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A Layman's Perspective On Women's Health Care In Ghana

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By

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Acknowledgments

I would like to express my sincere gratitude to Dr. Wilson and all the members of team D for graciously allowing me to become a part of your team for these past weeks, for tirelessly answering all of my questions, and for making me laugh when I needed to. I would also like to thank all of the nurses and midwives in the obstetrics and gynecology departments for giving me the opportunity to observe as much as possible during my limited time.

To Elizabeth Opuku, I would like to say thank you for helping myself and the other members of my group to learn more about your village. More importantly, thank you for being my entrance into the Ghanaian midwifery system.

To my homestay families, the Konadus and the Sakyis, I want to say thank you for welcoming me into your homes and hearts forever.

To Olayemi Tinuoye and Juliaynne Walker, my Academic Directors, thank you for guiding my entrance into this culture and for being there when I needed you.

Abstract

In an attempt to study women's health care in Ghana, an internship was acquired at Korle-Bu Teaching Hospital. For three weeks, the author joined a team of doctors, observed the methods they used, as well as the beliefs and traditions held by the patients, in regards to the fields of obstetrics and gynecology. The primary focus of the internship was to examine the system of care offered at KBTH, and compare it to an American system that the author had previously observed.

As expected, the system of obstetrics observer at KBTH was found to be quite different from that of the United States. The most basic difference was that midwives deliver the vast majority of the babies in Ghana, whereas obstetricians delivered all of the babies in the American hospital that the author observed. This difference afforded the Ghanaian patient a number of benefits. For instance, they are given more time to deliver spontaneously than their counterparts in the United States. But the system is not without its drawbacks; The amount of compassion given to the labouring woman in KBTH does not come close to the amount given in the United States.

These results led the author to conclude that there is a need for the medical officials in both the United States and Ghana to examine the other's system, and incorporate its most positive aspects into their own system, in order to improve the quality of care offered.

Methodology

Although the majority of this research project took place in it Accra, the process actually began in Kumasi. Initial contacts were made by visiting maternity homes and discussing common procedures. Next, informal interviews were conducted with various women to find out their conceptions of maternity homes and hospitals in order to lay the foundation for this project.

Once in Accra, I decided to work in a hospital instead of a maternity home because I knew it would provide steady work and possibly the opportunity to view procedures that I may not see in the United States, but most importantly because by this time, the decision had been made to broaden the scope of the paper to include gynecology as well as obstetrics. Through Dr. Hagan, a professor at The Institute For African Studies at Legon, I was referred to Korle-Bu Teaching Hospital (KBTH) and Dr. Wilson. Upon presenting myself and my objectives, I was allowed to join a team of obstetricians in which I basically assumed the role of a medical student.

During the three week internship period, most data was collected through participant and non-participant observation. Due to my lack of medical knowledge, non-participant observation was the dominant method, but this did not hamper the research in any significant way. Any free time was used to hold informal conversations with the physicians and students. I decided against conducting formal interviews with the staff members because I felt that it would hamper the development of any

relationship that we might wish to form, and that these relationships would be more important to myself and the project as a whole than the formal interview. They were aware of the fact that a paper would be written on my experience, but because no formal interviews were conducted, anything said to me in private will remain anonymous. An in-depth log of my activities and conversations was kept and examined at a later date for analysis.

If this study were conducted again, I would include more interaction with the midwives and nurses, who I only worked with on the team's 24 hr duty days, because I am sure that they would have me as much as the doctors did.

Introduction

Women's health care is an area which is often neglected in the United States. Despite the vast number of gynecologists who have dedicated themselves and their careers to maintaining the female body and advancing the care offered in the field, women are still among the last to benefit from new medical procedures or cures. Ironically, it is in the area of childbirth, where women should have more control over their bodies, that science is most willing to intervene and dominate. A knowledge of these injustices has instilled in the author a strong desire to learn how other cultures approach women's health care, in the hope that the best aspects of these systems may be integrated into the practice that she will one day develop.

The internship at KBTH began with the basic assumption that the methods and regulations observed would reflect both western medical standards and Ghanaian cultural beliefs regarding the fields of obstetrics and gynecology. In addition to proving this belief, this paper will highlight three distinct aspects of the internship experience: (1) The interaction with the doctors; (2) The system of care observed. Here, the primary focus is on the similarities and differences found between this system and the common methods observed in the United States1, and how I feel the patient's level of care is affected by these differences; and (3) The traditions and cultural beliefs observed. The reader should note that only those differences stemming from ideology or

culture will be discussed. Those resulting from the disparity between the economic statuses of Ghana and the United States were purposely omitted.

Part I
The Doctors

In The United States, African American doctors are few and far between, and African doctors are an even greater rarity. Therefore, being apart of a team of highly qualified African doctors, in a hospital run by Africans, was an unique and empowering experience. Beyond this initial gratification came the recognition that there were many things to be learned from the doctors of every stage. A definite hierarchy exists in the hospital and within the team, and as an acting team member the task was to find the correct behavior for my position in said hierarchy see fig 1. Because the position occupied was analogous to that of a medical student, the greatest contact came from those occupying the closest position in the hierarchy, the students and the young doctors, or house officers as they are commonly called.

In the beginning of the internship some of the house officers expressed concern, in a rather lighted manner, over whether the purpose of this study was to judge their methods primitive or proclaim the superiority of American medicine .2 It later became apparent that they were only voicing their own frustration over the additional hardships that Ghanaian doctors must endure like overcrowding and water shortages. These hardships combined with the low pay and the lucrative job offers from abroad make it very difficult for young doctors to remain in Ghana. Yet, it is a known fact that Ghana is in need of medical personnel. Therefore, it is believed that many young doctors are struggling

to resolve the conflict between remaining loyal to themselves an~ their desires, and remaining loyal to their country and its needs.

Within the medical community, this subject is one that has been debated, on some scale, by nearly every doctor. The end result is that some choose to leave while others chose to remain but the decision is viewed as one which must be resolved by each doctor in their own time. In general, no ill will is harbored towards those who decide to leave.3 But outside the medical community the opinions are quite different. Many Ghanaians like Mrs. Esi Sutherland-Addy regard those who leave as traitors or a the very least as quitters in their country's struggle .4 But to the average Ghanaian the shortage of doctors means long waits during clinics and at the very worst, waiting for hours and still being referred to another clinic day. There are at least one thousand Ghanaian doctors abroad, and many citizens believe that if everyone of them returned, Ghana's health are system would surely thrive .5 But this is an impossible if not unfair scenario. Keeping doctors here despite their better judgment would not help the progression of this country's health care system because their hearts would not truly be in their work. Therefore, it is only necessary that those who are truly committed remain. During the internship, it was observed that some of the doctors and medical students were able to resolve this dilemma for the time being by going abroad for electives or to finish their education, but others continued to struggle.

Part II The System Of Care

The field of women's health care may be divided into two main specialties, those of obstetrics and gynecology.

Gynecology

Two full days out of the average week were devoted solely to gynecology. On Mondays, surgeries were conducted for the teams' patients, and on Fridays, the doctors consulted patients at the hospital's gynecology clinic. On the clinic days, each doctor was assigned an examining room into which all of his/her patients flowed. The typical mode of treatment would begin with the patient speaking to the doctor and relaying her problems or concerns. She would then be instructed to prepare herself for an examination. This is done by removing only the slit and underwear. The doctor immediately comes in and examines her. The procedure ends with a discussion of the course of treatment and the woman's exit. This process holds much more compassion for women who may already be nervous about the examination experience than the American version the author observed, which involved women being made to exchange all of their clothing for a rear exposing hospital gown, and then waiting on the examining table for the doctor to arrive and begin the consultation.

One distinct difference between the Ghanaian and the American clinics is that most of the patients observed at KBTH did not have a working relationship with a gynecologist. The vast majority were referred by local clinics in time of illness. The average fee for a consultation was four hundred cedis. While

this is an extra expense that many people cannot afford, this should not be seen as a problem stemming solely from lack of money. Rather, it was observed that many Ghanaians are of the opinion that a gynecologist is someone you see when there is a problem, not for health maintenance. Education should be increased until all women view the gynecologist as someone they should develop a relationship with to maintain their health. Increasing regular checkups would prolong the life expectancy of many Ghanaian women by detecting disease like cervical cancer in their earliest stages where the outcomes are much more favorable.

Part of a doctor's responsibility during the clinic is to refer those patients in need of surgery to one of the team's theatre days. Ordinarily things run smoothly, but problems arise when time restraints force a patient to be moved to another day, or when a theatre day is missed altogether. So far this year the e: team has lost three theatre days to holidays: 6 March, Easter Monday, and May Day. This has caused many patients to wait weeks before having their operation.

When given a choice most of the women chose to remain in the hospital over the holidays despite the increase in cost, and the less than home-like conditions. Upon further inquiry, it was learned that the women do not leave because "the nurses tell them that if they go home, they will not have a bed when they wish to return. The doctors did everything in their power to absolve this belief and set their patients minds at ease. But bed shortages are a known problem throughout the hospital, and some

patients were still unconvinced, so they stayed the extra week or two it took to complete their treatment satisfied that they had made the right choice.

Obstetrics

From the beginning of the internship it was apparent that the delivery methods observed in KBTH would be remarkably different from the system observed in the United States because midwives deliver most of the babies here, whereas obstetricians delivered all of the babies in America. Therefore, the task was to find out what the midwives can and can not do and determine the benefits and drawbacks of the system to the best of my ability.

The following is an amalgamation of the delivery processes observed.

It is 10:00, a woman enters the labour ward and deposits her suitcase, which contains all of the food and clothing she and the her baby will need for their stay, on the storage shelf. Outside her husband or mother is waiting and trying to decide whether he/she should leave or stay because it may be hours before any news is heard. A midwife comes to meet the woman and instructs her to remove all clothing and wrap herself in a cloth. She is then escorted to a labour room where she will remain until she is at least eight cm dilated. Once she is settled, an attendant enters, shaves her, and starts an IV. Then a doctor comes in, reads her anti-natal record, and conducts a complete examination to determine her stage in labour and whether or not there are any irregularities present. She is four cm dilated, which means that she has a long way to go. Her next assessment is four hours away. Until then an attendant will use a partograph to plot the

progression of her labour see fig 2.

It is now 1:00 and she is still labouring but her contractions have grown much stronger. Although she is in pain, a request for medication is never made, she simply endures. At 1:30 her cervix is reassessed. She has progressed quickly and is now nine cm dilated. Her attendant escorts her to a delivery room to begin the second stage of labour. She climbs onto the table, lays on her back and puts her feet up in stirrups. Another midwife enters the room to care for the baby when it arrives. The woman is then instructed to bare down with each contraction. After a half hour of pushing the she is extremely fatigued and it shows as her efforts decrease. The attendant begins to fear that a vacuum extraction will have to be done. He is hesitant about ordering this because it means giving up and calling in a doctor. He listens to the fetal heart rate, FHR, it is strong, so he decides to wait a while longer. The midwife informs the woman of the attendant's dilemma and encourages her to push harder. She does and the head begins to press the perineum forcing one to wonder if it will tear. This worry is soon laid to rest as the midwife begins to manually stretch it. With the next contraction, the head emerges with the perineum intact. Moments later the entire body is born, the cord is clamped and cut, the baby is taken to be cleaned, and then there is silence. No congratulations for the mother's successful delivery, no joyous proclamation of the sex, just silence. After the placenta is delivered, the woman is cleaned up and left to

rest in the delivery room for a period of time, she is then transferred to the ward. If their health remains stable, mother and child will leave the ward after twenty four hours, provided the bill has been settled. The ward's record reads "Mrs. X delivered a live baby girl/boy by SVD at 2:15."

The most positive aspect of the processes observed is the amount of time women are given to labour. The FHR is the midwife's guide. As long as it is strong, there is time, within reason. One can truthfully say that they only interfere when it is truly necessary. Much of this has to do with the set up. In the American hospital the author observed the vacuum extractor was on a table adjacent to the obstetrician. Its easy accessibility resulted in the use of suction in at least seventy percent of the cases observed. At KBTH midwives are not allowed to do vacuum extraction or suture episiotomies. Based on observations of the midwives' behavior, it is believed that the fact that a doctor must be called in to conduct these procedures makes the midwives try harder to avoid them.

As in the United States and much of Europe, the lithotomy position is the only option for delivery in KBTH. Organizations throughout the world such as the National Association of Parents and Professionals for Safe Alternatives in Childbirth in the United States and the Association for Improvements in the Maternity Services in England have been working to convince hospitals and health care professionals to allow some variation in delivery position. 8 They are of the opinion that the lithotomy

position holds the least amount of comfort for women and is used only because it gives the attendant more accessibility. During the internship several women were observed attempting to lie on their sides during delivery. This variation on the lithotomy is more comfortable and it allows the attendant comparable access. Therefore, efforts should be made, in all hospitals, to include this along with the standard lithotomy as an acceptable delivery position.

It is a well known fact that "most women prefer not to be alone in labour."9 It is the policy of KBTH that no relative be allowed on the labour ward, they must wait outside on the bench or return at a later time. The limited space at KBTH makes this rule a necessity. But this is also the policy at the maternity homes visited, which have enough room to accommodate at least one relative. Yet, they continue to force women to labour alone. The separation of spheres that exists in Ghana would prevent many husbands from attending births, but if given the option the woman’s mother would certainly want to be present. When asked why family members are forbidden to attend deliveries in her maternity home, Mrs. Elizabeth Opuky replied "because that is the policy. While this statement appears vague and simplistic, it is actually quite telling. Most of the midwives running maternity clinics were once employed in larger facilities like KBTH and Thirty Seven Military Hospital where overpopulation is the motivating factor behind many of their policies. It has bee suggested that when the midwives leave to start their own

practice, they follow the hospital's procedure to the letter without truly understanding why the procedures are necessary. Mrs. Opuku's statement seems to attest to the validity in this claim.

Despite its many drawbacks, the American system has put greater emphasis on making the delivery process as comfortable as possible for the labouring woman. In addition to allowing the women's partners to attend the births, they are given water and allowed greater mobility during the first stage of labour. During caesarean sections, C.S., anesthesia is done so that the women are conscious, affording them the opportunity to see the baby as soon as it is born. During the internship, a case was observed where a C.S. was performed in an attempt to save the baby's life, but it died shortly after the surgery leaving the mother in anguish because she had never seen her child. The author is aware that many of the above suggestions are not possible in KBTH due to the financial and spatial constraints that the officials are under. But if made possible in the future, they should be considered for the betterment of the system of care.

Part III
Traditions And Cultural Beliefs

On Tuesday 11 April, the first procedure of the day was a C.S performed because the fetus had died in the womb, I.U.D, and could not be expelled vaginally. At first this seemed to be a rather routine case. But as the day went on and more information was gathered on the woman's story, it became apparent how unique this case actually was. The woman had entered the hospital in labour five days ago (She had a previous C.S). After a number o hours passed without any progression, the doctors decided that she should have a C.S, but she refused. When her husband came, the doctors tried to convince him that the operation was necessary, but he too refused. It seems that after her first C. she was chastised by her husband's family and accused of being unable to deliver like a real woman. Because of this treatment, she and her husband were determined that this baby would be born by spontaneous vaginal delivery, S.V.D.. On Sunday the F.H.R stopped and the baby died. The C.S was not carried out on Sunday because the woman still wanted to deliver vaginally. By Tuesday the doctors had managed to convince her that her life would be in danger if they waited any longer, so she ended up having a C.S after all. For the rest of her life she will have to live with the knowledge that if she had allowed the surgery to be performed five days ago, she would now have a healthy baby girl.

This story was my introduction to the fact that there is a definite stigma against C.S. in Ghana The basic belief is that

a woman has not truly delivered unless she did so vaginally. The belief exists primarily in rural areas that have not yet been reached by the education campaigns aimed at eradicating this stigma and preventing more senseless deaths. It goes without saying that this experience was unlike anything the author had ever delt with in the past and would probably ever deal with in the future. Every effort was made to try and understand the motivation behind this belief. But sadly, the author was forced to conclude that as a westerner, who has admittedly not completely escaped the biased views of Africa and its customs that are dominant in the western world, some things are beyond the realm of comprehension in the short amount of time available for the ISP.

Tradition

"Motherhood is the ultimate goal of Ghanaian women." And as such pregnancy, with all the hopes and dreams it brings of the future, is a time of great happiness. Because it is known to have resulted in the death of both mother and child, a successful delivery is one to be proud of. In order to display the love and pride that is felt for the newborn, tradition mandates that the mother dress in blue and white from head to toe, including white jewelry and shoes, whenever she goes out. The attire may be worn for up to three months, but the length most often depends on how soon the mother must return to work.

Working in the obstetrics ward of KBTH gave the author an unique view of the beauty of this tradition. Everyday the

clinic's waiting area is a sea of blue and white as the mothers come in for their postnatal checkups. During the consultation it is easier to see each woman individually, and it becomes clear that no expense is spared in creating just the right appearance. Every detail is perfect: the hair, the makeup, the jewelry, the nail polish; all perfect. Once the baby is unwrapped, it is shown to match the mother's attire. Both sexes can be dressed in the same of white outfit. Occasionally you may see a girl dressed in pink and a boy dressed in blue, but the outfits are still quite fancy. By practicing this tradition, a mother can proudly announce to everyone who sees her that she has just give birth. The fact that the message does not have to be spoken to be conveyed makes it even more powerful.

Conclusion

The results of this internship prove that the author's hypothesis was correct. The methods and policies in KBTH are based on western, specifically British, medical standards. But they also reflect the needs of the greater Accra community in which the hospital is set. In addition, the author observed several cultural beliefs that had a direct effect on the obstetrics and gynecology practices.

It is the author's opinion that the American and Ghanaian systems of women's health care can profit by learning from each other. The American system, where technology has gone awry, would be greatly enhanced by incorporating the patience that is the Ghanaian system's trademark. For its part, the Ghanaian system of women's health care should follow the course that the American system has undertaken in order to reach a patient-centered approach to health care.

The internship ended with the author feeling as though there are few problems at KBTH that do not result from lack of money for either staff salaries or equipment. The basic principles behind the actions of the physicians and midwives are fair and aimed at ensuring the dignity of every patient who comes to them for care. As the hospital enters a new phase and attempts to catch up with the technology of the western world, education efforts aimed at wiping out harmful beliefs and stereotypes must be increased. It is only through education that all Ghanaian women will have the opportunity to take advantage of the health

care offered at KBTH. If they choose not to patronize the hospital because they prefer more traditional methods, then so be it. But women must be given the opportunity to make an informed decision about what is best for them and their bodies.

1. A similar internship was conducted at John Randolph Hospital in Hopewell August 1994.

2. Confidential source, interview by author, 11 April 1995. Notes in possession of author.

3. Dr. Wilson, Head of Obstetrics and Gynecology KBTH, interview by author, 2 May 1995. Notes in possession of author.

4. Mrs. Esi Sutherland-Addy Education in Ghana lecture, University of Ghana Legon, Accra, Ghana. 27 March 1995.

5. Dr. Wilson, Head of Obstetrics and Gynecology KBTH, interview by author, 2 May 1995. Notes in possession of author.

6. Confidential source, information gained in group discussion 16 April, 1995. Notes in possession of author.

7. This figure is an approximation based on the author's observations. Notes in possession of author.

8. Emily Martin The Woman In The Body: A Cultural Analysis Of Reproduction (Boston: Beacon Press, 1992), 168

9. Betty Sweet. Bailliere's Midwives Dictionary (London:Bailliere Tindall, 1992), 259

10. Elizabeth Opuku, Nurse/Midwife of Boanim village in Ashanti region, interview by author, 7 March 1995, Boanim.

ll. Dr. Wilson, Head of Obstetrics and Gynecology KBTH, interview by author, 2 May 1995.

12. This story was recounted by a number of doctors, informal conversation 11 April 1995 KBTH

13. Dr. Wilson, Head of Obstetrics and Gynecology KBTH, interviewed by author, 2 May, 1995. Notes in possession of author

14. Peter Sarpong Ghana In Retrospect: Some Aspects Of Ghanaian Culture (Accra:Ghana Publishing Corporation, 1974), 69.

15. Dr. E-Essilfie, informal conversation with author, 26 April 1995.

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Dr. Wilson Head Of Obstetrics and Gynecology at KBTH, interview by author, 2 May 1995. Notes in possession of author.

Confidential source, informal conversation with author, 11 April 1995. Notes in possession of author.

Confidential source, informal interview by author, 16 April 1995. Notes in possession of author.

APPENDIX

Fig 1

The Professional Hierarchy In KBTH

Positions	Representatives in Team D
Senior Officer	Dr. Wilson
Consultants	Dr. Kwawukume Dr. Lassey
Residents	Dr. Ampofo Dr. Anipa
House Officers	Dr. E-Essilfie Dr. Menseh Dr. Nkpsong
Medical Students	

Daily Schedule

Monday	Gynecology Theatre
Tuesday	Ward Rounds
Wednesday	Anti-Natal Clinic
Thursday	Ward Rounds
Friday	Gynecology Clinic

Every five days is a duty day in which the team is on call for both obstetrics and gynecology for twenty four hours.

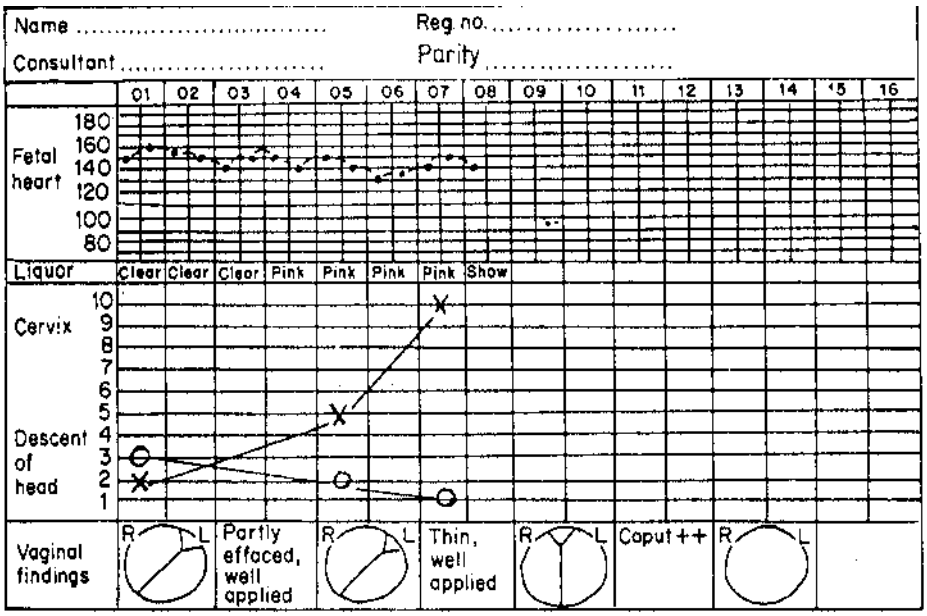

Figure 10. Diagram of a partogram.

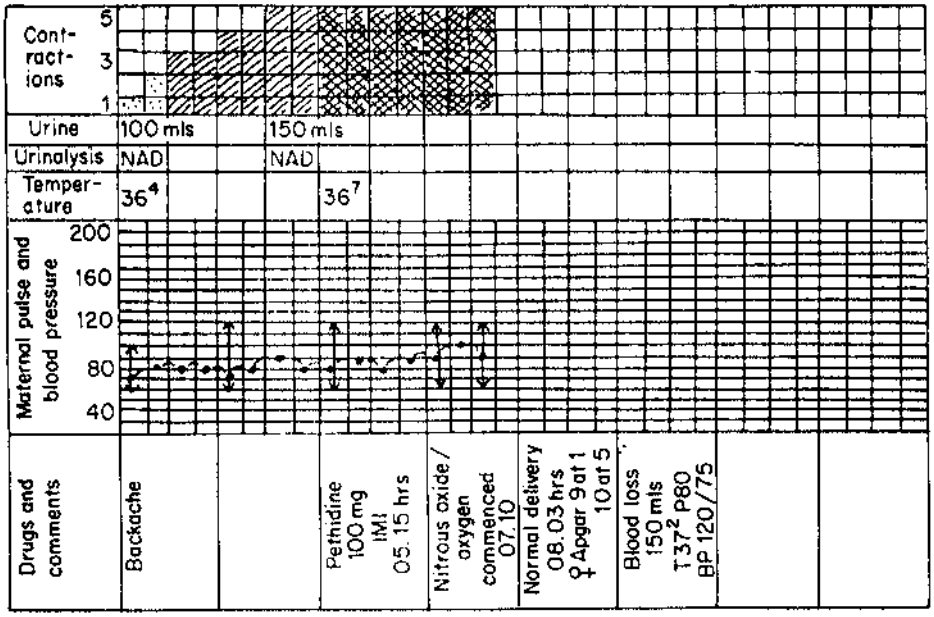

Figure 10. Continued.

[redacted] Bailliere's Midwives' Dictionary, page 364-365

Abbreviations

CS	Caesarean Section
FHR	Fetal Heat Rate
IUD	Intra Uterine Death
KBTH	Korle-Bu Teaching Hospital
SVD	Spontaneous Vaginal Delivery
Antinatal Record	Record of a woman's check-ups