

“WHY WE DELIVER ELSEWHERE”:

WOMEN’S PREFERRED PLACES OF DELIVERY AND THEIR EFFECTS

BY

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DECLARATION

I certify that with the exception of quoted statements and acknowledged ideas, this dissertation is my original work carried out under the supervision of Prof. Kodjo Senah and Dr. Dan-Bright Dzorgbo, of the Sociology Department, University of Ghana, Legon. I further affirm that this work has never been previously published at any educational institution nor has it been presented elsewhere for the award of a degree or any other certificate.

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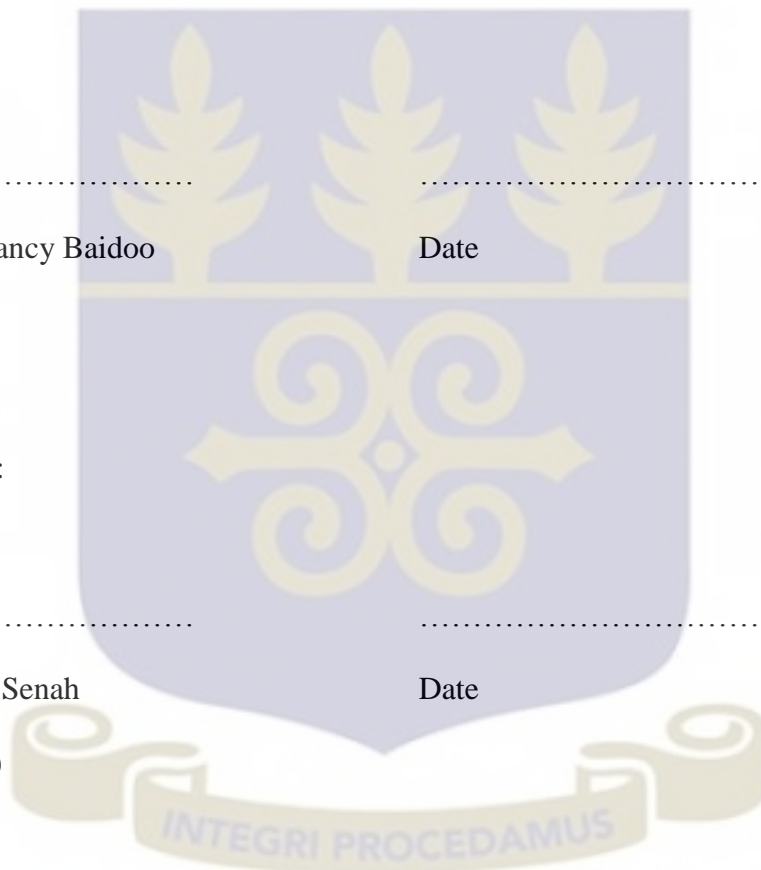
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Date



DEDICATION

I dedicate this work to my husband, Mr. Michael Kodom, for finding me and believing in me. Thank you for all your love and endless sacrifices. You are the best.



ACKNOWLEDGEMENT

I owe all thanks and gratitude to the Almighty God for His divine love and for showering his bountiful mercies on me by granting me the wisdom, knowledge, health and strength I needed to complete this academic exercise.

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I wish to appreciate the assistance of the authorities of the Assin Fosu Municipality as well as all my respondents for providing me with information while in the field.

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Again, to my husband, Mr. Michael Kodom, my parents, Mr. and Mrs. Annobil Koufie, my mother-in-law, Madam Monica Baffoe, and my siblings; Prince, Betty, Sandra, Perpetual, Philip, Daniel and Junior, I say “ayekoo”.

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In spite of the assistance rendered to me by various people, I am sorely responsible for any factual errors existing from the misinterpretation of data.

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LIST OF ABBREVIATIONS

ANC.....	Antenatal Care
CLADEM.....	Latin American and Caribbean Committee for the Defense of Women’s Rights
CRLP	Center for Reproductive Rights and Public Policies
ETC.....	Ethics Committee for Humanities
GDHS.....	Ghana Demographic and Health Surveys
GHS.....	Ghana Health Service
JHS	Junior High School
MOH.....	Ministry of Health
MDG	Millennium Development Goals
NGO.....	Non-Governmental Organisation
NHS.....	National Health System
ORID.....	Office of Research, Innovation and Development
PIH	Pregnancy Induced Hypertension
TBA.....	Traditional Birth Attendant
UNICEF.....	United Nations Children Fund
UNFPA.....	United Nations Population Fund
WHO.....	World Health Organisation



ABSTRACT

Despite the crucial role place of delivery plays in maternal and perinatal mortality and morbidity of women in Ghana, there continue to exist a gap between women who also utilize antenatal care service but fail to deliver at the hospital (elsewhere). This study was conducted in Assin Fosu in the Assin North district to examine why women prefer to deliver elsewhere (not the hospital). The objectives the study sought to investigate were: where women prefer to deliver; the factors that influence preferred places of delivery; the significant others that influence the decision of place of delivery; the effect of the places of delivery on the mother's health; and the beliefs and attitude about pregnancy. A qualitative approach was adopted to gather data through an in-depth interview with 45 respondents comprising 31 women, 4 TBAs, 2 nurses, 1 midwife, 6 men and 1 "Awoyo" priestess.

The results revealed that the use of TBAs and home delivery were preferred by some women despite the availability of hospitals and polyclinics in the community. Attitude of public health workers, emergency births, and financial constraints were the three major factors that prevented women from accessing and using institutional deliveries. While many women solely take the decision on the place of delivery, a number of them believed that institutional delivery was only aimed at women who experienced obstetric complications and also, the attendance of antenatal care was purposely to check for complications. Traditional beliefs about pregnancy and birth affected preparations made for delivery both positively and negatively.

The study therefore recommends a comprehensive strategy to train and equip traditional birth attendants since many women still use their services, and public health workers should be sensitized about their negative attitudes and how it affects patients.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Globally, it has been estimated that approximately 1000 women die each day from pregnancy related causes, 99% of them in developing countries and more than 50% in sub-Saharan Africa (WHO, 2008) with most deaths occurring around the time of delivery. In 2008, it was estimated that 2.65 million stillbirths occurred worldwide (Lawn et al., 2011). The recent worldwide statistics show a significant decline in maternal and child mortality with some countries already reaching the Millennium Development Goals (MDG) targets (Gayawan, 2014). However, the rates are still high among developing countries, especially sub-Saharan African countries. Even in some developing countries, maternal mortality ratio has witnessed some form of reduction in Asia and Latin America in the past two decades, but has remained near constant in sub-Saharan Africa (WHO, UNICEF, UNFPA, 2012). The lifetime risk of maternal deaths according to the World Health Organization (WHO) in sub-Saharan Africa is estimated at 1 in 39 as compared to 1 in 290 in South-Eastern Asia and 1 in 3800 in developed countries (WHO, 2012). Maternal death rates are on average 18-times higher in less-developed than more-developed countries, and 300 million women have short-term or long-term illness related to pregnancy or childbearing (WHO, 1998).

Giving birth at home is known to result in high maternal mortality and improving maternal health is one of the eight Millennium Development Goals five (MDGs 5) (WHO, UNFPA, WORLD BANK, 1999). There is, therefore, the emerging consensus in the literature that a greater proportion of all these deaths can be prevented if deliveries are overseen by skilled midwives. Skilled assistance during childbirth if, readily

accessible and appropriate in case of complications and effective postnatal care within the first 24 hours of delivery is a strategy that can improve perinatal outcomes for mothers and babies (Koblinsky, Matthews and Hussein, 2005; Filippi et al., 2006; Adegoke and van den Broek, 2009). A key strategy to reducing maternal and neonatal deaths is the 'health-centre intrapartum care strategy', where qualified skilled workers manage labour, effectively manage complications and are supported with effective referral systems for specialised care when needed (Koblinsky, Matthews and Hussein, 2005; Kitui, Lewis and Davey, 2013).

Generally, women have different preference for their places of delivery. While the majority prefers to deliver in the hospital, others prefer non-facility delivery. Facility delivery rates in sub-Saharan Africa are some of the lowest in the world: only 47% of women delivered in a health facility in 28 sub-Saharan African countries according to recent surveys (STATcompiler, 2008). In a research in rural Tanzania, Women frequently identified multiple barriers to accessing health care for themselves or their families, including the need to get permission from their husband or another family member (39%), not wanting to go alone (66%), needing money for treatment (80%), living a long distance from the facility (76%) and other socioeconomic factors (Tanzania Demographic and Health Survey 2004–2005).

Many countries even in sub-Saharan Africa have made great strides towards reducing maternal mortality. Countries such as Botswana, Burundi, Senegal, Uganda and Zimbabwe have developed policies such as free delivery policy for pregnant women as a strategy to increase proportion of deliveries attended to at the health facilities (UNFPA, 2004). Ghana in September 2003 also introduced the free delivery policy or exemption policy for users of maternity services from paying fees in the four most deprived regions

of the country which are Central, Northern, Upper East and Upper West (MOH, 2005). The free delivery policy was later extended to the remaining six regions of Ghana in April 2005 with the aim of reducing financial barriers to using delivery services (MOH, 2005). However, the national statistics indicate that Ghana has persistently unacceptably high maternal mortality ratio of 350 to 100,000 live births as at 2012 (MOH, 2012).

Traditionally, most pregnant women prefer home deliveries in Ghana (Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei & Adongo, 2008). Meanwhile, home deliveries often carried out by nonprofessional attendants under sometimes unhygienic conditions, whereas births delivered at a health facility are more likely to be delivered by a skilled care worker who is adequately trained and equipped with standard instruments and midwifery skills (Akoto, 2013). Delivery at home therefore partly accounted for the increasing maternal mortality rate in Ghana.

Experts argue that at current pace, Ghana will not be able to achieve the MDGs in relation to maternal and child health by the year 2015. There is, therefore, the suggestion for an urgent redrafting of the policy and operational strategies with the view to reposition maternal and child health promotion issues in Ghana (Yamikeh, 2008). Hence, the urgent need for government to intervene with policy measures that could help reduces this number.

1.2 Problem Statement

As it has been stated earlier, the choice of place of delivery contributes essentially to maternal mortality (AbouZahr and Wardlaw, 2000). According to Gayawan (2014), access to quality healthcare during pregnancy and, in particular, during delivery is a very crucial factor in explaining the huge disparity in maternal and perinatal mortality and

morbidity between developing and the industrialized worlds. Research all over the world has therefore shown that increasing the proportion of women who are cared for in health facilities during pregnancy, childbirth, and the puerperium has a significant impact in reducing the health risk of mothers and their children (Yoong and Chard, 1996; Harrison and Bergstrom, 2001; Ekele and Tunau, 2007; Gayawan, 2014). For instance, the 2012 MDG report showed that Equatorial Guinea recorded a 72% reduction in maternal mortality during 1990–2008 by improving the proportion of births attended to by skilled personnel from 5% in 1994 to 64.6% in 2000.

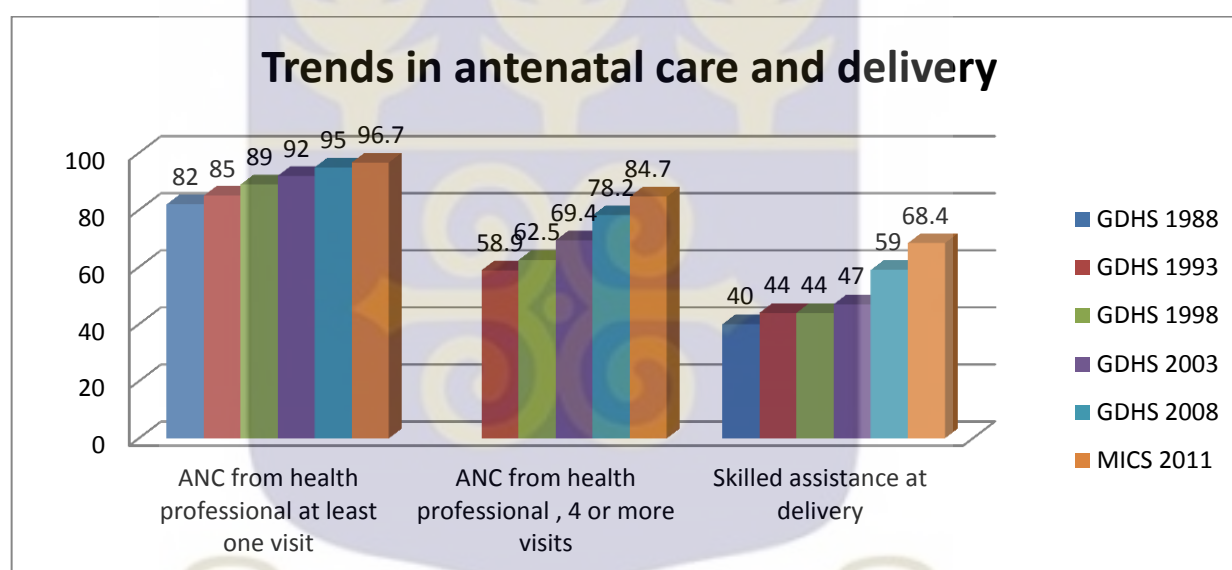
Most births that take place at home are often overseen by relatives or, at best, relying on personal experience of childbirth (Wagle, Sabroe and Nielsen, 2004). Increasing the percentage of institutional deliveries is, therefore, an important factor that links the women with skilled midwives leading to reduction in deaths arising from complications during childbirth. The expectation is that if complication arises, available skilled health workers can manage it or refer the mother to the next level of care (Gayawan, 2014).

Some countries in sub-Saharan Africa have recognized the importance of antenatal and supervised deliveries to maternal health and therefore made many initiatives and policy intervention to make antenatal relatively free or affordable to pregnant women. However, available studies have shown a gap between utilizing Antenatal Care (ANC) and delivery at hospital or medical facilities (Ekele and Tunau, 2007). In some countries and regions, the proportion of women who attend antenatal and deliver elsewhere is relatively low while some countries have high figures. Earlier studies by Telfer, Rowley and Walvaren (2002) in the Gambia and Nuwaha and Kaguna (1999) in Uganda showed that the percentage of women who utilize antenatal and delivered at the hospital were as low as

30% and 18%, respectively. This means that about a decade ago, as high as 82% and 70% of women were attending antenatal but delivering elsewhere in Gambia and Uganda, respectively.

In Ghana, there is also a gap between women who utilize antenatal care service but deliver elsewhere. The Ghanaian picture according to the Ghana Demographic and Health Surveys conducted from 1988 to 2008 and the 2011 Multiple Indicator Cluster Survey is shown in Figure 1.1 below

Figure 1.1 Trends in antenatal care and delivery



Source: Ghana Health Service (2014).

In the diagram above, women who attended antenatal care at least once increased considerably from 82% to 96.7% in 1988 to 2011 respectively. Though women who attended antenatal care at least four times also increased from 58.9% to 84.7% within the same period, there was a reduction in the number between the two groups (visited once and four or more). Interestingly, the number of women who delivered finally at the hospitals reduced drastically. Taking 2003 into consideration, the Demographic and Health Survey showed that even though 92% of women attended antenatal care at least

once and 69.4% also attended at least 4 times, only 47% of them actually delivered in a hospital. This shows that 45% of women who attended antenatal at least once delivered elsewhere, similar to 22.4% for those who attended antenatal four times or more.

As noted earlier, this behavior is not peculiar to Ghana but has been observed in other countries as well. Scholars have therefore examined the factors that influence the decision of pregnant women to attend antenatal at a particular place and yet deliver elsewhere – places other than where they seek antenatal care.

Some of the factors that have featured in literature range from individual factors (such as maternal age, parity, education and marital status) and household factors (such as family size, household wealth) to community factors (such as socioeconomic status, community health infrastructure, region, rural/urban residence, available health facilities and distance to health facilities) as determinants of women choice of place of delivery (Gabrysch et al., 2011).

There is, however, no point of convergence in the factors that influence the decision of women to attend antenatal and yet deliver elsewhere. The factors vary from country to country and region to region. There are often times when intra-country variations have been seen in the factors that influence women's decision making on the choice of delivery. For instance, in western Kenya, van Eijk et al. (2006) found distance to the nearest health facility as one of the significant factors that affect the choice to deliver at home instead of hospital but Kitui, Lewis and Davey (2013) did not find distance as a significant explanatory factory in their analysis of the 2008/2009 analysis of the Kenya Demographic and Health Survey.

In Ghana, empirical studies on the factors that influence women's decision to attend antenatal and yet deliver elsewhere are rare. Many studies that have been undertaken so far have only looked at the statistics and provide "armed chair" possible explanatory factors without necessarily going to the field to gather data to explain the reasons behind the gap. It is this premise that this study is being conducted, using Assin Fosu in the Assin North Municipal in the Central Region as a case, to examine the factors that influence women's decision to seek antenatal health care but deliver elsewhere.

According to the 2010 Population and Housing Census, Central Region, like other three regions (Northern, Upper West and Upper East) recorded maternal mortality figures higher than the national average. The maternal mortality for Central Region is 520 per 100,000 live births as compared to the national average of 485.2. Out of the 17 districts in the region, Assin North records the second highest in maternal mortality in 2012. Since Assin North municipal is a large district comprising 21 communities, the capital Assin Fosu will be used in this study. It is mainly a farming and trading community with a population of 20,541 (Ghana Statistical Service, 2012).

1.3 Objectives of the Study

The general objective of the study is to identify the possible reasons for the places women prefer to deliver. To adequately meet this objective, the research is intended to focus on the following specific objectives;

- To determine women's level of knowledge of maternal health care.
- To investigate where women prefer to deliver.
- To investigate factors that influence preferred places of delivery.

- To find out the significant others that influences the decision of place of delivery.
- To assess the effect of the places of delivery on the mother's health.
- To investigate the beliefs and attitude about pregnancy.

1.4 Significance of the Study

The limited evidence from well-designed studies on women's choices of places of delivery need urgent attention if strategies are to be implemented (Kingma, 2005). The understanding of the women's preference for delivery and the associated factors will provide evidence upon which to develop the health policies for women's safety.

In Ghana, like many other developing countries, it is very difficult to gather data on the issues that affect people's livelihood from the district level. This challenge even affected this study as statistics on maternal death from the communities within the chosen district were difficult to obtain. Since it is practically misleading for policy makers to make decision which is not evidence based, the findings from this study may assist the Ministry of Health at all levels to enact policy measure that can help reduce the cases of maternal death.

This finding is even expected to assist NGOs and other stakeholders who are interested in reducing maternal deaths in developing countries to enact intervention measures.

That notwithstanding, the findings from the study is to also open discussion and facilitate more research work at the community level all over the country. It is the hope of the researcher that this will go a long way to shape the perspective on women to give high preference to delivering at health facilities.

1.5 Organization of the Study

The study is organized into eight (8) chapters.

Chapter One is about the introduction to the study. It gives a background to the study including the definition(s) of the problem. It also states the research problem that will be focused on, including the objectives of the research. The chapter also states the research questions that the study seeks to answer.

Chapter Two reviews relevant literature such as previous research reports available, other relevant materials on the research topic, additional definitions and the theory used for this study.

Chapter Three describes the study area. It gives a detailed profile of Assin North Municipality. It reveals information about their political administration, marriage characteristics, religion, education and some economic activities.

Chapter Four discusses the methodology employed for the data collection. It provides information on the study population, size, method of selection of respondents and data collection approaches.

Chapter Five focuses on analysis, organization and interpretation of the responses obtained from the respondents including their demographics, cultural beliefs, preparations made before delivery and knowledge about maternal health care

Chapter Six discusses the core of the topic, where women prefer to deliver and who decides where to deliver.

Chapter Seven identifies the effect of the choice of place of delivery on the mother and baby.

Chapter Eight provides summary of the findings of the research and possible recommendations to address the challenges identified during the research. It also gives suggestions for future research into the problem.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Given the negative implications of poor maternal health and of maternal death, a number of researches have been conducted on the phenomena. Thus, literature on maternal health, choice of place of delivery and antenatal care is quite reputable. This chapter reviews some of the relevant literature on maternal health, specifically on the factors that influence women's preferred place of delivery. Evidence in literature shows that even for women who deliver elsewhere, almost all usually attend antenatal care (Hitimana-Lukanika, 1988; Arthur, 2012). Though the focus of the study is on why women prefer to deliver elsewhere, a little attention is used to examine the importance and reasons for using antenatal care.

2.2 Antenatal Care

Antenatal care is very crucial for maternal Health. The World Health Organization (2000) defines antenatal care (ANC) as “care before birth”, and includes education, counseling, screening and treatment to monitor and to promote the wellbeing of the mother and baby. According to the Ghana Demographic and Health Survey (GDHS) report, “the health care that a mother receives during pregnancy, at the time of delivery, and soon after delivery is important for the survival and well-being of both the mother and her child” (GSS, NMIMR & ORC Macro, 2009). Hence, one means of achieving an improvement in the health of women is providing maternal health services, such as antenatal care (ANC) during pregnancy (Arthur, 2012). The Ministry of Health (MoH) 2007 report states that “the objective of antenatal care is to promote and maintain the health of pregnant women. It aims to establish contact with pregnant women in order to

detect and manage current health problems. During this period women and their care-givers can develop delivery plans based on their needs, resources and circumstances”.

This suggests that it is only an appropriate ANC use that would significantly help in identifying and mitigating the risk factors in pregnancy. Magadi et al (2000) posits that the failure to receive appropriate ANC during pregnancy can lead to undesirable pregnancy outcomes such as maternal morbidity, low birth weight for the baby or even maternal and perinatal mortality. The MoH report (2007) states that,” In order for a particular woman to derive maximum benefit from antenatal care, it is essential for her to start utilizing the service early in pregnancy and to attain a minimum number of contacts with the service”. The World Health Organization (2000) recommends a minimum of four ANC visits for a pregnant woman before delivery if the woman cannot make the number of visits as directed by the physician/provider.

Despite the enormous benefits women stand to gain from utilizing ANC, research shows that women do not usually attend ANC and when they even do, they deliver elsewhere. In Uganda for instance, whereas more than 80% of women attend ante-natal care (ANC) at least once during pregnancy, only a small proportion (less than 40%) deliver in health units (Otim-Adoi, 1981; Munaaba, 1995; Hitimana-Lukanika, 1988). The 1995 Uganda’s Demographic and Health Survey (1995) showed that 92% of the women surveyed nationally attended ANC at least once with 47% attending more than four times and another 37% attending between two and three times. Regarding delivery, however, 64% were at home with only 35% in health units.

Majority of the deliveries that occur elsewhere are mostly attended to by traditional birth attendants (TBAs). For instance, in a Karen refugee camp in Thailand, more than half of deliveries that happen at home are assisted by TBAs despite short distance to the hospital and care being free of charge (Ishikawa et al, 2002). Most previous studies in Tanzania and elsewhere have shown that most mothers attend antenatal clinics at least once during pregnancy, but only a small proportion of them deliver in health facilities (Munaaba 1995; Amooti-Kaguna & Nuwaha 2000; National Bureau of Statistics & Macro International Inc. 2005). Continuous supportive care during childbirth, especially when the caregiver is a member of the hospital staff, improves the outcome of labour (Roosmalen et al., 2005).

2.3 Reasons for Attending ANC

Globally, about 60% of women attend antenatal care by 16 weeks gestation (Clarke et al, 1977, Heward et al, 1976). Women attend antenatal care for various reasons. Some of them are to obtain antenatal card, to know their health status and that of the baby, for medication, etc. The ANC card, is taken as a precautionary measure to avoid harassment by nurse/midwives should it necessitate delivering in a health unit. Usually, when mothers with an ANC card present for institutional delivery, they are complimented by nurse/midwives as good mothers (who attended ANC) and usually such mothers find it very easy to be admitted to delivery units. On the other hand, mothers who do not have an ANC card are usually abused by nurses/midwives and are told that they are negligent and not worth the institutional care. Such mothers also find it very difficult to be admitted to delivery units. They have to explain why they do not have an ANC card (Otim-Adoi, 1981; Munaaba, 1995; Hitimana-Lukanika, 1988).

Also, early contact by pregnant women with antenatal services is advocated for in an attempt to identify those at particular risk of developing complications so that these might be prevented (British Paediatric Association, 1978). In the study of Sreeramareddy (2006), one-third of the mothers had not gone for antenatal checkups and only a third of them received two doses of tetanus toxoid during their previous pregnancy. Studies show that women mainly go for antenatal to get an injection (tetanus toxoid).

Despite the availability of these services, many women book for antenatal care late in pregnancy and many attend only once, reducing the quality of care provided (Westaway et al, 1998). This well-known phenomenon across sub-Saharan Africa hampers the delivery of effective antenatal screening and treatment programs, potentially contributing in turn to avoidable maternal and child morbidity and mortality (Addai et al, 2000; Gharoro et al, 1999).

Meanwhile, there is widespread debate on the ideal structure of antenatal care in resource-limited settings. Traditional facility-based antenatal care commonly calls for frequent (often up to 12) antenatal visits. Although this schedule is supported by observational evidence suggesting that an increased number of antenatal care visits is associated with improved maternal and child health outcomes, this has often proved to be an unrealistic standard for antenatal care in the developing world (Villar et al, 1997). More recently, the World Health Organization has suggested that a shorter number of goal-oriented antenatal care visits (usually four) may achieve similar health outcomes as the more rigorous schedule (Berg, 1995; Villar et al, 2001).

However all guidelines for antenatal care recommends a first visit at or before 16 weeks gestation—substantially earlier than most women first seek antenatal care in South Africa, as in most other parts of sub-Saharan Africa, making late booking practices of concern regardless of the preferred care scheme.

2.4 Preference for TBAS

The World Health Organization defines TBA as “a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or by working with other TBAs”. TBAs are often older women and are generally illiterate. A few are men (Bergstron and Goodburn, 2001).

Despite the low literacy among TBAs, studies have shown that they play a crucial role in the maternal health of women especially in developing countries like Ghana. It has been reported that around 30% of neonatal mortality could be reduced by implementing skilled birth care services (Darmstadt et al, 2005). The effort to increase access to trained birth attendants was initiated by the World Health Organization in 1987 in Nairobi, Kenya, through the launching of the Safe Motherhood Initiative, aimed at ensuring women have a safe pregnancy and childbirth (Mahler, 1987; Maine et al, 1999). Attention to maternal health was demonstrated in 2000 when 147 heads of state and government and 189 nations in total signed the Millennium Declaration, in which the proportion of births assisted by trained birth attendants became an important indicator to measure the progress of improving maternal health (Millennium Development Goal 5) (United Nations 2001; Sachs et al, 2005).

Studies carried out in Kathmandu and its surrounding areas have reported socioeconomic status and multiparity as strong predictors of the place of delivery. In our study the reasons for planned home deliveries were related to 'preference' for home delivery and perception of home deliveries as 'easy' and 'convenient' and experience of previous home deliveries. For unplanned home deliveries the reasons cited were 'precipitate labor' and 'lack of transport' and 'lack of escort' during labor. (Sreeramareddy et al, 2006).

Women have given many reasons for their preference for TBAs. Among them include the potency of their traditional medicines, mode of payment for services, assured assistance and care, absence of list or hospital requirements and family tradition. Women who prefer birth with TBAs gave the most prominent reason for their choice as the potency of their traditional medicine/herbs. The herbs were said to have various roles such as: making the baby inside the womb grow well, cleansing the birth canal, treating and preventing some sexually transmitted diseases, preventing and treating abnormal vaginal discharges, and softening the 'bones' as pregnancy progresses. TBAs were also mentioned for their ability to treat children well, providing ANC and post-natal care services and their ability to also treat infertility (Amooti-Kaguna and Nuwaha, 2000).

Cost is one of the main reasons stated by women in low-income developing areas for using the services of traditional birth attendants. Thus, comparative to the amount that will be charged for delivering at a hospital, TBAs charges are relatively low. This therefore makes TBAs the optimal option for many women in low-income areas. In addition, the flexibility of the payment method for traditional birth attendants was more convenient (Titaley et al, 2010). For example, Amooti-Kaguna and Nuwaha (2000) mentioned some flexibility in their work as stated by the women as; sometimes

delivering women free of charge, payment being negotiable and sometimes in kind, delivering on credit, and near the place of abode of mothers. In Tanzania, for instance, most women from nearly all villages reported that they give birth at home because of lack of money to pay for delivery kits, fare and food. Home delivery cost was said not to exceed 600 Tanzanian shillings (roughly \$0.5) for gloves and a razor blade. In some private hospitals they had to pay about 5000 Tanzanian shillings (equivalent to \$4). Some health facilities were thought not to discharge women with no money until their debts were paid. (Mrisho et al, 2007).

Some women also emphasized that, when labour starts too abruptly or at night, the only helpful hand is a TBA. Some women argued that the services of a health professional are required only for those experiencing obstetric complications. Some community members stated that the midwife's services would be sought only if the condition could not be handled by the traditional birth attendant (Titaley et al., 2010).

Aside the abrupt delivery, which makes women to opt for TBAs, the quality of services delivered at the hospital has also come up strongly as a major factor influencing many women to use the services of TBAs to hospitals. Comments from some women point to concerns about quality of care at health facilities and the lack of confidence in health workers' ability to deal with pregnant and laboring mothers. Besides, many of the discussants mentioned that the health centers may not be open during nights and weekends (Shiferaw et al, 2013). In addition, for some community members, village midwives are too young and inexperienced; whereas traditional birth attendants were more mature, patient and caring as compared with the midwife (Titaley et al, 2010).

It is interesting to note that one of the reasons for preferring traditional birth attendants is the fact that mothers get the much needed support from their spouses and families' presence in home deliveries. Besides, some traditional birth attendants attend to some of the longstanding traditional practices which are rooted in the beliefs and cultures of the society (such as massaging the abdomen with butter and burying the placenta around home) (Shiferaw et al, 2013). Again, TBAs do not demand clean, new dresses for the new-born, old and dirty pieces of clothes were acceptable. The reality is that women are asked to bring delivery kits, such as razor blade, gloves and cotton wool and other materials which they can't afford to the hospitals hence, the preference for home delivery (Amooti-Kaguna and Nuwaha, 2000).

Another factor that influenced the use of traditional birth attendants was the view of family members such as the older sister, parents, or husbands. A long-time tradition in the community of using the service of traditional birth attendants, who had been the only delivery service providers for many years before the National Health System (NHS) started, was also mentioned as a reason for community members to use their services during childbirth (Titaley et al, 2010).

Our study found that being part of the community, speaking the local language, living in the community and sharing the same culture meant that traditional birth attendants have developed the feeling of trust in the community (Titaley et al, 2010). Some women have also given other reasons for home delivery such as unexpected labour. They did not necessarily prefer home delivery but it just happened. According to Amooti-Kaguna and Nuwaha, (2000) in their research in Rakai, Uganda, 94 women out of 211 delivered at home. They were asked the reason for their choice instead of the health unit. Twenty

gave reasons as quick labour which means that the stages of labour progressed so quickly that there was no time to go to a health unit.

Despite these merits of TBAs, studies have found some demerits in using the services of TBAs. These include the quality of delivery care. Studies have shown that some TBAs do not know how well to assist in delivery; they cause problems to some mothers and babies, for instance 'leaking urine'. Almost all the time, TBAs referred mothers late to the hospital in times of emergency (Amooti-Kaguna and Nuwaha, 2000). A study from rural areas of Makawanpur district, Nepal reported that a very large proportion (more than 90%) of deliveries took place at home. The study also reported that only six percent of home deliveries were attended by skilled government health workers and newborn care practices were unhygienic and high-risk (Osrin et al, 2002).

While the Ethiopian health system acknowledges the role of traditional birth attendants as volunteers working under the supervision of the health extension workers (Federal Ministry of Health of Ethiopia, 2003) their relationship has not been clearly defined. Experiences from other countries indicate that skilled attendance can be better promoted in a system that integrates traditional with the modern health system (Iyaniwura & Yussuf, 2009). Although the evidence is mixed (Ofili and Okojie, 2005), evaluations of programs which promote trained traditional birth attendants have indicated that their service could increase women's use of antenatal care and emergency obstetric care, and decrease perinatal and neonatal mortality in a context where access to health services is limited and maternal mortality is high (Sibley & Sipe, 2006).

Similar findings were reported from an earlier study in Kathmandu (Bolam et al, 1998). In urban areas there is a mix of traditional families and recent economic immigrant families. In rural areas women have a strong cultural preference for home deliveries because institutional deliveries are inaccessible. This could be the reason for women indicating 'preference' as the reason for delivering at home. It was found that 70% of the home deliveries were unplanned. These women would have sought institutional delivery if an ambulance service or local facility for delivery was made available. In this respect it may be worth investing on satellite maternity services run by midwives. Mothers might prefer to utilise such local and user-friendly services than a tertiary care hospital. Also the mothers need to have information about how to access a trained traditional birth attendant or a midwife during the delivery (Sreeramareddy et al, 2006).

2.5 Preference for Health Facilities

Most of the women who also prefer health facilities for delivery give almost the same reasons: the issue of normal or abnormal pregnancies and quality service. In the focused group discussions conducted by Amooti-Kaguna and Nuwaha, (2000), it was emphasized that it was abnormal pregnancies that needed more attention and hence they needed modern health assistance as compared to normal pregnancies. Some of the abnormal pregnancies included excessive bleeding, mal-position/presentation of the baby, a tear during delivery or when operational delivery is advised. The respondents added that, mothers who have had any of these complications should be the ones to consistently seek good health care. Again, they concluded that, if they attend ANC and are assured that the baby was fine, there was no need to deliver in the health units.

Quality of services was perceived to play a major role in the choice of place of delivery. For example, some women decided to go to private health facilities, where they had to pay, despite government health facilities with free delivery services being closer to their homes. Another reason for preference for private health care was the presence of relatives during delivery. Most women preferred the presence of their husbands or other close relatives during delivery, which private health care allowed. (Mrisho et al, 2007; Amooti-Kaguna and Nuwaha, 2000).

2.6 Barriers to Delivering in a Health Facility

Studies have shown that there are many barriers that usually prevent women delivering at health facilities. Though access to maternity services is one of the main factors in deciding the place of delivery, socioeconomic and physical variables such as distance from a health facility, money, time labour starts, attitude of nurses and poor quality of care in the various delivery sites influence the place of delivery (Elo 1992; Bolam et al. 1998; Yanagisawa et al. 2006). Ensor and Cooper (2004) also mentioned some significant barriers, such as financial, geographical and cultural factors, as well as, improper care within the health sectors. Ishikawa et al, (2002) indicated that following traditional practices can also affect women preferred place of delivery. That is, where the women in a family usually delivered is another strong social barrier to delivering in a health facility. Again, shyness towards the male staff in health facilities such as showing of legs and vaginal examination hindered the choice of hospital delivery. Another equally important barrier that Ishikawa et al mentions is the inability of family, especially husbands to be by their wives during the labour at health facilities hindered the desire to deliver at such places.

Proximity to health care facilities is an underlying issue for selecting delivery health care services, as also shown in previous literature (Thaddeus et al, 1994; Onah et al, 2006). In rural Tanzania for instance, 84% of women who delivered at home decided to deliver at health facility but did not because of distance and transportation problems. Poor road conditions and lack of transportation are associated with increased costs of visits to health care providers. An earlier study from West Java Province mentioned the problem of distance as a reason for a community's use of traditional birth attendants compared to midwives.

Various studies have reported barriers embedded in the beliefs, and traditions of communities fear or embarrassment related to receiving care at health facilities, as well as the perception that health professionals are not paying sufficient attention to traditional norms of the society (Bazzano et al, 2008; Otis et al, 2008; Iyaniwura & Yussuf, 2009; Gabrysch et al, 2009; Gleit et al, 2003). This subject is as important as it is disturbing.

One of the most challenging issues why some women refuse to deliver at health facilities is due to the negative attitudes of nurses. Apparently, midwives in public units are rude, proud, negligent and vulgar. Expectant mothers were also said to have been abused if they had never attended ANC or if they have had many children already (Amooti-Kaguna and Nuwaha, 2000). Thus, part of the problem lies in violence committed by health workers, which affects health-service access, compliance, quality, and effectiveness (WHO, 1998; Nogueira, 1994; Jewkes et al, 1998).

When discussing violence against women perpetrated by health workers there is no agreed definition of violence. There are about four types of violence: neglect; verbal violence, including rough treatment, threats, scolding, shouting, and intentional humiliation; physical violence, including denial of pain-relief when technically indicated; and sexual violence. These categories are similar to the forms of violence that occur in personal relationships—ie, emotional, physical, and sexual abuse. Other important forms of violence against women occur in reproductive health services and deserve more discussion. These forms include excessive or inappropriate medical treatments in childbirth, such as doctors doing caesarian sessions for reasons related to their social or work schedules or financial incentives (Murray et al, 2000; Belizan et al, 1999) or adhering to obstetric practices that are known to be unpleasant, sometimes harmful, and not evidence based, including shaving pubic hair, giving enemas, routine episiotomy, routine induction of labour and preventing women from having companions in labour (Alves et al, 2000).

A common sign of neglect in reproductive health-services is women giving birth unattended within health facilities. Many women describe neglect as the most distressing part of their experiences because they fear it will harm their babies as well as themselves, and interpret it as a sign that staff do not care or are acting unprofessionally. In a South African study in which expectant mothers were interviewed, (Jewkes, et al, 1998) most women expressed perceptions of neglect by midwives. In Nigeria, (Jaffre, 1994) women asserted that they were rarely physically examined during labour and were not attended to by staff qualified for that purpose. Neglect was also used as a systematic punishment and deterrent for non-compliance with the obstetric system. In many South African health facilities, women who arrived in labour without having booked a place were

routinely expected to wait until all other women had been attended to before receiving care, regardless of their medical needs. Midwives explained that this behaviour was to teach women to attend antenatal care the next time they became Pregnant (Jewkes, et al, 1998).

Verbal abuse is another common negative attitude of nurses. In several studies from different continents, many women described health-care providers as unkind, rude, brusque, unsympathetic, and uncaring and were often shouted at or scolded (Wood et al, 1997). Relations in maternity units were often so tense that women were afraid to call for help, yell, or express their pain for fear of reprisals (Mathai, 1997). Research in Nigeria showed women forced to clean the room after childbirth if they had failed to comply with the instructions of staff. Another form of humiliation noted quite widely in South Africa, (Jewkes et al, 1998) and Peru (CLADEM, 1996) consisted of crude and aggressive attacks on female sexuality via variations of the phrase:

“You liked it all right when it was time to give, so don’t shout now”. In these situations, health workers can be seen as people capable of, or actually causing, deliberate harm instead of care, and any routine physical contact may be perceived as an opportunity for inflicting physical punishment.

Aggressive relationships between health-care workers and patients can include physical violence. The Peruvian, (CLADEM, 1998) and South African study reported patients receiving slaps on the face and thighs while in labour. A senior midwife in South Africa told the researchers that she did not believe there was a midwife in the country that had never hit a patient and explained that they were taught how to do so during training.

2.6.1 Socioeconomic Barriers to Delivering in Health Facilities

Studies have found that certain socio-economic variables that influence the use of ANC are level of education, age, residence (rural/ urban), geographical location (region of residence) and number of living children (Henze, 2004; Tayie and Lartey, 2008; Arthur, 2012). These are potential variables that are likely to either aid or hinder women from using ANC. The level of education for instance, has been found as a major key factor that determines the level of utilization of maternal health services. According to Grossman (1972), education makes a person efficient in the use of health services and may enable the individual to choose a more health conscious behavior to improve health. Addai (2000), Henze (2004), and Tayie and Lartey (2008) are some studies that have found a positive and significant association between education and maternal health care use. In Tanzania for instance, the Demographic and Health Survey has established a strong relationship between the mother's education and the place of delivery. The proportion of births delivered at health facilities increased from 29% among mothers with no education to 79% among mothers with a secondary or higher education (National Bureau of Statistics & Macro International Inc. 2005). Among mothers with no education, the number of births delivered at health facilities increased from 29% to 79% among mothers with at least a secondary or higher education (National Bureau of Statistics & Macro International Inc. 2005).

Similarly, in Nepal, maternal education was among the important independent factors in determining the place of delivery (Bolam et al. 1998). According to Yanagisawa et al. (2006), women who had attended school for at least 7 years were six times more likely to deliver babies at health facilities as compare to those who have never attended school. Mrisho et al, (2007) also contributed that lack of education could make some expectant

mothers stick to their decision regardless of their condition. Overbosch et al (2004), concluded in Ghana that, “Women’s attitude to antenatal care seems to be influenced by their schooling. Thus, in the campaign to raise the utilization of maternal health care services, there is the need to encourage women to pursue higher education (Arthur, 2012). Interventions should also focus on improving the status of women in society including increasing female literacy and empowerment to tackle the maternal health problems (Simkhada et al, 2006).

Age and the number of living children of the mother may also affect her use of ANC. Empirical studies on age presents mixed evidence. For instance, in India and Honduras, Chandhiok et al (2006) and Henze (2004), found a reduction in the proportion of women obtaining ANC services with increasing age. On the other hand, in Turkey, Celik and Hotchkiss (2000) and Ortiz (2007) found a positive relationship between ANC and age in Turkey and Colombia respectively. Alongside age is the previous experience of the expectant mother. Previous experience influence the use of ANC positively (a pleasant experience at the health center) or negatively (an unpleasant experience at the health center) (Arthur, 2012). Complications experienced during earlier pregnancies also have a positive association with the use of ANC (Overbosch et al, 2004). For place of residence, Abor & Abekah-Nkrumah (2009), found that urban dwellers may be relatively closer to healthcare facilities than rural dwellers in most developing countries.

2.7 Who Decides Place of Birth?

In most African societies, women carry the major portion of responsibility for the welfare of the whole house. However, they do not have the independence to make

decisions for the house. They have to seek the consent of husbands, mothers-in-law or and senior household males before they are allowed to seek health care (Tanner & Vlassof, 1998), including place of delivery. Similar responses were derived from the work of Amooti-Kaguna and Nuwaha, (2000). According to them, the women admitted that the decision of place of delivery mostly depended on the husband. They continually quoted that the husband was 'the money maker'. Others who were also mentioned included mother-law, the mother, aunt, sisters or even neighbor. Surprisingly, counsel from TBAs and sometimes from modern health workers were also mentioned as influencing choice of delivery place.

In a FGD by Mrisho et al, (2007) at Nahukahuka village, Tanzania, a woman admitted that her last child was born at a health facility because her parents wanted to her to deliver in a health facility. She could not decide on her own because of lack of money.

Urassa et al (1997) indicated that, the place of delivery was also taken by a nurse. Nevertheless, it was decision on where to take her, in case of complications sorely lied with the husband or the mother.

If institutional delivery is deemed important, it is usually the husband who provides the transport and often accompanies the woman to a health unit. Alternatively, the woman goes to the health unit accompanied by a female relative e.g. mother-in-law, aunt, mother or sister. However, the husband or another male relative must follow them as soon as possible to help in making important decisions as the need arises (Amooti-Kaguna and Nuwaha, 2000). In Tanzania, although health facilities are closer to rural households than in many African countries, more than half of children are delivered at home despite a

high coverage (94%) of antenatal care (ANC) (National Bureau of Statistics & Macro International Inc. 2005).

There may be many cultural constraints for use of maternity services e.g. decision of the husband or mother-in-law which often over-rides that of the mother. The reasons for low uptake of maternity services in the urban population may be due to socioeconomic and cultural factors (Bolam et al, 1998; Waggle et al, 2004). Therefore, interventions should address not only the medical problems but also need to deal with wider social problems.

2.8 Cultural Beliefs about Pregnancy and Child Birth

Societies have their own beliefs. In the United States, most folks have found no truth in the superstitions of old, such as stepping on a crack will break your mother's back, walking under a ladder will bring horrible luck, or that the number 13 has some evil connotation. Society, as a whole, has come to the conclusion there are no consequences for petting a black cat or opening that umbrella in the house.

West Africa has been identified by the UN as one of the poorest areas in the world. Superstitions run rampant in this region, as the old practices of witchcraft, voodoo, juju and marabou, brought about through old traditions and culture and the practicing native spiritual mediums of the area. (Perry, 2015).

Amoafowaa, (2014), identified some believes relating to pregnant women in Ghana: if a pregnant woman eats eggs, she will give birth to a snake; she cannot be married until she delivers, or else the husband will be marrying both the wife and the child if the baby happens to be a girl. This girl will grow up and never be married; if a pregnant woman bathes in the night, she will miscarry; when twins are born, their mother must turn into a

beggar in order to feed them or they will die; if a pregnant woman watches horror movies, she will give birth to an ugly child; when one gives birth to a boy as a first child and one wakes up in the morning and the first person met happens to be a boy, that is a sign of good luck and vice versa. Finally, if a pregnant woman dies, those who bury her must have all her assets.

These beliefs are revered so much because of the fear of its consequences. Hence, pregnant women attach a higher level of importance to their cultural beliefs.

2.9 Conclusion

In summary, the literature reviewed explains why women deliver at home or at health facilities mostly in countries such as Tanzania, Uganda, Nigeria and other African countries. In Ghana, empirical studies on the factors that influence women's decision to attend antenatal and yet deliver elsewhere are rare. This study therefore, seeks to fill this gap by exploring areas such as knowledge in maternal health care, who decides the place of delivery, factors that influence the place of delivery, the effect of the place of delivery on the health of both the mother and the baby and the beliefs and attitude about pregnancy.

2.10 Theoretical Perspective

The Rational Choice Theory

Sociologists and political scientists have tried to build theories around the idea that all action is fundamentally 'rational' in character and that people do cost-benefit analysis of any action before deciding what to do. This approach to theory is known as the rational choice theory (Scott, 2000).

Rational choice theory was pioneered by sociologist George Homans (1961) and is influenced by Economic theories which look at the ways in which the production, distribution, and consumptions of goods and services are organized through money. Rational choice theorists have argued that the same general principles can be used to understand human interactions where time, information, approval and prestige are the resources being exchanged. According to this theory, individuals are motivated by their personal wants and goals and are driven by personal desires. Since it is not possible for individuals to attain all of the various things that they want, they must make choices related to both their goals and the means for attaining those goals. Individuals must anticipate the outcomes of alternative courses of action and calculate which action will be best for them. In the end, rational individuals choose the course of action that is likely to give them the greatest satisfaction.

One key element in rational choice theory is the belief that all action is fundamentally “rational” in character. This distinguishes it from other forms of theory because it denies the existence of any kinds of action other than the purely rational and calculative. It argues that all social action can be seen as rationally motivated, however much it may appear to be irrational (Crossman, 2014).

The fact that people act rationally has, of course, been recognised by many sociologists, but they have seen rational actions alongside other forms of action, seeing human action as involving both rational and non-rational elements. Such views of action recognise traditional or habitual action, emotional or affectual action, and various forms of value-oriented action alongside the purely rational types of action. Max Weber (1920), for example, built an influential typology of action around just such concepts. His ideas were taken up by Talcott Parsons (1937) and became a part of the sociological mainstream.

In a similar way, the father of social anthropology, Bronislaw Malinowski (1922) and Marcel Mauss (1925) looked at how social exchange was embedded in structures of reciprocity and social obligation. What distinguishes rational choice theory from these other forms of theory is that it denies the existence of any kinds of action other than the purely rational and calculative. All social action, it is argued, can be seen as rationally motivated, as instrumental action, however much it may appear to be irrational or non-rational.

George Homans (1961) set out a basic framework of exchange theory, which he grounded in assumptions drawn from behaviourist psychology. While these psychological assumptions have been rejected by many later writers, Homans' formulation of exchange theory remains the basis of all subsequent discussion. During the 1960s and 1970s, Blau (1964), Coleman (1973), and Cook (1977) extended and enlarged his framework, and they helped to develop more formal, mathematical models of rational action (Coleman, 1990).

The Rational Choice Theory focuses on the individual actor. Individuals are seen as rational and make rational decisions. According to this theory, actors are seen as being purposive and having intentionality that is the actors have ends and goals towards which their actions are aimed at. Also, the actor is seen to have preferences, although the theory does not concern itself with what these preferences are. According to the theory, the ultimate aim of the actor is to achieve his or her preferences (Coleman, 1990).

In relating this theory to the study, it can be said that individuals make deliberate and calculative efforts to make choices that will be beneficial to them. This means that the

choice a woman makes to deliver in a hospital or with a TBA is rational. She considers the benefits, challenges, gains and disadvantages with each choice before arriving at a final decision.

Like many other Sociological perspectives, the Rational Choice Theory has been heavily criticized. Criticisms against the theory include that fact that, the theory assumes too much rationalism in human behavior. Human beings are not always rational, they sometimes make some irrational decisions. This notwithstanding, the theory remain one of the most important theory in that it helps to understand human thought processes tied up as it were, with human interest. The theory also helps to explain the multi-level-interest and choices people make as they contend with many issues such as poverty and ill health (Senah, 1997).

However, in the course of pursuing these preferences, the actor is constraint by certain factors. First, the actor is constrained in achieving the preference due to scarcity of resources. Because resources are limited in supply, the actor has the option to forgo the next-most-attractive action termed as opportunity cost. Second, the actor is constrained by the social institutions. The social institutions according to the theory provide both positive and negative sanctions that either serve to encourage or discourage certain actions (Ritzer, 2000).

CHAPTER THREE

A PROFILE OF ASSIN NORTH MUNICIPAL

3.1 Introduction

This chapter presents a profile of the study area. Data was taken from the Ghana Statistical Service (2014) and the analytical report on the 2010 population and housing census. The chapter presents some important profile of the Assin North Municipal.

The Assin North Municipal is among the twenty (20) Metropolitan/Municipal District Assemblies (MMDA's) in the Central Region of Ghana. Assin North is situated in the northern corner of the Central Region. About 97 percent of persons in Assin North are Ghanaians. Almost half of the non-Ghanaians are from ECOWAS countries.

Figure 2. District map of Assin North



Source: Ghana Statistical Service, GIS

3.2 Physical Features

Assin North lies within Longitudes 10 05' East and 10 25' West and Latitudes 60 05' North and 60 04' South. The municipality shares common boundaries with Adansi East in the Ashanti Region to the north, Upper Denkyira to the North-West, Assin South to the South, Twifo Atti Morkwah to the West and Birim South in the Eastern Region to the East. The municipality covers a total land area of about 1,150 sq.km and comprises about 500 settlements including Assin Foso (the Municipal Capital), Assin Nyankumasi, Assin Akonfudi, Assin Bereku, Assin Praso and Assin Kushea. Characterized by undulating topography, the municipality has an average height of about 200m above sea level. Flood-prone plains of rivers and streams lay low below sea levels. The municipality is drained by numerous small rivers and streams. The main rivers include the Pra, Offin, Betinsin and Fum. Swamps also abound in the municipality which serves as potentials for fish farming and dry season vegetable and rice farming.

Assin North Municipal falls within the moist tropical forest, mainly deciduous forest. The area has an annual rainfall between 1500mm and 2000mm. Annual temperatures are high and range between 30oC from March to April and about 26oC in August. Average relative humidity is high ranging from 60 to 70 percent. The municipality comes under relative cool and moist South-West Monsoon Winds that blow from the Atlantic Ocean for some parts of the year, thus between December and February. The dry harmattan or North-East Trade Winds blow from the North to the area. Its dissipating effects, however is greatly reduced by long passage over the forest zone. The rainfall pattern is bi-modal. The major rainy season starts from April to July corresponding with the major farming season and the minor season starts from November to January. The most common dialect in this place is Twi and Fante.

3.3 Political Administration

Administratively, both political and social organizations of the region are based on modern and traditional institutions. Assin North Municipal was established by L.I. 1856 in 2012. The municipality has one (1) town council and six (6) area councils. The Assembly is made up of forty-seven (47) Assembly members out of which thirty-three (33) are elected and fourteen (14) Government Appointees. There are two (2) Members of Parliament since the municipality has two constituencies. The Municipal Assembly is the highest administrative and political authority in the municipality. It is responsible for the overall development of the municipality by way of the preparation of development plans and the budget related to the approved plans. There is a Presiding Member who chairs all General Assembly meetings.

Traditionally, each of the communities in the Assin North municipality has a chief who serves as the traditional leader of the community. He is seen as the custodian of ancestral and the community land; the custodian of culture, customary laws and traditions including history; the initiators and champions of development activities in their respective areas of jurisdiction and also responsible for settling disputes and the maintenance of law and order.

3.4 Household Size, Composition and Headship

The 2010 Population Housing Census defined a household as a person or group of persons who live together in the same house or compound and share the same house-keeping arrangement. Members of a household may be blood relations or simply friends who are living together and having the same catering arrangement.

On the average the majority of all dwellings in the municipality are owned by household members but this is true for rural households than for their urban ones and also for male-

headed than female-headed households. The majority of the households in dwellings use electricity while access to water within the dwellings is lacking or limited. Waste disposal (solid and liquid) are two major issues affecting the municipality. Dumping of solid waste in open space is paramount in the municipality and even more evident in rural areas. Liquid waste is also thrown onto compound in the municipality but more pronounced in the urban areas. Majority of the population in the municipality use the public toilet and also wood is the main source of cooking fuel for the district.

3.5 Sex

Sex ratio for the municipal has been relatively low as in some other districts in the region and has declined consistently falling below 100 in most of the age groups. The proportion of children is large compared to the aged. The population is largely youthful, with a potential to continue to grow into the near future. The relatively high fertility levels also indicate prospects of future population growth. The contribution of children (females under 15 years) to births was for the first time measured at the census. This age group contributed a similar proportion of total births as teenagers (15- 19 years) and justifies their inclusion on the fertility schedule at the census and the need to address the phenomenon.

3.6 Marital characteristics

About 40 percent of the population 12 years and older in Assin North have never married with about the same proportion currently married. Eleven percent of the remaining group is widowed with the others either separated or in informal or consensual union. About six percent of those married are in the age group 12 - 14 years.

3.7 Religious Affiliation

Almost all the people of Assin North are Christians. The largest religious group is Pentecostal or Charismatic. The second largest are the Protestants and Catholics. The Assin North Municipality also has a few people who are not affiliated to any religious grouping. Muslims constitute a small proportion of the population, with traditionalists making up less than one percent.

Religious leaders in this community are seen to be the first point of call for guidance and counseling concerning marital problems, joblessness, financial challenges, spiritual upliftment and settlement of disputes. These religious leaders are respected just as the traditional chiefs.

The people have a lot of religious underpinnings in their language, dressing, dancing and even food. For instance, almost everyone responded to the question, ‘how are you?’ with ‘by the grace of God I am fine’. The Catholics were seen in rosaries around their neck as part of their dressing. On Sundays, the Christians were seen singing and dancing with hands raised as a form of worship. They regarded certain foods such as ‘eto’ as sacred for the gods and should not be eaten on any ordinary day but during festivals.

3.8 Social and Cultural Structure

The major urban centres are Assin Foso (the Municipal capital), Assin Bereku, Assin Praso, Assin Nyankumasi, Assin Akropong, Assin Awisem and Assin Akonfudi. Assin North Municipality has two main paramountcies, Afutuakwa with its capital at Assin Foso and Wirenkyiman with Assin Kushea as capital. There are two other paramountcies, Assin Attandasu and Assin Apimenim which have towns and villages scattered around the Municipality with their Paramount Chiefs living in the Assin South District.

The major festival of the people of Assin North is the annual Tutu Festival celebrated during the second week of December which lasts for two weeks. The municipality has many historic sites of scientific and aesthetic importance which have the potential of serving as tourist attractions. These are Assin Praso Heritage Village, Flagstone with footprints and designs at Assin Fosu and the sacred rock formation at Endwa.

3.9 Literacy

Literacy means the ability to read and write with understanding. Apart from these languages, English, Ghanaian language or French no person is literate in any other language. The proportion of females who are not literate is higher than that of males. For the males there are more literates than non-literate in all the age categories. The trend is similar among the females except for age 60 and above where there are more non-literates than literates. This may be a result of the cultural belief in the rural communities in the olden days that females were not to be given formal education since their role is in the kitchen. The proportion of literates for ages below 20 years is low and this may presumably be due to the fact that these children may still be in school but can still not read and write. There is the need to take a critical look at the quality of education in the Assin North Municipality.

3.10 Education

Assin North is relatively endowed with a number of educational institutions both public and private including basic schools, technical/vocational schools, and second cycle institutions. Almost half of those attending school now are at the primary level. About 19 percent of those in school are at the Junior High School level, 18.3 percent in kindergarten with 8.4 percent in Senior High School. More than one percent of those in school now are at the tertiary level with 0.4 percent in Vocational, Technical or

Commercial institutions. The nursery schools contain about 4 percent of the pupils currently in school; these are mostly in the private schools which are not part of the public system.

The highest proportion of persons who attended school in the past ended either at the Junior Secondary or Middle School level. About 20 percent attained primary level, 10.3 percent attained Secondary level and 1.3 attaining tertiary level of education. The proportions of those with Basic level education are higher for those who attended school in the past than those currently in school. Of the total male and female population 3 years and older who are currently attending school, majority of them are in the Primary school with males and females. The proportion currently pursuing Tertiary programs are males (1.7%) and females (1.1%).

Whilst 2.5 percent of those who attended school in the past went to Vocational, Technical or Commercial school, only 0.4 percent of those currently in school are at that level.

3.11 Economic activity

The Assin North Municipal is one of the seventeen districts in the Central Region of Ghana with diverse physical environment and topography that support diverse economic activities in the region and for that matter Ghana. These include agricultural production, fishing, forestry and ecotourism. A higher percentage of persons 15 years and older in Assin North are economically active. Most of these economically active people are employed. About seven percent of the economically inactive group cannot work because they are disabled or sick. Nineteen percent of the unemployed are in the age group 15-19 years.

3.12 Agricultural activity

Agricultural production is a predominant economic activity in the district. A greater percentage of all the households in the municipality are engaged in it, and mostly in crop farming. Many households also engage in crop farming, followed by livestock rearing. Only a very small percentage of farming households engage in tree planting and fish farming.

The community like most Ghanaian communities also holds some taboos about farming. For instance, farmers do not go to farm on days such as ‘Akwasidae’ (every 40 days on a Sunday) and ‘Fodjor’ (once in 2 month on Mondays). When one goes to farm on these sacred days, it is believed that the person will come into contact with a god or a strange animal and the person will die instantly.

Another taboo is if a man and woman have sex in the bush or farm, it is believed that they will give birth to a child with a disability.

These taboos are obeyed in fear and the people uphold them in high esteem as tradition.

3.13 Health

The researcher was unable to attain information regarding health issues concerning the municipality from their municipal health directorate. This is due to the unwillingness of the authorities to open up as a result of previous challenges faced with researchers. The Ghana Statistical Service report used for this chapter also presented no information on health. Therefore, the researcher resorted to information from the respondents and the Ghana Health Service (GHS) head office in Accra.

The Francis Xavier General Hospital is the biggest mission hospital in Assin Fosu. It provides a wide range of health care services and it is the nearest referral hospital that serves both the Assin North municipality and its environs. With the introduction of the National Health Insurance Scheme (NHIS) and the broad range of services it provides, most of the citizens prefer to seek medical care directly at this hospital.

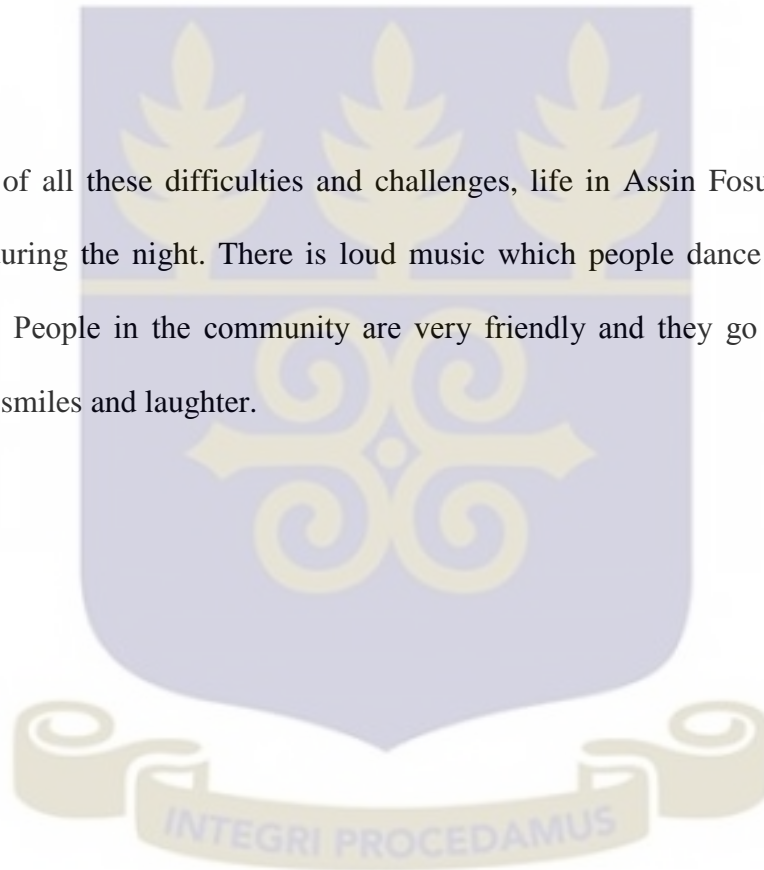
There are also five (5) registered private clinics, polyclinics and maternity homes well spread in the Assin Fosu community which supplement the efforts of the only public health facility available. These private facilities also provide a wide range of services including theatre, scan, labs, maternity etc. that caters for the health needs of the community members. There are a number of drug stores located all over the municipality and this serve as the first point of call for most people seeking health care. They believe certain sicknesses such as headaches and stomach pains are too trivial for the hospital. They attend the hospital only after taking the medication from the drug store and the ailment still persists.

With regards to issues concerning maternal health care and maternal mortality, a personal conversation with one of the authorities at the Ghana Health Service revealed that, generally, (not in Assin North alone) there are quite a number of women who die as a result of delivering at home with TBAs. However, the ministry has been unable to record such statistics since the TBAs quickly 'push' those women to the hospital before they die. Hence, this makes the health institutions record more deaths which might not be necessarily from their outreach.

3.14 Conclusion

A profile of the area presents some of the difficulties and challenges faced by the residents of Assin North. These challenges include, inadequate social amenities, low level of education and inadequate jobs. Most of the economic activities in the municipal also are all centered on farming and trading. Many of the women interviewed also complained about financial challenges which made them unable to access periodic health care since the National Health Insurance Scheme (NHIS) currently is not effective as it used to be.

In the mist of all these difficulties and challenges, life in Assin Fosu is very exciting especially during the night. There is loud music which people dance to after the hard day's work. People in the community are very friendly and they go about their daily chores with smiles and laughter.



CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

Research methods are the methods, procedures and techniques used in attempt to discover what we want to know about a problem of interest (Kumekpor, 2002). Research in the social science covers a wide variety of topics and this is because social science presents a variety of disciplines such as Psychology, Sociology, Political Science, Anthropology, and Economics among others. Within the various disciplines, researchers use a number of different methods to conduct research. These methods may include participant observation, case studies, interviews, focus groups, surveys, laboratory experiments, and field experiments. Despite the differences that exist in the methods used and the topics investigated, most social science researches share a number of common characteristics regardless of field, which involves an investigator gathering data and performing analyses to determine what the data mean.

For the purpose of unraveling research problems, there have been debates as to the most appropriate tool in conducting research among the social sciences to achieve objectivity and not being subjective. While those in the natural sciences criticize the social sciences as being too much subjective, some founding fathers of Sociology like Comte and Durkheim have advocated for the acceptance of social sciences like Sociology as a science in that the discipline follows the rules, methods and procedures of the natural sciences in conducting their research. It is through the systematic collection of data that research problems can be unraveled. As a means of unraveling research problems, quantitative and qualitative approaches are the most common type of research.

Although there are debates as to the appropriate research method, Creswell does not see the two types as polar opposites or dichotomies but should be viewed as different ends on a continuum (Creswell, 2009). Both quantitative and qualitative should not be viewed as mutually exclusive but rather as complementing each other. Mixed method is also used to bridge the gap between the two. It employs both quantitative and qualitative methods (Creswell, 2009). Quantitative research method is a means of testing objective theories by examining the relationships among variables while qualitative research method on the other hand aims at exploring and understanding the meaning individuals attach to a human problem (Creswell, 2009). In view of the nature of the problem under study, that is, why women choose the place they deliver, the researcher adopted the qualitative method. This approach enables the gathering of rich data and explanations that cannot be adequately covered using the quantitative approach alone.

4.2 Choosing the Study Site

As explained earlier, in Ghana, empirical studies on the factors that influence women's decision to attend antenatal and yet deliver elsewhere are rare. It is within this premise that this study is being conducted, using Assin Fosu in the Assin North Municipal in the Central Region as a case. Selecting Assin Fosu was influenced by the findings of the 2010 Population and Housing Census.

According to this report, the Central Region, like other three regions (Northern, Upper West and Upper East) recorded maternal mortality figures higher than the national average. The maternal mortality for Central Region is 520 per 100,000 live births as compared to the national average of 485.2. Out of the 17 districts in the region, Assin North recorded the second highest in maternal mortality in 2012. Since Assin North

Municipal is a large district comprising 21 communities, the capital Assin Fosu was used in this study. It is mainly farming and trading community with a population of 20,541 (Ghana Statistical Service, 2012).

4.2.1 Community Entry

Entering into an unfamiliar community can pose some challenges especially with regards to how to find the places intended. The use of social network is thus useful in such instances. Entry into the community was made possible by a known relative who resides at the place and social ties with friends who assisted and gave guidelines as to how to interact with the people. This made the research in the community less cumbersome.

The researcher greeted and introduced herself to the households as a student and not from the Assin Fosu community amid smiles. She told them the purpose of her visit. She told them the research was for academic purpose and that she will be grateful if they can spare a few minute of their time to help a student. With this explanation, they agreed to participate in the in-depth interview.

4.3 Study Design

Within the scope of this study the researcher adopted qualitative method in data collection. The use of this method enabled an in-depth understanding of the phenomenon as it allowed the researcher to ask follow-up questions to clarify issues. Qualitatively, the researcher adopted an interview approach to gather data concerning women's preference for place of delivery and the reasons accounting for that.

Even though the researcher could have used only quantitative method (like a survey), some useful details and explanations would have been left out. Also due to the time constraints, a mix method would have affected the timeliness within which the research was to be completed.

It must be noted that many studies that have been conducted to examine women's preferred choices used similar methodology. For instance, Mrisho et al. (2007) who conducted a study to examine the factors affecting home delivery in rural Tanzania adopted a qualitative approach where they combined both an in-depth interview and focused group discussion methods. Also, Seljeskog et al. (2006) conducted an explorative study in which they conducted an in-depth interview as a qualitative approach to explore the factors influencing women's choice of place of delivery in rural Malawi-an explorative study. There are many other similar studies that have solely used a qualitative methodology. Therefore, using only a qualitative approach do not in any way undermine the findings and conclusions from this study.

4.4 Sources of Data

The study made use of both primary and secondary data. The primary data was collected qualitatively through the use of a semi-structured interview guide. The interview questions were designed in such a way as to enable the researcher to probe further to enable clarity on the issues. Tape recorders were used during the interview with the permission of the respondents. Along with recording, notes were also taken. This was to make sure that no relevant information was missing from the analysis.

Secondary data were also obtained from the review of books, journals, articles and other internet resources. Data from these secondary sources were reviewed extensively to determine the position of other researchers and writers on this topic.

4.5 Target Population

According to Babbie (2005), the target population refers to the entire group of people, events or things of interest about whom we want to draw conclusions. The target

population for this research included all women, (i.e. pregnant women, young and old women), Traditional Birth Attendants (TBAs), midwives, private clinic operators and men.

The women were the main focus of the study. The older women were asked to recount their experiences. This included how many children they have and where they attended antenatal and delivered each one of the children, the challenges experienced at the antenatal facility and place of delivery, the beliefs concerning pregnancy and regarding these places of delivery. The younger and pregnant women were asked where they preferred to deliver and the reasons for the choice of those places.

The men, who are mostly the people who support the women financially, were also asked if they were those who decided where their wives must deliver. Midwives, TBAs and private clinic operators were also asked questions concerning why they thought their places of work had more advantages over the other places, challenges with maternal health care, deaths that have been recorded at their centers and many more.

4.6 Selection of Respondents

The researcher used respondents who are readily available (Stangor, 1998). The researcher went to households, shops and the market to interview respondents. The purpose of the study was explained to the respondents before each interview. They were made aware that there was no known risk in participating in the study and their confidentiality was much assured. They were also made aware that the information was solely for academic purpose and after the study the information will be destroyed. The permission to interview them was therefore sought and if a respondent agreed to participate in the study, he/she was interviewed. Hence, selection of respondents was

based on their availability at the time of their research and their willingness to participate in the study.

Studies have shown that one of the pitfalls in using qualitative study is the sloppy and arbitrary nature in which some researchers select the total number of people (Onwuegbuzie and Leech, 2007). Therefore, one criterion that has become accepted in the selection of qualitative method is data saturation method. The concept data saturation (developed originally for grounded theory studies but applicable to all qualitative research that employs interviews as the primary data source) “entails bringing new participants continually into the study until the data set is complete, as indicated by data replication or redundancy (Marshall et al., 2013, p. 11). In other words, saturation is reached when the researcher gathers data to the point of diminishing returns, when nothing new is being added” (Bowen, 2008). Thus, estimating the adequate size is directly related to the concept of saturation. Morse (1995) noted that the concept of saturation is the key to excellent qualitative work.

Using the saturation method as a guide, a total of 31 women were interviewed. Thus, after interviewing the 31st respondent, the researcher realized that, the responses had saturated. At this point, the respondents were giving the same responses. Since Saumure and Given (2013) pointed out that saturation is the point in data collection when no new or relevant information emerges, the researcher knew that the point of saturation has been reached. In addition to the 31 women, 4 TBAs, 2 nurses, 1 midwife, 6 men and 1 “Awoyo” priestess (“Awoyo” church leader) were also interviewed. This means that the total number of people used for the study was 45.

4.7 Data Handling

The responses from the interview were transcribed and where there were points of convergence or agreements on some of the issues, they were put under themes. Therefore, the main method used for the presentation of the interview data was content analysis. Content analysis is a widely used qualitative research technique where responses are directly quoted in the content of the discussions as exactly as it was said without any alteration. This was useful in ensuring data quality. Responses were also categorized with reference to the research objectives.

4.8 Ethical Consideration

An ethical clearance form was taken from the Ethics Committee for Humanities (ETC) at the Office of Research, Innovation and Development (ORID), University of Ghana.

After permission was given, informed consent was assured, as all the participants were informed about the purpose of the research. It was made known to them that the research is solely for academic purposes.

Voluntary Participation is another ethical issue that was adhered to by the researcher. Participants were not forced to participate in the research. They were informed about their freedom to withdraw from the study at any point in time.

Another important ethical issue that was considered is confidentiality. Participants were assured that their information will not be disclosed to anyone and for that matter their names and identity are not featured in the research. Disposal of information was also considered. The researcher assured the participants that all information relating to them will be destroyed after the work had been accepted by the Graduate School.

The researcher also gave participants small gifts like handkerchiefs to compensate for the loss of their time and to appreciate their contribution to the research. Even though the handkerchiefs were such lesser items, they appreciated it so much.



CHAPTER FIVE

PRESENTATION OF FINDINGS

5.1 Introduction

This chapter presents the findings of the interviews conducted in Assin Fosu of the Assin North municipal in the Central Region. For the sake of clarity, a few descriptive statistical tools such as frequencies were used in the presentation of the demographic characteristics of the respondents.

5.2 Profile of Respondents

Some personal questions were asked about the respondents. These included sex, age, marital status, level of education, occupation, religion, ethnicity and number of children so as to get an insight into their background and world view of the respondents. This section presents the findings.

5.2.1 Sex

Out of the total of 45 respondents in all, there were 38 women and 7 men. The women comprised of 31 women, 4 TBAs, 1 female nurse, 1 female retired midwife and 1 Awoyo priestess. The men also comprised 6 men and 1 male nurse. This means that both sexes were represented in the study.

5.2.2 Age

Questions on age were often met with shyness. Some respondents would like to reveal their actual age when others were out of sight. What the researcher noticed was that people's ages were shrouded in some kind of mystery. Some linked their ages to events

that happened in the country such as the day Ghana gained independence, the 1983 famine in Ghana and natural disasters. Based on this information, some of the respondents' age, mostly the elderly ones, were estimated.

The analysis of the ages of the respondents showed that the majority of the respondents were between the ages of 26-30. They were followed by respondents between the ages of 31-35, then those between 36-40, then 50 and above, then by both 21-25 and 41-45, then 46-50 and lastly 16-20. This illustrates that Assin Fosu has both the young, the middle aged and the old and all these categories are fairly represented in this study.

5.2.3 Marital Status

According to Lamanna and Riedmann (1994), marriage is important for so many reasons. These include; companionship, emotional security, desire to parent and raise children, economic advancement, social pressure and love. These reasons for marriage are similar in almost all societies including Assin Fosu. Out of the 45 respondents, 21 are married, 9 are single, 1 is divorced, 5 are separated and 9 are also widowed. Therefore, all the categories of the marital status are also represented in the study even though majority of the respondents fall within the married category.

5.2.4 Level of Education

The level of education is also one of the most important factors to understanding the choices of the places of delivery. In Nepal, maternal education was among the important independent factors in determining the place of delivery (Bolam et al. 1998). Mrisho et al, 2007 also contributed that lack of education could make some expectant mothers stick

to their decision regardless of their condition. The educational analyses of the respondents show that for 13 out of the 45 respondents, their highest level of education was primary. 19 of the respondents had JHS as their highest level of education, 8 went up to the SHS level, and 5 have attained tertiary levels of education. This shows that there are very few highly educated people in this area and more people have very low formal education.

5.2.5 Occupation

The broad category of the sector in which majority of the respondents work is the informal sector. Most of the respondents are traders, farmers and storekeepers. A few others are also teachers, seamstresses, hairdressers, students and pastors. This also illustrates the variety of occupations in the area. It also connotes that Assin Fosu is mainly a trading and farming area.

5.2.6 Religion

The religious life of people can give us an insight into their world view and how they perceive things. According to Durkheim, society is the source of religion (Ritzer, 2000). The Assin Fosu community is mainly dominated by Christians. On a Sunday morning in this community, the streets that are overcrowded with hawkers and traders from Monday to Saturday are all absent. Men and women are mostly seen in African fabrics carrying Bibles and busily hurrying to church. Though there were some few buying and selling after midday, there were not so many people as compared the other day.

5.2.7 Number of Children

The number of children is also a very important factor in this study since this shows the level of experience and knowledge one has about the issues discussed. 16 of the respondents have 4 to 6 children. This is followed by 15 respondents, who have 1 to 3 children, then 6 respondents who have 7 to 9 children, then 5 respondents who have 10 or more children, and lastly followed by 3 respondents who have no children. Children in this community were mostly seen later in the afternoon after they had returned from school. It was observed that most of them joined their parents in the markets right away from school without even going home first to change their uniforms. There were again seen running errands for their mothers as they strolled up and down carrying one load or the other. Others were also seen carrying pans on their heads selling food stuffs. In the evening, they helped their parents pack items displayed outside into their shops.

5.3 Beliefs and Attitudes about Pregnancy

Each culture has its own beliefs regarding pregnancy. It was interesting to find out some of these beliefs that the people in Assin Fosu held about pregnancy and if these affected the woman in anyway. According to the respondents, these beliefs were just sayings they had heard in the area and it did not necessarily mean they believed in them. Those who have had more education and were Christians also seemed to believe less in them as compared to those with no or very little education, elderly and yet Christians too. Some of the beliefs that the respondents gave cut across sicknesses, labour, dress code and eating habits. Below are the details of these beliefs.

There is this sickness called ‘asram’, that is the shrinking of the baby so that you deliver a baby as little as a lizard. The forehead will be green and more often they die within some weeks. If someone has ‘bad eyes’ and sees a pregnant woman eating outside, they might give you some of this disease. You don’t have to dress to expose your chest. Someone with an evil eye can give your child this disease (TBA).

When you are in labour, don't go too early to attract eyes. If people hear you have gone to the hospital for days to deliver, a witch can just remove her slippers and step on the ground barefooted. If they do that, you can never deliver. They shouldn't hear you are in the hospital still waiting to deliver. All they should hear is you have delivered. Then, it will be too late for them to do anything to you (elder woman, farmer).

Don't tie clothes around your neck otherwise the umbilical cord will be tied all around the baby when it comes out and it is very difficult to untie it (TBA).

Don't walk at night and don't bath deep at night. You have to bath very early in the morning. No one should see your stomach else the baby will shrink and become very small (female, trader).

In the 1970s, when you are pregnant, you don't help another pregnant woman carry a load. If she is protected and you are not protected, your pregnancy will spoil (elderly woman, storekeeper).

You don't have to retarch your hair. When you do that, you are cooking your baby. Second, you don't braid your hair by splitting the middle. Or else your baby will come out with cuts all over the body (female, hairdresser).

Don't take eggs and snails. Even if you have to take eggs, you don't need to chew it. Just swallow it or else you are chewing your baby. Never eat pawpaw else the baby's head will become 'patsapatsa' (very soft) (retired midwife).

Medically, some of these beliefs can affect the health of the pregnant woman. For instance, a pregnant woman should not eat pawpaw, snails or eggs even though they are very nutritious. Pawpaw is rich in vitamin c, minerals and enzymes (called papain and chymopapain) which help with digestion. Particularly, it breaks down the proteins in the food we eat into amino acids (Herbal Tray, 2014). Snails provide a heavy dose of protein, little carbohydrate and it is an excellent source of iron and other essential minerals such as potassium and phosphorus (Perkins, nd). Eggs are rich in protein and choline. Choline is a nutrient that fosters healthy brain development for adults and fetuses (Ask.com, 2015). Therefore, these foods should be eaten in rather large quantities and not stopped. However, the belief is that if a pregnant woman eats snails and eggs, she is chewing her unborn baby and if she eats pawpaw, the baby's head will be too soft.

The others such as not retarching the hair, not wearing clothes around the neck, not braiding the hair by splitting the middle and carrying load or helping someone to put

down a load are just lifestyles practices that are meant to protect the woman. These are the positive phase of the believes since it encourages the pregnant woman to take good care of herself. A sense of fear is simply attached to it to make it sound very important and the fear that the breach of it has consequences, force them to obey.

These beliefs result from the level of education of the people. As it was seen from the demographics, the highest level of education of most of the people is the Junior High School. Hence, these beliefs are obeyed without questioning and this affects their nutrition. This, in the long run affects the health of both the mother and the baby.

5.4 Preparations to Delivery

It was surprising to observe that, the women were excited to narrate how they prepared for a new baby as compared to the men. Amidst smiles, some of the women narrated how often they packed new items while others demonstrated how they did some exercises in the mornings to keep fit. Others also recounted joining more than one prayer group and praying frequently for spiritual protection. The men however, narrated how they had to work longer hours to make more money for the coming baby. The researcher grouped these preparations made into physical, financial and spiritual.

The physical preparations meant any bodily preparations the pregnant woman had to make for herself and for the coming baby. The study revealed that women made physical preparations by buying delivery items, dresses, toiletries and food items. These items bought were mainly from lists given by the hospital. Aside these items, some noted physical exercises and eating well as part of the physical preparations.

The first said:

You have to change your diet. You have to eat really nutritious food such as ‘kontomire’, ‘koansusoa’, fish and fruits and also exercise a lot (woman, trader).

An elderly woman also added:

In my time, all one needed was a ‘flour sack’. You wash till the flour is out. And you just add some few rags, then some firewood that will be used to heat water for you and you are good to go but now, you have to buy a long list of items (woman unemployed).

The researcher sought to find out if the mother, family, couple or even the entire family makes any financial preparations for the unborn child. What inspires that decision and who normally is responsible for that? The findings show that financial preparation is very crucial due to the huge financial burden associated with delivery. The man, mostly, have to save to enable them cover all the necessary expenditures.

One said,

I am a mason. I had to work extra-long hours. I had to save a lot for babies’ products. They are very expensive especially now (male, trader).

Another also said,

I didn’t save any money. That is the responsibility of the man. Mine is to carry the baby and deliver. All you need is a supportive husband. How much can you save from this peasant farming? (female, farmer).

Less variety of responses was derived for the spiritual preparations since the community was dominated by one religion; Christianity. They make spiritual preparation in the form of offering prayers to God.

Pregnancy is a thing people fear and others even fear for you. So you need a lot of prayers. Because of my pregnancy, I had to join the prayer group because labour is a matter of life and death. In one of our meetings, I was told that I would be operated. So they even fasted for me and I became very strong in spirit. I gave birth naturally without any operation (retired policewoman).

The preparations families make for the coming baby was quite impressive. Each respondent was aware that the baby had to be provided for physically, financially and even spiritually.

5.5 Knowledge of Maternal Health Care

To understand why women deliver at the places they do, it was important to find out if they had any knowledge of maternal health care especially ANC. This is because if they do not understand the relevance of antenatal care, then there will be no need for them to attend and their non-attendance could endanger both herself and the baby.

Hence, the first objective of this study sought to find out about the knowledge that the people of Assin Fosu have concerning antenatal care. This is to help the researcher to compare the number of attendance with the number of delivery. Surprisingly, most of them seem not to have heard those words before. After some explanations to illustrate antenatal care, the researcher found out that they mostly refer to it as ‘maternity’. The reasons for attending ANC as derived from the respondents are grouped under three major themes; attend ANC because of the pregnancy, attend ANC due to the health of the mother and lastly, due to the health of both the mother and the baby.

5.5.1 Reasons for Attending ANC

The first major reason given for attending antenatal care is because of the pregnancy. The results of the study revealed that one of the reasons for ANC was purposely for the health of the baby in the womb. Hence, some of the explanations they gave for antenatal care included:

Maternity is a place to go and check whether you are pregnant or not. If you are pregnant, they examine the baby to find out whether it is lying at a good place. If you don't go and the baby is lying with its leg facing downwards instead of the head, you will be operated on during labour. So you have to start going early for these things to be corrected (female, trader).

Another respondent also said:

Oh maternity is a very good place to go but you don't have to worry about it if you are strong. If the mother is strong, it means the baby is strong. And it is for the health of the baby that makes maternity important. So simply, if you don't fall sick often, it means you are strong and hence, the baby is also strong (male, trader).

The second reason why women attend antenatal care is because of the safety and health of the mother. From the study, some of the respondents mainly suggested that antenatal care was purposely important for the health of the mother. Some of the responses are:

Antenatal is going to the hospital to check if the woman can deliver the baby. They will check if she has blood, if she is overweight or underweight, her temperature and other vital information (female, nurse).

Another said:

Antenatal is when a woman goes to the hospital because she is pregnant. How frequent she attends depends on how many months old the baby is. You attend the antenatal care once a month in the first two trimesters then when the baby is seven and eight months the visits increases to every two weeks. Finally, in the ninth month, antenatal care is every week. If she doesn't go, she might lose the baby (female, seamstress).

Most of the respondents however, believed that antenatal care was for the wellbeing of both the mother and the baby.

Antenatal is going to the hospital because you are pregnant. You show yourself to the doctor so that he can determine sicknesses or complications. You are educated on your pregnancy. What to eat and what not eat. You take medications as well as lab tests and scans. They take care of the pregnant mother and the unborn child (female, trader).

Another also said,

You go to lab to find out if you have some diseases or sicknesses that will affect the baby. Some of these such as HIV can be transferred to the baby but if you go for antenatal care and they are able to detect it early, the doctors can stop it from being transmitted to the baby (male, storekeeper).

It can be perceived that the people of Assin Fosu did not really know antenatal care by formal education, but they knew it by experiencing pregnancy. The men were also able to explain it probably because their wives had told them the activities at 'maternity'.

This knowledge about antenatal care can once again be attributed to the level of education from the demographics of the respondents. It was realized that there were very few highly educated people in Assin Fosu. It was also observed that, the knowledge expressed by the women was mainly a recount of their experiences at the hospital. Some of them include; going for the purposes of checking for complications (position of the baby, diseases), how old the baby is, for education on what to eat, for safe delivery, and even to determine the sex of the baby. This is also reported by the British Paediatric Association (1978) that early contact by pregnant women with antenatal services is advocated in an attempt to identify those at particular risk of developing complications so that these might be prevented.

5.5.2 Level of attendance to antenatal care

It was also observed from the level of attendance to antenatal that it has received a lot of patronage in recent times than before. This is because, most literature report that many women book for antenatal care late in pregnancy and many attend only once (Westaway et al., 1998; Gharoro et al., 1999; Addai et al., 2000). This study's findings highlighted that mothers who have more than one child delivered at least their first children at home without any antenatal care but with the subsequent ones however, though they might have delivered at home, they still went for antenatal care before delivering at home even though the attendance was not monthly. Most of such respondents attributed the change to education, modernity, money and the order of the day. Some of the responses are as follows:

I have six children and I didn't attend maternity with the first four because my husband and I didn't know the importance of maternity. My mother always gave me some herbs. I cooked and drank them daily and sometimes I even inject some with a bulb syringe. However, with my last two borns, I went for antenatal care even though I wasn't regular. This is because with the fifth pregnancy, I was very sick despite taking my herbs daily

and the situation didn't seem to get better. A friend advised antenatal care and I tried. It helped (female, farmer).

The second also said:

At the market, where we all sell yams, I see a lot of the women go to the hospital when they are pregnant. They go very early in the morning to avoid long queues at the hospital. When they are back and someone asks where they had been the whole morning, they say they went to the hospital for maternity. I have two children now and I went to maternity for both of them because I learnt it from the women in the market. I didn't want to be the odd one out! (female, trader).

One also said,

I was lucky to be pregnant at a time when health insurance took care of all the antenatal and even delivery bills. So my third child was privileged. The first two didn't have that opportunity so no antenatal for them (female, storekeeper).

When asked what was the best time in pregnancy to begin antenatal care, most women stated that the first trimester was ideal. However, each of the women went on to describe a range of barriers that made early booking difficult. The reasons given were mostly; being unsure of pregnancy.

Sometimes it is difficult to tell that you are pregnant. Some people have irregular periods. They miss periods for months only to find that they are not pregnant, so it is better to wait, to see if you are really pregnant (female, unemployed).

5.6 Conclusion

This knowledge and attendance of the people to ANC is impressive despite the cultural beliefs that seemed to be obstructive. This might be attributed to increasing levels of education and the publicity from the Ghana Health Service and the Ministry of Health about maternal health care. Some also attributed the change to money which seemed to be a problem but could later afford it due to the free maternal health care and the National Health Insurance Scheme. Others still attributed the change to the modern way of life of not been left out.

CHAPTER SIX

WHERE WOMEN PREFER TO DELIVER AND FACTORS THAT INFLUENCE THIS CHOICE

6.1 Introduction

The question on where women prefer to deliver seemed to get most respondents thinking. Most of them smiled before finally coming up with an answer. The researcher sought to know where women preferred to deliver if they had the opportunity. This is to help compare the intended place and the actual place of delivery and hence find reasons for the gap.

Responses derived can be grouped into health facilities, home with Traditional Birth Attendants (TBAs) and prayer camps. Out of the thirty-one women interviewed, twenty-four intended or preferred to deliver at health facilities, six preferred home delivery and only one preferred delivery at a prayer camp.

6.2 Delivery at Health facilities

Health facilities come in the form of hospitals, maternity homes, clinics or polyclinics. Out of the women who intended to deliver at hospitals, most of them preferred the same place where they attended antenatal. Quite interestingly, all of them attended ANC at the St. Francis Xavier Hospital for at least one of their pregnancies. Even though St. Francis Xavier Hospital was not the only public hospital in Assin Fosu, it was the most preferred.

When asked the reason for this choice, all the respondents gave almost the same reasons for their choice in terms of the hospital's machinery, proximity and familiarity. Some of the responses are:

It is the biggest hospital in Assin Fosu in terms of machinery and equipment. When you are weak or there are complications, they have machines to help you. So I believe that is the best place to go. For St. Francis, they are experts in maternity care. Again, it was the only hospital there before other hospitals came up. I'm used to that place so wherever I relocate to, I will still go for my antenatal there. Unless I move out of Assin Fosu (female trader).

One man also said:

St. Francis hospital is the closest. It is better that I don't let her stress herself. Though it is also the best public hospital here in terms of machinery, I would have let her go to another hospital if it happened to be closer than St. Francis. Don't stress pregnant women! (male trader).

The respondents were also asked why they preferred hospital delivery (not just St. Francis Hospital) to other places. The responses of the women and men clearly show that before women make a choice to attend antenatal care and even delivery in a hospital, they take into consideration many factors. These factors can broadly be categorized into human factors (attitude of staff and treatment they are more likely to receive from the hospital) and institutional factors (ability of the institution to help them in case of any complications).

It was noted that respondents who preferred hospital delivery mainly attributed their reasons to the confidence they have in modern health care and its ability to save their lives. This is mainly due to their scientific methods of enquiry of diseases using scans, laboratory test and complicated machinery making the hospital superior to the traditional or conservative methods of delivery. Some also believed that it was prestigious for a woman to deliver at the hospital than at home. This showed their level of social class. This evidence was mostly observed from the responses of the men; especially those who had attained some higher levels in the social class. Others also gave reasons for hospital delivery as professionalism and literacy hence, devoid of all traditional beliefs. These are some of the responses;

One said:

It is important to go the hospital. When you are weak or there are complications, they have machines to help you but if you choose to deliver at home, you might die because the person helping you does not have the machinery and equipment to save you. Again, TBAs do not wear gloves and they may not as well use clean equipment unlike the hospitals. Delivering at hospital is again very important, especially if you are beyond thirty-five years. At this time and beyond, you are no longer a youth. Carrying the pregnancy becomes burdensome and delivery becomes dangerous. So you need not take chances (female, retired midwife).

Another also said:

We were taught the hospital is always one foot ahead of our traditional ways. Sometimes the TBAs themselves complicate the situation. They don't know what they are doing. Even if they know, they can never beat the professional medical people. Most of the TBAs too have evil spirits! They are all old women. Or have you seen a young TBA before? What if they impart something into your child? The hospital is the best (male, trader).

A man also commented that

I have two children and my wife delivered both at the hospital. For me it is not about any medical or professionalism per se but I'm respected here. If my friends hear that my wife delivered at home, it kind of means I couldn't afford the hospital...you know...and that is not good for my social class (male, building contractor).

The findings of this study support the evidence in the work of Tanzania's Demographic and Health Survey, which established a strong relationship between the mother's education and the place of delivery. Similarly in Nepal, maternal education was among the important independent factors in determining the place of delivery (Bolam et al., 1998). According to Yanagisawa et al. (2006), women who had attended school for at least 7 years were six times more likely to deliver babies at health facilities as compared to those who have never attended school.

6.3 Domiciliary Delivery

The stories behind delivering at home were much expressed with passion by the respondents. All of them seemed to despise hospital delivery with much enthusiasm.

They expressed the considerable delay in hospital delivery as also expressed by Senah (undated), who identified 6 delays in hospital delivery. They include; delay in arriving at the facility (transportation challenges), delay within the facility (no competent personnel, inadequate equipment), delay in producing requirements (such as detol, diapers, gloves, cot sheets etc.), delay in recognizing the problem, delay in taking a decision (especially by nurses) and delay in post-partum care.

Some of the reasons the respondents gave for their choice in home delivery also revolve around these delays. They gave reasons such as; the TBAs have patience, TBAs have effective traditional assistance to aid delivery, family tradition, perception about the bad attitude of nurses towards women in labour, less expensive, and knowledge of traditional medicine among others. This can be inferred from some of the responses they gave such as:

I prefer delivering at home because when you are in labour, even if it's a day, the TBAs spends the whole day with you. They have a lot of time for people. They will sit by you to wipe even your sweat. But at the hospital, they will keep moving up and down and you will lie there dying and you don't seem to know what else they are employed to do! My advice is, if you don't have a friend at the hospital, you don't deliver there (woman, trader).

A man also commented:

If my wife goes into labor, the first thing I would do is call a TBA. If she (TBA) believes that the labor can be managed at home, we will stay at home. We can't afford all those items on the list the hospital expects. The most annoying is if some of the items are unused they won't return them to the woman. We have confidence in the TBAs. They don't demand those lists either. (male, trader).

An elderly woman also commented:

I went to the antenatal to check if everything was safe. But at home I preferred to deliver because that is the family tradition. The TBAs are equally good and can handle all complications. In the case of my last born, the after birth (placenta) didn't come after the delivery. So the TBA immediately peeled some plantains and pushed it in my mouth down to my throat. When I tried to vomit, all the after birth dropped within some few seconds. The hospital couldn't have done this (woman, farmer).

Another added:

I hate nurses. I hear stories where they are so cruel to the patients that some die when nurses could have really saved them. A friend told me that when she was in labour, her husband had to actually bribe all the nurses and the midwife before they paid attention to his wife. The women in labour were many and what is so special about you in particular for them to give you a lot of care? Unless they are bribed! They actually call it 'tip' but I know its bribery. I prefer home delivery. I will deliver at home always (female, unemployed).

Another also added:

I was a teenager when I got pregnant so I felt shy to go to the hospital. My mum insisted I went but I couldn't imagine myself sitting with grown-ups in a queue and some staring at me with inquisitive eyes or even the bold ones asking me questions. So I never went and when I was due to deliver too, I was taken to a TBA (female, student).

These findings support the work of Amooti-Kaguna and Nuwah (2000). They explained in their work that women who preferred birth with TBAs gave the most prominent reason for their choice as the potency of traditional medicine/herbs; which is said to have various roles such as making the baby inside the womb to grow well, cleansing the birth canal, treating and preventing some sexually transmitted diseases, and preventing and treating abnormal vaginal discharges. According to Titaley et al. (2010), they also added in their research that the flexibility of the payment method for traditional birth attendants was more convenient for most women. They again confirmed that traditional birth attendants were more mature, patient and caring as compared to nurses and midwives. Nogueira (1994) and Jewkes et al. (1998) also reported in their study that part of the problem lies in violence committed by health workers, which affects health-service access, compliance, quality, and effectiveness. The violence of health workers, especially nurses, reflects in neglect, verbal abuse, physical abuse and sometimes even sexual abuse.

6.4 Delivery at Prayer Camps

Women all around the world are faced with an array of choices when it comes to childbearing. Traditional practices attract Ghanaian women because of their time-tested methods successfully used by generations of family, mothers, and grandmothers. Others chose to turn to their religion when it comes to having babies. And, indeed, since religion is so integrated into every aspect of life, why would childbearing be excluded? (Fischer, 2002).

None of the men interviewed wanted their wives to deliver at prayer camps. Respondents who preferred delivery at prayer camps (only one woman and the ‘Awoyo’ priestess) gave mainly biblical reasons for this choice. They expressed the gratification for prayers offered them persistently till labour was over. They believe that child birth was instituted by God and hence delivery should be done in the house of God.

She gave her reason as:

Labour is a matter of life and death. At the prayer camp, if you are in labour, that day's service is just for you. You have the entire congregation supporting you in prayers. You will hear all of them praying outside the tent. This inspires you and energises you for you have heavens support. It takes away all fear (trader).

6.5 Intended place of delivery versus actual Place of delivery

Using the case study of their last borns, (this is because the researcher cannot study all the number of births for the sake of time) the place where they intended to deliver was compared with the place where they actually delivered. This is to help explain the problem statement. That is, the reasons for the gap in preferred place of delivery and actual place of delivery.

As stated earlier, out of all the women who preferred to deliver at the hospital, most actually did, leaving a few who delivered at home. Out of those who delivered at the hospital, there were some who were able to deliver at their very same place of antenatal. The women who could not deliver at the very same hospital they started antenatal contributed in creating a gap in the number of women who actually register to start ANC and the number who return to deliver. The answer to 'where do they go?' is explained from relocation, developed complications, attitude of health workers and emergency or sudden births.

For instance, one explained;

With the first child, I had to travel because I was inexperienced. I really wished to deliver at St. Francis because that is where I have had my antenatal and I have created a good relationship with the nurses already but I had to go to my mother in Kumasi. I didn't know anything about babies. I didn't even know how to change baby's diapers let alone bathe him. On the other hand, I couldn't have let my mum come to Assin Fosu because my husband and I live in just a single room here. So I had to go (female, Trader).

Another also attributed the change to a developed complication. She said:

At 8 months, I was transferred to deliver in Korle Bu in Accra because all of a sudden, fibroid was growing alongside my twins. They found it strange. So they recommended I go to Korle Bu. (female, seamstress).

The other contributing factors were linked to the attitudes of public health nurses and these women delivered at private hospitals. One described the situation as appalling. She lamented thus;

One nurse embarrassed me so much when I was delivering my very first child. I didn't know I had to shave before labour. During my pregnancy, because of my big stomach, it was very difficult to bend and shave so I had not shaved for months. When the nurse saw my pubic area, she quickly run out screaming and calling all the other nurses to come and see. I felt so bad and even started crying. Since then, I delivered the rest of my two children at a private hospital. I don't know why nurses have to be so rude if they claim this work is a call by their founder Florence Nightingale. And the worse of it is, it is everywhere! All public hospitals! So if you have the means, just deliver in a private hospital to avoid been insulted and tortured (female, secretary).

Verbal abuse is another common negative attitude of nurses that affects the choice of place of delivery. In several studies from different continents, many women described health-care providers as unkind, rude, brusque, unsympathetic, and uncaring and were often shouted at or scolded (Wood et al, 1997).

Lastly, most of this change was attributed to emergency births. One explained that:

Delivery came before she got to the hospital. I attempted to get a taxi quickly but the road is such bad that before I get to the hospital, I might deliver in the car. So my younger sister quickly rushed to call an elderly woman and I delivered safely at home. The next day, I went to the hospital (trader).

Proximity to health care facilities is an underlying issue for selecting delivery health care services, as also shown in previous literature (Thaddeus et al, 1994; Onah et al, 2006). In rural Tanzania for instance, 84% of women who delivered at home decided to deliver at health facility but did not because of distance and transportation problems. Poor road conditions and lack of transportation are associated with increased costs of visits to health care providers.

6.6 Others that Influence the Decision of Place of Delivery

The majority of the women attested to the fact that they personally decide where to deliver. They mainly gave reasons that their husbands knew less about child birth and hence, they had to take that decision on their own. Most of them also said they were the ones about to go through the pains of childbirth, so they had to take that decision themselves.

This is different from the work of Tanner & Vlassof (1998), Amooti-Kaguna and Nuwaha (2000) and Bolam et al. (1998) who all found that though women carry the major portion of responsibility for the welfare of the whole house, they do not have the independence to make decisions for the house including the decision of the place of

delivery of their children. This difference could be due to the major changes and developments that have occurred in recent times especially the pace of women advocacy for women rights. Over the past few years, many women groups and gender activists have aggressively used all mediums to advocate for women right and women involvement in domestic and national decision-making. The activism for equal rights might have accounted for the difference in findings recognizing the long time between their study and this one.

The women who claimed they decided on their own were asked the reason behind the decision. Responses received included;

Well my husband doesn't know anything about births, so he just leaves every decision about child birth to me. Besides, it is only a matter of respect for the man to leave that decision for the woman because we go through a lot in pregnancy so we should decide where we wish to deliver. I made that decision and my husband said, 'your wish is my command'. We should be pampered at this stage (female, trader)

The few respondents who believed the man was supposed to make that decision alone or their husbands were the ones that made that decision for them also gave the main reasons as he is the one paying for the bills. Some of the men believed that if that decision is left to the woman because she is the one in pain, she will choose a private health facility that will be too expensive for the men to afford. The rest attributed the reason to the fact that men always want to be in charge of every decision made in the family.

Responses received included;

I have to take that decision because I am the man and the one in charge. Also, I am the one paying for the bills. If I can't afford it, she will have to deliver at home but if she doesn't want to deliver at home and insists on delivering in the hospital, then she should find her money to pay (male trader).

The third view was that both couple made the decision or they are supposed to make that decision together. The reason mainly given to this point is that both made the pregnancy, so both had to decide so that it suits each of them. The other reason was that in order to

avoid blame games resulting from the consequences of the choice of place made, both had to decide together.

Other family members also made the decision on where to deliver for some of the woman. These included mothers, aunties, sisters or grandmothers. Surprisingly, they are all female family members. The reason given for this was that every family has its own traditions which should not be thrown away. Hence, the woman is to stick to the decision of these relatives so that she does not break the family's tradition.

According to Amooti-Kaguna and Nuwaha (2000), the women admitted that the decision of place of delivery mostly depended on the husband. They continually quoted that the husband was 'the money maker'. Others who were also mentioned included the mother-in-law, the mother, aunt, sisters or even neighbor. Surprisingly, counsel from TBAs and sometimes from modern health workers were also mentioned as influencing the decision of delivery place.

6.7 Conclusion

As observed from the findings, the gap that is created from intended place of delivery and actual place of delivery can be attributed to attitude of health care providers, emergency births, and sudden complications. Respondents who preferred hospital deliveries made this choice based on assistance when there are complications and prestige whiles respondents who preferred TBAs mainly attributed this choice to family tradition, attitude of nurses and financial limitations. The only reason given for the choice of prayer camps is because the respondents believed that they were more likely to have a safe delivery at where there is the presence of God.

The overall findings of this study concerning women's preferred place of delivery (healthcare facility, at home or prayer camp) shows that individuals make a deliberate and calculative choice just as the rational choice theory postulates as used in this study by George Homans (1961). Again, the argument of who takes the decision to deliver at one place or the other is also very rational.



CHAPTER SEVEN

THE EFFECT OF THE PLACES OF DELIVERY ON THE MOTHER'S HEALTH

7.1 Introduction

Interestingly, authorities in delivery that is midwives, TBAs and the prayer camp priestess gave opposing opinions about the effect of the place of delivery on the health of the mother and baby. Each of them claimed their facility was the best and condemned the other.

A key strategy to reducing maternal deaths is the 'health-centre intrapartum care strategy', where qualified skilled workers manage labour, effectively manage complications and are supported with effective referral systems for specialized care when needed (Kitui, Lewis and Davey, 2013).

7.2 Effects according to Institutional Health Care Providers

According to the nurses and midwife, the place of delivery is very vital to the survival of both the mother and baby. Some of the effects associated with the places of delivery are; ability to handle unexpected sicknesses and complications, caesarian sessions and professionalism. They explained that in cases where the mother has complications such as Pregnancy Induced Hypertension (PIH), hemorrhage, ectopy, anaemia, sepsis, obstructed labour, wrong lying position of the baby, the doctors can easily help by giving blood, drips or perform caesarian sessions to save the mother and baby or at worst one of them.

In addition to the above complications for which a person should deliver at the health centre, the private hospital nurse also stressed that the woman should deliver at a place where good professional care is assured. At the private hospitals, they are given

professional treatment and special care that makes patients comfortable and content. Mrisho et al. (2007) also confirmed that most women wish to deliver in private hospitals because they are perceived to be very caring even though expensive. He added that most women preferred the presence of their husbands or other close relatives during delivery, which private health care allow. Therefore, pregnant women who could as well afford the services of the private hospital should patronize it. This is evidenced in the statement they gave:

One said;

The hospital is the best. There are so many complications in pregnancy and child birth like pregnancy induced hypertension, sepsis, ectopy, obstructed labour, haemorrhage, anaemia, some even have STDs and in each case, they should be attended to in delivery specially. But the TBAs can't determine these complications. If they see anything odd they will inject the patient using bulb syringes with herbs or insert some concoctions and to them, more times they give the same herb medication to different health cases. They might ignorantly kill a mother or a baby or even both. Finally when they realize they cannot handle the situation, they push them to the hospital and by the time they get to us, we can do little or nothing about it. Then they die in our hands but the TBAs killed them! (female, retired midwife).

The second respondent said;

Left to me alone, you should deliver where you can afford but some babies are stubborn. Instead of coming out with their heads, they may come with one leg or one arm. A TBA definitely can't handle this. They will have to rush the patient to a health facility. Then the problem of time, proximity and bad roads also comes in. If delayed, the baby or both baby and mother might die on the way. So I will definitely not choose home delivery since we don't know what the future holds (female nurse, private clinic).

The third also said;

You see, we attribute certain defects like madness and epilepsy to the devil but they are sometimes as a result of birth. With some women, their pelvic might be so small while the baby's head or even the entire body is so big. It makes pushing almost impossible. She definitely needs Caesarian Sessions (C.S) which the TBAs can't offer. So they will force her to push hence tearing the woman, and also giving the baby these health complications and even more. At worse, both of them might die. Childbirth is a serious issue. Women should make right choices! (male nurse, polyclinic).

The nurses and midwives expressed high in-depth knowledge about their area of work. They insinuated that childbirth was a matter of life and death and hence should be handled by expertise who have acquired professional training.

7.3 Effects according to TBAs

The TBAs on the other hand believe that the home birth is better and has fewer effects as compared to the hospital. According to them, it is less scary. Some women are naturally afraid of the hospital because it has a lot of machines and equipment. Some also complain of the scent that is in every hospital which makes them feel sicker. Others also complained of many deaths at the hospital. Seeing the next person to you die is enough to kill the other person too.

Again, according to all the TBAs interviewed, not even a single woman or baby has died in their hands for the number of years they have worked as TBAs. They again added that they charge very little and sometimes, nothing at all for assisting a woman's delivery. They all admitted that their work is more of a missionary job than a business. Some of their responses are as follows.

One TBA said;

Nurses don't have time for patients because the patients are many and have to attend to each of them. They even shout at women in labour but we pamper them and have time for them. Should you go to the hospital to deliver at a time, and they check the expected time to deliver and you still have not delivered, they take you straight to the theatre and cut you open. But for us, assuming you come at 6am and you are expected to give birth even at 4pm we have time for only you to wipe your sweat and tears and consistently checking with the fingers but the hospitals check with tapes. If the woman is still strong, we even walk around with her chatting until she is due to deliver (female, TBA).

The second TBA also added;

People seem to make the home delivery so scary but it is the hospital births that are scary. I'm afraid of the hospital. It also has some scent that makes me feel sick whenever I go there. I have nine children and I neither delivered any of them at the hospital nor called anyone to deliver me. I delivered all nine on my own. No woman I helped deliver has ever died in my hands. I've done this for over 38 years. Home delivery is simple but the hospital has a lot complications and fear. The only time I go to the hospital is if someone's baby is coming out with any other part other than the head. Even with that, if the woman can still push, I can deliver her safely. But hospital will soon operate you and when that happens, your chances of delivering naturally again is reduced drastically (female, TBA).

The first TBA again commented;

With the delivery in the hospital, if the woman can't afford the cost, she won't be tolerated at all. Assin Fosu is just a farming community. Most women don't have the money to afford all the lists the hospital writes and the hundreds of cedis charged for the delivery. You will lie there in pain till a family member brings at least half of the items. If not, they don't mind seeing you die. But with TBAs we don't write any list. We can't let any woman go through more pain than she is already in because of lists. All we need is about two old clothes, two geisha soaps and one detol to bath the baby. Even with that, most women don't bring any. I have used all my clothes for these women. We don't also charge any amounts before delivery but at the end of the delivery, you bring something to us to say thank you like eggs and at least 30cedis to help us buy some of the items we used for you. Even with that, most of them still are not able to afford them. So our job is just missionary work (female, TBA).

In the view of the TBAs too, the place a woman delivers can result in death. They believe the home delivery has fewer effects on the mother because the patients are pampered, home delivery is less scary and it is more affordable.

7.4 Effects according to the Priestess

The prayer camp priestess also was of the view that child birth is less dangerous when it is done by God's people. It is also free to deliver with them.

According to her,

It is God that instituted marriage. And He alone gives children too. He made the woman to give birth. And by the sins of our mother Eve, God says we must suffer childbirth, so if all these things happened through God's ordinances, why don't you bring it before God? He has given us directives on how to help these women. We pray for them and our midwives help them deliver when they are in labour. It is better to let God's people handle things which God has instituted. It is also free to deliver with us. We don't charge anything. It's all part of the kingdom business (Awoyo Sofo).

7.5 Conclusion

The above indicates that each of these ‘delivery attendants’ have in-depth knowledge and experience in their area of work. Each of them again expressed the need for patients or women to patronize their services instead of the others.

The effects of the place of delivery as discussed by the institutional health workers emphasized their ability to save lives immediately by surgery and other methods which the TBAs could not do. The inability for the TBAs to perform surgery when there are obstetric complications makes delivering at home riskier as compared to the hospital.

The TBAs also emphasized on financial limitations and attitude of health care providers as a major negative effect which could result in depression and sometimes death of mother or baby at the institutional health facilities. They also asserted that they give women in labour the maximum care and also charged very little and even sometimes nothing.

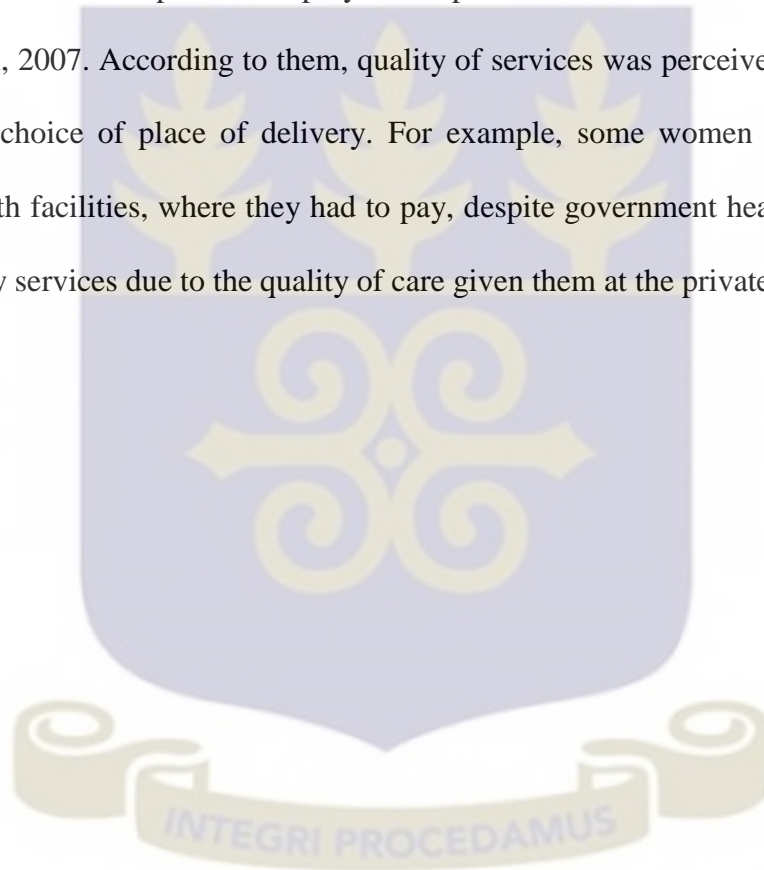
The ‘Awoyo priestess’ mainly emphasized the positive effect of their delivery on the mother and baby as been supported by the presence of God. She believed birth was instituted by God and hence has no negative effect when done in the ‘house of God’.

As it has been debated by the institutional health workers and the TBAs, the core of the decision is, should mothers consider the services provided at a place of delivery or the ability to survive death? Whiles the TBAs purported that their services are the best, since they have a lot of time and patience for the mother and baby, the midwives and nurses emphasized their greater ability to save lives because of modern equipment.

On the side of the respondents, whiles some of the respondents believed that the quality of services in terms of care and support received from nurses and midwives contributed

to higher chances of survival, others also placed much significance on their ability to evade death due to the hospital's machines.

Therefore, the mother-to-be or patient must assess the pros and cons of each of these services and decide which one is best for her. Most women who have assessed these factors and are well-to-do have been seen to patronize more of private hospitals where they can both enjoy the quality of health care and also advanced modern equipment to TBAs, government hospitals and prayer camps. This is also evident in the work of Mrisho et al, 2007. According to them, quality of services was perceived to play a major role in the choice of place of delivery. For example, some women decided to go to private health facilities, where they had to pay, despite government health facilities with free delivery services due to the quality of care given them at the private health facilities.



CHAPTER EIGHT

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

Maternal deaths have been a great canker in Ghana, Africa and the world at large. Each year, a lot of women lose their lives as a result of giving lives. The lifetime risk of maternal deaths according to the World Health Organization (WHO) in sub-Saharan Africa is estimated at 1 in 39, 1 in 290 in South-Eastern Asia and 1 in 3800 in developed countries (WHO, 2012). Maternal death rates are on average 18-times higher in less-developed than more-developed countries, and 300 million women have short-term or long-term illness related to pregnancy or childbearing (WHO, 1998).

As it has been stated by AbouZahr and Wardlaw (2000), the choice of place of delivery contributes essentially to maternal mortality. Generally, women have different preference for their places of delivery. While the majority prefers to deliver in the hospital, others prefer non-facility delivery. Sub-Saharan Africa records some of the lowest facility delivery rates in the world. Only 47% of women delivered in a health facility in 28 sub-Saharan African countries according to recent surveys (STATcompiler, 2008).

Also, according to Ekele and Tunau (2007), most studies have shown a gap between utilizing antenatal care and delivery at hospital or medical facilities. This is no different from the situation in Ghana as reported by the Ghana Demographic and Health Surveys showing a considerable decrease in the number of women who attend antenatal care and the number of women who go back to deliver. It is due to this gap that this study sought

to find out where women actually prefer to deliver following the following specific objectives;

- To investigate women's level of knowledge of maternal health care.
- To investigate where women prefer to deliver.
- To investigate factors that influence preferred places of delivery.
- To find out the significant others that influences the decision of place of delivery.
- To assess the effect of the places of delivery on the mother's health.
- To investigate the beliefs and attitude about pregnancy.

A total of 31 women, 4 TBAs, 2 nurses, 1 midwife, 6 men and 1 “Awoyo” priestess were engaged in an in-depth interview. This section of the study summarizes the key findings, draws conclusion and make relevant recommendations.

8.2 Summary of Findings

Results from this study on the knowledge of women on maternal healthcare, showed that most of the women and men had a good insight on antenatal care; that it was meant purposely for the wellbeing of the mother and the growing baby. They all also confirmed that antenatal care was an important phenomenon in pregnancy. This then implies that the choice some made not to attend antenatal care at all was conscious and deliberate.

It was also found that most women prefer to deliver at health centers such as hospitals and clinics. Most of these women also preferred the same hospitals where they attended antenatal. However, it was not always possible to deliver at health centers due to some factors. These factors as well explained the problem of this study; why there is a gap in the number of women who start antenatal care and the number of women who really turn up to deliver. The three main reasons for this gap are; first women who are delivering for

the very first time are inexperienced and may have to deliver at a different place from where they attended antenatal in order to get the assistance of an older relative who has experience in birth and baby care. Second; women attributed the gap to unexpected labour that suddenly occurs at home. Third; the reason for attending ANC is sometimes due to the fact that women just want to confirm if there are any complications but the very place they intend to deliver is home.

It was also realized that the decision on where to deliver was arrived by taking some factors into consideration. These included money, family traditions, attitude of nurses, teenage pregnancy, proximity, fear for the hospital and some cultural beliefs.

Furthermore, on the significant others that influence the decision of place of delivery, it was found that though the husbands and other relatives had an important role to play in the decision of where the woman had to deliver, most women purported that the decision sorely lied with them (the woman).

Again the researcher sought to assess the perceived effect of the places of delivery on the mother and baby's health. Here, all the respondents agreed that the place of delivery could have both positive and negative effects on the mother or baby or both of them. The TBAs emphasized the special empathetic care they give to women which empowered them (the women in labour) to push. They complained that nurses and midwives are sometimes mean to the patients and this could endanger the lives of both mother and baby. The nurses and midwives on the other hand also alleged that delivering at home rather endangers the live of the mother and baby because of lack of machinery and technical know-how to determine and solve unforeseen complications. The 'Awoyo' priestess also purported that the presence of the women at 'a prayer grounds' was

important for the survival of both the mother and the baby. They explained that God instituted child birth and hence delivery should be done on a 'spiritual ground'.

The final objective was to investigate the beliefs and attitude about pregnancy. The study found out that some cultural beliefs also affected women's perception about pregnancy and childbirth. Some of these positively influenced them to dress decently when pregnant and also the belief in some also restricted their movement at night which is safe for the mother. However, others about some foods they should not eat make the mother and baby deficient in some vital nutrients.

An additional finding was that all the respondents agreed that the presence of the new baby facilitated some preparations that had to be made for the comfort and survival of the baby. These preparations came in physical forms such as buying some items the baby will need, exercises and a good diet. The financial preparations which mostly rested on the man were done through extra savings. The spiritual preparations primarily took the form of prayers for the incoming baby.

8.3 Conclusion

Maternal mortality is disturbing in the lives of women. However, it is possible to reduce and even prevent it if the place of delivery is given an important look. Delivery at home cannot be branded as harmful even though it may have some major health implications for the mother and baby when there are complications. Just as this study supports the rational choice theory, that people make a conscious decision with each choice they make, many women will still deliver at home given the reasons they have elaborated. This makes it impossible to eliminate the services of traditional birth attendants. Therefore TBAs must be trained and equipped with instruments to meet formal and hygienic standards of delivery in order to save more lives. Experiences from other

countries indicate that skilled attendance can be better promoted in a system that integrates traditional with the modern health system (Iyaniwura & Yussuf, 2009).

There is also a clear need to raise awareness among women about health risks in pregnancy and how these may be addressed by timely and effective antenatal care. The key issues for sustainable effects are increasing information available for women at village level and in the long run trying to raise the level of women's education accompanied by the provision of a suitable and effective healthcare delivery system.

8.4 Recommendations

- ❖ The study recommends that the Ministry of Health and the Ghana Health Service should increase education on the need for antenatal care before delivery.
- ❖ Eradication of violence perpetrated by health-care workers against patients requires interventions in recruitment, training, socialization processes in professions and working environments, and improvements in working conditions. Health workers need training in genuine communication with patients that includes mutual agreement and decisions on treatments, and recognition that patients are ultimately responsible for their own lives and moral decisions.
- ❖ Information education and communication interventions targeting behaviour change should address such socio-cultural beliefs of communities.
- ❖ Future studies should also explore for important motivation factors that can help improve communication between traditional birth attendants and the formal health system. Again, future research should employ a mixed method approach to complement the weakness of the qualitative approach.

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Appendix 1: Semi-Structured Interview Guide

This interview guide has been designed to enable the researcher collect data on assessing the reasons behind women preferred place of delivery. Please be informed that this study is purely academic and that all information obtained shall be kept with utmost confidentiality. The outcome of this research may be used for academic and general purposes such as research reports, conference papers or books. Your anonymity is assured and there is no risk for participating in this study.

Thank you for your acceptance

Section A: Demographics

1. Age
2. Marital Status
3. Highest level of education
4. Major occupation
5. Religion
6. Ethnicity
7. Number of Children

Section B: Preferred place of delivery and reasons

8. What is Antenatal Care (ANC)?
9. Where did you attend ANC in your pregnancy(ies)?
(Probe further concerning first pregnancy, second pregnancy and third pregnancy)
10. Why the choice of those place(s)?
11. If the place(s) of attending ANC have been different, why the changes?
12. How often did you attend ANC?
13. Where had you intended to deliver?
14. Where did you actually deliver?

15. Have you been delivering at the same place you had been attending ANC?

(If no, probe for what accounts for the changes in the choice of place of delivery)

16. Who decides the choice of place for delivery?

(Probe for the reasons for the named person or persons)

17. What are the barriers to delivering in a health facility?

(Probe further for why they are barriers to the respondent)

18. Do previous places of delivery influence choice of subsequent place(s) of delivery?

(Probe further for reasons)

19. What physical preparations did you make towards delivery?

(Probe further for reasons)

20. What financial preparations did you make towards delivery?

(Probe further for reasons)

21. What spiritual preparations did you make towards delivery?

(Probe further for reasons)

22. What believes do you hold about pregnancy in your culture?

(Probe further for reasons behind those believes)

23. Does it affect the preparations you make towards delivery?

(Probe further for reasons)

24. Do those believes influence attitudes people show towards pregnant women?

(Probe further for reasons)

25. Your final comments.

Section C: For TBAs, Nurses, Midwives and Prayer Camp Leaders Only

26. What role do you play in maternal health care delivery?

27. How is health care delivery in this community?

28. What are the maternal health problems facing the inhabitants of this community?

(Probe further for reasons)

29. Where is the first point of contact for maternal health care?

(Probe further for reasons)

30. How do patients pay for maternal services in your outfit?

31. Do you think the place of delivery has an effect on the health of the mother?

(Probe further for reasons)

32. Do you think the place of delivery has an effect on the health of the child?

(Probe further for reasons)

33. Has your outfit ever recorded any maternal deaths?

(Probe further for statistics)

34. Any final comments?

