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Traditional Birth Attendants in Modern Ghana
A Discussion of Maternal Health Care

Emily Kennedy
May 7, 1999
School for International Training

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Mercy Dadzie who game answers to questions I had not even asked

J. V. the best friend in Africa a girl could have.

My family and friends at home who loved me from across the world.

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Abstract

Ghanaian women have been delivering their own babies for almost two thousand years now, using knowledge passed down from their elders and medicines prepared from herbs. It has only been in the past one hundred years that scientific medicines and institutions have been introduced to this country, yet more and more individuals are turning to these doctors and hospitals for care before, during and after pregnancies. The role of traditional birth attendants, (TBAs), has begun to be questioned as well as attacked for its more religious and holistic approach which is resulting in a growing schism between the TBAs and the formally trained doctors and nurses. However, these transitions that are occurring will never lead to the demise of the TBAs due to economic, cultural, social and psychological factors. TBAs, midwives and doctors are the three main sources of maternal health care in Ghana. Previously, women would select only one of the three, but today, they are using a combination of these health care providers. This has led to their inevitable dependence on one another, and the reality that with the failure of one, means the future of all.

INTRODUCTION

The family is the backbone which support African society. Knowing this, it becomes understandable why there is so much emphasis placed on having children. The manifest function for a married women is to bear children, and if for some reason she cannot fulfill this role, she becomes the object of ridicule and scrutiny.[1] To help prevent this, other women have taken on the responsibility to aid their fellow sisters: they are the traditional birth attendants, or otherwise known as TBAs. A TBA is a specialist in obstetrics, but is also sometimes involved in sex education and contraceptive counseling. A TBA is usually an older woman with little to no formal education, and she frequently has another job in addition to being a TBA. Her patients are in the same community as she, so there is an informal and relaxed relationship between them. The TBAs are trained by older family members, and the process is one of observation and apprenticeship which can last for as long as five years. It has been estimated that TBAs are responsible for over eighty percent of the deliveries in Africa.[2]

Why, one might ask, are TBAs becoming controversial of they are so much apart of African life? It is because in the past century, the numbers of hospitals, health clinics and health posts have been steadily increasing, giving women other alternatives to delivering at home with a TBA. The number of patients in these new hospitals is also rising due to the migration of rural peoples to urban centers where the majority of the hospitals and clinics are located. Furthermore, the formal education system is a factor as more people are going and for longer amounts of time. The constant shifting of the economy cannot be ignored, as well as the changes in the extended family structure.[3] All of these contribute to the comparisons being made of the methods and materials used by doctors, midwives and TBAs. It is giving way to a stream of questions such as: are the TBAs using proper hygiene? Are the doctors giving enough individual and personal care? Where do the midwives fit in?

The common and ultimate goal for these health care providers is to ensure a safe delivery for the mother and baby. It is the way in which they go about it which is causing the dilemmas. There first needs to be an understanding of the dichotomous health care system in present day Africa: "traditional medicine" and "scientific medicine" Traditional medicine is a practice where there is not discernible separation between natural and supernatural entities. The methods used are generally holistic or "magico-religious" in nature, and there is an emphasis put on the social

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[1] Kwame Gyekye. African Cultural Values. Sankofa Publishing Company, Accra. 1996. p. 82.
[2] Twumasi, P. A. Social Foundations of the Interplay Between Traditional and Modern Medical Systems. Ghana University Press, Accra. 1988. p.9
[3] Twumasi, P. A. Medical Systems in Ghana. Ghana Publishing Corporation, Tema. 1975. p.11.

and psychological aspects of an illness in addition to the physical aliments.[4] *Scientific* medicine is a practice that involves cause and effect; the causes always stemming from something natural as opposed to supernatural. There is a process of observations, hypotheses, experimentation and conclusions from which facts are derived, and these basic principles are subjected to change if new experimentation proves them wrong.[5]

The decision to go to a doctor who practices scientific medicine or a traditional birth attendant who practices traditional medicine is a very personal choice, and one that has a variety of reasons behind it. A woman may choose a TBA over the hospital because she does not have enough money to pay the doctor, or she may live too far from the hospital to get there in time to deliver, or she may be scared of or intimidated by the doctor. Another woman may choose to go to the hospital because she does not trust the medicines administered by the TBAs, or she is nervous of having a difficult delivery which the TBA may not know how to handle, or she may be used to going to the hospital for all of her other ailments, so it is just more comfortable to deliver there. Whatever the reason may be, it is ultimately the woman and her family's decision as to where the will go for maternal health care.

However, there are outside sources such as government and international organizations which are strongly suggesting that women go to hospitals and health centers for the actual delivery as well as antenatal care. These sources are also urging TBAs to obtain some level of formal training and to enroll in the Ghana Registered Midwives Association. The hope is that with these suggestions, the rates of maternal and infant mortality will decline. There have been improvements concerning infant mortality with the eradication or reduction in cases of diseases like smallpox and polio, but the maternal mortality is still staggering. Depending on the birth and death rate used, there are 3000-6000 estimated maternal deaths a year in Ghana.[6]

Unfortunately, telling a woman to go to the hospital for maternal health care is easier said than done. A lot more needs to be den on the part of these "do good organizations" to facilitate the move towards scientific and institutions. Moreover, in the process of evaluating the two medical systems, it may be seen that the former systems are just as good, if not better, than the new ones. This discussion of traditional midwives in present day Ghana will attempt to show the importance and relevance of these women who are so often overlooked as quack obstetricians. TBAs hold an extremely vital and important position in African society, and with the correct aid, their services can be utilized on a more widespread and competent level.

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[4] Twumasi, P. A. Social Foundations of the Interplay Between Traditional and Modern Medical Systems. Ghana University Press, Accra. 1988. p 6-.7

[5] Twumasi, P.A. Medical Systems in Ghana. Ghana Publishing Corporation, Tema. 1975. p.9

[6] Ampofo, Daniel, A. The Health Issues of Human Reproduction of Our Time: Ghana Academy of Arts and Sciences, Accra 1994. p. 21.

METHODOLOGY

In order to see the various aspects of maternal health care, I wanted to find an area that had a equal balance or rural and urban life. I thought Cape Coast was a good location due to its size, population and physical layout. I also wanted to find a small, intimate sample of informants so I could obtain in depth and congruent data as opposed to fragmented information from many different sources. My sample of interviewees consisted of two TBAs, one midwife, one medical assistant, one nurse, one doctor, and two women who I have labeled as mothers.

My research began at the Regional Health Offices in downtown Cape Coast. The nurses there pointed me in the direction of a midwife, Alice G. Asaam. Alice ended up being the head of all TBAs in the Cape Coast district, so was extremely helpful in giving me other names of TBAs in the area. I then went to Abura, a small village just outside of Cape Coast, in search of one of the TBAs that Alice had told me about. I did not find that particular TBA, but was directed to another TBA by a young woman named Mercy Dadzie who lived in Abura. (She graciously stepped into the role as my translator for many of my interviews). Mercy took me to a TBA that she knew, Hamamet (Ama) Ismale. Ama, in turn, gave me the name of a woman who had just recently given birth, Grace Arthur, who was one of the two "mothers" The other mother was one of Mercy's aunts, Esi Sekyiwa. It should be noted at this point that the TBAs did not know the spelling of the herbs described, so I took the liberty of making up my own spellings from what the words sounded like. Unfortunately, due to lack of time, I could not find a source that knew the correct spellings or botanical names.

I went to the Adisadel Urban Health Care Center and spoke with a few nurses, midwives, and the medical assistant. I have chosen to focus on the information I obtained from one of the midwives, Sarah Openg, and the medical assistant, Margaret Mwinyele, due to the frequency of our meetings. I also visited the Cape Coast Central Regional Hospital a few times, and met with a few nurses and a doctor. I focused on one of the nurses, Trinity Kpodo, and Dr. Seth Adu.

For my research, I used a list of general questions which I modified depending on who my interview was with. In addition, I used more specific questions that pertained to who I was speaking with. My list of questions invariably grew as my interviews progressed, so the following is my final grouping of inquires.

Questions for TBAs:

- Have you ever been to school? If so, which ones for how long?
- What is your religion?
- Does this affect what you do as TBA?
- Why did you decide to become a TBA?
- Who taught you?

- What and how did they teach you?
- How long did this training last?
- Have you trained anybody?
- Do you treat anything besides pregnancies and deliveries?
- Do you have any other jobs?
- How do your patients know about you/Why do they come to you?
- Do you see women before they actually deliver? What are the reasons?
- How many deliveries do you have in a month?
- Have you seen this number increase or decrease in the past few years? If there is a change, why do you think this is happening?
- What happens in an actual delivery, what, if any medications are used? Who is present?
- What happens if difficulties arise?
- How is the umbilical cord cut?
- Is there any immediate care to the infant?
- How is the placenta and cord disposed of?
- Do you use store bought materials in your practices, if so what?
- Do you refer any patients to hospitals? If so, what for?
- Do you administer any family planning or perform abortions?
- Is there any advice you give to expecting mothers on certain things they should or should not do? What do you tell them about breast feeding?
- What are your costs?
- Do you ever have women complaining of ailments from witchcraft/sorcery/magic?
- How many children do you have and how were they delivered?
- If you are ill, do you go to hospital?
- What is your opinion about doctors and hospitals for expecting mothers?
- If you could change or improve anything about your practices, what would they be?
- What do you see as the future for maternal health care, in TBAs as well as hospitals and health clinics?

Questions for hospital and health center workers:

- Where did you go to school?/Where did you receive your training?
- Why did you decide to become a doctor/nurse/midwife?
- How long have you been at this specific institution?
- Have you worked anywhere else?
- How many patients do you see in a day?
- How many deliveries do you see in a month?

- Have you seen this number increases or decrease in the past few years? If there is a change, why do you think this is happening?
- How often do women come in for antenatal check ups? Please explain one of these visits. What happens in an actual delivery: what, if any, medications are used? Who is present? What happens if difficulties arise? How is the umbilical cord cut? Is there any immediate care given to the infant?
- How is the placenta and cord disposed of?
- How long do the mother and child stay at the hospital/health clinic?
- Do you ever use traditional /local medicines?
- Do you ever refer patients to TBAs?
- What type of family planning to you offer/do you perform abortions?
- Is there any advice you give to expecting mothers in things they should or should not do?
- What do you tell them about breast feeding?
- What are your costs?
- Do you ever have women complaining of ailments from witchcrafts/sorcery/magic?
- How many children do you have and how are they delivered?
- If you are ill, do you ever go to traditional herbalists?
- What is your opinion about TBAs?
- If you could change or improve anything about your practices, what would they be?
- What do you see as the future for maternal health care, in TBAs as well as hospitals and health clinics?

Questions for mothers:

- How many children do you have?
- Have you ever been to school, how long?
- Where were they delivered and by whom?
- Did you have any difficulties during the pregnancy or deliver?
- Did your receive any medications? If so, who gave them to you, what were they, and what were they for?
- How was the umbilical cord cut and how was that and the placenta disposed of?
- Did the doctor/midwife/TBA give you any advice while you were pregnant?
- What did you pay for the exams/deliveries?
- What is your opinion of hospitals/TBAs? If you have been to both, which one do you prefer and why?
- Where do you go if you are sick?

The bulk of my information was derived from the interviews, but I also used book and newspapers for background, statistical information. Using the information from the various interviewees and literature. I developed three principal sections for my main report an introduction to the different health care providers, a detailed comparison of the techniques used by these health care providers during antenatal care and delivery, and an overview of the changes occurring in maternal health care. My goal was to introduce the beliefs and practices of all the people interviewed in the most respectful and objective way possible.

This paper is an extremely general overview of maternal health care in the Central Region of Ghana. because of such heavy time restraints, it was impossible to obtain every facet of information, hopefully though, it will give the reader a sufficient introduction to this topic. A significant number of the interviews were don with the assistance of a translator, which may have caused areas of communication breakdown. There was also a possibility that some of the informants may have said, or omitted, certain things during the interviews because, again due to lack of time, they did not feel comfortable enough with me. It would also have been helpful if I was able to interview more people in surrounding areas to get as many different opinions as possible.

1.a. **INTRODUCTION TO TBAs**

Hamamet (Ama) Ismale is old. She does not know how old she is, but she was engaged at age 18, and had her first of five children two years later. She has lost most of her teeth, and he skin is heavy with wrinkles, but she moves with the ease and agility of a woman much younger than she. Ama has never been to school, so she cannot read, she cannot write, and she only speaks Fanti. But her voice is strong and it has soothed and encouraged many woman in her lifetime: Ama is a practicing traditional birth attendant in the village of Abura. Ama's family is infiltrated with traditional healers; her father was a traditional herbalist and her mother and older sister were birth attendants. Her sister went to the Central Hospital for some formal training which she in turn shared with Ama, but her sister was the only one in the family to have done so. All of what Ama knows today stems from what these people taught her over the years, and now she is passing down the same information to her daughter, Khodija Easah Ahmed, who has been training with her for the past six months.[7]

Alice Asaam is another traditional birth attendant, but she is a little bit different than Ama. Alice is a corpulent, 65 year old woman who lives in the downtown area of Cape Coast. she, like her grandmother who taught her, was born with the knowledge and desire to become a TBA. She knows how to make medicines and cure certain illnesses from her dreams. It was never a question of what she was going to do in life, so at the age of 15 she began her apprenticeship with her grandmother, and by 20, Alice was delivering babies on her own. She went to school until she was 16 years old, so she can read, write and speak a handful of Ghanaian languages as well as English. In 1985 and again in 1991, Alice went to a three month long TBA training course that was being offered by the Jubilee clinic in Cape Coast. She was made the head of all TBAs in the Cape Coast District, so now oversees the work of more then twenty other trained TBAs. Alice's daughter Rose does Batik work now, but was training with Alice for awhile, and is able to deliver on her own as well. Together, they are known throughout Cape Coast, and in fact, many other parts of Ghana, for their expertise in maternal health care as well as other traditional healing.[8]

1.b. *Introduction to Hospital and Health Center Workers*

The Adisadel Urban Health Care Center is located right off one of the main roads in Cape Coast, and provides a variety of services such as administering medicines and vaccinations, dressing wounds and maternal care, both antenatal and deliveries. There is a maternal wing which has a delivery and recovery room that is used maybe four times a month, and a designated

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[7] Ama Ishmale, TBA, interview by author, 19 April 1999, Abura written notes, possession of author.
[8] Alice G. Asaam, TBA, interview by author, 19 April 1999 Cape Coast, written notes, possession of author.

area for the weekly clinic provided for the expecting mothers. On "clinic days," there may be as many as sixty patients, and on any other day, an average of about twenty women come to see the midwives. One of the midwives, Sarah Openg, left her job of sixteen years at the Central Regional Hospital to come work at the Health Center where she has been for the past five years. She had two year of nursing training in Cape Coast after she finished school, and went on to midwifery school in the Eastern Region for an additional two years. She, and her colleagues, occasionally go to workshops on safe motherhood and family planning as refresher courses. Sarah chose to become a midwife because she was interested in all the stages of pregnancy. It is a process that involves a mother and a baby, both of them require good care for the pregnancy to go well, and in her opinion, the "mechanism of labor is so unique."[9] One of her co-workers Margaret Mwinyele, is the medical assistant of the Health Center. She is the director of the Center and acts on behalf of the doctors. She labeled herself a "form four leaver," and then went on to describe how she went straight to nursing school at 16, and became a qualified registered nurse (QRN) in three years. She took a midwifery course for one and a half years, and followed that with a one year medical assistant course. She is constantly moving jobs because, according to her, "we're here to serve, wherever your services are needed to go." Margaret has been at the Center for ten months, and before that, she had been at the Central Hospital for three years, the Police Clinic for one year and the Ewim Health Center for six months.[10]

The Cape Coast Central Regional Hospital is an impressive, baby of an institution. It was just opened in August 1998, and has the facilities to handle pretty much any medical emergency. One of the two practicing obstetrician/gynecologists at the hospital is Dr. Seth Adu who as been involved with maternal health care for the past twenty-six years. He was originally planning on becoming a pediatrician, but after being posted in a remote area in the Upper West Region and seeing the "unacceptably high" numbers of maternal deaths, he decided to specialize in obstetrics. He went to medical school here in Ghana, but was also in the United Kingdom for eight years for further studies and practice. He has been back in Ghana now for four years, and has been at the Regional Hospital since it opened.[11] One of his nurses, Trinity Kpodo, had three years of nursing training in Cape Coast, and then went to the Korle Bu Teaching Hospital in Accra for one year of midwifery training. Similar to Sarah Openg and the midwives at the Health Center, Trinity and her fellow nurses go to occasional workshops and refresher courses. Trinity decided to become a nurse because as a young girl, she was frequently sick and had to go to the hospital. She got to know quite a few nurses, and not all of them were very nice, so she wanted to be able to give people better care than she had received. Dr. Adu and Trinity see

[9] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.
[10] Margaret Amwinyele, medical assistant, interview by author, 12 April 1999, Cape Coast, written notes, possession of author.
[11] Dr. Seth Adu, Ob/gyn, interview by author, 15 and 29 April 1999, Cape Coast, written notes, possession of author.

anywhere from thirty to fifty patients a day, and the hospital averages about two deliveries a day. there is a separate maternity ward that handles the actual deliveries; Dr. Adu and Trinity work in the main part of the hospital in an office/exam room.[12]

1.c. *Introduction to Mothers*

The first meeting with Ama, one of the TBAs, took place on a Tuesday afternoon in Abura, little did she or I know, but later on that night she was to get a knock on her door from the husband of a woman who was in labor. Twenty seven year old Grace Arthur started complaining of pains to her husband John Acquah, who in turn went to Ama so she could come and see Grace, who was, by that time, in full labour. There was no time to get her to the hospital, where she had delivered her first child, so Grace gave birth to her second child in her home with the assistant of Ama. She had been going to the hospital about once a month for antenatal check ups in addition to getting some medicine from her father in law who is a traditional healer. Her new son was just eight days old, and Grace looked as if she had not had too much sleep in that week. Her husband John did most of the talking, as Grace sat beside him with a dazed but content look on her face.[13]

The other "mother," Essie Sechwa, was a little more experienced than Grace, being forty nine years old and the mother of five children ranging in age from twenty four to twelve. Essie was the aunt of my translator, Mercy, and was living in Abura. Essie used to live in a neighbouring village called Ebou where all of her children were born with the assistance of one of her friends Araba Kakraba who is a TBA there. In the first five months of her pregnancies, Essie would go to the hospital for antenatal check ups, and would occasionally use their medicines. As the time got closer for her to deliver, she would go to her friend Araba if there was anything bothering her. She would also use medicines from Araba if the hospital medicines did not work.[14]

[12] Trinity Kpodo, nurse, interview by author, 15 April 1999, Cape Coast, written notes, possession of author.
[13] Grace Arthur, mother, interview by author, 28 April 1999, Abura, written notes, possession of author.
[14] Essie Sechwa, mother, interview by author, 26 April 1999, Abura, written notes, possession of author.

2.a. **ANTENATAL CARE**

An expectant mother is seen as a distinctive person and receives special treatment from her family and friends during her pregnancy.[15] There are certain precautions a woman may take, depending on where she comes from. Some women wear protective charms, others do not carry fire or go near icon objects. The pregnant woman may not be allowed to speak to her husband, or she will have to stay in her parent's house for a designated amount of time. There are also foods that the mother will be advised to eat or stay away from.[16] Interestingly, the literature used for this research explained the unique behaviours of pregnant women much more so than the people interviewed. There was a general consensus, however, that the women should eat healthy foods, get lots of rest, and not do anything terribly strenuous. There was no mention by the TBAs of any of the superstitions listed in the books, either because that was truly the case, or the sources did not feel comfortable enough in revealing that type of information. That aside, there were other various types of precautions and services rendered on the pregnant women for those crucial nine months.

If a woman was going to a TBA for her maternal health care, she would most probably only have a visit if something was wrong. Alice Asaam and Ama Ismale both mentioned a medicine used if the woman was having stomach pains that would prevent any diseases from harming the fetus or causing a miscarriage. It could also be used if the woman was having severe bleeding after delivery. It is called ayaforpechi and is a leafy herb with tiny yellow flowers. The TBA would collect it from the bush and either prepare it herself of let the pregnant woman prepare it if she knew how. They would grind the leaves and the flowers of the plant between two stones, add one pepper and a little water. They would then administer the concoction into the anus using a syringe type advice. (The syringe is usually an orange, rubber circle about the size of a baseball with a plastic applicator four inches long). When asked what this does to help the mother and fetus, the TBAs responded by saying that it would make the woman go to the toilet and thus flush all the impurities out of her stomach. This usually does not cost anything, but an additional charge is sometimes added on at the time of delivery.[17]

The TBAs will tell the women to eat certain foods such as *fufu, kontomire*, and *abenkwan* to keep themselves healthy. They advice the mother not to "roam about" while they are pregnant because it may put undue force on the baby. There is also information given about breast feeding; to prepare the breast by washing it with a cotton ball and warm water, and then applying shea butter to the nipple. They suggest that two years is a good amount of time to breast feed.[18]

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[15] Mbiti, John S. African Religions and Philosophy. Heinemann, London 1969. p. 110
[16] Mbiti, John S. African Religions and Philosophy. Heinemann, London 1969. p. 111 - 112
[17] Alice G. Asaam, TBA, interview by author, 1 May 1999, Cape Coast, written notes, possession of author.
[18] Ama Ishmale, TBA, interview by author, 19 April 1999, Abura written notes, possession of author.

A woman may also go to a TBA if she cannot conceive or is interested in family planning. If, for some reason, a woman cannot get pregnant, there is a medicine that will get rid of all the impurities in her system so she can "receive from her husband." The TBA will grind the leaves of the *akokonyindam* plant between two stones, add one pepper, a tiny bit of ginger and some water. This is then strained through a sieve before it is injected into the anus by the syringe.[19] The TBA can also help a woman who wants to prevent herself from getting pregnant. Pieces of mahogany wood are ground between two rocks until they become very fine in consistency. They are then placed in water and brought to a boil. The woman drinks the liquid after it has cooled for awhile. This can be drunk up to three times a day, but it was nuclear how often the woman needed to drink this beyond that. There was also no explanation as to what the mahogany actually did to prevent conception.[20]

If a woman chose to go to the hospital or health clinic, her visits would be a lot more frequent than if she went to a TBA. Sarah Openg, a midwife at the Adisadel Urban Health Care Center, discussed the entire process of antenatal care they administered. There are designated days that the Center holds clinics specifically for routine check ups, but the women can come in at any time if there is a problem. There is one main form that is used to record everything for each patient that comes in. on her first visit, the pregnant woman will give her and her husband's personal information: name, address, age, occupation, religion, education. She is also asked about her medical, obstetric, lactating and family planning history. The woman is then given a physical exam and any laboratory work that needs to be done. (There is no lab on the premises, but they send the tests to neigbouring hospitals or clinics.)[21]

The midwife also gives her a health talk and any other advise she may think the pregnant woman may benefit from such as proper food to eat, activities she should or should not do, and to breast feed for two years after the child is born and not to give the baby any water in the first six months. Family planning is also a much talked about topic, especially on clinic days. There is a midwife who specializes in administering birth control that ranges from condoms and vaginal foaming tablets to intra uterine devices (IUD) and Norplant.[22]

Once the woman leaves, there is a master list which the midwife then registers the patient into; her name, address, dates of visits, total number of pregnancies, which trimester she is in, and then what they have labeled as "risk factors:' parity (is this her first child or has she had more than four children), birth interval (risky if less than two years), age (below 20 or above 35), height (below 150cm), and hemoglobin (less than ten grams). It is suggested that woman go to the Center once a month during the first trimester, every two weeks during the second trimester,

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Ama Ishmale, TBA, interview by author, 27 April 1999, Abura written notes, possession of author.
[19] Alice G. Asaam, TBA, interview by author, 19 April 1999, Cape Coast, written notes, possession of author.
[20] Alice G. Asaam, TBA, interview by author, 23 April 1999, Cape Coast, written notes, possession of author.
[21] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.
[22] Margaret Mwinyele, interview by author, 12 April 1999, Cape Coast, written notes, possession of author.

and weekly in the third semester. Not every woman is going to go that many times, so it is also recommended that women go in for at least four antenatal check ups in the nine months, and as an incentive, the government has made these visits free of charge for the women. The medicine does not cost anything either during this time. If a serious problem is detected, the midwives will refer the women to a doctor at a hospital.[23]

The hospitals follow pretty much the same format as the Health Centers, but a little more focus is put in complications or problems with the pregnancies. They have a large contingency of resources such as ultrasound and sonogram machines which aid in detecting any abnormalities. There is a laboratory just down the hall which can produce immediate results, plus the obstetricians have access to doctors and nurses in other specialties if there is a problem out of their jurisdiction. A typical appointment will cost about 10,000 – 20,000 cedis, and the medicines are at an additional charge.[24]

2.b. ***The Delivery with the TBA***

In 1923, an anthropologist Robert S. Rattray, described a typical Ashanti delivery:

> "Dried plantain fibre is strewn upon the floor and upon this the woman sits with her back to the wall and is further supported by one of the midwives, who stands behind her, placing her arms under the arm-pits of the recumbent woman and placing her hands against her breast. Two other women each hold an arm. The fourth woman sits in front with her left foot under the patient's posterior and with her toe pressed against her anus."[25]

Things in the world of delivering babies has changed quite a bit in some areas, and stayed very much the same in others. Ether was no data from my research exactly like that of what Rattray found, but there was definitely a similarity to the practices of the TBAs. The deliveries take place in the home of either the TBA or of the delivering woman. Alice Asaam and Ama Ishmale both have specific delivery beds in their houses which they use. The woman's husband or mother might be close by, but the woman and the TBA are usually the only people directly involved in the actual delivery. However, if the TBA is training somebody, then that person may be there as well.

The first thing a TBA will do is check to see how close the woman is to delivering. She will do this by asking if a bloody mucus has come out, (the water breaking) and she will also

[23] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.
[24] Trinity Kpodo, nurse, interview by author, 15 April 1999, Cape Coast, written notes, possession of author.
[25] Rattray, Robert S. Religion and Art in Ashanti. Basel Mission Book Depot. Kumasi. 1954. p. 56

physically check the woman to see if she can see the baby's head. Ama Ishmale also described how she washed the woman's stomach with warm water and Lux soap. This would clean the stomach and make it easier to see the baby moving around inside.[26] If it is not time yet, the TBA will stand with the woman, talking to her all the time, telling her that she is doing fine and generally making her feel at ease.[27] If the baby is taking too long to come out, a medicine can be given to induce labour, a plant call *ntanta.* (Another version of this called *ataaba*). The woman will chew the stem of this herb as well as a *palm kernel* for about ten minutes before spitting them out. The reason given as to why this induces labour is that the ntanta makes it easier for the child to come.[28]

If there is a difficulty in the delivery, the TBAs will refer them to a hospital, although neither of the interviewed TBAs had sent a patient to the hospital because they had never had a "difficult" delivery. Ama Ishmale had had a breech delivery, but the baby had "come out so fast" that it was not a problem. Alice Asaam had never had a breech, stillbirth or maternal death, nor had her grandmother before her. This is somewhat hard to believe that neither one has ever had a troublesome delivery, but these TBAs may not want to admit to any problems which they have had because it would imply that they were not competent in their birth attendant skills.

At the time of the actual delivery, the TBAs use latex surgical gloves, warm water and clean cloths. These items, and the blades to cut the umbilical cord are either supplied by the TBA, or the patient brings them herself. Either way, the patient is financially responsible for them.[29]

Assuming that the baby comes out of the mother with little to no problems, the cutting of the umbilical cord and the removal of the placenta becomes the next issue. In traditional African culture, the placenta and umbilical cord are extremely important. They are the symbols of the child's attachment to the mother, to womanhood and the state of inactivity, thus they are dealt with great thought and care.[30] The TBA first ties the cord using pieces of string, approximately 3-7 inches long that have been soaking in spirits, a type of antiseptic. Ama Ishmale make three ties and would cut the cord using a new razor blade between the second and third tie, the first tie being closer to the baby and the third tie being closer to the mother. Alice Asaam would use two ties and cut the cord in the middle of them. Neither one gave a specific length of how long the part of the cord still attached to the baby should be, but they referred to their middle fingers when explaining it, pointing to their knuckles where they had made the ties.[31] The TBA will then dress the stub of the cord attached to the baby with a mixture of shea butter and salt, or

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[26] Ama Ishmale, TBA, interviewed by author, 27 April 1999, Abura, written notes, possession of author.
[27] Alice Asaam, TBA, interview by author, 19 April 1999, Cape Coast, written notes, possession of author.
[28] Ama Ishmale, TBA, interviewed by author, 19 April 1999, Abura, written notes, possession of author.
[29] Alice Asaam, TBA, interview by author, 19 April 1999, Cape Coast, written notes, possession of author.
[30] Mbiti, John S. African Religions and Philosophy. Heinemann, London 1969. p. 113
[31] Ama Ishmale, TBA, interviewed by author, 27 April 1999, Abura, written notes, possession of author
Alice Asaam, TBA, interview by author, 19 April 1999, Cape Coast, written notes, possession of author

chalk and salt until it falls off. It usually takes seven to fourteen days for the cord to completely detach from the baby, but once it does, the wound is then cleaned with heated water and dressed with dusting powder.[32]

At this point, the TBA moves on to the placenta, or *n'ekyir adze* as they call it. This needs to come out slowly, or the woman will suffer from severe bleeding. The TBA slowly pulls while the mother pushes, until it is completely removed from the woman. The mother will either take that that the cord home with her to bury some place in the bush, or the TBA will dispose of its in a toilet.[33] If the new mother takes it with her, it will usually be a man, the woman's husband for instance, who does the actual burying, a day or two after the delivery.[34]

Once the delivery is complete the baby and mother are washed with warm water and they, (or the TBA, depending on where the delivery takes place) go home. If any problems arise shortly after the delivery, the mother and baby will go back for treatment from the TBA. Sometimes the baby will appear to be dead; there is little movement and no sounds come from the child. These symptoms are the result of polio, and to prevent it, the TBAs will squeeze the leaves of *efumyuny,* producing a few drops of liquid that go into the baby's mouth. Then the leaves will be rubbed all over the infant's body. This can be applied once a day or as much as three times a day, for two weeks to one month after delivery.[35] There is also a common medicine given to the mother after she delivers. A woman becomes weak after delivering a child, so to give her strength, the TBA allows her to rest for three days, and then gives her something to further help her. The leaves of *nfufubier* are first ground between two stones, then ashes, one pepper, and water are added. A stone that has been heated by a fire is placed in the liquid to warm it. It is then put through a sieve to remove the large particles, and then administered into the anus using the syringe. Not all women are given this, and it is not given to any woman that is suffering from a hernia.[36]

The TBAs have varying costs depending on the difficulty of the pregnancy, the materials used, and the number of babies actually delivered, (multiple births cost more). A TBA can charge 5,000-15,000 cedis for a normal delivery and if it is an extremely simple birth, there is sometimes not charge at all. The delivery will also most likely be free if the TBA is related to the mother. If the mother and TBA struggle a lot with the delivery of if there are twins, the cost can be as much as 50,000 cedis, but this is only in extreme cases.[37] Some TBAs accept a

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[32] Ama Ishmale, TBA, interviewed by author, 19 April 1999, Abura, written notes, possession of author.
[33] Ama Ishmale, TBA, interviewed by author, 19 April 1999, Abura, written notes, possession of author.
[34] Ama Ishmale, TBA, interviewed by author, 19 April 1999, Abura, written notes, possession of author.
[35] Grace Arthur, mother, interview by author, 28 April 1999, Abura, written notes, possession of author.
[36] Ama Ishmale, TBA, interviewed by author, 20 April 1999, Abura, written notes, possession of author.
[37] Ama Ishmale, TBA, interviewed by author, 20 April 1999, Abura, written notes, possession of author.

combination of money and certain items. For instance, a TBA can charge 10,000 cedis, two eggs, a container of kerosene and some soap.[38]

2. c. *Delivery at a Hospital or Health Center*

When a woman comes to the Adisadel Urban Health Care Center complaining of labour pains, the first thing a midwife will do is look at her facial expression. Is she scared, is she tired, is she in extreme pain? The key to a good deliver is a good reception. The woman who is about to give birth is usually quite scared, and is only thinking about who can help her deliver her baby in the best possible way. The woman needs to be relaxed, so it is the midwife's job to make sure she is psychologically prepared.[39]

The midwife will then sit the mother down, assuming she is not in full labour at that time, and ask her questions about her contractions and any other symptoms she has been having. An exam takes place where all the vitals of the mother are taken, the fetal heart is listened to, and the cervix will be checked for dilation. If the baby is not coming immediately, the mother will sometimes take a bath, and warm water enema is administered through the rectum to empty the bowels which will facilitate the delivery. After that, the vitals of the mother and the heart of the baby will be checked every hour. If there are any problems, they can be checked as much as every fifteen minutes. There is also a vaginal exam every four hours.[40]

When a woman begins to sweat and complain of pains, the midwife will know the time is near. Normally, the woman will be having one contraction every ten minutes at this point. Once the woman says she feels like she needs to go to the toilet, the baby is ready to come and the midwife will tell the woman to "bear down" (push) and "by God's grace, she will deliver and we will hear the baby cry."[41] The baby's airway is first cleared by a small suction pump, and his/her color, movement and heartbeat is checked. The umbilical cord is clamped with two sterile forceps and is cut by sterile scissors in between the two forceps. The cord is then tied approximately ten centimeters away from the baby and is covered with a sterile bandage.[42]

If the placenta does not immediately follow the baby, an injection of either ergometrime or syntocinon is given to speed its expulsion. The midwife will also aid in its removal by massaging the stomach with one hand and gently pulling the placenta with her other hand. Once it is completely removed, the placenta is run under water and checked for any abnormalities. The midwives also look for any missing parts which would imply that there was still some left in the mother which would need to be removed to prevent infection. Sometimes during delivery, a

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[38] Essie Sechwa, mother, interview by author, 26 April 1999, Abura, written notes, possession of author.
[39] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.
[40] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.
[41] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.
[42] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.

midwife will administer a local anesthetic called xylocaine, but that is only if there are minor problems. If there are major difficulties, the patient will be sent to a hospital.[43]

One difficult delivery that the Central Regional Hospital has just handled was a woman who delivery five babies. All of the babies were born relatively healthy, but this woman and her new children had been at the hospital recovering for two months. The multiple medicines and procedures administered to this woman and her babies had added up to 800,000 cedis, and she unfortunately could not pay for any of it. The woman already had three children, and neither she, nor her husband had jobs. According to Dr. Adu, the overseeing doctor, this woman was going to able to leave the hospital without paying her bill. Because of the extraordinary case of this delivery, the hospital was going to handle her fees with money from the government.[44] Not all cases are like this by any means. A typical delivery will usually cost around 50,000 – 60,000 cedis, and more if there are any complications. The woman and the baby stay at the hospital for about a day before they go home. Again, if any problems arise, they will be there longer.[45]

The Health Centers charge quite a bit less for a normal delivery. The cost for the actual delivery itself is 4,000 cedis, but with all of the equipment and supplies used, the average price is 15,000 cedis. The mother sometimes brings her own gloves, blades and syringes too which can cut the costs.[46]

The disposal of the umbilical cord and placenta is also an issue at the hospitals and health centers. Occasionally, the mother will ask for it to take home with her. In that case, the midwife, nurse or doctor will wrap it in a cellophane bag and give it to the family. If the mother does not ask for it, the workers will bury in a designated place as in the case at the Adisadel Health Center.[47]

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[43] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.
[44] Dr. Seth Adu, Ob/gyn, interview by author, 15April 1999, Cape Coast, written notes, possession of author.
[45] Trinity Kpodo, nurse, interview by author, 15 April 1999, Cape Coast, written notes, possession of author.
[46] Sarah Openg, midwife, interview by author, 13 April 1999, Cape Coast, written notes, possession of author.
[47] Sarah Openg, midwife, interview by author, 29 April 1999, Cape Coast, written notes, possession of author.

3. a. CHANGING MATERIAL HEALTH CARE: THE PRESENT

Alice Asaam, a TBA in downtown Cape Coast, delivered two babies in March, and as of the middle of April, she had not delivered any babies that month. Thirty years ago, her grandmother, who was also a TBA, delivered about eight babies a month. Alice knows why these numbers of deliveries are decreasing, and it is not because she is a bad birth attendant. It is because women are deciding to go to the hospitals and health clinics for antenatal care and getting so accustomed to that type of service, that they decide to deliver there as well.[48]

Being a TBA is not a "fixed work" according to Ama Ishmale, who says six deliveries in a month is the highest number she has ever had. Two months may pass without one delivery, so they find other means of bringing home an income. Ama sells provisions and her daughter who has been training with her for the past six months is a nursery school attendant.[49]

It also needs to be taken into consideration that these women did not decide to become TBAs to become rich and famous. They do not think that what they are doing is that extraordinary or deserves critical acclaim. They are simply doing what their grandmothers and mothers taught them: delivering babies. This almost lackadaisical attitude which these women have towards their work is noted in how their patients perceive them. If a woman goes to the hospital to deliver her child, the nurses will yell at her and tell her to hurry up. But the TBAs are old and patient women who will sit with the delivering mother until she is ready to deliver.[50]

Some women decide to go to the hospital for antenatal care but then deliver with a TBA. Especially with the government paying for some of the first few visits, women have nothing to lose if they go see a doctor or midwife in the first few months. This is better than nothing some think, because early exams and test will pick up on any abnormalities with the fetus and the mother, giving them ample time to deal with it before it is time to deliver. It is the clinics and outreach programs that are having so much impact on the women, especially those from rural areas. They are becoming enlightened to the benefits of early health care during their pregnancies. They are aware of certain problems now which can easily be eradicated if picked up on early enough.[51]

However, going to the hospital and receiving medicines from the doctor is only half of the story. Some women do not finish the prescriptions or even take them at all. They complain of the hospital medicines not working, or causing constipation, or a myriad of other criticisms. At this point, they may go to their TBA or some other traditional healer to obtain another type of medicine which they believe will work.[52]

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[48] Alice Asaam, TBA, interview by author, 19 April 1999, Cape Coast, written notes, possession of author
[49] Ama Ishmale, TBA, interview by author, 28 April 1999, Abura, written notes, possession of author
[50] Grace Arthur, mother, interview by author, 28 April 1999, Abura, written notes, possession of author.
[51] Trinity Kpodo, nurse, interview by author, 28 April 1999, Cape Coast, written notes, possession of author.
[52] Esi Sekyiwa, mother, interview by author, 26 April 1999, Abura, written notes, possession of author.

There are also the women who go to the hospitals for all of their maternal health care. They usually have had a formal education so will be more likely to have a high level of income, they live in or near a city so the hospital is close by, and they come from younger generations who have started to separate themselves from traditional aspects.[53] They also may not trust the TBAs enough to deliver at home. The hospitals have a plethora of medicines to choose from if something goes wrong, the TBAs only have two or three.[54]

If the TBAs are adamant about what they do, the doctors are just as firm in their beliefs of their work. The doctors have had many years of formal obstetric and gynecological training, so they are skeptical of the TBAs who have never been in the classroom. According to a doctor at Central Regional Hospital, the TBAs include religion in their practices. If they have any training at all, it is only for a few weeks which is not nearly enough, and most times they deliver, it just good luck, not good obstetrics.[55] But a nurse working at the same hospital thought that TBAs were good for remote areas. The women cannot get to the hospitals and health clinics most of the time simply because of lack of transportation. TBAs ensure that a woman will not completely be on her own when she delivers, and if there is a problem, the TBA will be able to handle it better than the mother would if she was by herself.[56]

3.b. *Changes in material health care: The Future*

When asked if there was anything they would like to see changed or improved on concerning their services, the staff at the clinics and hospitals all wanted more personal and better instruments. At the Adisadel Health Center, there is only one set of delivery equipment. Ideally, they would like to have about four complete sets so they could immediately handle multiple deliveries if the case arose. Because their delivery room is not up to date, they are forced to improvise and make do with what they have a lot of the time.[57]

Another request from some doctors is simply more people. Dr. Adu who works at the Central Regional Hospital became an obstetrician because he saw so many maternal deaths in a remote area of Ghana. Yet he is not there practicing, because he feels his expertise is better utilized at the hospital which is a huge “referral center.” Doctors from various specialties and modern technologies can collaborate to give the best possible care. The care is unfortunately centered in one place, but at least it is better than having small amounts of health care

[53] Twumasi, P.A. Medical Systems in Ghana. Ghana Publishing Corporation, Tema. 1975.
[54] Mercy Dadzie, student, interview by author, 20 April 1999, Abura, written notes, possession of author.
[55] Dr. Adu, ob/gyn, interview by author, 15 April 1999, Cape Coast, written notes, possession of author.
[56] Trinity Kpodo, nurse, interview by author, 28 April 1999, CapeCoast, written notes, possession of author.
[57] Sarah Openg, midwife, interview by author, 29 April 1999, Cape Coast, written notes, possession of author

sporadically spread throughout the country. If there were greater numbers of doctors, they could be placed all over Ghana and supply more women with modern maternal health care.[58]

One more wish of scientific medical workers is that there could be more teaching aids, for them as well as patients. Doctors and nurses occasionally go to refresher courses, but not as much as they would like to. They leave nursing or medical school, and are then expected to stay up to date with their knowledge and practices on their own. There are new technologies and methodologies being discovered all the time, but they are taking a long time to reach the health workers as well as the general public here in Ghana. This information could be passed along through books, magazines and films. It is now just a matter of obtaining them.[59]

The hospital and clinic workers also mentioned a need for further training for the TBAs. The government knew that women would always go to TBAs, so it was thought that the TBAs should at least have a minimal level of training. This would include topics such as general hygiene during the actual delivery and proper health care for pregnant women. Some courses offered are six weeks, others are three months, but either way, it is not enough.[60] The TBAs still do not give antenatal care, and if there is an emergency during the delivery, it is sometimes too late by the time the TBA brings the patient into the hospital or clinic. The TBAs that do not have any formal training do not even know to bring emergency cases into the hospitals and clinics. It becomes very frustrating for the doctors, nurses and midwives to see to many women dying or becoming ill from preventable circumstances.[61]

Some health care professionals think that TBAs will be "phased out," or at least should be. Ghanaian society places so much emphasis on children and childbearing, it cannot afford to have the deliveries performed by illiterates with absolutely no level of basic education. It cost more in the long run to deal with the TBAs' referred emergency deliveries than it would if the women came in and had sufficient antenatal and preventive care.[62] Others, however, believe that TBAs will never leave the maternal health care system. The main reason being that so many people live in remote areas, they cannot reach anybody else but a TBA when the time comes for them to deliver. Their work can be improved though, mainly, through increased and better training. Ignorance is a paramount problem for some of the TBAs as well as the mothers, and the more they are subjected to basic health education, the more they will realize their benefits.[63]

The TBAs do not have much response to this. They know that they will always be needed, and most of them do not have any intentions of changing what they do. The TBAs do not see a need to alter their practices in any way, and when asked if there were certain aspects they would like to have added to their services, they could not think of anything. TBAs were

[58] Dr. Adu, ob/gyn, interview by author, 29 April 1999, Cape Coast, written notes, possession of author.
[59] Trinity Kpodo, nurse, interview by author, 28 April 1999, Cape Coast, written notes, possession of author.
[60] Trinity Kpodo, nurse, interview by author, 28 April 1999, Cape Coast, written notes, possession of author.
[61] Sarah Openg, midwife, interview by author, 29 April 1999, Cape Coast, written notes, possession of author.
[62] Dr. Adu, ob/gyn, interview by author, 29 April 1999, Cape Coast, written notes possession of author.
[63] Sarah Openg, midwife, interview by author, 29 April 1999, Cape Coast, written notes, possession of author.

around long before hospitals and clinics came about, and there was never an issue then. TBAs learn from practice, doctors and nurses learn through books. Women are more comfortable delivering with a TBA since she more patience than a doctor. Some women are simply scared of the doctors and nurses and so choose to go to the TBA instead. According to the TBAs, women prefer them over the hospitals, so the doctors and nurses can complain as much as they want, but the TBAs are not going anywhere.[64]

[64] Alice Asaam, TBA, interview by author, 1 May 1999, Cape Coast, written notes, possession of author.

CONCLUSION

The popularity of institutions such as hospitals and health clinics is on the rise, but they will never fully eradicate the presence of traditional birth attendants in Ghana. There are too many social, cultural and psychological attachments to these women who have been helping bring babies into this world for hundreds of years. However, there are improvements that could be made to facilitate and enrich the services of the TBA. These changes would not impose on the traditional practices of the TBAs, they would just make it safer and easier for the TBA, as well as the mother, to deliver a child.

It has been suggested that TBAs have some level of formal training provided by midwives, nurses or doctors. The first priority is to prove to the TBAs the importance and relevance of this training. If they understand why they should use clean razor blades to cut the umbilical cord for instance, then they will be more likely to implement their use. I found that the TBAs were familiar with a medley of medicinal herbs and traditional methods of health care, but did not seem to know the origins behind them. They had been told that a certain plant cured some ailment, or that they should not deliver a woman who is a hunchback, but they did not know how or why this was so.

There is also the recommendation that women go to a hospital or clinic for antenatal care to ensure there are no abnormalities with the mother or fetus. If picked up on early enough, many of these implications could be taken car of quite easily. There is a general trend towards preventive care in scientific medicine that is attempting to make the crossover into traditional medicine. Again, it is imperative that the traditional healers realize why it is better and easier to prevent a disease than cure it.

There are women, who if had the choice, would go to a hospital or clinic for the delivery of their babies. Unfortunately, it is impossible for many of them because of financial restraints and inaccessibility to transportation. Another tangent to this issue of maternal health care is making the hospitals and clinics more available to the general public. If more resources could go into things such as outreach clinics, ambulance services, and widespread health education, the infant and maternal mortality rates would inevitably decrease. With more knowledge of the Ghanaian languages, and more time at my disposal, I would have liked to visit more TBAs in rural areas of the country. I fear that my research was leaning towards the "modern" side as both of the TBAs I interviewed had had some contact with scientific medicine. It would also be interesting to speak with women who truly do not have a choice to go to a health clinic or hospital instead of a TBA for their maternal health care. I would strongly suggest a focus on these aspects for any further study.

The foremost goal of the TBAs, midwives, nurses and doctors is to help women who are expecting or delivering babies. It is the responsibility of these various groups of health care

providers to reach a compromise and work together in order for this to be accomplished. They each have specific and wonderful resources to contribute which could be made even better if they interconnected with each other. The TBAs could show the doctors how to use certain herbs to prevent miscarriages and the doctors could teach the TBAs how to perform a successful breech delivery. Medicine is a changing , yet stagnant entity which ultimately affects every person at some point in their life. The newest of technologies are being used at a hospital right around the corner from a traditional healer using medicines that were first discovered a thousand years ago. They are both attempting to heal the sick, only from different perspectives. It is hopeful, but of medicinal practices together.

BIBLIOGRAPHY

Adu, Dr. Seth. Obstetrician/gynecologist. Interview by author, 15 , 29 April 1999, Cape Coast. Written notes. Possession of author.

Ampofo, Daniel, A. The Health Issues of Human Reproduction of Our Time. Ghana Academy of Arts and Sciences, Accra. 1999.

Arthur, Grace. Mother. Interview by author. 28 April 1999. Abura. Written notes. Possession of author.

Asaam, Alice. Traditional Birth Attendant. Interviews by author. 19, 23 April and 1 May 1999, Cape Coast. Written notes. Possession of author.

Dadzi, Mercy. Student. Interview by author. 20 April 1999. Abura. Written notes. Possession of author.

Gyekye, Kwame. African Cultural Values. Sankofa Publishing Company. Accra, 1996.

Ismale, Ama. Traditional Birth Attendant. Interviews by author. 19, 20, 27, 28 April 1999. Abura. Written notes. Possession by author.

Kpodo, Trinity. Nurse. Interviews by author. 15, 28 April 1999. Cape Coast. Written notes. Possession of author.

Mbiti, John, S. African Religions and Philosophy. Heinemann, London. 1969.

Mwinyele, Margaret. Medical assistant. Interviews by author. 12, 23 April 1999. Cape Coast. Written notes. Possession of author.

Openg, Sarah. Midwife. Interviews by author. 13, 29 April 1999. Cape Coast. Written notes. Possession of author.

Rattray, Robert, S. Religion and Art in Ashanti. Basel Mission Book Depot, Kumasi 1954.

Sekyiwa, Esi. Mother. Interview by author. 26 April 1999. Abura. Written notes. Possession of author.

Twumasi, P. A. Medical Systems in Ghana. Ghana Publishing Corporation, Tema. 1975.

Twumasi, P. A. Social Foundations of the Interplay Between Traditional and Modern Medical Systems. Ghana Universities Press, Accra. 1988.