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UNIVERSITY OF GHANA LEGON

DO SOCIO-CULTURAL FACTORS INFLUENCE THE WOMEN IN KASSENANANKANA DISTRICT TO DELIVER OR NOT

DELIVER IN THE HEALTH INSTITUTIONS?

**AN EXPLORATORY STUDY IN THE
UPPER EAST REGION OF GHANA**

BY

CHARITY ADZO KARTEY

AUGUST 2003

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**THIS DISSERTATION IS SUBMITTED TO THE SCHOOL OF PUBLIC
HEALTH, UNIVERSITY OF GHANA, LEGON IN PARTIAL
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OF PUBLIC HEALTH DEGREE**

BY

CHARITY ADZO KARTEY

AUGUST 2003

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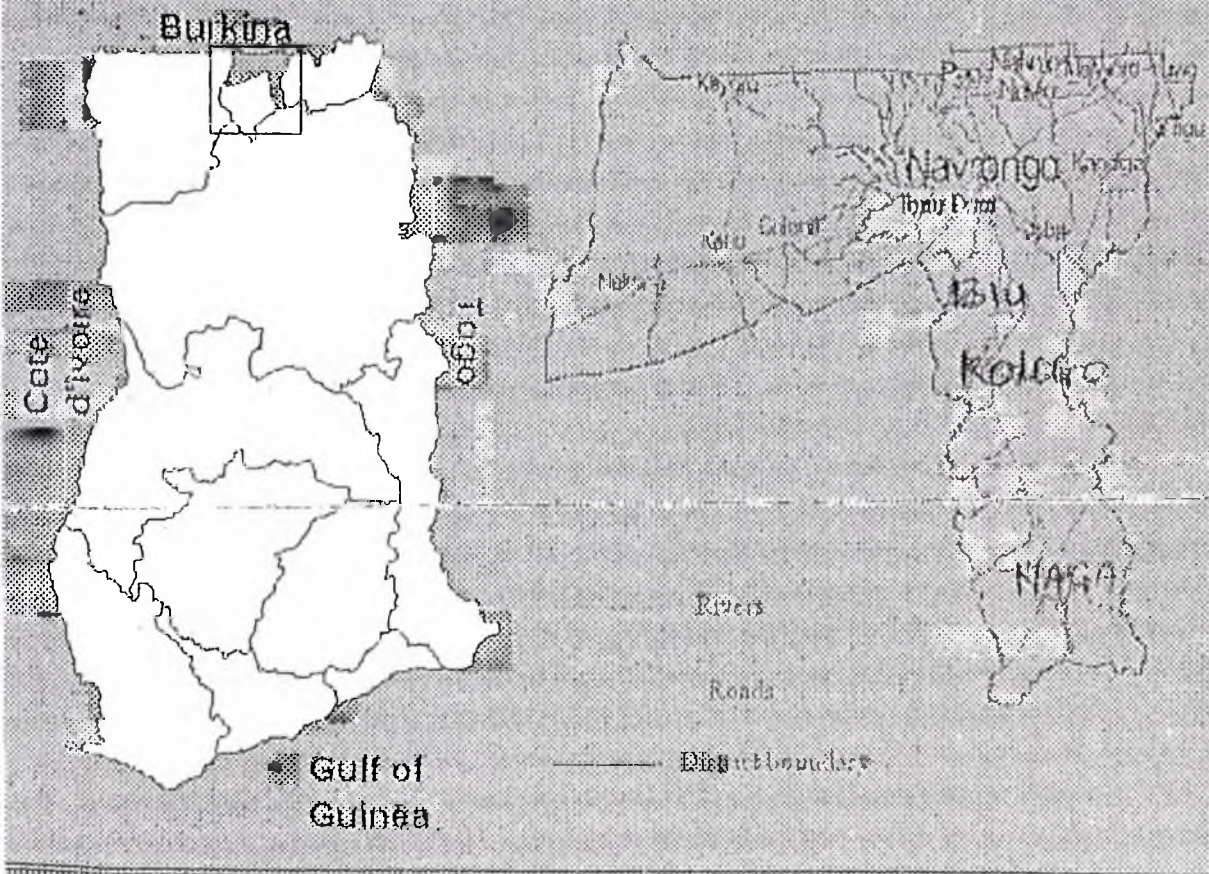
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UPPER EAST REGION

Map of Kassena-Nankana District



DEDICATION

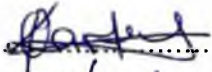
This Dissertation is dedicated to the Glory of God for
Having brought me this far and
To my family.

DECLARATION

I hereby declare that this dissertation is the result of my original research and that no part of it has been presented for another degree in this University or elsewhere.

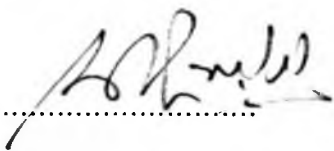
All references cited in the study have been fully acknowledged

Candidate: Charity Adzo Kartey

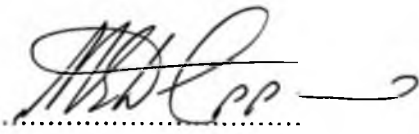
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ABSTRACT

The study explores the factors that influence decisions of women in the Kassena Nankana District from delivering or not delivering in the health care facilities despite their use of antenatal care services at the facilities.

Multistage sampling procedure was used to select two groups of women who had antenatal care at the facilities. Two hundred women were interviewed i.e. 100 who delivered at the facilities and 100 who delivered at home.

A structured questionnaire was used to collect data from the respondents on variables under study. The variables were related to socio demographic characteristics, influence of family, accessibility and affordability of services to clients and client satisfaction of services provided and how each influence the women's decisions to deliver or not at the facility.

The analysis of data consisted of data entry and computation of frequencies into percentages and proportions and presentation in tables and figures using SPSS and Excel soft wares.

The results showed that low social status due to low educational status and low income, influence of cultural beliefs; lack of access to health facilities due to distance and lack of transport and negative staff attitude towards women were major factors that contributed to women not delivering at the health facilities in the district.

The study found that majority (90.5%) of all respondents wish to deliver their next child at the health facilities and all of them knew at least one risk of not delivering at the health facility.

Recommendations are directed towards

1. Intensifying education to all community members on importance and benefits of delivering at the health facilities.
2. Involvement of spouses and relatives during Antenatal care to gain their support,
3. Expanding the Community-based Health Planning and Services initiative to all communities,
4. Expediting action on free delivery
5. Training of health staff on human relations and communication skills to ensure quality of care.
6. Provision of means of transport in distant communities for referral purposes.
7. Provision of effective communication systems to deprived communities
8. Giving awards a form of motivation to health care providers who accept posting to deprived areas.

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OPERATIONAL DEFINITIONS

1. A.N.C	----	Antenatal Care / Clinic
2. CHFP	----	Community Health and Family Planning
3. CHPS	----	Community-based Health Planning and Services
4. G.S.S	----	Ghana Statistical Services
5. F.G.D	----	Focus Group Discussions
6. K.N.D	----	Kassena Nankana District
7. M.C.H	----	Maternal and Child Health
8. M.O.H	----	Ministry of Health
9. NDSS	----	Navrongo Demographic Surveillance system
10. NHRC	----	Navrongo Health Research Centre
11. R.C.H	----	Reproductive and Child Health
12. T.B.A	----	Traditional Birth Attendant
13. WHO	----	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

Childbirth is a universally celebrated event, an occasion for dancing, merry making, eating and drinking and presentation of gifts. Yet for many thousands of women each day, childbirth is experienced not as the joyful event it should be, but a private hell that may end in death. In almost all societies, celebration of life is the dominant theme, while the grimmer side of childbearing is often shrouded in silence known only to those who attend to them.

Maternal mortality and morbidity in developing countries constitute a tragedy of vast proportions. It is estimated that in the developing world the average life time risk of dying of a pregnancy related cause is between 1 in 15 and 1 in 50 compared with an average life time risk of dying between 1 in 4,000 and 1 in 10,000 in developed countries (Royston and Armstrong, 1989).

According to the Ministry of Health mid-term Report, maternal mortality in Ghana still remains high and is estimated to be between 214 – 740 per 100,000 live births (M.O.H., 1999). Women and children form about 70% of the population, therefore morbidity and mortality among these groups account for a large proportion of all ill health and deaths in Ghana making them the most vulnerable group (M.O.H., 2001). Ironically, these illnesses and deaths are preventable.

Since women and children are significant contributors to the nation's development, their needs are a national priority. The Ghana government has as its objective to decrease maternal mortality rate from 214/100,000 live births to 150/100,000 live births by the year 2006 (M.O.H. Reproductive and Child Health Report, 2002). This is to be achieved through

the implementation of safe motherhood programmes which include among others, antenatal care and supervised delivery.

1.1 STATEMENT OF PROBLEM

Supervised delivery is a delivery attended by skilled health personnel irrespective of the outcome (2001 RCH Report). In Ghana, skilled attendants include midwives, general medical practitioners, obstetricians, and trained Traditional Birth Attendants (TBAs). Labour and delivery are important components of the safe motherhood programme and key to reducing maternal morbidity since even with the best Antenatal Care screening, any delivery can turn out to be complicated requiring emergency intervention.

According to the 2001 Reproductive and Child Health Report (R.C.H.), there has been a steady improvement in the proportion of supervised delivery. This is not to say however, that the achievement is satisfactory as there is a wide gap between the proportion of women who receive antenatal care and those who receive supervised care during delivery. This problem of disparity is nationwide and peculiar to all regions including Upper East Region as the table below shows.

Table 1 –Trends in ANC & Supervised Delivery in Ghana from 1996-2001 (in %)

YEAR	1996	1997	1998	1999	2000	2001
ANC Coverage	84.4	85.25	87.5	86.4	96.7	98.4
Supervised Delivery	37.7	40.6	40.8	43.5	51.6	50.4

According to the 2001 R.C.H. report, the proportion of women receiving antenatal care has increased from 84.4% in 1996 to 98.4% in 2001, as against the proportion receiving supervised care during delivery from 37.7% in 1996 to 50.4% in 2001 (2001R.C.H.report). Similar trends have been observed in the Kassena Nankana District (KND). Data show that there has been a progressive increase in the proportion of women receiving antenatal care

in the district from 40.7% in 1999 to 78.2% in 2001. However, the proportion of supervised deliveries still remains low as can be observed in table 2 below.

Table 2 – Trends in ANC & Delivery in Kassena Nankana district. (In %)

YEAR	1999	2000	2001
ANC Coverage	40.7	76.6	78.2
Supervised Delivery	17.1	35.1	37.3

During the year 2002, out of the expected pregnancies of 6050 the district recorded a total of 5755 women who attended antenatal clinics constituting 95.1%, however, only 2173 deliveries were conducted under supervision constituting 35.9% out of the expected deliveries of 6050. Out of the 2173 supervised deliveries only 830 (38.2%) were delivered in the health institutions, that is 13.7% of the total expected deliveries. This data indicates that majority of all pregnant women are delivered by unskilled personnel who might not be in the position to recognize and manage complications of labour and delivery promptly thereby putting the life of both mothers and babies at risk. It must be noted that traditional birth attendants (T.B.As) who attend millions of births in developing countries have a role to play during childbirth by providing women with supportive care and assistance through recognizing and referring some complications to health care facilities. However, TBAs even those who have received training generally do not have the skills to manage delivery complications and must not be substituted for skilled attendants.

The low level of deliveries in the health institutions is a real problem and the question one would ask is why are the women not delivering in the health institutions even though they receive antenatal care from there? What are the factors influencing women's choice of place to deliver in the district? Studies carried out in some parts of the country have found

lack of geographical accessibility, high cost of deliveries or inability of clients to pay for services and poor staff attitude as some of the factors (Gyamfi, 2001, unpublished). In the Kassena Nankana District all these factors might exist. In addition to these there might be some socio-cultural factors that influence decisions to deliver or not to deliver at the health facilities, this is because naturally, socio-cultural factors contribute to people's behaviour and this area has not been explored to ascertain the extent of its contribution to the low institutional deliveries in the K.N.D. To solve the issue of cost the District Health Directorate had adopted a free delivery services for all pregnant women in the district, but this has not improved the utilization the services. The Community-based Health Planning and Services (CHPS) initiative which was developed from lessons from the Navrongo Community Health and Family Planning Project (CHFP) is an attempt to make health services accessible to community members, however, the community compounds are not equipped to provide supervised delivery services.

1.2 MAIN OBJECTIVE OF THE STUDY

The study therefore seeks to identify the factors that influence women in Kassena Nankana district from delivering or not at the health care facilities .

1.3 SPECIFIC OBJECTIVES

To accomplish the main purpose of the study the following specific objectives would be addressed:

- i. To determine whether there are cultural/religious beliefs related to delivery in the district and how these influence women's decisions to deliver or not to deliver in the health care facilities.
- ii. To determine the level of influence of the following factors in women's

choice of place of delivery.

- a. Level of education
 - b. marital status
 - c. parity of the women
 - d. age of the women
 - e. occupation
 - f. family influence
- ii To find out whether accessibility and cost of services are a factor in the choice of place of delivery
- iii. To find out whether clients are satisfied with services provided at the Health Care facilities

1.4 THE STUDY LOCATION

Kassena Nankana District is one of the 6 districts of the Upper East Region. It lies within the Guinea Savannah woodland of Ghana bounded to the north by Burkina Faso at Paga, to the west by Builsa district, to the east by Bongo district and to the south by Bolgatanga district.

The district's population for the year 2002 is 151,257 (estimated from the 2000 census) The district covers an area of 1,658 square kilometers and has a population density of 92 people per square kilometer. There are dispersed settlements of about 14,500 compounds within 151 communities majority being rural surrounded by semi-arid grassland and only about 13% living in towns. Each compound consists of closely - knit extended families of 10 to 100 residents. A compound is made up of several small connected huts and surrounded by the family's farm land. With this nature of dispersed settlement pattern there are no compact villages, hence service delivery is often difficult.

The district has two main ethnic groups: the Kassenas and the Nankanas with a minority group of Builsas and Mamprusis. Subsistence agriculture is the main occupation of the rural people. KND has the highest illiteracy rates in the country with a rate as high as 62% among females of six years and above. The district is divided into six sub-districts, that is

- 1 1 Kassena Nankana Central (Navrongo area)
- 2 Kassena Nankana South
- 3 Kassena Nankana North
- 4 Kassena Nankana North East
- 5 Kassena Nankana East
- 6 Kassena Nankana West

The district has high mortality level and high fertility level. Health seeking decision making is strongly influenced by customary practices, traditional religion and poverty. (NHRC Vol, 1 No 3, Sept.2001)

Health facilities in the district include,

1. The Navrongo War memorial hospital which is level C facility located at the district capital (Navrongo Central) and serves as a referral point for all health centres and clinics in the district.
2. Three level B facilities (health centres) are located at
 - Paga in the North
 - Chiana in the West
 - Kandiga in the East

There are also three clinics built by the Catholic Church at Sirigu, Nakolo and Bui. There is only one private maternity home located in Navrongo central. There are also a few

trained T.B.As in the communities but majority of those who assist women in deliveries in the communities are untrained. The district has one Community Health Nurses School which commenced in 2002. The Navrongo Health Research Centre (NHRC) which started in 1989 as a field station to investigate the impact of repeated large doses of Vitamin A Supplementation on child survival in the Kassena Nankana District was designated a research centre by the M.O.H. in 1992 to investigate health problems of the sahelian ecological belt of Northern Ghana and advice policymakers. The centre's primary activities revolve around research and dissemination of research findings. Currently, the centre's interests are in Malaria, Diarrhoea, Pneumonia, Cerebro-Spinal Meningitis (CSM), Community Health Service delivery and Reproductive Health. The centre is playing a vanguard role in the implementation of the MOH countrywide Community-based Health Planning and services (CHPS) initiative which was developed from lessons of the Navrongo Community Health and Family Planning Project(CHFP). Underlying all the research activities is the Navrongo Demographic Surveillance System (NDSS). This is a continuous population registration system which monitors demographic dynamics of the entire district. All the 14,500 compounds in the district are visited to update vital events such as births, deaths, pregnancies, marriages and migration in and out. The centre also serves as a field station for students of the School of Public Health at the University of Ghana, Legon and the Community Health Nurses Schools in Tamale and Navrongo (NHRC vol.3 No.1, June, 2002). With these, the centre is playing an important role in the health delivery in the district.

CHAPTER TWO

2.0. LITERATURE REVIEW

According to MacDonald and Starrs, motherhood related afflictions are the biggest cause of sickness and deaths among women between the ages of 15 and 45 years in developing countries. Each year out of the estimated 120 million pregnancies that occur world wide, more than half a million women die from the complications of pregnancy and childbirth (MacDonald and Starrs, 2002). They also estimated that more than 50 million suffer from a serious pregnancy related illness or disability and at least 1.2 million newborn infants die from complications during delivery.

Out of the numbers who die world wide from the complications of pregnancy and child birth, 99% live in developing countries (WHO 1997).

Vast discrepancies continue to exist in access to maternal health care between developed and developing world, between richer and poorer women, urban and rural women and between educated and uneducated women as stated by AbouZahr in her paper on 'Improving Access To Quality Maternal Health Service' (AbouZahr, 1997). She said, "In developing countries 35% of women still receive no Antenatal care, almost 50% give birth without a skilled attendant and 70% receive no postpartum care".

In contrast maternal health care is nearly universal in developed countries. About 97% of women make at least one ANC visit, 99% deliver with skilled attendants and 90% make at least one post partum care visit.

The proportion of pregnant women who have care during delivery is universally lower than those who receive ANC. Yet it is during labour, delivery and immediate post partum period that complications are most likely to arise and that care is most needed.

Almost half of all postpartum deaths take place within one day of delivery and 70% within the first week. Skilled care during childbirth and immediately afterward can make a critical contribution to preventing these maternal and newborn deaths and disabilities. Skilled birth attendants or providers refer exclusively to people with midwifery skills e.g. Doctors, midwives and nurses who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer complications (WHO,1999).

Studies have shown that in the developing world just over half of the women give birth with the help of a skilled attendant. This means that every year whether by choice or necessity 50 million women in the developing countries give birth cared for only by a family member, a traditional birth attendant or no one at all. In developed countries where only a small fraction of maternal deaths occur, (just 1% of the global total), skilled care during child birth is nearly universal.

The traditional birth attendants (T.B.As) who attend millions of births in developing countries have a role to play during childbirth by providing women with supportive care and assistance and recognising and referring some complications. However TBAs even those who have received training generally do not have the skills to manage delivery complications and are not substitutes for skilled attendants. (MacDonald and Starrs, 2002).

It is estimated that 15% of pregnant women will experience a life-threatening complication during pregnancy or child birth. Clinical experience indicates that skilled birth attendants properly equipped and supported can prevent or manage many of these complications. Data from a range of developing countries indicate that maternal mortality is generally lower in countries where a higher proportion of deliveries are conducted by skilled attendants (AbouZahr, 1998). Based on the information available experts agree that skilled care should be a central element of any policy or programme that aims to reduce maternal deaths. (MacDonald and Starrs, 2002).

2.1 Barriers to Providing and Using Services

A range of barriers limit women's access to skilled care. Access means that maternal health care is within the reach of women who need it and that they can get to it easily and are not deterred from using the services available. The barriers include:

1. Distance or inability to reach service
2. Cost of services
3. Poor treatment by staff or service providers (attitude of providers)
4. Quality of care
5. Type of services provided
6. Socio-cultural factors, including women's lack of decision-making power within the family and community, low status of women, lack of education etc.

2.1.1 Distance and Lack of Transport:

Geographical accessibility to health care facility is a major constraint to the utilization of services. In most rural areas one in three women live more than 5kms from the nearest health facility and 80% of rural women live more than 5kms from the nearest hospital. The

scarcity of vehicles especially in remote areas and poor road conditions can make it extremely difficult for women to reach even relatively nearby facilities, walking is therefore the primary mode of transportation even for women in labour.(World Bank,1994).

In rural Tanzania, 84% of women who gave birth at home intended to deliver at a health facility but did not due to distance and the lack of transportation (Biego et al, 1995).

Again, in Malawi, a study found that 90% of women wanted to deliver in a health care facility but only 25% of them did. The most important reason given by 53% of the women was that by the time they realized they were in labour, they did not have enough time to get to a health facility (Lule and Ssembataya, 1996).

A study in Dangme west district of Ghana on why women in the district do not deliver in the health institutions also found distance and lack of transportation to the health facility as a major factor (Gyamfi, 2001).

2.1.2 Financial Accessibility or Cost of Services.

According to Ministry of Health, Ghana vision 2020 report, financial barrier was a factor as far as accessing health care was concerned. It is estimated that 30% of the population live below the poverty line and the people in the last quartile of income access health less frequently (MOH, 1999).The document also stated that the introduction of user fees in 1985 led to market reduction in out patient attendance at public health care facilities.

Fees reduce women's use of maternal health services and keep millions of women from having hospital based deliveries or from seeking care even when complications arise. Even when formal fees are low or non-existent there may be "informal" fees or other costs that pose significant barriers to women's use of services. These may include costs of transportation, drugs, food or lodging for the woman or the family members who help care for her in the hospital.

In Zaria, Nigeria a study found that the shift from free to fee-based services for obstetric care reduced admissions over all but significantly increased emergency cares and the number of maternal death rose correspondingly (Harrison, 1997).

It is also found that the poorer the women, the more likely fees are to affect their use of health services. Studies in Cote de Ivoire (Gertler and Van der Gaag, 1988), and Peru (Gertler, 1988) found that fees deter every one from using health services but deter poor women most of all.

2.1.3 Dissatisfaction with service quality (staff attitude)

According to 1998 WHO Report, many women describe providers in the formal health care system as unkind, rude, brusque, unsympathetic and uncaring. Where health workers are perceived to be hostile and unfriendly, many women rely instead on traditional healers or TBAs for antenatal, delivery and post partum care (WHO, 1998). This can lead to delays in seeking adequate care for pregnancy related complications.

In Tanzania, a study found that 21% of women delivered at home because of the rudeness of health staff even though they thought delivery in a health facility was safer (Biego et al, 1995).

Leshie and Gupta (1989) indicated that formal health services can conflict with cultural norms surrounding child birth including preferences for privacy, modesty and female attendants. Studies among the Saraguro Indians in Ecuador, found that, hospital-based deliveries were perceived to violate privacy. Many health providers were men which was unacceptable culturally and the birth positions preferred by providers were not those preferred by women in labour. As a result affordable and accessible maternal health care services were under utilized.

In Sudan, a study found that many women were ashamed of being poorly dressed in front of health workers who were generally of a higher socio economic class and were also afraid the health workers would react negatively to their illiteracy. These feeling deterred many women from using formal maternal health services (Demographic and Health surveys).

A study in the Ashanti-Akim district of Ghana indicated that the quality of health care was a more important determinant of utilization of health services than its cost (Waddington and Enyimayew, 1989). The quality of care was defined in terms of the perceived quality of medical care, staff attitude and availability of drugs. An important input to service delivery is to find out what clients want and to tailor services to their needs. Client's perception of rude, uncaring staff must give way to more friendly customer-oriented staff. Hence, the M.O.H Ghana has as one of its 5 pillars, quality of care in service delivery (MOH, 2000).

2.1.4 Socio-Cultural Barriers

According to MOH report, socio-cultural barriers to health care are major contributing factors to low institutional care (MOH, 1999). The knowledge and perception of disease have influence on health care seeking behaviors, and according to findings in a lot of places the knowledge of disease causation is low. In a number of rural communities nearly 70% of persons consult traditional medicine men when sick and not the formal sector. The belief that some sicknesses are amendable to traditional care e.g. Boils prevent people from seeking appropriate health care (Leshie and Gupta, 1989).

It has been observed that the existence of facilities for Reproductive health care does not necessarily mean that they will be used even by women who have been advised to use them (Rahman, 1981). The explanation in some cases is that the clinic or hospital is too far from the woman's home and she may lack the time, transport or possibly the money to reach it. A study of women's perception determining the use of maternal and child health services in Bangladesh identified a number of reasons for non-use among which were long distance and lack of company for visiting the clinics (Rahman, 1981).

In many parts of the world women's decision making power is extremely limited particularly in matters of reproduction and sexuality. Report on Safe Motherhood at the South Asia conference in Pakistan (1990) stated that decisions about maternal care are often made by mothers-in-law, husbands or other family members. For example, in Nepal mothers-in-law attend to most deliveries and additional care or help is sought only if the mother-in-law decides that such care is needed. One study found that 75% of mothers-in-law did not believe an antenatal check up was necessary.

A study in Zaria, Nigeria found that in almost all cases, a husband's permission is required for a woman to seek health services, including life saving care. If a husband was away from home during a delivery those present were often unwilling to take the woman for care no matter how pressing the need appeared to be (Thaddeus and Maine, 1994).

Royston and Armstrong (1989) also noted that in some parts of the world a woman cannot visit a clinic or hospital without the permission of her husband or mother-in-law, where this tradition was strong when the husband was away others might not be prepared to take the decision even on behalf of a woman suffering in labour.

A study in Kassena Nankana District of women who died of pregnancy-related complications found that 64% of the women had sought help from a herbalist, soothsayer or other traditional provider before going to a health facility. Families cited cost and the belief that the woman's condition would improve or that the woman was not ill enough to justify the cost involved as the main reasons for not taking a woman to a hospital (Odoi-Agyarko, Dollimore and Owusu-Agyei, 1993).

Other possible factors such as women's status, educational level, and age of the woman, parity or birth order may influence women's decisions to deliver or not deliver in a health care facility.

A woman's status is often described in terms of her income, employment, education, health, fertility as well as the roles she plays within the family, the community and society. It also involves society's perception of these roles and the value it places upon them. There

is evidence from various studies that maternal education is one of the most important determinants of the use of health care services in developing countries. Various studies have found that women with higher educational attainment are more likely to use formal pregnancy-related care than the less educated. Education empowers women to take personal responsibility for their health and for that of their children. (Royston and Armstrong, 1989).

A study in Bangladesh on how women's education and autonomy affect their use of maternal health services showed a strong relationship between women's education and their use of maternal health services. They found out that women with secondary education or above were nearly seven times more likely to receive Antenatal care than women with no education (Hussein et al, 1998).

The Ghana 1998 Demographic and health survey found that use of delivery facilities rises sharply with maternal education from 24% among women with no education to 86% among women with secondary education. And women who received antenatal care services were more likely to subsequently deliver in a health care facility (Ghana Statistical Services, 1999).

It also found out that older women and women who have had many births were much more likely to have received no assistance at delivery, where as first births and births to younger women tend to receive better care during delivery including more frequent supervision by a physician. Again urban women were much more likely than rural women to receive medical supervision during delivery. Hence the quality of postnatal care for births

delivered in a health facility is much better than for non-institutional care (Ghana Statistical Services, 1999).

It must be noted that most of the factors discussed above might be relevant contributors to low institutional deliveries in the K.N.D. However what is not known is the magnitude of each of the factors and the degree to which they influence women's decision to deliver or not at the health care facilities. To remove financial barrier, the Kassena Nankana district is offering free services for women seeking ANC and delivery services yet institutional deliveries remain low compared with A.N.C. The Community-based Planning and Services initiative where community health officers are stationed in the community is an effort to make health care delivery accessible to community members. However, the community health compounds are not equipped to render delivery services in the district so lack of access to skilled care during delivery may still exist. For an appropriate intervention to improve skilled care during labour and delivery information is required on factors which influence women's choice of place to deliver. In the light of scarce resources which of the factors need priority attention in order to increase institutional deliveries? Are there any other alternative ways of making deliveries under skilled supervision more accessible and acceptable to the women? This is what the research seeks to find out.

CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY TYPE:

The design of the study is exploratory to identify factors that influence women's decisions to deliver or not to deliver in the health institutions. An initial qualitative interview i.e. focus group discussion (FGD) was done to gain insight to all variables of the study to facilitate design of questionnaire for quantitative data.

3.2 SAMPLING

3.2.1. STUDY POPULATION

The study population was all women who had antenatal care at the health facilities (Registered) from 1st January, 2002 to 31st December 2002. This was to avoid recall bias. Two groups of women were interviewed

1. One group comprised all who had antenatal care and delivered at the health facility.
2. The second group was all who had antenatal care but did not deliver at the health facility.

3.2 STUDY UNITS

The study units were:

1. A mother who had ANC at the health facility but did not deliver there
2. A mother who had ANC and delivered at the health facility.

3.2.3. SAMPLING PROCEDURE

Multistage ~~sampling~~ procedure was used to select two groups of mothers who had ANC at the health facility, and either delivered or did not deliver at the health facility from five sub districts in the district. This was done by compiling a list of communities from where the women came from. The communities which were far from the health facility and not likely to use it for delivery were eliminated. Four communities were selected by simple random sampling. From the ANC registers all the registrants from the selected communities for the year 2002 were listed according to their ANC numbers. Forty respondents were selected from each subdistrict using the lottery method i.e. twenty for those who delivered at the facility and twenty who did not. Two focus group discussions were done in one community .This was done to gather information on the variables under study to facilitate design of questionnaires for the study.

3.2.4 SAMPLE SIZE

A total of two hundred (200) respondents were selected for the quantitative study i.e. 100 for those who delivered and 100 for those who did not deliver at the facility. This number was chosen because of time limitation and the fact that a sample of thirty respondents was significant for each cell using the age groupings of the cells as the bases. In collecting the data there were a few non-responses due to wrong addresses. More respondents were therefore selected to make up the number 200.

3.3 DATA COLLECTION TECHNIQUES AND TOOLS

Data collection technique and tools used involved

- i. Focus group discussion: one for women who delivered at the health facility and another for women who did not deliver at the health facility using focus group discussion guide. This was done in one community.
- ii. The instrument used for data collection was structured interview questionnaire. This consisted of close-ended and open-ended questions to elicit respondents' opinions. The questions were developed based on the objectives of the study and the variables under study which included socio-demographic characteristics, i.e. age, parity, educational level marital status occupation and religion. Cultural/religious beliefs related to delivery, family influence, accessibility to health facility, cost of services and client satisfaction.

3.4 DATA PROCESSING AND ANALYSIS

1. Data processing and analysis were carried out in the following ways:

For the FGD, the responses were sorted out, stored and then transcribed.

The findings were used to complete the questionnaire for the quantitative data.

2. The responses for the quantitative data were analyzed using SPSS and Excel software. After having been sorted presentation of the findings was done using cross tabulations and figures according to the variables in the two groups.

3.5. ETHICAL CONSIDERATIONS

Respondents were assured of confidentiality in order to obtain their informed consent to carry out the study. Permission was obtained from the head of family or husbands of the women after explaining the purpose of the study to them in order to allow the women to take part in the study.

3.6. SELECTION AND TRAINING OF INTERVIEWERS

Twelve field workers were selected to assist in data collection from the communities. They were given two days training in the technique of interviewing after having been briefed on the purpose of the study.

They were made to translate the questionnaires into the local languages (that is, Kassem, Nankam and Buli) to ensure uniformity.

3.7. PRETEST

Pretesting of the questionnaire was carried out using nursing mothers at Vorania community near Navrongo. This was to assess the validity, reliability, relevance and acceptability of the questionnaire and also to assess how long it will take to interview one respondent. Appropriate corrections were made.

3.8. LIMITATIONS

Language barrier was a major constraint to the researcher in addition to time as she has to combine other field work activities with the research.

CHAPTER FOUR

FINDINGS FROM THE STUDY

4.0 Introduction

This chapter presents the research findings. As stated in the introductory chapter the objective was to identify factors that influence women in the Kassena Nankana District from delivering at the health care facilities.

The data analysis was based on the following variables:

- a. Socio-demographic characteristics of the women
- b. Influence of family in decisions concerning choice of place to deliver
- c. Accessibility and affordability of services to clients
- d. Client satisfaction of services provided

The analysis was done by looking at responses from women who delivered at the health facilities and from those who did not and comparing the two responses where necessary to deduce reasonable conclusions about factors influencing the decisions of women to deliver or not at the health care facilities.

4.1 Socio-Demographic characteristics

The background information of respondents is presented here. Characteristics such as age, marital status, birth order of last child, educational status of respondents and their husbands occupation and religious affiliation and how each influences choice of place of delivery are presented in tables and figures.

4.1.1 Age of Respondents

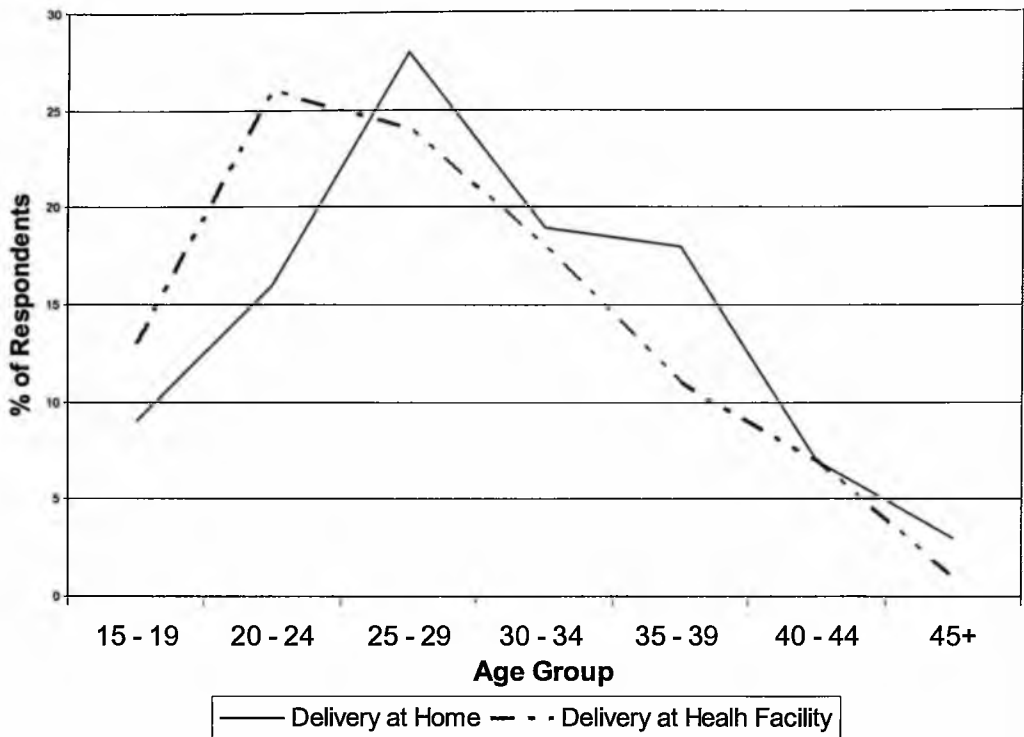
Ages of respondents are presented in table 3 below.

Table 3: Distribution of Respondent by Age Group and Place of Delivery

Age Group	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
15-19	9	40.9	13	50.1	22
20-24	16	38.1	26	61.9	42
25-29	28	53.8	24	46.2	52
30-34	19	51.4	18	48.6	37
35-39	18	62.1	11	37.9	29
40-44	7	50	7	50	14
45+	3	75	1	25	4
Total	100		100		200

The table shows that among the twenty-two(22) respondents who are within the age group of 15-19 years, majority (50.1%) delivered at the health facility and 40.9% delivered at home. Out of a total of 42 respondents within the age group of 20-24 years, 61.9% delivered at the facility as against 38.1% at home. Among the majority (52) of all respondents who were in the age group of 25-29, 46.2% delivered at the health facility and 53.8% at home. The least number of respondents (4) were within the group 45 and above and three (75%) delivered at home. The relationship between age and choice of place of delivery is presented in figure 1 below. Age does not seem to influence choice of place of delivery.

Fig. 1: Chart Showing Distribution Age of Respondents and Choice of Place of Delivery



4.1.2 Marital Status

Out of the majority 148 respondents who are in monogamous marriage, 78(52.7%) delivered at home and 70(47.3%) at the health facility. Fifty percent (22) of the forty respondents in polygamous marriages delivered at home and 50 %(22) delivered in Health Facility. The remaining eight respondents (8) are single parents; six not married one widowed and one Divorced all delivered in the health facility. Here again type of marriage did not seem to have any influence in the choice of place of delivery as there was not much difference between choice of place of delivery and marital status of respondents.

4.1.3 Birth order of last child (Parity)

Respondents were asked to state the birth order of their last child. This is presented in table 4 below.

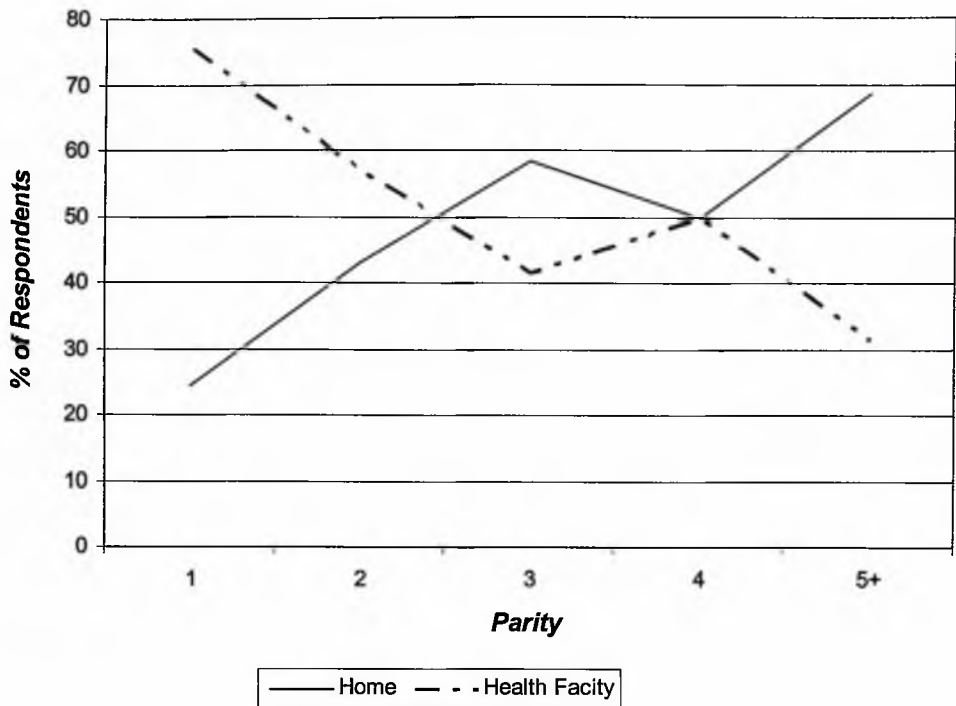
Table 4: Distribution of Respondents by Parity and Place of Delivery

Parity	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
One	10	24.4	31	75.6	41
Two	16	43.2	21	56.8	37
Three	24	58.5	17	41.5	41
Four	15	50	15	50	30
Five and above	35	68.6	16	31.4	51
Total	100		100		200

From the table it would be seen that 31(75.6%) of the 41 respondents with a parity of one delivered at the health facility as against 10(24.4%) delivered at home. Out of a total of 51 respondents with a parity of five and above as many as 35 (68.6%) delivered at home as against 16 (31.4%) who delivered at the health facility.

The relationship between parity and choice of place to deliver is shown in the figure 2 below.

Fig. 2: Chart Showing Relationship Between Parity and Choice of Place of Delivery



. The graph indicates that birth order (parity) has an influence on choice of place to deliver. The higher the parity the more likely is the woman to deliver at home and less likely to use Health Facility. Women with first births are more likely to deliver at the health facility than home.

4.1.4 Educational Status of Respondents**Table 5: Distribution of Respondents by Educational Status and Place of Delivery.**

Ever Been to School?	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
Yes	26	31.7	56	68.3	82
No	74	62.7	44	37.3	118
Total	100		100		200

From the table above it is seen that majority of respondents i.e.118 (59%) had never been to school and out of these number 74 (62.7%) delivered at home and only 44(37.3%) delivered at the facility. Out of the 82(41%) who had been to school, only 26(31.7%) delivered at home and majority 56(68.3%) delivered at the facility.

With regards to the educational status of their husbands, majority i.e.115 (57.5%) of respondents said their husbands had not been to school and out of these 71 (61.7%) of them delivered at home and 44(38.2%) delivered at the Health facility. Eighty-five (42.5%) of respondents said their husbands had been to school. Out of these as many as 56(65.9%) delivered at the health facility and 29(34.1%) delivered at home.

Table 6: Educational Status of Respondents' Husbands and Place of delivery

Husband Ever Been to School?	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
Yes	29	34.1	56	65.9	85
No	71	61.7	44	38.2	115
Total	100		100		200

The highest level of education reached by respondents and the level for their husbands is presented in tables 7 and 8 below.

Table 7: Distribution of Education Level Reached by Respondents and place of Delivery

Educational Level of Respondents	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
Primary	17	45.9	20	54.1	37
Middle/JSS	7	25	21	75	28
Sec./SSS/Tech.	2	15.4	11	84.6	13
Post. Sec	0	0	1	100	1
Voc./Com.	0	0	2	100	2
University/Poly.	0	0	0	0	0
Non-formal	0	0	1	100	1
Total	26		56		82

Table 8: Educational Level of Respondents' Husbands

Educational Level of Respondents' Husband	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
Primary	9	39.1	14	60.9	23
Middle/JSS	13	43.3	17	56.7	30
Sec./SSS/Tech.	5	26.3	14	73.7	19
Post. Sec	1	16.7	5	83.3	6
Voc./Com.	0	0	1	100	1
University/Poly.	0	0	2	100	2
Non-formal	1	25	3	75	4
Total	29		56		85

From the table it is seen that among the respondents who had been to school majority i.e. 37(45.1%) reached primary school level. Out of these 20(54.1%) delivered at the health facility and 17(45.9%) at home. Twenty eight (34.1%) reached middle/junior secondary level thirteen (15.9%) reached secondary school. Only one and two respondents reached post secondary and vocational level respectively and they all delivered at the health facility.

Out of 85(42.5%) of respondents' husbands who had been to school, 23 (27.1%) reached primary level and 14(60.9%) of them delivered at the health facilities, 9 (39.1%) delivered at home. Only 2(2.4%) of respondents' husbands who went to school reached university/polytechnic level and all the two respondents delivered at the health facility. There seems to be a relationship between educational status and use of the health facility as the data indicates. And the higher the educational level by both respondents and the husbands the more likely the use of the health facility for delivery.

4.1.5 Occupation

Majority of respondents i.e.117 (58.5%) are subsistence farmers. Out of this number, 41(35%) delivered at the health facility and 76(65%) delivered at home. Seventy-three (36.5%) of respondents are in other occupations such as trading, hairdressing/seamstress, and teaching. Of this, 54(74%) delivered in the health facility and 19(26%) delivered at home. The remaining ten (0.5%) are unemployed.

The type of occupation one is engaged in is suggestive of the persons income and thereby ability to afford cost of services or not.

4.1.6 Religion

Their religious affiliations is presented in Table 9 below

Table 9: Distribution of Respondents by Religion and Place of Delivery

Religion	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
Christian	37	37.8	61	62.2	98
Moslem	9	45	11	55	20
Traditional	49	66.2	25	33.8	74
No Religion	5	62.5	3	37.5	8
Total	100		100		200

The results shows that a total of 98(49%) of all respondents are Christians. Out of the number 61(62.2%) delivered at the health facility and 37(37.8%) at home. Out of 74(37%) who are of traditional religion, 49(66.2%) delivered at home and 25(33.8 %) delivered at the health facility. A total of 20(10%) are Moslems and 11(55%) delivered at the facilities and 9 (45%) delivered at home. The remaining 8(4%) of respondents said they do not belong to any religion. Religion seems to have an influence in choice of place to deliver as more women with traditional religion delivered at home than the other religions.

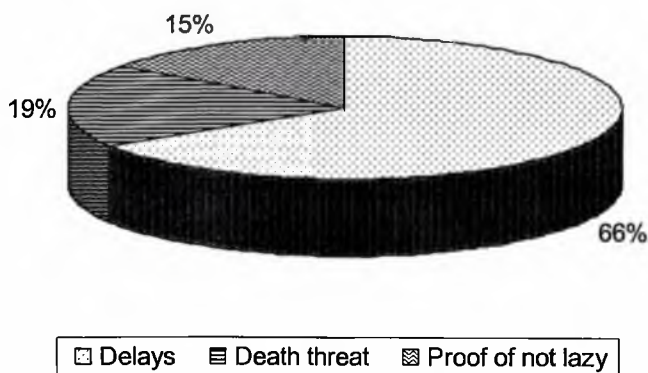
4.1.7 Influence of Cultural / Religious beliefs

The respondents were asked whether there are any beliefs (Cultural or Religious) in their communities related to delivery and how these affected or influenced their decisions regarding choice of place to deliver. Majority i.e.125 (62.5%) of all respondents said they did not know of any and 75(37.5%) said there are beliefs related to delivery. 'Out of this number, 47(62.7%) delivered at home and 28(37.3%) of respondents delivered at the health facilities.

Out of the 75 respondents who said there were beliefs, 49(65.3%) said consulting the gods/soothsayers during labour was common. Twelve(16%) said there exists the belief that women who deliver in hospital are lazy or not strong, 14 (18.7%) said there is the belief that the baby in the womb does not want to be born in hospital and so must be delivered at home. This normally happens after consulting the soothsayers. Other beliefs stated were: prolong labour attributed to unfaithfulness of the women; belief related to type of food to eat during pregnancy, sleeping position during labour were stated by 3(4%) of respondents.

When respondents were asked how these beliefs influences choice of place of delivery, 50(66%) of the respondents said it causes delays in seeking care in the health facilities, 14(19%) said women are threatened of death if they insist to go to hospital so they deliver at home, 11(15%) said to prove they are not lazy they deliver at home. This is presented in the figure 3 below.

Fig. 3: Chart Showing the Effects of Cultural/Religious Beliefs on Choice of Place of Delivery



It would be inferred that Religions affiliation is associated with beliefs related to delivery and hence influence choice of place of delivery to some degree.

4.1.8 Family Influence

Respondents were asked to state the one who makes decisions concerning the place to deliver in the family. Their responses are presented in table 10 below

Table 10: Distribution of the Proportion of Decision Maker at Home and Choice of Place of Delivery

Decision Maker	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
Family head	13	46.2	15	53.8	28
Husband	14	42.4	19	57.6	33
Mother-in-law	6	54.5	5	45.5	11
Myself	35	53.0	31	47.0	66
Other	12	92.3	1	7.7	13
Myself & husband	9	56.3	7	43.7	16
Husband & mother-in-law	2	20	8	80	10
Myself, husband, mother-in-law & head of family	9	39.1	14	60.9	23
Total	100		100		200

The results showed that, majority, 66(33%) of all respondents made the decisions alone. Out of these 35(53.0%) delivered at home and 31(47.0%) delivered at the health facility. Twenty-eight (14%) said head of family, 33(16.5%) said husband alone, 11(5.5%) by mother in-law and the remaining 62(31%) by joint decision of self and husband, husband and mother in-law or self/husband and mother in-law and sisters in-law

From the result influence of family seem not to be a main factor in choice of place to deliver, but it is an area that needs to be explored further.

To ascertain whether there was a relationship between educational status and respondents who made decisions alone, cross matching was done for the two variables. The results are presented in Table 11:

Table 11: Educational Status of Respondents Who Made Decision Alone and Choice of Place of Delivery

Ever Attended School?	Delivery at Home		Delivery at Health Facility		Total
	No. of Respondents	%	No. of Respondents	%	
Yes	7	24.1	22	75.9	29
No	28	73.7	9	26.3	37
Total	35		31		66

From the table it would be seen that out of 66(33%) who made decisions alone, 29(44%) had been to school. Twenty-two (75.9%) of these delivered at the health facilities and only 7(24.1%) at home. The remaining 37(56%) of respondents had never attended school out of these majority 28(73.7%) delivered at home as against only 9(26.3%) in the health facility. It would be deduced that educational status of women has an influence on their decision to deliver or not to deliver at a health facility.

4.4 Reasons for choice of place to deliver.

The main purpose of the study is to identify factors that made women to deliver or not deliver at the health facilities. Information was solicited from respondents on reasons for delivering where they did. The reasons given by both groups are presented in figures 4 and 5 in the next page.

Fig. 4: Chart Showing Proportion of Each Reason Given by Respondents For Delivering at Home

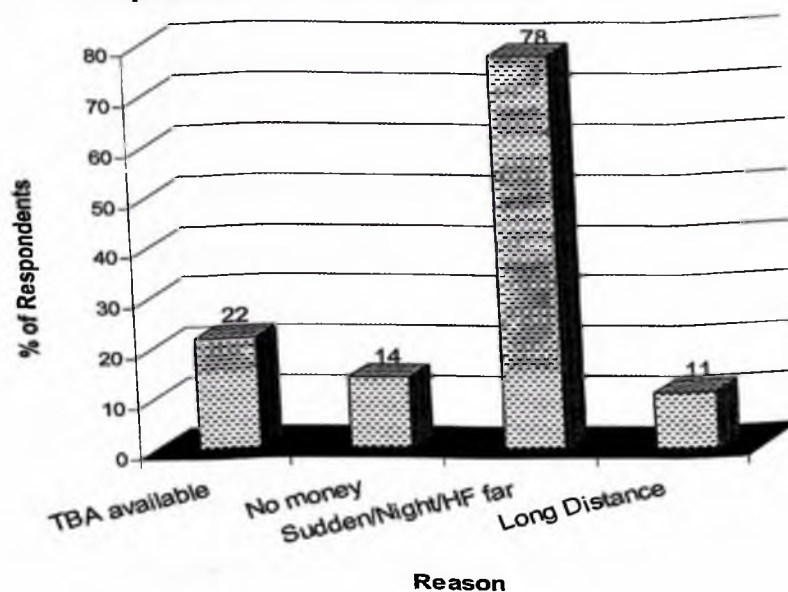
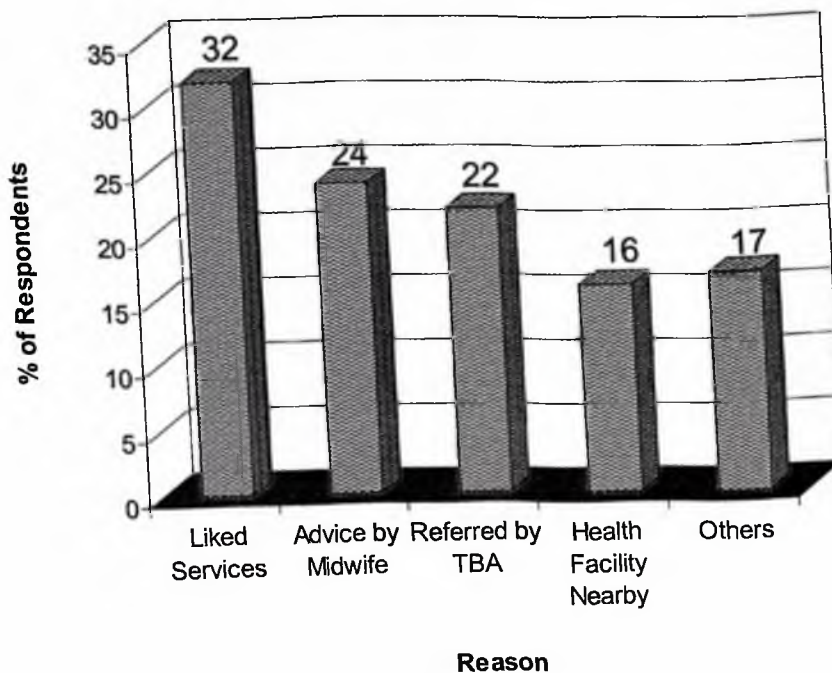


Fig. 5: Chart Showing Proportion of Each Reason Given by Respondents for Delivering at a Health Facility



It would be inferred from the figures above that for those who delivered at home majority; 78 responses were related to sudden onset of labour in the night and health facility far from home as the main reason for delivering at home. Twenty-two (22) related to availability of TBAS, 14 as a result of no money for services at the health facility and home far from health facility was stated by 11 respondents. For some it was a combination of two or more factors, i.e. sudden onset and no money, sudden onset in the night and availability of TBAS, availability of TBAs and no money.

For those who delivered at the Health facility, 32 responses were related to liking services at the health facility, 24 because of advice by midwives, 22 were referred by TBAS, 16 because health facility was near their homes, other responses were that health facility was safer stated by 15 respondents, one person said there was no one at home to help her deliver and another that she was advised by her father to deliver at the facility.

They were asked to state the difficulties they encountered by going to the Health facility to deliver. Sixty-two (62%) of them said they did not encounter any difficulty. Out of the 38 who had difficulties 12(31.6%) said there was no means of transport to convey them to health facility, 8(21.1%) respondents said there was no money and 13(34.2%) said they had difficulty or unable to meet the demands of midwives for baby clothes and soaps and one person said there was nobody to accompany her to the hospital.

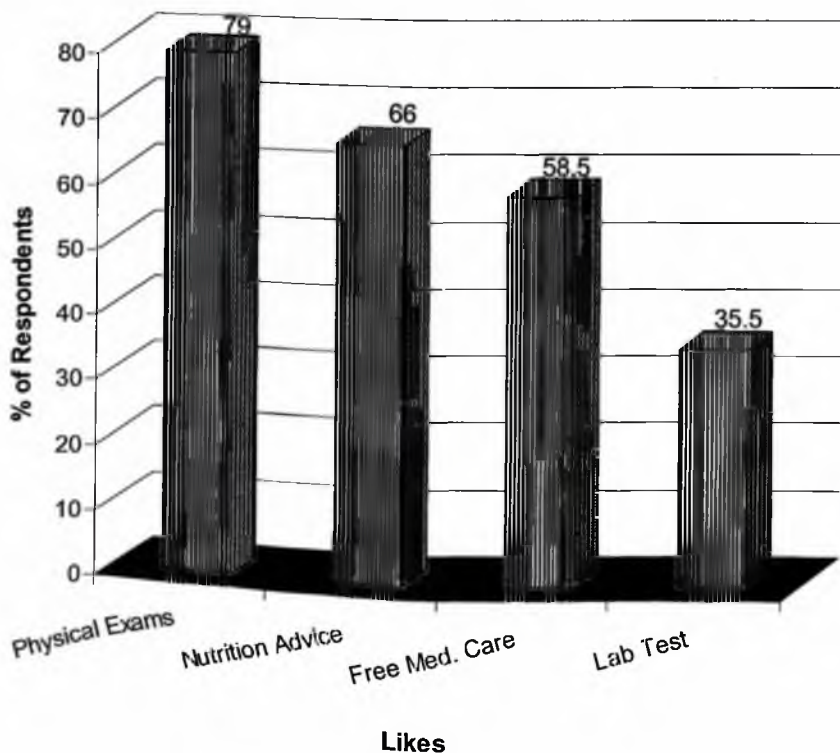
It would be deduced from the responses that sudden onset of labour in the night coupled with distance and lack of transport to convey women in labour were major contributors to the women not delivering in the health facilities.

4.5 Client Satisfaction

Respondents were asked to state reasons for attending A N C during pregnancy. For both groups, majority 160(80%) of responses were to checking their conditions, 157(78.5%) to check position of the baby in the womb and 142(71%) to collect medicines for proper growth. It must be stated that the respondents gave more than one reason.

Respondents were asked to state what they liked at the clinics. Their responses are shown in fig. 6.

Fig. 6: Chart Showing Proportion of Each Item Respondents Liked About Antenatal Care

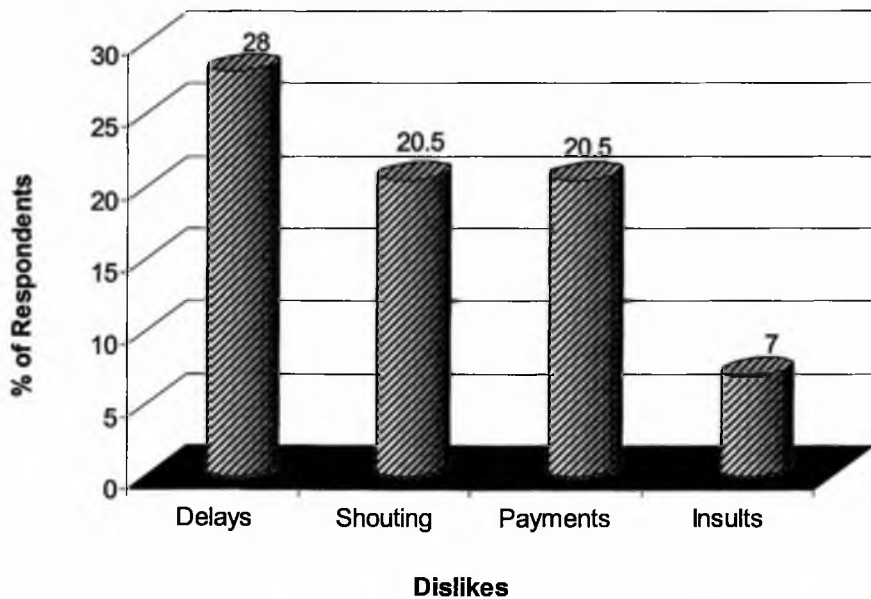


As many as 158(79%) of responses related to physical examination, 132(66%) liked the nutrition advice given, 117(58.5%) liked free medical care and least liked was blood and

urine test which was 71(35.5%) of responses. This is probably because this involved some pain or involved payment of fees for the laboratory tests.

They were then asked to state what they did not like. Their responses is presented in fig. 7 below

Fig. 7: Chart Showing Proportion of Each Item Respondents Disliked About Antenatal Care



Majority i.e. 101(50.5%) of respondents said they liked everything. Fifty-six (28%) responses of dislikes were related to delays at the clinics, 41(20.5%) disliked been shouted at as if they were children, 41(20.5%) disliked payments of fees at the clinic and 14(7.0%) disliked the insults by midwives.

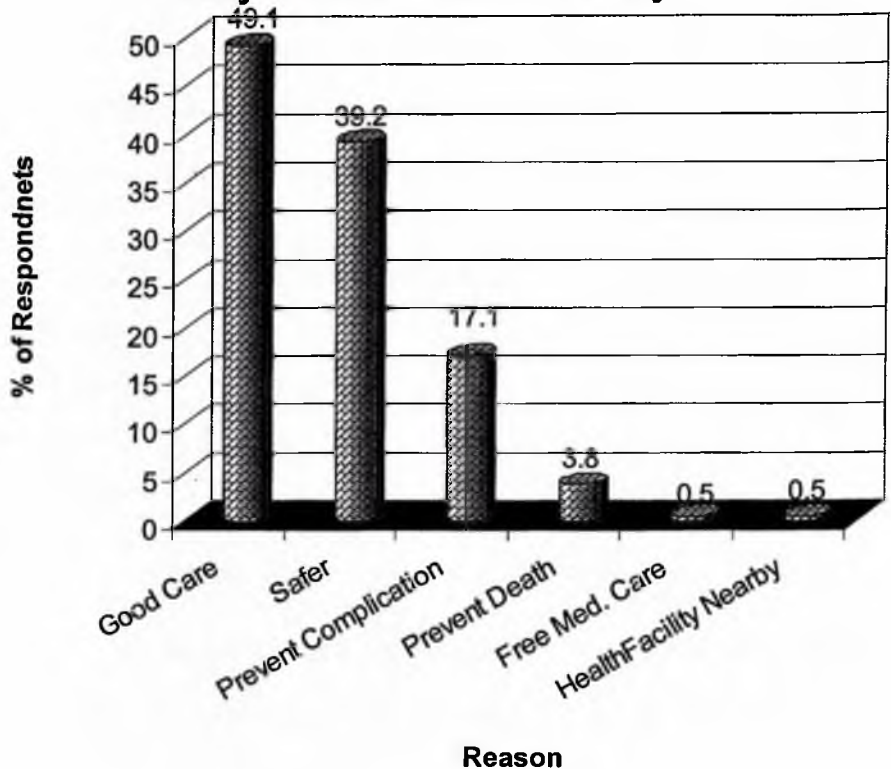
It would be noted that people are likely to make, subsequent visits to health facilities when they are satisfied with services they receive. Dissatisfaction with services stated by 99

respondents may be a contributory factor for low utilization of health facilities for deliveries in the district

Respondents were asked to state where they would want to deliver their next child if any again. Almost all respondents for the two groups, 181 (90.5%) said they would want to deliver in the health facility. However 15(7.5%) of respondents said they would want to deliver at home and 4(2.0%) were uncertain.

When they were asked to give reasons for their choice of place various reasons were given as presented in figure 8.

Fig. 8: Chart Showing Proportion of Each Reason Given by Respondents for Choosing Health Facility as Next Place of Delivery



Out of those who chose health facility, majority 89(49.1%) said because they would be taken good care of at the Health Facility, 71(39.2%) said because it is safer to deliver there, 31(17.1%) said to prevent complications, 7(3.8%) said to prevent death, 1(0.5%) said free medical care and 1(0.5%) said because Health Facility is near home

For those who will not deliver at Health facility, 3 said because they were uncertain where they would deliver, 3 believed God would help them deliver at home, 3 think there would

be no payment when they are delivered by the TBA and 3 said they have short duration of labour and do not have to travel to hospital, one said she will not deliver again.

Information was sought from respondents about risks of delivering elsewhere other than in a health facility. The responses are presented in table 12:

Table12: Proportion of Risks Mentioned by Respondents about Risks of Delivering Elsewhere

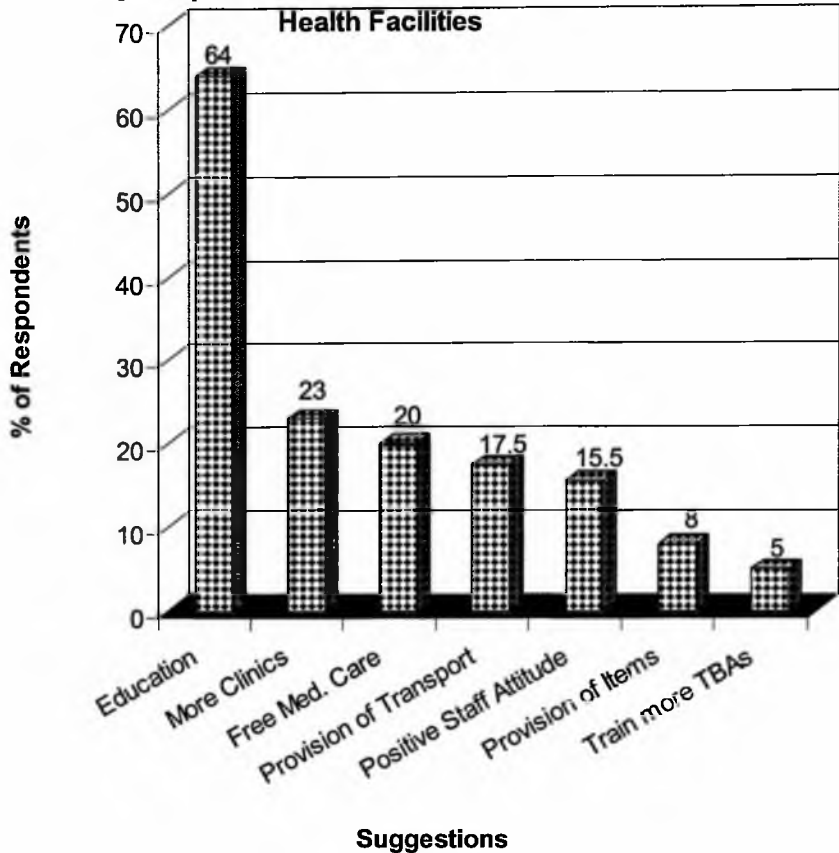
Risk	No. of Respondents	%
Prolong Labour	112	56.0
Profuse Bleeding	86	43.0
Death of Baby	128	64.0
Death of Mother	125	62.5
Other	12	6.0

Their responses show that all of them knew at least one risk. Risks mentioned included prolong labour, death of baby in the womb, profuse bleeding and death of mother.

4.6. Suggestions by respondents

Respondents' opinions were sought as to what should be done to make more women deliver at the health facilities. Their opinions are presented in fig 10:

Fig. 9: Chart Showing Proportion of Each Suggestion Given by Respondents to Make More Women Deliver at Health Facilities



Majority i.e.128 (64.0%) think education given to pregnant women, community members and chiefs about the importance of delivering in health facilities would improve utilization. Forty-six (23.0%) think building more clinics in communities and training more nurses for the clinics would help. Forty (20.0%) of respondents said there should be free medical care during delivery. Thirty (17.5%) of respondents said transport / or ambulance be provided in the communities to convey women in labour to health facilities. Thirty-one (15.5%) of them said midwives should speak politely to women and they should not shout at them, insult or beat them during delivery and they should not force them to buy items they sell.

Sixteen (8.0%) said food, mosquito nets and beds should be provided at the health facilities and 10(5.0%) of them think more TBAS should be trained.

In conclusion a number of factors precisely some cultural beliefs, low educational status of women lack of access to health facilities, lack of transport and money and negative staff attitude were found to be contributing to women not delivery at the health care facilities. These will be discussed in the next chapter.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

In the previous chapter the analysis of responses from the questionnaire were considered. This chapter discusses the results of the study and gives recommendations.

5.1 Socio- Demographic Characteristics

The background information of respondents was obtained and how each variable influenced their choice of place of delivery was ascertained.

Factors such as women's status, Age of the women, parity or birth order, educational level, occupation and marital status may influence women's decision to deliver or not to deliver in a health care facility. The results of the study showed that age was not a major influence as there was no significant difference in the ages of the two groups.

Marital status did not also show any difference. However parity or birth order and level of education were seen to be an influence in choice of place to deliver. The results showed that only 10(24.4%) of the 41 respondents with first births delivered at home as against 31(75.6%) delivering in health facility and as many as 35(68.6%) of 51 respondents who had a birth order of 5 and above delivered at home and only 16(31.4%) delivered at the health facility. The results showed that the higher the parity the more likely is the woman to deliver at home and less likely to use the health facility.

Again 74(62.7%) of the 118 respondents who have no education delivered at home as against 44(37.3%) delivering at the health institutions. As many as 56(68.3%) of the 82

respondents with some education delivered at the health facility and only 26(31.7%) delivered at home. This confirms studies by Ghana Statistical Services (1999) and Royston and Armstrong (1989) that older women and women who have had many births were much more likely to have received no assistance at delivery whereas first births and births to younger women tend to receive assistance from health workers. Again, confirms the study by Hussain et al (1998) that there is a strong relationship between women's education and their use of maternal health services.

Education empowers women to take personal responsibility for their health and that of their children.

Majority (76%) of the women who delivered at home were also found to be subsistence farmers hence their status in terms of income was low and therefore unlikely to afford cost of services from health care facilities.

5.2 Influence of Cultural or Religious Beliefs

The study revealed that majority (129) of all respondents did not know of any cultural or religions beliefs. 71 respondents who said there were cultural/religions beliefs said consulting the gods or soothsayers during labour to seek permission, caused delays in seeking help from health facilities. This cultural practice has an influence in choice of place to deliver in the District and contributes to the low deliveries in health facilities and confirms the study by Odoi-Agyarko et al (1993).

5.3 Family Influence

The study revealed that majority of the women in the two groups (66) made the decisions themselves to deliver where they did. The influence of family members in decisions concerning choice of place to deliver might still exist in some cases; however it would be deduced from the study that it is not a major factor for women not delivering at the health facility. This calls for further investigation.

5.4 Reasons for Choice of place of delivery

Distance to health facility, lack of transportation and lack of money were found to be a major factor why women do not deliver in the health facilities in the district as majority (76%) of women who delivered at home said labour was sudden and in the night and there was no transport.

Those women who delivered in the health facility also sited lack of transport and money as difficulties they encountered in going to the facilities.

Long distance to service delivery points and lack of transport and money may discourage clients from using the facility even if they had wanted to as was confirmed by Rahman, (1981) for non-use of M C H services in Bangladesh, Biego et al (1995) a study in Tanzania and by Gyamfi (2000) in a study in Dangme west district of Ghana.

5.5 CLIENT SATISFACTION

The indications used to measure client satisfaction showed positive results on most of the services received. Almost all respondents were satisfied with what they went in for during ANC basically to check their conditions and position of the baby. Most of them (158) liked

physical examination on them, (132) liked the advice given and the free medical care by 117 respondents. Most of them liked more than one item.

The indicators which revealed dissatisfaction were long waiting time (delays) during the clinic, been shouted at as if they were children, payments for unnecessary items and insults from midwives. These were stated by 99 respondents and relates basically to staff attitude. Clients' dissatisfaction with health care providers is capable of discouraging them from using the facility even though they may consider it safer. This was shown in their response to the question of where they would want to have their next child. Almost all (181) wish to deliver at the health care facilities because they would be taken good care off and is safer, this confirms the 1998 WHO Report that where health care workers are perceived to be hostile and unfriendly, many women rely instead on traditional healers or TBAs for antenatal, delivery and post partum care.

5.6 Suggestions of respondents on ways of improving deliveries in Health

Facilities.

All respondents made at least one suggestion to help improve deliveries in the health facilities. Majority (128) think education of pregnant women, community members and chiefs on the importance of delivering there will ensure that they use the facilities.

Others were of the opinion that building more clinics in communities and training more nurses would help. Again provision of free medical care during delivery and provision of transport/ambulance services in the communities to convey women in labour to health facility as well as positive and friendly attitude of midwives towards women in labour were highlighted as measures to encourage women to deliver at the health facilities.

5.7 CONCLUSION

The issue of low utilization of health facilities for deliveries despite high antenatal attendance is a major concern to not only the Kassena Nankana District health administration but also to the whole Ministry of Health and for that matter the government of Ghana, as it contributes to the high maternal mortality in the Nation.

Low educational status of women leading to low income, influence of cultural beliefs, lack of access and transport to health facilities and negative staff attitude were found to be the major factors for women not using the health facilities for deliveries in the district. The high level of desire by respondents to deliver their next child in the health facility is a positive sign that they want to use the facilities. Appropriate interventions by all stakeholders to address the factors identified would improve utilization of health facilities in the near future.

5.8 RECOMMENDATIONS

Based on the findings from the study the following recommendations would be useful in ensuring that clients receive skilled care at the health facilities.

Intensification of education to all members of the community especially chiefs, heads of families, husbands and women's groups on importance of delivering at the health facilities must be given prior attention by the district health administration and all concerned citizens in the district.

2. There should be restructuring of safe motherhood services and facilities in the district to ensure involvement of spouses and relatives during antenatal service to gain their support.
3. Retraining of health staff on human relations and communication skills to ensure that quality care is provided to clients at the health care facilities should also receive immediate attention.
4. To address accessibility problems, the CHPS initiative should be expanded to cover all communities especially those which are far from health facilities. It is recommended that the community health compounds (CHCs) should be equipped with midwifery kits and trained community health midwives should be deployed as community health officers (CHOs) to be in charge of these compounds to render more comprehensive health services.
5. The government should expedite action on free medical care for all aspects during delivery i.e. drugs, supplies and delivery fees.
6. Efforts should be made to provide means of transport for the two remaining sub-districts in Kassena Nankana has access to used for referral purposes.
7. The District Health Administration in collaboration with District Assembly and Non-Governmental Organizations should provide effective communication systems to deprived communities and referral points to ensure that prompt attention is given to clients who need assistance to utilize health facilities during labour.
8. The Ghana Health Service and the District Health Administration should give awards as a form of motivation for health care providers who accept postings to the deprived areas in the district.

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APPENDIX ONE**DATA COLLECTING INSTRUMENTS****INTERVIEW SCHEDULE FOR WOMEN WHO DELIVERED IN THE HEALTH FACILITY****INSTRUCTION TO INTERVIEWER**

This questionnaire should be used with women who had Antenatal care and delivered at the Health facility.

Ask the woman if she is willing to answer the questions after explaining to her or the head of family the purpose of the study.

Purpose: The purpose of the research is to find reasons why women in the district attend antenatal clinics when pregnant at the health facilities but do not deliver there in order to find solutions to improve utilization of the health facilities.

Your responses would be strictly confidential

Name of Subdistrict

Name of Town or Village.....

Name of Respondent.....

Name of Compound Head.....

Compound Number.....

Name of Interviewer.....,

Date.....

A. Socio – Demographic Characteristics

1. How old are you?

1. -----years

2. What is your current marital status? (probe for exact status)

1. Married (monogamous)

2. Married (Polygamous)

3. Single (Never married)

4. Divorced/Separated/Widowed.

5. 3. Have you ever attended school?

1. Yes

2. No

4. If yes, what is the highest level of school attended?

1. Primary

2. Middle/JSS

3. Secondary/SSS /Technical

4. Post Sec

5. Vocational /Commercial

5. University/Polytechnic

6. Non-formal

5. Did your husband attend school?

1. Yes

2. No

6. If yes, what is the highest level of school attended?

1. Primary

3. Middle/JSS

4. Secondary/SSS/Technical

5. Post Sec

6. Vocational/Commercial

7. University/Polytechnic

8. Non-formal

7. What is your Religion?

1. Christian 2. Moslem 3. Traditional 4. No Religion

5. Other specify

9. What is your occupation?

1. Farmer 2. Trader 3. Hairdresser/Seamstress

4. Teacher/Nurse 5. Other Specify.....

B. Reproductive health issues.

10. What is the birth order for your last child?

1. First 2. Second 3. Third 4. Fourth 5. Other specify _____

11 Why did you go for ANC? (circle as many as is applicable)

- 1.To check my condition
- 2.To check the position of the baby
- 3.To collect medicine for proper growth
- 4.To know the day I will give birth
- 5.Other Specify.....

12. What did you like about ANC services provided ? (circle as many as is applicable)

1. The blood and urine tests
2. The advice on type of food to eat
3. The examination done on me
4. The free medical care
5. Other Specify.....

13. What did you not like about ANC services provided? (circle as many as is applicable)

- 1.The insults by the midwives
- 2.Delays in attending to us
- 3.Shouted at as children
- 4.Paying of money we don't understand
- 5.Other Specify.....

14. What made you decide to deliver there? (circle as many as is applicable)

1. It is near my home
2. I was referred by the TBA
3. I like the services provided by the midwives
4. I always deliver there
5. The midwife advised me to deliver in the hospital
6. Other Specify.....

15. Did you encounter any difficulties in going to the health facility to deliver?

1. Yes
2. No

16. If yes, what were the difficulties you encountered?

1. No transport to take me to the hospital in the night
2. There was no money
3. Others Specify.....

17. Who makes decisions concerning choice of place to deliver in your home?

1. Head of family
2. Husband
3. Mother-in-law
4. Soothsayer
5. Myself
6. Other specify.....

18. How does the decisions of the person affect your choice of place of delivery?

1. I have to obey
2. I can't go to the hospital alone
3. They will blame you for any negative consequences if you insist
4. Others Specify.....

19 What are the cultural, or religious beliefs concerning labour and delivery in your community?

1. Consulting the gods/soothsayers for permission to deliver in hospital
- 2 The belief that women who deliver in hospital are lazy or not strong
- 3 The belief that the baby in the womb does not want to be born in hospital
- 4 Other Specify.....

20. How do the beliefs/taboo affect your choice of place to deliver?

1. Delays in seeking care in the hospital
2. Threat of death if you insist to go to hospital
3. To prove I am not lazy I deliver at home
4. Other Specify.....

21. Where would you like to deliver your next child (if any again)?

1. Health facility
2. At home
3. At the TBA
4. Other Specify

22. Why would you want to deliver there?

State.....
.....

23. What are the risks of delivering else where apart from the health care facility?

1. Prolonged labour
2. Death of baby in the womb
3. Profuse bleeding after delivery
4. Death of mother.
5. Other Specify.....

24. In your opinion what should be done to make more women to deliver in the health facilities?

Thank you

INTERVIEW SCHEDULE FOR WOMEN WHO DID NOT**DELIVER IN A HEALTHCARE FACILITY****INSTRUCTION TO INTERVIEWER**

This questionnaire should be used with women who had Antenatal care but did not deliver at the Health facility.

Ask the woman if she is willing to answer the questions after explaining to her or the head of family the purpose of the study.

Purpose: The purpose of the research is to find reasons why women in the district attend antenatal clinics when pregnant at the health facilities but do not deliver there in order to find solutions to improve utilization of the health facilities.

Your responses would be strictly confidential

Name of Subdistrict -----

Name of Town or Village-----

Name of Interviewer.-----

Name of Respondent.....

Name of Compound Head.....

Compound Number.....

Name of Interviewer.-----

Date.....

A. Socio – Demographic Characteristics

1. How old are you?

1.-----years

2. What is your current marital status? (probe for exact status).

1. Married (monogamous)

2 Married (Polygamous)

3.Single (Never married)

4. Divorced/Separated/Widowed

3. Have you ever attended school?

1. Yes

2. No

4. If yes, what is the highest level of school attended?

. 1. Primary

. 2. Middle/JSS

3. Secondary/SSS/Technical

4. Post Sec

5. Vocational/Commercial

6. University/Polytechnic

7. Non-formal

5. Did your husband attend school?

1. Yes

2. No

6. If yes, what is the highest level of school attended?

1. Primary
2. Middle/JSS
3. Secondary/SSS/Technical
4. Post Sec
5. Vocational/Commercial
6. University/Polytechnic
7. Non-formal

7. What is your Religion?

1. Christian 2. Moslem 3. Traditional
4. No Religion 5. Other specify -----

8. What is your occupation?

1. Farmer 2. Trader 3. Hairdresser/Seamstress
4. Teacher/Nurse 5. Other Specify.....

B. Reproductive health issues.

9. What is the birth order for your last child?

1. First 2. Second 3. Third
4. Fourth 5. Other specify -----

10. Why did you go for ANC? (circle as many as is applicable)

- 1.To check my condition
- 2.To check the position of the baby
- 3.To collect medicine for proper growth
- 4.To know the day I will give birth
- 5.Other Specify.....

11 .What did you like about ANC services provided ? (circle as many as is applicable)

1. The blood and urine tests
2. The advice on type of food to eat
3. The examination done on me
4. The free medical care
5. Other Specify.....

12. What did you not like about ANC services provided? (circle as many as is applicable)

- 1.The insults by the midwives
- 2.Delays in attending to us
- 3.Shouted at as children
- 4.Paying of money we don't understand
- 5.Other Specify.....

13. What made you decide to deliver there? (circle as many as is applicable)

1. Availability of TBAs
2. No money for the hospital
3. It was sudden and in the night
4. The family people refused to take me to hospital
5. Other Specify.....

14. Who makes decisions concerning choice of place to deliver in your home?

1. Head of family
2. Husband
3. Mother-in-law
4. Soothsayer
5. Myself
6. Other specify.....

15. How does the decisions of the person affect your choice of place of delivery?

1. I have to obey
2. I can't go to the hospital alone
3. They will blame you for any negative consequences if you insist
4. Others Specify.....

16 .What are the cultural, or Religious beliefs concerning labour and delivery in your community?

1. Consulting the gods/soothsayers for permission to deliver in hospital
2. The belief that women who deliver in hospital are lazy or not strong
3. The belief that the baby in the womb does not want to be born in hospital
4. Other Specify.....

17. How do the beliefs affect your choice of place to deliver?

1. Delays in seeking care in the hospital
2. Threat of death if you insist to go to hospital
3. To prove I am not lazy I deliver at home
4. Other Specify.....

18. How does the presence of a rival affect decisions about place of delivery?

1. She can influence your husband to send you to hospital during labour
2. She may not allow your husband to send you to hospital
3. During a quarrel she will insult you for delivering in hospital
4. Other Specify.....

19. Where would you like to deliver your next child (if any again)?

1. Health facility
2. At home
3. At the TBA
4. Other Specify.....

20. Why would you want to deliver there?

State.....
.....

21. What are the risks of delivering else where apart from the health care facility?

1. Prolonged labour
- 2 .Death of baby in the womb
- 3 Profuse bleeding after delivery
4. Death of mother.
5. Other Specify.....

22In your opinion what should be done to make more women to deliver in the health facilities?

State.....
.....

Thank you.

APPENDIX THREE**FOCUS GROUP DISCUSSION GUIDE FOR WOMEN WHO HAD ANC IN 2002 IN
KASSENA NANKANA DISTRICT****INSTRUCTIONS****INSTRUCTION TO INTERVIEWER**

This questionnaire should be used with women who had Antenatal care at the Health facility.

Purpose: the purpose of the research is to find reasons why women in the district attend antenatal clinics when pregnant at the health facilities but do not deliver there in order to find solutions to improve utilization of the health facilities.

Your responses would be strictly confidential

Reproductive Health Issues

2. Where do women in your district go for Antenatal Care?
3. Why do they go there?
4. Do you like the services provided (probe for specific things they like)?
5. If they don't like the services probe for things they don't like
6. Where do women in the district normally deliver? (Probe for all the places.
7. Why do they deliver there?
8. Why do most women not deliver in the health facility (Probe for reasons?)
9. Are there any cultural, social or religious beliefs / taboos that make women not to deliver in the health facility?
10. If Yes probe for the beliefs / taboos.
11. Who makes decision concerning choice of place for delivery Probe for reasons?
12. Does the type of marriage / presence of rival influence women's decisions to deliver or not to deliver in the Health facility. How (probe)
13. What are the risks for not delivery at a health facility?
14. What in your opinion should be done to make more women deliver in the health facilities?

Thank you.