RESEARCH ARTICLE

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The Determinants of Places of Delivery by Women in the Savelugu/Nanton Municipality, Ghana

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ABSTRACT

Despite improvement in health care services in Ghana, many women still choose to deliver at home. This practice has serious implications for maternal and child health. The phenomenon is not different in Savelugu/Nanton Municipal is even seriously educated women sometimes ignore the health facilities and deliver at home. This paper examines the factors associated with the choice of places of delivery by women in the Savelugu/Nanton Municipality. An analytical cross-sectional study design was used involving women, health workers, Traditional Birth Attendants, opinions, traditional and religious leaders and some key informants. Data was collected through questionnaires, in-depth interviews, focus group discussions and observations. The result indicates that distance to health centres, personal likes and dislikes of women and availability of TBAs in the community were among the factors influencing the choice of places of delivery. It was also revealed that bad attitudes of health workers and ineffective communication between health workers and patients are some of the factors that influence women's choice of places to deliver. The paper concludes that, despite improvement in health service delivery in Ghana, many women still deliver at home. The paper recommends effective health education by stakeholders to reverse the situation.

Keywords: Health Centres, Place of Delivery, Pregnant Women, Traditional Birth Attendants.

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I. Introduction

In Ghana, certain socio-cultural practices are still underpinning pregnancy and childbirth thus, affecting pregnant women's choice of places of birth (Abbey, 2008) coupled with inadequate knowledge and skills of some health workers to manage obstetrics cases, compels some women to deliver outside health facilities (Adeyemi, 2007, Kabakyenga, 2012). It has been reported that women still make the choice to deliver at TBAs' homes due to cultural and social factors (Berman, 2000). Several researchers have attributed this low rate of delivery at the health facilities by women to several factors including demographic characteristics of women, socio-economic status of women, cultural practices and beliefs prevailing in the community the woman lives, lack of obstetrics knowledge by women especially during pregnancy and poor health delivery system (Berman, 2000; Birungi & Ouma, 2006).The national target for supervised delivery is 60% (GHS, 2008); however, supervised delivery in Savelugu/Nanton Municipality is only 46.8% which is far below the national target of 60% (SNMHDR, 2013).

In an attempt to increase the proportion of institutional deliveries, and thereby, the safety of the birth process for mothers and their infants, the Government of Ghana introduced in 2003 the fee exemption policy on maternal deliveries in the four most deprived regions of the country (Northern, Upper East, Upper West, and Central Regions). The policy aims to remove financial barriers to accessing maternity services by women in these regions. Since October 2005, this policy has been extended to cover the rest of the country (Moses *et al*, 2014).

Despite the fact that the government, NGOs and other philanthropists have initiated various measures to improve upon institutional deliveries, many women still opt for delivery at home, TBAs' centres, and spiritual centres. The 2014 Municipal Health Directorate report of Savelugu/Nanton Municipality indicated that 97% of antennal clinic attendance was achieved, however, only 64% supervised deliveries were attained with the remaining 36% having unsupervised deliveries. This 36% of unsupervised deliveries took place at home with the help of TBAs or family members as well as spiritual centres. However, there have not been any empirical studies on factors that influence the women in the Savelugu/Nanton Municipality to choose a place of delivery. Besides, a few researchers in the country including Bougangue (2010), Amenya (2014) and Bisianin (2013) have conducted research in a similar vein in the Awutu Senya District of the Central Region, Adidwan in the Mampong Municipality of the Ashanti Region and Builsa North

District of the Upper East Region respectively. However, their respondents were limited to only expectant mothers and their husbands and therefore could not be considered holistic since other important stakeholders such as married men, opinion leaders and health workers who can influence the choice of place of delivery were left out. Therefore, this paper seeks to bring all these stakeholders on board and examine the factors associated with the choice of places of delivery by women in the Savelugu/Nanton Municipality. The findings of this research will bridge the existing gap in the literature on factors associated with the choice of places of delivery by women in the Savelugu/Nanton Municipality.

The main objective of this paper is to examine the factors associated with the choice of places of delivery by women in the Savelugu/Nanton Municipality. Specifically, the paper examines the factors that influence women's choices of the place of birth and determines the risks and other challenges associated with healthcare providers that bother the choice of place of delivery.

II. Literature Review

A. Sociocultural Beliefs Underpinning Pregnancy and Childbirth

In a cross-sectional survey conducted by the Institute of Public Health (2006) in Uganda, concerning pregnant women's knowledge of cultural factors affecting pregnancy and childbirth, it was discovered that 90% of the pregnant women stated that they were aware that cultural factors affecting pregnant women's place of choice of birth whiles 10% stated otherwise. In a related development, a survey carried out in Ghana revealed that certain cultural practices were still surrounding pregnancy and childbirth thus, affecting pregnant women's place of choice of birth (Abbey, 2008). Similarly, social and cultural factors primarily influence women's decision making whether to seek ANC care or not and whether to make a decision to deliver at a health facility or at home (Kyomuhendo, 2009). Few studies reported some traditional beliefs that affect the choice of place of delivery of women in the world. A study in the northern part of Tanzania, found that women believed that normal delivery should be conducted at home and delivery at health facilities was beneficial for those with complications only (Adeyemi, 2007; Mpembeni, *et al.,* 2007; Ochako, 2011).

According to a study conducted in rural communities in Kenya, by Cotter, *et al*., (2006), it was revealed that there was a strong relationship between cultural beliefs and pregnant women's choice of home delivery or TBA deliveries. For that cross-sectional survey report, 33% of the pregnant women opted to deliver at home because their cultures did not allow them be delivered at the health centres, 45% of the respondents said it was believed that the newborn baby was not supposed to be seen by everyone and hence opted to deliver at TBAs' residence while 22% of the respondents said their previous deliveries at home has been very successful hence they were preparing to deliver at home.

A study conducted by Adeyemi (2012) among women in Kenya revealed that prolonged labour means the woman was not faithful to the husband and needed to confess before she could deliver successfully at home without any problem, 6% of the respondents said that home delivery was a sign of bravery on the part of the woman and 6% of the respondents indicated that traditionally, a newborn was not supposed to be seemed by everybody (Adeyemi, 2012)

A study to assess cultural factors affecting women's choice of place of birth in Thailand revealed that women had no knowledge of cultural factors affecting their choice of place of birth and were constantly going to the hospital to deliver (Mbaruku & Msambichaka (2009). In a study to assess social factors influencing pregnancy and childbirth in Zaria, Nigeria, it was discovered that community norms, beliefs and personal likes and dislikes of pregnant women, availability of TBAs and long distance to health facilities were the most dominant factors affecting pregnant women's choice of place of birth. Most women opted for home delivery because they did not want to travel a long distance before reaching a health facility to deliver (Idris *et al*., 2006)

Similarly, according to a cross-sectional survey conducted by Mbaruku and Msambichaka (2009) in selected hospitals in Tanzania, hospital delivery was considered as culturally inappropriate by most pregnant women. According to the opinions of the pregnant women, health workers were seen to be strangers, who were rude, delivered women in an uncomfortable supine position, hasten to do episiotomies and prematurely performed caesarian sections when the woman could have struggled on her own to deliver. This situation compelled most women to deliver at home (Mbaruku & Msambichaka, 2009). It is therefore not surprising that most pregnant women in rural Tanzania communities preferred to deliver with TBAs and relatives who were community members and were sensitive to cultural and community norms of childbirth (Amooti & Nuwaha, 2000 Adam & Salihu, 2002; Mbaruku *et al.*, 2009) Hospital delivery was only resorted to in cases of emergencies (Mbaruku *et al*., 2009).

In a related study carried out by Idris *et al*., (2006) on why women seek ANC services from TBAs in rural communities as against going to the health centres, it was discovered that 88% of pregnant women perceived the attitude of health workers to be very bad. This, they said motivated them to go to the

traditional birth attendants who in their views understood them very well. The study found also that economic and cultural factors were the major barriers associated with seeking health care among pregnant women in Kano state, Nigeria (Idris *et al*., 2006).

B. Demographic Factors Affecting Women's Choice of Places for Delivery

In a study to ascertain why pregnant women in Syria were delivering at home, it was observed that most of them felt okay being surrounded by family members and friends during labour and did not like the vaginal examination by health workers (Bashour & Abdul Salam, 2005). In a descriptive study to assess the variables for the choice of place of delivery for pregnant women in the Southern part of Ethiopia, Abyot and Asres (2010) revealed that most of the women identified factors affecting women's choice of place of delivery to include; inadequate income of pregnant women to pay health care bills, feeling of privacy and being surrounded by family members and friends during labour at home, fear of operations, fear of repeated vaginal examination, level of education of women, parity of women, religion, age of mothers at pregnancy and history of antenatal follow up.

This finding is similar to what has been observed in the study conducted in Rakai districts, in Uganda where the identified factors influencing women's choice of place of delivery were: income level of women, age of the woman, the privacy of women during labour at health centres, fear of operations, fear of repeated vaginal examination by health workers, educational level of women, parity of women, age of the mother at first pregnancy, and the number of antenatal visits before childbirth (Amooti & Nuwaha, 2000; Adeyemi, 2007; Abyot & Asres, 2010).

While in Nepal, Acharya and Cleland (2000) followed the delivery patterns of pregnant women in a cross-sectional survey. Low maternal education and multi-parity were the significant factors that influenced home delivery by pregnant women. In a related situation, a cross-sectional survey was carried out by Abraham (2001) to compare the socio-demographic characteristics and pregnancy outcomes of pregnant women in Cape Town, South Africa. The study revealed that a very large percentage of home deliveries was reported among teenage mothers and the majority of them were from rural areas, were poor, less educated and were not married at the time of the research (Abraham, 2001).

According to research conducted by Abraham, (2001) on why women opt for home delivery as against health centre in certain selected rural communities, some of the reasons given by those who chose home as a preferred place of delivery included the cost of hospital bills (50%), the unfriendly attitude of health care workers (30%) and unexpected labor (20%). Others mentioned distance to the health facilities, failure to book for ANC early, and some of them had no particular reason for choosing the home as a place to deliver.

In rural Orissa, 51% of families did not have enough cash for a normal delivery and 74% did not have enough for a cesarean section and so had to borrow money from a money lender or relative (Alastair & Pepper, 2005) thus, compelling women to deliver at home. In Uganda and Tanzania, a number of women still preferred to deliver at home than to deliver in health facilities (Abraham, 2001; Idris *et al*., 2006). Reasons given by respondents on why women were not delivering in health facilities, 102 (27.7%) respondents mentioned sudden onset of labour at home and 82(22.3%) respondents mentioned the presence of TBAs in the community who were competent and provided friendly services to pregnant women in the community (Idris *et al*., 2006).

III. Study Area and Methodology

A. Study Area

The study was conducted in the Savelugu/Nanton Municipality of the Northern region of Ghana. The Savelugu/Nanton Municipality was carved out of the then Western Dagomba District Council which comprised of Tamale, Tolon and Savelugu. The Municipality has its administrative capital at Savelugu. It shares boundaries with Tolon District and Kumbungu District to the west, Tamale Metropolis to the south and Yendi Municipal to the south-east. The Municipality also shares boundaries with Karaga District to the East and West Mamprusi and Mamprugu / Moaduri District to the North (GSS, 2010).

The Municipality, like many others in the Northern Region, has a single rainy season, usually stretching from May to October, and this period naturally coincides with the farming activities in the Municipality. Annual rainfall average ranges from 600 mm to 1100 mm, the peak is usually between July and August. The dry season starts in November and ends in March/April with maximum temperatures occurring towards the end of the dry season and minimum temperatures in December and January (GSS, 2010). The Harmattan winds, which occur during the months of December to early February, have considerable effect on the temperatures in the community, which may vary between 14 ºC at night and 40 ºC during the day (GSS, 2010). Daily temperatures vary from season to season. During the rainy season, there is high humidity with relatively less sunshine and heavy thunderstorms. The mean day temperatures range from 28º C (December - mid-April) to about 38 ºC (April - June) while the mean night temperatures range from 18ºC (December)

to 25ºC (February, March) (GSS, 2010). The people are predominantly Dagombas and a few other tribes such as Gonja, Frafra and Sisalas. These tribes are made up mostly of Muslims and Christians interspersed with traditional believers. These tribes celebrate traditional festivals such as the annual Damba festival and the Fire Festival. The Christians however also celebrate Christmas, Easter, Palm Sunday, Pentecost Day and Good Friday, while Eidul-Ahda and Eidir-Fitir are equally celebrated by the Muslims (GSS, 2010).

The males are mostly engaged in farming while the females assist the men with farming activities**.** Polygamous marriages are common among people. There is a high illiteracy rate among the people. There are currently functioning government and private health facilities in the Municipality providing health care for diverse groups. The Savelugu/Nanton municipal hospital serves as a referral center for the rest of the health facilities. There are eight operational Community-based Health Planning and Services (CHPS) compounds, at Dipale, Kundanali, Guntingli, Nanton-Kurugu, Fazihini, Nambagla, Pigu, and Nyolugu.

There are three Health Centres and these are located in Nanton to the East and Pong Tamale and Diare to the north. The five clinics are located at Moglaa, Janjori-Kukuo, Tampion and Zoggu. Bruham clinic and Modern Surgical center are privately owned and operated in the municipality. Records on fertility, mortality and migration are indispensable as far as socio-economic planning and policy formulations are concerned. Moreover, in a developing country such as Ghana, where data on these indicators are not readily available, census data become very important in providing data on fertility, mortality and migration.

B. Research Design

A descriptive cross-sectional study design was used for the study to examine the factors that were associated with the choice of places of delivery by women in the Savelugu/Nanton Municipality. This type of study is usually conducted to estimate the prevalence of the outcome of interest for a given population, commonly for the purposes of public health planning. In this way, cross-sectional studies provide a 'snapshot' of the outcome and the characteristics associated with it, at a specific point in time.

The data collected was based on socio-demographic characteristics of respondents, the social and cultural beliefs and factors underpinning pregnancy and child birth, the economic, geographic and bottlenecks that influence the choice of places of birth of women, the risks and challenges associated with health care provision that bother on the choice of place of delivery in the Savelugu/Nanton Municipality.

C. Sampling Technique

The paper employed a multistage sampling technique. In the first stage, Savelugu/Nanton Municipality was purposively chosen for the study because of its demographic characteristics such as high poverty rate, high fertility rate, and adherence to religious and socio-cultural practices which largely affect health delivery in the municipality. Then the Municipality was clustered into five sub-municipalities and out of these, three (Savelugu, Pong-Tamale and Nanton) were selected at random. Then three communities from the Savelugu sub-municipality and two communities each from the Nanton and Pong-Tamale sub-municipalities were further selected at random. These were from the Savelugu sub-Municipality, the communities selected were Bunglung, Libga, and Nakohigu west; the communities selected from the Nanton sub-municipality were Chamkpem and Nanton Nayilifong while Laligu and Tibali were the communities selected from Pong-Tamale sub-municipality. Health workers were purposively sampled from the health facilities in the three selected sub-Municipalities while simple random sampling was used to select pregnant women in these same health facilities.

Data collection techniques included questionnaire administration, focus group discussions (FGDs), observations and key informant interviews. For instance, FGDs were held with women at Libga and Laligu. The group members did not know each other and were homogenous in terms of gender and fulfilled the inclusion criteria of the research work. Before the FGDs, the researchers introduced all the team members, and explained the general purpose of the study and the topic of the discussions. The purpose of the FGDs was to assist in finding answers to objective one which was on social and cultural beliefs and factors underpinning pregnancy and childbirth by women in the Savelugu/Nanton Municipality.

IV. Results and Discussions

A. Demographic Characteristics of Respondents

This section discusses the socio-demographic characteristics of the respondents. A total of 250 respondents were assessed from February to August 2015. Also, married men, health workers, traditional birth attendants and opinion leaders who are considered to be key stakeholders on choice of places of delivery were involved in the study. The category of health workers sampled were three Community Health Nurses, two Public Health Nurses, three midwives and two general nurses.

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TABLE I: BIODATA OF RESPONDENTS

Socio-demographic variables		Frequency	Percentage
Age of respondents	25-35	125	50
	36-45	99	40
	45+	26	10
Total		250	100
Occupational status	Housewives	45	18
	Traders	137	55
	Salaried workers	68	27
Total		250	100
Religious affiliations	Christians	85	34
	Muslims	155	62
	African Traditional Religion	10	4
Total		250	100
Marital status	Married	230	92
	Single	12	5
	Separated	8	3
Total		250	100
Educational level	No formal education	140	56
	SHS/ Vocational	50	20
	Tertiary	60	24
Total		250	100

B. Factors that Influence the Choice of Place of Birth of Women

1) Cost of transportation and medical bills

All 250 respondents stated that the cost of transportation to health centres influences women's choice of places of delivery. Pregnant women who have no money were more likely to deliver at home because they would not be able to afford the cost of transportation and medical bills at the health centre as compared to the rich. This finding corroborates the study by (Khalid, *et al*., 2006; Adeyemi, 2007; Envuladu *et al*., 2012) where the income status of women was a major factor influencing women's choice of places of birth. This finding is similar to that of Olatunji and Sule-Odu (1997) where women with high income would choose to deliver at a health facility because they could afford to pay the costs associated with skilled delivery care. Less advantaged women with low income who could not afford transportation costs were more likely to deliver at home.

2) Financial status of the family

The results show that 78% of the respondents claimed that poor women were more likely to deliver at home because they may not get the money to buy the items normally given to the midwife after delivery. Thus, 85% of the respondents mentioned that women still deliver at home because their husbands and family members may not support them to go to health centres to deliver due to a lack of money. This finding corroborates the works by Amooti and Nuwaha (2000); Adeyemi (2007) and Abyot and Asres, (2010) where the income level of women was a strong predictive factor influencing where they should go and deliver. Despite the free maternal health policy launched in Ghana in 2003, pregnant women still claimed they pay some amount of money to the midwives when they deliver at the health facility. The time spent looking for money can delay the decision to seek health care and this may cause them not to receive timely health care. It has been reported that most of the rural poor women in Bangladesh who could not afford health bills had to rely on friends and family members for assistance and most were compelled to deliver at home (Abyot & Asres, 2010). Furthermore, the finding from this study is in line with what was found by Kabakyenga, (2012) and Adeyemi, (2007), that household financial capacity is also seen to be a major factor in the determination of place of delivery by women. The financial status of the family depends on the occupations of the husband and wife. Women who are working and earning money may be able to save and decide to spend it on facility delivery as compared to those who are not working.

3) Distance to the nearest health facility

Long distances to health centres coupled with the meager income of rural people influence women's places of birth. Most of them usually would have to resort to home delivery because of the long distance to the nearest health centres. The analyses revealed that women who were staying very far away from a health centre were five times more likely to deliver at home if sudden labour occurred as compared to those who were staying very close to a health centre. The findings revealed that 75% of the respondents stated that long distances to health centres compelled women to make the choice of delivering at home while 25% of them stated otherwise. Where the health facility is closer to them, women will opt to deliver there because they can easily move from their residence to the facility. However, where the health facility is far from them and may involve boarding a vehicle to get there, women will opt to deliver at home.

A lot of factors come into play as far as the location of the health facility is concerned. For instance, some may not have their own means of transport and may not have money they will use and board a taxi or motorbike to the health centre. Others held the view that women sometimes deliver on their way to the health facility due to the fact that it is sited far away from their residences. Besides, they explain that it was

very dangerous to go to the health facility when labour sets in late in the night. The implication of this finding is that long distances to health centres negatively influenced the choice of places of childbirth. This finding is similar to the study by Olatunji and Sule-Odu (1997) that found that long distances to health facilities especially in rural communities prevented women from going to the health centre to deliver. It also supports the work done by (Khalid *et al.*, 2006; Adeyemi, 2007; Envuladu *et al.*, 2012) which revealed that income and long distance to health centres were major factors influencing women's choice of places of birth. It is worth noting that the location of the health facilities plays a major role in where women choose to deliver. When the health facility is located far away from the residence of women, they normally would opt to deliver at home because movement from their homes to the health centres comes with its own implications. Most of these women get to the health facility by walking or at best side on motorbikes and bicycles. Sometimes women deliver on their way to the health facility because of long distances. Women, therefore take into consideration the suffering and pain they may go through by moving from their homes to the health facilities and opt to stay home and deliver. Furthermore, labour may set in late in the night and because the health facility is located far from their residence, they consider it risky to go there at that time of the night. An unreliable transport system especially in rural communities is a serious barrier to accessing skilled delivery. The inability of some women to plan in advance for transport also compel them to deliver in their homes even if they had wanted to deliver in health facilities.

4) Availability of Cheap Traditional Birth Attendants (TBAs) Services in Communities

Cheap services rendered to women by TBAs have an impact on where they choose to deliver. Though the majority of the respondents (56%) indicated that the cheap services rendered by the TBAs do not influence where they choose to deliver, we cannot run away from the fact that, once they do not have specific charges for their services, some women would like to opt for their assistance. Pregnant women who have no money were more likely to deliver at home because they will not be able to afford medical bills at the health centre as compared to the rich. Over 35% of the women relied on the services of traditional birth attendants simply perhaps they are readily available, affordable and accessible. The study found that traditional birth attendants served as one of the critical bottlenecks that impede the utilization of health facilities by expectant mothers in many rural communities, especially where their services are highly demanded. Apart from conducting deliveries, TBAs are sensitive to women's needs, preserve the dignity of the woman and are sensitive to their cultural values and practices. This finding corroborates the study by Ogunlesi, (2005) who stated that women in Nigeria patronized the services of TBAs because they provided cheap services to them. It is, however, vital to note that apart from the unmanaged birth complications that may arise, home delivery if not conducted by professionals, increases the risk of transmission of HIV/AIDS and other infections to relatives or traditional birth attendants who conduct deliveries without protective equipment. The risks associated with home delivery are enormous and cannot be underestimated.

5) Attitude of healthcare professionals

It is vital to note that the attitude of healthcare professionals towards their clients can be a major hindrance to where women may choose to deliver. The results suggest this since the majority (86%) of the respondents stated that the poor attitude of health workers affects women's choice of places of birth whiles 14% of them said the attitude of health workers could not influence women to deliver at home. One of the women remarked during a focus group discussion that;

> *Pregnant women who are abused by the health workers during ANC attendance, labour and child delivery would not like to deliver in the hospital again.*

The findings from the work by (Olatunji, & Sule-Odu, 1997; Khalid & Lale, 2006; Kamga *et al.*, 2012) showed that the perceived poor attitude of health workers prevents women from going to health centres to deliver for fear of abuse and disrespect. Research findings are also in line with what was found by (Kyomuhendo, 2009; Ochako, 2011; Kabakyenga *et al*. 2012). According to them, the issue of health workers' attitudes towards women has been a major obstacle to women seeking health care. In many studies, women have identified the rude behavior of health workers as a major contributory factor for women delivering at home. In a survey conducted in Tanzania, women revealed that until health workers become friendly in providing health care and not being rude to them, they would continue to deliver at home. Though health centres have been described as the best place or environment, where special delivery can be conducted as indicated by GHS (2007). However, some researchers have revealed that health centres can sometimes create a perception of a cold sterile atmosphere, especially if it is the women's first contact with a healthcare delivery unit. It is totally an unfamiliar and scaring environment to those who think that deliveries at health centres can cause death (Khalid & Lale, 2006; Envuladu *et al*. 2012). This causes women to be scared and feel insecure because they do not know the purpose and procedures of all the equipment. Kamga *et al*. (2012), Hazemba and Siziya, (2009), and Ogunlesi, (2005) indicated in their separate research that since the hospital environment may create some form of uneasiness for women, the health care

professionals should stand in the gap by providing a calm and supportive atmosphere and not to be hostile towards their clients.

Health workers' interpersonal relationships with women are therefore an important factor influencing women's choice of places of delivery. The huge percentage (86%) of the respondents who think the attitude of health workers can influence where a woman chooses to deliver could suggest that some of these women might have experienced one form of the hostile attitude of the health workers during their regular ANC visits or previous delivery. It can be deduced from what the respondents said that a woman who has been previously abused or disrespected during pregnancy and childbirth is more likely not to go back there to deliver again at the health facility. The Savlugu/Nanton Municipal Health Directorate's report affirms that the attitudes of some health workers deter residents from seeking health care from these facilities when the need arises (SNHDR, 2013).

However, it is vital to note that what some pregnant women consider to be abuse by health care providers is not really so. Nurses and midwives have various ways of motivating women to deliver as labour progresses. One of the strategies they employ especially when the women are due to deliver is to verbally tell the woman to push. Sometimes this is said in a high tone especially when the woman relaxes a bit in pushing. To further make the woman push, they sometimes "slap" their thighs or hands. According to health care providers, this is done just to save the lives of the baby and the mother. However, the women describe such acts as tantamount to being beaten and shouted at by nurses and midwives. It is therefore important to note that failure on the part of health care professionals to properly communicate with their clients paves the way for them to misconstrue certain procedures carried out.

C. Quality of Health Services Rendered

It was also revealed that 85% of the respondents identified poor health service provided at health centres as a challenge whiles 15% of the respondents thought otherwise. Among the former, a key reason identified was that if pregnant women do not get all the needed access to maternal care at the health centers, they would not like to go there to deliver. Because they know that even if they go there, they would not be given the needed maternal health services. So this makes women opt for other places like TBAs and spiritual centres. This finding is similar to earlier research done in Tanzania. It revealed that women who delivered at home mentioned poor health care rendered to them by the health care professionals. They indicated that healthcare givers shouted at them during weighing and delayed in giving them care at the hospitals. These and many other factors prevent women from delivering at health centres (Berman, 2000). The finding also collaborates with Abbey (2008) and Amooti and Nuwaha (2000) studies which revealed that patients often complain about the poor quality of services in public healthcare facilities, and these are mostly centered on waiting time, unhealthy hospital environment, abuse and disrespect and apathy of health service providers. Upon further probe to know what respondents consider as poor services, they indicated that some of the health care providers usually engage themselves in other activities such as phone calls and conversations and therefore do not give them the needed concentration. One of the respondents remarked,

> *Some of the nurses especially the young ones sometimes engage in making phone calls or play games on their phones and leave us in pain.*

A survey conducted in Egypt has shown that the quality of care provided to women is a key determinant of good maternal and child health outcome and most women because of the perceived poor health care that they received at the health facility, preferred to deliver at home instead of delivering at health facility (WHO, 2004)

1) Level of education of women

The level of education attained by women can influence where they will choose to deliver. It is therefore not surprising that the majority (87%) of the respondents said the educational level of women could motivate them to deliver at health centres and only a few (13%) of them thought otherwise. The greater percentage of respondents who agreed that the educational level of women influences where women choose to deliver suggests that educated women are enlightened on the likelihood of complications arising during the course of delivery and know the dangers associated with it when it occurs at home and there is no skilled attendant to salvage the situation. Women with high education are also aware of the dangers of infections and therefore know that delivering at the hospital setting reduces their chances of getting infections to the barest minimum. Besides, educated women are more likely to know when their time is due and prepare for hospital delivery as compared to less educated pregnant women who may experience a sudden onset of labour at home. Furthermore, women with high education are in a better position to appreciate health education messages and act on them accordingly. In addition, women with more years of education have high self-confidence and feel comfortable delivering in healthcare facilities.

The uneducated women may also opt for home delivery possibly due to the last successful home delivery. This finding is similar to those found by Abbey (2008); Olatunji and Sule-Odu (1997); Hiluf and Fantahun

(2007) which indicated that women with higher education have a strong desire for choosing a health facility to deliver as compared to those with less education. This finding also corroborates with Adeyemi's (2007) and Olatunji and Sule-Odu's (1997) results which revealed that educational level of women was a strong factor that motivated them to seek ANC services regularly and possibly made the effort to deliver health centres. It is vital to note that these educated women are enlightened on the effects of some of the social and cultural practices on their health. They would therefore likely stick to modern practices instead of holding on to the defunct traditional practices that are injurious to their health. However, this finding is at variance with those found by Hazemba and Siziya, (2010) and Kabakyenga (2012) when they argued that education has no link with where a woman chooses to deliver.

2) Antenatal Services

The study further found that the number of times women attend ANC could influence them to deliver at health centres since they would be in a better position to be educated on the importance of skilled delivery. The study established that there was a correlation between the number ANC attendance and the choice of places of delivery. Women who attend ANC more often are more likely to deliver at the health facility compared to those who do not often go for ANC. Women who attend ANC get the opportunity of being educated on pertinent issues pertaining to pregnancy and child delivery. They get to know more about risk detection and signs of complications so they can quickly seek remedies as and when the need arises. They are sensitized to the dangers associated with home delivery. Findings from the research revealed that the majority of the respondents (55%) said they attended ANC during their last pregnancy four times.

The opinions expressed by most of the women during the focus group discussion were that they have attended ANC at least four times during their previous delivery. It is worth noting from the findings that all the respondents attended ANC during their last delivery, even though at different rates. This goes a long way to affirm the fact that the Savelugu/Nanton Municipality records high antennal clinic attendance. The antenatal period presents an important opportunity for identifying threats to the mother and unborn baby's health status, as well as for counseling on birth preparedness, delivery care, and family planning options after birth. Despite these benefits associated with ANC most women do not seek it during pregnancy frequently simply because of the long distance to health facilities and lack of money to transport themselves to health centres. This finding is consistent with that of Marjolein (2003) who reported that women who made more ANC visits were more likely to deliver at health facilities under the care of a skilled birth attendant as compared to those who made fewer visits. According to Mesko (2004) women who make more visits to ANC also were more likely to deliver in health facilities as compared to those who never did. This could be because of the constant reminder during ANC visits, on the importance of delivering in the health facility and being assisted by a skilled birth attendant. However, the research findings are at variance with what other researchers have found. Some researchers observed that over 90% of pregnant women do attend ANC at least once during pregnancy. ANC attendance has only been linked to helping pregnant women to make appropriate birth plans but does not necessarily attract them to come and have childbirth in the same health centre as would be expected (WHO, 2010). Despite the high number (74%) of pregnant women who attended ANC in Kenya (Birungi & Ouma, 2006), a lot (39%) still preferred home delivery. Furthermore, the findings do not support that of other studies where home delivery was the preferred choice of delivery for most pregnant women in Uganda who attended ANC more than once (Hiluf & Fantahun, 2007; Ochako, 2011; Kabakyenga, 2012). The study in Zaria, Nigeria also found that adequate ANC attendance during pregnancy by women did not significantly influence hospital delivery (Idris *et al*., 2006).

3) Husband and family influences

The result indicates that respondents (80%) identified the husband's influences on the choice of place of birth. It was claimed by the women that the men have the right to tell the women to deliver at a health centre or at home and the women would have no option but to comply. This is a worrying trend since this could have the repercussion of causing a woman to lose her life and her unborn baby through labour related complications. Respondents frequently mentioned that most of the time decisions were made by their husbands and TBAs on where to deliver. The research revealed that most (80%) of the respondents did not want to disrespect their husbands' decisions and had to always listen to their husbands before they would act. The respondents further indicated that unless labour became complicated and TBAs who managed the pregnant women decided to refer them to the health centres, their husbands would not allow them to go to health facilities to deliver. This is in conformity with what was found by Adeyemi (2012) that husbands sometimes technically discourage their wives from going to hospitals to deliver for fear of paying high medical bills especially when a caesarian section is to be conducted or when there is a referral and an ambulance or any other transport service is to be sought. The research findings are also in line with that of Idris *et al*. (2006) which indicated that decision-making power of women's husbands had a key influence on the choice of delivery place of women in most deprived communities in the world. It was revealed that the majority (80%) of women during labour requested permission from their husbands and relatives to go

to the health facilities. In any case, the husband seems to be the key person in the decision-making process in this regard.

D. Risks and Challenges Associated with Home Delivery

1) Fear of unprofessional health services

There are instances where child delivery in health facilities may not be successful and result to either the death of the mother, child, or both. The majority of the respondents (55%) indicated that pregnant women who have not had successful delivery in a health centre and possibly died would create the impression that the health workers in those facilities lack adequate knowledge on delivery and this may compel women to make the choice to deliver at home instead of going to the health centres to deliver but 45% of the respondents think otherwise. It is observed that a lot of maternal and child deaths still occur in our health facilities. Sometimes, negligence on the part of the healthcare providers accounts for these maternal and child deaths. There are a lot of bureaucratic processes clients are usually expected to follow in seeking health care in health facilities. This includes checking the history of the woman in the folder, taking her vital information, weight, temperature, and blood samples, doing various tests, and scanning amounts of others. Surprisingly, when complications arise, there may not be a quick response to salvage the situation and this may cost lives. Therefore, when women go to the health facilities where they think they can get the best out of their situation and it turns out to be below their expectations or worse, they may resort to other available avenues of seeking care instead of going back to the health facilities. We should not lose sight of the fact that these women serve as ambassadors who propagate information on what goes on in the health facilities. If one woman does not deliver successfully, many other women will get to know what accounted for the unsuccessful delivery. The results support the study done by (Olatunji & Sule-Odu, 1997; Khalid *et al*, 2006 and Kamga *et al*. 2012) where most women opted for home delivery because health centres were seen providing poor services to women which led to the loss of lives.

2) Absenteeism and lateness of health workers

It was observed that sometimes, clients may go to the health centers and there may be no healthcare professionals to attend to them. It is therefore not surprising that 68% of the respondents indicated that health workers may not be available at the time of labour to assist the women which may lead to needless deaths of either the mother or child or both. One of the women remarked during the focus group discussion "*sometimes when you go to the hospital to deliver, you may not find the nurses and midwives and you will continue to suffer in your pain***"**. They felt that it was psychologically better for a woman to have her baby at home than to go to an environment that may be new to them and there is no one to assist her.

The huge percentage (68%) of the respondents who said health workers may not be present suggests that it is not all the time health care professionals may be at the post as at the time their clients come. It is a common phenomenon that many workers may not be staying in the towns or communities where their workplaces are located. They sometimes stay away from work on some days or turn up late for work due to the long distances they cover to their respective places of work. For instance, midwives and community health nurses may be staying in Tamale while working in Savelugu, Nanton or Pong-Tamale. They can be constrained by any circumstance that may not allow them to be at the post or get there early. Women may therefore go to some health facilities and nobody may be present to attend to them. Other times, they may wait for a long before the arrival of the health care professionals. Women, therefore, consider this phenomenon to be risky. This finding is similar to the work by Abbey (2008) in Ghana, which revealed that most rural women who risked giving birth at home said health workers were not at post, especially during the night and there was nobody to attend to them when they were in labour. Most women preferred to deliver at home as against health facility delivery for fear of being left there alone. The following researchers (Olatunji & Sule-Odu, 1997; Mahdi *et al.,* 2010; Abbey, 2008) indicated that it is particularly important that all births are attended to by skilled health professionals, as timely management and treatment can make the difference between life and death. It is therefore vital for health care professionals to be at post all the time to assist women when they are seeking health care.

3) Poor communication between health workers and pregnant women

The majority (85%) of the respondents were of the view that poor communication by health workers may compel women to deliver at home or at TBAs' homes. The Ghana Health Service recognizes this and indicated that because the reaction of women surrounding pregnancy and labour varies from excitement to fearful expectations, the nursing care that is provided to them is very important (GHS, 2007). Researchers have therefore advocated that it is the responsibility of midwives to inform and educate women on different issues regarding pregnancy and childbirth (Idris, *et al*., 2006; Adeyemi, 2007; Kyomuhendo, 2009).

Many procedures like internal investigations, physical examinations, and observations are done on women and are not always explained to them. Cotter *et al*., (2006) further emphasized that clients must freely give informed consent before any invasive treatment or procedures are conducted to protect the privacy of client. Each client needs a full explanation of the benefit and risks to herself and to her unborn

baby, in a language she understands most. More often than not, healthcare providers do not communicate properly with expectant mothers, and they do not usually understand why certain procedures are to be carried out on them. Some of these healthcare givers usually think they are in charge of affairs and therefore the views and consent of the clients are not so important. However, it is vital to note that some of these clients may resist the decisions of the caregivers if they fail to involve them.

Poor communication can take various forms ranging from the instruction's health workers give to clients and even among themselves. Patients' perceptions of the quality of healthcare they receive are highly dependent on the quality of their interactions with their healthcare providers. There are times healthcare providers may not take their time and explain certain procedures to their clients before carrying out certain operations on them. Once clients are not given a proper explanation on why these operations are to be carried out, they consider it risky. Besides, healthcare professionals may not properly communicate to clients on appropriate ways of administering the medications that may be given to them and they may see them as risky. Furthermore, healthcare professionals sometimes do not properly keep records of their clients and any other persons who take over may find it difficult to continue with the remaining procedures. This is equally seen to be risky.

4) Poor delivery services at health facilities

Results revealed that the majority (85%) of the women respondents indicated that they were not satisfied with the health services they had received from the various health centres they had ever attended during pregnancy, labour and childbirth. With this huge number of the women being dissatisfied with the services, they received from the various health centres, it could influence them to make the voluntary choice of delivering at home with assistance from TBAs. This finding corroborates the work of the WHO (2010) which found that women were compelled to deliver at home because of perceived lapses in health centres. The time that health workers devote to their patients is an aspect where patients showed their level of dissatisfaction. This, however, may be attributed to the workload that health workers have to deal with daily.

These observations suggest the existence of factors that not only affect patient satisfaction but also influence their expectations. Such factors include long waiting times, the kind of medications given to them and as well as the courtesy provided to them. Some of these factors have been known for decades, but efforts to ameliorate them have not yielded the desired results. For instance, various governments have instituted policies such as the establishment of more health training institutions to train more health care professionals, building health centers and CHPS compounds in deprived communities and several other interventions but there are still challenges in the service delivery which goes a long way to affect the level of satisfaction of clients.

More than half of the respondents (56%) also mentioned long waiting times before being attended to by health workers at the health centres, especially on ANC days as a factor influencing their level of satisfaction. They also indicated that sometimes inadequate medications were given to them whiles they were asked to buy the rest of the medications at the pharmacy or chemical licensed stores. They considered it a risk to their health as most of those in charge of selling drugs may not be knowledgeable in medicine and may substitute a particular drug for them which may affect their health.

5) Inadequate privacy for women in labour

This study revealed that 75% of the respondents expressed the view that lack of privacy during delivery could influence women's choice of places of delivery whiles 25% of the respondents stated that privacy during delivery may not influence women to deliver at home. One of the respondents remarked during a focus group discussion that "… all pregnant women deserve privacy during delivery. If the pregnant women did not get privacy at the hospital during their last delivery, they may not like to go back there to deliver again". This may compel them to deliver at home". Another respondent said "I like delivering at a TBA's home because when I am to deliver in the hospital, I will be exposed to so many people and our culture does not allow for many people to see a woman during childbirth" This finding collaborates with what Cotter *et al.,* (2006) and Abyot and Asres (2010) found in their researches that women love to have privacy during child delivery and also feel comfortable when they are surrounded by family members instead of people they do not know.

V. Conclusion

Most women still do not deliver at health facilities because of social, cultural, economic and distance to health facilities factors. The socio-cultural factors still influence women's choice of place for delivery. In some of the cultures in Northern Ghana, to prove that a pregnancy belongs to the husband, a woman must deliver at home. The society also frowns upon women who go to the hospital to deliver because they think it is a cover-up. Such women may not be respected by their peers, especially in polygamous marriages. In

critical situations, women in labour will have to seek approval from their husband's family heads before they can go to the hospital for delivery. The availability and approval by the family head may also take some time since he may have to consult another family member too. This can further delay in sending women in labour to the hospital. Poverty, poor road networks and poor means of transportation have combined effects on forcing women to deliver at home. The availability of Traditional Birth Attendants (TBAs) also encourages women to deliver at home. TBAs are easy to approach, less costly and understand the needs of their clients. The ignorance of most women coupled with the unprofessional behaviour of some health workers and an unfriendly hospital environment also compels most women to give birth at home. The danger associated with these could be a high risk to pregnant women that could lead to maternal mortality. The reasons accounting for these include unsuccessful delivery, sometimes absence or lateness of health care providers, poor communication to pregnant women, poor privacy of women in labour, and poor service delivery at health facilities.

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