Saving mothers’ lives: things can go wrong
Richard Konteh

One of the goals of Sierra Leone’s primary care programme, established in the 1980s, was to reduce maternal mortality by 30% by the end of the twentieth century, but no significant progress has been made in this direction. The reasons are examined below in the light of a study conducted in one of the country’s Chiefdoms.

In 1978 a primary care programme was launched in Sierra Leone’s Bombali District, which covers some 3000 square miles and has a population of about 245,000. The programme operated on three levels.

- Populations of about 500 people were served by village health workers, traditional birth attendants, and maternal and child health aides in maternity clinics or treatment centres.
- At the Chiefdom level, each health care unit serving 10,000 to 24,000 people within a radius of about six to nine kilometres was managed by a nurse, a dispenser or a community health officer.
- Cases beyond the scope of health centres were referred to district hospitals.

In 1984 a national action plan for primary health care was drawn up, one of the goals of which was to reduce maternal mortality by 30% by the end of the twentieth century. Unfortunately, no baseline study was conducted, so there were no reliable estimates of maternal mortality before intervention.

An assessment was made of the impact of the primary care programme on maternal mortality in Gbendembu Ngowahun Chiefdom, one of 13 in Bombali District, by examining the services and facilities provided and soliciting the opinions of interested parties. The author lived in the area for about four months while collecting data, most of which were qualitative. Interviews were conducted by means of questionnaires containing both open-ended and structured questions, which were administered to 400 randomly selected households and 31 traditional birth attendants and primary health care staff. Informal interviews, mostly unstructured, were held with 200 community members.

The primary health care programme operated a community health centre at Kalangba and a maternal health post at Gbendembu. At each site there was a maternal and child health aide. Clinics and outreach clinics were organized regularly. Both facilities were expected to supervise traditional birth attendants and maintain satisfactory records.

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Opinions and observations

Community leaders had difficulty in distinguishing between services provided by the mission dispensary in Gwendembu and those of the primary care programme. Some community leaders knew little about primary health care. They considered it to be inadequate and doubted whether they received everything to which they were entitled. The charges for drugs were sometimes much higher than those stipulated in the programme, and nurses sometimes made unauthorized charges for attendance at clinics and the performance of deliveries.

Some 40% of males aged over 18 years said the programme was doing well but the attitudes and practices of community members, deeply rooted in tradition and culture, undermined the efforts being made. About 60% said the efforts of the programme were inadequate and felt that better results would have been achieved if the maternal and child health aides had not left tasks in the hands of traditional birth attendants. It was considered that the aides were selfish, hostile and more interested in themselves than in the work for which they were paid.

About 80% of adult males commended the training and equipment of traditional birth attendants and praised the Expanded Programme on Immunization for immunizing women of childbearing age. However, some men were ignorant of primary care activities in the Chiefdom.

Females aged 15 years and over complained that clinic sessions were not held regularly in remote villages. About 70% expressed satisfaction with the services that were available, especially those of immunization and the provision of essential drugs. However, about 35% commented that there was much scope for reducing maternal mortality, and advocated improved training, remuneration and equipment for traditional birth attendants.

Primary care personnel agreed that there was no specially designed package intended to reduce maternal mortality. The integrated health care delivery package included the training and deployment of maternal and child health aides and traditional birth attendants, immunization, health education, disease treatment, food distribution and environmental sanitation. The highly inefficient and unreliable record-keeping system failed to provide information on maternal mortality. Although traditional birth attendants played a leading role in maternal and child health care in the villages they were poorly supervised because of transport and fuel problems, and they had received no training for several years. Transport deficiencies were also a major obstacle to holding regular clinics in villages. The complaint was made that some community members were not receptive to change, refusing to attend clinics regularly and not responding positively to advice given by nurses. Some people had harmful food taboos and health habits.

The primary health care programme gave special attention to cleanliness in its efforts to reduce maternal mortality. Maternity homes were expected to be clean, there was an insistence on using only disposable or well-sterilized instruments, and kerosene refrigerators were required for preserving certain medicines and vaccines.

However, most of the homes in which deliveries took place were insufficiently hygienic and thus presented a heightened probability of complications at childbirth.
There was a need for improvements in the training and supervision of both traditional birth attendants and maternal and child health aides and in the supply of kits for these workers.

The attitudes and practices of some maternal and child health aides discouraged patients from attending clinics regularly. Some aides were very hostile towards patients and charged exhorbitant amounts, obliging women to go to traditional birth attendants instead, who were usually relatives or neighbours and in most cases were not paid for their services.

Most people held strongly to their traditional beliefs and practices. Any disease or complication during pregnancy was thought to have supernatural implications. Many people refused to attend clinics and to take precautions, thus heightening the risk of death and undermining the work of the primary care programme.

**Constraints**

Most traditional birth attendants and maternal and child health aides kept no record of deliveries and maternal deaths, thus making it difficult to monitor and evaluate the programme. Health unit personnel, for the most part, found it hard to complete mothers' health records correctly, and consequently the design of interventions presented a serious problem.

Transport and logistic support were not adequate to ensure the best possible supervision of staff at the Chiefdom level, who in turn failed to monitor and supervise staff at the village level for similar reasons. The referral system was also adversely affected by the scarcity of transport. The operation of outreach clinics in some remote villages was made almost impossible because primary health care staff could not walk for long distances with their medicines and kits on their heads.

The primary health care staff and traditional birth attendants were not given proper incentives and inducements. They were obliged to seek additional employment in order to supplement their salaries, and this had a negative effect on the programme. The inadequacy of funds largely precluded planned activities, periodic evaluations and corrective measures.

The general population was not receptive to change. There was strong loyalty to established cultures, taboos and norms. Attitudes and practices relating to maternal and child health did not alter.

**Did primary health care achieve its goals?**

No baseline study on the maternal mortality rate was conducted, the only available data being a 1976 estimate of 800/100,000 for selected hospitals, a 1989 estimate of 450/100,000 for the country as a whole, and one of 816/100,000 for the Chiefdom in 1990 (1). Unfortunately, none of these figures could be safely used in assessing the success of the primary health care programme in reducing maternal mortal-
ity. There was a marked increase in the numbers of untrained traditional birth attendants in the villages, representing a rise in the risk of death for expectant mothers, and the primary care programme failed to address this dangerous situation.

The general philosophy of the programme, had it been put into practice and maintained at all levels, might have achieved the goals, especially if appropriate strategies had been designed to deal with specific matters such as maternal and child health. Unfortunately, the evidence indicates that the programme as put into practice failed to have a significant impact on maternal mortality.

Some of the main factors accounting for the failure of the primary health care programme in the Chiefdom of Gbendembu Ngowahun to reduce maternal mortality significantly were as follows:

- failure to devise specific intervention techniques;
- selfish and hostile attitudes of some maternal and child health aides and primary health unit staff;
- refusal of many women to use the services available;
- failure of women to attend antenatal and postnatal clinics on a regular basis;
- a slack attitude within the primary care service towards traditional birth attendants and their activities;
- failure to organize regular outreach clinics in remote areas;
- performance of most deliveries in people’s homes.

The overall philosophy of the programme, embracing preventive measures and community participation, was sound, but poor record-keeping made it difficult to monitor activities. Furthermore, in the absence of a baseline study to determine values for health indicators, the programme was launched somewhat prematurely. The difficulty of evaluating the impact of the programme was compounded by the fact that for 50 years there had been a well-organized mission dispensary in Gbendembu, which continued to provide better facilities and less costly drugs than the new community health centre at Kalangba.

Some members of the target population were not receptive to the innovations of the primary health care programme, preferring to remain loyal to their traditional beliefs, whereby, for example, women were not encouraged to attend antenatal and postnatal clinics regularly or even to give birth in hospitals or other specially equipped facilities to which, by and large, complicated cases were referred if they could not be handled in people’s homes.

Proper coordination of the different levels of the programme could help to reduce maternal mortality. Chiefdom health staff should be able to provide effective supervision of village and district personnel if transport deficiencies are overcome. Efforts should be made to encourage funding agencies to give their support in this as in other areas of primary care.

Reference