

# 17

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## Empowering Traditional Birth Attendants in the Gambia: A Local Strategy to Redress Issues of Access, Equity and Sustainability?

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### The Resource Gap in the African Health Care System

As an arena and a vector of power relations in society, the health system both embodies and conveys questions of access, equity, justice and sustainability that require to be followed through for a proper understanding of the functioning and functionality of the system... Amidst the crisis that has gripped the health sector, the decline in the overall health status of many Africans, the cut-back in the public health expenditure of the state, the various health emergencies facing the continent, and the challenges of reform that are posed, questions of access, equity and sustainability clearly arise both as important issues in their own right and as elements integral to the exercise of citizenship, democratic rights and the social contract. – (CODESRIA 2004:2).

The African continent, particularly the sub-Saharan region, has experienced several diverse natural and man-made calamities that widely devastated the physical infrastructure, social organisation, systems of governance and provision of public amenities. Civil wars, droughts, hunger, famines, epidemics, social upheavals, political unrest, dictates of international bodies, reform policies, dependency syndromes, corruption and multi-faceted poverty have gradually negatively impacted African communities; variously exhausting the existing limited resources which are critical to the establishment and sustenance of development efforts. Consequently, there exists a disproportionately high demand upon scanty resources, which is replicated in the health care system of sub-Saharan African countries.

The outbreak and persistence of epidemics of fatal diseases including HIV/AIDS, tuberculosis, malaria, ebola, cholera, and even preventable childhood diseases

pose a major challenge to the meagre available resources. The effects of internal and foreign policies, specifically the Structural Adjustment Policies (SAPs) of the International Monetary Fund and the International Bank for Reconstruction and Development (IBRD), have amalgamated with economic and financial crises creating bigger debt burdens, more critical balance of payments deficits and depleted government revenues. These factors challenge the practicality of efforts to budget efficiently for appropriate and meaningful health care systems in sub-Saharan Africa (Birungi 1997). The health care system is further impoverished by severe brain drain as professionally trained, highly qualified and experienced health personnel not only die from the HIV/AIDS epidemic, but also either seek more fulfilling careers out of Africa due to several 'pull factors' in more developed countries, or they are forced out by inherent 'push factors' including political insecurity, natural disasters, sub-standard levels of amenities or diminishing returns from service. Furthermore, there is a disproportionate number of qualified health personnel (doctors, nurses, midwives, other paramedical manpower) to provide for a large population with ill-health, particularly in the rural areas because of limited training facilities, insufficient capacity building, and the few professional elite tend to congregate in the urban centres where the benefits accruing are relatively higher (Wallace 1990, Asghar 1999).

### **The Gravity of Reproductive Health in Africa**

Fathalla (1988) defines reproductive health as 'the ability to live through the reproductive years and beyond with reproductive choice, dignity and successful child-bearing, and free of gynaecological disease and risk'. In this definition, concepts of choice (a woman's control over her reproductive processes), dignity (social and psychological well-being from the process of reproduction) and physical health of the reproductive organs, are integrated. However in sub-Saharan Africa, as in other developing areas, access to, equity over, and sustainability of reproductive health care are limited by several inherent factors including inequitable distribution of services, patriarchal cultural dictates, inequalities, diverse social cultural mechanisms, inadequate resources, economic disparities, the vicious circle of poverty, lack of drugs, misappropriation of public resources, poor governance, insufficient physical infrastructure, and limited numbers of professional health personnel. Although the fact that the lives of women in sub-Saharan Africa predominantly revolve around their reproductive functions, and despite the reported high fertility rates (Mayell 2001), the majority of women lack access to healthcare generally and specifically to the much needed reproductive healthcare. Consequently, sub-Saharan Africa is riddled with drastically low levels of reproductive health indicators.

According to WHO/UNICEF (1996), reproductive health problems account for over one-third of the total burden of disease in women. More than ninety-nine percent of the annual global estimates of 585,000 maternal deaths occur in

developing countries; a woman in sub-Saharan Africa who becomes pregnant is seventy-five times more likely to die as a result, than a woman in Europe (excluding Eastern Europe) or North America (Walraven et al. 2000). Estimates of maternal mortality rates in developing countries are at an average of about 450 per 100,000 live births (and this goes up to 2000 in some areas) compared to 30 per 100,000 live births in developed countries (WHO 1991, Paul 1993, Asghar 1999). Rates vary between different areas, regions and even within a country. For example Asghar (1999) reports a two-fold increase in maternal mortality in rural as compared to urban areas. An estimated 500,000 women die every year in developing countries as a result of complications of pregnancy and abortion (Mbizvo 1996, Fauveau 1993). The disabilities arising out of pregnancy, which drastically impair reproductive health functions of women and limit their economic activity, are often under-reported because they do not result in death. However, these are reported to be even more common: for example it is estimated for sub-Saharan Africa that for every maternal death, another fifteen women are disabled or permanently crippled by incontinence, uterine prolapse and infertility due to pregnancy or birth-related causes (Asghar 1999).

Between two and three million African women are left handicapped from obstetric complaints every year (Paul 1993). The most common causes of obstetric complications are prolonged obstructed labour, hypertensive disorders of pregnancy, haemorrhages, sepsis and unsafe abortions (Sibley 1997, Walraven et al. 2000).

Maternal mortality is also influenced by fertility rates. The fertility rates in rural sub-Saharan Africa are the highest in the world (Kirk and Pillet 1998, Ratcliffe et al. 2001, Ratcliffe, Hill and Walraven 2000). The demand for large families remains strong in most rural populations (Ware 1994, Oppong 1992). Modern family planning is uncommon in the rural areas and the continuing high levels of fertility are important contributors to the poor levels of reproductive health. Several social and cultural factors contribute to the high fertility rates, namely propagation of the family line, extension of the patrilineal clan, more children imply greater production due to more free labour, women's status in society is commonly established on the basis of reproductive performance particularly in virilocal marriage systems, religious factors, and the influence of the extended family (Bledsoe, Banja and Hill 1998, Caldwell, Orubuloye and Caldwell 1992, Oppong 1992). Cultural malpractices including female genital cutting, arranged marriages, early sexual debut, widow inheritance, levirate marriage, and ritual cleansing by sex with a virgin all exacerbate the injustices faced by African women through the abuse of their rights to reproductive health. Lastly, childhood mortality rates in sub-Saharan Africa are among the highest in the world (Blacker et al. 1985, UNICEF 1997). According to studies conducted in West Africa, the mortality of children aged 1-4 years is especially high (Hill et al. 1998, Leach et al. 1999).

### Statement of the Problem

The reproductive health burden of African women is still a major challenge to African health systems that must of necessity be prioritised. In the light of depleted resources, shattered infrastructure and insufficient numbers of professionally trained health care personnel, traditional birth attendants (TBAs) offer a relatively low-cost, locally appreciated social group that could intervene to redress the gap in resources and improve African reproductive health.

### Traditional Birth Attendants: Bridging the Gap?

According to the WHO Alma Ata definition, 'a traditional birth attendant (TBA) is a person - usually a woman - who assists the mother at child birth and who initially acquired her skills delivering babies by herself or working with other TBAs' (WHO 1978). Studies (*Maternal Neonatal Health* 2004) have classified three major types of TBAs. There is the TBA who is a full-time worker who can be called upon by anyone and expects to be paid either in cash or in kind. Secondly there is the TBA who is a woman's elderly relative or neighbour who does not make a living from the work and will only assist with the birth if the mother is a relative or a daughter or a daughter-in-law of a neighbour or close friend. This TBA assists in the birth as a favour and does not expect to be paid, but may receive a token or gift in appreciation. Lastly there is the family birth attendant who only delivers babies of close friends. In any society, the role of the TBA often reflects the culture and the social organisation.

Estimates indicate that sixty percent of births in the developing world occur outside a healthy facility and forty-seven percent are attended by a TBA (WHO 1997). In rural Africa, between sixty and ninety percent of deliveries are assisted by a TBA. High quality maternity care is often unavailable and home birth remains a strong preference for many (Butlerys et al. 2002). TBAs in many regions have been trained in midwifery and basic hygiene as part of the Safe Motherhood Initiative aimed at reducing maternal mortality. In resource-poor countries, this training has comparative advantages in attempting to provide professional health care for each birth (Walraven and Weeks 1999) because of the popularity of and easy access to TBAs who not only speak the local languages and allow traditional birthing practices, but also often have the trust of the local communities (Bij de Vaate 2002, Heeren 2001). There is a debate about the benefits of this form of empowerment of TBAs through education (De Brouwere et al. 1998).

This study investigated the role of TBAs in the health care of women in The Gambia. This paper discusses whether the empowerment packages provided to TBAs in The Gambia constitute a local strategy that redresses issues of access to, equity over, and sustainability of reproductive health.

### Study Design and Methods

Library research was triangulated together with ethnography. Ethnographic fieldwork was conducted among sixty TBAs, 120 women who delivered in the presence of a TBA, twenty women who did not, and key informants including Divisional Health Team members, Village Development Committee members, and Community Health Nurses (CHNs). The research techniques included a literature review, a policy-statement review, ethnographic participant observation, participatory rural appraisal (PRA), ten focus group discussions and fifty-four individual in-depth interviews. The author participated in several birthing processes, and had babies named after her anthropological name at naming ceremonies in the study villages. Interviews conducted in the local languages of Wolof, Fula and Mandinka were recorded on audio-tape, transcribed verbatim, translated into English, entered into a computer and subjected to narrative analysis using Atlas.ti - standard computer software designed for the analysis of qualitative data.

### Study Area and Population

Fieldwork was conducted in the hamlets, villages and urban centres surrounding Farafenni town, located in the North Bank of The Gambia, and approximately 200 kilometres from the capital Banjul. Geographically the area is flat Sudan savannah with wet season cultivation of rice, millet, sorghum and groundnuts. The study population is served by a hospital in Farafenni town and five dispensaries in nearby villages, and several 'trekking clinics'. Transportation is limited to walking or using bicycles, horse or donkey carts, or some bush taxis travelling on dirt roads (Greenwood 1990). Telephone services between Farafenni and the big villages were introduced in 1990. However, many of the smaller villages and hamlets still lacked telephone networks during the fieldwork period. Ambulance services are available to the main hospital. Eighty-eight percent of compounds have a reliable supply of safe water and most compounds have pit latrines (Hill et al. 1996). There are three predominant tribes: Mandinka (48 percent), Wolof (16 percent), and Fula (6 percent) (Walraven et al. 2000). The main income generating activity is subsistence farming, with a few petty traders. Education levels are mostly low for adults, with the majority of men having some basic Koranic school attendance. Islam is the predominant religion of The Gambia. The population is poor; in 1996 less than 10 percent of compounds owned bicycles, two thirds of compounds possessed a radio, 35 percent owned some form of cart, and less than half slept on iron or wooden beds (Hill et al. 1996). According to Walraven et al 2000, the total fertility rate was 7.5 births per woman, mean birth intervals were 33 months and just 9 percent of women were using either traditional or modern contraceptives. Polygamy is common with 51 percent of women with one or more co-wives, 56 percent of women aged 15-19 years are married and just over three percent of the women had attended school.

### **The Role of TBAs in the Health Care System in the Gambia**

The Gambia adopted primary health care as the basis for national policy in 1978 (Ministry of Health 1993). This programme developed in the early 1980s and is now established countrywide. It includes classification of primary health care key villages based on size and population of 400 or more, so that they receive CHNs who are trained by the Medical and Health Department and paid from central funds. CHNs are the link between village-level primary health care services and referral health services available at dispensaries, health centres and hospitals. Each of the CHNs is responsible for the supplies, supervision and continuing education of the village health workers (VHNs) and trained TBAs in about five key villages.

TBAs are an integral part of the primary health care system in The Gambia. Before the establishment of this primary health care, several TBAs were already practising. In key primary health care villages, the community under the leadership of their development committees select two out of the existing TBAs to attend the centrally organised training as midwives. This generates resources within the community to contribute to the support of the village health system. In 1997 there were 460 trained TBAs and 52 assistant TBAs nationwide who conducted half of the deliveries (Gambia/UNICEF 1997).

All the TBAs in our study were illiterate. However, each of them had attended the initial training and more than half had attended at least one refresher course in the last two years. They reported that they gained immensely from the training sessions. Indeed there were reported differences particularly in the ability to identify complicated cases that needed immediate referral, better hygiene and sanitation practices during delivery and provision of more ante-natal monitoring and advice to pregnant women. The trained TBAs complained about some untrained women in the villages who were assisting in deliveries and often making blunders owing to ignorance because they lacked the basic training, thereby soiling the reputation of the good work of other trained TBAs. Likewise, some of the rural women stressed the fact that they valued the services of TBAs in their husband's clan because these elderly women were culturally attached to particular families. Thus they claimed in such cases it was irrelevant whether or not the TBA had received formal training. Culturally, preference was given to these familial ties. TBAs repeatedly requested more expanded programmes of training because it was impractical for an untrained TBA not to offer her services when she was urgently required to attempt to save the life of an unborn child and its mother.

Many TBAs were receiving supervision from their CHN, although a few reported they were disregarded by their CHN and two elderly women did not know who was supposed to supervise them. We observed good working relationships between the formal health care system and the primary health care system in cases where trekking, professionally trained, health personnel worked in close collaboration with the TBAs who mobilised pregnant women to attend mobile ante-natal clinics, jointly assisted in examinations of women, weighing of

infants, summoned mothers and children for immunisation campaigns, referred complicated cases or even escorted them to the health facilities. However, there were instances of some TBAs discouraging women from using bio-medical medicine in preference to herbal concoctions, specifically in the case of women who needed 'softening of bones to aid delivery'. Others openly campaigned against modern contraception because it runs contrary to religious and cultural beliefs. There were few instances of reports from the TBAs of discrimination and disregard by medical personnel in hospitals, specifically when they travelled with critically complicated cases of women whose pregnancies had begun away from the hospital setting. In addition, some TBAs felt that their knowledge was despised as inferior by educated health persons, specifically if they were working with foreign-aided health centres. Furthermore, local women who initially went for ante-natal care at the TBA and then moved to the hospital towards the time of delivery reported that they were often ridiculed by hospital midwives for seeking unprofessional help, combining bio-medical drugs with traditional herbs or Koranic portions and sticking to the traditional health care system. They commented about the frequent contradictions between information from bio-medical health professionals and the indigenous traditional knowledge of the TBAs. Several TBAs lamented that pregnant women who went to the hospital were often subjected to caesarean section from the hands of foreign doctors because they over-looked some of the traditional birthing customs, rituals and practices which were effective at reducing this possibility. These disparities need to be addressed so that the gaps in information that TBAs hold can be addressed in the training and refresher courses. Furthermore, it is important that the politics of health care systems in which bio-medicine assumes supremacy as reflected by some professional health personnel is addressed through sensitisation about the need for mutual existence, support and collaboration so as to enhance the active participation of the TBAs and other lay village health workers.

Several TBAs were the sole providers of ante-natal care, delivery assistance, birth rituals, naming ceremonies or post-natal care for pregnant women in their areas. The majority of the women in the villages reported that they preferred to deliver with the help of a TBA, although the TBAs reported that some women waited until the last minute to notify them of their pregnancies, or only called them when they experienced complications. One woman revealed that she was shy and embarrassed of revealing her nakedness to another woman and thus resorted to seeking TBA assistance as a last resort when her labour was too long to bear. A few women (particularly those in the urban area) chose to deliver in hospital. There were disparities in reports about society's perception of TBAs: while some said they were still highly valued in their villages and rewarded for their services, some other TBAs lamented that they were fast becoming despised, over-worked with meagre or no reward, and sometimes even scorned for some of their traditional beliefs and practices. The majority of the TBAs emphasised

the fact that the communal farm labour that the village is supposed to offer them on their rice fields was steadily becoming an ideal of the past. Decisions about whether or not a woman goes to a TBA, when, and how often she attends, are mostly made by the husbands. Husbands provided the money for all the women who had used the services of a TBA. The majority of the TBAs in the study did not support the use of modern contraceptives, even though they were trained about the benefits. There was evidence of widely held myths and misconceptions about the hazards of contraceptive use. TBAs provided more than reproductive health services in their villages. These TBAs were providing nutrition lessons, sanitation and hygiene information, health education against malaria, social role of leadership, collaborating in village development schemes, distributing herbal treatments, some bio-medical pain-killers, participating in income generation activities, and acted as society's gate-keepers who stored knowledge about sacred traditional norms, values and customs. The major challenges they face include lack of appropriate transport to facilitate referral of emergency cases, some resistance to collaboration with professionally trained health personnel, a shortage of refresher courses for all, and a heavy work-load for some who serve many villages and hamlets.

### Conclusions

Empowering TBAs with training and support supervision backup by professionally trained health personnel bridges gaps in access to and equity of reproductive health care in The Gambia to a large extent. TBAs, although filling a big gap, may also be promoting inequity in the quality of the healthcare received by their clientele, specifically as they hold misconceptions about contraception, and believe in cultural nutrition taboos. They play a multiple role in the social, cultural, ritual, community development, and local leadership and are gatekeepers of the sacred traditional norms and values of their societies. Communities must be encouraged to support their TBAs in order to facilitate sustainability.

### Acknowledgement

I acknowledge the support of Dr Gijs Walraven, Hawah Manneh, Emily Lopy, Yamundow Jallow, Ousman Bah, Sulayman Joof and Jarrai Bangoro who assisted with data collection, processing and entry. I am grateful to the MRC CHNs, CHNs, DHT, TBAs and women who participated in the study.

### References

- Asghar, R. J., 1999, 'Obstetric Complications and the Roles of Traditional Birth Attendants in Developing Countries', *Journal of Physicians and Surgeons*, Pakistan 9 (1): 55-57.
- Bij De Vaate, A., Coleman, R., Manneh, H. and Walraven, G., 2002, 'Knowledge, Attitudes and Practices of Trained Traditional Birth Attendants in The Gambia in the Prevention, Recognition and Management of Postpartum Haemorrhage', *Midwifery*, 18: 3-11.



- Bledsoe, C. H., Banja F. and Hill A. G., 1998, 'Reproductive Mishaps and Western Contraception: An African Challenge to Fertility Theory', *Population Development Review*, 23: 15-57.
- Bledsoe, C. H., 2002, *Contingent Lives: Fertility, Time and Aging in West Africa*, Chicago and London, The University Of Chicago Press.
- Butlerys, M., Fowler, M. G., Shaffer, N., Tih, P. M., Greenberg, A. E., Karita, E., Coovadia, H. and De Cock, K. M., 2002, 'Role of Traditional Birth Attendants in Preventing Perinatal Transmission of HIV', *British Medical Journal*, 324: 222-225.
- Caldwell, J. C., Orubuloye, I.O., Caldwell, P., 1992, 'Fertility Decline in Africa: A New Type of Transition?', *Population Development Review*, 18.
- CODESRIA, 2004, Call for Abstracts, Institute for Health, Politics and Society in Africa. [www.codesria.org](http://www.codesria.org).
- Department of State for Health And Social Welfare, Gambia, 1998, *Public Expenditure Review of The Health Sector*, Banjul.
- Dowling, S., 1983, 'Health for a Change', Children Poverty Action Group.
- Fathalla, M. F., 1988, 'Research Needs in Human Reproduction', in E., Diczfulsi, P. D., Griddin and Khanna, P. D., eds., *Research Needs in Human Reproduction: Biannual Report 1986-1987*, Geneva, WHO 18.
- Fauveau, V., 1993, 'Maternal Tetanus', *International Journal of Gynaecology and Obstetrics*, 40: 3-12.
- Heeren, J. A., 2001, 'Knowledge Attitude and Practices in Postpartum Care in the North Bank East Division of The Gambia', Nijmegen, University of Nijmegen.
- Hill, A. G., Hill, M. C., Gomez, P. and Walraven, G., 1996, 'Report of the Living Standards Survey Conducted in the Villages of the MRC Main Study Area, North Bank Division, Republic of The Gambia in June-July 1996', Farafenni, MRC.
- Hill, A.G., Macleod, W.B., Joof, D., Gomez, P., Ratcliff, A.A. and Walraven, G., 2000, 'Decline of Mortality in Children in Rural Gambia: The Influence of Village-Level Primary Health Care', *Tropical Medicine and International Health*, 5(2): 107-118.
- Kirk, D. and Pillet, B. 'Fertility Levels, Trends and Differentials in Sub-Saharan African in The 1980s and 1990s', *Studies In Family Planning*, 29: 1-2.
- Maternal Neonatal Health, 2004, 'Traditional Birth Attendants: Linking Community and Services', [Www.Mnh.Jhpiego.Org/Best/Tba.Asp](http://Www.Mnh.Jhpiego.Org/Best/Tba.Asp).
- Mbizvo, M.T., 1996, 'Reproductive and Sexual Health', *Central African Journal of Medicine*, 42(3): 80-85.
- Oppong, C., 1992, 'Traditional Family Systems in Rural Settings in Africa', in E. Berquo and P. Xenos, Eds., *Family Systems and Cultural Change*, Oxford, Clarendon Press, 69-86.
- Paul, B. K., 1993, 'Maternal Mortality in Africa, 1980-1987', *Social Science and Medicine*, 37 (6) 745-52.
- Ratcliffe, A. A., Hill, A. G. and Walraven, G., 2000, 'Separate Lives, Different Interests: Male and Female Reproduction in The Gambia', *Bulletin of the World Health Organisation*, 78: 570-579.
- Ratcliffe, A. A., 2000, Men's Fertility and Marriages: Male Reproductive Strategies in Rural Gambia, PhD Thesis, Boston, Department of Population and International Health.
- Ratcliffe, A. A., Hill, A. G., Harrington, D. P. and Walraven, G., 2002, 'Reporting of Fertility Events by Men and Women in Rural Gambia', *Demography*, 39 (3): 573-586.
- Sibley, L., 1997, 'Obstetric First Aid in the Community - Partners in Safe Motherhood', *Journal of Nursing and Midwifery*, 42 (2): 117-121.

- Wallace, H. M., 1990, *Health Care for Women and Children in Developing Countries*, Third Party Publishing Company.
- Walraven, G. and Weeks, A., 1999, 'The Role of Traditional Birth Attendants with Midwifery Skills in the Reduction of Maternal Mortality', *Tropical Medicine and International Health*, 4 (8): 527-29.
- Walraven, G., Telfer, M., Rowley, J., Ronsmans, C., 2000, 'Maternal Mortality in Rural Gambia: Levels, Causes and Contributing Factors', *Bulletin of the World Health Organisation*, 78 (5): 603-613.
- Walraven, G., Scherf, C., West, B., Ekpo, G., Paine, K., Coleman, R., Bailey, R. and Morison, L., 2001, 'The Burden of Reproductive Organ Disease in Rural Women in The Gambia, West Africa', *The Lancet*, 357: 1161-1167.
- Ware, H., 1994, 'Thoughts on the Course of Fertility Transition in Sub-Saharan Africa', in Looch, T., And V. Hertrich, eds., *The Onset of Fertility Transition in Sub-Saharan Africa*, Liege, IUSSP, 289-296.
- World Health Organisation, 1978, *Report of the Alma Ata Conference on Primary Health Care*, Health for All Series, No. 1, Geneva, WHO.
- World Health Organisation, 1990, *Integrating Maternal and Child Health Services with Primary Health Care*, Geneva, WHO.
- World Health Organisation, 1991, *Essential Elements of Obstetric Care at First Referral Level*, Geneva, WHO.
- World Health Organisation/ UNICEF, 1996, *Revised 1990 Estimates of Maternal Mortality*, Geneva, WHO/FRH/MSM/96.11.