

TRADITIONAL BIRTH ATTENDANTS AND HEALTH SERVICE DELIVERY IN NORTHWEST GHANA: OPERATIONAL DYNAMICS AND NEW FRONTIERS

Emmanuel Kanchebe Derbile

Department of Planning, Land Economy and Rural Development,
University for Development Studies, Wa Campus, Ghana.
Email: kanchebe@gmail.com

ABSTRACT

In the context of the Upper West Region of Ghana, the author sheds light on the dynamics in the practices and roles of Traditional Birth Attendants in community health service delivery. With reference to Traditional Birth Attendants (TBAs) in Charia and Lambussie communities, the study explored the trend in practices and roles they play in community health delivery systems. Drawing on empirical data from a qualitative research approach, the author notes that one of the most significant changes in the health sectors of rural communities is a change in the practices and roles of Traditional Birth Attendants. He argues that over the past few decades, this change represents improvements in hygienic and clinical practices of Traditional Birth Attendants in child delivery services. In addition, the roles of new generation Traditional Birth Attendants have transcended their traditional role of baby delivery services or midwifery. The author notes that new generation Traditional Birth Attendants have assumed new roles in the general domain of community health services through increased collaboration with public health institutions. In the context of these changes, the author concludes that by focusing on the practical gender health needs of rural women, Traditional Birth Attendants are increasingly participating in health service management decision-making. As a corollary, Traditional Birth Attendants have made a significant leap in the total effort towards addressing strategic gender needs of women in rural northwest Ghana.

KEY DESCRIPTORS: Reproductive Health, Triple Roles, Delivery Care, Generational Shift, Community Health Practice.

INTRODUCTION

In the light of widespread poverty, the participation of stakeholders in a bottom-up decentralized planning system has become the guiding principle in development governance in developing countries in general and Ghana in particular. In this context, community participation takes a center stage in sustainable community development initiatives and processes. The support of government and other development agencies such as non-governmental organizations are still important but this must be to play a catalytic role through policy, technical and resource support. The daunting challenge of such a development planning system has been how to bring on board all segments

of communities particularly, women to actively participate in the development process. In the Upper West Region of Ghana, rural communities have a patriarchal culture and orientation. This patriarchal culture therefore, prescribes not only the subordinate position of women to men but also inherent cultural normative roles to which strict compliance is applauded and commended by male counterparts.

In this study, the author examines the evolving roles and practices of Traditional Birth Attendants (TBAs) in community-based health delivery systems in the Upper West Region of Ghana. In the light that decentralization in Ghana provides the stage for participation of stakeholders in development, what roles are Traditional Birth Attendants playing in the delivery of health services in rural communities of northwest Ghana? Are there any differences in roles and practices between TBAs in the past and those of present day? Are there development implications emanating from the trend in roles and practices among TBAs and how do these impact on gender and development? These are the central questions that are addressed in this paper.

This paper is organized into four sections. In section one, the subject of study and objectives are introduced. Section two provides a brief overview of the study area and the methodology that was used for conducting the study. In section three, the author reviews existing gender development approaches and the concept of Traditional Birth Attendants in relation to the triple roles of women. The author presents findings with respect to the evolving roles and practices of Traditional Birth Attendants in the provision of community health services in section four. In section five, the author concludes his article by way of summary and recommendation for enhancing the cause of gender and development in general.

STUDY AREA AND METHODOLOGY

Occupying the extreme northwestern part of the country, the Upper West Region has a population of 576, 583 as at the year 2000. Out of this, women constitute about 52% of the total population of the region (GSS, 2002). As evidenced by the statistics, women constitute an immeasurable human resource pool for development in the region. For the purpose of this study, two communities were sampled from the region by means of combination of stratified and purposive sampling. The author has been doing some research and development work on traditional institutions and land administration in the region. This exposed him to Lambussie, where the inhabitants are Sissala by ethnicity and located within the Jirapa-Lambussie District. Lambussie was therefore, considered in the sampling frame to allow for representation of one of the two dominant ethnic groups in the region. Charia on the other hand was sampled from amongst three purposively identified sub-district capitals through simple random sampling. These sub-district capitals include – Charia, Daffiama and Dorimon – all of which are Dagaaba ethnic communities – the other dominant ethnic group in the region.

The qualitative approach was used in this study. Qualitative research may be defined by its three main primary data collection strategies – interviews, observation and document analysis (Grady, 1998). Miles and Huberman express their preference for qualitative approach noting that qualitative data are attractive and a source of well-grounded descriptions and explanations occurring in local contexts (Miles and Huberman, 1984; in Bacho, 2001). Within the framework of qualitative research, the author conducted group interviews among TBAs and individual interviews among health personnel at sub-district levels. In all, two group interviews were conducted and four individual interviews administered to health personnel. Observation was also used as an additional tool for data collection. Interview of health personnel was particularly important for validating findings on the roles and practices of TBAs.

TRADITIONAL BIRTH ATTENDANTS AND DEVELOPMENT

Traditional Birth Attendants and the Triple Roles of Women

Traditional Birth Attendants are predominantly and traditionally female community-based volunteers that provide traditional midwifery services in their communities. TBAs may be categorized according to type of practice. The Ministry of Health (MOH) reports that the majority of TBAs (59%) practice straightforward midwifery, 22% include spiritual practices and 19% are herbalists (MOH, 1990; Galaa, 2006). Other researchers such as West (1981) distinguish several categories of TBAs based on experience, compassion, ‘strength of heart’, social standing and training experience from a study on the Sande of Sierra Leone. Galaa (2006) in a study on the constraints of using TBAs in modern family planning services categorize TBAs in selected communities of northern Ghana as:

- TBAs possessed by spirits of either ‘kontome’/‘kpukparise’ or ‘Tengan’ (earth spirit) as a directing agent in midwifery practice;
- TBAs who inherited midwifery practice and administration of herbal medicine
- TBAs socialized into midwifery practice through apprenticeship and observation.

He further notes that the first and second types of TBAs have immense depths of knowledge of care, techniques of midwifery practice, have wide client base, administer herbal medication and offer treatment for complications in delivery.

Conceptually, the roles of women and particularly, TBAs in community development can be grouped into three broad categories known as the “triple role of women.” These are the (a) reproductive, (b) productive and (c) community management and political works (Moser, 1993). The reproductive works of women include the biological reproduction of children and the undertaking of domestic chores required for

the maintenance and reproduction of the family and labor force. This role therefore, extends beyond childbearing responsibilities to include care and maintenance of the workforce (husband and working children) and the future workforce. The productive roles of women comprise work done by women for payment in cash or kind. Such production may be for the market with an exchange value, or subsistence production with a use-value, but also a potential exchange value. For women in agricultural production, this includes work as independent farmers, peasants' wives and wage-workers. In respect of community level, women's engagement in community level activities are hereby, known as community level management and politics.

In the case of TBAs, one can find them involved in the promotion and service of the triple roles of women as identified by Moser and popularized by development workers. In the first place, these women although might not be birthing themselves, they offer services toward their delivery of babies. Hence, they place the support roles that fall within the realm of reproductive labor. Within the politics of the gender division of labor this roles helps to sustain the social and patriarchal machinery. Yet, its import in providing services for the many women who can not afford the cost of health service, do not have the right to make decision regarding the delivery of their babies and/or those who have to prove their womanhood and strength through delayed reporting of labor, TBAs are central to plugging the holes. As professionals whose skills, knowledge's and experiences service the reproductive industry, TBAs play productive roles. Yet as community-based members whose services are hardly rewarded in cash but kind, TBAs play very critical community roles through their practice. It is the recognition of these critical roles, gaps in health services delivery and collaboration to stem the high toll of maternal and infant mortality that TBAs have become very important players in health services delivery in Ghana.

Traditional Birth Attendants and Health Service Delivery in Ghana

The involvement of TBAs in health service delivery, particularly maternal and child health services has a long historical development in Ghana. Traditional Birth Attendants have been long recognized for their, *"availability, steadfastness and cultural appropriateness in caring for mothers, newly born infants and children in every corner of the country. Numerous and determined efforts to upgrade their skills and improve the quality of community-based care date back to the 1970s"* (MOH, 1990; in Galaa, 2006:56).

To enhance community-based care in Ghana, a number of initiatives with the view to include TBAs in community based health service delivery have been undertaken by various governments. These include the Danfa Comprehensive Rural Health Care and Family Planning Project, in which TBA training was an integral component aimed at reducing maternal and infant mortality. The second major initiative was the Brong-Ahafo Rural Integrated Development Project, which was launched by the government in the mid 1970's. The programme objective was to make health care deliv-

ery the responsibility of communities (Boamah, 1977) and to determine practical ways for molding social processes in community health care (Twumasi, 1982; in Galaa, 2006). The National Traditional Birth Attendants (NTBA) programme launched in 1989 was the last of these efforts to integrate traditional and modern health systems of health care. The NTBA was designed to improve the quality and expand the volume of the midwifery care of TBAs in ordinary obstetrics and family planning. Other objectives of the programme included the institutionalization of a two-tier referral system in complicated obstetrics and the provision of essential drugs and immunization (MOH, 1990; Galaa, 2006).

GENERATIONAL ANALYSIS OF TRADITIONAL BIRTH ATTENDANTS IN NORTHWEST GHANA

For the purposes of comparing the current with past practice, TBAs have been categorized into two: Old generation and new generations. The difference in the two generation has emerged from the support base and the new roles assigned to the generation by external authorities during various collaborations.

Old Generation Traditional Birth Attendants – Roles and Practices

For operational reasons, old generation TBAs refer to the immediate predecessors of present day TBAs. Traditionally, the role of TBAs is to support the delivery of babies. In this context, old generation TBAs mainly played traditional midwifery roles in the delivery of babies in rural communities of the Upper West Region. They offered antenatal and postnatal care to their clients.

In aide of their main role of child delivery, old generation Traditional Birth Attendants offered support services associated with antenatal and postnatal care. Focus group discussants report of a wide range of health related problems that old generation TBAs managed with their indigenous knowledge and practices. These include:

- Abdominal pains and miscarriages
- Abnormalities in the development of the fetus such as the improper lying of the baby in the womb
- Stunted growth of the fetus – administered herbs to enhance growth
- Vomiting during pregnancy
- Lack of appetite for food among pregnant women
- Offered palpating services
- Child delivery and bathing
- Post natal care for women and babies after delivery
- Weakness among women after delivery – administer drugs to enhance recovery

The practices of old generation TBAs in child delivery services – were basically traditional. Focus group discussants also reported that old generation TBAs resorted to the use of herbal preparations and medication for dealing with antenatal and postnatal health problems of their clients. According to discussants, a local herb called ‘Mansugo’ in Dagaare was commonly used for treating antenatal and post-natal problems of their clients. A TBA from Charia in contributing to the subject of practices among old generation TBAs had this to say:

‘The practices of our mothers who were traditional birth attendants certainly differed from our practices today. In the past, a TBA returning from the farm when called to duty responded right away with her bare hands. She might not even wash her hands. She immediately pressurizes the woman in labour to push for delivery. When she is not able to push, she is impatient with her. She shouts at her and blames her for delay in delivery. She uses any cloth available to rap the baby when the baby is finally born. She might not border if the cloth was clean or dirty because she depended on what resources were readily available to save live. She uses ‘subarhi’, a local knife that was used for shaving to cut the cord of the baby. She uses thread for braiding to tie the cord of the baby. She does the first bathing of the newly born’. So you see, she conducts the delivery depending on most resources from the household members of the woman in labour.

(Felicia Dery, Charia, 30/02/07)

New Frontiers for Improved Health Care Delivery through New generation TBAs

For operational purposes, new generation TBAs refers to present day TBAs. Fundamentally, the role of the TBA is to offer support services during child delivery. The new generation TBA play this traditional role as evidenced in this conversation between the Investigator and a TBA during a focus group session at Lambussie.

Investigator: What are your roles as TBAs?

TBA : Our roles as TBAs is to save lives.

Investigator: What do you mean by ‘saving lives’?

TBA: It is God that saves live. So with the support of God, we help pregnant women deliver their babies successfully. Quite recently, I helped a woman in the village deliver twins.

See picture below showing Traditional Birth Attendants.



Three new generation TBAs from Lambussie. From left to right, they are Bamie NaFisah, Kosua Fio and Baliimul Wiwerito.

Source: Field Survey/ Pictures, October 2006

The new generation TBAs, however, have different orientations in executing their roles and practices. These differences in practices are succinctly captured in the contribution of another TBA during a focus group discussion session at Charia. She had this to say in response to the question: 'how different are your child delivery practices from those of your predecessors?'

Today, when a 'pogedorgha', that is TBA is called to duty, she picks her 'pogrdorgha daga' (TBA Kit or Box) and starts running in response to the call. In this box, she has the following items – spread rubber sheet, towel, sponge, soap, cotton and goss, pocket of blade, thread (cord liture) and in some instances dettol. In preparing to receive the baby, she spreads the rubber sheet on the ground for women to sit on. She washes her hands with soap and wears hand gloves. She is patient with the woman in labour and encourages her to push only when it is ripe to push. She raps the baby with the towel when it is born. She cuts the umbilical cord with new blade and ties it with 'cord liture'. You know we are volunteers, and are not paid for our work. We don't charge fees for deliveries but we often ask our clients to replace the items that we used for their deliveries

so that others can benefit from our services. We do all these in order to conduct deliveries under good hygienic conditions. We are occasionally invited to Wa for training. The Nurse In-Charge at the Chairia Health Center also invites us to the center sometimes. She shares her experiences with us and we together share ideas about how to conduct safe deliveries in the village.

(Habiba Meyeri, Charia, 30/02/07)

Drawing on the findings, it is clear that new generation TBAs have changed their practices in child delivery services. These changes represent a shift from traditional practices to modern midwifery and health practices owing to support programmes of various development agencies – such as the Ministry of Health (MOH), non-governmental organizations and the Christian Mothers Association of Ghana. To the extent that “*the most important features of delivery care are skilled and hygienic attendance at birth*” (Eade et al, 1995:656), TBAs are certainly playing a cardinal role in improving community based health care systems. These new practices of TBAs represent remarkable improvements in hygienic and basic obstetrics. While this is certainly a welcome development, one emerging difference in the practices between old generation and new generation TBAs is the use of herbal medicines. While old generation TBAs used herbal medication in their practices, this practice is declining or unpopular among the new generation TBAs. In the context of endogenous development, this development poses the risk for the extinction of such practices and must be an issue of concern for development planning. Although studies might be required to establish the efficacies and safety of such herbs in medical practice, the use of these herbs in the past is indicative of their utility in their indigenous knowledge and practices.

THE CHANGING ROLES OF TBAs

The examination of the roles of the two generations of TBA shows changes in their practices and services due to the new roles that current use of TBAs by the MOH and Ghana Health Service (GHS) support. Efforts to promote cultural relevant, community based health delivery the MOH and GHS have in recent time trained and supported the TBAs to improve their practice. Data from the 2003 GDHS shows that many Ghanaian women, especially of rural origin continue to deliver at home due to various challenges and preferences. Hence, the effort by MOH and GHS is serving to enhance delivery. This study identified a number of new roles that new generation TBAs play in community health service delivery. Some of these roles relate directly to their traditional roles of child delivery services while others relate to health services in general. These include their roles in the following areas: health education and information; referrals of patients; health records and management; and health service management discussed next.

Health Education and Information

The study revealed that TBAs are involved in community health education and information dissemination. Their roles in health education transcend their roles in traditional midwifery. They undertake house - to - house education on health policies and programmes, family planning and emerging health issues as per discussions by sub-district health management teams. A female discussant contributing to the discussion on the subject had this to say:

We undertake education on many health matters in the community. We usually go from house to house and talk to both men and women on various health matters that we decide on with the staff of the health center. We have even undertaken education on the current National Health Insurance Scheme (Noba Angbing, Charia, 30/02/07).

Another discussant in her contribution had this to say:

Let me tell you about our last three meetings with the health center staff and the kind of education we undertook. At one of our meetings with the Nurse in - Charge, she observed that there was poor patronage of antenatal services at the health center. We discussed it and took up the responsibility to encourage pregnant women to attend antenatal services. We did this through house-to-house education and many pregnant women started attending antenatal services. Again, in another meeting, it was recognized that deliveries at the health center was low. We again educated women on the need to patronize the health center for deliveries and the situation improved. Again, at another meeting, the Nurse - in - Charge complained that there was poor administration of drugs the sick received from the health center. We took it up again and educated people through house-to-house education (Felicia Dery, Charia, 30/02/07).

In Lambussie, TBAs have undertaken similar education programmes. They reported during a focus group discussion session that they have embarked on education to convince the people on the efficacy of orthodox medicine for treating certain illnesses or diseases. This targeted education was accordingly meant to erase certain erroneous impressions and widely held views that there were many illnesses that orthodox medicine lacked efficacy for curing.

Referral of Patients to Public Health Facilities

One of the new roles of TBAs is that they now refer clients to public health service delivery institutions. This was found to be common practice in all the study communities – Lambussie and Charia. One TBA in Charia had this to say in respect of referrals:

We as TBAs also refer clients to the Health Center. If a pregnant woman consults us, we treat if we realize that we can handle the problem at our level. If we notice that the problem is complicated and require referrals, we do just that. We each have two kinds of referral cards – a blue card and a pink card. If we notice that the problem is not so serious and can be handled at the health center, we give the patient the blue card and ask her to go to the Health Center. If we also assess and think that the problem is serious and should rather be handled at the hospital level, we give the pink card to the patient and still ask her to report to the health center. The health staff at the health center understands what the different colors mean – and would also upon their assessments take the appropriate action. The health staff that attends to the referred patient in turn asks the patient to return the cards to us. This way, we can ask our patients what happened (Habiba Meyiri, Charia, 30/02/07).

Health Records and Management

New generation TBAs are involved in the collection and compilation of basic statistical records concerning health and demographic change in the community. The information that is compiled by TBAs relates more to their child delivery records but also deaths in the community. For instance, TBAs in Charia record such statistics on a booklet code named 'Antenatal' while their counterparts in Lambussie record such statistics in exercise books. Although the booklet makes provision for recording a wide range of information concerning delivery, records that are often time entered include – the name of mother of the newly born, the date of delivery, the sex of the baby and whether the baby survived or died. From an examination of five such booklets, it was clear that TBAs are more inclined to recording the name of the baby's mother and the date of delivery – than other aspects concerning delivery that the record books make provision for. The reason for this preference seem to be influenced by the fact that these TBAs are illiterates and lack the ability to fill in other information details though they may seek assistance from literates in the community. In the case of Lambussie, the registration of deaths by TBAs was particularly, striking and this is reported to facilitate the preparation of death certificates by the Department of Births and Deaths.

Health Service Management Decision-Making

The study revealed that TBAs are now participating in management decision-making concerning health service delivery at sub-district levels. In both Lambussie and Charia, TBAs reported that they were invited to attend quarterly sub-district health management team meetings usually convened by the Nurses –in charge at the health centers. A TBA from Lambussie had this to say in respect of their participation in health service management decision-making:

We are invited to meetings at the health center to discuss many matters concerning how to improve health care in the community. We are six TBAs in the community. All of us usually invited for the meetings. During these meetings, we all participate

in discussions. Although we are volunteers, anytime we attend these meetings, the health center pays each of us fifteen thousand cedis. We are happy to be recognized this way. This encourages us to want to give more in service to our people and to work with the health center staff (Bamie Nafisah, Lambussie, 9/10/06).

The Secretary to the Lambussie Sub-District Health Management Team acknowledged the participation of TBAs in their meetings. In his words:

The TBA contribute a lot to decision making during our quarterly meetings. We appreciate their contributions. That is why we instituted a sitting allowance of fifteen thousand cedis per Traditional Birth Attendant per every meeting attended. As additional motivation, we sometimes give them soap and kerosene. In some instances, we exempt them from paying user charges when they seek health care from the center' (Ibrahim Nabubie, Lambussie, 9/10/06).

Although outstanding issues may border on extent of participation and may require further investigations, the fact that TBAs are invited by the officers- in-charge at the health centers (meeting conveners) to attend quarterly meetings of sub-district health management teams must not go unrecognized. In both Lambussie and Charia, it was reported that TBAs are invited to these quarterly meetings where decisions concerning health management at the sub district are taken. These TBAs accordingly participate in discussions leading to decision-making and planned health service delivery in the sub-district.

SOME EMERGING ISSUES

The discussions above show that new generation TBAs are providing child delivery services and a wide range of maternal and child care services. These particular roles geared towards enhancing maternal and child health care is helping to promote reproductive health concerns in rural and very remote communities. As TBAs continuously work towards enhancing maternal and child health, they work towards integrating women into the development arena as better mothers by focusing on the reproductive roles and practical gender needs of women. These serve women's biological needs for playing a traditional role.

As TBAs gradually get recognized and integrated into public health service delivery systems, their self-esteem and social standings in society are gradually being enhanced in these patriarchal communities. Most importantly, however, the evolving participation of women in health service management decision-making is a significant change and progress towards addressing the strategic gender needs of rural women. New generation TBAs have gradually found their way into community politics and management – participating in decision-making on issues that impinge on their practical gender needs. Although the extent to which their engagement in community politics is subject to debate, there is a positive trend that should not elude re-

searchers and development practitioners. In working hard to meet the practical gender health needs of their fellow women, TBAs have won the recognition and confidence of public health delivery institutions. In this regard, new generation TBAs are collaborating with public health service personnel not only in the provision of health services but also in management decision-making. By their participation in health management decision-making at the sub-district levels, new generation TBAs are gradually representing the women fold in making inroads into community politics.

In as long as the domains that TBAs venture into have to do with creating better conditions for enhancing the play of the normative roles of women at the household level, it creates an enabling environment for gradually addressing the strategic interest of women in the domain of community politics. As Sureshabu and Apusigah (2005) put it, 'strategic interests in particular, are long-term ends that have the benefit of transforming social status'. This means that the process of addressing strategic gender interest may be painstakingly slow, requiring gradual, systematic and an incremental approach in which addressing the practical gender needs of women is prerequisite. This therefore, underlies the importance of pursuing multiple gender development approaches in the development process. In the phase of patriarchal culture, the very culture that many refer to as sustaining the subordination of women to men, has been at least flexible enough to allow for adaptation and a changing trend in the roles of TBAs in community health service delivery. Indeed, no more can we confidently conclude that the full potentials of women in development are kept in check by culture – although cultural hurdles and limitations may be common and widespread as pointed out by Apusigah (2004) in the case of women in the Upper East Region.

CONCLUSION

In this paper, the author set out to examine the evolving roles of TBAs in the evolution of health delivery systems in rural northwest Ghana. Drawing on qualitative empirical data in two rural communities of the Upper West Region, namely, Charia and Lambussie, the author concludes that the practices and roles of TBAs in community health delivery services have changed over the past few decades. In this change, TBAs have adopted improved hygienic practices and obstetrics. However, there is risk of extinction of certain potentially good traditional obstetrics, particularly those involving the application of herbal medication. In addition, new generation TBAs are playing new roles in the broader domain of health services, which their predecessors hitherto did not play. These differences in practices between TBAs in the past and those today are therefore, reflective of the dynamics in practices and roles of this old institution. In playing their roles towards addressing Practical Gender Health Needs of their fellow women, TBAs are gradually making inroads in the efforts towards enhancing the meeting of Strategic Gender Health Needs of women in northwest Ghana.

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