



RESEARCH REPORT

STRENGTHENING INTEGRATED HEALTH SYSTEMS



Acknowledgement

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List of Abbreviations

BPHS	Basic Package of Health Services
CHO	County Health Officer
FGD	Focus Group Discussion
INGO	International Non-governmental Organizations
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MWH	Maternal Waiting Homes
NPHIL	National Public Health Institute of Liberia
PHL	Public Health Law
TBA	Traditional Birth Attendant
TM	Traditional Medicine
TTM	Trained Traditional Midwives
TTM	Trained Traditional Midwives

Introduction



TTMs during the focus discussion in Bulna Community, Grand Bassa County

Traditional medicine (TM) or indigenous medicine also known as complementary and alternative medicine (CAM), is the oldest form of health care system in Liberia. These practices and knowledge are ancient and culture-bound methods of healing that Liberians have used to cope and deal with various illnesses before colonization, and has persisted beyond colonization in spite of colonial prescriptions.

There is no single universally accepted definition of the term TM because of its broad definition and usage. Notwithstanding, one of the most acceptable definitions of TM has been provided by the World Health Organization (WHO). According to the WHO, TM is “the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in

the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses” (WHO, 2000b:1). Traditional healer/ practitioner, on the other hand, is

“a person who is recognized by the community where he or she lives as someone competent to provide health care by using plant, animal and mineral substances and other methods based on social, cultural and religious practices” (WHO, 2000a:11).

Prior to the introduction of the Western Medicine (WM), TM used to be the dominant medical system available to millions of people in Africa; both rural and urban communities. Indeed, it was the only source of medical care for a greater proportion of the population (Romero-Daza, 2002). The arrival of the WM marked a significant turning point in the history of this

age-long tradition and culture. There are strong indications that traditional medicine is still in use by the majority of the population especially in rural Liberia despite this turning point. Medical pluralism has become the norm even when colonial services receives the lion's share of resources and legal protections and set the terms of debate for what constitutes acceptable medical practice.

To date, Liberia's public health sector continues to be overly reliant on professionalized public health consulting and funding, with a number of donor agencies offering technical assistance as public health experts since the end of the civil war.

These external partners and technical experts often seek to redefine existing knowledge and practices in favor of WM and trainings for the health sector



despite possessing little or no knowledge about the local context and problems they are trying to fix. Given the limited reach of the adopted westernized health system in Liberia, and the resurgence of growing interest in “traditional medicine” arguably out of critiques of the westernized health approaches, scientific superiority, and the notion of WM being a monopolistic path for strengthening public health systems, this paper makes an argument for integrating traditional practices and WM, as an effective and sustainable way of expanding the reach and outcomes of health care in Liberia. It also draws on situational analysis and a mixed-methods approach to make an argument characterizing the health system with focus on maternal care/ Traditional Birth Attendants as an example, as their agency is being considered illegal despite extensive use of their services during labor and delivery in both urban and rural Liberia.

This research challenges the effects of colonialism in public health in Liberia by understanding and documenting the perceptions of both Traditional Birth Attendants (TBA) and formal health workers regarding an integrative healthcare system as an effective and sustainable way of expanding the reach and outcomes of health care in Liberia. Lastly, this report documents how colonialism is playing out in the health sector and how traditional solutions like TBA are improving health outcomes.

Background

An issue that highlights the thorny nature of WM across cultures is the way in which colonial states used both civil and criminal laws to challenge and marginalize most forms of African therapeutics. However, no matter how dominant WM has become in sub-Saharan Africa, they never “entirely usurped other forms of healing practices already present”.

Liberia is located in West Africa and covers an area of 111,369 square kilometers. The country is divided into 15 political subdivisions called counties and five regions. These counties are further subdivided into 93 health districts. The country’s estimated total Population is 4.2 million people, with Liberia’s healthcare system heavily dependent on international donor support. Many healthcare facilities are run by the government, donors, or through non-governmental organizations (NGOs), including faith-based organizations.

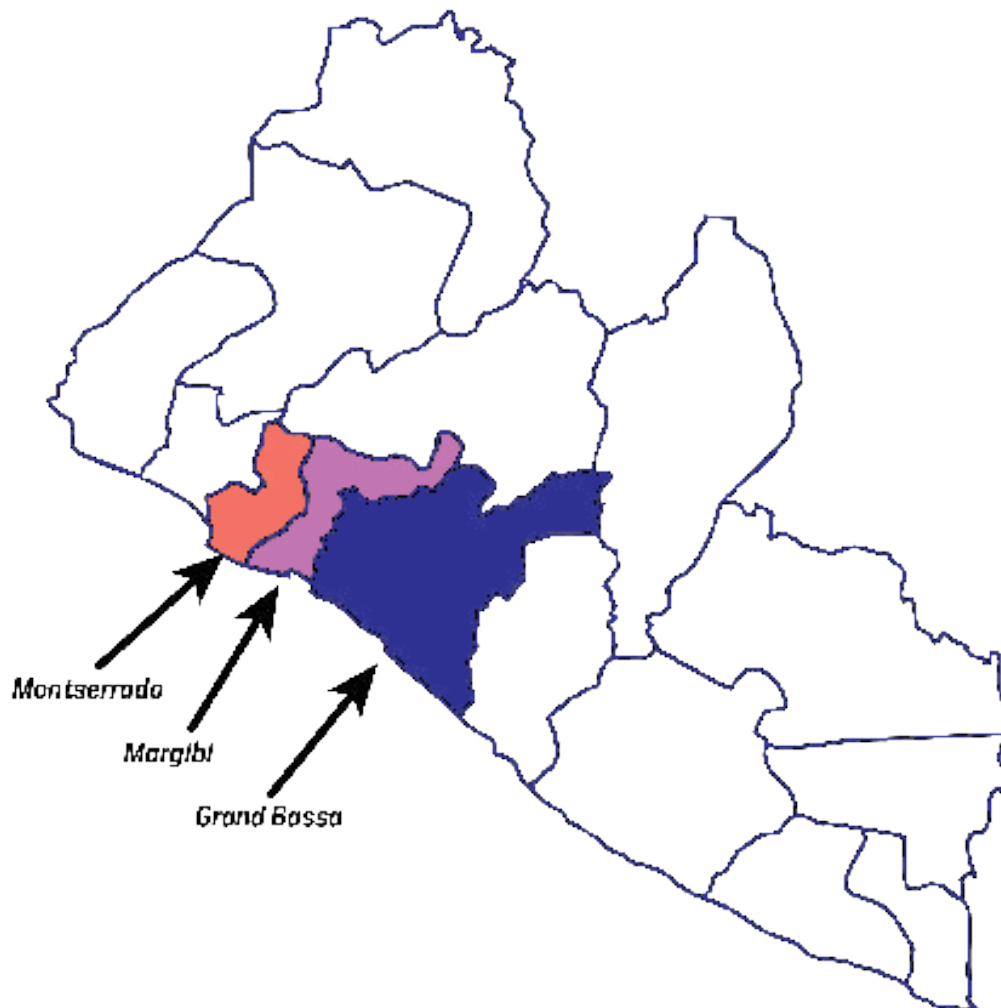
Liberia is a low-income country with a GDP per capita of US\$ 622 in 2019 . Nearly 39% of Liberia’s population lives below the World-Bank-determined international poverty line of \$1.90 per day. Such economic hardship is linked in part to the high direct and indirect costs of seeking and receiving medical care in the absence of adequate social protection against catastrophic health expenditures in a post war decimated national health system.

Worldwide, major causes of maternal death are: hemorrhage, hypertensive disorders of pregnancy, pre-eclampsia, sepsis, unsafe abortion, and other direct causes, including obstructed labor . However, “deaths from these causes have become readily preventable in western countries through the delivery of western medicine (evidence-based interventions) during the antenatal, perinatal, and postpartum periods” . Nevertheless, all of these causes remain prominent contributors to maternal mortality in Liberia despite the westernized National Public health system, strategies and laws.

In Liberia, public health is supervised by the National Public Health Institute of Liberia (NPHIL) in collaboration with the Ministry of Health (MOH). The MOH and NPHIL remains overly reliant on donor funding from high income countries accounting for nearly 65% of their annual expenditure. Example: In the national budgets for the fiscal years 2017-18 and 2018-19 the government appropriated 14% and 13%, only, to the health



The road to Yarpah Town,
Margibi County



sector, leaving a huge financial gap to be filled by donor partners. As a result, Liberia's public health system often adopts western-produced health knowledge and health care delivery approaches introduced through these donor partners despite seeming disparity in economic livelihood, access to new technologies, equipment, transportation, sanitation, electricity, culture and beliefs between Liberia and high-income countries. This results in a national health sector that is constrained by deplorable road network, weak supply chain management, particularly in terms of distribution

and storage of pharmaceuticals and other supplies, as well as limited human resources, particularly in terms of doctors, specialists, pharmacists, quality nurses and laboratory technicians especially in rural areas.

Moreover, research on health care utilization in Liberia suggests that rural Liberians disproportionately use TM sources of care compared with modern health care (Kruk et al. 2010). Data from Demographic and Health Surveys also indicates the low utilization of basic health care, particularly in rural areas, where only 25.5 percent of rural

women delivered with a health professional.

Thus, this study aims to identify barriers regarding the "adopted" WM, and argue why and integrated health system is more sustainable in Liberia's context with emphasis on maternal care and Traditional Birth Attendants (TBA). This study will also serve as a baseline-study aiming to qualitatively explore the views of TBAs and formal health care practitioners in three counties in Liberia; Montserrado, Grand Bassa and Margibi counties in both urban and rural areas, where maternal health workforce is especially lacking.

Methodology

This research is inspired by critical theoretical concern with challenging the status quo in healthcare by exploring the perspectives of TBAs and formal (maternal and reproductive) health care workers on maternal health practices in Liberia. It was conducted in March 2021 within three randomly selected counties in Liberia and the County Health Officers of the three counties selecting communities (Garmanyah, Valley-Ta, Yarpah Town, Tartee Town, Senyah and Bulna) with the most recorded out-of-hospital births in said counties. At the inception of the project, a desk review was conducted on the prevalence of western medicine and practices in Liberia's National Public Health System and health policies.

Subsequently, a total of six (6) Focus Group Discussions (FGDs) consisting of five (5) Trained Traditional Midwives were held (This complies with a recent recommendation by 'Guest and colleagues' to conduct between three (3) to six (6) FGDs in order to ensure 90% discovery of themes) and forty-five (45) semi-structured interviews were conducted. Participants were not paid participation, however, transport reimbursements were provided at the end of the FGDs due to travel distances.

PARTICIPANTS

Participants were eligible for the study if they had insight in maternal care context. In our sampling criteria, we strove to include perspectives from participants: (a) whom were facility-based health workers, delivering maternal health services; (b) occupied roles such as policy makers, or; (c) worked in the field of Reproductive Health. Additionally, voices of TBAs providing home-based maternal care in their communities were specifically sought, given their unique experiences. Purposive and snowball sampling were employed to recruit participants to ensure sampling criteria were satisfied.

DATA COLLECTION

Data collection was carried out over a four-week period between February and March 2021. The interviews were unscheduled and held at the health facilities, health workers such as; Medical Directors, Ambulance Supervisors, County & District Reproductive Health Supervisors, OB Ward Supervisors, Officers in Charge OPD, District Health Officers, County Surveillance Officers, District Reproductive Health Supervisor, Hospital Administrators, Nursing Directress, OR Supervisors, Directors Community Health Program and District Surveillance Officers were engaged to participate in the semi-structured interviews. Whereas, the FGDs were held at the

community centers or catchment clinics and administered in English; health workers volunteered assistance with translation as necessary. Prior to FGDs and individual interviews, the researcher provided an explanation of the study and obtained verbal or written informed consent based on literacy level of the participant. All community members provided verbal informed consent, making a mark on the consent form and witnessed by the researcher. All healthcare workers gave written informed consent. Participants were informed they could refuse to answer any questions or stop participation at any time. Each FGD consisted of 5–7 participants to ensure variation of opinions, and lasted between forty minutes to one hour. All data were de-identified and audio recorded.

DATA ANALYSIS

Data analysis was conducted collaboratively and consisted of six phases as per the DEPICT method.

1. The first step of this process, dynamic reading; involved each researcher reading a subset of transcripts and making note of broad concepts that emerged inductively.
2. In the second stage, engaged codebook development, these concepts were physically mapped to facilitate the emergence of codes derived inductively from the data, which became the draft codebook.

3. The draft codebook was piloted by two of the team members who independently coded the same two transcripts and compared results to ensure stability of the codes.

4. The revised, final codebook was then used to code each transcript twice independently in the participatory coding phase to ensure all relevant data were captured. Data in each code were then descriptively analyzed by team members in the fourth phase, inclusive reviewing and summarizing of categories, resulting in a set of descriptive analyses (one/code).

5. In the fifth phase, collaborative analyzing, the research team used a series of meetings to iteratively reflect on how the results contributed to answering our research questions.

6. The final phase, translation, involved transforming the study findings into a text.

RIGOR

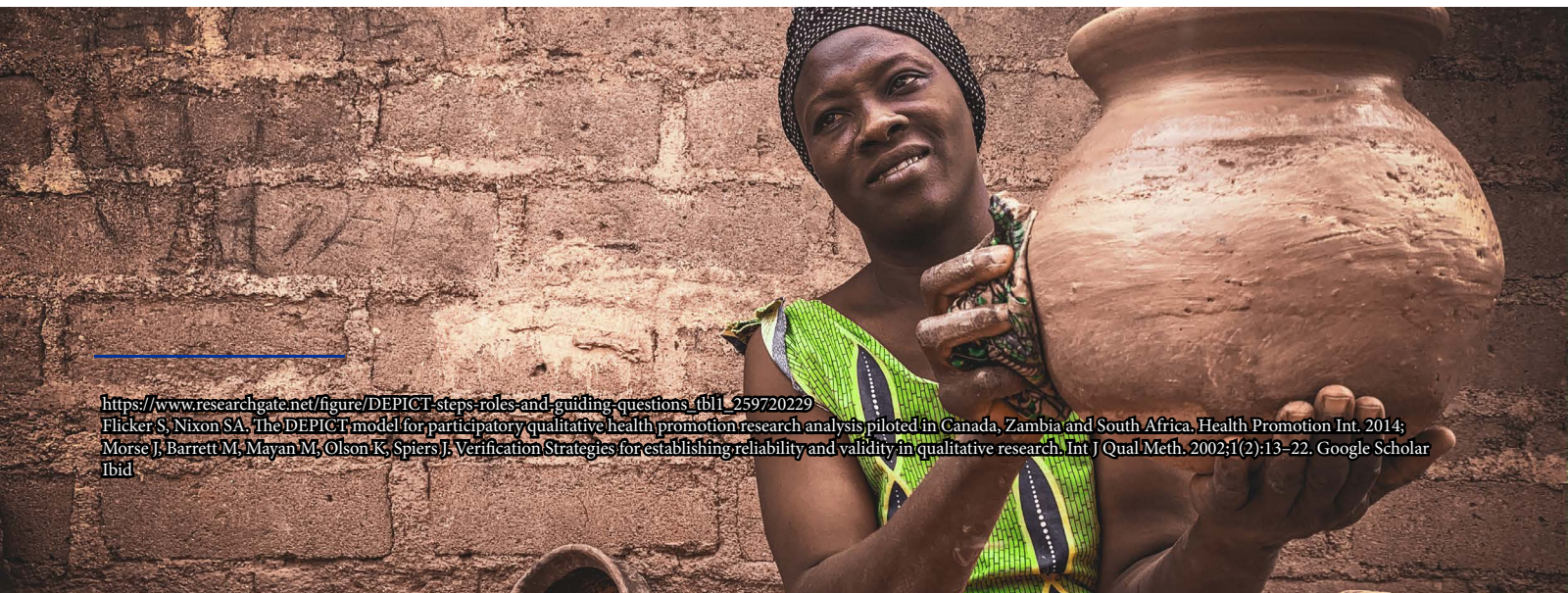
Strategies for verification (“checking, confirming, making sure and being certain”) were built into all steps of the research process and not restricted to post-hoc evaluation

strategies. Strategies for enhancing the trustworthiness of the analysis involved clarifying researcher bias which included reflexive examination of our past experiences and orientations to be more aware of how our social locations served to shape the interpretation and approach to the study. The DEPICT method of collaborative analysis provided a framework for explicating our analytic steps, while promoting creativity within the process. An audit trail, or copies of all documents reflecting methodological changes over time, was maintained for confirmability. Finally, by engaging in rich, thick description, and quotes we sought to provide sufficient descriptive detail of the participants and the context to assist with transferability of the data. (All interview quotes in Liberian English)

LIMITATIONS FOR THE STUDY

Several limitations are important to consider in the interpretation of our results. We did not employ a random sampling method, so the results cannot be generalized beyond the study area. The small participant pool (although it includes all health posts in the given catchment area) and data collection relied

on perceived opinions of the respondents. Also, interactions between TBAs and facility-based health workers, for example, may be quite different in other counties. The variability of these interactions even across our study sites suggest that the dynamics between these two groups are likely to be different in other parts of Liberia. We also did not gather data on peri-partum's experiences of both facility-based versus community-based maternal care, therefore we cannot verify respondents' claims about preferences. There may be some social desirability bias in TBAs' responses regarding services, as their practices are considered illegal and there are legal restrictions on their scope of practice. Similarly, there may be a degree of social desirability bias in both providers' responses about their motivations, and in their presentation of the importance of their role in the local community. However, at the community level relationships between these two providers were examined in greater depth, and given the consistency of responses both within each study population and across the two populations, we believe that respondents were for the most part forthcoming.





Desk Review Findings

This desk review attempts to increase the knowledge on colonialism in public health and enhance the safety of traditional medicine and practices amongst traditional practitioners with focus on maternal health by analyzing existing documents, trends across Liberia as well as efforts to address maternal mortality. This review also seeks to highlight related vulnerability of traditional practitioners (TBAs), and to inform policy makers and program implementers in creating effective policies and strategies to address colonialism in public healthcare.

A revision of existing laws shows the poor links and integration of traditional practitioners into public health policies on national levels, restraining effectiveness of traditional practitioners' services related efforts. Example: In 2015 the Ministry of Health developed the National Policy on Traditional Medicine in Liberia to integrate TM practices with the

conventional WM practices within Liberia's health system. With focused attention on leadership and governance, financing, human resources, research and development including infrastructure and manufacturing.

However, gaps in the policy include: 1) the lack of well-developed rules to regulate the practice of the Traditional Medicine

2) The lack of an acceptable standard of practice for traditional medical practice,

3) the lack in requirements to establish a documented referrals pathway between traditional practitioners and the formal health systems,

4) the lack of financing to conduct research and

5) lack of consistent legal framework for informal practitioners' rights.

Additionally, the revised Public Health Law of Liberia fails to implement a collaborative framework and recognition for the roles of TBAs in "Labour and

Delivery". Therefore, the delivery methods and approaches of these TBAs are often discounted and their expertise are considered illegal or harmful in most instances by public health professionals.

Legislation and programs do not have common definition of services to be provided by Traditional Practitioners (TP). This leads to challenges in data collection, making it difficult to address problems adequately and establish good cooperation between parties. Example: The most recent published Liberian Demographic Health Survey state that, 56% of all births in the country take place in a facility, with profound rural/urban differences, leaving 44% out of hospital births for consultation of TBAs. However, disregarding research statistics health workers assumes the increase in MMR is due to TBAs practices. Unfortunately, said numbers cannot be proven, nor can the assumption that the increased death rate in maternal care be attributed to out of hospital delivery due to lack of data.

NPTM: <http://moh.gov.lr/wp-content/uploads/Complementary-Medicine-Policy-v6.pdf>

RPHL: https://moh.gov.lr/wp-content/uploads/FINISHED-DRAFT-REVISED-PUBLIC-HEALTH-LAW-REPUBLIC-OF-LIBERIA-2019_Validation.pdf

Liberia Institute of Statistics and Geo-Information Services, 2013. Liberia demographic and health survey 2013.

Liberians are disadvantaged by the persistent colonial notion of white superiority in formal health care practices. Furthermore, Liberian-trained formal healthcare providers (HCPs) are at risk of becoming agents of colonialism in other contexts if they do not develop the skills to critically examine and deconstruct the Western dominance, racism and ethnocentrism underpinning healthcare practice. An example is the “Margibi County June 16th, 2016 Maternal Health Conference Agreement” between the communities and County Health Team which states: “all deliveries must be done in a health facility by a skilled provider”, disregarding Chapter 44 of the Public Health Law, Republic of Liberia which states as objective: “To promote and advocate for the use of traditional, alternative/complementary, preventive, and curative health care programs that have been proven

to be safe, effective, cost effective and consistent with government standards on medical practice” and the “National Policy on Traditional Medicine in Liberia” (2015-2019) to complement conventional medical practices in Liberia.

The health sector has formulated an Essential Package of Health Services (EPHS) with well-defined maternal health interventions at both the community and health facility levels to accelerate attainment of health related Millennium Development Goals (MDG) and other development agenda. The EPHS is an assortment of health services that the Ministry is committed to providing in every health facility. However due to limited access and cost of formal health care, some studies found that the majority of the population sometimes consulted both Western medicine and traditional practitioners.

Also, various studies have indicated that a potential solution would be integrating TM into a people-centered health system approach ; the involvement of the TP, which works actively alongside the formal health care system .

The persistent attention for TBA throughout the last years has acknowledged their importance but also how they have been excluded from the community health care delivery. Moreover, there is lack of recent qualitative studies that investigate informal maternal health care from their point of view, which has left a knowledge gap. If the maternal health care system in Liberia is to be successfully improved by involving TBAs and setting up collaboration with the formal health care system, it is vital to understand the current practices and perspectives.

Document Title	Reference
National Public Health Law	<i>Chapter 44, Traditional and Alternative Complementary Medicine</i>
Traditional Medicine in Lofa County, Liberia	<i>Self-Reported news among patients</i>
National Policy on Traditional Medicine in Liberia	<i>Policy Objective 3.3</i>
Safe Motherhood	<i>Family Care International</i>
United Nations Millennium Declaration	<i>Resolution (55/2) United Nations New York 2000</i>
LDHS	<i>2019-2020 Delivery Care 3.12.2</i>
Transforming Our World	<i>2030 Agenda for Sustainable Development</i>
World Bank Group	<i>Poverty and Equity Brief, Liberia 2018</i>
Causes of Maternal Mortality	<i>Systemic Analysis for the Global Burden of Disease Study, 2013</i>
WHO Liberia, 2007	<i>Roadmap for accelerating the reduction of maternal and new born morbidity and mortality in Liberia</i>
Liberia Institute of Statistics and Geo Information Services	<i>Liberia Demographic and Health Survey 2013</i>

Qualitative Findings

A total of forty-five (45) respondents were interviewed during this study, and thirty (30) participants in the FGDs. Participants' perspectives on strengthening integrated health systems were analyzed into three themes: (1) current formal health care structure; (2) challenges in the current structure, and; (3) discussions; "why an integrated health system is important". Participants indicated how considerations regarding integrated health systems could influence the delivery of maternal health services. The first theme provides insight into the current health structure, by showing how they are categorized. The second and third themes display existing challenges and discussions on their perspectives. These themes serve well to understand views and practice of maternal health, and reflect on the challenge. In light of those challenges, the final theme covers the potential solutions that are put forward by both respondents.

Characteristics		TBA	Health Worker
No. of Participants		30	45
Sex	Male	3	5
	Female	27	40
Age	>65	14	5
	>40	12	12
	>30	1	8
	<30	3	20
Years of Experience	<35	11	7
	<20	13	8
	<15	3	10
	<10	0	7
	>10	3	13
Level of Education	None	25	0
	Primary	3	0
	Secondary	1	0
	Polytechnic	1	21
	University	0	14
	Post Grad	0	10

Table 3: Demographics of participants

Formal Health Care Structure

The health systems in Liberia are powerfully shaped by the structures and attitudes created throughout history. Liberia's public health sector continues to be overly reliant on professionalised public health consulting, with a number of donor agencies offering technical assistance as public health experts. These external partners and technical experts often seek to redefine existing knowledge and practices in favour of Westernized health structures and trainings for the health sector

despite possessing little or no knowledge about the local context and problems they are trying to fix. These Western-produced health knowledge often dismiss Liberia's existing health structures and networks, values, local relevance, and their sustainability. Exhibiting the colonial mindset of dismissing oral transmission and illiterate or experience-based knowledge, to instead give most value to written and academic knowledge, thus excluding those not educated such as TBAs. It is not a relationship

in which TP such as TBAs are collaborating equally because of their understanding of the problem and context



“Whenever we take patients to the hospital, they will ask us out of the delivery room. They don’t even have a place for us to sit and we sometimes have to spend the night”. (Community-based TBA)

“They tell us not to do delivery at home, before this hospital came here, I was in the community doing this work, and by the grace of God no big belly nah leave in my hand, but now they refusing us”. (Community-Based TBA)

Additionally, in line with literature on maternal health, it has been theorized that approximately 15% of pregnancies with complications require modern obstetric care. However, research information suggests that formal health systems in Liberia are far from prepared due to limited accessibility, availability and affordability. Example: upon arrival at the catchment clinics (six clinics in hard to reach areas) this research found that 67% of the participating communities are at

least four (4) hours walk from the nearest catchment clinics. Of the six (6) catchment clinics visited, only two (2) had skilled health workers present, all six lacked medical supplies and ambulances for referral. When asked, Formal healthcare workers informed that the ambulances are always parked at the referral hospital and will have to be requested for during emergencies before they commence their journey.

“All the ambulances parked at the county hospital, and you have to call them before they start coming. This place is more than one (1) hour drive from the hospital in good weather, and when it raining, it even worse. The ambulance can take too long to arrive”. (Facility-based health worker)

For instance, in Margibi County where County Health Team (CHT) has put a ban on the work of TBAs, there is still a visible absence of skilled health care workers and or

limited access to catchment clinics.

“Nobody here, all the people can leave us here and go to Monrovia. They say the place too far. Even to receive phone call here can be hard.” (Community-based TBA)

“They say we must not help deliver the big belly them, we must bring them to the hospital, but when you get here nobody to help the big belly. You have to wait and wait before they come. All that can lead to problems.” (Community-based TBA)

Additionally, when TBAs were asked to list three reasons why patients could refuse formal healthcare services, 80% of the the TBAs informed that the rural population may not have confidence in the formal health system because it is largely sponsored by foreign organizations, treatments are administered in English, which poses a communication gap, and affordability and accessibility were listed as the most common reasons.

Challenges

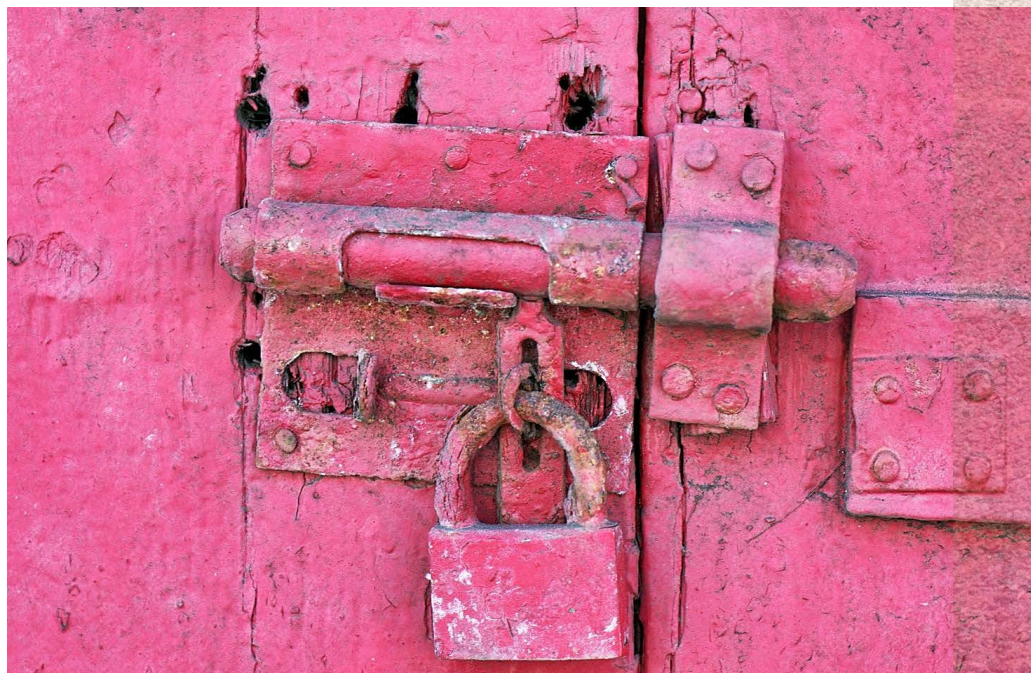
A. Accessible Health Facilities Distance:

when asked to list two (2) reasons preventing women from attaining treatment in existing facilities, 90% of the participants listed distance as one of the main reasons. Participants informed that distance and bad road network posed a significant challenge to accessing and utilizing maternal services. Some catchment communities can only be accessed via foot path, community made bridges or bush road; no vehicle, and in some cases motorcycles, cannot be used to reach said communities especially during the rainy season. In most instances, women only reach the facilities by foot. TBAs explained that this walk is strenuous for pregnant women, especially when in labor.

“That is one of the reasons women prefer to deliver at home with a TBA rather than walks for hours to get here”. (Facility-based health worker)

“See that hill? As soon as the big belly climbs it, she delivers at the top of the hill. We have to wrap the baby and continue walking to the hospital”. (Community-based TBA)

“Last time me and the big belly walked and came here, after she suffered for long the nurse say we have to go to the big hospital. We had to wait for long before the ambulance can come. The big belly



really suffer. The finally helped the big belly but the baby nah make it”. (Community-based TBA)

One aspect of health system strengthening efforts has been the introduction of maternity waiting homes to house women in the last few days or weeks of pregnancy, offering easy access to a nearby healthcare facility capable of providing emergency obstetric care (EmOC) once labor begins. Upon arrival at three (3) rural catchment clinics adjourned to the six (6) participating communities, all of the Maternal Waiting Homes (MWH) were found to be empty. When asked, participants informed that the MWHs were not being utilized due to food scarcity, distances from communities and inadequate capacity.

“When the big belly here, who will feed her? Her family won’t walk for hours just to bring her food and go back and the hospital people will not take care of her. So they can stay

in the communities”. (Community-based TBA)

Transportation: both TBAs and health workers agree that when at a catchment clinic, in cases of emergencies leading to referral, patients should be provided an ambulance; however, interviews with 75% of the facility-based health workers showed that transportation of emergency patients by ambulance was unreliable. Some health workers mentioned the lack of fuel also being a challenge, in cases where ambulances are available. Hence, mandating caregivers to search for commercial vehicles which are most times unaffordable for rural community dwellers because of low/lack of income and distances.

“We only have one ambulance that is stationed at the main hospital, patients usually have to wait for the ambulances to travel from the hospital to them and return. The distances are sometimes over an



hour one way depending on the road condition. Such delays can have significant health consequences and, in some cases, lead to death.” (Facility-based health worker)

Furthermore, an ambulance supervisor interviewed reported that sometimes the ambulance’s ground clearance is too low for off main roads travel.

“When the woman develops a complication at a catchment clinic and requires hospital management, she is forced to remain at the clinic because of the lack of transportation. Sometimes the ambulance driver will have to ask the patient’s relatives to transport her to a main road”. (Community-based TBA)

“We have two ambulances, but one is very low. It can’t afford to go to on bad roads. So, we ask patients to meet us on the main roads, which is sometimes 2-3 hours walk. But we don’t have a choice because there is not enough money for maintenance and repair, and if this ambulance breakdown, we will have the same problems or even worse” (Facility-based health worker)

“With the bad roads and poor fleet maintenance, the ambulances often breakdown on their way to pick up the patients” (Community-based health worker)

During interviews with facility-based health workers, several admitted to instances of ambulances breaking down and patients dying because of the resultant delays.

Cost Implications

The cost of transportation was found to be a barrier at three key points: from homes to the clinics, clinic to the hospital during transfer if required, and hospital or clinic back to home. In a few instances, TBAs who lived closer to accessible roads also noted that they were often unable to summon a vehicle due to financial constraints.

Additionally, the cost of delivery was found to be high for community dwellers despite “Labor

and Delivery” being a part of the Basic Package of Health Services (BPHS). During the FGDs, TBAs informed that peri-partum mothers are frequently told by health care workers to provide a kit of personal items, to be used by the mother and staff at the time of labor and delivery. This birth preparedness kit must contain bleach, Dettol (a surgical disinfectant), gloves, alcohol, and

soap, swaddling clothes (or a lappa), a small towel, and sanitary pads. They also reported that patients could be



denied admission to facilities when they do not have a complete birth kit. When asked, healthcare worker admitted to requesting for Birth preparedness kits because they lacked said materials which ideally should be provided by facilities/ government under its declared provision of free healthcare, and that services could not be provided during labor and delivery without the minimum required materials as they would be exposed to blood borne pathogens. Both health workers and TBAs reported experiencing stock outs of medical supplies. Patients are

frequently given a prescription (“paper”) for necessary supplies or medications. TBAs also reported that some of their patients refused to report to a facility for delivery because they did not have money to buy the drugs they knew would be prescribed.

TBA respondents also expressed that they were the preferred labor and delivery service providers because of their ability to provide more affordable access, flexible payment methods and customer care.

“As for us, we cheap. The people can even talk to us if they don’t have money and we will accept because we all from the same place”. (Community-based TBA)

ELWA HOSPITAL

From: Marie Tamba
To: All OB
Sub: **Materials for use during and after delivery**
Date: September 12, 2019

Please deliver the below listed items to the OB Ward before delivery. These items will be used during and after delivery.

1. Big bottle of chloral	1
2. Big size of delta	1
3. Parks of cortex	3
4. Rolls of tissue	2
5. Park of pampas	1
6. Parks of tag soap	2

MATERIALS FOR BABY

1. Joint suit	4
2. Pairs of sox	4
3. Blankets	4
4. Baby hat	4
5. Towel for bathing	1
6. Towel to wipe baby of delivery	1
7. Vaseline for baby	1
8. Baby bath soap	1

MATERIALS FOR MOTHER

1. Clean lapper	4
2. Panties	5
3. Bath soap	3
4. Bath towel	2
5. Toothpaste	1
6. Drinker cup	1
7. Eating spoon	1



Challenges

B. STAFF RELATED CHALLENGES

Upon arrival to the health posts, an unexpected finding was that although 90% of the centers had skilled health workers on staff, skilled health workers were only present at three (3) of the six catchment clinics. There were various explanations for their absences, including being on a leave, taking a short break to attend to family matters, attendance at conferences or seeking medical care. According to one of the County Health Officer (CHO) interviewed, the staff shortages has been mitigated with adequate staff placement. However, this system put in place can only tolerate a few unanticipated absences which are impossible to manage due to staff resignations and burnout, resulting in the neglect of patients. Resignation is common in rural Liberia. "Retaining public health care workers in rural settings has been a challenge" said one CHO. New grads often accept rural assignments in public facilities, but after a couple years of service, they seek employment in urban areas, or leave public service to work with a nongovernmental organization (NGO) due to higher offers and benefits.

"I have worked here for two year now but nothing here, so I have asked for a transfer, and if they can't find me another place of work I will leave the job" (facility-based health worker)

Upon arrival to the health posts, an unexpected finding was that although 90% of the centers had skilled health workers on staff, skilled health workers were only present at three (3) of the six catchment clinics. There were various explanations for their absences, including being on a leave, taking a short break to attend to family matters, attendance at conferences or seeking medical care. According to one of the County Health Officer (CHO) interviewed, the staff shortages has been mitigated with adequate staff placement. However, this system put in place can only tolerate a few unanticipated absences which are impossible to manage due to staff resignations and burnout, resulting in the neglect of patients. Resignation is common in rural Liberia. "Retaining public health care workers in rural settings has been a challenge" said one CHO. New grads often accept rural assignments in public facilities, but after a couple years of service, they seek employment in urban areas, or leave public service to work with a nongovernmental organization (NGO) due to higher offers and benefits.

"I have worked here for two year now but nothing here, so I have asked for a transfer, and if they can't find me another place of work I will leave the job" (facility-based health worker)

APPROACH TOWARDS PATIENTS

TBAs noted that patients preferred their services because in many cases they are usually from the same ethnic groups, communities and speak same dialects. Which is not the same in the case of the health care workers, whom also often fails to approach patients with care and courtesy. Fifty per cent of the participants listed "bad approach" to the question; name two reasons why women would prefer to be treated by the TBA than a HCP". Interviewees reported that many facility-based midwives often had no respect for the patients and spoke harshly to them. Patients are shouted at, sometimes insulted and beaten, during delivery at health facilities.

Also, during treatments, patient's consent is rarely sought. Patients may view medical interventions differently from the facility-based health worker, leading to mistrust, misunderstanding, and resistance. TBAs explained that such harsh treatment from facility-based midwives discouraged community women from seeking services at some facilities.

"Sometimes the big belly will refuse to go there, because the people who are there, are not doing the work well. They can talk to you rough. When somebody is sick, they can be like baby. But they will be shouting: Sit down! Don't make noise! And just giving them medicines, nobody knows what all they can be giving"

(Community-based TBA)

“You know the parable, it can go in like catfish but come out like crab? That it there! So, people have to understand that the woman can be in pain and not be shouting at her”.

(Community-based TBA)

“Too little, too late and too sloppy: delivery care is not a mere matter having a hospital with trained clinicians, it is also a question of how professional staff perform and behave. (Bergström 2001, Buekens 2001).”

Challenges

C. TRADITIONAL MIDWIVES INFRASTRUCTURE:



When asked “do you value the contributions of the TBAs?” ninety-five per cent of the healthcare providers reported the importance of working with the TBAs and valued their contribution in the provision of awareness and/or serving as a linkage between the facilities and the communities. The TBA infrastructure, rooted in local customs and belief systems, provides easy access because they are trusted within communities.

However, fifty per cent of the interviewed healthcare workers did not think that TBAs should be providing labor and delivery services as they are not equipped to handle obstetric complications. They also reported that the trainings provided TBAs were not sufficient to handle instances of complications because they had not

acquired western education. When asked, the same question TBAs had a differing view. Although they viewed their role as filling an essential gap in access to healthcare services, they also expressed clear limits to the type of services they could offer because they had experience and Deliver. Eighty per cent of the TBAs claimed to have over 20- 35 years of experience. They admitted to not knowing the medical terminologies or symptomatology but knew when to refer patients to the hospitals.

Also, TBAs mentioned no longer providing Labor and Delivery services in their various communities because of “a law passed”, abolishing labor and delivery in communities. This document was only available in one county, other counties were

implementing said “law” but didn’t not provide a copy of the law.

“When the woman pregnant, I will observe her. After every month I will check her stomach to see if the baby lying down good. If the baby not lying down good or I see other problems, I will tell her to go to the hospital, and when she refuse I can carry her myself. Because we living together in the community and I don’t want problem” (Community-based TBA)

“Me I started doing this work before the war, I used to work with one woman here. Not all big belly you can help in the house. When I go check the big belly and the baby not lying down good, I can tell her to go to the hospital, because the baby will come with the foot”. (Community-based TBA)

Challenges

D. COMPENSATION

After Liberia’s civil war, in order to increase rates of facility-based delivery and reduce poor maternal outcomes, the government worked with NGOs

to incentivize TBAs to refer their clients to health facilities. TBAs who referred patients were often provided with money or fabrics valued at US\$ 10.00 (Ten United

States Dollars). From 2014 onwards, this program gradually ceased, as funding dried up. However, recognizing the effectiveness of TBA systems, some county health

systems restarted the program, offering TBAs cash payment for each woman referred for a facility-based delivery. TBAs have come to expect cash payments in return for their referrals, but the county does not have an adequate budget to fund said program. Consequently, in some communities, referral compensation for TBAs has often become the responsibility of individual patients. The existence

of unidirectional referrals between TBAs and public health facilities highlights the extent to which their roles in providing primary health services were complementary.

“If the woman call me in the night to help her delivery her child because it late even though I know she will not have money to pay me, I will have to go and help her, in the morning, I carry her to the hospital

for the baby to take the injection (vaccine)”. (Community-based TBA)

“When checking the big belly in the community, if I notice something not right, I will take them to the hospital straight. Sometimes I have to spend my own money. But, if the big belly can't pay me, and the hospital can't pay me, how I supposed to eat?” (Community-based TBA)

A close-up photograph of a woman with dark skin and curly hair, shouting into a red megaphone. Her mouth is wide open, and her expression is one of intense effort or passion. The background is a plain, light color.

Challenges

E REFERRAL

Ninety per cent of the facility-based health workers interviewed, acknowledged that TBAs were an important access point for primary care, because they often bridged existing infrastructural barriers such as poor roads network, shortage of human resources, equipment, and drugs in rural Liberia with their consistent presence in the communities and their ability to utilize locally made materials/ equipment or herbs in the provision of services. When asked: “should TBAs be allowed to refer patients to formal health facilities and share concerns with the facility-based health workers?” forty percent said yes and continued to add that they would sometimes allow the TBAs to conduct delivery within the health facility when accompanying a patient to observe their performance and provide feedback. Amongst other health workers interviewed, in contrast,

they thought that the presence of TBAs exacerbated improper care-seeking behaviors among patients, and that TBAs thus constituted an impediment to their work. These respondents expressed concern that TBAs provided inappropriate, ineffective care, and contributed to high MMR due to illiteracy or low literacy rates. This reinforces the understanding of TBAs being dismissed as part of the colonial construct that imposes ideas of superiority of Western knowledge and practices over practices and knowledge bred locally.

Thirty per cent of facility-based health worker also said that potential patients preferred services from TBAs when they should have gone to the catchment clinics, and that customarily TBAs delayed referrals and caused patients to arrive when their conditions are already severe.

Some facility-based health workers' view of TBAs contained a degree of professional animosity. A few even view TBAs' general motivations with suspicion, and thought that they were willing to try to provide care beyond their level of knowledge. As a result of these complex dynamics, some facility-based health workers regard TBAs in their communities as something of a necessary evil: a poor-quality source of care, but one that nevertheless was important in providing access to labor and delivery services in their underserved communities.

“Sometimes the big belly don't have no option; some don't have money for transportation and cannot walk the long distances at night because of their security and condition. They will definitely send for the TBA. She's right next door” (facility-based health worker)





DISCUSSIONS

Upon analyzing the data, facility-based health workers and TBAs viewed their role as providing primary healthcare, respondents of both types emphasized the particular importance of TBAs in terms of the provision of care to underserved rural communities. This was particularly true in Margibi and Grand Bassa, where a number of TBAs described their role in relation to the poor availability of health services in their communities. TBAs viewed labor and delivery practices as acceptable in their own cases specifically because they had received training on labor and delivery, either through TBA programs or through an apprenticeship, even though they often recognized that delivery services were not permitted within their legal scope as per the “law”.

The TBAs interviewed for this study viewed themselves as an essential part of their community health system, not just as livelihood seekers. Although TBAs’ and public healthcare workers’ views of each other and the services they provided

(or the cost and availability of those services) were not always positive, most recognized a degree of interdependency in their roles providing primary healthcare to underserved rural communities, which argues for the inclusion of TBAs in a people-centered approach to improving maternal service delivery in these areas.

While respondents generally agreed that TBAs played an important role in extending geographic and financial accessibility in maternal care, they considered the TBAs service delivery role as differentiated from, and at a more restricted and lower level of maternal care than, the role within the public health facilities. At the same time, there is an overlap between the actual qualifications and practices of TBAs and facility-based health workers.

Both TBAs and the staff of public healthcare facilities in the study areas explained their motivation to work in the health field should not be assumed to be purely profit-oriented. However, some health

workers were suspicious of TBAs’ true willingness to refer away patients, and we are unable to verify the extent to which profit versus altruistic motivations influenced TBAs’ actual interactions with their patients. Nevertheless, interventions that aim to improve the quality of care provided by TBAs, including encouraging proper referral practices, should consider the potential to appeal to their non-financial as well as financial motivations for providing quality services. In addition, TBAs’ desire to be considered part of the healthcare system is in and of itself a non-financial motivation for improved referral and continuity of care.

Another consideration in terms of service integration is the fact that TBAs’ and healthcare facilities’ roles were differentiated, and largely complementary, in the eyes of the health systems actors. However, these relationships stopped well short of the level of integration that could provide users with continuity of care.

Recommendations

Inclusive Laws and Policies: TPs provides essential services to their communities in several ways with access to health services that might not have been available otherwise. Integrating traditional and formal health systems expands the reach and improves outcomes of community health care. Also, from a MMR perspective, supporting stronger and more consistent linkages between TBAs and public health facilities through the implementation of referral instruments would be a key step towards improving continuity, quality care and regulations.

Funding for research: there is a lack of research data, lack of financial support and general technical guidance for research and evaluation of TM related to safety, quality and efficacy. Hence, funding to study the efficacy of traditional medical approaches should be a priority, because it's equally important that there are mechanisms in place to ensure that TM research is conducted at a high level, with checks on quality.





Conclusion

Colonial rule has marginalized forms of care and therapy that made sense to many people. Prior to the introduction of western medicine, traditional medicine used to be the dominant medical system available in both rural and urban communities in Liberia. In areas such as the rural Liberian communities where parts of this study took place, the reality of the situation is, care-seekers still rely extensively on traditional medicine to meet their health needs because of the location of traditional practitioners; close to communities, both geographically, sociocultural, financially and could serve as an avenue through which cultural heritages are preserved and respected.

This paper concludes that to minimize the current distrust between western and traditional medicine, promote an integrated public health system, and to achieve the objective of regulation,

standardization and cooperation, both traditional and western medicine practitioners must:

1. Acknowledge their areas of strengths and weaknesses from which they operate;
2. Donor organizations and health experts must genuinely consider the local challenges before implementing or enforcing western knowledge and practices; and
3. Not impose ideas of superiority of Western knowledge and practices over anything bred locally.

Example in such contexts, we argue that a pragmatic approach to working towards reduced maternal mortality goals in the shorter-term is to incorporate TBAs, building on the motivations of these TBAs to provide primary care, increase healthcare accessibility, and help alleviate some of the access gaps in

the current provision of maternal care, because they are the source of a significant percentage of maternal care delivered.

This suggests the need for bold actions to recognize existing traditional practices and collaborate to foster sustainability, resist the neo-colonial narrative in which high income countries are “saving” poor people, develop communication campaigns to promote attitudinal change towards traditional medicine, and conduct research that are rooted in African realities and knowledge.

Therefore, it is important to note that unless alternative solutions and the improvement of referral pathways are sought to reduce this gap between traditional- and western medicine, and avail the necessary resources to further understand the traditional African models, the burden of high mortality rates is expected to grow.

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