	5,095	5,276	7,345
Public Health Nurses	50	78	61	80	115	139	157	176	154	146
Total	3,515	3,889	4,111	4,507	4,943	5,684	5,808	8,144	8,615	10,966

Source: Ghana Statistical Service, Analysis of Demographic Data, Vol. 2, Accra, 1995, GHA/89904.

In 1970, the same year in which the government efforts considered the reorientation of TBAs in the Danfa Project, the physician to population ratio was poor, as shown in table 5 below. Also as late as 2014, the physician to population ratio in Ghana was placed at 1:20,000. Thus 1 Doctor provided

[174] Deborah Pellow and Naomi Chazan, *Ghana: Coping with Uncertainty*, (USA, 1986), 145.

services to 20,000 people. In Accra, which is the country's capital, the ratio was 1:6,000. In the northern regions this was 1:100,000. Thus the situation in the rural areas was worse off. However with the provision of traditional healthcare, the ratio was 1:200. As a result of these statistics, Elizabeth Hill et al mentioned that about 80% of the country's population relied on Traditional Methods.[175] However, it cannot be denied that this percentage of the population also resorted to conventional healthcare at some points in time.

Table 5: Doctor to patient ratio for the Volta, Ashanti and Brong-Ahafo Regions in 1970.

Region	Doctor/Patients Ratio
Volta	1/16,000
Ashanti	1/42,000
Brong - Ahafo	1/127,000

Source: Parliamentary Debates, Second Series – Vol. 3, National Assembly Official Report, Session 1969 – 70, Ghana Publishing Corporation, Accra, p. 462, Balme Library, UG.

Also, the quality of education and deployment of formal healthcare providers in the country greatly affected the choice of maternal healthcare provision that is formal or traditional. Most of the nurses deployed from the Nurses Training Colleges lacked the experience needed to do obstetrics. In the urban areas, they had enough experienced doctors and midwives to help them in delivery and to provide maternal health services generally. However, in the rural areas they lacked the necessary monitoring and supervision, and lacked the confidence to practice.

[175] Elizabeth Hill, "I don't Know Anything about their Culture".

5.3 Literacy and Illiteracy in Women

Literacy and illiteracy created a gap in accessing conventional maternal healthcare. In Ghana, a majority of men rather than women went to school and thus majority of women remained illiterate. This suggests that most women were unable to comprehend many of the rudiments and terms of the formal healthcare system. Some women preferred to use the services of TBAs due to the fact that they did not understand much of what they were told in the hospital and the nurses there did not want to waste much time on them.[176]

Table 6: Percentage Distribution of Population 15 years and above by school attendance 1960, 1970 and 1984.

Gender	Never Attended	Attended In the Past	Presently Attended	Total Number
Males				
1960	6.9	23.8	6.3	1,884,552
1970	54.0	34.1	11.9	2,227,000
1984	39.9	48.1	12.9	3,261,072
Females				
1960	89.4	8.8	1.81	1,845,757
1970	17.3	17.2	5.48	2,316,348
1984	59.8	33.3	6.84	3,499,893

Source: Ghana Statistical Service, Analysis of Demographic Data, Vol. 2, Accra, 1995, GHA/89904, p. 206.

Culturally many Ghanaians did not send their girl-children to school and as indicated in table 6 above, even though the population of women was higher than men, the number of women who attended school in the past, were so few and did not form 10% of the entire population. This meant that a majority of women at least from 1960 to 1984, and were sound enough to give birth (15 years and above) could not appreciate or comprehend some medical

[176] Interview with Margaret Anin, a mother in Accra, 5 August 2018.

terms and policies of the formal healthcare system. The inability to understand how the formal healthcare system worked or even to communicate with the healthcare provider presupposes that many women could not ask questions about their health status or even suggests the type of treatment to be given out to them.

This implies the tendency to resort to traditional methods, where TBAs were known to carefully explain processes and methods to patients, and because they lived in the same community with their clients, accessibility to such knowledge was easy to come by and could be sought for at any time.

5.4 Attitudes of Conventional Healthcare Providers

An alarming gap that the conventional healthcare system had exhibited was the poor attitude of its workers. There is no doubt that many women refrain from going to the hospital because of the harsh tone and undesirable attitudes of some health personnel. A mother interviewed mentioned that the nurses talked to pregnant women harshly with little regard for their condition. This attitude did not allow them to freely express how they felt and they also refrained from asking any questions out of fear of being embarrassed.[177] This was a woman who had three children and had delivered the first in the hospital and the other two with a TBA. She further mentioned her distaste for hospitals and her interest to always seek the services of TBAs in future due to their kind attitude. Other women in the rural areas complained that the nurses in the hospitals were too busy and did not have enough time to care for them.

[177] Interview with Comfort Mensah, a mother in Winneba, 2 August, 2018.

Even in the urban areas, there were cases of unprofessional conduct by some nurses that dented the image of the formal healthcare system. A Member of Parliament narrated an ordeal of his relative to the house in 1970. He mentioned that,

> I should like to narrate an experience, which I had even in the Korle Bu Hospital when my brother's wife was admitted there for treatment. She was suffering from a tummy trouble or some stomach trouble and she was actually attended to by one of the best surgeons in this country in the person of Dr. Easmon. It was even necessary to operate on this patient and after the operation the medicine prescribed by the medical officer had been administered. But later on she started to complain of pains in her tummy. I went again the next day and she continued to complain, and so it was necessary for another operation, and when she was operated upon the amount of pus that came out of her tummy was anybody's guess. What had been happening was that she had not been given the treatment that had been prescribed by the doctor. The nurse who should have given her the drugs hid the drugs instead of giving them to the patient. Later on we raided the Korle Bu nurses quarters and we seized as many as 250 bottles of penicillin from some of the nurses.[178]

What makes this experience alarming is the fact that it took place in one of the very well established medical institutions in the country, Korle Bu Teaching Hospital, and in an urban area where western medical services were more scrutinized. One cannot imagine what the situation was like in the rural areas, where there was less supervision and monitoring.

5.5 Coverage versus Population Growth

In 1969, a population policy was introduced and stated that, "Recognizing the crucial importance of a wide understanding of the deleterious effects of unlimited population growth and of the means by which couples can safely and effectively control their fertility, the Government will encourage and itself undertake programmes to provide information, advice and assistance to couples wishing to space or limit their reproduction. These programmes will

[178] Parliamentary Debates, Second Series – Vol. 3, National Assembly Official Report, Session 1969 – 70.

be educational and persuasive and not coercive."[179] This statement was an indication of the government's commitment to involve everyone in accepting family planning in order to reduce Ghana's population to a manageable level. However, comparing the personnel available to the country's population, this was not achievable.

In order to realize the family planning agenda, TBAs had to be included in the formal healthcare system. The inclusion of TBAs became even more necessary due to their large clientele as compared to the conventional health personnel. Inclusion of TBAs meant that women who did not have access to conventional healthcare or were unwilling to seek the services of conventional healthcare providers would still gain insight on family planning techniques through the TBAs they consulted in their communities. This way, the family planning idea reached a larger population. That is to say that family planning played a key role in the decision to include TBAs in the formal healthcare system, and this was necessitated largely by the unfavourable economic conditions of the country. Additionally, the inability of the conventional maternal healthcare to reach all rural areas played a role in making TBAs indispensable.

[179] As cited in the Ghana Statistical Service, Analysis of Demographic Data, Vol. 2, Accra, 1995, GHA/89904, p. 31.

Table 7: Population of Ghana by Regions, 1960 and 1970

Region	Population (1960)	Population (1970)
Greater Accra	491, 817	903, 447
Eastern	1,094, 196	209, 828
Western	626, 155	770, 087
Central	751, 392	890, 135
Volta	777, 285	947, 268
Ashanti	1, 109, 133	1, 481, 689
Brong Ahafo	587, 920	766, 509
Northern	531, 573	727, 618
Upper West	288, 706	319, 865
Upper East	468, 638	542, 858
Total	6, 726, 815	8, 559, 313

Sources: 1960 Population Census of Ghana, Vol. 1, Accra, 1962 1970 Population Census of Ghana, Vol. 111, Accra, 1975.

In 1960 Ghana's population was 6,726,815 and increased to 8,559,313 by 1970 as shown in Table 7 above. The rise in the country's population within this period paralleled a high rate of inequality in the provision of healthcare services when compared with the number of health facilities and personnel available. In table 7 above, figures indicate that a high number of health facilities existed in Greater Accra, even though that region recorded a lower population figure than the Eastern and Volta Regions, the latter having lower numbers of health facilities than the former. The same can be said for the availability of maternity homes in these regions. In the three northern

regions, maternity homes were non-existent by 1971, and the number of other health facilities was 23. This implies a continuous reliance on traditional methods.

Table 8: Health Service Institutions by Type 1960 – 1970

Type of Institution	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970
Gov't Hosp.	32	34	36	43	42	38	41	43	43	43	43
Regional	3	6	6	8	9	9	9	9	9	9	9
District	29	28	30	35	33	29	32	34	34	34	34
Private Hosp.	42	51	54	76	65	74	74	74	74	76	75
Missions	28	29	31	41	38	34	64	34	34	34	33
Mines	10	11	11	12	11	12	12	12	12	12	12
Commercial	1	1	1	1	1	1	1	1	1	1	1
Private Clinics	3	10	11	22	15	15	15	15	15	17	17
Quasi Gov't	-	-	-	-	-	12	12	12	12	12	12
HEALTH CENTRES	22	27	33	41	33	38	38	38	38	40	38
HEALTH POSTS	-	-	-	-	-	-	-	-	-	-	-
Total Number of Institutions	74	112	114	160	140	150	153	155	155	159	156

Source: Ghana Statistical Service, Analysis of Demographic Data, Vol. 2, Accra, 1995, GHA/89904.

The population in the various regions compared to the number of facilities and medical personnel available, as shown in tables 8 and 9, corroborates the fact that health provision was insufficient and also suggests that a majority of people, especially in the rural areas where these facilities were few, did not have access to them. Also this goes to show that they continually relied on traditional practices. In fact even in the urban areas it

was reported that some Ghanaians relied on quack doctors.[180]

Table 9: Distribution of Hospitals by Region, 1971

Region (s)	No. of Gov't Health Centre 1970	No. of Maternity Home 1971	No. of General Hospitals 1971 (excluding special hospitals)	Quasi - Gov't Hosp. 1971	Mission Hosp. 1971	Mines Hosp. 1971	Private Hosp. 1971	Rural Health Centres	Total number of Health facilities
Greater Accra	7	21	4	**4**	**4**	**0**	**4**	**0**	**44**
Eastern	0	9	8	**1**	**0**	**2**	**1**	**8**	**29**
Western/ Central	1	14	9	**2**	**6**	**8**	**0**	**6**	**46**
Volta	0	6	5	**1**	**7**	**0**	**0**	**4**	**23**
Ashanti (Asante)	2	16	3	**2**	**5**	**2**	**11**	**6**	**47**
Brong-Ahafo	0	3	1	**1**	**7**	**0**	**0**	**6**	**18**
Northern (Upper East and Upper West included)	0	0	9	**1**	**5**	**0**	**0**	**8**	**23**
Total	10	69	39	**12**	**34**	**12**	**16**	**38**	**230**

Source: Ghana Medical Facilities, ADM 5/4/48, PRAAD, Accra.

5.6 Socio-Cultural Beliefs

The culture of a people generally denotes their way of life, which is also characterized among other things by their beliefs, values, lifestyle, customs and behavior. These attributes could be found in their everyday activities

[180] Parliamentary Debates, Second Series – Vol. 3, National Assembly Official Report, Session 1969 – 70.

including child delivery. Therefore it was commonplace to find out that there were certain beliefs associated with pregnancy and delivery in a given culture, which continued to be observed despite the introduction of conventional healthcare or influences from foreign cultures. The existence of festivals and family connections despite migration have continued to preserve some of these traditions[181] including those associated with pregnancy and delivery.

Because socio-cultural beliefs are unique to different communities or societies, it takes the person who hails from the community, grew up there or specifically studied their culture to have knowledge of, and appreciate their culture. Since TBAs are within the communities where they practiced, they knew and observed most of these customs. It is not an error to conclude that they remained the custodians of indigenous pregnancy related customs. Some of these customs included wearing of beads or ornaments, avoidance of market places, or eating limited amounts of eggs or protein and honey by pregnant women.[182]

However, for those trained in conventional healthcare, many of them did not know the customs of the people whom they served. As far as they were concerned, many of the customs were detrimental to the life of the mother and child. Many nurses complained of the refusal of TBAs to make their clients eat eggs and some protein foods due to their customs. However, a TBA interviewed explained that, they did not prevent pregnant women from eating eggs, but rather advised them to limit the intake. This was because, if the baby

[181] Pellow et al, *Coping with Uncertainty*, 91
[182] Dove, 'A Return to Traditional Health Care', 825. 112

grew fat, this could cause problems during delivery.[183] This went to show that conventional healthcare providers did not understand how these TBAs operated, and did not also understand many of the customs observed in societies in Ghana, which could also be explained to have a positive rationale.

Clearly, at the dawn of introducing conventional healthcare, little or no attempts were made to understand the rationale of some pregnancy related customs. This however caused a gap in assessing conventional healthcare due to the fact that several Ghanaians still kept in touch with their customs and traditions. The lack of knowledge in and inability to appreciate the customs of the people, also stemmed from the fact that these conventional healthcare providers were posted to new areas other than where they themselves grew up. An appreciation of the people's culture and willingness to understand these was an important tool to bridge the gap to accessing conventional healthcare.

In Accra, an Environmental Health Officer interviewed mentioned that TBAs had great knowledge that should have been tapped into by the government for use by conventional health providers. Being a native of Accra, he easily accepted some cultural practices of TBAs and affirmed that some of these cultural practices including the use of certain herbs as remedies for complications, worked anytime it was applied.[184] As a result of this the people in the community trusted the TBAs, at least as having some pertinent skills that the conventional healthcare could not provide. This explained the pluralistic nature of seeking healthcare by Ghanaians.

[183] Interview with Sarah Agyeman.
[184] Interview with Mr. Brunt.

5.7 Conclusion

At the dawn of independence, the Government of Ghana (GOG) was silent on the use of TBAs. The government continued the socio-economic and political policies and practices of the colonial government. When the government shifted its position to socialism and nationalism in 1960, Africanizing the civil and public services formed a part of this policy. However, no attempt was made to include TBAs or improve their profession to meet any accepted standards of the country. For the postcolonial government, socialism and nationalism included particularly, the modernization and industrialization of Ghana by the use of Ghanaians to Africanize various sectors of the economy. Therefore, with regards to health, the government focused on improving the formal healthcare sector, by training more Ghanaians as conventional healthcare persons and providing the needed facility. By doing so, the existence of TBAs was largely neglected until the 1970 and 1989 reorientation of TBAs.

The social and economic conditions after colonialism however showed that TBAs continued to be a valuable resource for the country. In many areas where the government failed to provide the maternal health needs of the people, TBAs filled that gap. Based on the socio-economic conditions of the country, it is presumed that most women relied on traditional methods, as the number of health personnel who graduated each year could not meet the demands of the increasing population.

Despite efforts to induce women to seek hospital care, a majority of Ghanaians, even those who had access to western medical facilities did not go

to the hospital. There were two main reasons for their behaviour. One was the treatment they received and the inadequate attention of western trained medical staff. The other was the fact that the numbers of medical personnel were insufficient and patients sometimes had to wait two to three days to see a doctor.[185] Therefore reliance on TBAs was as a result of the inability of the formal healthcare system to cover the entire country with healthcare, coupled with the treatment of patients at the hospital, which made some patients recede from accessing conventional healthcare.

Also, illiteracy and the lack of education became a barrier to seeking of conventional healthcare. On the other hand, most African midwives were preferred to western trained midwives and nurses by pregnant women due to their skills in delivery, the cost of service, which was generally very low, and the women knew them and therefore trusted them.

There is little doubt that the general socio-economic situation of the country by 1970, greatly informed the need to reorient and use Traditional Birth Attendants, which provided available and cheaper resource to deal with the poor conditions of maternal health and the general quality of healthcare provision in the country. The knowledge of TBAs concerning the cultural beliefs of their clients also played a role in maintaining their clientele and inducing more women to seek their services.

[185] Parliamentary Debates, Second Series – Vol. 3, National Assembly Official Report, Session 1969 – 70, 456,

CHAPTER SIX

SUMMARY AND CONCLUSION

This thesis has explored government's policy on the practices of Traditional Birth Attendants (TBA) with the introduction of conventional maternal healthcare in Ghana from 1931 to 1992. It examined how these policies affected the social status of TBAs and their provision of maternal healthcare in Ghana. It focused on the exclusion and inclusion of TBAs in the formal healthcare system. It was argued that, the inclusion of TBAs through policy implementation was as a result of the need to augment the formal healthcare system, and not as a result of improving the professional or social position of TBAs. Also the decision to include TBAs in the formal healthcare system was influenced by different factors and this thesis focused on the gaps inherent in the provision of conventional healthcare that indirectly sustained the operation of TBAs.

Before the colonial experience and contact with the western world, TBAs remained the only maternal healthcare providers in Ghana. The introduction of conventional healthcare in the county led to the sidelining of TBAs whose practices were deemed unworthy to provide maternal healthcare to women. However the colonial government was unable to cover the entire country with conventional healthcare. Yet, the colonial government introduced the Midwives Ordinance in 1931 that banned TBAs from practicing. Though, the ordinance sought to include TBAs by training them, several TBAs were not included in this training process as the training of midwives in general was done at a limited number each year. Moreover, the conventional healthcare

system introduced came with its own problems. This included, but was not limited to, the prioritization of infant health over maternal health. This was coupled with the lack of facilities and limited human and material resources.

This thesis has shown that the practices of TBAs, which justified their ousting in the colonial period, was not the sole rationale for excluding them in the formal healthcare system. In the colonial period, the need for the government to impose the superiority of the western culture cannot be overlooked, and reaffirms the fact that their changing roles in the postcolonial period was as a result of a lingering wish to phase them out of the system. Nonetheless TBAs continually practiced their culture of medicine despite a ban on their practices. For some, that was the only thing they knew how to do. A TBA interviewed indicated that she could not bring herself to stop because it was a gift received and it was her duty and responsibility to make others benefit from it.[186]

In the postcolonial period, the existence of indigenous midwives was for a long period neglected. This was evident in the introduction of policies like the Nurses and Midwives Act of 1966 and the Nurses and Midwives Decree of 1972. By defining who was qualified to be a midwife, TBAs were projected as illegal midwives. Deborah Pellow et al have mentioned that, TBAs were banned from practicing in 1972 through the decree.[187] In 1978, a more progressive declaration, the Alma Mata Declaration on Primary Health Care was established by the Ministry of Health. The Declaration recognized TBAs as significant stakeholders in the provision of maternal healthcare services

[186] Interview with Sarah Agyeman.
[187] Pellow et al, *Coping with Uncertainty*, 115 – 119.

especially in the rural areas. This helped to clear some notions that TBA practices were illegal as depicted by the Nurses and Midwives Ordinance of 1972.

In 1970 the government recognized the roles TBAs could play in maternal healthcare in Ghana during the rolling out of the Danfa Rural Health and Family Planning Project. On this project, which also became a pilot to reorient TBAs, TBAs were recognized as already existing resource that could help in achieving the aims of the Danfa project, which sought to educate people in all rural areas on family planning amongst other health related issues. International Non-Governmental Agencies and Christian missionaries played diverse roles in improving maternal health in Ghana, and in the initiative to include TBAs in the formal healthcare system. First of all they believed in the potential of TBAs to aid maternal healthcare in the country. Also they took the initiative to fund reorientation programmes and also offer training to TBAs.

Unlike the Danfa project, the National Traditional Birth Attendants (NTBA) reorientation and training was started from the roots as a project to reorient TBAs, and expected the Ministry of Health (MOH) to continue the training on long-term basis. The guidelines used for setting up the NTBA programme included among other things, the need to involve the community and get their collaboration in placing TBAs who were chosen by the community, acceptable to the community members and given the confidence to render the services needed by the community. The curriculum of the TBA programme showed that in reorienting TBAs, their culture and beliefs, as well

as their socio-economic conditions were largely neglected and this explains the effect it had on TBA's provision of maternal healthcare in Ghana. Due to persisting social-cultural and economic conditions, some TBAs reverted back to their traditional practices.

That is, TBA reorientation programmes, which saw their inclusion into the formal healthcare system, to a large extent, did not meet intended outcomes. This was as a result of the lack of consultation with TBAs and women concerning which ways to include TBAs so that their socio-cultural and economic backgrounds would have been considered in structuring the reorientation programmes.

The most significant effect of TBA reorientation in the 1970s and 1990s was the confidence of TBAs to refer their patients to the hospital or health centres upon realization that they could not help them anymore. Also it affirmed their status with the Chiefs, community leaders, decision makers, and the MOH workers and eradicated their fear when practicing obstetric and doing referrals.[188] That said, it is right to suggest that the TBA reorientation did not entirely fail.

An analysis of the TBA reorientation and training programmes showed that it did not affect the training of conventional healthcare in terms of limiting the financial resources available for the training of maternal healthcare providers. First and foremost, these training programmes were funded with help from International Agencies. Also, the study structure, curriculum and

[188] Rose M. Schneider et al, 'Final Evaluation of the Ghana National Traditional Birth Attendant Program', *PTAP DUAL Inc. and Int. Science and Technology Institute Inc.; Virgina (*1992), 19.

schedule of the programmes indicate that time spent in reorienting and training TBAs was far lower than time spent in training conventional healthcare providers. This suggests that TBAs were viewed as having the knowledge and skills pertaining to delivery. However, the reorientation suggests attempts to change specific practices of TBAs such as unhygienic practices of not wearing gloves whiles practicing.

This research has shown that with the introduction of conventional healthcare, the health seeking strategy of Ghanaians was pluralistic. Despite efforts to make women seek conventional healthcare, Ghanaian women chose both services, thus traditional and conventional. This largely explained the need to include TBAs. This pluralistic attitude towards seeking healthcare also brought to bear the gaps in conventional healthcare, to understand why women would choose both traditional methods rather than conventional healthcare. In understanding these gaps, the socio-economic conditions, educational status, population and access to conventional healthcare and cultural beliefs were factors discussed.

In the immediate postcolonial period, though the Nkrumah government had preached Africanization and nationalism, this did not reflect on how TBAs were treated as far as maternal health was concerned. Being one of the oldest African institutions of the country, one would have thought that the idea of Africanization and nationalism would have sought to improve the welfare of TBAs. However, that was not the case; the existence of TBAs was neglected while much effort was made at improving the conventional healthcare system just as was done in the colonial period.

Indicators like the economy and high population growth rates helped to establish the continuous failure of the conventional health system and continuous reliance on TBAs. Also, low levels of education especially in women, who are of considerate relevance to this research, explained the inclusion of TBAs. Because majority of women did not have the opportunity to be educated, they were economically handicapped and this suggests their inability to afford conventional healthcare. On the other hand, the services of TBAs have been rather cheap. Also the inability of the government to train more health personnel influenced the continuous dominance of TBAs.

This thesis was mainly shaped by the question of how government and policy makers conceptualized the roles that TBAs played that led to their reorientation and use. This question was raised as a result of the various polices that were introduced and the effect on TBAs. To answer the question, the research focused on government policies that affected TBA practice in Ghana. The thesis has shown that policies affecting TBAs from the colonial to the postcolonial period suggests a lingering wish to face out TBAs.

TBA reorientation programmes started in the 1970s indicated a policy to reorient and include TBAs in maternal healthcare provision; however, these programmes did not aim at enhancing the profession of TBAs. Rather TBAs were included after it was realized that TBAs could be a valuable resource in maternal healthcare provision especially due to gaps in conventional healthcare.

That is TBAs played in terms of care and knowledge of their skill, which was combined with their knowledge in the cultural beliefs of Ghanaian

women, and therefore created an irreplaceable bond with Ghanaian women, and as such, attempts through policy implementation to ban them from practicing, in the colonial and postcolonial periods failed.

The policies introduced between 1931 and 1992 showed some inconsistency with regards to policies concerning TBAs. Whiles others sought to ban TBAs, others, especially from the 1970s tried to include TBAs in Ghana's maternal healthcare delivery system. In light of these inconsistencies, this thesis proposes that future research looks into whether TBA reorientation programmes were detrimental to the training of conventional healthcare providers. Also, policies concerning other indigenous healthcare providers like Indigenous or Traditional Medical Practitioners (TMP) present another case that can be studied to understand how government dealt with TMP with the introduction of conventional healthcare in the Gold Coast and Ghana.

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Afua Mansa	75	Traditional Birth Attendant	29 May 2017	Winneba
Akua Nyinsin	69	Traditional Birth Attendant	23August 2016	Esuekyir
Comfort Mensah	75	Mother of 3 children	2nd August 2018	Winneba

Margaret Anin	79	Mother of 5 children	5th August 2018	Accra
Mr. Briant	55	Environmental Health Officer	17 December 2016	Danfa Health Center
Nii Afutu Brempong III	70s	Chief of Danfa, Medical Records Officer at the Danfa Health Centre from 1969 – 1976,	5 December 2016	Danfa
Osofo Kakraba Stephen Nartey	49	Traditional Birth Attendant	23 August 2016	Esuekyir
Sarah Agyeman	72	Traditional Birth Attendant	14 January 2017	Akpoma

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