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FACTORS CONTRIBUTING TO UPTAKE OF SKILLED DELIVERY IN ADA-FOAH SUBDISTRICT IN THE GREATER ACCRA REGION

BY

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DECLARATION

I, HALIDU **IMURANA**, hereby declare that this research project report is my original work except for other people's works which have been duly acknowledged and has not been submitted in any institution of learning for examination purposes.

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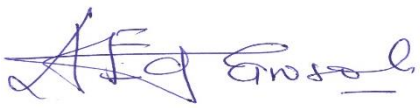
Signature:  Date: 17th October 2019

DEDICATION

I wish to dedicate this thesis report to my lovely wife Hajia Rukayat Imran and children Sraj Ben Imran and Khalid-Islam Ben Imran for their continuous support during my studies and in the preparation of this dissertation report.

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LIST OF ABBREVIATIONS AND ACRONYMS

ABBREVIATION	MEANING
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-Natal Care
CHW	Community Health Worker
IFGO -	International Federation of Gynaecology and Obstetrics
GDP	Gross Domestic Product
MDGs	Millennium Development Goals
SDGs	Sustainable Development Goals
MMR	Maternal Mortality Ratio
NGOs	Non-Governmental Organizations
PHO	Public Health Officer
SBA	Skilled Birth Attendant
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organization
CHPS	Community- based Health Planning Services
DHIMS	District Health Information Management System
GDHS	Ghana Demographic Health Survey
GSS	Ghana Statistical Service
LMICs	Low and Middle Income Countries
MOH	Ministry Of Health

NHIS	National Health Insurance Scheme
PPH	Postpartum Hemorrhage
DHD	District Health Directorate
DA	District Assembly
WIFA	Women in Fertile Age

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ABSTRACT

Background: Uptake of skilled delivery is identified to be the best pointer of advancement concerning decreasing maternal mortality globally. Also 50% or more pregnant women deliver yearly without a skilled birth attendant worldwide .Maternal mortality Ratio (MMR) in Ghana is currently 319 per 100,000 live births. Majority of the women in the Ada-Foah sub-district do not utilize skilled delivery services according to the District Health Information Management System figures. Maternal Mortality Ratio (MMR) of 70 per 100.000 live births or less by 2030, was the target set by the Sustainable Development Goal which Ghana is working to achieve due to the high maternal mortality ratio in the country.

Therefore, assessing the factors contributing to uptake of skilled delivery in Ada- Foah sub district was the purpose of the study.

Method: A cross sectional survey was carried out in 10 Child Welfare Clinics (CWC) in the Ada-Foah sub-district with a sample size of 295 mothers with babies born between January and December of the previous year. The data was collected using structured questionnaires. Descriptive statistics such as frequency and percentage distribution were used to describe the socio-demographic characteristics of respondents. Bar chart was used to describe multiple selection questions from the study participants. Pie chart was also used to describe the uptake of skilled delivery chi-square and binary logistic regression analyses (inferential statistical analyses) were used to assess the factors contributing to uptake of skilled delivery. 0.05 level of significant was set.

Results: The results of the study indicated that uptake of skilled delivery was high (80%). Factors such as marital status, partner's level of education and employments status of study participants, cost, and means of transport, staff attitude, previous ANC attendance and affordability of services were the factors that showed significant association with uptake of

skilled delivery. Persons who make health and pregnancy related decision did not show significant association with uptake of skilled delivery

Conclusion: Numerous factors such as socio-demographic characteristics, cultural perceptions, accessibility to health facility and quality of care influence uptake of skilled delivery. Therefore adequate measures should be put in place by the district health directorate, chiefs, NGO's and opinion leaders to improve on the uptake of skilled delivery in the sub-district and the district as a whole.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The Sustainable Development Goals (SDGs) cross-cutting theme of fairness is recognized worldwide to advance maternal and child health (WHO, 2013). Uptake of skilled delivery is encouraged worldwide to increase maternal survival. However, decreasing maternal mortality in terms of percentage has not been achieved notwithstanding the uptake of skilled delivery, hence the greater disparity being reported as compared to other interventions concerning maternal mortality (Kachikis, Moller, Allen, Say, & Chou, 2018)

According to (Gabrysch & Campbell, 2013), maternal mortalities of more than five hundred thousand (500,000) occur yearly across the globe, including four million newborns and three million stillborn babies . The lower and middle income countries recorded majority of the deaths due to inadequate contemporary medical care. Globally, maternal mortalities are prevented with contemporary medical care. The availability and accessibility to skilled birth attendants capable of managing normal delivery and also identifying complications and managing it or refer promptly is very essential since a lot of obstetric complications are difficult to be anticipated and mostly arise during childbirth. Skilled birth attendant accessibility is vital in increasing maternal survival that is why the Sustainable Development Goals Three (3) uses the number of pregnant women who utilize skilled delivery services as one of their indicators. Also, it helps in averting stillbirths and improving newborn survival. However, the expected duties of a healthcare provider such as a midwife and doctor could be rendered outside a health or a health facility such as CHPS compound, health centre or a hospital. In the lower- income countries, the most effective approach is to place the pregnant

women in health centers where referrals are done promptly. Uptake of skilled delivery in most of the nations is tantamount to delivering in a healthcare setting in real practice.

Lack of access and decreased utilization of skilled attendants are considered as the major factors associated with maternal mortalities (WHO, 2013).Uptake of skilled delivery worldwide is only 62% (UNICEF, 2014) but the rate is 39% in the least developed nations. Absence of a midwife or doctor during labour might not essentially be a decision of choice but one of the conditions (Vallely, Homiehombo, Vallely, Homer, & Whittaker, 2013).

Countless women attend antenatal care clinics than seek skilled delivery services in Sub-Saharan Africa, even though the degree of this gap differs. This means irrespective of the interactions the expectant mothers had during antenatal care, substantial number of pregnant women still delivered with traditional birth attendants or relatives (Cotter, Hawken, & Temmerman, 2006).

The global expectation each day is that, about one thousand five hundred (1,500) maternal mortalities occur whilst five hundred and thirty six thousand (536.000) maternal mortalities occur every year based on the World Health Organization report (WHO, 2013). The lower income nations are recording majority of these maternal mortalities since the rate at which women become pregnant is higher as compared to the developed nations. Maternal mortalities recorded in the developed nations are as low as nine (9) per 100.000 live births as compared to four hundred and fifty (450) in the lower income nations. Undoubtedly the risk of maternal mortality in the lower income nations is higher than the developed nations (Abugri, Med, Educ, & Akum, 2013)

The utmost health divisions between the developed countries and the undeveloped countries is maternal mortality. About 99% of all maternal mortalities occurred in the lower income nations worldwide (UNFPA, 2014). However, African countries felt the highest burden of

this tragedy thereby accounting for 40% of the world's total maternal mortalities (Carter, 2010). The unexpected through mere statistics are the distressing effects on populations where the already poor family in Africa is affected by the demise of the breadwinner which might have a heavy toll on the family and the economic status at large. Realizing the depth of the problem, the United Nation through the Millennium Development Goal (MDG) 5 in 2000 developed a strategy toward enhancing quality of care given to all expectant mothers which is the Sustainable Development Goals (SDG) 3. Decreasing the death of pregnant women by three-quarter by the end of 2015 was the target which was signed by Ghana along with all member states (UN, 2008). The two inappropriate goals for checking the achievement of MDG 5 were; number of maternal deaths per 100,000 live births and proportion of births through skilled birth attendants. Skilled birth attendant is any healthcare professional (nurse, midwife or doctor), who has gone through training from an accredited institution and has passed the licensing examination to attend to pregnant women from pregnancy, childbirth to six weeks after delivery and having the capacity to detect medical conditions, complications earlier and manage and also refer promptly when the need arises (WHO, 2004).

Uptake of skilled delivery is considered to be the panacea for decreasing both maternal deaths and diseases significantly (Kumar et al, 2018). Most nations where uptake of skilled delivery is greater than eighty percent (80%) have MMRs less than 200 (WHO,2015).This is attributed to the various developments of professional midwifery during the 20th century for the significant decrease in maternal mortalities in the developed nations (Van Lerberghe et al, 2001).

Most of the pregnant women still utilize TBAs or relatives for skilled delivery service in the lower income nations. Traditional birth attendants are well respected in the communities they reside in Ghana because they attend to the pregnant women throughout pregnancy and child birth. The Ghana health services under the ministry of health previously built the capacity of

existing traditional birth attendants and trained new ones to improve on early identification of health conditions and prompt referrals and safe deliveries devoid of complications and infections. The capacity building and the training of new ones came as a result of the shift toward community based interventions when the 1987 International Safe Motherhood Initiative was introduced .This made the TBAs to be seen as ambassadors of mortality reduction for years (Starr, 2006). Upon various researches done by the WHO, UNFPA and the Ministry of Health, it came to light that there was no any significant improvement in the fight against maternal mortality despite the training given to the TBAs hence the need to stop the training of the TBAs and concentrate on facility delivery through trained professionals and improved access to emergency obstetric care services in increasing maternal survival rate. Delays by TBAs in some of the referrals have rather increased postpartum infections despite their training and capacity building. TBAs remain one of the most visited in most of the villages in Ghana despite the curtailment of their training (GDHS, 2014). The death of pregnant women in Ghana due to pregnancy related complications is still in the ascendency moving from 414 to approximately 560 per 100,000 live births (GDHS, 2014).

Currently in Sub-Saharan Africa, the number of maternal deaths occurring in a given year per 100,000 live births during the same period is five hundred and ten (WHO et al. 2014). Furthermore, inequalities also exist in women's lifespan risk of death comparing the developed nations to the developing nations. Women's lifespan risk of death from the conditions associated with pregnancy in Sub- Saharan Africa is 1 in 38 against 1 in 3,700 among their counterparts in developed countries (WHO et al. 2014). In Ghana, the risk is about 1 in 66 (Adjei, 2015).

The SDGs set target of 70 maternal deaths per 100,000 live births or less by 2030 compared to current ratio of 319 per 100,000 live births in Ghana makes it imaginary or challenging to reach the set target. Uptake of killed delivery is an indicator and a strategy to decreasing

maternal deaths, but uptake of skilled delivery is very low in Ghana since the number of skilled deliveries in term of percentages is not encouraging with vast difference between the pregnant women who live in cities and those in the villages (Gudu & Addo, 2017).

Utilization of skilled delivery in Ada- Foah sub-district was fewer than national average (DHIMS, 2018). In 2018, out of the population of 43,001 and 10,320 women in fertility age and expected pregnancy of 1,720, only 22. 5% deliveries were conducted by skilled birth attendant. Findings from other studies stated that, half of the maternal mortalities that occurred in United States of America could have been prevented if maternal care were available ,accessible and of quality (Carter,2010). Pregnancy outcomes mostly depend on the attitudes of skilled birth attendant since it plays a vital role complemented by cost, supposed quality of care and nearness to services. Therefore uptake of skilled delivery is affected by the above mentioned components of care thus both medical and non-medical either positively or negatively (Ambruoso, Abbey, & Hussein, 2005). Carter (2010) found that despite the fact that care given to pregnant women during pregnancy helps in preventing diseases or early identification and management of diseases and also preparation toward childbirth, most pregnant women access it only when there is complications .Esena et al,(2013) identified that the protocols under which the health facilities are run, execution of duties by health professionals and the relationships between the clients and the health professionals influence the uptake of skilled delivery either positively or negatively depending on each client. It also detected that difficulty in accessing suitable care by pregnant women with complications at the appropriate facilities is due to lack of structured referral policies between the CHPS compounds or zones, health centres and hospitals (GDHS, 2014). Also there are delays that occur at the various health facilities thus the time the clients report at the health facilities and when the needed services are rendered by the health professionals (GDHS, 2014).

Moreover, lack of logistics, medications, health apparatus and health professionals result in the lackadaisical attitude and haphazard response to obstetric emergencies at the health centres during uptake of skilled delivery. Esena et al. (2013) found that the main demotivating factor towards uptake of skilled delivery is the way health professionals behave toward the clients. For instance, the inhumane, unprofessional and rude treatment clients receive from health professionals deters them from uptake of skilled delivery and even do not recommend facility delivery to others because of what they experienced at the facility before. Carter (2010) for instance found that discouragement of birth preparedness by the Swahili culture since it is believed that birth preparedness could lead to obstetric complication for instance stillbirth hence influencing facility delivery. Women in Afghan communities (87%) always needed consent of their partners when seeking health care, and 45% held in high esteem that the beatings of the wives by their partners when they refuse to comply with their orders remains the sole right of their partners (Samson, 2012). Some of the practices which are connected traditionally are gunfire and noise which are assumed to increase contractions of the womb and faster dilatation for a normal delivery (Carter, 2010) .The vast difference between antenatal care coverage and uptake of skilled delivery has called for healthcare providers and policy makers to be looking for solutions. In view of that, it is very crucial to identify all contributory factors to acceptance of the care given to pregnant women during pregnancy and facility delivery so that policy interventions aimed at behavior change are put together for implementation. That is why this study assess the factors contributing to uptake of skilled delivery. Additionally, understanding what informs decisions on place of delivery, the preferred health care professional to attend to or TBA so that it will update the policy makers and the health professional on the best policies and interventions to make and implement.

1.2 Statement of the problem

Pregnancy and childbirth complications remain a challenge amongst women of reproductive age (15-49) in lower income nations worldwide (Baral, et al, 2010). Availability, accessibility and quality of maternal care in the United States of America could have been prevented half of the maternal mortalities (Baral, et al, 2010). Esena et al. (2013) found that the main demotivating factor towards uptake of skilled delivery is the way health professionals behave toward the clients. For instance the inhumane, unprofessional and rude treatment they receive from health professionals deters them from uptake of skilled delivery and even do not recommend facility delivery to others. Concerning decision making on utilization of antenatal care and skilled delivery, (87%) of the women in Afghan communities relied solely on their husband whilst (45%) of them also support the cultural believe that if a wife disobeys the husband, the husband has the right to flog the wife (Samson, 2012). Most obstetric complications arise during delivery causing majority of the maternal mortalities irrespective of the antenatal care given. That is why uptake of skilled delivery is very crucial so that if there is the need for interventions or prompt referral it could be recognized and managed as such since the crucial period for a pregnant woman is during labour and delivery where complications cannot be predicted. In the context of Ghana, skilled deliveries can only be accessed in health facilities and institutional deliveries therefore can be used as a proxy for skilled attendance. The TBAs are mostly responsible for deliveries that occur outside the health facilities especially in the villages, thus either by older women in the community or by self-assisted delivery (GSS et al. 2009). Over the past years, uptake of Antenatal Care (ANC) has remained high in Ghana. The opportunity of promoting the uptake of skilled delivery and other important practices like breastfeeding, early postnatal care, and family planning are achieved during antenatal care visits. The success in Ghana continues to be the coverage of antenatal care thus, more than 80% of expectant mothers utilized antenatal care at least a

visit in 2016 (Ministry Of Health, 2016). In 2014, about 98.2% of expectant mothers utilized antenatal care at least once and 77.0% utilized antenatal care four or more times (GDHS, 2014). However, this does not translate into proportion of institutional deliveries in Ghana. Uptake of skilled delivery was only (57%) (GDHS,2014).This shows uptake of skilled delivery was low due to factors such as financial challenges, nearness to a health facility and perceived poor services rendered (GSS et al. 2009). In Ada –Foah sub district the story is the same because in 2018 uptake of skilled delivery was 22.5% even though there are numerous interventions being implemented (DHIMS, 2018). Comparing utilization of antenatal care from 2013-2018.In 2013, ANC attendance was 42.2%, 2014 was 44.6%, 2015 was 51.8%, 2016 was 49.5%, 2017 was 54.6% and 2018 was 50.3% respectively. Uptake of skilled delivery in 2013 was 23.0%, 2014 was 24.0%, 2015 was 21.1%, 2016 was 22.7%, 2017 was 22.3% and 2018 was 22.5% respectively (23%, 24%, 21.1%, 22.7%, 22.3%, 22.5%). Even though antenatal care has increased slightly, skilled deliveries however is lower even with the existence of the free maternal care policy intervention aimed at resolving cost challenges. Despite the fact that the interventions started some years back, there is no improvement in antenatal care and facility delivery. The inconsistent marginal increase and decrease in uptake of skilled delivery in Ada –Foah sub district which falls far below the national target of 80% and above is a great challenge hence the need for this study on this subject matter to serve as an empirical evidence for policy formulation and implementation. In addition, the behavior of the pregnant women should be influenced positively by recognizing their attitude and what is being practiced in the communities as the yardstick for behavior change communication. Uptake of skilled delivery in the subdistrict is not encouraging comparing the figures from 2013 to 2018 hence the need to know why .The socio- demographic characteristics, cultural perception, accessibility to health institutions and providers and perception on quality of care together with other roadblocks linked with uptake of skilled delivery was what the study

sought to assess.

1.3 Justification

The agreement reached globally when the Millennium Development Goals (MDGs) now known as the Sustainable Development Goals was set up some years back on the best intervention to decrease maternal mortalities was the uptake of skilled delivery, specifically the low income nations where almost 99% of maternal mortalities occur. Universally, uptake of skilled delivery is considered the best indicator for decreasing maternal mortalities (WHO, 2015).

Deliveries attended by skilled care providers in 2016 were 56.2% as compared to 73.7% recorded in 2015 which means uptake of skilled delivery has decreased significantly defeating the assumption that data is not well captured from the private healthcare facilities including the maternity homes (MOH, 2015).

The eighty percent (80%) and above national target set seems unsurmountable to achieve looking at the yearly decrease in uptake of skilled delivery coverage.

There are many complications in births assisted by TBAs and other unqualified persons both in rural and urban communities in Ghana. Many women die as a result of late referrals by TBAs and some suffer complications leading to complete removal of the uterus. A lot of the deaths are avertable through uptake of skilled deliveries with good referral system. In Ghana, about 75% of maternal mortalities usually arise through childbirth and immediate postpartum (GSS, 2012).Therefore, the evidence is clear that the relevance of institutional delivery by Skilled Birth Attendants cannot be underestimated, hence the need for this study to help unearth the challenges and measures adopted toward increasing uptake of skilled delivery in Ada-Foah subdistrict in Ada East District. The ministry of health will also use it in policy planning and program design for maternal services to be implemented by the Ghana Health

Services. Also, the outcomes of the study will increase the knowledge on uptake of skilled delivery in the country and will be shared with appropriate institutions.

1.4 General Objectives

To assess the factors contributing to uptake of skilled delivery in Ada- Foah subdistrict in the Greater Accra Region

1.4.1 Specific Objectives of the study

1. To determine the socio – demographic characteristics of women which influence uptake of skilled delivery in Ada-Foah subdistrict in the Greater Accra Region.

2. To explore the cultural perceptions which contribute to uptake of skilled delivery.

3. To assess the factors influencing women's accessibility to health facility for uptake of skilled delivery

4. To identify the factors which affect perceptions on the quality of care at health facility for uptake of skilled delivery.

1.5 Research questions

The study answers the following questions:

1. What socio-demographic characteristics of women contribute to uptake of skilled delivery?

2. What cultural perceptions of women contribute to uptake of skilled delivery?

3. In what ways does accessibility to health facility contribute to uptake of skilled delivery?

4. In what ways does perception of the quality of care at health facility contributes to uptake of skilled delivery?

1.6 Significance of the Study

The 2014 Demographic and health Survey reported that most maternal and infant mortalities occur in the rural areas of Ghana since Ada-Foah sub district has a lot of rural communities, the results of these studies will help to address some of the challenges pregnant women face which discourage them from utilizing both antenatal care and uptake of skilled delivery but utilize the TBAs instead. Findings from this study would therefore guide the District Health Management Team and other agencies that are working in the area of maternal health to devise ways of improving the uptake of skilled delivery services. Also this can provide reference information for further studies in future

1.7 Assumptions of the study

The assumptions for the study were;

That the opinions expressed by the participants were fairly representative of the views of the general population and that these findings were extrapolated to the general population; that the participants understood the questions; that the participants were truthful and did not give socially wanted answers.

1.8 Delimitations of the study

Women in their reproductive age (15-49 years) who have given birth to at least a child in the Ada-Foah subdistrict from January to December 2018 were the targeted respondents. The number of respondents who participated were 295 breastfeeding women. The study variables included; Socio–demographic characteristics of women; Cultural perceptions of women; Accessibility to health facility and Perceptions on the quality of care at health facilities.

1.9 Limitations of the study

Problem of fear was expected from the respondents as respondents might be reluctant to give out the needed information but was dealt with through explanations to the respondents the reason for the study and privacy and confidentiality was assured.

There was the fear of educational status of the participants and also language barrier that might affect data collection but the researcher acted proactively by recruiting personnel who understand the language and thoroughly explained the questionnaire to the respondents during data collection.

1.10 Definition of significant terms

Skilled care

Skilled care is defined as the care given to expectant mothers during pregnancy, childbirth up to six weeks after delivery by a trained healthcare personnel (a doctor, midwife or nurse) by an accredited institution and licensed to practice, having the necessary logistics needed for rendering services and prompt referrals

Socio-demographic characteristics

These are the unique features of the respondents of the study to be used which include; age, religion, marital status, education, employment status or occupation. This information will be useful for understanding the factors that influence reproductive behavior of the respondents concerning facility utilization.

Cultural perceptions

This refers to what a group of people think in relation to pregnancy, childbirth and puerperium taking into consideration terms of their beliefs, norms and value.

Accessibility to health care

This refers to the use or easy to reach, which includes the proximity of the health facility to the clients.

Perception on the quality of care

This refers to the client's opinion of a health facility's services and staff's ability to fulfill his or her expectations. This may have little or nothing to do with the real services received.

Skilled birth attendant

Any healthcare professional (e.g. doctor ,midwife or nurse) ,having gone through training from an accredited institution and passed the licensing examination to attend to pregnant women, from pregnancy to delivery and having the capacity to detect medical conditions, complications earlier and manage and also refer promptly when the need arises.

Maternal Mortality Rate

The death of expectant mother within 42 days of abortion, regardless of the period and location of the pregnancy from any cause connected to or deteriorated by the pregnancy or its management but not from unintentional or accompanying causes

1.11 The study arrangements

It was basically arranged in chapters. Chapter one contained the introduction to the study, background, statement of the problem, purpose, objectives , research questions, significance, assumptions, limitations, delimitations and the definition of significant terms.

Chapter two reviewed the literature bearing in mind the objectives of the study, designed conceptual framework and summary.

Chapter three also contained the research methodology, design, study area, target population, sampling procedure, tools and techniques for data collection, pre-testing, data analysis, ethical considerations and the working definition of variables.

The response rate, findings on socio-demographic characteristics, cultural perceptions, accessibility to health facilities and quality of care rendered at the facilities were all in chapter four. The discussion of findings and summary were contained in chapter five. The conclusion and recommendations were also contained in chapter six.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

A relevant literature review related to barriers to uptake of skilled delivery by all the women in their reproductive age is provided in this chapter. Also the knowledge gap the chapter seeks to fulfill is presented.

2.1 Socio demographic characteristics of women and uptake of skilled delivery

Decision-making on uptake of skilled delivery is influenced largely by social factors irrespective of where the health facility is located and it is mostly the right of the family (Gage, 2007).

2.1.1 Age

From the 2014 GDHS, uptake of skilled delivery is influenced by age of the pregnant women as (58.9%) of pregnant women aged 20-34 years utilized skilled delivery closely followed by 35-49 years with (53.8%) and last but not the least was 20years with (50.9%) respectively (GSS et al, 2012).

Buttressing the above findings, Chubike and Constance (2013) in Nigeria found that, expectant mothers who were under nineteen years were the least in terms of uptake of skilled delivery, therefore concluding that uptake of delivery was also influenced by the age of the pregnant woman.

Age is often offered as a substitute for amassed experience, comprising the utilization of skilled delivery by a pregnant woman (Burgard, 2004). Household decision-making is influenced by mature women who were extra buoyant and effective compared to adolescents who were pregnant (Glei et al, 2003). Moreover, the likelihood of developing complications during delivery is higher in older women hence the need to utilize uptake of skilled delivery

(Bell et al., 2003). But some studies found that expectant mothers (adolescents) are likely to seek facility delivery more compared to older expectant mothers who might utilize TBAs or relatives (Navaneethan & Dharmalingam, 2002). Age is frequently considered in studies on uptake of skilled delivery; adjusting parity, uptake of skilled delivery or age has no effect on pregnant women who are matured and those who are adolescent (Magadi et al., 2007).

2.1.2 Marital Status

Uptake of skilled delivery may be influenced by marital status. Women who are not married or separated may be challenged in terms of financial support but may enjoy greater independence than those presently married. Skilled attendance may be encouraged through the care given to young single mothers by their family, especially for a first birth. Whilst single mothers expect an undesirable provider dealings and stigmatization hence the utilization of TBAs during delivery (Duong et al., 2004). Some studies have found marital status to have no association with skilled attendance (Nwakoby, 1994), whereas some studies find married women to be among those who have less health facilities visits (Letamo & Rakgoasi, 2003).

Pregnant women with younger children may possibly have concerns of taking care of the other young children during uptake of skilled delivery, especially in a nuclear family. Most often women go together with their family members when utilizing healthcare, and the other children cannot be taken care of during these periods (Duong et al., 2004). Also, considering what influences leaving home, women who stay with the extended family usually contribute to decision-making, hence influence it.

2.1.3 Education Level

Various possible pathways are there that can elucidate why maternal education is consistently and strongly associated with all types of health behavior (Bell et al, 2003). Other strong

reasons why educational level is strongly associated with uptake of skilled deliveries are; enhanced knowledge on the advantages of preventive and curative health care, greater openness to information related to health, enhanced relationship with the healthcare providers, understanding the contemporary medical culture, access to financial resources and health insurance, more control over resources within the household and prudent spending, more independent relationship and better communication with the spouse, more decision-making power, improved self-worth and self-confidence and better coping abilities (Thaddeus & Maine, 1994).

An appreciable percentage of women with at least secondary education were linked with facility delivery according to other studies in Africa (Stephenson & Tsui, 2002). Uptake of skilled delivery is associated with secondary education of adults (not specifically women) in Mali and Haiti, but in Mali, the association was between the women who have been resident for the past five years, whereas in Haiti, the association was trivial (Gage & Guirlane, 2006).

Husband's educational status might enlighten him on modern medicine, knowing the significance of uptake of skilled delivery thereby motivating him to associate with healthcare providers and requesting appropriate care for the spouse. Moreover, fewer restrictions might be put on their spouses' movement and decision-making, hence enabling uptake of skilled delivery (Short & Zhang, 2004). Occupation and household wealth are associated with husband's education. Husband's education is even used as a measure of household socioeconomic status by some studies. Majority of the studies identified that educational status is associated with utilization of skilled delivery when husband's education was used as a measure, even though the effect is insignificant compared to the mother's own education (Short & Zhang, 2004).

2.1.4 Occupation

Various scopes of independence comprising economic status, mobility, position of individual and power for decision making are more likely to influence utilization of healthcare (Furuta etal, 2006).

In many countries, majority of the women in many countries utilize healthcare based on the decisions of their husbands or other family members (Gage, 2007). Moreover, women's inability to pay for their expenditures, transportation is more likely to restrict the movement when utilizing healthcare. Nevertheless, the unceremonious power of women in the house might lessen these predicaments. The independence of women mostly depend on the status of the women involved. Decision taking by women in the society is seen to be weird and strange causing the neglect and lack of support for the women reasonably because women are considered weak agents in the society. Resource constraints might be a challenge to majority of the women hence the utilization of healthcare is lesser (Furuta et al, 2006).

Age, education, marital status, wealth and parity might improve autonomy and status effects (Gage, 2007). Examination of the effect of independence of women on utilization of healthcare was done by numerous studies. Substantial associations for at least some dimensions were found and with variation in the level of significance, where the decision-making power, income control, household chores, communication, movements, other relatives and who heads the household were studied.

Utilization of healthcare by women is motivated by the work they do and the salary they receive. Nonetheless, majority of the women do not even work, let alone receiving salaries in many settings. Women's utilization of healthcare is influenced by access to information and increased range of movement and this might be as a result of official work. "On the other

hand" uptake of skilled delivery by working women might be as a result of work that is poverty-induced showing resource limitations (Gyimah et al, 2006).

The variables associated with occupation which could be considered as confounders at the same time are educational status, economic status and residential status. Few studies considered the occupation of women but majority of the studies identified women who are farmers do not or less utilize healthcare compared to those in other profession (Nwakoby etal, 1996). That emerged due to poor socio-economic status and inadequate healthcare in rural areas. Economic status and residence were not adjusted. Maternal working status or occupations do not have any effect according to most of the studies (Toan et al., 1996). However it was found in other studies that formally employed women usually seek healthcare. Contrarily, it was the opposite in a study conducted in two southern India states and Nepal (Stekelenburg et al., 2004).

2.1.5 Religion

Uptake of skilled delivery by pregnant women is largely influenced by their culture, religion and ethnic background since the independence of a woman mostly depend on the above mentioned factors (Gyimah et al., 2006)

Fishbein (2000) suggests that the main reason why women who are Christian or Muslim usually seek healthcare compared to traditional and other religions is that women of the traditional and other religions are more dependent on their cultural beliefs, norms and values. Other studies have confirmed it indicating that women in the traditional and other religions might be old fashioned, trusting and relying on their beliefs.

2.2 Cultural perceptions and uptake of skilled care during delivery

Utilization of healthcare depends largely on what a group of people think in relation to pregnancy bearing in mind their cultural beliefs, norms and values. The discrimination

against certain religious groups by the healthcare providers during uptake of skilled delivery and postnatal care deters them from seeking healthcare (Glei et al, 2003).

Cultural and social norms, as well as religious and other belief systems have impact on health seeking behavior of most pregnant women even when they are within reach and readily available. For instance, in most African societies, decision are taken by the head of the household which is the man (Ganle et al., 2015).

Studies also show that choosing a birth place at home in India is more related to cultural practices which is mostly ignored (Baral et al, 2010) .Home is not only a dwelling place but also a common place for past, present and future generations where ancestors are the presiding deities (Nyaboke et al,2016). Many of the families feel that, if you are unable to link their cultural preferences with modern institutional sites (Haq, 2008). Buttressing that, a study in rural areas of Jharkhand found that throwing away of placenta in health care facilities was considered inauspicious by women and therefore they were reluctant to go for an institutional delivery (Barnes, 2007). Besides, women also stated that health care providers were insensitive towards their needs. Women were abused, scolded and slapped during labour pain. They were being questioned about their post-partum beliefs and were forced to accept family planning programme against their desire (Van Hollen, 2003). Their family members or partners were not allowed to accompany them (Kumar et al, 2018).

Shiferaw (2007) detected that there was no traditional backing or support (not necessary or customary) for uptake of skilled delivery in Ethiopia that is why expectant women avoid uptake of skilled delivery. Moreover in Vietnam, ethnic minority living in remote areas stood at a high risk of utilizing TBAs or relatives. More specifically, women of other cultural background might shun uptake of skilled delivery simply because of their custom of isolation by family members during this period (Mesko et al, 2003) and also due to particular

necessities around the position adopted during delivery, hotness and placenta burial. Infidelity is believed by some ethnic groups in Africa to be the cause of complications during delivery hence deterring them from the utilization of skilled delivery services (Thaddeus and Maine, 1994)

Giving birth alone by some women without a trained healthcare professional is because of the belief that birth is a test of strength and facility delivery is a sign of feebleness (Kyomuhendo, 2003).

The uptake of skilled delivery by Muslims and traditional members in Ghana is lesser compared to Christians but no ethnic differences were identified (Bell et al., 2003). Ethnic or religious disparities were not identified by majority of the studies conducted in their settings (Bell et al., 2003). Beliefs and attitudes were also looked at by few studies directly. The few studies conducted revealed that women who believed in modern medicine and have been taken care of by male healthcare professional were likely to be higher when it came to uptake of skilled delivery .There is no link between using traditional medicine and uptake of skilled delivery in two studies conducted separately (Nyaboke et al, 2016). Also no association between the traditional birth attendants (TBAs) and the Ayurveda (5th Veda) in Uttar Pradesh a community where the study was done (Stephenson and Tsui, 2002). Carter (2010) for instance found that in the culture of the Swahilis, birth preparedness is a taboo signifying bad luck hence disobedience could lead to obstetric complications. In Afghanistan, 87% of the women asked for permission before visiting a health facility, whilst 45%of the women said they believed in the right to be beaten by their husbands when they disobey them (Samson, 2012). Firing of bullets and noise making during delivery are believed to be the traditional practices helping the laboring mother's cervix to dilate faster to permit safe delivery (Carter, 2010).

2.3 Accessibility to health facility and uptake of skilled delivery

The most important variables in health service utilization is accessibility which includes the proximity of the health facility (Gage, 2006). Availability, accessibility and quality of maternal care in the United States of America could have prevented half of the maternal mortalities (Baral, et al, 2010).

The dual influence exerted by distance to health services on use are the impediment to utilization of healthcare and the definite hindrance to reaching healthcare facility after deciding to utilize healthcare. The many kilometers that a pregnant woman is expected to walk to utilize skilled delivery services especially when labour set in at night deters them from the uptake of skilled delivery due to lack of transportation. Most of them don't even attempt to walk leading to the death of the pregnant women usually caused by obstetric complications (Nyaboke, 2016) .

One of the reasons why most pregnant women neglected uptake of skilled delivery was the long distance coverage before reaching the health facility (GSS et al., 2014). The distance was estimated at 3-5km in the rural areas (MOH, 2015).

It has been debated that distance to hospital also captures other aspects of remoteness such as poor road infrastructure, poor communication between communities, poverty, limited access to information, strong adherence to traditional values and other disadvantages that are difficult to measure quantitatively (Reynolds et al., 2006). Owing to insufficient data on distance and despite the importance attached to distance or the time spent when reaching a health facility for healthcare, in majority of the studies on uptake of skilled delivery, distance is not always considered (Stephenson & Tsui, 2002; Gage & Guirlene, 2006; Thaddeus and Maine, 1994). However some studies considered the quality of roads, means of transport largely the distance covered (Potter, 1988).

Distance as an important hindrance from uptake of skilled delivery especially when labour set in at night or suddenly when there is no means of transport immediately, this was mentioned by most qualitative studies (Mesko et al, 2003).In Maharashtra, a study established that irrespective of the long distance to the healthcare facility, two pregnant women from a very remote area defied the odds and delivered at a private facility claiming that the distance from their village to the primary health centre made them skeptical about delivering at home in the village in case complications occurred (Celik, 2000).

Some quantitative studies that considered distance as a variable found that uptake of skilled delivery was lesser among expectant mothers living far away from health facility whilst other studies did not find any effect. Moreover, a study in Cambodia (Yonagisawaoum et al, 2006) identified that uptake of skilled delivery was influenced by the distance from both health centre and hospital. Also, in two other settings where health care and transport infrastructure were good, distance did not play a role (Duong et al., 2004).

Interesting interactions were reported by two separate studies. Potter (1988) identified in rural Mexico that, any village located 25km away from a market do not take road quality into consideration whilst Pebley (1996) interacted with ethnicity in Guatemala revealed that uptake of skilled delivery by Latino women who are pregnant is massively influenced by the distance from healthcare facility but concerning the local women, there is no such influence. The local women seem to utilize the TBAs irrespective of the closeness to a health facility, perhaps due to other obstacles. With reference to uptake of skilled delivery, pregnant women who do not speak Spanish have only 1/100, whilst those who speak Spanish have 6/100 (Pebley, 1996).

2.4 Perception on the quality of care during and after uptake of skilled delivery

Majority of the women were discouraged from choosing certain facilities for skilled birth attendant due to the care they received when they visited healthcare facilities which they perceived to be poor. Inadequate utilization of care given to pregnant women during pregnancy are the immediate cause of pregnancy related complications, ill health and deaths (Reynolds et al., 2006).

Esena et al. (2013) reported that, uptake of skilled delivery was greatly influenced due to the bond between the clients and the healthcare providers, health system and protocols. It also detected that suitable healthcare during obstetric complications is impeded by the lapses in the referral system from the CHPS compounds or zones, health centres and hospitals.

Uptake of skilled delivery was influenced by the poor care perceived by the pregnant women that fairly overlap quality of medical care. Quality assessment largely depends on people's own experiences with the health system and those of people they know (Thaddeus et al, 1994). The impartial measurement of waiting time as a problem or not could be done but as to whether it has an effect thus positively or negatively is very subjective in terms of the perception of the clients. Client satisfaction is mostly related with the outcome of the interventions and services rendered by the healthcare providers to the client which consist of approachability of the staff, availability of logistics and supplies and time spent when accessing healthcare. The protocols of the health facilities usually doesn't permit the families of the clients to enter the labour ward which sometimes causes misunderstanding, not allowing the laboring woman to adapt the positions she is comfortable .Few studies identified that, the pregnant women reported of better care at the private facilities compared to the public facilities but complained of the cost involved which is higher at the private facilities than the public facilities demotivating them from using the private facilities (Mrisho et al., 2007).

It was found that, increase in uptake of skilled delivery was influenced by good attitude of healthcare professionals without disrespect, yelling and dejection but full of reassurance and courteousness (Baral et al., 2010). Pregnancy outcomes mostly depended on attitudes of skilled birth attendants whilst cost, perceived quality of care and proximity to services also played a vital role. Therefore uptake of skilled delivery is affected by the above mentioned components of care either positively or negatively (Ambruoso et al, 2005).

Staff attitudes and quality of care featured conspicuously in nearly all the studies that considered uptake of skilled delivery (Kumar et al., 2018). Majority preferred utilization of TBAs or a relative due to discontent report with disrespectfulness and careless behavior experienced by the pregnant women. Moreover, the culturally inappropriate care of not openly expressing pain when in labour that is admonished by healthcare providers in Uganda also encourages TBAs or relatives utilization during delivery (Kumar et al, 2018). Most of the women also complained about the unhygienic nature of the toilet facilities at the various healthcare settings, absence of water and sterile practices and more often, lack of vital medications together with haphazard caesarean sections discouraging them from utilizing skilled delivery services (Kyomuhando, 2003).

Quality of care have been assessed by few studies (Adjei et al., 2015). A study by a Vietnamese found that a significant number of pregnant women with experience in childbirth ranked quality of care higher compared to communication and conduct of personnel but other pregnant women who utilized the TBAs or relatives ranked quality of care at the facility as very low (Duong et al., 2004).

Healthcare providers usually take advantage of the antenatal care to give salient information to the pregnant women which eventually influences their decisions on uptake of skilled delivery. Place of delivery is mostly recommended after risk assessment is done during

antenatal care, that is why twin pregnancies are encouraged to utilize a well-resourced facility during delivery (Barnes ,2007) .Moreover, pregnant women with single viable fetus without complications usually are reinvigorated to utilize TBAs or relatives at home during delivery. Eighteen (18) nurses molested pregnant women who visited the health facility in Uganda without the antenatal cards which eventually impeded uptake of skilled delivery. Also those without antenatal cards were deterred from utilizing skilled delivery services because of their previous experience. (Grosse, 1989).

Antenatal care attendance increases the pregnant women's familiarity with the way the health system works and deepens relationship between clients and healthcare providers at large. Most pregnant women who utilize antenatal care may possibly utilize skilled delivery services. Otherwise, utilization of antenatal care might indicate proximity of a health facility, influencing utilization of skilled delivery services. Majority of CHPS compounds or zones that do not provide skilled delivery services in many settings however, provide antenatal care by mobile clinics. Furthermore, timing for antenatal care mostly is conducive bearing in mind the conditions of the pregnant women and the service rendered is free, but in terms of uptake of skilled delivery it is not free (Toan et al, 1996).

Antenatal care attendance is always used as a predictor by majority of the studies when assessing the contributory factors of uptake of skilled delivery .Some studies found substantial relationship with utilization of antenatal care and uptake of skilled delivery, others found none. Communities where antenatal care is provided by healthcare professionals mostly influence increased uptake of skilled delivery, as described in Haiti (Brentlinger et al., 2005).

Women with previous experience on uptake of skilled delivery become more conversant with this setting, which might have impact on uptake of skilled delivery the next time she is pregnant again(Carter,2010).

Lack of experience mostly makes the first childbirth very challenging, therefore family members of the first time pregnant woman give the best care to the first timer within their jurisdiction because of the importance they attach to the pregnancy (Navaneethan et al, 2002). Furthermore, multipara who had previous normal delivery are usually demotivated to utilize Skilled delivery service due to their delivery experience whilst uptake of delivery by a primipara may be highly recommend by healthcare providers. In addition, the need to arrange for child care by women with younger children may impact uptake of skilled delivery due to greater challenges women face regarding who takes care of the younger children (Stephenson et al, 2002).

Obstetric complications experienced by pregnant women during a tried TBA or relative delivery forces them and their families for uptake of skilled delivery, although their original intention was to utilize the TBAs or relatives. "On the other hand" a pregnant woman with the intention of utilizing skilled delivery services might end up utilizing TBAs or relative or delivering on the way due to a precipitate labour (WHO, 2015).

Most of the studies identified that uptake of skilled delivery is mostly associated with obstetric complication that arose during home deliveries in communities where uptake of skilled delivery is very low .Studies conducted in places where uptake of skilled delivery is known to be very low established that, majority of the women experienced uptake of skilled delivery due to complications that occurred during childbirth (Gudu et al,2017) Other studies were conducted where the first found that uptake of skilled delivery has a link with obstetric

difficulties like obstructed labour whilst the second study found no link but with breech delivery which are all obstetric complications (Gage, 2006).

2.5 Conceptual Framework on uptake of skilled delivery

Conceptual framework is a diagrammatic presentation of the connection between dependent and independent variables of the study. The dependent variable was uptake of skilled delivery while the independent variables were the factors contributing to uptake of skilled delivery of this study such as the socio-demographic characteristics, cultural perceptions, accessibility to health facility and perceptions on the quality of care.

The framework considered a person's related factors as well as health facility factors. The person related factors included some factors that may influence women's uptake of skilled delivery. It includes the socio-demographic characteristics such as age, occupation, marital and educational status and religion. These factors determine the perceived benefit and need of facility use. It also considers how community attitudes influence family decision making with the location of residence influencing other factors. Knowledge on skilled birth attendance is also an important factor and all these together have influence on the decision to seek care.

Economic and geographical accessibility mainly influence whether the woman actually reaches the facility. The health facility factors are related to availability of skilled delivery services as well as the quality of care rendered in terms of waiting time and staff attitude.

A conceptual framework of uptake of skilled delivery and the factors that influence uptake of skilled delivery guided the study that was conducted. Figure 1 is the frame work of the study.

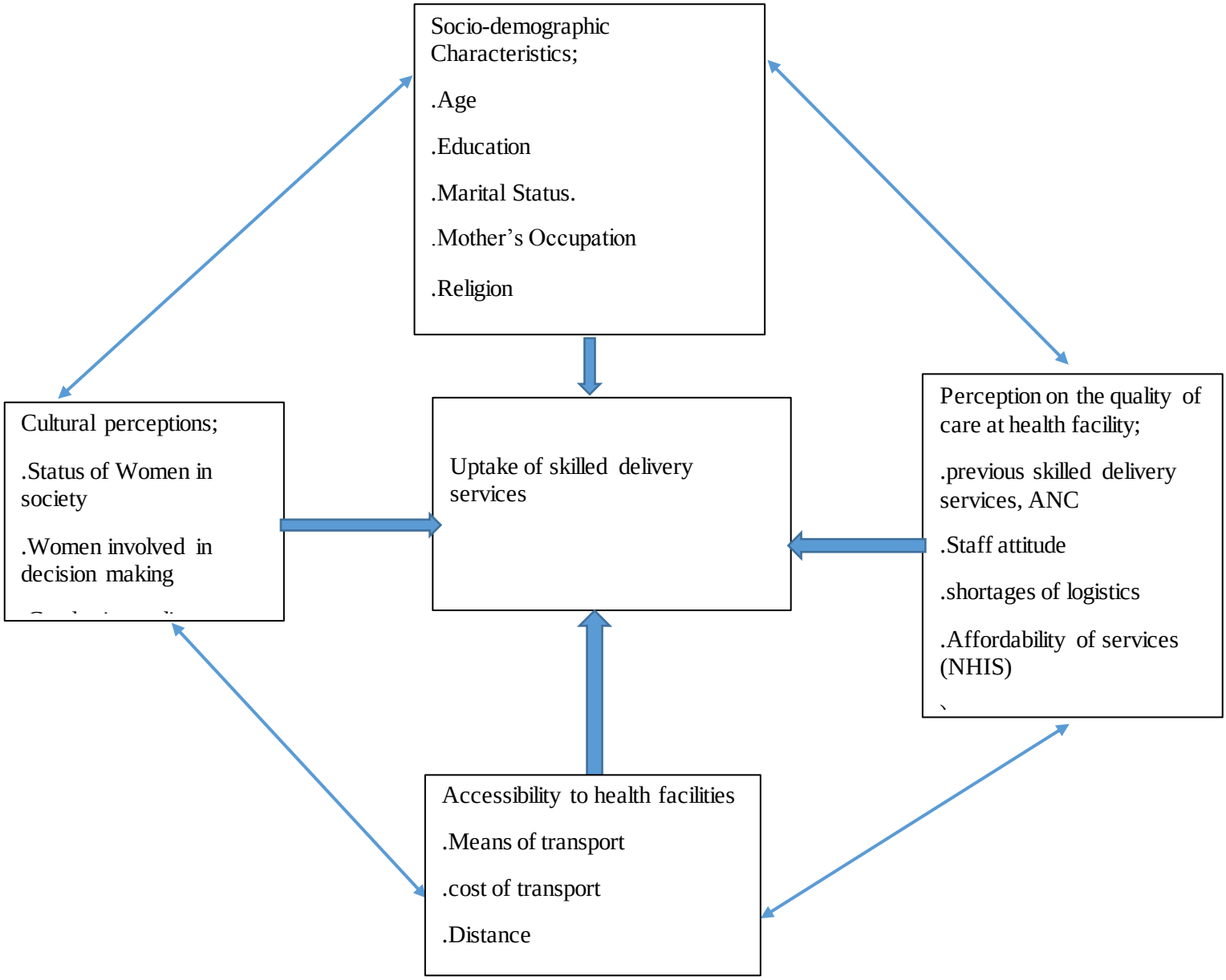

Figure 1: Conceptual framework of the study

The framework (Figure 1) expounded how uptake of skilled delivery could influence both high and low rates of maternal morbidity and mortality in Ada-Foah sub district vice versa. But there are also factors that are hindering the activities of both the service provider and client which must be dealt with such as the availability of health facility, access in terms of the distance, cost of transport, attitude of health workers and shortage of staff. However affordability of services (valid health insurance, traditional beliefs and practices maternal age

and parity, educational level of woman, previous delivery and ANC attendance and cultural factors play a major role in affecting clients decision on the uptake of skilled delivery or not.

2.6 Summary of Literature Review and gaps to be filled

A number of studies have been carried out globally on uptake of skilled delivery. Majority of maternal mortalities occurring in Sub-Saharan Africa which are associated with birth complications related to lack of skilled delivery care. The research therefore intends to assess the factors contributing to uptake of skilled delivery among women in their reproductive age (15-49). The chapter highlighted theoretical reviews of literatures which were guided by the objectives and explained under different sub-topics which were; socio-demographic characteristics of women, cultural perceptions, accessibility to health facility and perceptions on the quality of care all related to uptake of skilled delivery. It also highlighted the conceptual framework, relationship between variables and research gaps.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.0 Introduction

This chapter describes the methodology used for data collection .The design, study area, population, sampling design, sample size determination, sampling technique and procedure, variables, instruments for data collection ,validity and reliability of the instrument, ethical considerations, data collection, analysis, quality control, data management and presentation methods used

3.1 Research Design

A cross –sectional (descriptive) survey design was adopted. This design was appropriate for this study, since the study collected detailed information through descriptions and was useful for identifying variables. The design was also appropriate in trying to establish the factors contributing to uptake of skilled delivery of women in their reproductive age (15-49).

3.2 Study Area

Ada-Foah Subdistrict in Ada East District was where the study was conducted (fig 2).The district is located in the eastern part of the Greater Accra Region. The District shares boundaries with Central Tongu District to the north, South Tongu District to the west, Ada West District to the west and Gulf of Guinea to the south .The population of the District according to the 2010 population and housing census stands at 71,671 with 34,012 males and 37,659 females. The population of Ada-Foah subdistrict is 43,001, women in fertility age (WIFA) 10,320 and expected pregnancy is 1,720.Economic activities are mainly fishing and farming. There is one health centre, three CHPS compounds and ten CHPS Zone (DHIMS, 2018).

Figure 2: Map of Ada East District showing study area

Source: Google Maps, 30/05/2019

3.3 Target Population

The target population included women in their reproductive age (15-49) who have given birth to at least a child between January and December 2018, in Ada –Foah subdistrict in the Ada East District where the study was carried out. They were the best to answer questions pertaining to uptake of skilled delivery because of their experience.

3.4 Sample size determination

Cochran formula was used, which is;

$$n = \frac{Z^2 \times pq}{e^2}$$

Where n= sample size, Z = confidence level of 95% (standard value of 1.96), e= margin of error = 0.05, p = prevalence of skilled delivery =22.5% and q = 1-p

$$n = \frac{Z^2 \times pq}{e^2}$$

$$= \frac{1.96^2 \times 0.225\ (1-0.225)}{(0.05)^2} = 267.95$$

To make up for non-response, 27 participants (10% of 267.95) were added totaling 295 respondents in all.

3.5 Sampling technique and Procedure

A multistage sampling technique was followed to select a representative sample. There are 34 static and outreach points for growth monitoring and promotion for children 0-5years of age in Ada- Foah sub-district currently .Ten (10) out of the thirty four (34) outreach and static points were chosen by simple random sampling balloting. After the selection was done, the total sample size of 295 was shared equally among the 10 outreach and static points giving an average of 29 participants per each child welfare clinic remaining 5 participants which was chosen randomly from the 10 child welfare clinics to finally arrive at 295 respondents.

The randomly selected outreach and static points were visited. A simple random sampling procedure was used to select each mother with child born between January and December 2018, attending child welfare clinic. The names of all mothers who attended the child welfare clinic services have been written in the child welfare clinic register and therefore registers for each clinic was taken and all eligible mothers were listed and given numbers (e.g. A1, A2, A3, A4 …An). An electronic or computer-based number generator was used to randomly select the required number of participants (i.e. 29 for each clinic plus additional 5 from the 10 child welfare clinics). The randomly selected mothers were visited by the researcher exclusively on their growth monitoring and promotion days to administer the questionnaire.

Where a randomly selected mother was not prepared to participate in the study, the selection procedure was repeated to get a mother who substituted her.

3.6 Variables of the study

Below were the independent and dependent variables that were investigated;

3.6.1 Independent Variables

- Age, education, marital status, religion, occupation
- Means of transport ,cost of transport ,distance
- Status of women in society ,women involved in decision making
- Staff attitude, staff shortages, affordability of services, previous skilled delivery services, ANC.

3.6.2 Dependent variable

- Uptake of Skilled delivery services

3.7 Data Collection Instrument

Primary data was collected using questionnaires from the respondents. The questionnaire was structured to provide respondents with clear understanding to fill in the data. The questionnaire contained open and close ended questions. The questionnaire had two sections. Section one collected information on the bio data of the respondents while the second section focused on the study variables.

3.8 Reliability and Validity of the Research Instruments

When formulating a specific instrument, reliability and validity are two most important aspects to be considered. Reliability and validity are the statistical criteria which were used to assess whether the researcher provided a good measure.

3.9 Reliability of research instruments

To ensure reliability of the research instrument, questionnaires were administered to ten respondents who were part of the study in an interval of two weeks to test the consistency in results. Stata version 15 was used in computing the reliability analysis to measure how reliable the research instruments were.

3.10 Validity of research instruments

The validity of the research instrument was ensured when questionnaires were pre-tested on ten respondents but were not included in the final study. The questionnaires were then corrected before distribution. Before the pre-testing of the research instruments, the supervisor from the University of Ghana, Legon reviewed the questionnaire and corrections were made based on the mistakes found. A pretesting was conducted before full scale data collection was done to check the feasibility of questions and to ensure that the questions produced the responses needed, uncovered ambiguous wording or errors before the survey was fully launched.

3.11 Inclusion criteria

The study included women in their reproductive age living in Ada-Foah sub- district who have at least a child, a registered child welfare clinic attendant ready to give their consent and participate in the study.

3.12 Exclusion criteria

All women in Ada-Foah sub-district who have at least a child, but do not attend child welfare clinic and also not registered were excluded from the study

3.13 Ethical considerations

Ethical issues were upheld in high esteem for the maintenance of the dignity of the participants throughout the study. Informed consent, privacy and confidentiality, anonymity

and conduct of the individual researcher were major concern in the study. Data collected was known to only the researcher and the supervisor and was used for its intended purposes. The data was stored under lock and key in a cabinet. The data that was generated from the study was shared with School of Public Health for academic purposes, and Ada East District Health Directorate which serves as a reference point for all the participants. The researcher maintained approachable attitude during the data collection exercise and where clarification was sought by the respondents, they were assisted accordingly

The questionnaire was pre-tested in Kasseh sub district which has a population with similar demographic characteristics. It ensured that the questions were clear enough to produce answers to the research questions.

3.14 Data collection procedures

After the ethics review committee of the Ghana Health Services approval of the proposal, letter introducing the researcher was written and presented to the District Health Directorate (DHD) of Ada East. This enabled access to the facilities and communities within the area of study. The researcher then went ahead and carried out the research study. The researcher first visited the research location, introduced himself to the target population and administered the questionnaires to the participants.

3.15 Quality Control and Data Management

A team of five research assistants were selected and trained for the administration of questionnaire. The administered questionnaire were scrutinized for accuracy and wholeness after every field visit, errors corrected when identified and serial numbers given to each questionnaire for avoidance of double entry. The data was handled well and protected with a pass-word on the computer where the data was entered as soft copy and the hardcopy was protected under lock and key.

3.16 Data analysis Techniques

The questionnaires were checked for completeness and consistency of information at the end of every field of data collection before storage. The data from the completed questionnaires were cleaned, re-coded and entered into excel and imported in Stata version 15 for analysis. Participants' socio-demographic characteristics were described using frequency and percentage distribution. Factors contributing to uptake of skilled delivery were examined with inferential statistical analyses such as Pearson chi-square and binary logistic regression. A confidence level of 95 percent was used, and a p value < 0.05 was considered to be statistically significant.

CHAPTER FOUR

RESULTS

4.0 Introduction

This chapter presents the results of the study and emphasized on the socio-demographic characteristics of respondents, cultural perceptions, and accessibility to health facility and perception on the quality of care.

4.1 Socio-demographic characteristics of respondents

Table shows data on the socio-demographic characteristics of respondents. A total of 295 mothers were interviewed in the study. Most of them were within the age range 25-34 years, 37.29% in the age range 15-24 years, 16.95% in the age range 35-44 years and 2.71% in the age range 45-49 years. Nine out of every ten (92.2%) of them were Christians. A fifth (19.66%) of the 295 study participants had no formal education, 29.15% had primary education, 39.32% were with JHS education, 8.81% were with SHS/VOC/Technical education and 3.05% were with tertiary level of education. Most (34.24%) of the partners of the mothers had JHS education, with only 8.47% of them having tertiary level of education. Majority (73.22%) of the respondents were employed and majority (83.05%) also had their first birth between 15 and 24 years (Table 1).

Table 1: Socio-demographic characteristics of respondents

Variables	Frequency (N=295)	Percentage
Age		
15-24 years	110	37.29
25-34 years	127	43.05
35-44 years	50	16.95
45-49 years	8	2.71
Religion		
Christians	272	92.2
Islamic	14	4.75
Traditional	9	3.05
Educational level		
No education	58	19.66
Primary	86	29.15
JHS	116	39.32
SHS/VOC/TECH	26	8.81
Tertiary	9	3.05
Marital status		
Divorced/Widow/separated	12	4.07
Married/cohabitating	232	78.64
Single	51	17.29
Partner's education		
No education	42	14.24
Primary	70	23.73
JHS	101	34.24
SHS/VOC/TECH	57	19.32
Tertiary	25	8.47
Employment status		
Employed	216	73.22
Unemployed	79	26.78
Age at first birth		
15-24years	245	83.05
25-34years	50	16.95

4.2 Uptake of skilled delivery

Of the 295 women in the study, 80.3% (n=237) of them used skilled delivery whilst 19.7% (n=58) used unskilled delivery. The reason being that, most of the respondents delivered outside the jurisdiction of the subdistrict due to referrals and partners place of work hence the low uptake of skilled delivery in the subdistrict. A 95% confidence interval estimated of the uptake of skilled delivery is between 75.3% and 84.7%.

4.3 Socio-cultural practices among pregnant women

From Figure 3 below, the most socio-cultural practices among pregnant women were eating of clay (55.4%), postponement of ANC visits to second trimester or beyond (36.2%) and the non-attendance of health facilities by pregnant women until delivery (35.1%).

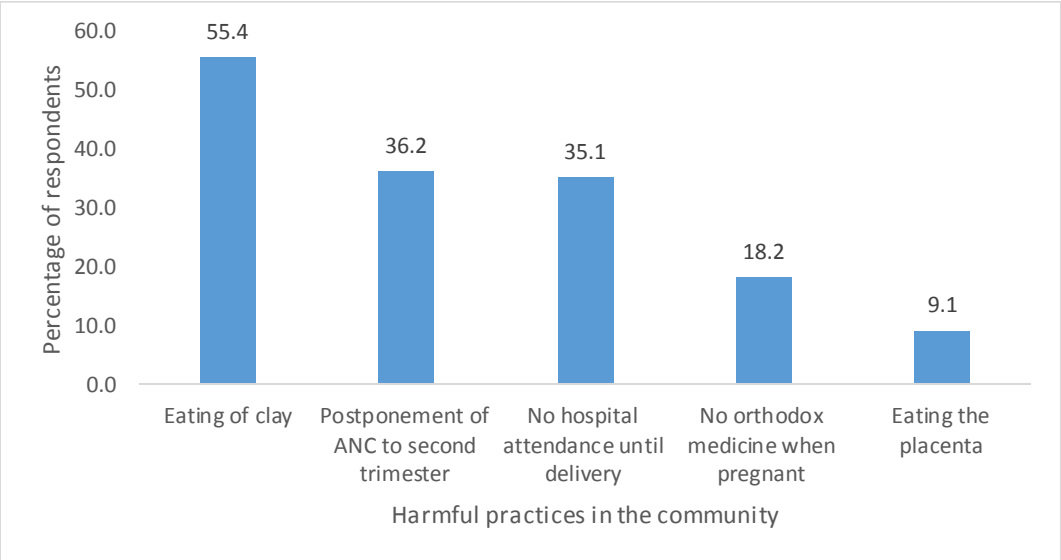

Figure 3: Social cultural practices among pregnant women in the community

4.4 Reasons for uptake of skilled delivery

There are various reasons for low uptake of skilled delivery. More than a third (36.5%) of the respondents cited financial constraints and challenges as the reasons for not delivering at health facilities. Also, 22.0% and 21.3% of the women reported 'no means of transport' and 'poor attitude of health care providers' as reasons for not delivery at the health facilities respectively. Family preference (3.4%), availability of TBA (3.0) and language barrier (3.0%) were the least cited reasons for not delivering at the health facility (Figure 4).

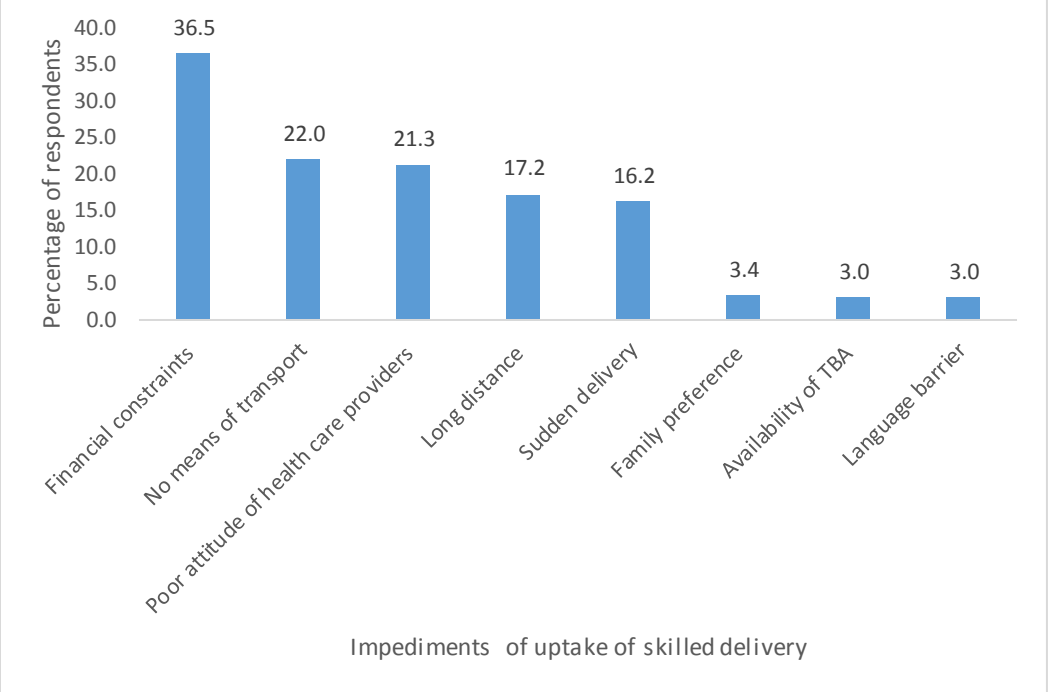

Figure 4: Reasons for non- skilled delivery

4.5 Topics discussed or counselled on during ANC visits.

Among the study participants, majority of the respondents said they discussed or were counselled on birth preparedness (72.3%), adequate nutrition (57.1%) and danger signs (55.4%) topics during their visits to the ANC clinic. Family planning (47.3%), importance of supervised delivery (45.3%), child welfare clinic (34.5%) and Breastfeeding practices (33.1%) were other topics the respondents were counselled on during their visits to the ANC clinic (Figure 5).

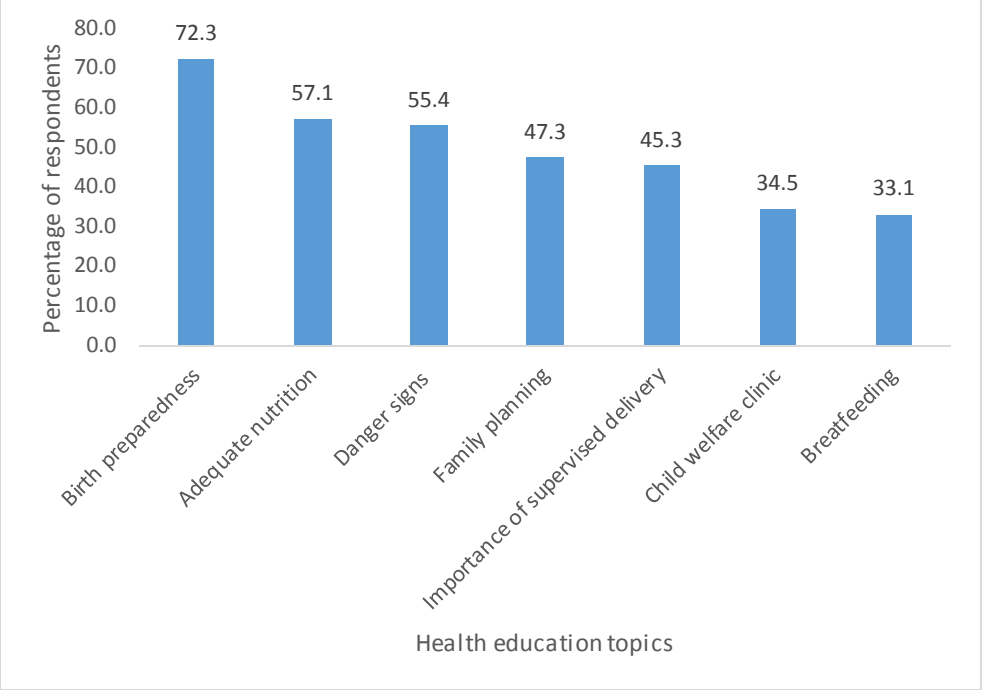

Figure 5: Topics discussed during ANC visits

4.6 Association between socio-demographic characteristics and uptake of skilled delivery.

The Pearson's chi-square test was used to assess the association between socio-demographic characteristics and uptake of skilled delivery among study participants. From table , marital status, partner's level of education and employments status of study participants were the factors that were significantly associated with uptake of skilled delivery (p-value<0.05).

Also 85.34% of the 232 married women used skilled delivery, 83.33% of the 12 women who were divorced, widowed or separated used skilled delivery whilst 56.86% of the 51 single women used skilled delivery. Uptake of skilled delivery was significantly high among women with partners with higher level of education. Uptake of delivery among women whose partners had no formal education (64.29%) was significantly low compared to those whose partners were with primary (78.57%), JHS (83.17%), SHS/Vocational/technical (84.21%) and tertiary (92.0%) level of education. The uptake of delivery was significantly

higher among the unemployed compared to those who were employed (88.61% vs. 77.31%) (Table 2).

Table 2: Association between Socio-demographic characteristic and delivery type

		Uptake of skilled delivery			
Variables	**Total**	**No (%)**	**Yes (%)**	**Chi-square**	**P-value**
Age				2.23	0.526
15-24 years	110	22 (20)	88 (80)		
25-34 years	127	22 (17.32)	105 (82.68)		
35-44 years	50	11 (22)	39 (78)		
45-49 years	8	3 (37.5)	5 (62.5)		
Religion				3.61	0.057
Christians	272	50 (18.38)	222 (81.62)		
Non-Christians	23	8 (34.78)	15 (65.22)		
Educational level				7.51	0.111
No formal education	58	17 (29.31)	41 (70.69)		
Primary	86	19 (22.09)	67 (77.91)		
JHS	116	18 (15.52)	98 (84.48)		
SHS/VOC/TECH	26	4 (15.38)	22 (84.62)		
Tertiary	9	0 (0)	9 (100)		
Marital status				21.54	<0.001***
Divorced/Widow/separated	12	2 (16.67)	10 (83.33)		
Married/cohabitating	232	34 (14.66)	198 (85.34)		
Single	51	22 (43.14)	29 (56.86)		
Partner's educational level				10.2	0.037*
No formal education	42	15 (35.71)	27 (64.29)		
Primary	70	15 (21.43)	55 (78.57)		
JHS	101	17 (16.83)	84 (83.17)		
SHS/VOC/TECH	57	9 (15.79)	48 (84.21)		
Tertiary	25	2 (8)	23 (92)		
Employment status				4.67	0.031*
Employed	216	49 (22.69)	167 (77.31)		
Unemployed	79	9 (11.39)	70 (88.61)		
Age at first birth				0.21	0.648
15-24years	245	47 (19.18)	198 (80.82)		
25-34years	50	11 (22)	39 (78)		

%: row percentage. *: p-value<0.05. **: p-value<0.01. ***: p-value<0.001.

4.7 Association between decision making process and delivery type.

From Table 3, persons who make health and pregnancy related decision did not show significant association with uptake of skilled delivery from the Pearson's chi-square test of association (p-value>0.05).

Table 3: Association between decision making process and delivery type

Variables	Total	Uptake of skilled delivery		Chi-square	P-value
		No (%)	Yes (%)		
Decision to visit facility when sick				1.48	0.476
both	117	19 (16.24)	98 (83.76)		
husband	103	22 (21.36)	81 (78.64)		
wife	75	17 (22.67)	58 (77.33)		
Deciding number of children and when.				2.69	0.261
both	159	27 (16.98)	132 (83.02)		
husband	85	17 (20)	68 (80)		
wife	51	14 (27.45)	37 (72.55)		
Seeking permission before doing anything				1.15	0.562
both	92	15 (16.3)	77 (83.7)		
husband	136	30 (22.06)	106 (77.94)		
wife	67	13 (19.4)	54 (80.6)		
Decision on expenditure				0.76	0.685
both	88	18 (20.45)	70 (79.55)		
husband	136	24 (17.65)	112 (82.35)		
wife	71	16 (22.54)	55 (77.46)		
Deciding place of delivery				3	0.223
both	85	22 (25.88)	63 (74.12)		
husband	83	15 (18.07)	68 (81.93)		
wife	127	21 (16.54)	106 (83.46)		
Decision on ANC attendants				0.21	0.900
both	76	16 (21.05)	60 (78.95)		
husband	74	15 (20.27)	59 (79.73)		
wife	145	27 (18.62)	118 (81.38)		
Decision on income				0.97	0.614
both	104	23 (22.12)	81 (77.88)		
husband	139	24 (17.27)	115 (82.73)		
wife	52	11 (21.15)	41 (78.85)		

%: row percentage. *: p-value<0.05. **: p-value<0.01. ***: p-value<0.001.

4.8 Association between other background characteristic of study participants and uptake of skilled delivery.

Table 4 shows other characteristics of respondents that is association with uptake of delivery. Uptake of skilled delivery was associated with respondents whose community have no

cultural practices during delivery compared to those whose community had cultural practices during delivery (81.65% vs. 67.86%).

Uptake of skilled delivery was also among respondents whose means of transport to the health facility is taxi/car (83.87%) or motorbike (84.03%) compared to those who walk (66.67%). A significantly higher percentage of participants who attended ANC at their last pregnancy used skilled delivery compared to those who did not visit the ANC (83.2% vs. 64.44%).

A higher percentage (89.47) of the respondents who said the quality of care at health facility was very good used skilled delivery compared to those who said it was average (70.27%) or it was good (77.3%) (Table 4).

Table 4: Association between other background factors and uptake of skilled delivery

Variables	Total	Uptake of skilled delivery		Chi-square	P-value
		No (%)	Yes (%)		
Women have power to make health decisions				2.33	0.311
Don't know	30	4 (13.33)	26 (86.67)		
No	123	29 (23.58)	94 (76.42)		
Yes	142	25 (17.61)	117 (82.39)		
Recommendation of place of delivery				18.79	<0.001***
TBA's home/home	19	11 (57.89)	8 (42.11)		
Health facility	276	47 (17.03)	229 (82.97)		
Community have cultural practices during delivery				3.05	0.081
No	267	49 (18.35)	218 (81.65)		
Yes	28	9 (32.14)	19 (67.86)		
Means of transport to health facility				8.37	0.015*
Motorbike	114	19 (16.67)	95 (83.33)		
Taxi/car	124	20 (16.13)	104 (83.87)		
Walk	57	19 (33.33)	38 (66.67)		
Time of travel to health facility.				1.47	0.225
<1 hour	274	56 (20.44)	218 (79.56)		
1 to 3 hours	21	2 (9.52)	19 (90.48)		
Decider to go to health facility				2.6	0.272
Self/self-included	119	19 (15.97)	100 (84.03)		
Partner only	156	33 (21.15)	123 (78.85)		
Others	20	6 (30)	14 (70)		
Attended ANC at last pregnancy				8.49	0.004**
No	45	16 (35.56)	29 (64.44)		
Yes	250	42 (16.8)	208 (83.2)		
Checked baby health after birth				56.66	<0.001***
No	29	21 (72.41)	8 (27.59)		
Yes	266	37 (13.91)	229 (86.09)		
Quality of care at health facility				8.35	0.015*
Average	37	11 (29.73)	26 (70.27)		
Good	163	37 (22.7)	126 (77.3)		
Very good	95	10 (10.53)	85 (89.47)		
Experience of misconduct from health provider				1.00	0.317
No	264	54 (20.45)	210 (79.55)		
Yes	31	4 (12.90)	27 (87.10)		

%: row percentage. *: p-value<0.05. **: p-value<0.01. ***: p-value<0.001.

4.9 Factors influencing uptake of skilled delivery.

The binary logistic regression model was used to assess the factors that influence uptake of skilled delivery among the study participants. From the adjusted model in table below, marital status, partners' level of education, recommendation of place of delivery by respondents, participants whose babies were checked after birth and the rating of the quality of care at the health facility were significant factors influencing uptake of skilled delivery.

The adjusted odds of uptake of skilled delivery among married or cohabiting mothers was significantly higher compared to those who were single (AOR: 3.6%, 95% CI: 1.54-8.42, p-value = 0.003). The adjusted odds of uptake of skilled delivery among mothers whose partners had JHS level of education was also significant higher compared to those whose partners had no formal education (AOR: 3.31, 95% CI: 1.15-9.51, p-value = 0.026), whereas the odds was also four times significantly higher among those whose partners have SHS/vocational/technical level of education compared to those whose partners have no formal education (AOR: 4.02, 95% CI: 1.17-13.77, p-value = 0.027).

The adjusted odds among mothers who would recommended health facility delivery to their friends was five times higher compared to those who would recommended TBA delivery to their friends (AOR: 4.93, 95% CI: 1.31-18.6, p-value = 0.019). Also the adjusted odds of uptake of skilled delivery was significantly high among those who rated the quality of care at the health facility to be very good compared to those who said it was average (AOR: 2.65, 95% CI: 1.06-6.63, p-value = 0.038) (Table 5).

Table 5: Factors influencing uptake of skilled delivery

	Unadjusted logistic model		Adjusted logistic model	
Variables	**UOR (95% CI)**	**P-value**	**AOR (95% CI)**	**P-value**
Marital status				
Single	ref		Ref	
Divorced/Widow/separated	3.79 (0.75, 19.09)	0.106	5.78 (0.76, 44.1)	0.091
Married/cohabitating	4.42 (2.28, 8.57)	<0.001***	3.6 (1.54, 8.42)	0.003**
Partners educational level				
No formal education	ref		Ref	
Primary	2.04 (0.87, 4.77)	0.101	2.37 (0.81, 6.97)	0.116
JHS	2.75 (1.21, 6.22)	0.016*	3.31 (1.15, 9.51)	0.026*
SHS/VOC/TECH	2.96 (1.14, 7.67)	0.025*	4.02 (1.17, 13.77)	0.027*
Tertiary	6.39 (1.32, 30.92)	0.021*	3.17 (0.58, 17.4)	0.184
Employment status				
Employed	ref		Ref	
Unemployed	2.28 (1.06, 4.9)	0.034*	1.92 (0.77, 4.74)	0.159
Recommend place of delivery				
TBA	ref		Ref	
Health facility	6.7 (2.56, 17.55)	<0.001***	4.93 (1.31, 18.6)	0.019*
Means of transport to health facility				
Walk	ref		Ref	
Motorbike	2.5 (1.19, 5.23)	0.015*	1.39 (0.48, 3.99)	0.545
Taxi/car	2.6 (1.25, 5.39)	0.01*	1.58 (0.54, 4.64)	0.402
Attended ANC at last pregnancy				
No	ref		Ref	
Yes	2.73 (1.36, 5.47)	0.005**	0.97 (0.34, 2.79)	0.958
Checked baby health after birth				
No	ref		Ref	
Yes	16.25 (6.7, 39.38)	<0.001***	33.1 (10.83, 101.12)	<0.001***
Quality of care at health facility				
Average	ref		Ref	
Good	0.69 (0.31, 1.54)	0.368	1.09 (0.37, 3.25)	0.876
Very good	2.5 (1.18, 5.29)	0.017*	2.65 (1.06, 6.63)	0.038*

UOR: unadjusted odds ratio. AOR: adjusted odds ratio. CI: confidence interval. ref: reference category. *: p<0.05. **: p<0.01. ***: p<0.001.

4.10 Factors that can improve uptake of skilled delivery

A number (43.4%) of the study participants suggested that education on importance of ANC and supervised delivery can improve uptake of skilled delivery. Also 30.2% suggested reduction in cost of delivery and drugs, 17.3% suggested improvement in the quality of care at the health facility, 9.5% suggested provision of adequate equipment for delivery and 4.4% suggested fixing of deplorable roads to the health facility can help improved the uptake of skilled delivery (Figure 6).

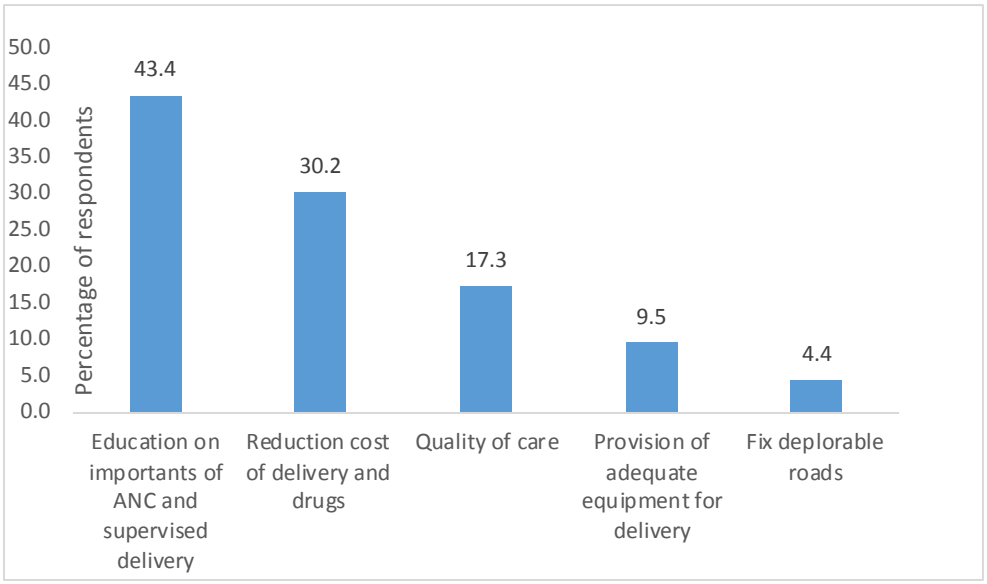

Figure 6: Factors that can improve uptake of skilled delivery

CHAPTER FIVE

DISCUSSIONS OF THE RESULTS

5.1 Introduction

This chapter discusses the key findings of the study. Results are compared with the already existing literature across Ghana and the world at large and the possible elucidations of the results and the repercussions for policy and practice.

5.2 Discussions

The first objective was to determine the socio-demographic characteristics of women which influence uptake of skilled delivery in Ada-Foah sub-district and the study showed there was a significant relationship between the partner's educational level, marital status and employment status of women and uptake of skilled delivery. In Ada-Foah sub-district, women of reproductive age delivered at an early age ranged from 15-24yrs according to the results of the study and this is driven by lack of education coupled with poor socio-economic status. Age is often offered as a substitute for amassed experience, comprising the utilization of uptake of skilled delivery by a pregnant woman (Burgard, 2004). Household decision-making is influenced by mature women who were extra buoyant and effective compared to adolescents who were pregnant (Glei et al, 2003). Moreover, the likelihood of developing complications during delivery is higher in older women hence the need to utilize uptake of skilled delivery. (Bell et al., 2003). Moreover, some studies also found that expectant mothers (adolescents) are likely to seek facility delivery more compared to older expectant mothers who might utilize TBAs or relatives (Navaneethan et al, 2002). Various possible pathways are there that can elucidate why "maternal education is consistently and strongly associated with all types of health behavior" (Bell et al, 2003). Other strong reasons why educational level is strongly associated with uptake of skilled deliveries are; enhanced knowledge on the

benefits of preventive and curative health care, greater openness to information related to health, enhanced relationship with the healthcare providers, understanding the contemporary medical culture, access to financial resources and health insurance, more control over resources within the household and prudent spending, more independent relationship and better communication with the spouse, more decision-making power, improved self-worth and self-confidence and better coping abilities (Thaddeus et al, 1994).

Husband's educational status might enlighten him on modern medicine, knowing the significance of uptake of skilled delivery thereby motivating him to associate with healthcare providers and requesting appropriate care for the spouse. Moreover fewer restrictions might be put on their spouses' movement and decision-making, hence enabling uptake of skilled delivery. Occupation and household wealth are associated with husband's education. Husband's education is even used as a measure of household socioeconomic status by some studies. Majority of the studies identified that educational status is associated with utilization of skilled delivery when husband's education was used as a measure, even though the effect is insignificant compared to the mother's own education (Short & Zhang, 2004). . Few studies considered the occupation of women but majority of the studies identified women who are farmers not to or less utilize healthcare compared those in other profession (Nwakoby, 1994; Hodgkin, 1996).). However it was found in other studies that formally employed women usually seek healthcare. Contrarily, it was the opposite in a study conducted in two southern India states and Nepal (Stekelenburg et al., 2004) .Uptake of skilled delivery by pregnant women is largely influenced by their culture, religion and ethnic background since the independence of a woman depends solely on the above mentioned factors (Gyimah et al., 2006)

Fishbein (2000), suggest that the main reason why women who are Christian or Muslim usually seek healthcare compared to the traditional and other religions is that women of the

traditional and other religion are more addicted to their cultural beliefs norms and values. Other studies have confirmed it indicating that women in the traditional and other religion might be old fashioned, trusting and relying on their beliefs).

The findings of the study on the second objective revealed that cultural perceptions of women contribute to uptake of skilled delivery. The study found that majority 117 (82.39%) of the women in the sub-district have power to make decisions as compared to 94 (76.42%) who said women do not have power to make decisions. This is contrary to the findings of the study that majority of the women in many countries utilize healthcare based on the decisions of their husbands or other family members (Furuta et al, 2006).

Uptake of skilled delivery by Muslims and traditional members in Ghana is lesser compared to Christians but no ethnic differences were identified. Ethnic or religious disparities were not identified by majority of the studies conducted in their settings (Bell et al., 2003). This is consistent with the findings of this study that majority 272 (92.2%) of women who were Christians delivered at the health facility compared to 14(4.75%) Islamic and 9(3.05%) traditional religion respectively. In Afghanistan, 87% of the women in that communities asked for permission before visiting a health facility, whilst 45%of the women said they believed in the right to be beaten by their husbands when they disobey them (Samson, 2012) This is contrary to the findings of the study that majority 98(83.76%) respondents indicated that seeking permission before visiting hospital was a mutual consent thus both husband and wife whilst 81(78.64%) said they sought permission from the husband.

Concerning accessibility to a health facility the study found that, more than a third (36.5%) of the respondents cited financial constraints and challenges as the reasons for not delivering at health facilities. 22.0% and 21.3% of the women reported 'no means of transport' and 'poor attitude of health care providers' as reasons for not delivery at the health facilities.

Family preference (3.4%), availability of TBA (3.0) and language barrier (3.0%) were the least cited reasons for not delivery at the health facility. This is consistent with a study which found that , means of transport in the area was scarce showing that the facilities are far from them therefore forcing women to seek for alternative delivery options available in the sub-district. The obstacle effect of distance is stronger when combined with lack of transport, poverty and poor roads (Thaddeus et al, 1994). Also It has been debated that "distance to hospital also captures other aspects of remoteness such as poor road infrastructure, poor communication between communities, poverty, limited access to information, strong adherence to traditional values and other disadvantages that are difficult to measure quantitatively" (Reynolds et al., 2006).

Regarding the fourth objective, the study found that there was a strong relationship between perceptions on the quality of care at health facilities and uptake of skilled delivery. Uptake of skilled delivery was influenced by the poor care perceived by the pregnant women that fairly overlap quality of medical care. Quality assessment “largely depends on people's own experiences with the health system and those of people they know." (Thaddeus et al, 1994). The findings of this study revealed that 27(87.10%) of the participants said the quality of care they received was very good as compared to 126 (77.3%) and 26 (70.27%) who said it was good and average respectively. This is consistent with a study which found that rise in skilled delivery uptake was influenced by the good attitude of healthcare professionals without disrespect, yelling and dejection but full of reassurance and courteousness (Baral et al., 2010). Also, quality of care has been assessed by few studies. A study by a Vietnamese found that a significant number of pregnant women with experience in childbirth ranked quality of care higher compared to "communication and conduct of personnel" but other pregnant women who utilized the TBAs or relatives ranked quality of care at the facility as very low (Duong et al., 2004). Furthermore, the findings of this study stated that 27 (87.10%)

experienced misconduct from healthcare providers during the uptake of delivery whilst 210 (79.55%) said they didn't experience any misconduct from the healthcare providers during the uptake of delivery. This is consistent with other studies that found that staff attitudes and quality of care featured conspicuously in nearly all the studies that considered uptake of skilled delivery and majority preferred utilization of TBAs or a relative due to discontent report with nude, disrespectfulness and careless behavior experienced by the pregnant women. Also the culturally unfitting care of not openly expressing pain when in labour that is admonished by healthcare providers (Kyomuhando, 2003).

The study also found that the women who delivered in healthcare settings gave a considerably higher average quality score for uptake of skilled delivery, but not for "communication and conduct of personnel" as compared to women who delivered at home. The study further found that the respondents are convinced that better quality of care can be realized in health facilities, but the cost involved and means of transport especially at night, deters them from using the better quality of care in Health facilities.

5.3 Summary of the findings

The first objective of the study was to determine the socio-demographic characteristics of women which influence uptake of skilled delivery in Ada –Foah subdistrict, the findings of the study were as follows: majority 127 (43.05%) of the respondents were within age range 25-34 years ,nine out of every ten (92.2%) were Christians and a fifth (19.66%) had no formal education. Moreover most 232 (78.64%) of the respondents were married although 42 (14.24%) of their partners had no education. 101 (34.24%) had attained JHS education. With regards to women's occupation, majority 216 (73.22%) revealed they were employed and 79 (26.78%) of them were unemployed. Therefore, socio-demographic characteristics of women thus marital status, partner's level of education and employments status of study participants were the factors that revealed significant association with uptake of skilled delivery.

The second objective was to explore the cultural perceptions that contribute to uptake of skilled delivery in Ada- Foah sub-district. According to the results of the study, majority of the respondents 117 (82.39%) showed that women have the power to make health decisions. Concerning the cultural practices in the sub-district that can be harmful to women or girls health, majority (55.4%) of the respondents indicated that eating of clay during pregnancy was one of the most harmful practices, postponement of ANC to second trimester (36.2%) and eating the placenta (9.1%) was the least among the cultural practices that are harmful to the health of women or girls. With regards to whether women had the power in the community to make any decision on health issues for instance visiting health facility when sick, majority 81 (78,64%) indicated that women do not have the power to make those decisions. Also concerning where the respondents would advise their friends to go to deliver their baby, majority 229 (82.97%) stated that health facility delivery would be advised. On whether the community have any cultural practices performed during delivery, majority 218 (81.65%) said no whilst 19 (67.86%) said yes. Therefore, uptake of skilled delivery was significantly high among respondents whose community have no cultural practices during delivery compared to those whose community have cultural practices during delivery (81.65%) and (67.86%) respectively .In all, cultural perceptions did not show significant association with uptake of skilled delivery but contributed to uptake of delivery.

The third objective was to assess the factors influencing accessibility to health facility by women for uptake of skilled delivery in Ada-Foah sub-district, the findings were: majority 104 (83.87%) used taxi/car to a health facility which would take less than 1 hours and would mostly be decided by self /respondent thus 100 (84.03%) of the respondents. Also the study wanted to know from the respondents why some women would not want to deliver in a health facility and more than a third (36.5%) of the respondents cited financial constraints and challenges as the reasons for not delivering at health facilities. 22.0% and 21.3% of the

women reported 'no means of transport' and 'poor attitude of health care providers' as reasons for not delivery at the health facilities respectively. Family preference (3.4%), availability of TBA (3.0) and language barrier (3.0%) were the least cited reasons for not delivery at the health facility. (36.5%) of the respondents said it was due to very long distances and 29 (18.7%) said it was due to lack of transport means. The study therefore showed that uptake of skilled delivery was also significantly higher among respondents whose means of transport to the health facility is taxi/car (83.87) or motorbike (84.03%) compared to those who walk (66.67%).Therefore, accessibility to health facility had significant association with uptake of skilled delivery.

The fourth objective was to identify the factors which affect perceptions on the quality of care at health facility for uptake of skilled delivery in Ada- Foah sub-district, the study found that: Most of the respondents 208 (83.2%) attended ANC at last pregnancy whilst 229 (86.09%) said their babies health were checked after birth. Majority of the respondents said they discussed or counselled on birth preparedness (72.3%), adequate nutrition (57.1%) and danger signs (55.4%) topics during their visits to the ANC clinic. Family planning (47.3%), importance of supervised delivery (45.3%), child welfare clinic (34.5%) and Breastfeeding practices (33.1%) were other topics the respondents were counselled on or discussed during their visits to the ANC clinic. Also, 85 (89.47%) of the respondents indicated that the quality of care received from healthcare professionals was very good whilst 27(87.10%) experienced misconduct from healthcare providers. Therefore the results showed that there was a significant relationship between the perception on the quality of care and uptake of skilled delivery.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

This study concludes that there is a significant relationship between the socio-demographic characteristics (marital status, partner's level of education and employment status of women in Ada- Foah sub-district and uptake of skilled delivery. The age range at which women are giving birth in the sub-district and the low levels of education has led to failure of women practicing health seeking behaviors including planning of their family and hospital delivery.

Cultural perceptions of women of reproductive age in Ada- Foah subdistrict contribute to uptake of skilled delivery. The study found that some traditional practices are still practiced in the community which has decreased the uptake of skilled delivery among women of reproductive age. Most of the women avoid facility delivery due to cultural requirements of privacy and positions during delivery (from the TBAs), handling of the placenta and the belief that in –laws should have the powers in decision making.

Accessibility to health facility contributes to women's uptake of skilled c delivery in Ada-Foah subdistrict .Most of the pregnant women do not even try uptake of skilled delivery since walking many kilometers before reaching a health facility is challenging in labor and unbearable if labor starts at night, and means of transport are frequently unobtainable. If the means of transport are available, the cost involved is always a challenge since majority of the drivers charge them exorbitantly especially at night.

Perceptions on the quality of care at health facilities influence uptake of skilled delivery. Some of the women experienced misconduct from the healthcare providers during the uptake of skilled delivery and chose to be attended to by a TBA or relative. Also facility protocols of not allowing family members in the labour ward, male doctors and midwives attending to

clients during delivery and sometimes imposition of delivery position on the clients conflicting with what the clients expected always led to perception of poor quality of care.

6.2 Recommendations of the Study

Bearing in mind the findings and the discussions of the study, the following policy implications and recommendations are highlighted by the study.

1. All the cultural practices and perceptions that affect women's health and uptake of skilled delivery should be addressed by the District Health Directorate in collaboration with the District Assembly ,Chiefs and opinion leaders of the district through the organization of community durbars and health education in churches and mosques in the sub-district to increase their knowledge on the harm they are causing themselves and come up with solutions gearing toward improving maternal and child health for all-inclusive implementation.

2. Lobbying and negotiating with the car owners in the various communities by the District Health Directorate and the District Assembly to subsidize lorry fares for women in labour at any point in time. This should be done by the chiefs and opinion leaders in the communities in collaboration with the driver and vehicle unions.

3. Regular health education on the importance of antenatal care and uptake of skilled delivery should be intensified by the midwives and community health nurses during antenatal care services and home visit with the help of the District Health Management Team and the District Assembly.

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APPENDICES

Appendix A: Consent form

CONSENT FORM FOR BREASTFEEDING MOTHERS

STUDY TITLE: Factors Contributing To Uptake of Skilled Delivery In Ada-Foah Sub-district In Ada East District In The Greater Accra Region, Ghana

PARTICIPANTS' STATEMENT (BREASTFEEDING MOTHERS)

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and all questions have been satisfactorily explained to me in a language I understand (English or Dangme). I fully understand the contents and any potential implications as well as my right to change my mind (ie withdraw from the research) even after I have signed this form.

I voluntarily agree to be part of this research.

Name or Initials of Participant…….. ID Code ……..

Participants' Signature …… OR Mark (Please specify)…….

Date: …….

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name: Halidu Imurana

Signature ……Date: …….

Contact for Further Clarification/Questions

1. Halidu Imurana; 0242211843 or via email: imranbenkhalid@yahoo.com

2. Prof. Alfred Edwin Yawson (supervisor): 0206301049 or via email: aeyawson@nacp.org.gh

3. Hannah Frimpong, GHS-ERC Administrator, Office: +233 302 681109, Mobile: 0243235225 / 0507041223 or **via** email:Hannah.Frimpong@ghsmail.org

Appendix B: Questionnaire

I am currently a student pursuing a master's degree in the University of Ghana Legon and I am carrying out a research on factors contributing to uptake of skilled delivery services among women of reproductive age (15-49) in Ada-Foah sub-district in the Greater Accra Region. This is in partial fulfillment of Master of Public Health degree

Kindly respond to the questions as accurate as possible, to make this research a success. The data collected will strictly be used for academic purposes, and shall remain confidential as possible.

Your cooperation will be highly appreciated. Please note: 1• Please tick where appropriate. 2• Do not write your name on the questionnaire 3• All responses will be treated strictly confidential.

Do you agree to continue with the research? 1. Yes [ ] 2. No [ ]

Socio-demographic characteristics of respondents.

1. How old are you?

1=15 yrs -24yrs

2= 25 yrs - 34 yrs.

3= 35 yrs- 44yrs

4= 45yrs – 49yrs

2. What is your religion?

1=Christian

2=Traditional

3=Islamic

4=other specify_____

3. What is the highest level of education you have attained?

1= No education

2=Primary

3=JHS

4=SHS

5= Vocational/Technical

5=Tertiary

4. What is your marital status?

1=Single?

2=Married/cohabiting?

3= Separated?

4=Divorced

5=Widowed?

5. What is your husband's highest level of education he has attained?

1= No education

2=Primary

3=JHS

4= SHS

5= Vocational/Technical

6=Tertiary

7=other specify

6. What is your main occupation?

1=Unemployed

2=Farming

3=Fishmonging

4=House wife

5= Apprentice

6=Student

7=Other specify----------

8. How old were you when you gave birth to your first baby? _____

Cultural Perceptions

9. Who do you think should have the greater say in each of the following decisions below: the husband, the wife or both equally:

No	**Statement**	**1 Husband**	**2 Wife**	***3 Both equally***
A	Deciding if to visit health facility when sick			
B	Deciding on the number of children to have and when to have them			
C	Seeking permission before doing anything planned			
D	Deciding on expenditure			
E	Deciding on where to deliver when pregnant			
F	Deciding on when and where to start antenatal care services			
G	Making decision on income			

10. What are some of the practices in your community that may be harmful to women/girls health?

a. Eating the placenta?

b. Postponement of ANC until second trimester or more?

c. Eating of clay during pregnancy?

d. No hospital attendance till delivery when pregnant?

e. No orthodox medicine when pregnant?

f. Other specify _____

11. Do women in this community have the power to make decisions on matters affecting their health e.g. number of children to have, place of delivery, etc?

1= Yes

2= No

3= Don't know

12. Where would you advise your best friend or relative who is pregnant to deliver the baby?

1= At health facility

2= At home

3= At TBA's home

5= other specify _____

13. Does your community have any cultural practices performed during delivery?

1=Yes

2= No

14. What are some of the cultural practices in your community performed during delivery?

Accessibility to health facility

15. How do you get to the nearest health facility?

1= Walk

2= Motorbike

3= Cycle

4= Taxi/ car

5= other specify _____

15. How long would it take you to get to the health facility?

1= Less than one hour

2= 1 to 3 hours

3= More than 3 hours

5= Don't know

16. Who decides before you go to the health facility?

1= Respondent/ Self

2= Husband

3= Mother

4= Mother-in-law

5= Father in law

6= Friend/neighbors

7= other (specify)

17. What do you think some women do not deliver in a health facility?

1= Distance very long?

2= No means of transport?

3= Cost of transport very high

4= Abrupt delivery?

5= Staff shortage/ No female provider?

6= Poor treatment by staff?

7= Inadequate commodities and supplies?

8= Language barrier?

9= Husband/ family did not allow?

10= Other _____

Perception on the quality of care at health facility

18. Did you attend antenatal care while you were pregnant with your last child?

1= Yes?

2= No?

19. Who attended to you during antenatal?

1= Medical Doctor

2= Midwife

3= Nurse

4= CHW

5= Other (Specify) _____

20. During the antenatal care, which of the topics below were you counselled on

1= Birth preparedness

2= Breastfeeding

3= Family planning

4= Danger signs of pregnancy

6= Adequate nutrition

7= importance of supervised deliver

8= child welfare clinic

9= None

21. Who assisted you with your last delivery?

1= Doctor

2= Midwife

3= Nurse

4= TBA s

5= CHW

6= other specify _____

7= None

22. Where was the baby put immediately after birth?

1= with mother?

2= In a cot?

3= on floor?

4= other specify _____

5= Don't know?

23. After your baby was born, did anyone check on your health?

1= Yes?

2= No?

24. In your opinion, what was the quality of care you received from health workers during your pregnancy, delivery and postnatal?

1=Very poor?

2=Poor?

3=Average?

4=Good?

5=Very good?

25. Did you experience any misconduct from the health workers during your pregnancy, delivery and postnatal

1. Yes

2. No

3 .If yes specify----------

26. Suggest various ways in which awareness and uptake of skilled care during delivery can be improved in Ada –Foah sub-district.

1= _____

2= _____

3= _____

Thank you!!!!!

Appendix C: GHS Ethics Approval Letter

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

My Ref. GHS/RDD/ERC/Admin/App \
Your Ref. No.

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Tel: +233-302-681109
Fax + 233-302-685424
Email: ghsrc@gmail.com
28th February, 2019

Halidu Imurana
University of Ghana
School of Public Health
Legon

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	GHS-ERC064/02/19
Project Title	Factors Contributing to Uptake of Skilled Delivery in Ada-foah Sub district in the Greater Accra Region
Approval Date	28th February, 2019
Expiry Date	27th February, 2020
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra