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Women Assisting Women in a Village in Ghana: The Role of Traditional Birth Attendants in Wurubegu-Anansu

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Report

Abstract

This article examines the impact of traditional birth attendants (TBAs) in rural areas of Ghana and Wurubegu-Anansu community in particular. It examines the challenges that TBAs face as well as the reasons why pregnant women in the community find it difficult to attend antenatal check-ups at modern health centres or hospitals. The narratives bring to the fore the kind of advice that TBAs give to women who go to them for antenatal care as well as delivery care. The absence of a clinic within the Wurubegu-Anansu community was identified as one of the many reasons for pregnant women resorting to TBAs for assistance when their time is due for delivery. The findings suggest that TBAs in the study area do not practise on a full time basis because of the meagre income they receive after assisting women in delivery. TBAs therefore engage in different economic activities to support their families. Most of them engage in farming activities or in petty trading and only attend to women when the need arises. If the government of Ghana is unable to provide health facilities in all rural communities in the country, it should adopt the reformist approach through the auspices of the ministry of health. Thus, it should continuously equip and empower TBAs with medical training and delivery tools to enable them to carry out safe and efficient deliveries rather than encourage any policy or action that will hinder their activities.

Keywords: Traditional birth attendants, Pregnant women, Ghana, Antenatal care

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Introduction

According to the World Health Organization (WHO), traditional birth attendants (TBAs) are individuals who assist the mother during child birth and who have initially acquired their skills by delivering babies themselves or through an apprenticeship to other TBAs (WHO, 1992). TBAs are only specialist in obstetrics, but they sometimes give sex education (Kennedy, 1999). TBAs also provide women with basic health care, support, and advice during and after

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childbirth based principally on the know-how and information they acquired informally through the traditions and practices of the communities where they practice (WHO, 2010).

The role of TBAs started to be taken seriously in the early 1950s when high maternal mortality became a concern in many developing countries (Shamsu-Deen, 2013). TBAs around the world especially in developing countries have contributed enormously to the reduction of maternal mortality. Globally, it is estimated that TBAs assist in about 60% to 80% of all deliveries and even more in rural areas (Fatmi, Gulzar, & Kazi, 2005). Ghanaian women have been delivering their own babies for almost two thousand years using the knowledge which was passed down from their elders and medicines prepared from herbs (Kennedy, 1999). In Ghanaian communities, the most important function for a married woman is to bear children, and if for some reasons she cannot fulfil this role, she becomes the object of ridicule and scrutiny (Gyekye, 1996). In Ghana, a TBA is usually an old woman with little or no formal education and she frequently has another job in addition to being a TBA (Kennedy, 1999).

TBAs are usually elderly women (generally over 40 years of age) who are mothers and members of the community who help to deliver babies, and are known in their communities for their good outcomes during deliveries and affordable prices (Singh, 1994; Wyatt, 2001; Kruske & Barclay, 2004; Adu-Gyamfi, 2010). In pre-colonial Asante, a person who assisted women during delivery was seen as a TBA and such a person had the requisite knowledge to attend to deliveries after she had successfully gone through a successful apprenticeship with an experienced TBA (Adu-Gyamfi, 2010).

TBAs speak the local dialects and their practices are consistent with those of the community and also provide cultural consistency in the childbearing process; they have trust and respect in the communities in which they serve (Lefeber & Voorhoever, 1997; Chipfakacha, 1997; Paul, 1999). Among the characteristics that one has to possess in order to be regarded as a TBA are good delivery outcomes, and a strong personality along with the warmth and patience that will enable the birthing woman to move through the event with courage, power, and ease (Bajpai, 1996; Smith, 2006).

Jeffery, Jeffery, and Lyon (1984) observed that TBAs did not have any skills or previous experience before assisting their first delivery. This argument by Jeffrey et al. (1984) seems anecdotal because it will be very difficult for one to assist in delivery if he or she has no knowledge about it. Maya (1999) has argued that, generally, TBAs assist in births as a secondary occupation as it is difficult to earn a living by working only as a TBA because it is a low-paying job. For instance, Hitesh (1996) has posited that given the cost involved in accessing the formal health care service in India, TBAs are much more affordable for low income earners. Moreover, Adu-Gyamfi (2010) has reported that TBAs in Asante, in pre-colonial Ghana, advised pregnant women not to consume much protein since it can cause the foetus to overgrow in the womb and also advised them not to take alcoholic beverages which was seen by TBAs as harmful to the health of the mother and foetus.

Significantly, anthropological research suggests that the postpartum healing of the body parallels the social reintegration of the person and has a symbolic, physical, and social value in the community; this service is duly rendered by the TBA (Pinto, 2006). TBAs are also noted for their potential in reducing prenatal mortality. Sibley, Sipe, and Barry (2012), in their systematic review, concluded that "the potential of TBA training to reduce peri-neonatal mortality is promising when combined with improved health services." Trained TBAs may have more knowledge and willingness to disseminate information about breastfeeding and immunization than untrained TBAs;

however, the mother's health practices are independent of the suggestions provided by the TBA (Goodburn, Chowdhury, Gazi, Marshall, & Graham, 2000). TBAs have a complex status which is associated with pollution, but, on the other hand, they are very much needed and required by the community (Smith, 2002). Traditionally, the TBA's role in reproductive health begins immediately after a woman becomes pregnant (Swantz, 1996).

TBAs are seen as educators of pregnant women on appropriate meals to take, pregnancy-related taboos, and how to take care of newborn children after birth (Eresund, 1979; Cosminsky, 1983). Some of the taboos and previously strict preferred ways of life for pregnant women may be currently seen as negative factors in the health of the expectant mother and her child. In the management of pregnancy and child delivery, "TBAs frequently examine the vagina often using bare hands and apply herbal medicines to the vulva or vagina to ensure health of the growing foetus and safe delivery" (Adu-Gyamfi, 2010). However, Kayombo (2013), among others, contrasts this position. For instance, Kayombo (2013) argues that some of these practices may cause genital infections including pelvic sepsis which is noted to be one of the principal causes of infertility, menstrual disorders, and ectopic pregnancies.

Medical doctors and professionally trained midwives, with the exclusion of TBAs, are the main maternal health professionals in Ghana especially in urban areas. Most TBAs in Ghana practice in rural communities like Wurubegu-Anansu; however, there are a few of them who still practice in cities and towns that are still attached to their culture. Women who patronize the services of TBAs are often within the same areas that they operate which helps to create an informal and relaxed relationship between them. TBAs (trained or untrained) assist in about one-third of all deliveries in Ghana due to the government's inability to provide maternal health delivery posts in every community in Ghana (Twumasi, 1998). Wurubegu-Anansu, a farming community in the Atwima Mponua District of the Ashanti region, is one of the rural areas in Ghana that does not have a health post which sees to the health needs of the people, especially maternal health care for women within their reproductive age. The absence of a formal health post has caused TBAs to take up the responsibility to provide maternal health care delivery services to women within the community. However, women who wish to be attended to by professional midwives have to trek afoot and sometimes risk their lives and that of the unborn child.

In September 2000, the United Nations (UN) signed the United Nation Millennium Declaration, which launched the 8 Millennium Development Goals (MDGs). Among these goals is the MDG 5 which seeks to improve maternal health globally with a target of reducing the maternal mortality ratio across the world by 75% between 1990 and 2015 and achieving universal access to reproductive health by 2015 (World Health Organization, 2015). Ghana, being a member of the UN has the duty to ensure that the set goals of the MDG 5 are achieved by the stipulated time. Past and present governments have put many resources into the health sector of the country through the provision of modern maternal health care delivery equipment and facilities in addition to the training of skilled birth attendants (like midwives) to ensure safe delivery for women in labour. However, despite the efforts of the government to attain the set goals of the MDG 5, the Ministry of Health (MoH) has not been able to provide formal health posts with maternal health care facilities in every community, especially in Wurubegu-Anansu. Due to the situation at hand, pregnant women, who want to be attended to by professional midwives and doctors during antenatal, delivery, and post-delivery periods, have to trek long distances or risk their life and that of the unborn child

by boarding vehicles that ply the bad road that links Wurubegu-Anansu to Bibiani government hospital which is about 20 Km away. TBAs therefore become the only option for most women in Wurubegu-Anansu to resort to when they are pregnant or in labour. This research therefore seeks to investigate the impact that TBAs have on the reproductive lives of women in rural areas of Ghana, focusing on Wurubegu-Anansu.

The United Nations Population Fund (UNFPA) has also noted that the percentage of skilled attendants in developing countries also increased from 42% to 52% from the years 1990 to 2000, a representation of 24% in developing countries as a whole (Abou-Zahr & Wardlaw, 2003). The WHO, in the 2007 report on the proportion of births attended by skilled attendants, estimated that 63.1% of births are attended to by skilled professionals globally, 59.1% in more developed countries, whilst 34.3% in less developed countries (World Health Organization, 2007). However, in Ethiopia, Niger, Chad, and Burundi, this rate was 9.8%, 15.7%, 16.2%, and 19.1%, respectively (Cotter, Hawken, & Temmerman, 2006). Cotter et al. (2006) also noted that the rate of deliveries assisted by skilled personnel is still very low. Concerning Ghana, the WHO in 2007 confirmed that the proportion of births attended to by skilled professionals in 2003 had been 47% (WHO, 2007).

The proportion of skilled attendants during delivery has increased in the whole world as mentioned above, but the fact remains that the target set by the MDGs (2000), which calls for 90% of births to be delivered by a skilled attendant, has still not been met. As reported by the UNFPA on the progress in the field, Botswana, Burundi, Senegal, Uganda, and Zimbabwe have developed policies defining a skilled attendant and strategies to increase the proportion of deliveries they attend. They indicted that, in Burundi in 1995, only 9.5% of deliveries took place in health facilities. Burundi has since that time designed a reproductive health programme which has designated strategies to increase the proportion of attended births, such as enhancing the technical capacity of personnel and facilities and promoting the use of pantographs during labour (Abou-Zahr & Wardlaw, 2003). From the above indications, it is clear that the mechanisms which have been put in place to augment the services of skilled attendants are not enough since most rural communities are still underserved.

In contemporary Ghana, there is much talk on the human resources crisis in the health sector. In such a setting, the potential for utilizing TBAs, even if under demoted circumstances, is paramount. Thus, understanding their current practices, their future roles, their effectiveness, and women's barriers to accessing modern healthcare is critical. Zahr and Wardlaw have posited, through the reviewing of data from the Demographic Health Surveys (DHS) of 45 developing countries, a possible and continuous link between the use of antenatal care and delivery by skilled personnel. They further noted that, women reporting for 4 or more antenatal visits are far more likely to give birth with professional assistance than women reporting for fewer visits (Zahr & Wardlaw, 2003). The 2003 Ghana Demographic and Health Survey (DHS) report also showed that 59% of women with 4 or more antenatal visits delivered with skilled assistance in a health facility in contrast to just 10% of women who did not receive antenatal care delivery at a health facility with skilled personnel in attendance (Ghana Statistical Service (GSS), 2003). Even though the majority of hospitals with a maternity ward in Ghana have a waiting room, many women still choose not to stay because of the unpredictability of the amount of time they will have to wait. Figa-Talamanca has argued that among other things pregnant women have noted that the costs of food, transport, and the requisite family member or guardian to assist them due to shortage of staff are hindrances in waiting at the hospital (Figa-Talamanca, 1996; Maimbolwa, Yamba, Diwan, & Ransjo-Arvidson, 2003).

Approach

The present research focused on the impact of the activities of TBAs on the maternal and reproductive health of women in Wurubegu-Anansu. Wurubegu-Anansu is a farming community in the Atwima Mponua District of Ghana with a population of about 700 people. It is located in the south-western part of the Ashanti Region which covers an area of approximately 895.15 kilometres with Nnynahin as its capital. Wurubegu-Anansu is one of the 323 scattered settlements of the district. Wurubegu-Anansu has a population of about 800 and it is basically a farming community with cocoa as the principal economic crop.

In this research, the mixed method design was used for the collection of both qualitative and quantitative data from both respondents and interviewees. As it was a case study, the researcher collected and analyzed data from a sample of the entire population of Wurubegu-Anansu. The study design focused mainly on TBAs and women who fall within the reproductive age range. This design enabled the researcher to explore and solicit various opinions, perceptions, and ideas of people with respect to the impact of the activities of TBAs on women in the study area. This technique was also adopted to help the researchers to perform an in-depth study of the population and explore the factors that influence maternal health. A combination of the research instruments of questionnaires and interview schedules was adopted for this research. The questionnaires were used to collect data from the 45 women in the study area. The 45 respondents who responded to the questionnaires consisted of women who were in the reproductive ages. The interview schedule was used to collect data from 5 practicing TBAs selected from the target population. To facilitate the data collection process, both closed and open-ended questions were incorporated in the drafting of the questionnaire. The close-ended questionnaire asked respondents to provide brief responses by merely ticking the spaces on variables such as age, sex, and occupation. This enabled the respondents to provide quick and time saving responses. The open-ended questions were fused into the questionnaire items to enable the researchers to gather responses on the views, perceptions, and ideas that respondents had about TBAs in Wurubegu-Anansu.

Both the closed and open-ended questions were found to be very helpful, since they assisted many respondents in providing their views, reasons, and responses needed for the research. It also enabled the researchers to get a general overview of the attitudes, views perceptions, and life experiences of the respondents. The interview schedule was used to fill the gaps associated with the questionnaire survey. The interview schedule was used to solicit information from TBAs who had been identified as indispensable stakeholders of maternal health care delivery in Wurubegu-Anansu. Thus, 10 open-ended questions were drafted on issues related to challenges TBAs encounter during the provision of their services. The interview offered the TBAs the opportunity to exhibit their skills and also portray their professional experiences. To ensure the reliability of the research findings, the researchers conducted a one-on-one interview with the interviewees (TBAs). The interviews were recorded and played back to the interviewees to ascertain the accuracy and authenticity of the data collected. Interviews were conducted in Asante-Twi and later transcribed into English. The data was pieced together to form a thematic presentation on the role of TBAs in Wurubegu-Anansu, which has wider ramifications for maternal health in Africa and Ghana in particular.

Discussion

The researchers set out to answer the following questions among others in the study area:

1. What is the nature of the practice of TBAs in Wurubegu-Anansu?
2. What are the views and perceptions that

people have about TBAs in Wurubegu-Anansu?

3. What are the impacts that TBAs in Wurubegu-Anansu have on the maternal healthcare of women?

4. What are the challenges that TBAs in Wurubegu-Anansu face in the provision of their services?

Based on the data presented in table 1, with regard to age distribution of respondents, 48.9% were 26 to 30 years of age and 15.6% were above 30 years of age. Moreover, 14 out of the 45 respondents (31.1%) were 21 to 25 years of age, whiles 2 of the respondents were below 21 years of age. As much attention was given to the ages of TBAs as the respondents. The ages of the 5 TBAs that were interviewed for this study ranged from 52 years to 75 years. In terms of parity, 17 out of the 45 respondents (37.8%) had at most 2 children, while 57.8% and 4.4% of the women, respectively, had 3-5 and 6-7 children.

All the TBAs who were interviewed indicated that they have children. Out of the 45 respondents, 6 were single, 30 were married, 5 were widowed, and 3 were divorced. Only 1 of the respondents did not indicate her marital status. With respect to the marital status of the TBAs who were interviewed, 3 were widowed and 2 were married. The distribution of the educational background of the respondents revealed that 22.2% had no formal education and 28.9%, 46.7%, and 2.2% had attended primary school, junior high school, and senior high school, respectively. However, none of the respondents indicated that they had been schooled up to the tertiary level. Among the 5 TBAs that were interviewed, 2 had a formal education, while the remaining 3 pointed out that they had never set foot in a classroom before. However, Madam Agnes Kwartengmaa, one of the TBAs who had a formal education recounted how she was forced to stop schooling at a tender age in order for her elder brother to go through formal education. In relation to occupation, only 11.1% of the mothers who responded to the questionnaires were employed in the civil service. The other 60.0% and 28.9% were farmers and traders, respectively.

Table 1. Background information of respondents

Variable	N (%)
Age (years)	
16-20	2 (4.4)
21-25	14 (31.1)
26-30	22 (48.9)
31-35	7 (15.6)
Total	45 (100.0)
Parity	
< 3	17 (37.8)
3-5	26 (57.8)
6-7	2 (4.4)
Total	45 (100.0)
Marital status	
No response	1 (2.2)
Single	6 (13.3)
Married	30 (66.7)
Widowed	5 (11.1)
Separated/divorced	3 (6.7)
Total	45 (100.0)
Educational level	
Not educated	10 (22.2)
Primary	13 (28.9)
JHS/JSS	21 (46.7)
SHS/SSS	1 (2.2)
Total	45 (100.0)
Occupation	
Farmer	27 (60.0)
Trader	13 (28.9)
Civil servant	5 (11.1)
Total	45 (100.0)
Ethnicity	
Akan	34 (75.6)
Frafra	2 (4.4)
Gruma	5 (11.1)
Kusaasi	4 (8.9)
Total	45 (100.0)
Religion	
Christian	35 (77.8)
Moslem	10 (22.2)
Total	45 (100.0)

JSS: Junior secondary school; JHS: Junior high school; SHS: Senior high schools; SSS: Senior secondary Schools; Source: Authors field data, 2015

From table 1, it can be inferred that most of the women in Wurubegu-Anansu engage in agricultural activities which are the main occupation in the community. All the TBAs indicated that they farm in addition to their work as TBAs because they cannot cater for themselves and their families with the tokens

they receive after assisting women in delivery. Upon further question about how much they receive after assisting women in delivery, Agnes Kwartengmaa, alias Maame Kune, reiterated: "*Oh! When they come for the herbs, I take five cedis and a bottle of Akpeteshi to say prayers (apaye) for the herbs that I pluck in the bush, but after they give birth, I charge them five cedis in addition to a hen or a cock based on the sex of the child* (Participant 1).

The TBAs hinted that they were mostly satisfied with what they received from clients. They also receive additional gifts from some clients who are kind. Moreover, the reasons for accepting tokens were found in the belief that they might lose their skills and the efficacy of their medicine if they charge what would be referred to in modern times as reasonable costs or worst exorbitant charges (Participant 1). However, through the interviews with the TBAs, it was revealed that there were differences in the amount that each of them charges. One of the interviewees indicated that she charges 10 Ghana cedis, soap, and 3 eggs of local poultry in addition to a bottle of Akpeteshi (Participant 1). The study identified that the TBAs in Wurubegu-Anansu do not charge the same price. However, Kumar, 2007 has reported that the differentiation in prices charged by TBAs comes about as a result of the kind of care that their clients seek from them, the level of their experience, and most importantly the kind of relationship that exists between them and their respective clients (Borghi, Ensor, Neupane, & Tiwari, 2006).

Concerning ethnicity, 34 out of the 45 respondents were Akans, while 11 were from the northern and upper regions of Ghana. The ethnic distribution confirms that the people in the study area are predominantly Akans. All 5 TBAs who were interviewed were Akans with the exception of 1, an Ewe from the Volta region of Ghana. However, due to her long stay in the community, she is able to interact with her clients like the other TBAs because of her knowledge about the traditions of the community and above all, her fluency in the Asante Twi dialect (Participant 3).

In terms of religious affiliation, 35 out of the 45 respondents indicated that they were Christians, while the remaining 10 respondents indicated that they were Muslims. Though interviewees claimed they were either Christians or Muslims, some of them believed in ancestral worship as one of them indicated that she always asks for support from her ancestors before she assists a woman in labour (Maame Doku, 2015).

Prenatal/Antenatal care during pregnancy: Table 2 shows the raw figures on the number of visits and the responses on antenatal visits before delivery and place of delivery among others.

With regard to antenatal visits to a TBA by respondents during their last pregnancy, 71.1% of the respondents indicated that they visited the TBAs 3-4 times, and 11.1% indicated that they visited the TBAs less than 2 times. Moreover, 13.3% and 4.4% reported that they visited their TBAs 5-6 times and 7 times and above, respectively. Out of the 45 respondents, 26 first visited their TBAs within their first trimester of pregnancy with 16 and 3 indicating that they first visited their TBAs within their second and third trimesters of pregnancy, respectively. With respect to the kind of advice they were given by their TBAs, 64.4% indicated that they were given advice on diet which is very important for women and their unborn babies as noted by Adu-Gyamfi (2010).

Furthermore, 60.0% of the respondents affirmed that they were given advice on danger signs. In addition, 71.0% and 91.0% of the respondents indicated that their TBAs did not advise them on newborn care and family planning, respectively. The higher percentage of respondents who indicated that their TBAs did not advise them on family planning to a large extent explains why women in rural areas in Ghana like Wurubegu-Anansu are largely confronted with the challenge of family planning.

Table 2. Factors and reasons for antenatal visits to TBAs

Variable	N (%)
Total number of visits to the TBA	
> 2 times	5 (11.1)
3-4 times	32 (71.1)
5-6 times	6 (13.3)
7 times and above	2 (4.4)
Total	45 (100.0)
First visit to the TBA	
First 3 months	26 (57.8)
4-6 months	16 (35.6)
7-9 months	3 (6.7)
Total	45 (100.0)
Were you given advice on danger signs?	
Yes	27 (60.0)
No	16 (35.6)
Unanswered	2 (4.4)
Total	45 (100.0)
Were you given advice on delivery care?	
Yes	13 (28.9)
No	29 (64.4)
Unanswered	3 (6.6)
Total	45 (100.0)
Were you given advice on newborn care?	
Yes	12 (26.7)
No	32 (71.1)
Unanswered	1 (2.2)
Total	45 (100.0)
Were you given advice on family planning?	
Yes	2 (4.4)
No	41 (91.1)
Unanswered	2 (4.4)
Total	45 (100.0)
Where did you give birth?	
Your home	16 (35.6)
TBA's home	28 (62.2)
Other	1 (2.2)
Total	45 (100.0)
Reasons for not delivering at the hospital	
Long distance	
Yes	9 (20.0)
No	36 (80.0)
Total	45 (100.0)
No transport	
Yes	16 (35.6)
No	28 (62.2)
Unanswered	1 (2.2)
Total	45 (100.0)
Travel time	
Yes	0 (0.0)
No	44 (97.8)
Unanswered	1 (2.2)
Total	45 (100.0)
No confidence in health professionals	
Yes	6 (13.3)
No	38 (84.4)
Unanswered	1 (2.2)
Total	45 (100.0)
Better trust in TBAs	
Yes	20 (44.4)
No	23 (51.1)
Unanswered	2 (4.4)
Total	45 (100.0)
Financial problem	
Yes	24 (53.3)
No	16 (35.6)
Unanswered	5 (11.1)
Total	45 (100.0)

TBA: Traditional birth attendants
Source: Authors field data, 2015

There are significant cultural and social issues that have served as major drivers for this; they include the high status and respect traditional communities like Wurubegu-Anansu attribute to those who have given birth to more children. In several Akan societies, a husband whose wife gave birth to 10 children was rewarded with sheep.

Regarding the location in which women in Wurubagu-Anansu delivered their babies, 35.6% and 62.2% of the respondents affirmed that they gave birth at their homes or that of the TBAs, respectively. Among the 45 women who responded to the questionnaires, 36 answered that long distance to a health facility was not the main reason for them delivering at home. Furthermore, 35.6% of the women indicated that they delivered with the help of TBAs because they had no means of transportation at the time of labour; however, 62.2% affirmed that their choice of delivering with the help of a TBA was not due to the unavailability of means of transport. In addition, 44 of the respondents indicated that the time spent in travelling to the hospital had no influence on their decision to deliver at home. The same number of respondents indicated that they choose to deliver with the help of TBAs because they trust them more than the hospitals. Furthermore, 24 (53.3%) of the respondents indicated that they gave birth with the help of a TBA because they did not have the fiscal capacity to travel long distances to a hospital.

First Contact with TBAs: Among the respondents, 28.9% and 4.4% stated that their first contact with TBAs was within the second and third trimesters, respectively. However, 30 (66.7%) of the respondents indicated that they first contacted the TBAs during their first trimester, and from this it can be inferred that they were conscious of their wellbeing and that of their unborn babies. One of the TBAs stated; "Usually pregnant women come to me when they notice that they have missed their periods; they inform me that they are pregnant, and

sometimes they tell me that they are sick. Also most of them come early in order to prevent their unborn child from 'asram' which is a form of disease which enlarges the head of babies" (Participant 1). Maame Owuo, one of the TBAs also indicated that most of her clients come to her for medicine when they are in their second, third, and fourth months of pregnancy (Participant 1). In addition, 36 of the respondents hinted that they visited the TBAs because of antenatal advice, but 91.1% of the respondents indicated that they did not visit the TBAs because they had problems during pregnancy. It is also noteworthy that 71.1% of the respondents indicated that delivery care was not an issue for their visits to the TBAs, while only 13.3% indicated that they went to antenatal check-ups because they had problems with their previous pregnancies. TBAs asserted that they gave their clients many vital advices concerning their diet and lifestyle; one of them puts it this way:

"I advise them not to squat for a long time, not to eat some foods like groundnuts, okra, roasted plantain, and pawpaw. Pawpaw also serves as a blood tonic in itself, so if a pregnant woman eats it, she will bleed profusely during childbirth, and also when a pregnant woman squats a lot, her baby will vomit frequently after birth. Okra also reduces the efficacy of herbs that are administered to the expectant mother" (Participant 1).

These findings confirm Adu-Gyamfi's assertion that, in pre-colonial Asante, TBAs attached much importance to the kind of foods that they advised pregnant woman to eat during pregnancy. Significantly, when a pregnant woman eats unwholesome food, it will have a negative effect on both the mother and her unborn child.

Delivery care for Babies: Regarding the time of referral to TBAs, 75.6% of the respondents indicated that they called upon the TBAs when the labour pains had progressed, while 15.6% and 6.7% of respondents, respectively, indicated that they called upon the TBAs when the labour pains started and when the baby was about to be delivered. On the issue of when TBAs are called to assist in the delivery, Maame Kune reported that most of the women come to her house when the labour pains intensify beyond their control (Participant 1) Maame Owuo, not refuting Maame Kune's assertion, asserted that women usually call on her when the baby is about to be born (Participant 2). This revelation confirms the assertion made by Bang, Bang, Baitule, Reddy, and Deshmukh that TBAs are generally called at the onset of strong labour pains. However, Bajpai, 1996 also believes that TBAs are mostly called upon when the head of the baby is crowning.

Concerning preparations towards delivery, 64.4% of respondents made preparations toward their deliveries, while 35.6% indicated that they did not make any preparation toward delivery. The majority of the respondents indicated, among other things, that they prepared for the safety of their babies. The preparation included buying items that they would need during the early stages of post-partum. One interviewee stated: "*I bought protective clothing for my unborn child, because I knew that I was going to give birth during the harmatan season"* and *"I bought a mosquito net to protect my baby from malaria."* However, it was revealed by one of the TBAs that not all the women who come to her make preparation towards their delivery. Sometimes she assists some of them financially or in terms of necessary products in order for them to fend for their babies (Participant 3).

With respect to labour pains, 48.9% and 35.6% of respondents, respectively, indicated that their delivery was painful and very painful. Moreover, 36 of the interviewees hinted that the TBAs checked the position of their babies when they were about to deliver, while 8 of them indicated that TBAs did not examine them. In addition, 33 respondents indicated that they were not given abdominal massage; however, 21 of the respondents

indicated they were given a cervix examination when they were in labour. Furthermore, 38 of the respondents indicated that the TBAs did not check their heart beat or that of the baby.

Maternal Complications and Referrals to Health Facilities: Of the respondents, 80.0% indicated that they did not face any problems during pregnancy; however, 15.6% of the respondents indicated that they faced problems during their last pregnancy. The few respondents who indicated that they had complications reported umbilical cord prolapse, retained placenta, and failure to dilate. To establish the validity of the assertions made by the respondents on the issue of maternal complications and referral to a health facility, it was necessary to seek the views of TBAs on the subject. All the TBAs interviewed, with the exception of Maame Kune, indicated that they always followed-up when they referred women to the hospital due to complications that were above them.

Delivery tools: Among the respondents, 91.1% indicated that clean razors were used to cut the umbilical cord, while 4 of the respondents indicated that other tools were used to cut the umbilical cord. The TBAs also indicated that they use a clean razor with only 1 indicating that she uses a kitchen knife to cut the umbilical cord. With regard to delivery tools, one TBA stated; *"I have some herbs that I squeeze in my palms before I attend to women, and after delivery, I also have another herb that helps to remove or bring out the afterbirths successfully"* (Participant 1). Another TBA indicated that she takes along some herbs and salt, and cracks some palm nuts when she is going to assist a woman in delivery (Participant 4).

It is dangerous for the placenta to be retained in the mother's womb after delivery (Participant 4). TBAs use their palms to slap the abdomens' of women for some time, then, they hold the placenta to remove it; this always works because of the herbs they are given when they are pregnant (Participant 1). It is rare for the placenta to come out before the baby is born, but Maame Kune stated that there was an instance in which the placenta came out before the child was born and that child survived (Participant 1).

Post Natal care: Regarding postnatal care, 88.4% of the respondents indicated that the weight of their babies were not checked immediately after delivery by the TBAs, while 11.6% indicated that the weight of their babies were checked by the TBAs. All the respondents indicated that their newborn babies were bathed by the TBAs immediately after they were born. However, interviewees hinted that their babies were bathed with warm water and some herbs. An interviewee said: "*The TBA bathed the baby with warm water in addition with some herbs which were meant to drive away evil spirits from the child."*

Both mothers and TBAs affirmed that TBAs paid post-partum visits to their clients based on many reasons. Some pointed out that they visited their clients to ascertain at first hand the wellbeing of the mother and the child, and also to give them some vital information, an example being the kind of foods they should eat. Maame Owuo responded that her reasons for post-partum visits among others are that *"some women bleed a lot after birth. It is disturbing; that is why I check on them and also give the women advice on the kind of foods they should eat in order to replenish the blood that they lost during delivery"* (Participant 1).

In addition, 15 of the respondents indicated that they were instructed by TBAs not to eat certain foods. Nevertheless, 28 respondents indicated that they were not under any restrictions concerning the choice of food to eat as pregnant women. In connection with immunization, 73.3% of the respondents indicated that their TBAs recommended immunization for their babies, while the remaining 26.7% indicated that their TBAs did not recommend immunization for their babies. Some TBAs made it compulsory for women to take their babies to the hospital for check-ups and

immunizations after delivery and failure on the part of the nursing mother to observe the dictates of the new mother toward this end meant a forfeiture of the opportunity of being aided by the same TBA in another delivery (Participant 4).

Challenges that TBAs in Wurubegu-Anansu face: TBAs do not have permanent places to assist in delivery and this makes their work uncomfortable, since they have to trek for long distances to assist women in their homes. Moreover, TBAs are not well remunerated; they receive meagre amounts from people they assist in delivery. Furthermore, the issue of recognition and respect for TBAs in the community seem to be a challenge. One of the TBAs stated:

"My main problem is that at my age, when I am called upon to assist in delivery, they do not pay me well, so I have planned to stop. I have even decided to make an announcement that I will no longer deliver babies in this community again, because the work is too filthy and disgusting. They do not pay me well. If I ask for my money, sometimes it turns into confrontations, so I think I have to stop working as a TBA" (Participant 1).

Another TBA said: "My main challenge is our transportation network. It is too bad. I have a strong feeling that the woman who died in my hands would not have died if we had a vehicle in this town, because she started bleeding around 11 am and died around 5 pm" (Participant 1)

In this regard another TBA stated: "The main problem which hinders my work as a TBA is the fact that the government does not recognize me as a TBA" (Participant 4).

Views and Perceptions that people have about TBAs in Wurubegu-Anansu: The majority of the respondents responded that TBAs provide high quality services to pregnant women when they were asked whether they think that TBAs provide higher quality services to pregnant women compared to hospitals. One of the reasons they provided was poor treatment by nurses during delivery at the hospital. An interviewee said: "*I will say yes, because when I went to the hospital to deliver my first child, the nurses treated me badly, but the TBA is patient, caring, respectful, dedicated, and above all humble.* "However, some indicated that although TBAs are doing a good work in Wurubegu-Anansu, their outputs cannot be compared to hospital delivery which is the best. The TBAs also acknowledge this, as upon sensing danger during delivery, their first point of call is the hospital. One of the respondents stated: "*TBAs are doing a good work here, but I think that hospital care is better than TBA care because they always refer their clients to hospitals when they notice complications during delivery.*"

However, almost all the TBAs that were interviewed indicated that their family members and the members of the community think that they are doing a good job. One interviewee said: "*Everybody thinks that I am doing a good job and my family members know that I am a TBA and they also think that I am a good TBA, so they are not afraid when I am called upon to deliver pregnant women in different communities*" (Participant 1). *Maame Kune* reiterated that she is very good as a TBA, and she does not charge much so members of the community see her as a good TBA. She also stated:"*Oh! My grandmother was also a TBA, so my family members support me as a TBA*" (Participant 1).

Supervision of and Expectations from TBAs by the Government of Ghana: Among the TBAs who were interviewed, only one indicated that she was not supervised by anyone. Those who claimed that they were under the supervision of someone, stated in their responses that they were previously under supervision, but they were not at the time of conducting the interview. One of them reported that she is not under any supervision, but she has taken some short courses at the Nyinahin hospital and she is sometimes called upon to teach some people at the hospital (Participant 1).

With regard to record keeping on the work they do as TBAs, only one of the TBAs

indicated that she keeps records of the women she has assisted during delivery. She reported that she has officially assisted 480 women in their delivery since she was instructed to keep records on women that she assisted by officials from the *Gyereso* Clinic (Participant 1).

In connection with the kind of expectations that they think can help them improve upon their work as TBAs, all the TBAs interviewed for this study were quick to point out what they want because of their earlier encounters with some non-governmental organisations (NGOs) and government officials. In this regard, Maame Owuo stated:

"When some NGOs came here, they informed us that they want TBAs who can help. So, their leader instructed the Assemblyman to get me a permanent place for delivery in addition to someone who can keep records of my work, but he told me that he cannot do that because no one was willing to give him the land to build the maternity home for me. As a result of the failure of the Assemblyman to build the maternity home for me, I no longer have any hope that I will get some help again. However, if someone or the government will come to my aid what I will ask for is a permanent place for delivery, so that I will no longer walk long distances to people's homes" (Participant 1).

Furthermore, one of the TBAs who seemed to be conscious of her health indicated that, if the government or any organizations come to her aid, she will request gloves, protective clothing, and delivery tools such as scissors and disinfectants like "Dettol" to clean herself after assisting women during delivery (Participant 3). The specific expectations of the other TBAs were in line with the above expectations.

Conclusion

Antenatal care is of much importance to every pregnant woman who values her life and that of her unborn child. The present research did not point to any natural herbs that delayed ovulation or prevented pregnancy. The chances of pregnant women in urban communities, such as Kumasi and Accra, delivering at a hospital or clinic is high, but such is not the case for women in Wurubegu-Anansu. They have to continue to rely on TBAs to aid them during delivery. Unreliable means of transportation to the nearest health facility and at times financial difficulties prevented the women of Wurubegu-Anansu from delivering at a hospital or clinic. As emphasized in an earlier study by Duke (2015), some women chose to deliver with the help of TBAs because they had greater trust in them than hospital workers who often do not treat them well (Duku, 2015). Furthermore, this study showed that TBAs in Wurubegu-Anansu pay much attention to the wellbeing of women and their babies as they frequented the houses of their patients to ascertain at firsthand their health conditions after delivery and also to give them some herbs and advice concerning how new mothers are to conduct themselves to ensure their wellbeing and that of their children.

Moreover, the study revealed that transportation problems, lack of permanent delivery rooms and sophisticated tools, and low remuneration are some of the challenges of TBAs in Wurubegu-Anansu. In addition, some of the TBAs restrict pregnant women from eating some foods that have enough nutritional values because they think it is not good for pregnant women due to related pregnancy taboos. This has a trickle-down effect on the unborn child as it may be born underweight or suffer from some diseases. However, reduction in the rate of maternal and infant mortality in the community is a clear indication of some of the positive impacts of TBAs in the community.

If the government of Ghana and NGOs are serious about achieving the MDG 5 which aims at improving maternal health, more attention must be paid to the issue of building more maternal clinics in rural areas such as Wurubegu-Anansu to augment the

efforts of TBAs in the provision of maternal healthcare services. Since the provision of maternal health posts in every rural community is unattainable in the scheme of things in Ghana, the country should adopt the reformist approach which includes equipping and empowering TBAs with relevant medical training and delivery tools to enable them to carry out safe and efficient deliveries rather than victimizing them. Furthermore, the government of Ghana should set up a task force to supervise the activities of TBAs to ensure that they do not abuse the privileges they enjoy due to the respect they receive from their respective traditional communities and to further ensure that they do not violate the rights of rural women through harmful practices.

Conflict of Interests

Authors have no conflict of interests.

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