



Factors influencing the utilization of TBA services by women in the Tolon district of the northern region of Ghana

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ABSTRACT

Maternal mortality issues have become a major cause for concern especially in developing countries as they struggle to attain the Sustainable Development Goals 3.1 and 3.2. Traditional Birth Attendants (TBAs) have played a significant role in providing maternal health services, especially in rural Africa. Health service providers have done a lot to provide maternal health services to pregnant women in Ghana yet most women, especially in rural areas, still, patronize the services of (TBAs). The aim of this paper is to determine the factors that influence women in the Tolon district of Ghana to patronize the services of TBAs. The paper employed a mixed research approach and adopted the cross-sectional survey design to collect and analyse data. The study involved 360 women who have sought the services of TBAs within the last five years. Data were collected with the use of questionnaires containing both open-ended and closed-ended questions. The factors that influenced the patronage of TBAs included the fact that TBA services are cheaper, more culturally accepted, nearer to the homes of pregnant women than the hospital, TBAs being more caring than orthodox health workers and being the only maternity care that women know. It is recommended that since the factors that influence the patronage of TBA services cannot easily be abolished the health authorities should integrate TBA services in mainstream maternal health care delivery.

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Introduction

In most developing countries especially those south of the Sahara, most women do not have access to a skilled birth attendant [18] which invariably leads to the rising maternal and infant mortality [18]. Traditional Birth Attendants (TBAs) stand to help reduce maternal and child mortality. According to the World Health Organization ([18], p 18) a TBA is "a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs". Traditional Birth Attendants (TBA) have been in existence as long as the human race has inhabited the earth. TBAs play an important role as far as the delivery of maternal care is concerned, especially in rural areas [7,11]. According to Lane & Garrod, [14] TBAs are more geographically accessible and culturally acceptable to provide most of the basic but most important care that pregnant women require along with antenatal and post-natal care. Even before the introduction of initiatives to eliminate maternal mortality, TBAs have been an integral part of the community

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and recognized for their continued availability, handiness and emotional and social closeness to the community [9]. Most pregnant women in rural Africa prefer the services TBAs as against trained midwives because women believe childbearing is a normal rite of passage for women and it is supposed to be without complications which the TBA can easily handle. It only becomes necessary to consult a trained midwife if there are complications the TBA whom they consider as being more patient, tolerant, and soft and can gently touch and examine them till they are delivered of the babies cannot handle [4]. This situation arises especially when the pregnant women are told by trained midwives that their pregnancies are normal [2]. The low level of education of pregnant women, socio-cultural factors and the belief that the herbs, concoctions, and prayers offered by the TBA are efficacious are other reasons pregnant women will prefer the TBA [15] backed by economic factors such as the lack of funds, poor road network and lack of transport to the clinic [20]. Most women will patronize the services of the TBA because the TBAs practice some of their longstanding traditional practices which are part and parcel of the beliefs and culture of the society [21] and the mere fact that the TBA lives in the community and speaks the same language means that pregnant women will develop trust for them [23]. Despite the role that TBAs play in the society as far as maternal health issues are concerned, the Ghana Health Service has failed to include TBAs in the provision of maternal health services in Ghana. Ghana failed to achieve MDG 4 and 5 at the end of 2015 [12]. With the introduction of the SDGs, Ghana must strive to achieve SGD 3.1 and 3.2 which aim to reduce by 2030, the global maternal mortality ratio to less than 70 per 100,000 live births; and end preventable deaths of new-borns and children under 5 years of age. With all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births respectively. A lot of efforts have already been put in place to improve maternal and child health in Ghana. One notable effort is the introduction of the Community-Based Health and Planning Services (CHPS) nationwide after the Navrongo experiment. The main aim of CHPS is to provide primary health care to the rural areas of Ghana by building CHPS compounds manned by Community Health Officers (CHOs). The CHOs to be deployed to the CHPS compounds include the Community Health Nurse (CHN), Community Health Nurse-Midwives (CHNM), midwives, enrolled nurses and field technicians. The frontline staffs are given standard conventional courses with additional midwifery skills (if they do not possess them already). The CHOs are required to move away from the traditional centralized health delivery system and take health care to the doorsteps of community members and also work with community-based volunteers, community/traditional health delivery personnel (native doctors, TBAs, herbalist etc.) among others. The inclusion of CHNMs and midwives and provision of additional midwifery training means that provision of maternal care services is important in the provision of CHPS. Over the years CHPS has been successful in promoting maternal and child health [1] and have contributed to expanding skilled delivery in Ghana [13,19]. However, the lack of midwives in CHPS compounds [6] and lack of education for men [19] greatly affect the provision of maternal health services. The preference of women in rural Ghana to use the services of other persons especially Traditional Birth Attendants (TBAs) [5] also affect the provision of maternal health services. The aim of this paper, therefore, is to investigate women's preference for TBA services in the Tolon district.

Methodology

Research techniques

The study employed both qualitative and quantitative techniques of data collection and analysis and adopted the cross-sectional survey design to make logical inquiries to its findings. The cross-sectional survey design was adopted to have a view of how the situation concerning the use of TBA services looked like at the time of the research and also because it is more suitable for conducting research in public health planning and measuring community needs [8].

Study site

The study site was the Tolon District of the Northern region; one of the new districts to be created. Tolon was selected because in spite of the existence of many CHPS compounds and health centres almost every community has more than two TBAs.

Sample technique and sample size

A non-probability sampling technique was adopted to select women who have utilized the services of a TBA in the past. The snowball technique was used, where a few women who had sought the services of the TBAs within the past five years, identified by consulting the various TBAs in communities directed the data collectors to other women whom they knew have also sought the services of the TBAs within the past five years. Snowball sampling was used because the TBAs did not keep a register of women who used their services and also because it was easy to identify respondents. It was important to limit respondents to women who have sought the services of the TBAs within the last five years because it would be easier to remember circumstances surrounding the delivery than those that go beyond five years.

Data collection techniques and tools

Data was collected, by the use of a questionnaire that contained both open-ended and closed-ended questions over an eight week period from 360 women. Data was collected by students of the University for Development Studies who were

Table 1
Demographic Data.

Variable	Response	Frequency (N = 360)	Percentage (100)
Age	Below 20	40	11%
	21–30 years	55	15%
	31–40 years	183	51%
	41 and above years	82	23%
Educational background	None	195	54%
	Primary	81	23%
	JHS/middle school	43	12%
	Secondary school	41	11%
Number of children	0–2	43	12%
	3–5	96	27%
	6–8	198	55%
	9 and above	23	6%
Estimated monthly income	Ghc < 50	295	82%
	Ghc 50–1000	65	18%
	Ghc > 1000	0	0%

Source: Field data.

doing their Third Trimester Field Practical Programme (TTFPP) in the district. The inclusion of open-ended questions was critical because the researcher wanted to give respondents the chances to explain and clarify some responses that they gave to the data collectors.

Ethical consideration

Permission was sought from the elders in each community, and the district health director. The identified women who had visited the TBAs to deliver within the past five years were also approached for their permission to participate in the study by giving verbal consent before being interviewed. The verbal consent was given after a consent form was read to them in a language they understand.

Results and discussion

Characteristics of respondents

Out of the 360 respondents who took part in the study, 11% were below the age of 20, 15% between the ages of 21 to 30 years, 51% between 31 to 40 years and 23% above the age of 41. The analysis shows that older women are more likely to use the services of TBAs as compared to their younger counterparts. This corresponds to the findings of Oshonwoh, Nwakwuo, & Ekiyor, [17]. The 41% recorded by the age group 41 years and above could be attributed to the fact that most women at this age are at the stage of menopause that affects childbearing. In terms of the highest educational background of respondents, 54% had no formal education, 23% completed primary education, 12% completed Junior High School (JHS) or Middle school, and 11% completed Secondary school with no respondent completing tertiary education. These results show that the higher the level of educational attainment, the lesser the likelihood a woman would visit TBAs. This corresponds to the findings of Oshonwoh et al., [17]. Twelve percent (12%) of respondents had 2 children and less, 27% had between 3 and 5 children, 55% had 6 to 8 children and 6% had between 9 children and above. There was also a relationship between the use of TBA services and the monthly income of respondents, as 82% of women who used TBA services earned below 50 cedis, 18% earned between 50 and 1000 cedis while no respondent earned above 1000 cedis. So the higher a woman's monthly income the less likely she would use TBA services, [Table 1](#).

Respondents' reasons for using TBAs services

Respondents gave a host of reasons why they patronize the services of TBAs. Twenty-eight percent of respondents stated that the use of TBA services was cheaper than attending the health centre or CHPS compound, this finding is interesting because maternal health services are supposed to be free in Ghana. This is consistent with the findings of Awotunde et al. [3], Sarker et al. [20,22] and Ebuehi & Akintujoye [10] that lack of funds determines women's choice of TBA as a point of delivery. The respondents in explaining this indicated that they are required by the trained midwives to bring certain items including sanitary pads, soap, ultrasound results, dresses etc. which served as an extra cost to them. As respondents put it, [Table 2](#):

"When you go there (clinic) to deliver they (midwives) will tell you it is free, they will not collect anything, but they will tell you to bring a lot of things. They will say bring a pad (sanitary pad), soap, blade, cloth and baby things and me I do not have those things".

Table 2
Reasons.

Reasons	Frequency (N = 360)	Percentage
Cost	99	28
Culturally accepted	93	26
Accessibility	88	24
Lovingness	61	17
Knowledge	19	5

Source: Field data.

Another respondent said:

"When you go to the nurse measure to your stomach (Antenatal Care) she will ask you to go to Tolon or Tamale and take a photo (scan) of your stomach. She will also say you do not have health insurance so go to Tolon and me I do not have money for that. Here before you go to Tolon you have to take 'motor king' (tricycle) and I cannot sit on it with my pregnancy".

Twenty-six percent (26%) indicated the use of TBA services were more culturally accepted than the use of the services of a midwife which confirms the findings of Ebuehi & Akintujoye, [10] and [22]. The TBAs, they indicated are women who are well known so it is culturally more acceptable to show their private parts to them than to a midwife, who in most cases are total strangers. As most of the respondents indicated:

"I cannot go and show my private part to someone I do not know, my husband will not agree".

Another respondent said:

"That girl (midwife) is a small girl, she is like my daughter so I cannot go there and show my private part to her. Even though they say on the day of labour there is no shame, I will not show my private part to a small girl and she is even a stranger".

Twenty-four percent (24%) said they live nearer the TBA than the nearest health centre and therefore it is easier for them to consult the TBA when labour sets in, which is consistent with the findings of Ogunyomi & Ndikom, [16] and Sialubanje et al., [22]. The women explained that, for a woman to be considered "strong", she must not show signs of pain during the early stages of labour and so they wait till the latter stages of labour before making others know what is happening. By this time, it is a bit too late to travel to the trained midwife who is further than the TBA. Some statements made by the respondents included:

"Where the clinic is located is far, you have to walk to the next community to see the midwife but the TBA is leaving just behind our house. So instead of me walking for that long distance I will just go round my house and see the TBA".

Another said:

"For me, I always wait when it is left with small for the baby to come out then I will go to the TBA, by that time I cannot go to the clinic because I may give birth on the way".

Seventeen percent (17%) of the respondents preferred the services of the TBA because according to them the TBA is more caring than the trained midwives as also contained in the work of Awotunde et al., [3], Sialubanje et al., [22] and Ebuehi & Akintujoye [10]. This finding was explained in relation to the fact that the TBAs allowed the women to choose their preferred birthing position as opposed to the midwife who chose the birthing position for them.

In relation to this, some of the respondents said:

"When you go to the clinic those small girls (midwife) will be shouting on you as if you don't know anything. I have given birth several times but they (midwives) will be talking to you anyhow".

Another said:

"For me, I prefer to squat when I am giving birth but they say when you go to the clinic they (midwives) will let you lie down on a bed and they will now tell you to push. That one (lithotomy position) is difficult, the first time I went to the TBA she tried using that one (lithotomy position) but I suffered so she allowed me to squat and it was easy. So now every time I to the TBA she will let me squat".

Five percent (5%) of respondents, however, stated that the services of the TBA were the only maternity care they knew. The respondents stated that:

"As for me, it is only the TBA I know who helps women to give birth as for the clinic it is when you are sick that you go there".

Conclusions and recommendations

TBAs continue to be the preferred choice of women when it comes to childbearing in rural and peri-urban areas. Over the years the Ghana Health Service has not done much to improve the service provided by TBAs in the country. It is evident that because of the many reasons offered by women why they patronize the services of TBAs, they (TBAs) will continue to play a role in the provision of maternal health services. With the country seeking to achieve the SDGs especially SDG 3.1 and 3.2, it is important for the health authorities to regularise the services of TBAs in the country to ensure improved services are delivered to pregnant women. This can be done by integrating TBAs into Ghana's mainstream health provision just like it has been done with traditional health practitioners (herbalist and bone setters) who are now attached to various hospitals in most parts of Ghana. The system of integrating TBAs in the primary health care has been successfully implemented in Burundi where TBA have been re-assigned the role of 'birth companions'. This allows them to undertake maternal health promotion activities within their communities. The possibility of women delivering at home or TBAs providing care that does not measure up to the quality expected of health authorities is most likely to reduce when Ghana adopts such a system. TBAs could also be given training in maternal health issues such as infection control measures, the use of surgical gloves in their operations among and basic modern midwifery skills to complement what they do already, if they cannot be integrated in the mainstream primary health care. In addition, TBAs should be encouraged to refer complications to the nearest trained midwife for prompt attention to prevent or reduce cases of maternal and child mortality in the communities.

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Conflict of interest

The authors certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

Supplementary material

Supplementary material associated with this article can be found, in the online version, at doi:[10.1016/j.sciaf.2018.e00010](https://doi.org/10.1016/j.sciaf.2018.e00010).

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