

# **SCHOOL OF PUBLIC HEALTH**

## **COLLEGE OF HEALTH SCIENCES**

**UNIVERSITY OF GHANA**

### **FACTORS INFLUENCING DOMICILIARY DELIVERIES IN THE WEST GONJA DISTRICT**

**PRESENTED BY:**

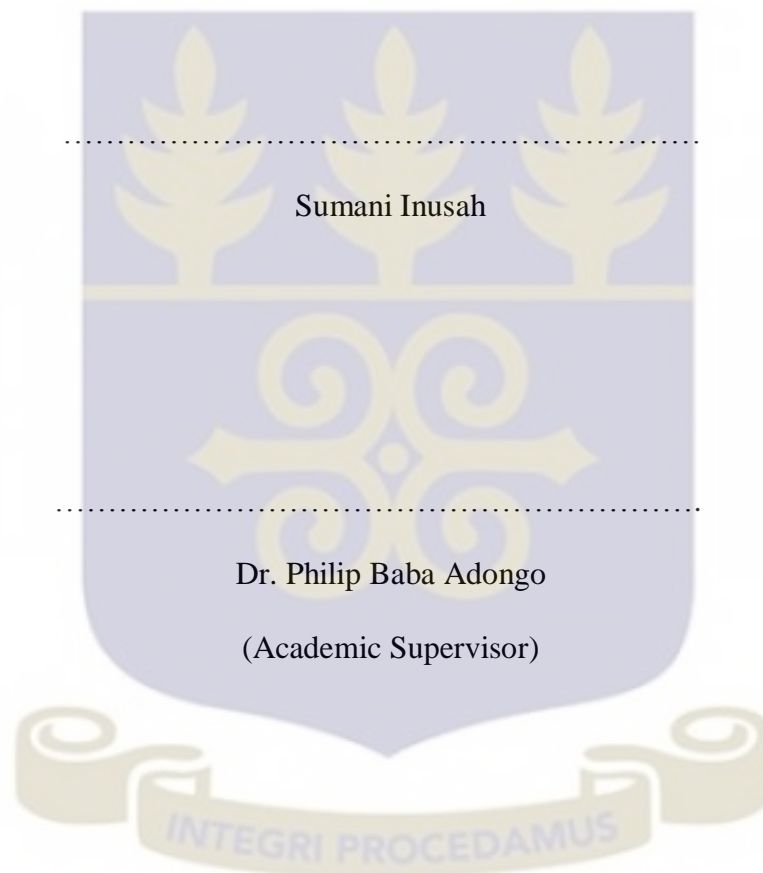
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**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,  
LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD  
OF MSc APPLIED HEALTH SOCIAL SCIENCE DEGREE.**

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## DECLARATION

I declare that with the exception of those works cited and which have been duly acknowledged, every aspect of this work is the result of the research conducted and that, no part of this work has been produced anywhere either partially or fully by anyone for an award.



## **DEDICATION**

This work is dedicated to my father Mr. Sumani Seidu and my mother Ewunio Bakari of blessed memory for their immeasurable care in bringing me up.



## ACKNOWLEDGEMENT

My first and profound appreciation goes to the Almighty God whose divine intervention and guidance has brought me this far in my academic life.

Secondly, my sincere thanks goes to my able supervisor, Dr. Philip Baba Adongo for the fatherly manner in which he handled me throughout this work. To him, I say God will richly bless you for the good criticisms and suggestions offered me in the course of this research.

To be equally acknowledged are my family members particularly my father Mr. Sumani Seidu and my mother Ewunio Bakari. Mum, may your soul rest in the bosom of the Almighty God for you actually lived up to the expectations of a dear mother. My profound gratitude also goes to my brothers and sisters namely, Adam, Mohammed, Sulemana, Fati, Wuriatu and my late brother, Issifu for their constant moral and spiritual support for me to achieve my aims. To all of you, I say, let us strengthen the bond of brotherhood amongst us.

To those whose works have been cited in this research, I humbly acknowledge your invaluable services to me in making my work easy.

Also, I humbly express my heart-felt appreciation to all my friends whose moral, physical and psychological support made it possible for me to carry out my field work. Your role in my movement from one rural community to the other is greatly appreciated.

## ABSTRACT

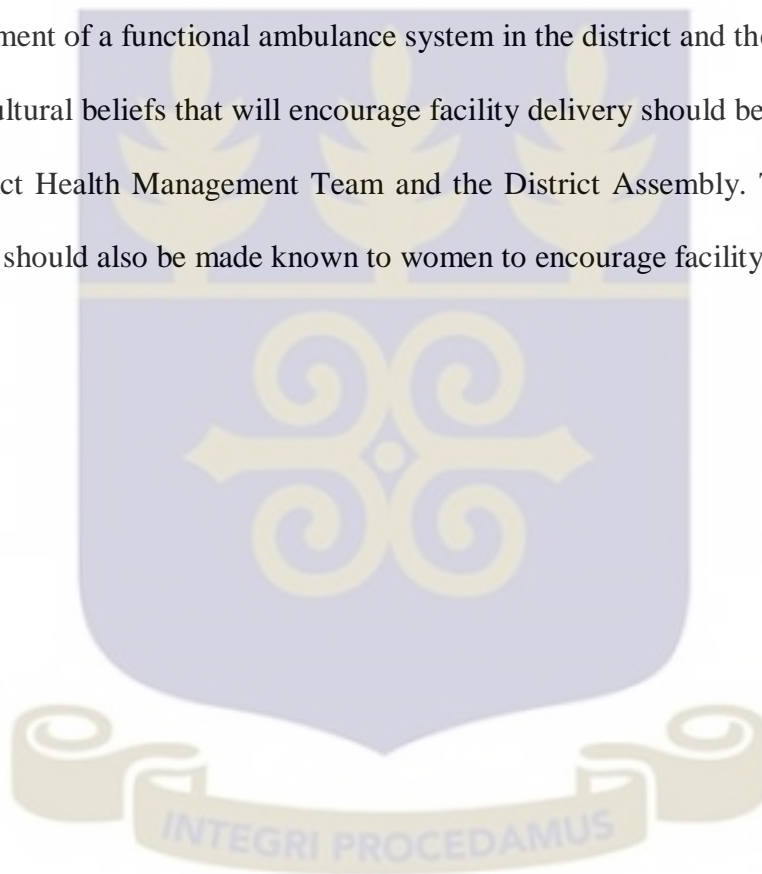
This study was done to explore the factors influencing domiciliary deliveries in the West Gonja District despite high antenatal care coverage in the health facilities. The study sought to: assess the socio-cultural perceptions about the choice of place of delivery, assess the role of cost considerations in women's choice of place of delivery and to examine the institutional and health systems' factors influencing the choice of place of delivery.

A population-based qualitative and quantitative study was used to collect data for the study. A sample of 360 women attending ante-natal clinic at various health facilities participated in the survey. In-depth interviews were conducted with 30 community members including women in their child-bearing age, married men, religious leaders, health workers and Traditional Birth Attendants.

Findings from the study revealed that the majority of the women representing 82.8% preferred to deliver at home because of the following reasons: lack of transport to health facilities, inability to acquire delivery items, proving their faithfulness to their husbands and families, concealing their nakedness, high cost of transport to the health facility, long distance to the facility and the poor attitude of healthcare personnel towards them.

Findings from the qualitative interviews also revealed that, the majority of the women delivered at home because of the poor attitudes of health workers towards them, high transport cost to the facility and inability to buy delivery items needed at the facility.

The development of a functional ambulance system in the district and the education of women on cultural beliefs that will encourage facility delivery should be embarked on by the District Health Management Team and the District Assembly. The policy of free delivery should also be made known to women to encourage facility deliveries.



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## LIST OF ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

ANC: Antenatal Care

ANM: Auxiliary Nurse Midwife

CHPS: Community Health Planning and Services

GDHS: Ghana Demographic and Health Survey

GHS: Ghana Health Service

GMHS: Ghana Maternal Health Survey

GSS: Ghana Statistical Service

HIV: Human Immune Virus

MDGs: Millenium Development Goals

MOH: Ministry of Health

NHIS: National Health Insurance Scheme

SBA: Skilled Birth Attendants

STIs: Sexually Transmitted Infections

TBAs: Traditional Birth Attendants

UNFPA: United Nations Population Fund

WGDHMT: West Gonja District Health Management Team

WHO: World Health Organisation

## CHAPTER ONE

### Introduction

#### 1.1 Background

Reproduction is a right and women are being seen today as people possessing reproductive rights among other fundamental human rights. These reproductive rights include the right to safe motherhood and the right to plan ones family and have access to full and timely knowledge about all aspects of reproductive health and sexuality. In the execution of their reproductive role of pregnancy and delivery, women are exposed to the problem of maternal mortality. Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, 1992). In 1988, the maternal mortality ratio in the developing world was 420 per 100,000 live births in contrast to only 26 in the developed world. An African woman's lifetime risk of dying from pregnancy related causes often exceeds one in 20 whilst the risk of dying as a result of a particular pregnancy in the richest developed country is one in 2,000 (Wallace et al, 1995). What then are the causes of this obnoxious phenomenon in Africa according to Wallace et al are that, the majority of women deliver at home less than 50 percent of deliveries are attended to by a trained health care worker and also, health facilities in rural areas are isolated due to poor infrastructure and communication.

Thaddeus and Maine in their "Three Delays Model" identify delays in seeking, reaching and receiving care as some of the factors contributing to maternal death (Thaddeus and Maine, 1994).

Maternal deaths mostly occur during labour, delivery, or the first 24 hours after delivery and most complications cannot be prevented or predicted (Campbell and Graham, 2006). The high maternal mortality in Africa can be reduced by the provision of skilled care during pregnancy, childbirth, and the immediate postpartum period, by health care professionals with appropriate skills (WHO, 2004a). It must therefore be realised that, this high maternal mortality occurs as a result of low deliveries in health facilities in Africa.

Before 1880, women giving birth in the United State of America were aided mainly by female relatives and birth attendants. Only occasionally were doctors called in to help with difficult labours, but even then the power to make decisions about the birth remained with the woman, her family, and friends (Cecil, 2007). An important component of efforts to reduce the health risks of mothers is to increase the proportion of babies delivered under medical supervision. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and or baby.

The Ghana national health policy and standards document has been revised to provide new focus for improving the quality of health services and for reducing maternal and neonatal morbidity and mortality towards the achievement of the millennium development goal for maternal health. The policy emphasises preventive and promotive aspects of safe motherhood, improving access to obstetric care, increasing coverage of family planning services to reduce the need for family planning and unwanted pregnancies, prevention of unsafe abortion including provision of abortion care services where permitted by law, prevention of reproductive tract infections and STIs including HIV/AIDS (MOH, 2006).

The government of Ghana introduced user fees into the public health system in 1983. The user fees were intended to fill the financing gap in the provision of comprehensive health services and contribute to improving quality of health services. The user fees cover the cost of clinical care including consultations, drugs, non-drugs, consumables and admissions. All maternal health services provided in public health institutions with the exception of the immunisation of pregnant women against tetanus and family planning, attracted user fees under this policy. To reduce the financial barriers to services while retaining the positive elements of user fees, an exemption scheme was instituted against the user fees. The key element to the exemption policy are to promote the use of services of public health importance which are that might otherwise be used sub-optimally while concurrently minimising the cost of care to the poor. Government prioritised the delivery of safe motherhood services and provided exemptions for antenatal care and deliveries in addition to family planning and immunisation (GHS, 2003).

Antenatal care coverage remains at about 90% in all regions in Ghana and the average number of antenatal visits has increased slightly from 3.1% in 2003 to 3.3% in 2004 as against the target of four (4). It appears that the exemption policy, which covers visits continue to contribute to this increases in antenatal coverage. Generally, quality of antenatal care is being improved through the introduction of individualised maternity care. Coverage of supervised delivery (excluding the TBAs), though rising, is still too low at 44.3% with marked regional variation. Supervised delivery coverage for both skilled attendants and trained TBAs for the year 2004 was 53.4% indicating an increase over the 2003 coverage of 52.1%. This could be attributed to the implementation of the exemption for supervised delivery nationwide (MOH, 2006).

Access to professional health care during delivery is considered to be critical for maternal mortality reduction (Seljeskog et al, 2006). Most deaths during the vulnerable periods associated with pregnancy and childbirth occur because of a failure to recognise the seriousness of problems and to make use of available services in good time, together with poor health infrastructures. In many developing countries, health care institutions are inadequate and not easily accessible. However, if there is timely identification and referral of cases at risk by the Primary Health Care services, the limited resources available in institutions can be fully utilised to help those most in need (WHO, 1978).

In Ghana, the antenatal care coverage is 95 per cent. However, this high antenatal attendance does not reflect into high institutional delivery rates. Of this high antenatal attendance, only 57 per cent births are delivered in a health facility and 59 per cent births assisted by a skilled provider (GSS et al, 2009). This disparity between antenatal care attendance and institutional deliveries shows that there are factors that influence domiciliary deliveries, despite information and knowledge about the abilities of skilled health personnel to conduct deliveries and identify high risk pregnancies and referral cases.

In all the regions of Ghana, antenatal care coverage exceeded 90% but this did not match with facility deliveries. The Greater Accra region had 95.7% antenatal coverage with 83.7% of facility deliveries while the Northern region recorded 95.6% of antenatal care coverage with only 26.3% delivering at a health facility (GSS et al, 2009).

The aim of this study is to explore the individual, health facility and community level factors that influence domiciliary deliveries in the West Gonja District.

## 1.2 Statement of the Problem

The patronage of antenatal care services among pregnant women in West Gonja district is as high as 96.7%, but only a small proportion of 27.6% deliver in health facilities (WGDHMT, 2009). Antenatal coverage and deliveries in health facilities are far lower at the national level where antenatal coverage and institutional deliveries are 95% and 57% respectively (GSS et al, 2009). The maternal mortality rate in the West Gonja District is one hundred and six deaths per one hundred thousand live births (106/100000).

In order to reduce this high rate of domiciliary deliveries in the West Gonja District, a number of initiatives should be put in place to promote institutional deliveries by all women who will eventually lead to the safe delivery of a baby whilst maintaining the health of the mother. In the West Gonja District, delivery services are rendered in the hospitals, maternity homes, community clinics, and health centres which constitutes the formal health sector while spiritual healers and Traditional Birth attendants makes up the non-formal health sector. In the West Gonja District, it is a belief among most women that exposing one's nudity to people other than a family relation is a taboo and especially to a younger person. As a result of this, most women who believe that they are older than the health care providers who are mostly the Community Health nurses refuse to seek health care from them with the perception that the nurses should not see their reproductive organs.

Despite the high antenatal care coverage, home deliveries remained higher than supervised deliveries in health facilities. The question then is why do most women receive antenatal care but deliver at home.

The study into the factors influencing domiciliary deliveries, that is the factors contributing to the disparity between the high antenatal and low institutional delivery coverage in health institutions by trained personnel can be used to adopt better strategies that will go a long way to promote health educational programmes and health delivery in an effort to promote the welfare of women in the West Gonja District.

### **1.3 Research Questions**

The study wishes to address the following questions:

1. What social and cultural factors promote delivery at home?
2. Does the existing institutional structure within the health sector encourage home delivery?
3. Are economic considerations important in the choice of place of delivery?

### **1.4 Objectives**

#### **1.4.1 General Objective**

The general objective of the study is to document the health seeking behaviour for pregnancy and delivery in the West Gonja District.

#### **1.4.2 Specific Objectives**

1. Assess cultural and social perceptions about place of delivery.
2. Assess the role of cost considerations in the choice of place of delivery.

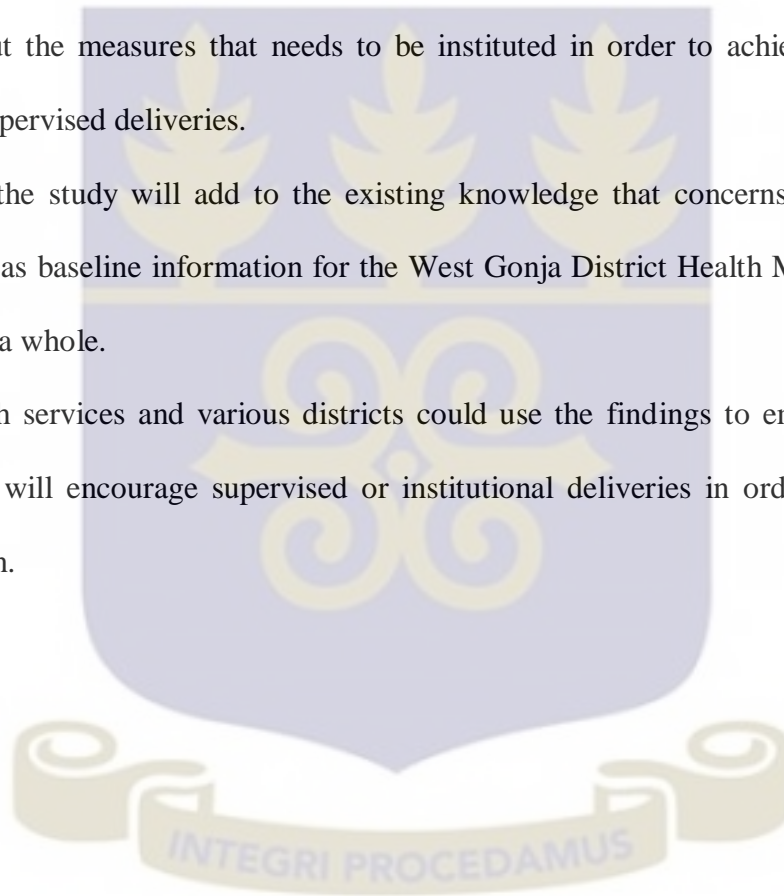
3. Examine institutional and health systems factors which influence the choice of place of delivery.

### **1.5 Justification/Rationale for the Study**

Findings of the study into the factors influencing domiciliary deliveries in the West Gonja District will inform policy makers, the Ministry of Health and the Ghana Health Service and the Community about the measures that needs to be instituted in order to achieve a high rate of institutional or supervised deliveries.

The findings of the study will add to the existing knowledge that concerns child delivery in Ghana and serve as baseline information for the West Gonja District Health Management Team and the nation as a whole.

The Ghana health services and various districts could use the findings to embark on program intervention that will encourage supervised or institutional deliveries in order to improve the welfare of women.



## CHAPTER TWO

### Literature Review

#### 2.1 Introduction

The child-bearing function of a woman, especially in developing countries, has been one that has long been taken for granted as a normal or routine process. It is estimated that, every minute of every day, a woman dies as a result of pregnancy or childbirth somewhere in the world (Wallace et al, 1995). The period of birth is critical in the life of the mother and the baby. Ideally, it needs to be assisted in a competent manner by a skilled birth attendant (SBA) supported by an enabling environment. This goal has yet to be achieved in all countries (Narayanan, 2004). Maternal mortality is one of the most sensitive indicators of the health disparity between richer and poorer nations and the lifetime risk of dying due to maternal causes is about one in six in the poorest countries, compared with about one in 30,000 in Northern Europe (Ronsmans and Graham, 2006). Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO, 1992). With each passing year, over half a million women worldwide die as a result of complications associated with pregnancy and childbirth and nearly 99% of these deaths occur in developing countries which accounts for 88 percent of the world's births (Wallace et al 1995).

It is believed that most deaths of women in their reproductive ages are as a result of maternal mortality.

In Asia and Africa, maternal deaths account for between 21 percent and 46 percent of all deaths of women in the reproductive age, compared with less than 1 percent in the United States. Asia has the highest number of maternal deaths of about one-third of a million with South Asia being worst affected and Africa being the second with an estimated 150,000 deaths each year (Wallace et al, 1995).

In sub-Saharan Africa, over 150,000 women a year die of maternal causes. These losses occur even though the knowledge and means exist to remove or minimise the hazards associated with the process. Yet women die from haemorrhage, infection, obstructed labour, hypertension disorders and abortion, all because of lack of proper care, especially during delivery (MOH Ghana, Annual Report 1994). The causes of high maternal mortality in the regions reflect demographic and socioeconomic factors as well as the inadequacies of health care systems. Pregnant women have little access to health services, are malnourished due to poverty and sociocultural traditions, and are uneducated (Wallace et al, 1995). A challenge in most low and middle income countries means finding ways to enable the many actors in the health sector to address these basic health needs more effectively. Progress on the Millenium Development Goals (MDGs) and on diseases-specific programs depend on the availability of health systems to provide services (David et al, 2009)

Maternal, neonatal and perinatal mortality rates are unacceptably high in most developing countries (WHO, 1994). In addition to the adverse effects on the families involved, these high rates are of serious concern to health workers, planners, political leaders and society as a whole. Most deaths during the vulnerable periods associated with pregnancy and child birth occur because of a failure to recognise the seriousness of problems and to make use of available

services in good time, together with poor health infrastructures (Patel, 1992). In addition, many deaths occur in “at risk” cases in which one or more of the conditions and characteristics considered to be risk factors are present. In many developing countries, health care institutions are inadequate and not easily accessible. However, if there is timely identification and referral of cases at risk by the Primary Health Care Services, the limited resources available in institutions can be fully utilised to help those most in need (WHO, 1994). In developed countries and in “transitional” countries such as Malaysia and Sri Lanka, improvement of delivery care has resulted in reduced maternal mortality. In addition, regions with the highest proportion of deliveries assisted by skilled birth attendants (SBAs) have the lowest perinatal and neonatal mortality rates (Narayanan, 2004).

In an effort to deal with the problem of maternal mortality, proper care during pregnancy and childbirth is important to the health of the mother and child (GMHS 2007, 2009). Antenatal attendance is therefore very important in dealing with maternal mortality since its objective is to identify and treat problems during pregnancy such as anaemia and infections and it is during antenatal care visit that screening for complications and advice on a range of issues including birth preparedness, place of delivery, and referral of mothers with complications occur (GSS et al, 2009).

The Ghana government has introduced the National Health Insurance Scheme (NHIS) as a social protection policy with the objective of improving financial access to quality health services (MOH, 2007). As a result of this social protection policy, pregnant women who received antenatal care from a skilled provider rose as high as 95 percent so that pregnancy-related complications could be identified at an early stage (GSS et al, 2009).

The introduction of the free care for delivery by the previous government in 2008 to cater for all costs involved in the course of labour was a social protection policy in an effort to deal with maternal mortality. In Ghana, 59 percent of births are assisted by a skilled provider with 57 percent of births delivered in a health facility (GSS et al, 2009). These figures are however not homogenous across the countries as some regions records as low as 26 percent of deliveries in a health facility. An important component of efforts to reduce the health risks of mothers and children is to increase the proportion of babies delivered under medical supervision ( GMHS 2007, 2009).

## **2.2 Why Women Prefer Domiciliary Delivery to Institutional Delivery**

People's decisions on which kind of health care to seek is greatly influenced by factors such as economic, geography or location, socio-cultural and the quality of health care provided by the health care system. The quality of health care is the most important factor since people often consider quality first. In most rural communities, a woman with a complicated labour may have difficulty accessing the closest facility because it may be ill equipped to handle complicated health problems.

The various costs involved in delivering in a health facility contribute to the low usage. Ghana has made some progress in reducing poverty levels since 1990. Between 1991/1992 and 1998/1999, the proportion of Ghanaians in extreme poverty declined from 37% to 27%. However, considerable poverty still exists in some areas and pockets in the country. For instance eight out of ten persons in the three northern regions are poor and pockets of extreme poverty exist in urban areas (MOH, 2007).

The total cost of a delivery to a household include direct and indirect costs such as expenditure on food, transport, drugs, tests, blood transfusion, informal care giver's time costs(opportunity

cost ), hospital dues and informal payments such as tips and bribes (Attia K. and Shakila Z., 2010). Access to health services is inadequate in deprived and rural areas and the poor suffer from the catastrophic cost of ill health both from the cost of accessing services and from productive days lost (MOH, 2007).

The fear for a caesarean section is seen as a factor influencing domiciliary deliveries. When comparing women with low-risk pregnancies, women who give birth at home are less likely to have episiotomies, C-sections, and all other forms of medical interventions than women giving birth in hospitals. Low-risk pregnancies had infant death rates of 2.0 per 1,000 for home birth and 2.2 per 1,000 for hospital birth. Only 3% of low-risk mothers intending to deliver at home end up with C-sections, compared with 8-27% of low-risk mothers delivering in the hospital (Barclay, 2005). By keeping mother and child together immediately after birth, home birth promotes bonding and breast-feeding. Advantages of early breast-feeding include helping the mother to stop bleeding, clearing mucus from the baby's nose and mouth, and transferring disease-fighting antibodies in the milk from mother to baby (Barclay,2005).

### **2.3 Accessibility to health facilities**

The factors responsible for the geographical access include inadequate investments in health facilities relative to need, hard-to-reach communities, sub-optimal spatial distribution of health facilities and lack of communication equipment (MOH, 2007). 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).

In many developing countries, Skilled Birth Attendants (SBAs) assist less than 50% of births. In certain areas, especially in those with difficult terrain or socio-cultural factors that hinder the acceptance and utilization of skilled birth attendants, SBAs assist less than 10% of births (Narayanan et al, 2004).

Ideally, SBAs should be available to assist in childbirth both at the facility level and at home. Historically, however, SBAs have been available primarily at facility levels.

With the exception of areas that have qualified private providers, it is difficult to support fully qualified SBAs with the necessary equipment and supplies in areas close enough to homes. This is especially the case in rural areas. Often, roads are non-existent or in disrepair, and safe transportation to take the SBA to the expectant mother's home is grossly inadequate. Except in selected places, deliveries assisted by true SBAs are mostly facility-based (Narayanan et al, 2004).

In Sub-Saharan Africa, where nearly half of the world's maternal deaths occur, only 46% of deliveries are assisted by skilled attendants. In Southern Asia, the proportion is even lower (Narayanan et al, 2004).

Enormous disparities remain within countries: Impoverished and rural women are far less likely than their urban or wealthier counterparts to receive skilled care during childbirth. In rural areas health clinics and hospitals are often spread out over vast distances and transportation systems are often rudimentary. That is one of the reasons why UNFPA supports increasing the number of community-based midwives, and strengthening district-level health systems to provide backup support (UNFPA, 2010).

## 2.4 Socio-cultural considerations

The different roles and responsibilities of men and women, inequalities in access to resources and lack of information are reflected in their health-seeking behaviours and subsequent vulnerability of women to illness and quality of care available to them (MOH, 2007).

Tsui et al (1997) state that with respect to obstetric care, it is often the family and not the woman alone who makes these decisions. They further stressed that men are the obvious target audience because, in many cases, they control the cash reserves or their permission needs to be obtained for obstetric care-seeking (Dallabetta et al, 1997).

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 to seek care 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).

The gender of the birth attendant influences whether childbearing women and their families will accept assistance from the birth attendant. In Senegal, skilled attendants such as nurses are available at peripheral centers, but many of these nurses are male. Women in traditional societies, especially in rural areas, often prefer to be attended by female health workers (Narayanan et al, 2004).

According to Barclay, some women believe that having their babies at home is beautiful, inspiring and awesome and it offers them complete freedom of movement and absolute choice in everything that they want to do. Most women have the feeling that, being able to relax in a

familiar, comfortable environment surrounded by those you love decreases anxiety, which in turn decreases pain (Barclay, 2005). Studies have shown that, women who feel anxious or stressed release more adrenaline, a hormone that interferes with labour (Barclay, 2005).

The real benefits of home birth cannot be measured in dollars or in statistics. Mother-child bonding, parenting, breast-feeding, and infant health may all be enhanced by the home birth experience. Women believe that, delivery is a family-centred event and those first early hours of delivery are so precious. Women always believe that, at the delivery period, you are bringing a baby into a home full of love rather than a hospital full of germs (Barclay, 2005). Mothers and babies may be exposed to more types of disease-carrying organisms in the hospital environment, particularly in the nursery where all newborns are clustered together. While the home environment is hardly sterile, at least the mother has been exposed to the same organisms before and may have built up immunity against them (Barclay, 2005).

## **2.5 Health care system considerations**

Health providers in the public and private sectors as well as the formal and informal sectors, play key roles in delivering health interventions. Some are efficient, delivering high quality services and being responsive to the needs of their patients and clients. But many are not. Many SBAs have had some pre-service training in care of the mother, but for most, competence achieved in newborn care is, at best, inadequate. Moreover, in some countries, even after formal training in midwifery, an SBA at the peripheral level is responsible for an overwhelming number of duties

that often have no relevance to childbirth. As a result, the SBA may conduct deliveries infrequently and is likely to forget some of the skills (Narayanan et al, 2004). An auxiliary nurse midwife (ANM) in India, for example, has family planning and immunization responsibilities

that have no connection to childbirth and care of the newborn infant. Many do not stay near enough to village homes to easily attend deliveries. Transportation is poor and the ANM is not always equipped with the supplies to efficiently care for the mother and baby at birth (Narayanan et al, 2004).

Furthermore, health providers in both the formal and informal sectors are not adequately regulated. Quality implies that services take into account and are responsive to the needs and preferences of users, particularly women and the characteristics of a high quality programme include: easy access to information, technical competence of service providers; positive interpersonal relations between users and providers and an appropriate constellation of services (Wallace et al, 1995). In Ghana, shortages of equipment, consumable supplies and some essential drugs undermine facility functioning, damage reputations, inflate out-of-pocket costs to patients and fuel a spiral of distrust and alienation. Also, huge gaps in staffing of frontline health facilities make reliable, quality services virtually unattainable. Some clinics stand empty while others are overcrowded and health service users routinely complain of abusive and humiliating treatment by health providers.

The quality of health service is constrained by absence of comprehensive standards and norms, weak organisational and management capacity, weak support systems such as transportation and equipment for service delivery, inadequate numbers and poor distribution of human resources.

The exodus of critical health professionals in recent years is undermining efforts to improve access (MOH, 2007).

## CHAPTER THREE

### Methodology

#### 3.1 Introduction

This chapter explains the research methodology and discusses the data collection methods and justification of selected research techniques. The contribution of primary, secondary, qualitative, and quantitative methods of data collection are demonstrated here. The chapter starts with a background to the study area, the research population, design, discusses the choice sample and size, the types of data used in the analysis, and the data analysis techniques adopted and concludes with how these results were presented to readers. It further explains the kind of sampling procedures employed and offered information on how the collected data was analysed.

#### 3.2 Background to the Study Area

The West Gonja District is located in the Northern Region of Ghana on longitude 1°5' and 2°58' west and latitude 8°32' and 10°2' north. It is bounded by the Central Gonja District in the south, Bole and Sawla-Tuna-Kalba Districts in the West, East Gonja District in the East and Wa East District in the North. The West Gonja District has a population of 139,329 with a population density of 8.3 persons per square kilometre which is below the regional population density of 25.3 persons per square kilometre. The district's population growth rate of 3.1% is higher than the national and regional growth rates of 2.7% and 2.8% respectively (GSS, 2001).

Of the total population of this district, there are 70,166 males representing 50.3% and 69,213 females representing 49.7% of the population. The sex ratio in the district is 103 males to 100 females and this is due to females being more mobile and migrates outside the district than their male counterparts.

The West Gonja District has in one of her priorities the delivery of good health in the area of reproductive and child health to her citizens. Based on this, the district has 8 health institutions that are rendering reproductive and child health services in the district. The institutions include the West Gonja Hospital which serves as the district hospital and jointly owned by the district and the Roman Catholic mission, the Damongo Poly Clinic, Health centres at Busunu, Daboya, Mole, Bawena, Mankarigu and a Community Health Planning and Services (CHPS) Compound at Lingbinsi.

The main economic activity of the West Gonja District is agriculture which is mainly peasant farming. According to the 2000 population and Housing Census, the agricultural, animal and forestry sectors of the district accounts for 81.5% of the economically active population or the labour force. Farming continues to be the major economic activity undertaken by over 60% of the total labour force and the major crops cultivated are yam, cassava, cereals (millet, sorghum, maize and rice), and legume made up of beans, groundnuts, neri, cowpea and soyabeans).

The cultivation of vegetables such as tomatoes, okro and pepper is mainly done by women. However, due to the erratic nature of the rains in the savanna region coupled with land degradation, yields are drastically falling and this may make food security in the area very fragile and unsustainable in the years to come if measures are not taken to arrest the situation. Apart from the agricultural sector, other occupations such as professional and technical, administrative and managerial, clerical and related workers, sales workers, service workers, production and transport and other labourers have each accounted for less than 6% of the economically active population or labour force (GSS, 2001). Hunting is an important economic activity in the District especially among communities bordering the Mole National Park. On the employment status of

the economically active population, the West Gonja District has 71.5% of the labour force who are self-employed, 21.6% who are unpaid family workers, 4.4% who are employees and 2.5% who falls within other employment categories (GSS, 2001).

On industrial activities, less than 15% of the labour force is in the industrial sector with males dominating this sector. The industries are the cottage – types using traditional skills, simple tools and are mainly family businesses. These industries include handicrafts, baskets and mats weaving, metal and woodwork. Agro-based industries also abound in the district with women dominating the food processing activities such as, gari, starch and kokonte district wide. Damongo is renowned for its quality gari in the northern sector. Other industries include textiles and leather works.

The District gain economically from its several tourist attractions prominent among which are the Mole National Park, the Ancient Mosque and Mystic Stone at Larabanga and several others. The Mole National Park which is located about 30km West of Damongo, is the largest in the country and one of the best managed game and wildlife parks not only in Ghana but Africa, South of the Sahara desert. The Park covers an estimated area of about 5500 hectares and it is the home of an array of flora and fauna. This brings in a lot of foreign exchange to the district and in 2004, 10,427 people visited the park.

### **3.3 Study Population**

The study population was women who attended antenatal at health facilities and delivered at home and at health facilities within the period 1<sup>st</sup> January, 2009-31<sup>st</sup> December, 2009. This period offered enough data on deliveries in the district. This antenatal care should have been

received at a health facility.

Key informant interviews were carried out in each of the three communities of the health institutions. Two informants each from each of the following categories in the locations of the three health institutions were interviewed. These categories were:

- Married men
- Religious leaders (Priests/ Imams/ Spiritualists)
- Health workers (Midwife/Doctor/ Public Health Nurse)
- Women in their child-bearing age
- Traditional Birth Attendants (Trained/Untrained).

These key informants were interviewed individually for their views on the factors influencing domiciliary deliveries in the West Gonja

### **3.4 Study Design**

The study design was a cross-sectional survey that utilised structured questionnaires and indepth interviews to find the factors that influence domiciliary deliveries in the West Gonja District despite high antenatal care coverage in health institutions.

### **3.5 Variables**

The independent variable is the high level of domiciliary deliveries.

The dependent variables are:

1. Age
2. Marital status
3. Educational level
4. Religion

### 3.6 Sampling Procedure

The study was a cross-sectional study that looked at women who received antenatal care at health facilities and chose to deliver at home or at a health facility.

In the West Gonja District, there are eight health facilities that offer antenatal care and supervise deliveries. They are:

- One district hospital at Damongo,
- One Poly clinic also in Damongo,
- Five health centres at Busunu, Daboya, Mankarigu, Bawena and Mole
- One Community Health Planning and Services (CHPS) Compound at Lingbinsi.

Based on this set- up, separate sampling frames were prepared from the hospital and the health centres. The CHPS Compound was excluded from the sampling frame because it was recently opened less than a year ago.

In selecting the sampling frame, the only district hospital was purposely selected from that level of the study since it recorded much of the antenatal care coverage of the district. Through balloting, the Busunu and Mole health centres were chosen and samples drawn from them.

On the Child Welfare Clinic days at each of these respective health institutions, sampling frames were prepared from Child Welfare Clinic records of women who delivered within the period January 1<sup>st</sup>-December 31<sup>st</sup>, 2009 from the three selected health institutions. Mothers who did not attend the Child Welfare Clinic were difficult to trace due to the short duration of the research. After this, through random sampling, the mothers were selected and interviewed.

Based on an estimated level of 50% fertility rate and a confidence level of 95%, with a worse acceptable result of 45%, a minimum of 360 women were selected for the study using Epi Info

version 3.5.1. Given that some of the respondents may be absent or due to non-response, a total respectively had 200, 80 and 80 respondents selected from them.

### **3.7 Data Collection Techniques**

In the collection of data, a review of Child Welfare Clinic records at the respective health institutions was done to obtain the sample of mothers who delivered at home and at a facility. A date was arranged on which structured questionnaires were administered on them. The collection of both quantitative and qualitative data was carried out from June –July, 2010 with the help of two research assistants who 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 elimination of information bias. Structured questionnaires were used in interviewing women who delivered from January 1<sup>st</sup> –December 31<sup>st</sup> 2009 for the quantitative data whilst an interview guide was used in carrying out an in-depth interview of the key informants.

### **3.8 Quality Control**

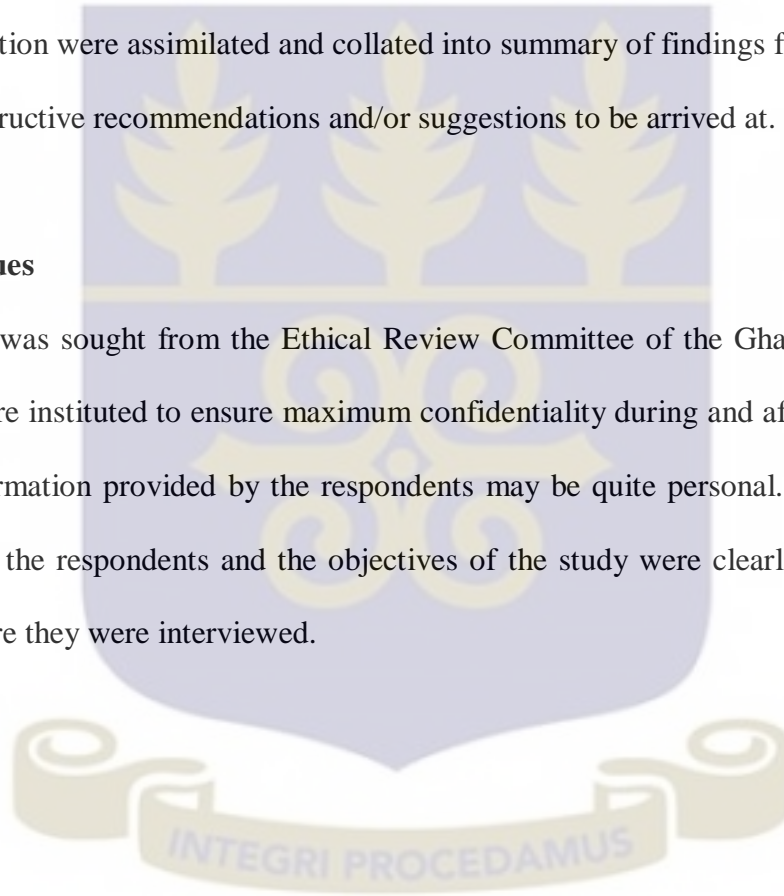
Twenty five (25) questionnaires and an Interview guide were pre-tested at the Bawena health centre and changes were made to the content and format of the questionnaires and interview guide where necessary for the smooth collection of data at the 3 localities of the health institutions. Research Assistants were trained in questionnaire administration, interpretation of questions into the local languages and on ethical issues.

### **3.9 Data Processing and Analysis**

The primary data collected from questionnaires and interviews were coded and analysed using the Statistical Package for Social Sciences (SPSS) software and displayed in the form of percentages, bar graphs, pie charts, and other pictorial form. This is intended to make understanding of the facts easier. The outcomes are backed by explanatory notes and descriptive assessment to enhance clarity of the results and ease understanding of the study findings. These pieces of information were assimilated and collated into summary of findings for the study which allowed for constructive recommendations and/or suggestions to be arrived at.

#### **3.9.1 Ethical Issues**

Ethical approval was sought from the Ethical Review Committee of the Ghana Health Service and measures were instituted to ensure maximum confidentiality during and after the study since some of the information provided by the respondents may be quite personal. Informed consent was sought from the respondents and the objectives of the study were clearly explained to the respondents before they were interviewed.



## CHAPTER FOUR

### Research

#### 4.1 Introduction

This section of the study comprises the data analysis and interpretation of results. Statistical and descriptive analyses are used to present the responses from the women sampled for the study. It presents the information in the following format:

1. The socio-demographic characteristics of the respondents,
2. Decisions and discussion about pregnancy and place of delivery,
3. Women's preferred place of delivery,
4. Socio-cultural beliefs that influence women to deliver at home,
5. Financial factors influencing decision to deliver at home and
6. Institutional and health system factors that influence choice of place of delivery.

#### 4.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Findings from the study revealed that most of the respondents were between the ages of 25 – 34 years, representing 43.1% (155) of the total responses. This is followed by those aged 35-34 years, representing 32.8% (118). About 17.2% (62) of the respondents were aged 15-24 years whilst those who were 45 years and above were 6.9% (25).

In terms of religious denominations, 85.8% (309) of the respondents were Moslems, 13.6% (49) of them were Christians whilst the traditional religion and other faiths were 0.3% (1) each.

Findings from the study revealed that, most respondents did not have any formal education. This is indicated by 60.8% (219) of the respondents. Those with middle or Basic Education Certificate represented 15.8% (57).

The majority of the respondents representing 47.2% (170) were into trade activities. The rest are mostly into such other activities as farming (14.2%), teaching (11.4%), Artisan work (8.9%), civil servants (2.2%), and the remaining comprise workers in other occupations and those who are unemployed.

On the marital status of respondents, as high as 86.4 % (311) of them were married, 4.7% (17) of them were single parents, 3.6% (13) of them were divorced while 3.1% (11) and 2.2% (8) of them were widowed and separated respectively.



**Table 4.1: Socio-demographic characteristics**

<b>Background characteristics</b>	<b>Frequency</b>	<b>Percent</b>
<b>Age</b>		
15-24	62	17.2
25-34	155	43.1
35-44	118	32.8
45+ years	25	6.9
<b>Marital status</b>		
Married	311	86.4
Single	17	4.7
Divorced	13	3.6
Widowed	11	3.1
Separated	8	2.2
<b>Level of education</b>		
Primary	26	7.2
Middle/JSS	57	15.8
SSS/Voc/Tech	29	8.1
Post sec/Nursing/Poly	13	3.6
University	16	4.4
None	219	60.8
<b>Religion</b>		
Moslem	309	85.8
Christian	49	13.6
Traditional	1	0.3
Others	1	0.3
<b>Occupation</b>		
Trading	170	47.2
Farming	51	14.2
Teaching	41	11.4
Artisan	32	8.9
Civil Servant	8	2.2
Others	58	16.1

**Source:** Field survey, 2010.

#### **4.3 Decision and discussion about pregnancy and place of delivery**

Findings from the study revealed that majority of the respondents, representing 93.6% (337) attend antenatal clinics. However, some women, represented by 5.6% (20) said that they visited

traditional birth attendants. The remaining 0.8 percent revealed they usually visit a spiritualist for advice and prayers. These are shown in table 4.2.

**Table 4.2: What women do when pregnant.**

Action	Frequency	Percent
Attend antenatal clinic at a health facility.	337	93.6
Consult Traditional Birth Attendants	20	5.6
Consult Spiritualists	3	0.8
Total	360	100

**Source:** Field Survey, 2010.

The qualitative interview revealed that, child bearing is a hectic process which demands God's intervention during the process. An informant said, *"During the process of child delivery, one is closer to one's grave; delivery time is the dangerous time of a woman's life"*.

The respondents were given the liberty to indicate as many places as they would prefer to deliver. Their responses are displayed in Table 4.3.

**Table 4.3: Preferred place of delivery**

Preferred Place	Frequency	Percent
Home	298	82.8
Clinic	193	53.6
Hospital	187	51.9
Spiritual home	27	7.5

**Source:** Field Survey, 2010  
(Multiple responses allowed)

From Table 4.3 above, 82.8% (298) prefer to give birth at home. Another 53.6% (193) preferred to give birth in a clinic and 51.9% (187) of them preferred the hospital whilst 7.5% (27) mentioned the spiritual home.

Findings from the study showed that, 74.2% (267) prefer to deliver at home because of lack of

transportation to the available health facilities, 16.7% (60) cited their inability to afford items usually required for delivery at a health facility, 9.7% (35) wanted to prove their faithfulness to their husbands since some husbands feel their wife's nakedness should not be seen by many others especially male nurses and lastly, 3.9%(14) preferred the home to prevent people who are not close relations from seeing their nakedness.

The study also revealed that 49.7% (179) of the respondents preferred to deliver at the hospital as a result of the distance to the hospital being convenient, 24.2% (87) also stated that they would choose to deliver their children at the hospital if the attitude of health workers towards women in labour is favourable while 20% (72) said when the cost component of the services provided for them is reduced to affordable levels. When the delivery facilities prove to be available and better was chosen by 11.4% (41).

The findings of the study also indicated that, 38.6% (139) would prefer delivery at a clinic if there are drugs in the clinic, 28.6% (103) preferred it due to its proximity to the community, 15%(54) chose the clinic due to the availability of midwives while 15.3% (55) preferred it due to the favourable attitude of health workers. Another 8.9% (32) said affordable transport cost influenced them to deliver in the clinic.

The study also revealed that 34.7% (125) of the women go to the spiritual homes when delivery is delayed for over nine months, 33.3% (120) said they deliver in the spiritual home due to their inability to conceive long after marriage.

Another 19.4% (70) prefer to deliver at a spiritual home where the spirits will protect the new born baby from death while 10.6%(38) said they would deliver at a spiritual home when labour starts earlier than 9 months. The wish for a male child or female child in particular when they get

pregnant was the view of 2.2% (8) of the respondents who believe that, delivering at a spiritual home will let them get their wishes and 1.9% (7) of the respondents revealed that, they would also go to these spiritual homes if that is the nearest delivery centre.

**Table 4.4: Reasons for choice of place of delivery**

	<b>Frequency</b>	<b>Percent</b>
<b>Reasons for delivery at home.</b>		
Lack of transport.	267	74.2
Inability to acquire delivery items.	60	16.7
Prove faithfulness to husband and family.	35	9.7
To conceal her nakedness.	14	3.9
<b>Reasons for delivery at a hospital.</b>		
Convenient distance to the health facility.	179	49.7
Attitude of health workers are favourable.	87	24.2
Affordable cost of delivery services.	72	20
Availability of quality delivery facilities.	41	11.4
<b>Reasons for delivery at a clinic.</b>		
Availability of drugs at the clinic.	139	38.6
Proximity to the clinic.	103	28.6
Attitude of health workers are favourable.	55	15.3
Availability of midwives.	54	15
Affordable transport cost.	32	8.9
<b>Reasons for delivery at a spiritual home.</b>		
When delivery is delayed.	125	34.7
Inability to conceive for a long time after marriage.	120	33.3
Death of infants after each delivery.	70	19.4
When labour begins earlier than nine months.	38	10.6
The wish for a male or female child.	8	2.2
Proximity of the spiritual home.	7	1.9

**Source:** Field survey, 2010.  
(Multiple responses allowed)

#### **4.4 Beliefs that Influence Women to Deliver at Home**

The findings from the study showed that, 22.2% (80) of the respondents believed that, to prove they are faithful to their husbands, they had to deliver at home. Seventy (19.4%) of them revealed that people who are not their close relatives should not see their nudity because that is the preserve of their husbands and close relations when necessary. Also, 18.6% (67) of them were under the belief that fees charged for delivery services at the healthcare facilities are quite high, especially for those who do not have the health insurance while 10.6% (38) of the respondents revealed that many of the healthcare workers are not qualified to do their jobs. Another 10.3% (37) of the respondents cited the avoidance of a caesarean section and 6.4% (23) of the respondents believe that one is better off delivering in the midst of relatives.

The qualitative interview revealed the views of religious leaders on the socio-cultural beliefs that encourage deliveries at home. A spiritualist at the Busunu community when asked the beliefs that do not allow women to deliver at the health facility had this to say; *“women who are not faithful to their husbands go to give birth at the hospital, faithful ones always give birth at home because the gods are good to them”*. Another belief that was mentioned by the informants was to prevent other people from seeing the private parts of their wives.

#### **4.5 Knowledge of Public Health Facilities for Child Delivery in the Community**

Findings from the study showed 82.8% (298) of the respondents have knowledge of the existence of public health facilities in their communities. The remaining 17.2% (62) of the respondents indicated that they do not have any knowledge of the existence of public health facilities in their communities.

#### 4.6 Reasons for Low Patronage of Public Health Facilities When in Labour

Findings from the study showed that 37.8% (136) of the respondents did not go to the hospital to deliver because of the poor attitude of healthcare workers towards pregnant women, especially those in labour. Also, 25% (90) of the respondents revealed that most of the healthcare facilities are quite distant from their homes, hence, their delivery at home.

Another 17.8% (64) of the respondents also said they did not deliver at hospitals because they could not afford delivery fees. This was the response of those who are mostly not under the National Health Insurance Scheme. The absence of a qualified midwife at the Public health facility was mentioned by 6.1% (22) of the respondents. They therefore prefer to deliver at home with the help of ‘experienced’ traditional birth attendants whom they usually know and can trust. The remaining 12.5% (45) respondents did not respond to this question.

#### 4.7 Mode of Transportation of Pregnant Women to Health Facilities When in Labour

The study revealed that 76.1% (274) went to the healthcare facility by an ambulance or by a lorry. Another 23.6% (85) of the respondents also said they sometimes go by motorbikes whilst 3.9% (14) and 0.8% (3) went by foot and bicycle respectively.

**Table 4.5: Mode of transport to and from the health facility**

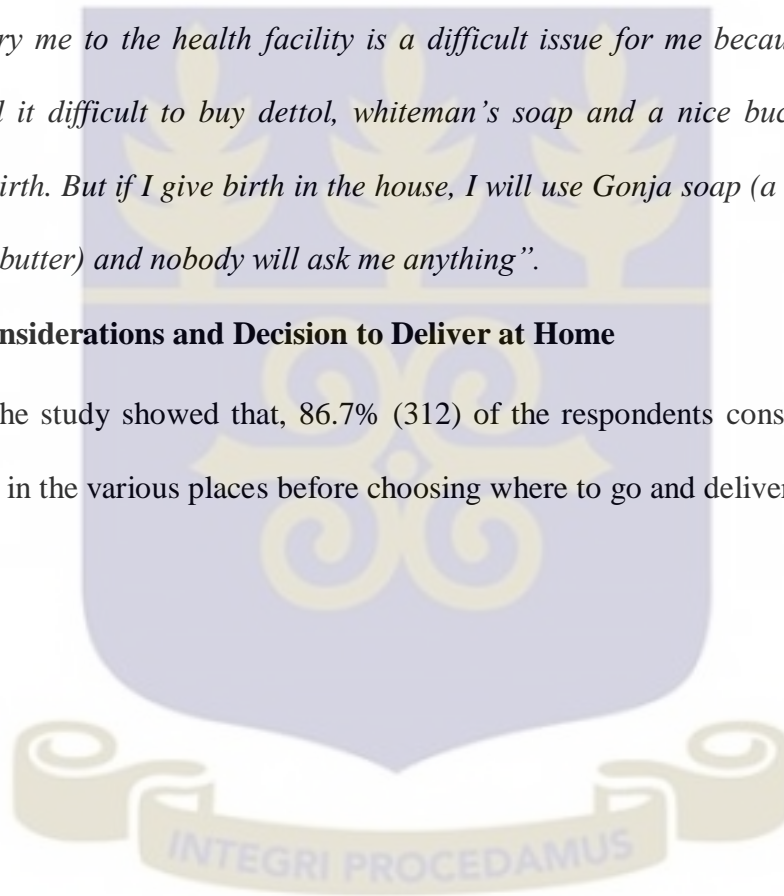
Mode of transporting women in labour to health facilities	Frequency	Percent
By an ambulance or lorry	274	76.1
By a motorbike	85	23.6
By foot	14	3.9
By a bicycle	3	0.8

**Source:** Field Survey, 2010.  
(Multiple responses allowed)

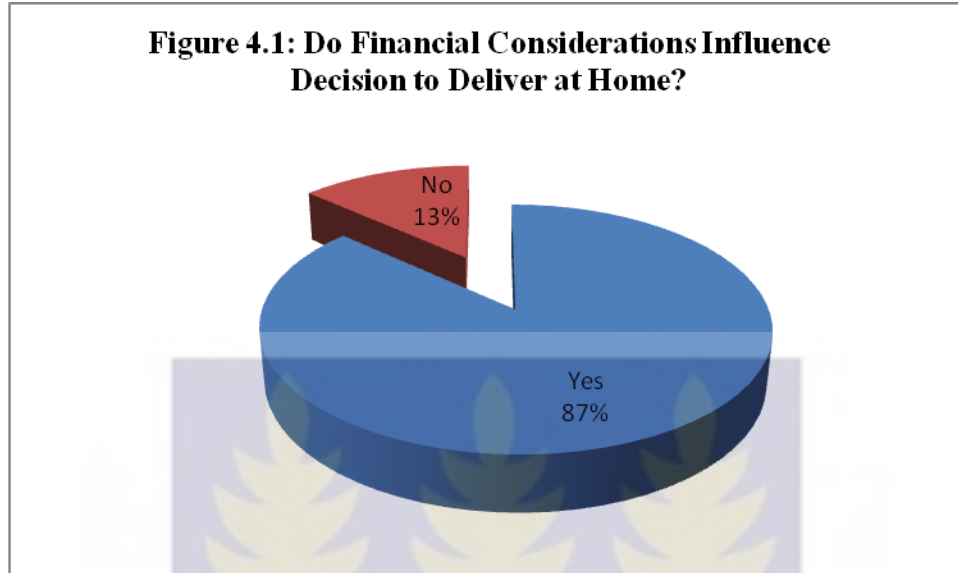
The qualitative interview revealed a lorry or an ambulance, a motor bike and sometimes walking as the various modes of transporting a woman in labour to a health facility. Most of the informants were of the view that, transportation plays a greater role in people delivering at home. A woman in her child-bearing age said; *“holes are all over the roads and if you are not lucky, your baby would come out before you get to the health centre; because of this I always want to give birth in the house. Buying of petrol which is around six Ghana Cedis into someone’s motorbike to carry me to the health facility is a difficult issue for me because I don’t do any work; I also find it difficult to buy dettol, whiteman’s soap and a nice bucket to take to the hospital to give birth. But if I give birth in the house, I will use Gonja soap (a local form of soap made from shea- butter) and nobody will ask me anything”*.

#### **4.8 Financial Considerations and Decision to Deliver at Home**

The findings of the study showed that, 86.7% (312) of the respondents considered the relative cost of delivering in the various places before choosing where to go and deliver. The rest of the



13.3% (48) said they did not consider financial factors before taking their decision.

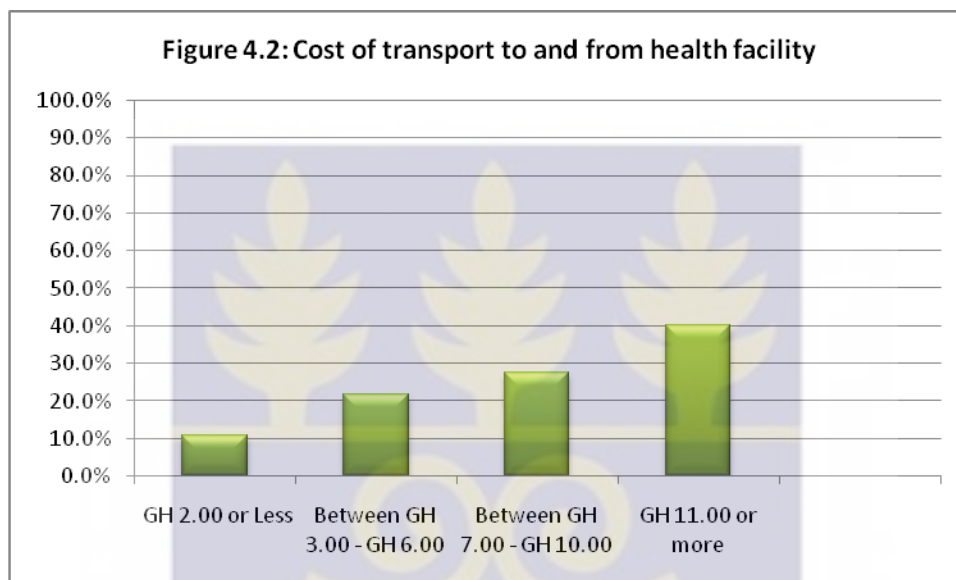


**Source:** Field survey, 2010.

Findings from the study showed that 46.7% (168) of respondents mentioned the cost of transport to and from the health facility as a factor influencing women's decision to deliver at home. The difficulty in acquiring delivery "prospectus" was mentioned by 23.9% (86) of the respondents and 21.7% (78) also mentioned the high cost of hospital bills for the non-insured as the factors that influence women's decision to deliver at home. The remaining 7.7% did not respond to this question.

It was also revealed by 40% (144) of the respondents that it cost more than 11 Ghana Cedis to travel to a health facility and back, especially when one uses an ambulance or a car. The next highest cost was between 7 – 10 Ghana Cedis representing 27.5% (99) of the respondents. Seventy-eight (21.7%) of the respondents said that, transportation to health facilities when in

labour costs them between 3-6 Ghana Cedis while 39 (10.8%) of the respondents said that, transportation costs 2 Ghana Cedis or less. Since these women are mostly rural folks who engage in petty trading, they find it difficult to afford such high transport cost, hence their choice to deliver at home.



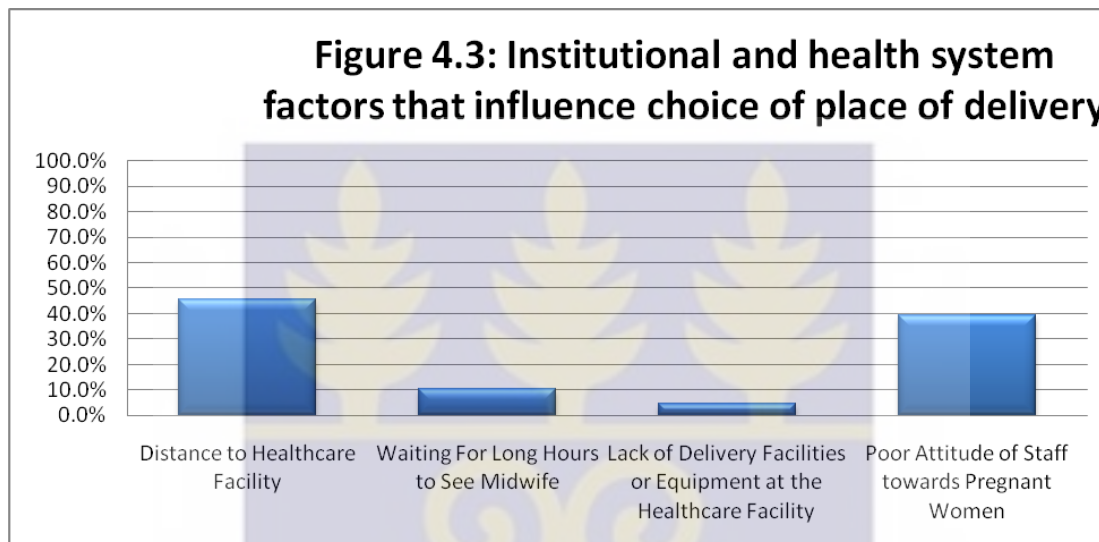
**Source:** Field survey, 2010.

#### **4.9. Institutional and Health System Factors that Influence Choice of Place of Delivery**

The study showed that 45.3% (163) of the respondents decided to deliver at home because most healthcare facilities are located far from their homes. Another 39.4% (141) of the respondents gave poor attitude of staff towards pregnant women at the health facilities, especially from nurses and midwives when women go to deliver whilst 13.6% (49) respondents mentioned queuing for long hours to receive healthcare, and being in labour for long periods without any attention from midwives.

The remaining 4.7% (16) respondents revealed that, they refuse to go to hospitals to deliver because these facilities also lack the needed equipment to help in safe and smooth delivery.

These are displayed in Figure 4.3



**Source:** Field survey, 2010.

The qualitative interview revealed that the distance from the health facilities to their homes was quite great and as such, when they are about giving birth, they preferred delivering under an untrained traditional birth attendant at home. A woman in her child-bearing age confirmed that, *“when I was to deliver Jebuni (my third son), and decided to move to the health centre, hmm (exclaimed), it occurred midway to the facility”*.

The attitude of health workers was seen by most informants as being negative and as such, discourages most women from patronising health facilities for child delivery. The women said that they are always beaten and insulted by the midwives.

A woman had this to say; *“as for me, what pains me most is that, these nurses are too young and when you go there to deliver, they don’t respect your age and insult you”*.

Facilities and equipments at the health centres were seen as good and available by most of the informants but to them, the negative behaviours of the health workers discourage them from using the facility.

The health workers generally believe that home deliveries are unsafe and that women with little or no education and live in rural areas not closer to the health facility are more likely to deliver at home. During the interview, the key informants mentioned lack of transport, poor attitude of health care personnel and financial cost as the main factors preventing women from utilising health facilities and leading to a high level of home deliveries in the West Gonja District.



## CHAPTER FIVE

### **Discussion of results**

#### **5.1 Discussion**

This section presents a discussion of the study findings. The results from the survey carried out indicates that, the majority of the mothers sampled were between the ages of 25 and 34 years and this group of women are usually the most reproductive groups in terms of child-bearing. Women who had no formal education constituted 60.8% of the total respondents.

Islam is the dominant religion in the area and attending antenatal clinics when pregnant was high among the respondents where 93.6% of them said they attend antenatal clinics when pregnant but most do not deliver at the facility. This statement confirms the Ghana Demographic

and Health Survey's report where deliveries in health facilities are far lower at the national level and antenatal coverage and institutional deliveries are 95% and 57% respectively (GSS et al, 2009).

It was discovered in the findings that as high as 82.8% of a total of 360 respondents said that, most women deliver at home and they cited the lack of transport to health facilities as the main reason for delivering at home.

Other factors influencing deliveries at home included; proving their faithfulness to their husbands and families, inability to buy the required items for delivery and to conceal their nakedness from people who are not their close relations.

Deliveries at hospitals are seen as the safest and respondents were of the view that, convenient distance to the health facilities is the main reason for most deliveries in the facility. The availability of drugs at the clinic and proximity of communities to the clinic accounts for

deliveries in clinics. Studies have shown that the highest proportion of people who utilize health the users declining as the radius increases. The effect of distance become stronger when there is the lack of transport coupled with the non-existence of a good road network as can be found in rural areas (Ekwepu et al, 1990).

Socio-cultural beliefs also influence the women to deliver at home. Eighty (22.2%) of the women mentioned proving of their faithfulness to their husbands and members of their families as the main reason why some women prefer home deliveries to institutional deliveries. This was followed by the concealing of ones nudity, avoidance of a caesarean section, the avoidance of paying fees for delivery services and the presence of unqualified staff at the health facility.

Patronising a public health facility for child delivery helps the mother to remain healthy even after delivery. This however, does not happen as a majority of the women attributed the poor attitude of health care personnel towards women in labour as the main reason why they do not patronise health facilities.

The long distance to and from the healthcare facility also contributed to the problem. The location of some communities to a health facility does not match the generally accepted distance of locating a health facility. Studies have shown that, in rural areas, health clinics and hospitals are often spread out over vast distances and transportation systems are often rudimentary. That is one of the reasons why the UNFPA supports increasing the number of community-based midwives, and strengthening district-level health systems to provide backup support (UNFPA, 2010).

Other factors enumerated were the absence of a qualified midwife at the health facility, unaffordable delivery fees when one possesses no national health insurance and the prevention of one being instructed to undertake exclusive breastfeeding.

The cost of transport to and from health facilities, high cost of hospital bills for the non- insured, difficulty in acquiring delivery “prospectus” add on to the cost of delivery care. Transporting a woman in labour to and from a health facility costs 11 or more Ghana Cedis and due to the inability of the women to acquire better education and good jobs, they are not able to pay for transport when in labour. Studies have shown that, the total cost of a delivery to a household include direct and indirect costs such as expenditure on food, transport, drugs, tests, blood transfusion, informal care giver’s time costs (opportunity cost ), hospital dues and informal payments such as tips and bribes (Attia K. and Shakila Z., 2010). Access to health services is

inadequate in deprived and rural areas and the poor suffer from the catastrophic cost of ill health both from the cost of accessing services and from productive days lost (MOH, 2007). This tends to influence home deliveries.

The location of health centres plays a major role in the utilisation of health facilities. Forty-five point three percent (45.3%) of the women attributed the long distance to the health facility as the major reason why health facilities are under utilised. Most pregnant women as a result of the inconvenient location of the health centre prefer delivery at home than undergoing hardships in getting to a health facility. Attitudinal change is required of every institution. However, the poor attitude of healthcare personnel towards pregnant women has influenced most of them to prefer home deliveries to institutional deliveries. Waiting for long hours to see the midwife and the lack of delivery facilities at the healthcare facility also influences the delivery of children at a health facility.



## CHAPTER SIX

### CONCLUSION AND RECOMMENDATIONS

#### 6.1 Key Findings

Based on the study, the following key findings were revealed as the factors influencing domiciliary deliveries in the West Gonja District:

1. Lack of transport to the health facility during periods of labour.
2. Inability of the women to buy the required items for delivery at a health facility.

3. The belief that one is seen as being faithful to the husband and members of the family when one delivers at home.
4. The poor attitude of healthcare personnel towards women in labour.
5. The long distance from the community to the healthcare facility and
6. The high cost of transporting a pregnant woman in labour to a health facility for delivery.

## 6.2 CONCLUSION

Child delivery is seen as a major component that relates to maternal mortality in Ghana and through child delivery, several lives of women all over the world have been lost. It is a critical moment in a woman's life which needs all hands on deck to solve its negative consequences.

Reducing maternal mortality by 75% by the year 2015 as being promoted by the safe motherhood initiative cannot be realised if measures are not proposed to reduce the impacts of the factors influencing domiciliary deliveries in the West Gonja District of the northern Region.

Some of the factors found to be influencing domiciliary deliveries in the West Gonja District are the lack of transport to the health facility, their inability to buy the required items needed for child-delivery at a health facility, socio-cultural beliefs such as, proving one's faithfulness to her husband and members of the family and concealing their nudity from people who are not their close relations, poor attitude of health care personnel towards women in labour, long distance to and from the health care facility and the high cost of transport to and from health facility and the difficulty in acquiring delivery "prospectus"

The education of women on cultural beliefs that will encourage facility delivery should be intensified and a functional ambulance system developed to respond to women in labour in the various communities. Also, the policy of free delivery should be made known to women.

Health facilities for delivery which are not well equipped could be upgraded and motivational staff posted to those facilities to offer their services to encourage facility deliveries.

### **6.3 RECOMMENDATIONS**

Based on the findings of the study, the following recommendations are made to the District Health Management Team:

1. The District Health Management Team should encourage facility delivery through a community health education programme. The program should be organised by the District Health Management Team in collaboration with the District Assembly to outline the benefits of delivering at a health facility to the women.
2. The District Health Management Team should organize programmes for the healthcare personnel where they will be taught good human relationship and to see the patient as supreme.
3. As a result of the transportation difficulties and bad roads, the Community Health Planning and Services (CHPS) concept should be introduced by the District Health Management Team in the very difficult to reach areas and a community Health Officer

posted to render health services to the people. This will make healthcare readily available to the rural women.

4. The District Health Management Team in collaboration with the District Assembly and other Non-governmental Organisations in the district should help by providing health facilities with some delivery items such buckets, dettol, blades etc which the poor women in the society cannot afford themselves.
5. The District Health Management Team should organise fora where the advantages of delivering in a health facility will be mentioned to the people in order to erase their mentality of delivering at home as a sign of faithfulness.

Based on the findings, the following recommendations are made to the District Assembly:

1. In the area of transportation, the West Gonja District Assembly in collaboration with the feeder Roads Department should improve the road network to the rural areas to allow easy movement of the various modes of transport. This will make movement to health facilities very easy for women in labour.
2. The District Assembly should also discuss with the local transport unions to offer discounts on fares to pregnant women when in labour in the district.



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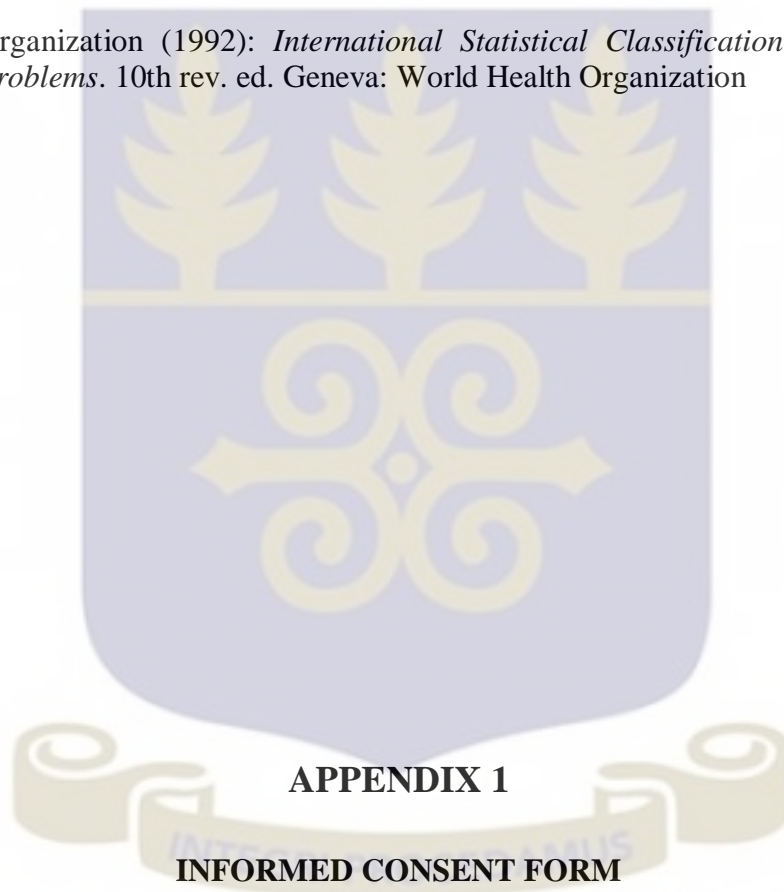
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My name is ..... I am working on a research to find reasons influencing domiciliary deliveries in the West Gonja District. The purpose of the study is to gather information that will inform the District Health Management Team, the Ghana Health Service and the West Gonja district communities the reasons why most women delivers at home so that measures will be put in place in order to achieve a high rate of supervised deliveries in the district.

Your participation in this research is voluntary and if you agree to join the study, you will be asked questions on the socio-cultural perceptions about place of delivery, the role of cost considerations in the choice of place of delivery and the institutional and health systems factors influencing the place of delivery. If a question makes you feel uncomfortable, you may choose not to answer it and also feel free to ask for the repetition of a question when is not clearly heard. All information that you provide will be considered private and confidential and any report on this study will not use your name. There are no risks involved in taking part in the study. This study has been approved by the Ghana Health Service Ethical Review Committee on Research Involving Human Subjects (GHS-ERCIHS) which is a committee task to make sure that research participants are protected.

Do you have any questions now? You may contact the Principal Investigator at the District Health Management Team office in Damongo if you have questions later.

His name is Sumani Inusah (Tel. 0243586561)

Do you voluntarily agree to participate in this study?

1. Yes [  ]                      2. No [  ]

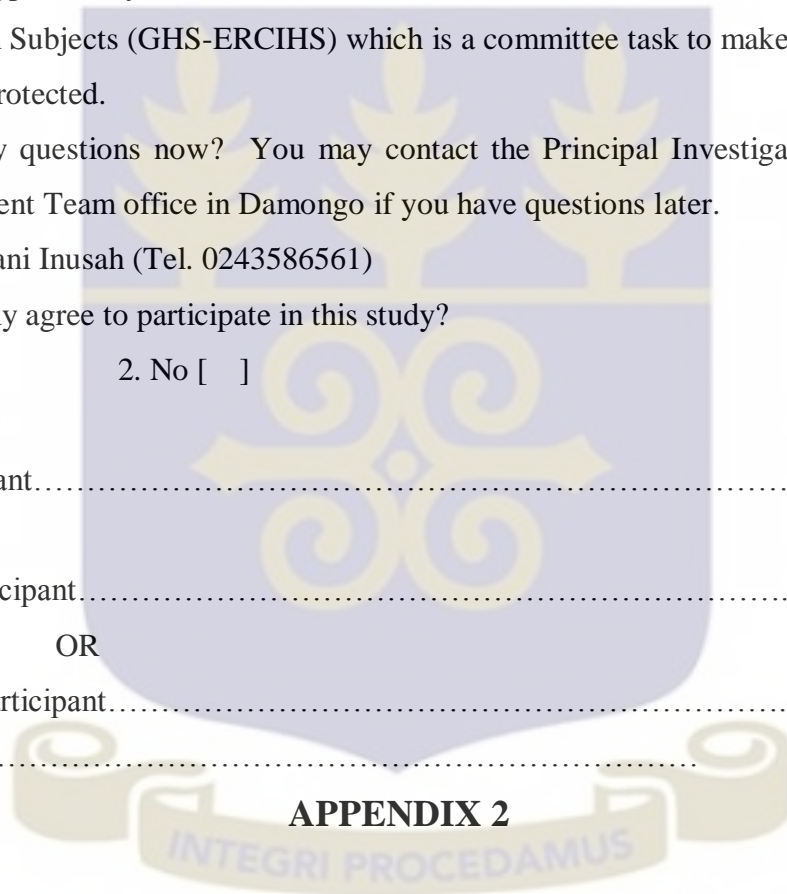
Name of Participant.....

Signature of participant.....

OR

Thumbprint of participant.....

Date.....



**APPENDIX 2**

Dear respondent, I implore you to respond to this questionnaire as objectively as practicable to help me carry out my study on the factors influencing domiciliary deliveries in the West Gonja District.

It is in partial fulfilment of the requirement for the award of the Master of Science in Applied Health Social Science degree in the School of Public Health at the University of Ghana, Legon.

Every information given will be treated as confidential as possible.

## SURVEY QUESTIONNAIRE

### SECTION A

#### IDENTIFICATION

1. Name of health facility: .....
2. Date: .....

### SECTION B

#### DEMOGRAPHIC CHARACTERISTICS

3. Name of respondent: .....
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 [  ] Moslem [  ] Traditional [  ]  
Other (Specify).....

### SECTION C

#### SOCIOECONOMIC CHARACTERISTICS

7. Have you ever attended school?

Yes [ ] No [ ] ( If No, skip 8).

8. What is your level of education?

Primary [ ] Middle/ J.S.S. [ ] SSS/Voc/Technical [ ]

Post-Sec/Nursing/Polytechnic [ ] University [ ] None [ ]

9. What is your occupation?

Farming [ ] Civil Servant [ ] Trading [ ] Teaching [ ] Artisan [ ]

Other (Specify) .....

**SECTION D**

**CHOICE OF PLACE OF DELIVERY**

10. What do women do when they are pregnant? ( Tick only one)

A. They attend antenatal clinics at a health facility

B. They consult spiritualists

C. They consult Traditional Birth Attendants.

11. Where do women go to when they want to deliver? (Tick more than one).

A. At home

B. The hospital

C. The clinic

D. The spiritual home

12. Under what condition will a woman deliver at home?

- A. Lack of transport to the health facility
- B. To prove her faithfulness to her husband and members of the family.
- C. Inability to buy the required items to be used for delivery at the hospital
- D. To conceal ones nakedness from people who are not her close relations.

13. Under what condition will a woman deliver in the hospital?

- A. Distance to the health facility is convenient
- B. When attitude of health workers are favourable
- C. Availability of quality delivery facilities
- D. Affordable cost of delivery services

14. Under what condition will a woman deliver in a clinic?

- A. Availability of midwives
- B. Attitudes of health workers are favourable
- C. Availability of drugs at the clinic
- D. Location of clinic closer to the community
- E. Affordable transport cost to the clinic

15. Under what condition will a woman deliver at a spiritual home?

- A. When the period of pregnancy is more than the normal nine months
- B. When labour begins earlier than nine months

- C. Inability of the women to conceive for a long time after marriage
- D. Death of infants after each delivery
- E. The wish for a male or female child
- F. Nearness of the spiritual home to ones house

### SECTION E

#### SOCIO-CULTURAL PERCEPTIONS ABOUT PLACE OF DELIVERY

16. In your opinion, would you say more women deliver at home in this community?

Yes [ ] No [ ] ( If No, skip 17)

17. Which of the following beliefs will influence you to deliver at home?

A. To prove my faithfulness to my husband and members of the family

Yes [ ] No [ ]

B. To conceal my nudity from people who are not members of my family

Yes [ ] No [ ]

C. To avoid undergoing a caesarean section

Yes [ ] No [ ]

D. Presence of unqualified staff at the health facility

Yes [ ] No [ ]

E. To deliver in the midst of relatives

Yes [ ] No [ ]

F. To avoid paying fees for delivery services

Yes [ ] No [ ]

18. Do you have a public health facility for child delivery in your community or in a nearby community?

Yes [ ] No [ ] ( If No, skip 19)

19. If yes, why didn't you use this health facility when delivering your child?

A. The absence of a qualified midwife

Yes [ ] No [ ]

B. Could not afford delivery fees

Yes [ ] No [ ]

C. Poor attitude of health care personnel(midwife) towards women when in labour

Yes [ ] No [ ]

D. Long distance of travelling to the health facility

Yes [ ] No [ ]

E. To prevent one being instructed to undertake exclusive breastfeeding

Yes [ ] No [ ]

## SECTION F

### THE ROLE OF COST ASSOCIATED WITH THE CHOICE OF PLACE OF DELIVERY

20. If a woman is to deliver, how do you transport her to the health facility?

- A. By a bicycle. Yes [ ] No [ ]
- B. By a motorbike. Yes [ ] No [ ]
- C. By an ambulance. Yes [ ] No [ ]
- D. By foot. Yes [ ] No [ ]
- E. By a tractor. Yes [ ] No [ ]

21. Do you think there are financial considerations that influenced you to deliver at home?

Yes [ ] No [ ] ( If No, skip 22)

22. If yes, what are these financial considerations?

A. Cost of transport to and from the health facility.

Yes [ ] No [ ]

B. High cost of hospital bills.

Yes [ ] No [ ]

C. Difficulty in acquiring delivery “prospectus”

Yes [ ] No [ ]

23. How much does it cost to transport a woman in labour to a health facility in this community? (In Ghana Cedis).

A. Less than 2.00

Yes [ ] No [ ]

B. 3-6

Yes [ ] No [ ]

C. 7-10

Yes [ ] No [ ]

D. 11 and more

Yes [ ] No [ ]

**SECTION G**

**INSTITUTIONAL AND HEALTH SYSTEM FACTORS INFLUENCING  
THE CHOICE OF PLACE OF DELIVERY**

24. Which institutional and health facility factors influenced you to deliver at home?

a. Long distance to the health facility

Yes [ ] No [ ]

b. Waiting for long hours to see the midwife

Yes [ ] No [ ]

c. Lack of delivery facilities and equipment at the health facility

Yes [ ] No [ ]

d. Poor attitude of staff towards pregnant women

Yes [ ] No [ ]



### **APPENDIX 3**

#### **INTERVIEW GUIDE FOR KEY INFORMANTS**

I am a student from the School of Public Health of the University of Ghana and I am doing a research on the factors influencing domiciliary deliveries in the West Gonja District. I kindly implore you to help me answer the following questions.

***A. SOCIO-CULTURAL PERCEPTIONS ABOUT PLACE OF DELIVERY***

1. Please, what are your views on childbearing?
2. What are your views about the process of child-delivery?
3. Traditionally, are any norms or beliefs associated with deliveries in this community?
4. What are these beliefs that are associated with deliveries in this community?
5. Of all the beliefs that you have mentioned, which one of them is important?
6. Why do most women in this community prefer to deliver at home?

***B. THE ROLE OF COST CONSIDERATIONS IN THE CHOICE OF PLACE OF DELIVERY***

7. Please, can you briefly tell me the modes of transporting a pregnant woman to a health facility in this community?
8. In your opinion, how does transportation influences women to deliver at home and not at a health facility?
9. Apart from transportation, what are the other costs that you think influences women to deliver at home?

***C. INSTITUTIONAL AND HEALTH SYSTEMS FACTORS INFLUENCING THE CHOICE OF PLACE OF DELIVERY***

10. Can you briefly tell me your views on the location of the health facility that offers delivery services to women in this community?

11. In your opinion, what do you think is the attitude of the health workers in the health facility which discourages women from going to the facility to deliver?
12. What can you say about the equipment and facilities in the health facility in your community where childbirth and deliveries are done?

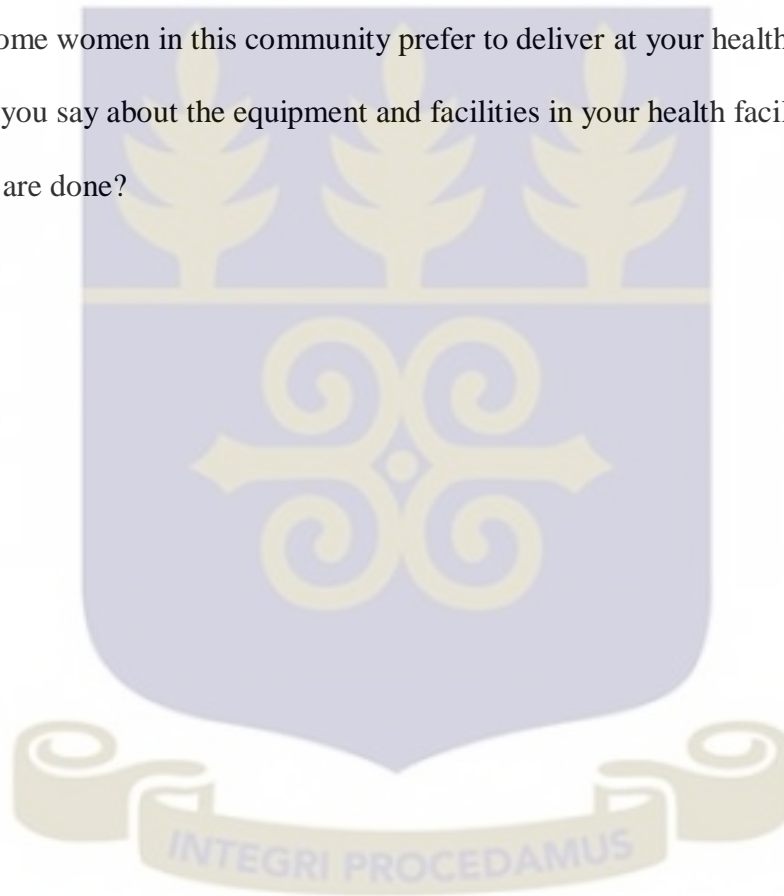


#### **APPENDIX 4**

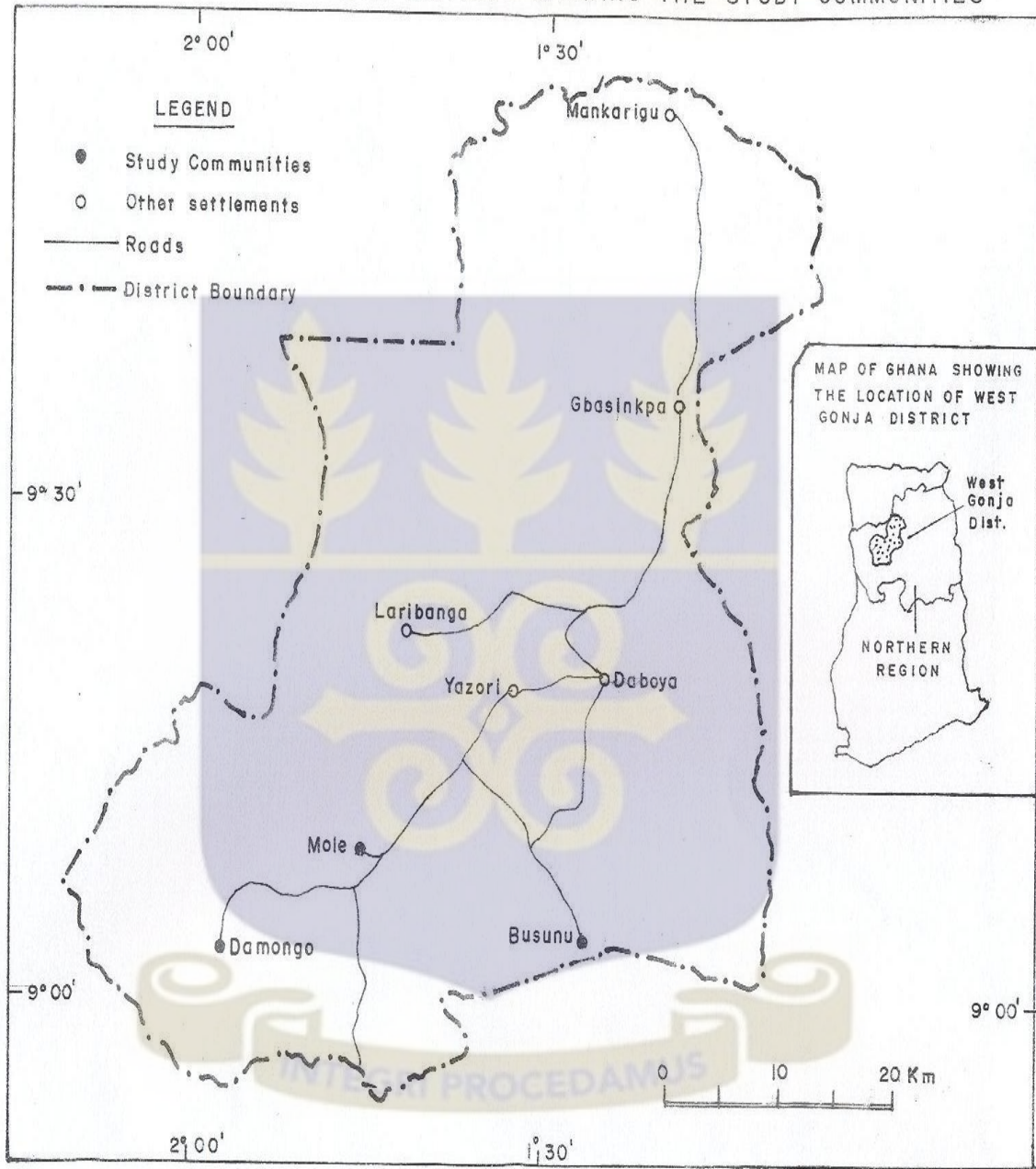
#### **INTERVIEW GUIDE FOR HEALTH WORKERS**

I am a student from the School of Public Health of the University of Ghana and I am doing a research on the factors influencing domiciliary deliveries in the West Gonja District. I kindly implore you to help me answer the following questions.

1. Please, what are your views about child-delivery in this community?
2. Traditionally, are any norms or beliefs associated with deliveries in this community?
3. Kindly mention the traditional beliefs associated with deliveries in this community.
4. Which one of these norms is the most important belief associated with deliveries?
5. Please, in your opinion, why do most women in this community prefer to deliver at home?
6. Why do some women in this community prefer to deliver at your health facility?
7. What can you say about the equipment and facilities in your health facility where deliveries are done?



A MAP OF WEST GONJA DISTRICT SHOWING THE STUDY COMMUNITIES



SOURCE : WEST GONJA DISTRICT ASSEMBLY - DAMONGO