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**FACTORS ACCOUNTING FOR LOW  
SUPERVISED DELIVERY SERVICES IN ADANSI  
EAST DISTRICT**

**BY**

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**A DISSERTATION SUBMITTED TO THE SHOOOL  
OF PUBLIC HEALTH IN FULFILMENT  
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**DECLARATION**

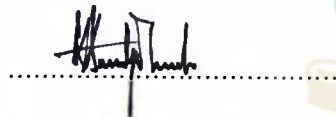
I declare that this dissertation is the result of my own research. References from the work of others have been clearly stated.

This original work has neither been submitted for any degree, nor being submitted concurrently, for any other degree.

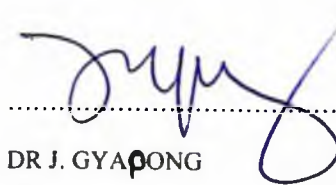


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## DEDICATION

This work is dedicated to the almighty Allah who makes all things possible.

My lovely wife - Asana, daughters - Hawa, Sheriffah, Raisa have been the source of inspiration to complete this course of study.



## ACKNOWLEDGEMENT

This work would not have been completed without the effort and assistance of many people. I wish in this section to acknowledge their support and assistance and say that I am indeed very grateful.

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## ABSTRACT

In each year, more than 150 million women become pregnant in the world. According to WHO, 19 million of them ( more than 15% ) developed complications requiring skilled treatment. Maternal mortality in Adansi East district stands at 90 / 100,000 live births and about six out every ten deliveries occur at home. This study investigated the factors influencing women in the Adansi East to either at home or in health care facilities and reasons for their choice of place of delivery.

### Data Collection

A structured questionnaire was administered to eighty – eight (88) women, who received antenatal care and delivered between 1st January 2001 and 31st December 2001. Also, ten (10) key informants were also interviewed to provide in – depth information on issues pertaining to home and facility delivery.

### Key Findings

- This study showed that one in every five (i.e. 20%) women who deliver in health care facilities, had attended a secondary or higher educational institutions compared to three percent (3%) of those who delivered at home.
- It was revealed that, the level of education, age, number of antenatal visits, place of residence are some of the factors which influenced the choice of place of delivery.
- Safety was the main reason for the choice of facility delivery among 78.5% of women who delivered on health facilities while only 14.8% of those who delivered at home indicated safety to be the main reason for their choice.

### Key Recommendations

- Greater effort should be made by the district assembly and the Feeder Road Department to improve the road network in the district to ease the transportation problems.
- Community sensitisation must be intensified in the area of health education or health promotion to improve the importance of health care facilities for safe delivery.
- Advocate to make delivery services free of charge since it is during this period that women experienced complications in that could lead to their death.
- The district Health Management Team (DHMT) should lobby at the regional level for more midwives to be posted to the district.
- Dialogue with the Adansi East district assembly to link health post to district hospitals by wireless or Motorola services.

## CHAPTER ONE

### 1.0 INTRODUCTION

#### 1.1 Background

Globally, it is estimated that 1.3 billion people are poor and that nearly 70 per cent are women. Between 75 and 80 per cent of the World's 27 million refugees are women and children. Also of the world's nearly one billion illiterate adults, two-thirds are women. Each year more than 150 million women become pregnant. According to WHO, 19 million of them (more than 15%) develop complications requiring skilled treatment. Maternal mortality rates vary widely. An African woman's lifetime risk of dying from causes related to pregnancy and childbirth is 1 in 23 compared to 1 in 40,000 for women in North America (Fourth World Conference on Women, 1995, Fact Sheet 3).

The global picture as outlined above on the vulnerability of women and children is not that much different from that of Ghana and Adansi East district in particular.

However, in spite of the gloomy picture of high mortality rates in some parts of the globe, over 100 countries have initiated new strategies to further the advancement of women after the 1995 Fourth World Conference on Women held in Beijing. This conference resulted in agreement on a five-year plan to enhance the social, economic and political empowerment of women, improve their health, advance their education and promote their reproductive rights.

In the past three decades, various international and local initiatives have been instituted and their implementation is on-going.

The United Nations Decade for Women (1975-1985), the Nairobi Conference on Women in 1985, the Mexico Population Conference in 1984 and the Cairo Population Conference in 1994, all brought the world's attention to the issue of women's reproductive health problems. The Global Commission on Women's Health considers reproductive health as referring to all aspects of well-being related to the reproductive system throughout the life cycle. It encompasses fertility, infertility and the enjoyment of sexual health without fear of disease or unwanted pregnancy. The Program of Action of the 1994 Cairo World Conference on Population and Development clearly states that all countries should strive to make reproductive health care – including family planning counselling, information, education, services for prenatal care, safe delivery and postnatal care – accessible to all through the primary health care system. Community participation in reproductive health care services and other services should be promoted by decentralising the management of public health programmes as done for example in Ghana.

Women are increasingly seen today as people possessing reproductive rights, among other human rights. These include:

- The right to safe motherhood
- The right to plan one's family and have access to full and timely knowledge about all aspects of reproductive health and sexuality.

To respond to the high rates of maternal mortality, the Safe Motherhood Initiative was launched in February 1987 at a conference in Nairobi. The Initiative identified the underlying causes of women's death in childbirth as the lack of proper prenatal care, having too many children, fear of going to the hospital or using contraception, illicit and unsafe abortions, and malnourishment among others. Also the Initiative called for political commitment to reallocate priorities and resources to implement the available strategies that can reduce maternal mortality thus making a comprehensive and multisectoral approach very essential. One of the most successful strategies used to reduce maternal mortality in Ghana and elsewhere has been the involvement of traditional birth attendants (TBAs) in the process.

The New Partnership for Africa's Development (NEPAD) is a Vision and Strategic Framework for Africa's Renewal that is designed to address the current challenges facing the African continent on issues as the escalating poverty levels and underdevelopment, which greatly affect women and children. It is for this reason that the primary objectives of NEPAD are:

- To eradicate poverty
- To accelerate the empowerment of women.

In Ghana the NEPAD initiative is directed towards policy reforms and increased investment in priority sectors as:

- Agriculture;
- Human development with a focus on health, education, science and technology and skills development;

- Building and improving infrastructure, including Information and Communication Technology (ICT), Energy, Transport, Water and Sanitation.
- The Environment.

On the local scene, an Agency like the National Commission on Women and Development (NCWD) was established in 1975 to oversee, collate and coordinate all views and policies of government and other stakeholders in the area of women and children's welfare. The NCWD Post Beijing activities included proposals to all Ministries and relevant institutions which lead to establishment at the Ministries of Education, Health, Agriculture, Trade Union Congress (TUC), National Board for Small Scale Industries (NBSSI) women's desks/focal person to ensure that issues concerning women are attended to. Universities have been encouraged to integrate courses in gender and development, enrolment quotas in all programmes. Most of the proposals towards enhancement of access of girl child to equal opportunities in education are being implemented under the Free, Compulsory Universal Basic Education programme (FCUBE). The NCWD contributed to the establishment of Science Clinics for girls, is collaborating with Ghana National Commission on Children (GNCC) and the newly formed Ministry of Women and Children's Affairs to advocate for the amendment of laws on rape, defilement, circumcision and ritual slavery i.e. Criminal Code Amendment.

The Interstate Succession Law PNDCL III has been promulgated into law, which allows the girl child to inherit property in the event of the loss of a parent.

A Women and Juvenile Unit (WAJU) has been formed in most police stations throughout Ghana which has been empowered by the passage of a bill entitled Domestic Violence Act 2003 to provide protection from domestic violence, particularly for women and children.

In Ghana it is enshrined in the constitution under Fundamental Human Rights and Freedoms that: (1992 Constitution of Ghana).

1. Special care shall be accorded to mothers during a reasonable period before and after childbirth, and during those periods, working mothers shall be accorded paid leave;
2. Facilities shall be provided for the care of children below school-going age to enable women, who have the traditional care for children, realize their full potential.

Ghana's National Education Policy after independence aimed at providing basic education for all, while generally raising the quality of education. The Education Act of 1961 therefore provided for free compulsory primary education, and for measures by the state to improve the quality of education by training large numbers of teachers and making adequate provision for textbooks and other educational inputs. Major educational reforms were introduced in 1987, which sought to increase school enrolment at rates faster than population growth and strengthen the relationship between educational content and national socio-economic needs.

The constitution of 1992 further provided for free, compulsory and universal basic education to all children. This policy position was re-emphasised in the

National Development Policy Framework, Ghana Vision 2020, which seeks to transform Ghana's socio-economic status into that of a middle income country by the year 2020. Consequently, in 1996, the FCUBE programme was introduced.

In the health sector, cost had been a factor in the utilization of services as mostly poor women and children are affected since they cannot access it. For this reason there has been measures introduced which offer four free antenatal care to pregnant women. Likewise, free services are given to children of five years and below as well as the elderly or aged who are 70 years and above.

The Government of Ghana under the Highly Indebted Poor Country (HIPC) initiative, is pursuing the Poverty Reduction Strategy through the District Assemblies to alleviate the poverty levels of most of the people of the country especially women. This is done in collaboration with the National Board for Small Scale Industries (NBSSI) in the form of offering soft loans, credits and inputs to individuals and co-operative groups for the establishment or expansion of their businesses.

As a result of all the initiatives outlined above, women have made some remarkable gains since 1995: they are living longer and healthier lives; they receive better schooling; they are more economically active; and more women have the franchise than ever before. Despite these gains, worldwide, women continue to predominate among the ranks of those living in poverty and who

suffer from illiteracy, dislocation, violence, poor nutrition and ill health. According to United Nations estimates, they still lag behind in virtually all aspects of life.

## **1.2 Problem Statement**

The majority of pregnant women (90%) in the Adansi East District receive antenatal care, but only a small proportion (23%) deliver in health institutions (Annual Adansi East MCH Unit Report 2002, unpublished). This gap between a high antenatal coverage and a low institutional delivery in the district is wider than at the national level, where antenatal coverage and institutional deliveries are 89 per cent and 43 per cent respectively (Calverton, Maryland 1999, p. 91-100). The maternal mortality rate in the Adansi East district is 90/100,000 live births (Adansi East DHMT 2002 Annual Report, p. 23). In order to reduce this high rate, a number of initiatives should be put in place that would promote the welfare of all pregnant women leading eventually to the safe delivery of a baby whilst maintaining the health of the mother. Data on the epidemiological characteristics of women who deliver at home, and the activities of birth attendants in the non-formal health sector is lacking. Delivery services in the district are rendered by both formal and non-formal health sectors. In the formal sector delivery services are available at all hospitals, health centres, community clinics and maternity homes. However, in the non-formal sector TBAs (trained and untrained) as well as traditional or spiritual healers provide such service.

Thus this study into the factors contributing to the disparity between a high antenatal coverage and low supervised delivery coverage in the health institutions by trained and skilful personnel can be used to design strategies in health educational programmes to promote safe delivery by the DHMT, District Assembly, NGOs and other stakeholders in a collaborative effort for the welfare of women.

### **1.3 OBJECTIVES**

#### **1.3.1 General Objective**

The general objective of the study was to determine and compare the characteristics of both groups of women, who after antenatal care services, opt for home or institution delivery.

#### **1.3.2 Specific Objectives**

- To determine the association, if any, between such demographic factors such as age, religion, educational level and marital status, and the choice of place of delivery.
- Determine the relationship between cost, distance and the utilization of delivery services in the district.
- To find reasons for low utilization of reproductive and child health services.

### 1.3.3 Operational Definitions

**Supervised delivery:** Deliveries handled by trained service providers, that are trained traditional birth attendants, midwives, nurses and doctors both in the public and private sectors.

**Antenatal care:** Care (both preventive and curative) given to the pregnant woman and the foetus, up to the onset of labour.

**Postnatal care:** Care given to mothers and their babies from the end of delivery up to six weeks after delivery.

**Coverage:** The proportion of pregnant women of the expected number of pregnancies in a year that made use of any of the maternal health services provided (antenatal care, supervised delivery care and postnatal care).

**Cost of service:** The fee charged at the health facility for any of the maternal services rendered.

**Traditional Birth Attendant (TBA):** A birth attendant who initially acquired her ability or skills by delivering babies herself or through apprenticeship to other traditional birth attendants.

**Income:** Possession of certain household goods.

**Health facility:** A physical dwelling structure with equipment and medications for the successful rendering of both curative and preventive health care services.

**Obstructed labour:** Is a complication in which the process of labour does not function or progress normally due to a mechanical obstruction.

**Prolonged labour:** Is a condition when a woman has been in labour for a day or night (12 hours or more) and not delivered.

**Eclampsia:** Is characterized by high blood pressure with diastolic pressure of 90 mm Hg or more, swelling of lower limbs and protein in urine, which can progress to convulsions and can lead to brain damage, renal failure and death

## CHAPTER TWO

### 2.0 LITERATURE REVIEW

With each passing year, over half a million women worldwide die as a result of complications associated with pregnancy and childbirth. Nearly 99 per cent of these deaths occur in developing countries. Maternal mortality rate in Africa is higher than anywhere else in the world. In Sub-saharan Africa, 150,000 women a year die of maternal causes. These losses occur even though pregnancy and child bearing constitute a natural biological process, and the knowledge or means exist to remove or minimize the hazards associated with the process. Yet women die from haemorrhage, infection, obstructed labour, hypertensive disorders (eclampsia), and abortion, all because of lack of proper care, especially during delivery (M.O.H, Ghana, Annual Report 1994, p. 6).

#### 2.1 Why do Women Not Use Available Services?

It has been suggested that distance, cost and quality affect peoples decision to seek prompt care, but there is evidence, that people often consider quality more than cost. In most rural areas, the closest facility may often be equipped only for minor ailments and a woman with a complicated labour may have difficulty in accessing appropriate treatment.

Several factors affect the utilization of delivery services. Available literature identifies reasons why women do not use available services as pertaining to

(<http://www.unfpa.org/mother/skilled> - att.htm.3/38/02 Ensuring skilled attendant at birth).

- High cost
- Physical inaccessibility of the health facility
- Poor information
- Cultural preferences and
- Quality of the service rendered.

A study done in the Ejisu district of the Ashanti Region revealed that factors inhibiting the utilization of health services were prohibitive hospital fees, illegal fees and bribes, irregular transport and uncooperative attitude of drivers, poor and unmotorable roads, lack of drugs and essential supplies and negative staff attitudes (Martey, et al, 1990).

### **Distance**

Studies have shown that the highest proportion of people who utilize health facilities usually live close by the facility – within a radius of five miles or kilometres, with the proportion of the users declining as the radius increases. Distance exerts a dual influence by acting as an obstacle to reaching a health facility and also acting as a disincentive to trying to seek care. The effect of distance becomes stronger when there is lack of transport coupled with the non-existence of a good road network as can be found in rural areas (Ekwepu, et al, 1990).

**Cost**

The various costs incurred in utilizing health facilities contribute to their non-use by pregnant women. The various costs include that for transportation, facility fees, fees for drugs and other supplies and the opportunity costs of leaving an income generating activity to go to a health facility. Researchers at the Ahmadu Bello University in Nigeria found that obstetric admissions declined sharply with an increasing incidence in maternal deaths when government instituted fees for prenatal care and delivery (Ekwepu, et al., 1990).

**Quality of Care**

The perception of quality of care offered at a health facility has been shown to take precedence over concerns about distance and cost. In a study conducted by Annis in the Guatemalan highlands, government health posts seemed to be conveniently located, yet that proximity did not guarantee utilization, probably because the facilities were understaffed, under equipped or both. Annis thus concluded that, "the current low utilization of Ministry facilities reflects the poor quality of services and certainly not physical access or mysterious cultural barriers (Annis, 1981).

Quality of care affects the decision to seek care in two ways, satisfaction or dissatisfaction with the encounter. Satisfaction may come from the effectiveness of therapy prescribed or dissatisfaction with the services received, e.g. staff attitudes, hospital procedures, availability of supplies and the efficiency of the services on the whole – long waiting times. Lack of

emotional support from nurses and the lack of privacy in the hospital setting as compared with that obtained from home are some of the factors that contribute towards dissatisfaction with the service.

## **Socio-Cultural and Socio-Economic Factors**

### Illness factors

Available literature emphasises the recognition of the severity of a disease and its etiology as influencing the decision to seek care. Although pregnancy and childbirth are acknowledged as being potentially risky, in most populations they are considered as a natural phenomenon for women to go through. Just as pregnancy is viewed as being natural, so also can the complications of pregnancy and death during labour be considered normal or inevitable and therefore be ignored as being of no consequence (Thaddeus and Maine, 1994).

The severity of an illness is an important determinant for seeking health care. If the assessment of symptoms is considered to be serious enough to warrant the time and expenditure to be incurred in seeking health, then this is justified.

Once the decision to seek care is justified by the perceived severity of the illness, the type of care that will be sought will depend on the cause to which the illness is attributed to by the patient and his/her family. This is especially so in the developing world where there is a trend toward the utilization of both traditional medicine and orthodox medicine.

### Women's Status

This is composed of the educational, cultural, economic and political position of women in society. Women's status underlines the decision to seek care and shapes their access to health services. Whilst this situation pertains in both developed and developing countries, there are specific ways in which it directly affects and delays the decision to seek care and the constraints they face in seeking care.

In countries like Nigeria, Ethiopia, Tunisia, India and Korea, studies have shown that women do not decide on their own to seek care. The decision belongs to a spouse or to a senior member of the family. Furthermore women's mobility is limited in certain areas because they need permission to travel. Often this permission must be granted by the spouse or mother-in-law (Stock, 1983)

Women tend to use Primary Care facilities close to their homes and may find them equipped only for basic treatment and therefore these may not be useful in the case of a complicated labour and delivery process.

## CHAPTER THREE

### 3.0 METHODOLOGY

Despite the current technological advancement and its positive impact on health, global dynamics have given rise to perpetuated diseases, deprivation, poverty, service disparities and inaccessibility and illiteracy. These have presented as a complex interrelated multidisciplinary socio-economic public health problem, which requires adequate knowledge and skills to effect a positive change.

This change is to maintain and/or bring about improvement in the health status of the affected masses of the people, especially those in the developing countries like Ghana and in Adansi East district in particular.

### 3.1 STUDY AREA

The Adansi East District is one of the newly created administrative and political districts in the country from the former Adansi District in 1989 with a population of 156,710.

Reproductive and Child Health activities form the bedrock of the Adansi East District's Primary Health Care Programme. Presently there are twelve institutions rendering this service to the district (Kyei-Faried S. 1996).

The institutions include the New Edubiase District Hospital and the Merciful Clinic (Private) at Praso. There are seven Reproductive and Child Health (RCH) centres and four health centres under the umbrella of the Ghana Health Service which offer delivery services.

In line with the government's policy of improving the health and well being of women and children and as a result of the safe motherhood initiative embraced by the government, the Adansi East District Health administration has trained sixty (60) traditional birth attendants (TBAs) to assist with maternal and child health activities in the communities. The coverage for supervised deliveries in the year 2000 was the sum total obtained from all these service points listed. The District Health Administration is divided into five sub-districts. These are New Edubiase, Ataase, Asokwa, Akutreso and Aboabo.

### **3.2 STUDY POPULATION AND DESIGN**

The study population was all women who attended antenatal clinic and delivered within the period 1<sup>st</sup> January 2001 – 31<sup>st</sup> December 2001. Antenatal care should have been received at a health facility.

The women selected above were then divided into two groups:-

1. Women who received antenatal clinic service and delivered at home, and
2. Women who received antenatal clinic service and delivered in health facilities.

### **Study Design**

It was a cross-sectional comparative study that focused on the epidemiological characteristics of 140 parous women who received antenatal care and delivered at home, or in a health facility in the Adansi East District.

### **3.3 VARIABLES**

The independent variable was the non-utilization of supervised delivery services. The dependent variables were:

#### **Characteristics of the subject:**

##### **Demographic**

- Age
- Parity
- Marital status

##### **Socioeconomic**

- Educational level
- Occupation

##### **Sociocultural**

- Ethnicity
- Religion

##### **Characteristics of the facility**

- Quality of care provided
- Financial accessibility
- Physical accessibility

### 3.4 SAMPLING PROCEDURE

The study was a cross-sectional comparative one that looked at the epidemiological characteristics of 140 parous women who received antenatal care services but chose to either deliver at home or deliver in a health care facility. The epidemiological characteristics of these two groups of parous women were then compared to find any association influencing their choice of place of delivery.

Reproductive and Child Health activities form the bedrock of the Adansi East District's Primary Health Care programme which also forms the basis for this study. There are twelve health care facilities in the district which offer services for supervised delivery and these are:

One (1) District Hospital at New Edubiase (capital of District)

Four (4) Health Centres in four sub-districts at (Ataase, Asokwa, Aboabo and Akutreso).

Twenty-six (26) outreach centres in communities of the four sub-districts.

As a result of this set-up, separate sampling frames were prepared from three levels – hospital; health centre and outreach centre. On the Child Welfare Clinic (C.W.C) days at these respective levels, sampling frames were prepared from the CWC records of women who delivered within the period 1<sup>st</sup> January 2001 - 31<sup>st</sup> December 2001. The total number of women chosen from each of the levels delivered either at home or in a health care facility and were divided into these two categories.

In Adansi East district, the only hospital (the District Hospital at New Edubiase) was automatically chosen from that level for the study. There are 4 health centres and so from balloting, the Aboabo health centre was chosen. Lastly, from the total district outreach centres of 26, the Odumase outreach centre is chosen.

It is to be noted at this juncture that in all cases, the number of study units chosen from each of the three facilities was proportional to the average daily attendance at their respective CWC. The ratio was 2:1:1 respectively for the CWC attendance at New Edubiase hospital, Aboabo Health Centre and Odumase outreach centre.

The required number of study units was then selected at random from each group by drawing lots (where the number of listed names on the sampling frame was more than the number of study units required for the study).

At New Edubiase, Aboabo and Odumase, a total of 60,30, and 26 women respectively who attended the CWCs were in the category of those who delivered in health facilities. Through the sampling technique outlined above, twenty-five (25) out of the sixty (60) mothers and twelve (12) out of thirty (30) were chosen from New Edubiase and Aboabo respectively, whilst fourteen (14) mothers from Odumase were chosen. However, for the mothers who delivered at home only twenty-two (22) were present at the New Edubiase CWC and all were included in the study. Aboabo and Odumase recorded thirty-four (34) and twenty (20) of the mothers in this category respectively. A

total of twelve (12) women each were similarly chosen from Aboabo and Odumase for the study.

The sample size was calculated to be fifty-four (54) each for both category of women who delivered at home and those who delivered in health facilities. The sample size was increased to seventy (70) each to account for a non-response rate assumed to be approximately 30 per cent. Detailed description of the sample size calculation is shown in Appendix 1.

### **3.5 DATA COLLECTION TECHNIQUE**

The collection of both quantitative and qualitative data for the study was carried out during the period 18<sup>th</sup> June – 20<sup>th</sup> July 2003. Two research assistants were trained in the administration of questionnaires by the principal investigator. The training involved detailed interpretation of the questions into the local languages, ethical issues and the prevention of information bias carefully considered.

#### **Pretesting**

The questionnaire was pretested at a CWC different from those chosen for the study – Ataase CWC. A total of twenty-five (25) questionnaires were administered. After evaluating the results, changes were made to the contents and format of the questionnaire to ensure the smooth collection of the data.

## **Interviews**

Questionnaires were used to obtain quantitative information on the two categories of parous women in the Adansi East district who delivered between 1<sup>st</sup> January 2001 and 31<sup>st</sup> December 2001:

**Category I:** Pregnant women who received antenatal care and delivered in a health facility between 1<sup>st</sup> January 2001 and 31<sup>st</sup> December 2001.

**Category II:** Pregnant women who received antenatal care and delivered at home within the same period.

**Category III:** Pregnant women who did not attend antenatal and delivered at home within the same period.

**Category IV:** Pregnant women who did not attend antenatal but delivered in a health facility.

The questionnaires were administered to fifty-one (51) women in category I and thirty-seven (37) in category II.

Categories III and IV were omitted because their inclusion will require a household survey which would be time-consuming and very expensive considering the limited time and financial resources available at the time of study.

Thus, among the women in category I, all those chosen for the study were interviewed. That is, twenty-five (25) women who delivered in institutions were interviewed at New Edubiase, twelve (12) in Aboabo and fourteen (14)

in Odumase. Similarly, at New Edubiase all the twenty-two (22) chosen for the study in category II were interviewed but four (4) and five (5) women chosen at Aboabo and Odumase respectively could not wait to respond. Therefore, in all, questionnaires were administered to twenty-two (22), eight (8) and seven (7) women at New Edubiase, Aboabo and Odumase respectively.

Key informant interviews were held with two each of community members from this category of persons:

- A religious leader (Priest/Imam/Spiritualist)
- Elderly women (over 45 years)
- Health workers (Midwife/Doctor/Public Health Nurse)
- Traditional Birth Attendants (trained/untrained)
- Married Men.

They were interviewed individually for their views on factors influencing choice of place of delivery and also covered issues of safe delivery.

### **3.6 DATA PROCESSING**

The questionnaires were sorted into the broad categories of home and facility deliveries, and then cross-checked for completeness and internal consistency. They were then coded and entered into a computer for further processing and analysis, using the EPI-INFO (version 6.0) software program which was used to calculate the frequency distributions of variables, and for significance testing using the chi-square test.

### **3.7 LIMITATIONS OF THE STUDY**

There are quite a lot of migrant farmers in the New Edubiase District some of whom were of child bearing age and might have delivered and emigrated from the district. Also, traditionally, some women go to their mothers or hometowns to deliver. Thus in both situations, this study did not take into account the in and out migration of such women. Also, those who lost their babies before the study were not included since they were not in attendance at the Child Welfare Clinics (CWCs). Most visits to the CWCs were by appointments, so mothers who attended on the days of the study may not be representative, but due to lack of time and resources, household surveys could not be done.

During the sampling procedure for health facilities, the New Edubiase District Hospital was an automatic choice because it was only one in the district.

Many of the respondents did not know their date of birth, so their ages were estimated. Although efforts were made to ensure accuracy of such estimates, some of the ages assigned to respondents could be inaccurate. Therefore, the findings of this study may not reflect the true situation in the district. However, they may fairly represent trends in the utilization of antenatal health services.

### **3.8 ETHICAL ISSUES**

Measures were instituted to ensure maximum confidentiality during and after the study, since some of the information provided by the respondents were quite personal. The objectives of the study were clearly explained to the respondents before they were interviewed. Respondents who participated as well as those who refused to, did not gain or lose anything.

## CHAPTER FOUR

### 4.0 FINDINGS

This section presents the findings from the health care facility records and from the survey of 88 respondents who delivered between 1<sup>st</sup> January 2001 and 31<sup>st</sup> December 2001. In all 37 of them delivered at home, and 51 delivered in health facilities.

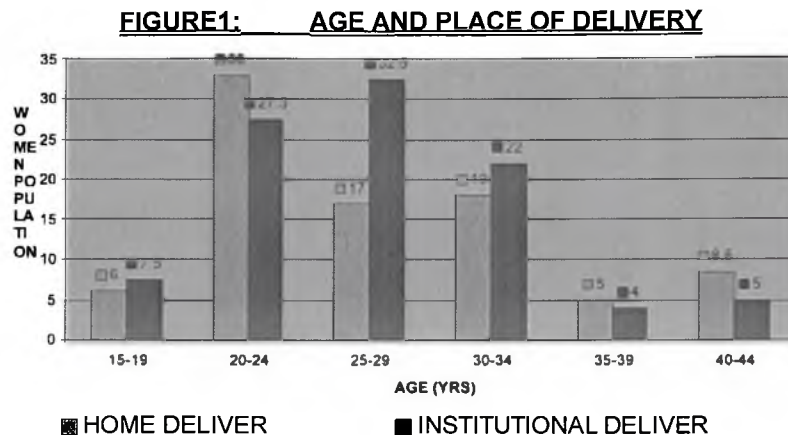
Among the respondents, 36.2% were either illiterates or had only primary education; 11.8% were educated to the secondary or tertiary level. Most of the women interviewed were married and 53.2% of them were rural dwellers. Teenagers formed 8% of the respondents, while those aged 35years and above, made 12.6%.

### 4.1 AGE OF MOTHER

The age distributions of teenagers were similar for both groups of women. Those aged below 20 years formed 6.0% of those who delivered at home, and 7.5% of those who delivered in institution. Among the respondents who delivered at home, 85.3% of them were between the ages of 20 and 34 years, and 74.6% of those who delivered in institutions were also in the same age group.

The proportion of older women (35-44 yrs) among those who delivered at home was higher than that of those who delivered in institutions (4.8%).

Among women who delivered at home, those aged 20-24 years was the largest (33.0%), but in the case of the mothers who delivered in facilities those aged 25-29 years constituted the largest proportion (32.5%). Results in figure 1 below:



#### 4.2 LEVEL OF EDUCATION

In the category of women who delivered at home, there were nearly thrice as many women with no education (27.0%) compared to those who delivered in institutions (7.8%).

The proportion of mothers who had attended primary, middle or junior secondary schools, were similar for both groups of women. However, mothers with secondary or tertiary education formed 8.1% of those who delivered at home, but this group constituted a higher proportion (21.6%) among those who delivered in institutions. Detailed results are found in Table 4.2 below.

**TABLE 4.2 EDUCATIONAL LEVEL AND PLACE OF DELIVERY.**

LEVEL OF EDUCATION	HOME DELIVERIES DELIVERIES		INSTITUTIONAL	
	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE
Nil	10	27.0	4	7.8
Primary/JSS/Middle	24	64.9	36	70.6
Secondary +	3	8.1	11	21.6
Total	37	100	51	100

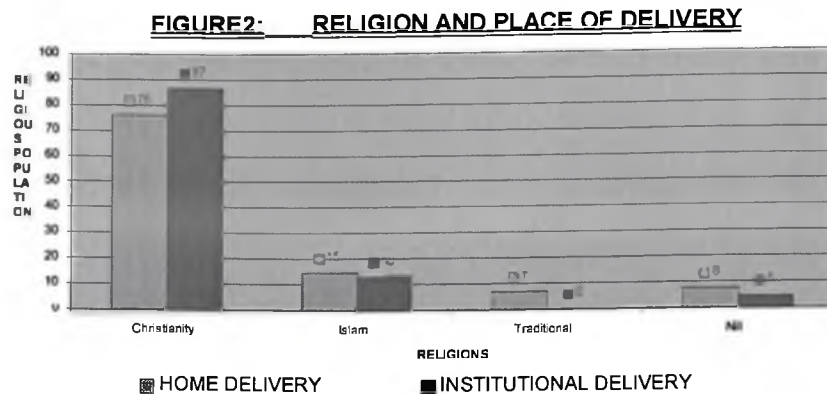
Significance testing between those with primary, middle/JSS education on one hand, and those with secondary or higher level of education on the other, was by chi-square testing. P-value was 0.00642 at a significance level of 5%.

#### 4.3 MARITAL STATUS

Most of the women interviewed were found to be in marital relation. In the case of those who delivered at home, 89.3% were married. On the other hand, for those who delivered in institutions 91.4% were also married.

#### 4.4 RELIGION

Christianity was the predominant religion among all the women whilst the Islamic faith was the second major religion for both categories of women. The only three respondents who belonged to traditional religions, also delivered in shrines. This is graphically shown in figure2 below:



#### 4.5 OCCUPATION

The majority of respondents who delivered in the district were farmers (47.8%). About a quarter of the respondents were traders (23.6%). Civil servants and teachers constituted 5% and housewives 15%. This indicates that the majority who delivered were peasant farmers. This has implications for their ability to purchase delivery care services.

#### 4.6 ANTENATAL VISITS

Five (5) and four (4) are the median numbers of antenatal visits for those who delivered at health facilities and home. Out of the number of women who delivered at home, 40.5% recorded up to three antenatal visits, but only 11.8% mothers who delivered in facilities recorded that number of antenatal visits.

A higher proportion 88.2% of mothers who delivered in facilities had four or more antenatal visits and 59.5% of those who delivered at home, had the same number of visits. Results as in Table 4.6 below.

**Table 4.6 ANTENATAL VISITS AND PLACE OF DELIVERY**

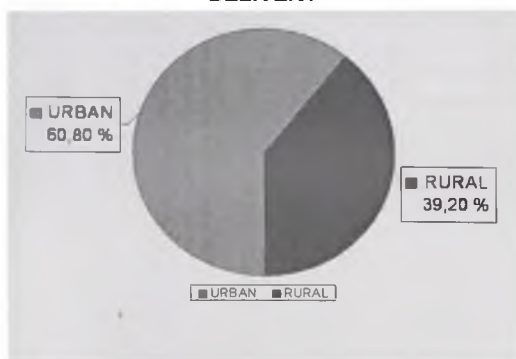
NUMBER OF ANTENATAL VISITS	HOME DELIVERIES		INSTITUTIONAL DELIVERIES	
	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE
1-3	15	40.5	6	11.8
4+	22	59.5	45	88.2
TOTAL	37	100	51	100

The testing between the two groups is by chi-square testing. This gives a P-value of 0.000007 at significance level of 5%.

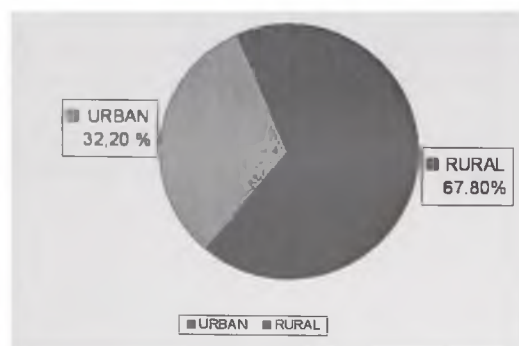
#### 4.7 PLACE OF RESIDENCE

From the analysis of data urban women were more likely than their rural counterparts to deliver in health institution. Majority of women who delivered at home (68.2%) were from rural areas. However, most of those who delivered in health facilities (60.8%) were urban dwellers. A graphical presentation of the findings is as below:

**FIGURE 3A INSTITUTIONAL DELIVERY**



**FIGURE 3B HOME DELIVERY**



## ASSOCIATIONS BETWEEN COST, DISTANCE, QUALITY OF CARE AND DELIVERY AT HEALTH FACILITY

### 4.8 COST

Home deliveries were found to be less expensive than institutional deliveries. A large proportion of those who delivered at home (59.4%), paid ₵24,000 or less compared to 13.7% of those who delivered in institutions. Also only 8.2% of mothers who delivered at home paid more than ₵50,000, but more than half (51.0%) of those who delivered in institutions, paid that much for the delivery service.

Flexible terms of payment were available to the women who delivered at home. Also those who delivered at home could pay the equivalent of delivery fee in kind (eg. soap, kerosene or a fowl).

The results as shown below:

**TABLE 4.8: COST OF DELIVERY**

DELIVERY COST/CEDIS	HOME DELIVERIES		INSTITUTIONAL DELIVERIES	
	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE
LESS THAN 24,000	22	59.4	7	13.7
25,000-50,000	12	32.4	18	35.3
GREATER THAN 50,000	3	8.2	26	51.0
TOTAL	37	100	51	100

#### 4.9 REASONS FOR CHOICE OF PLACE OF DELIVERY

When asked for the main reason for the choice of place of delivery, 96.5% and 84.8% responses were obtained from those who opted for institutional and home deliveries respectively. There were major differences in the reasons given by the two groups of women for their choice of place of delivery. Among those who delivered in facilities, the majority of them (78.5%) indicated that safety was the main reason for doing so. For the women who delivered at home, only 14.8% cited safety as the main reason for delivering there, and 39.5% of those women gave a variety of other reasons. Some of these reasons included, bad staff attitude in hospitals, lack of transport, inaccessibility to facilities, religious reasons and family tradition.

**Table 4.9: MAIN REASON FOR CHOICE OF PLACE OF DELIVERY**

RESPONSE	HOME DELIVERIES		INSTITUTIONAL DELIVERIES	
	FREQUENCY	PERCENTAGE	FREQUENCY	PERCENTAGE
SAFETY	12	14.8	84	78.5
SUDDEN ONSET OF LABOR	23	28.4	0	0
FINANCIAL PROBLEMS	14	17.3	0	0
OTHER	32	39.5	23	21.5
TOTAL	81	100	107	100

#### **4.9.1 Making Home Deliveries Safe**

The response rates on measures to make home deliveries safe were quite low as in that case only 36.2% of the women interviewed responded. The rate was 58.0% for those who delivered in facilities. Majority of those who delivered at home (70.3%) and 65% of the women who delivered in facilities indicated the training of TBAs as a priority. However, only 13.6% of those who delivered at home and 20% of those who delivered in facilities thought that there is need to place nurses or midwives in the communities. Others suggested banning all untrained TBAs from delivering women and increasing both geographical and financial accessibility to health facilities where clients with complications could be promptly referred.

#### **INTERVIEW WITH KEY INFORMANTS**

Trained and untrained TBAs are responsible for delivering nearly all the women in their extended families as well as about a half of those in the communities where they live. They are called from their farms and social engagements to perform deliveries. It was made clear that lower cost, the convenience of being delivered in their own homes or communities, and the pleasant attitude of attendants, were some of the main reasons why some women patronize the service of TBAs.

The untrained TBAs were unhappy with the 'commercialization' of the services of the traditional birth attendants-thus many TBAs are now practicing because of money, which might be putting the lives of women in danger. On the other

hand the trained TBAs expressed the wish that only those trained should be permitted to practice in the villages for safety reasons.

The health workers generally believe that home deliveries are unsafe and that poor women with little or no education, who live in rural areas with no access to health facilities, are more likely to deliver at home. The urban health worker thinks that deliveries by TBAs should be discouraged because they are responsible for most of the 'very bad obstetric cases' referred to hospitals, whilst the rural counterparts believe that the services of TBAs are very essential only if they are trained or retained adequately. All the key informants believe that inaccessibility to health facilities, poverty, lack of transport, high cost of institutional delivery coupled with the unfriendly staff attitude are the main factors preventing pregnant women from utilizing health facilities leading to the low supervised delivery coverage in the district

## CHAPTER FIVE

### 5.0 DISCUSSION

It is clear from the results that, there is a tendency for women with higher education to deliver in health care facilities and those with lower education to deliver at home. This study also showed that older women were more likely to deliver at home than younger women similar to the trend found in the (GDHS 1998). The observed trend may be due to the fact that older women are generally less educated than younger women. Women who have had a minimum of five years education are said to make full use of health facility according to the World Development Report 1993, "Households with more education enjoy better health for both adults and children" (World Bank, 1993). The relation between deliveries at health facility with education has confirmed this statement. Education empowers women to make informed decisions concerning their health. Thus education has an important role in shaping the values, attitudes and perceptions of people, which indirectly affects the utilization of health services.

The findings show that women who attend antenatal clinic on more than four occasions, are more likely to deliver in health facilities. This can be attributed

to the fact that through repeated health education given on each visit by health workers, the women become more familiar with the benefits of institutional delivery. Thus with greater familiarity with staff and the environment of the facility, women are more likely encouraged to deliver in facilities.

This study did not find any relation between marital status and use of health facility for delivery. This is in contrast with the study done by Sekyi-Appiah in the Birim South District, who found an association between being married and using a skilled attendant for delivery. The study concluded that a married woman stands a better chance of using the services of trained personnel during her time of delivery because of economic support she receives from her husband and in-law (Sekyi-Appiah , 1996).

Distribution of the women among the various religious groups reflects the strengths of the religions in the district. However three respondents who delivered with spiritualist where they also worshipped may have been influenced by their religious beliefs. A study has revealed that religious belief serve as a push towards 'traditional' forms of health care, and not for example the facilities available or the quality of staff (Twumasi, 1975). Facility fees, the cost of drugs and other supplies all add on to the cost of delivery care. This study shows a significant relation between charges and the use of a health facility for delivery.

rural areas. The implication of all this is that pregnant women may not get the means of transport to convey them to health facilities for delivery. This may be particularly so at night and may also explain why many rural women deliver at home, though it might be their wish to deliver in health facilities.

Safety appears to be strong motivational factor in the choice of institutional delivery. For all the women who delivered in facilities, as high as 83.2% cited safety as their main reason for doing so. Similarly, the traditional role of men as heads and breadwinners of families may account for the 53.6% who indicated that their choice of institutional delivery was influenced by their husbands.

## CHAPTER SIX

### 6.0 CONCLUSION AND RECOMMENDATIONS

#### 6.1 Conclusion

With all the initiatives outlined above, women have made some remarkable gains since 1995, they are living longer and healthier lives; they receive better schooling, they are more economically active than ever before. Irrespective of these gains, worldwide, women continue to predominate among the ranks of those living in poverty and who suffer from illiteracy, violence, poor nutrition and ill health. According to United Nations estimates, they still lag behind in virtually all aspects of life.

Delivery care is seen as one of the major components that relate to maternal mortality. The quest by the safe Motherhood initiative to reduce maternal mortality, by 75% by the year 2015 cannot be achieved if measures are not put in place to ameliorate the effects of the factors contributing to low supervise deliveries in Adansi East district. Some of the factors found to influence the low utilization of health facilities for supervised deliveries are distance from health facility, charges, and staff attitudes. It was realized from the study that education, attendance at antenatal clinic are strong points for women who want to use a health facility for delivery. Education of the child, which is a popular slogan should be taken seriously by all and sundry so that women would have improved health and maternal mortality would be reduced.

In the Adansi East district, not all the primary health care facilities are adequately equipped to provide all the required services. Where facilities exist they could be upgraded and well staffed with motivated personnel to render required services. With the transportation difficulties and bad roads in certain parts of Adansi East district, the Community Health Planning and services (CHPs) concept should be embraced where a community health officer is placed in those hard to reach communities to render the much needed services including especially supervised delivery services.

## **6.2 RECOMMENDATIONS**

The District Assembly and the Feeder Roads Department should improve the road network in the district to ease the problem of transportation. The local transport union must be encouraged to offer priority and special discount fares to pregnant women in the district. The DHMT should lobby for more midwives to be posted to the district. A community health education programme should be initiated by the DHMT in collaboration with the District Assembly to highlight the importance of health facilities for safe delivery and other health problems.

Advocacy to make delivery services also free of charge since it is during that women experience complications that could lead to their death.

DHMT to dialogue with Adansi East district assembly to link health posts to district hospital with a wireless.

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# APPENDIX I

## SAMPLE SIZE

A representative sample size of 140 women, who satisfied the stated criteria for the study units, will be selected. A half of the same shall consist of women who delivered in health institutions. And the other half will constitute those who delivered at home. The sample size for each category consist of a calculated figure of 54, and an additional 16, to account for non-response.

The sample size calculation is shown below:

$$\text{Sample Size, } n = \left\{ \beta \sqrt{[P_1(1-P_1)+P_2(1-P_2)]} + \alpha \sqrt{[2P(1-P)]} \right\}^2 / (P_2 - P_1)^2$$

Where

$n$  = Sample size of each group

$\beta$  = A one – sided percentage point of the normal distribution corresponding to 100% (the power = 0.84 (80% power))

$P$  = Average of the two proportions  $P_1$  and  $P_2$

$P_1$  = Proportion of one group (women who delivered in health care facilities) within the study populations. ( i.e.

Institutional deliveries / Antenatal registrants =  $773/6620 = 0.118$ )

$P_2$  = Proportion of the other group ( women who delivered at home) within the study population (i.e. Home deliveries / Antenatal registrants = 2268 / 6520 = 0.347)

$\alpha$  = A percentage point of the normal distribution corresponding to the (2 – sided) significance levels. (In this case a 5% significance level = 1.96)

$P$  = Average of the two proportions  $(P_1 + P_2) / 2 = 0.12 / 0.35 = 0.23$ .

Hence by substitution:

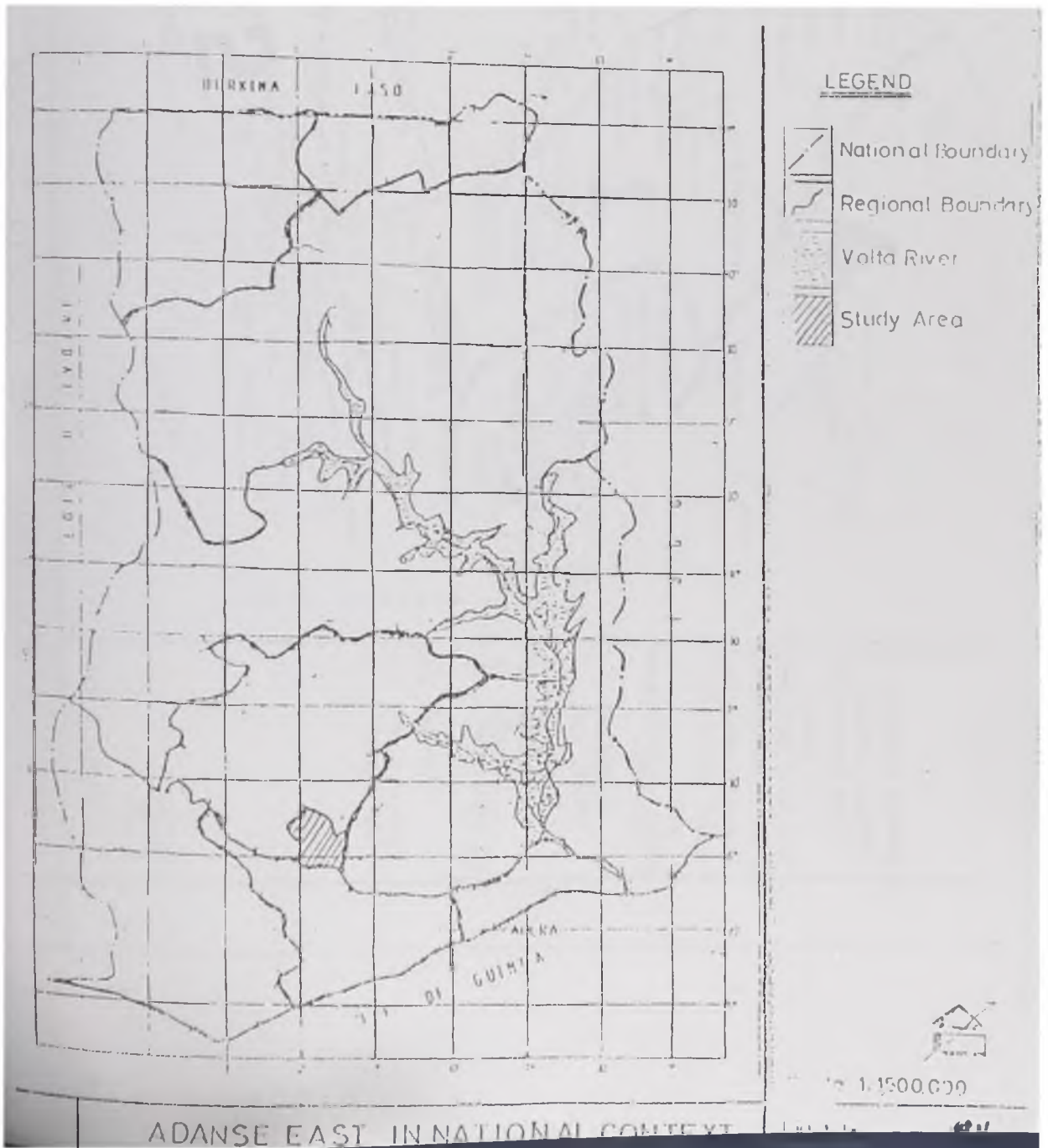
$$n = \{0.84 [0.12(0.88) + 0.35 (0.65)] + 1.96 \sqrt{[2 \times 0.24 (1-0.24)]}\}^2 / (0.35 - 0.12)^2$$

$$= 54$$

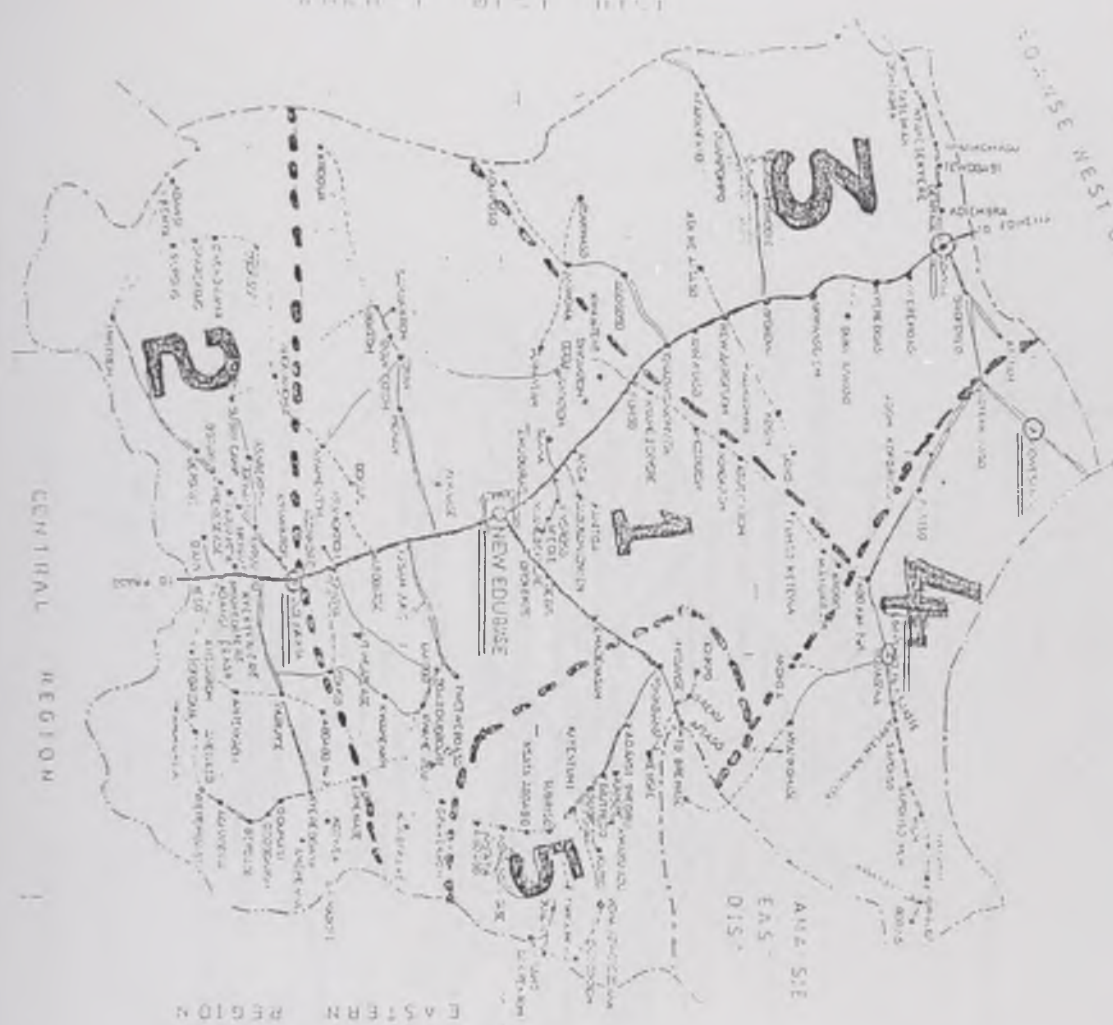
Allowing for 16 non – respondents,

$$n = 54 + 16$$

$$= 70 \text{ respondents (for each group)}$$



MAP OF ADANSI EAST DISTRICT



Scale 1:62500

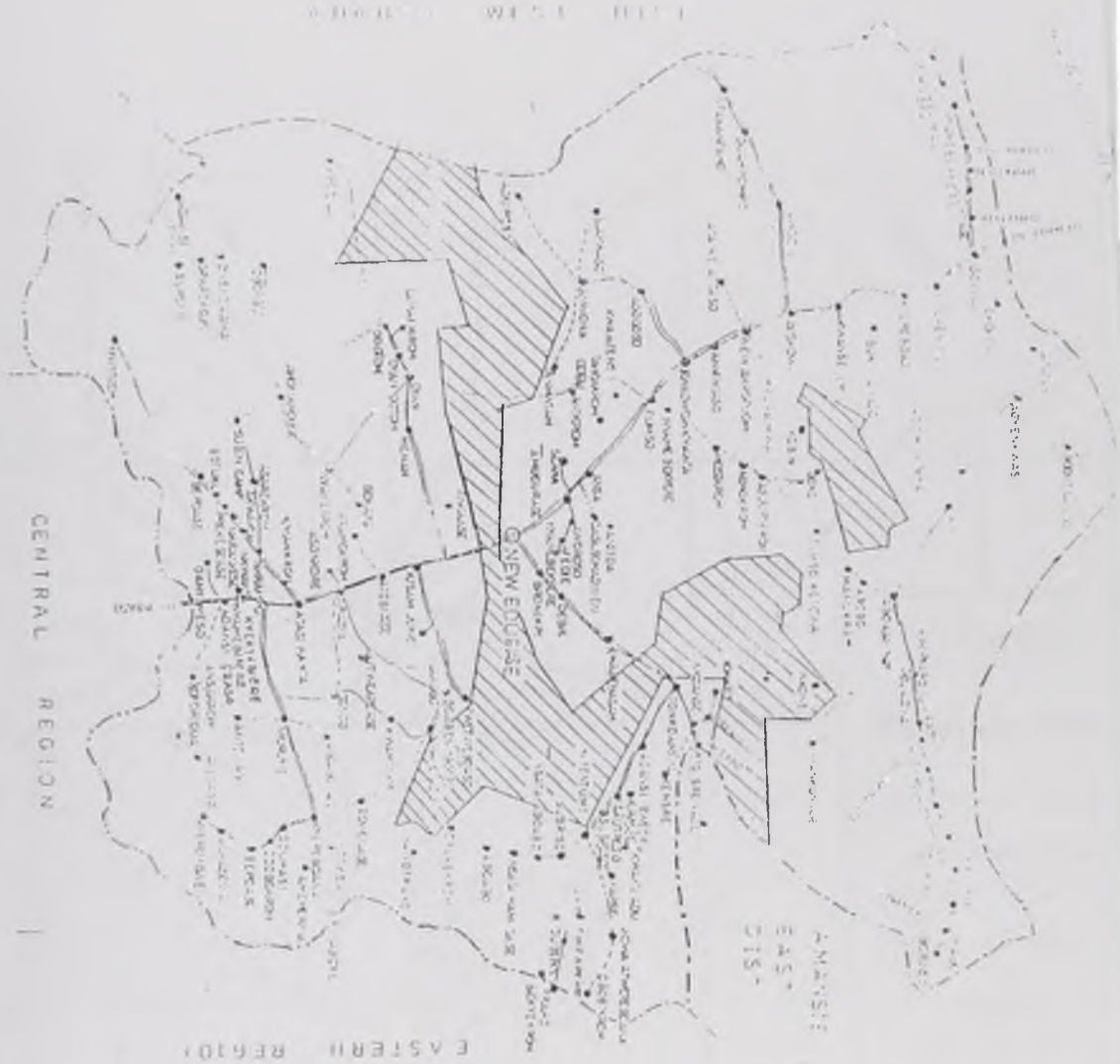


- REGIONAL BOUNDARY
- - - DISTRICT BOUNDARY
- ⊙ DISTRICT CAPITAL
- TOWNS
- FIRST CLASS ROAD
- SECOND CLASS ROAD
- THIRD CLASS ROAD
- FOOTPATH/TRAIL
- Trail
- Supplies (health)
- STADIUMS
- 1. NEW EDUBASE
- 2. ATHASIE
- 3. ASOKWA
- 4. ASABA II
- 5. AKUTRESSO
- HOSPITAL
- HEALTH CENTRE
- HEALTH PSI

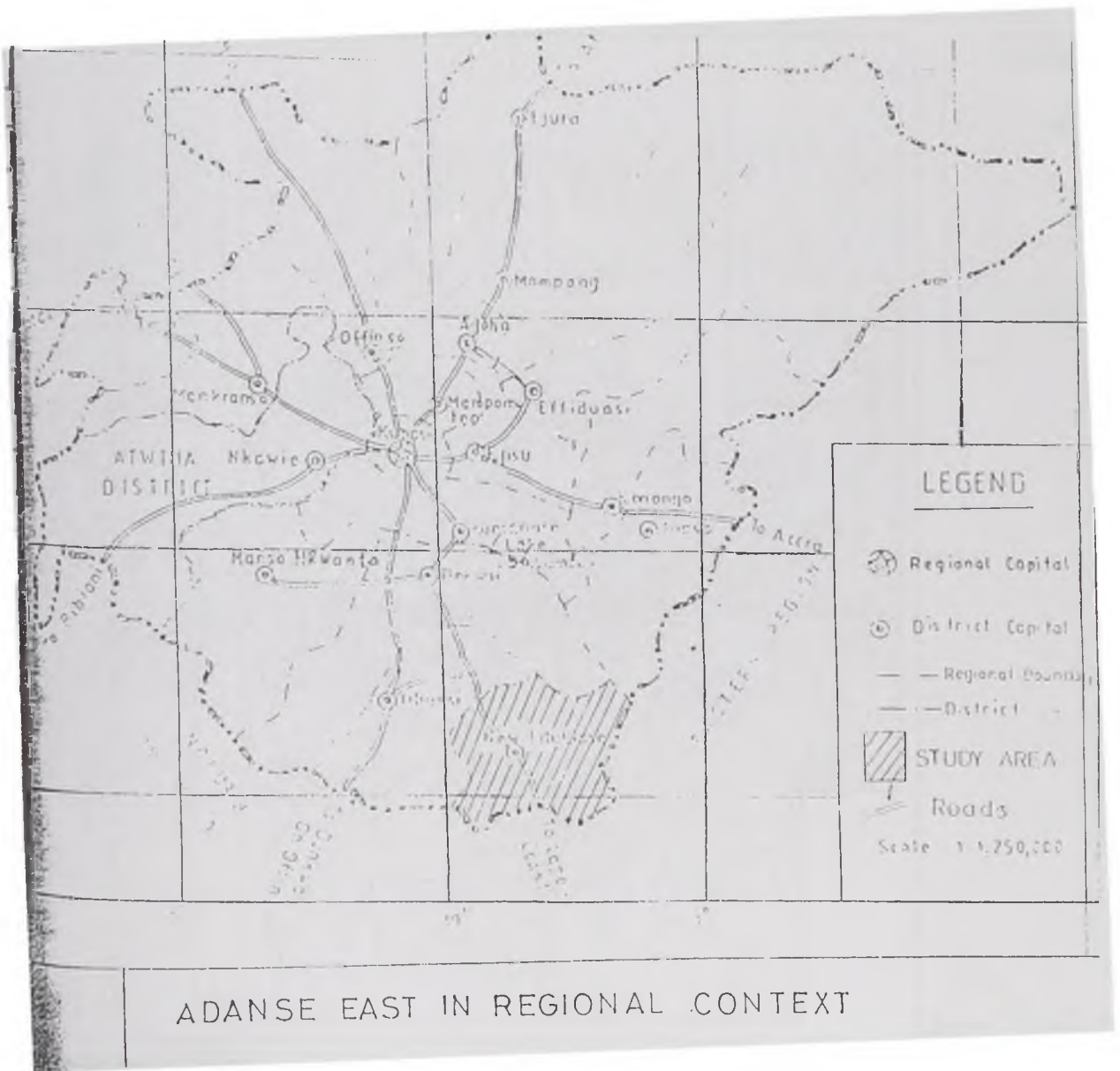
FIG

FOREST RESERVE MAP OF ANANKE EAST DISTRICT

Scale 1: 62500



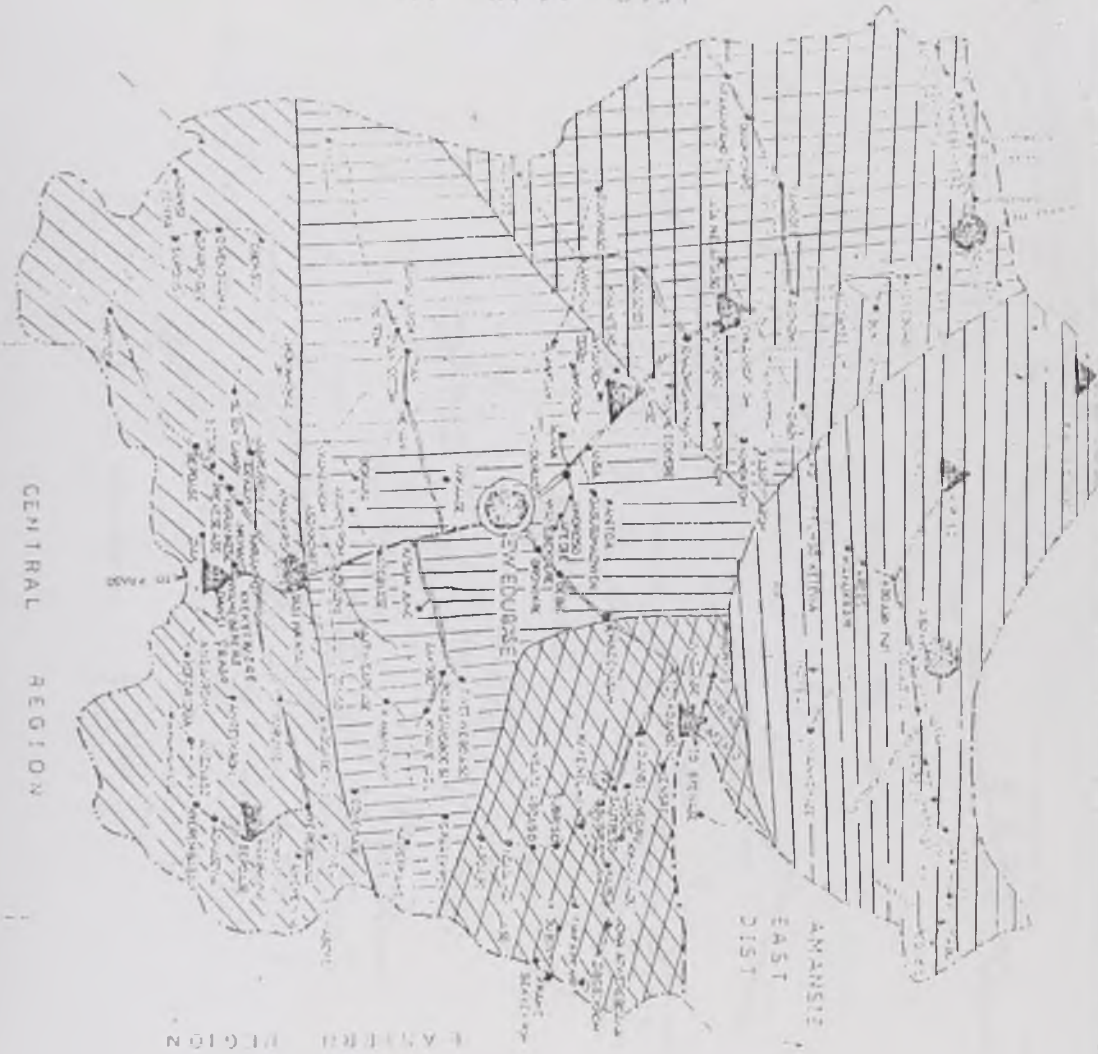
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- 10000 FT. ROAD







ADANSE WEST DIST

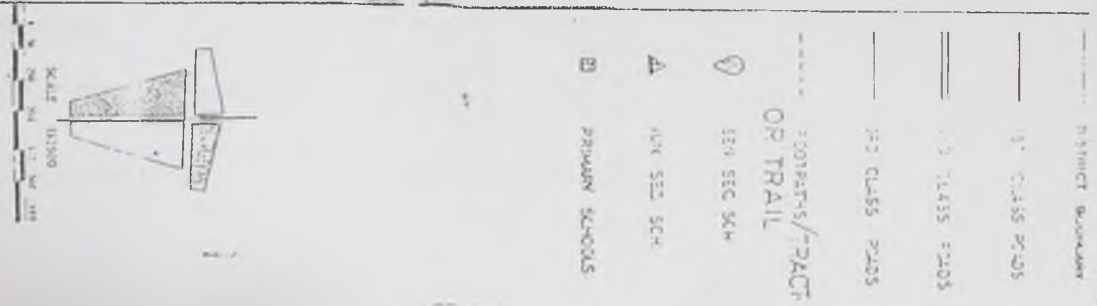
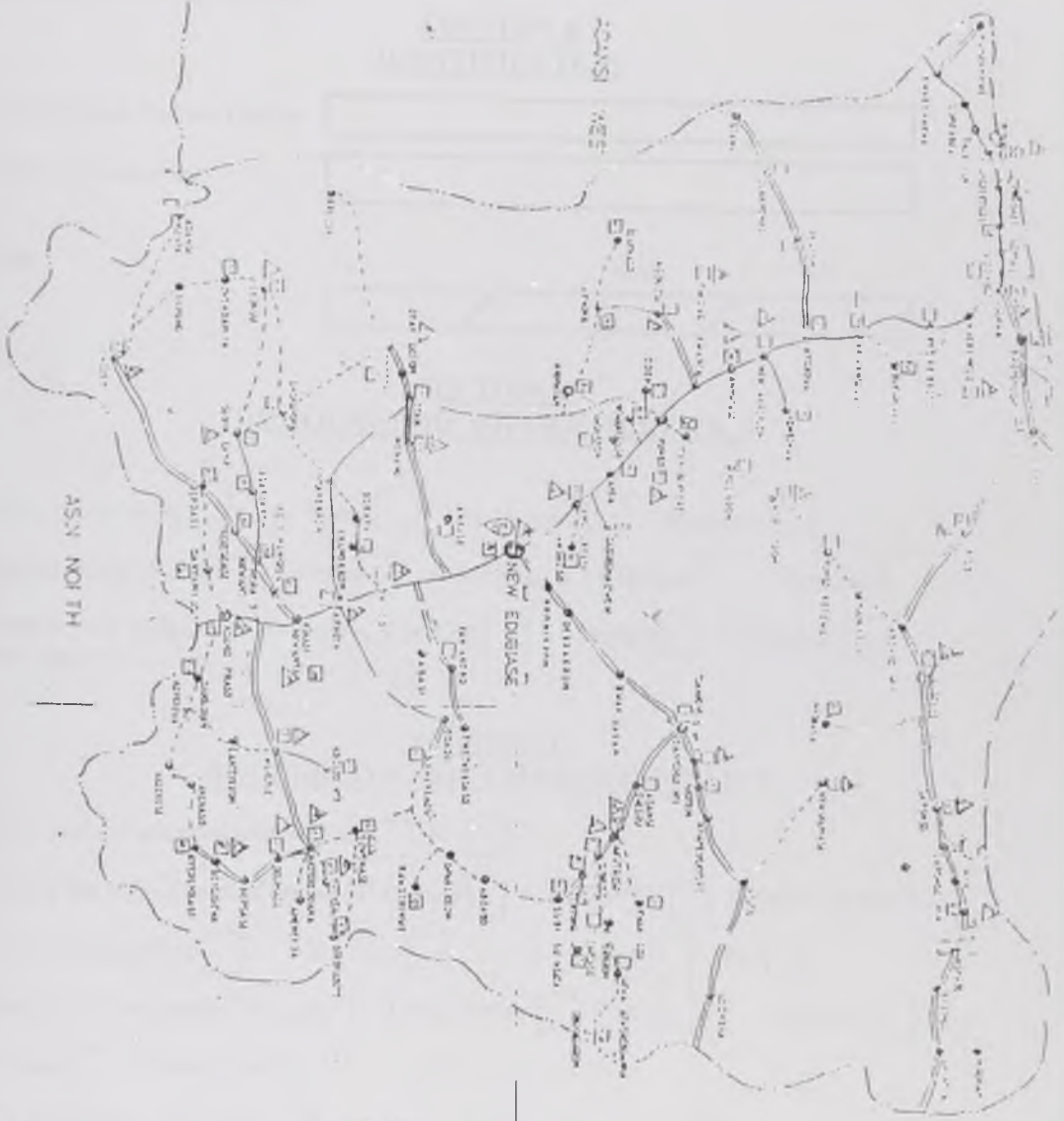


HEALTH FACILITIES LOCATION MAP OF ADANSE EAST DISTRICT

Scale 1:62,500

	Health Centre (Upgraded Health Centre)
	Dressing Station
	MCH/FP (Upgraded Health Centre)
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	Zone 3
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DISTRIBUTION OF EDUCATIONAL FACILITIES



## APPENDIX 2

FACTORS ACCOUNTING FOR LOW SUPERVISED DELIVERY SERVICES INSAMPLE ADANSI EAST DISTRICT  
QUESTIONNAIREQUESTIONNAIRE FOR ALL WOMEN WHO ATTENDED ANTENATAL CLINIC AND  
DELIVERED WITHIN THE PERIOD 1<sup>ST</sup> JANUARY 2001 - 31<sup>ST</sup> DECEMBER 2001*Please, answer all questions*SECTION A  
IDENTIFICATION

1. Name of Sub-District/ Facility
2. Name of Respondent
3. Date  DD  MM  YY

SECTION B  
DEMOGRAPHIC CHARACTERISTICS

4. Age: 15-24 years  25-34 years  35-44 years  45 years +
5. Marital status: Married  Single  Divorced  Widowed  Separated
6. What is your Religious denomination: Christian  Muslim  Traditional   
other (specify).....

SECTION C  
SOCIO-ECONOMIC CHARACTERISTICS

7. Have you ever attended school? Yes  No
8. What is the highest level of education? Primary  Middle/JSS  SSS/Comm/ Voc/Tech   
Post-Sec/ Nursing/Poly  University  Non-Formal  N/A
9. What is your occupation? Farming  Civil servant  Trading  Teaching   
Artisan  Other (specify) .....
10. Please indicate which of the following items you have in your household.
- i. Electricity Yes  No
- ii. Functioning Television Yes  No
- iii. Functioning Fridge Yes  No

- iv. Functioning Radio/Cassette player, Yes  No
- v. Functioning Video Deck Yes  No
- vi. Bicycle Yes  No
- vii. Motor Cycle Yes  No
- viii. Motor Vehicle Yes  No

### SECTION D

#### UTILISATION OF DELIVERY SERVICES

11. At which place(s) did you receive antenatal care during your pregnancy? Hospital   
Health Centre  Community Clinic  Maternity home  TBA  other .....
12. How many antenatal care visits did you make during your pregnancy? 1  2  3   
4  5  6+
13. Why did you go for antenatal care? To get registration card   
To know if baby or foetus is healthy/alive  To get injection (TT)  To receive free medicines   
Other reasons .....
14. For the period 1<sup>st</sup> January 2001 to 31<sup>st</sup> December 2001, did you deliver a baby? Yes  No
15. If Yes, who performed the delivery? Midwife  Trained TBA   
Untrained TBA  Spiritualist  Other (specify) .....
16. Why did you go to this person or facility to deliver?
- i. Distance to health facility convenient Yes  No
- ii. Presence of good doctor/ doctor Yes  No
- iii. Cost of services affordable Yes  No
- iv. Attitudes and conduct of staff good Yes  No
- v. Availability of drugs at facility Yes  No
- vi. Availability of equipments at facility Yes  No
- vii. Convenient Clinic days Yes  No
- viii. Health facility location suitable Yes  No
- ix. Transport cost affordable Yes  No

x. Rapid recovery/cure

Yes  No

xi. Other (specify)

.....

**SECTION E**  
**ACCESSIBILITY**

17. Is there a Public or Private health facility in your community for delivery services? Yes  No

18. Why don't you use this facility?

i. Long distance to health facility Yes  No

ii. Presence of a good doctor/doctor Yes  No

iii. Cost of services not affordable Yes  No

iv. Poor attitude and conduct of staff Yes  No

v. Availability of drugs Yes  No

vi. Availability of equipments Yes  No

19. How much does it cost for one to travel to the health facility and back?

i. Less than ₵1,000 Yes  No

ii. ₵1,000-₵5,000 Yes  No

iii. ₵6,000-₵10,000 Yes  No

iv. More than ₵10,000 Yes  No

20. How long does it take one to get to the health facility?

i. Less than 30min. Yes  No

ii. 30min-less than 1hr. Yes  No

iii. 1-3hrs Yes  No

iv. More than 3hrs Yes  No

21. How long does one wait in the health facility before she can be seen by a midwife/doctor?

i. Less than 30min. Yes  No

ii. 30min-Less than 1hr Yes  No

iii. 1hr – 2hrs Yes  No

iv. More than 3hrs Yes  No

### SECTION F COST OF SERVICES

22. Did you pay anything for registration to see the midwife /doctor and for other medical services provided? Yes  No

23. How much did you pay for the delivery after your discharge? ₵20,000 -₵25,000   
₵30,000 -₵ 35,000  ₵40,000 - ₵45,000  ₵50,000+  Don't know

24. Were you given receipts for these payments? Yes  No

25. Did you pay for any additional fees? Yes  No

26. What were those fees/charges for? Doctor  Midwife  Laboratory fee

Dressing/injection fee  Don't know

27. Were you given receipts for these payments? Yes  No

### SECTION G CLIENT SATISFACTION WITH QUALITY OF SERVICE

1. Please are you satisfied with the services provided at the private or public delivery points in your community? Yes  No

2. Prompt respondent when necessary

What reason do you have for your answer?

- i. Appropriate questioning of patients , Yes  No
- ii. Good clinical examination Yes  No
- iii. Use of diagnostic equipment Yes  No
- iv. Appropriate prescription Yes  No
- v. Drug dispensed rapidly Yes  No
- vi. Proper way injection is administered Yes  No
- vii. Good reception given Yes  No
- viii. Compassion and support from staff Yes  No
- ix. Staff show kindness, respect and politeness Yes  No
- x. Get access to Midwife/Doctor on arrival Yes  No
- xi. Availability of drugs Yes  No
- xii. Availability of equipments Yes  No
- xiii. Cleanliness of facility Yes  No
- xiv. Free services provided Yes  No
- xv. Appropriate method of payment of charges Yes  No