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**FACTORS ASSOCIATED WITH CHOICE OF PLACES OF DELIVERY BY
WOMEN IN THE SAVELUGU/NANTON MUNICIPALITY**

RICHARD WONNSIBE TIIMOB

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WOMEN IN THE SAVELUGU/NANTON MUNICIPALITY**

BY

RICHARD WONNSIBE TIIMOB (BSc. APPLIED BIOLOGY)

(UDS/CHD/0157/13)

**A DISSERTATION SUBMITTED TO THE DEPARTMENT OF PUBLIC
HEALTH, SCHOOL OF ALLIED HEALTH SCIENCES, UNIVERSITY FOR
DEVELOPMENT STUDIES IN PARTIAL FULFILMENT FOR THE AWARD OF
MASTER OF PHILOSOPHY DEGREE IN COMMUNITY HEALTH AND
DEVELOPMENT**

SEPTEMBER, 2017

UNIVERSITY FOR DEVELOPMENT STUDIES



DECLARATION

Student

I hereby declare that this submission is my own work towards the Master of Philosophy and that, to the best of my knowledge it contains no materials previously published by another person nor material which has been presented for the award of any degree of the University, except where due acknowledgement has been made in the text.

Candidate's Signature

Date

Name: RICHARD WONNSIBE TIIMOB

Supervisor

I hereby declare that the preparation and presentation of the dissertation was supervised in accordance with the guidelines on supervision of dissertation laid down by the University for Development Studies

Supervisor's Signature

Date

Name: DR. ABDULAI ABUBAKARI.



ABSTRACT

The study examined factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality. Descriptive cross sectional study design was used with simple random sampling technique to select the respondents from the study area. Structured questionnaires were administered to obtain Primary data. The study involved 250 respondents in the study area. Data was analysed quantitatively using SPSS version 20 and excel 2013. Qualitative data was analyzed manually by coding and making thematic and content analyses. The results indicated that women went to health centres, spiritual centres or remained at home to deliver. The findings from the survey revealed that those who were married were 2 times more likely to deliver at a health centre as compared to those who were not married (OR =2.0; 95% CI: 0.9– 4.2; P= 0.089). It was also revealed that poor attitude of health workers and the location of the health centres influenced women to deliver at home. Furthermore, twenty five percent respondents indicated previous successful home delivery can influence where a woman will choose to deliver the next child while seventy five percent did not believe this is so. Those who had no knowledge on social and cultural beliefs were 8 times more likely to ignore them and choose health facility as delivery place. This study recommends that health authorities should continuously monitor the health workers' professional conduct and disciplinary procedures for staff should be instituted to improve their behaviour. Organize frequent in-service training for the staff of health facilities on communication and good interpersonal relationship with their clients and endeavour to provide services that meet the expectations of these clients.



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DEDICATION

This thesis is dedicated to my lovely father, Mr. Tiimob D. Jabik and mother, Mrs. Cecilia T. Tiimob both of blessed memory, my lovely wife, my siblings and my Spiritual Father, Pastor A. L. Fant.



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LISTS OF ACRONYMS AND THEIR MEANINGS

AIDS	Acquire Immune Deficiency Syndrome
ANC	Antenatal Clinic
CDR	crude death rate
EOC	Emergency Obstetric Care
GFR	General Fertility Rate
GHS	Ghana Health Service
GDHS	Ghana Demographic and Health Survey
HIV	Human Immune Virus
HSDP	Health Sector Development Program
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
OPD	Out Patient Department
PHC	Population and Housing Census
TBA	Traditional Birth Attendant
TDHS	Tanzania Demographic and Health Survey
TFR	Total Fertility Rate
TMA	Tamale Metropolitan Assembly
UDHS	Uganda Demographic and Health Survey
WHO	World Health Organizations
WIFA	Women in Fertile Age



CHAPTER ONE

INTRODUCTION

1.1 Background to the study

A significant number of women in developing countries, particularly in the sub-Saharan countries, do not have the opportunity to be attended to by skilled personnel during childbirth. This is a major factor in maternal and infant mortality. Lack of female education, inadequate female empowerment, poor attitude of health care workers and long distance to health facilities in most communities are factors influencing women's choice of places of delivery. (Kyomuhendo, 2009; Kirigia *et al.*, 2011; Kabakyenga *et al.*, 2012).

This study, seeks to examine the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality.

Globally, the predictors of women's choice of place of delivery as a single factor has been very complex, even more complex than ever, in the age of globalization to examine (Kowalewski *et al.*, 2002). Often socio-economic status, demographic and biomedical factors have been found to be significant predictors of the demand for health care and health care utilization among women (Kyomuhendo, 2009). The structure of societies, through myriad social interactions, cultural norms and institutions, are affecting women's choice of places of birth throughout the world (Kyomuhendo, 2009; Mahdi & Habib, 2010). Throughout the world, women have constantly made effort to deliver at a place that would be convenient and less painful for them (WHO, 2012). Globally, studies have shown that over 80% of pregnant women make the effort to deliver at health centres



where most of them consider it to be safe but end up delivering at home (WHO, 2010; Ochako, 2011)

In Africa, the relationship between family's socio-economic status (SES) and women's choice of place of birth is well established in few studies. While there is disagreement over the best way to measure socio-economic status of a woman, a study by Maureen & Peter (2008) found that women from low socio-economic backgrounds do not deliver at health centres as compared to women from high socio-economic backgrounds. Most studies, however, compare women and families from across all socio-economic backgrounds to reach the conclusion that low socio-economic status adversely affects a range of women's choice of places of birth outcomes (Mbaruku, *et al.*, 2009). In Nigeria, women opted to deliver at home because of long distance to health centres (Marjolein, 2003; Mesko, 2004; Mbaruku, *et al.*, 2009).

The quest for health care especially among women has compelled many women far and wide to seek medical attention of various forms especially during pregnancy (McDonagh, 1996; Mesko, 2004 Kowalewski, 2010). Whatever form it may take is informed by one's cultural beliefs as well as accessibility and affordability factors (WHO, 2010; Ochako, 2011 Owumi, Patricia & Olorunnisola, 2013). In a study conducted by Ogunlesi (2005) concerning what influenced women's choice of place of birth, it was revealed that most women opted for home delivery because they wanted cheaper and quicker services during delivery. In Africa, traditional birth attendants (TBAs) enjoy high patronage and confidence from women in the communities where they exist (WHO, 2010). It has been documented that the patronage of the service cuts across every strata of the society including the educated and the rich (WHO, 2010). The practice is widespread including areas well served with modern healthcare facilities (Mulusew, 2003; Ochako, 2011).



Despite criticisms on the efficacy of TBAs in conducting deliveries which include reported cases of complications, complaints about unsatisfactory results and pains/discomfort among women, researches have revealed TBAs can be efficient and effective (Singh, 2004; Ochako, 2011).

In Sub-Saharan Africa, women still deliver at home due to various reasons. Home deliveries often do not result in death but nevertheless place a considerable birth complications on the woman, her family, other caregivers, the community, and society at large (Marjolein, 2003; Maureen & Peter, 2008 Kowalewski, 2010;). Over recent decades, international health agendas have tended to oscillate between: (1) approaches relying on narrowly defined, technology-based medical and public health interventions aimed at motivating women to deliver at health centres and (2) an understanding of health seeking behavior of women as a social phenomenon, requiring more complex forms of intersectoral policy action, and sometimes linked to a broader social justice agenda (Marjolein, 2003)

World Health Organization's (WHO) 1948 Constitution clearly acknowledges the impact of social and political conditions on health seeking behavior of women, and the need for collaboration with sectors such as, health sectors, housing and social welfare to achieve health gains for women especially with regards to delivery. In Kenya, one of the key determinants of women's choice of places of delivery was the availability of traditional birth attendants which the women admitted understood their culture and were always readily available in time of needs (Marjolein, 2003). In Uganda, one of the major determinants of women's choice of places of birth was the issue of male dominance at home (Ochako, 2011). In Tanzania, how the placenta was buried became an issue that discouraged pregnant women from going to the health centre to deliver (Mulusew, 2003).



In Ghana, pregnant women deliver at home because they perceived that they are always being abused at health centres by health workers during delivery. Similarly, studies in Ghana concluded that it is not the economic status of a woman that only determines the choice of places of birth but also pointed to other social and cultural factors such as poverty, educational background, occupational and income level of husbands and harmful cultural practices. Studies have emphasized that poverty has a strong association with women's choice of place of birth in rural communities in Ghana. Low income level increases the number of women delivering at home as compared to health centre. According to Abbey (2008) it has been noted that the preference of women on the choice of places of delivery is dependent on a number of factors including cultural and demographic factors.

The Ghana Demographic and Health Survey of 2008 (cited in Gumanga *et al*, 2011) shows that over 95% of pregnant women attended antenatal clinic but only 27% had supervised delivery by skilled provider while 56% of women were delivered by a TBA and about 17% were delivered by a relative or no one in the northern region. Studies have indicated that Northern Ghana has a high rate of women delivering at home (GHS, 2010). These deliveries usually results in birth complications with these women often ending up in the health centres for proper care. However most of the women who patronised the TBAs' services later return to hospitals with several complications sometimes very fatal making obstetric management very complicated and costly and sometimes leading to surgery which regrettably strengthens the belief of the people that the only treatment option by the hospital is surgery.



1.2 Statement of the problem

In Ghana certain cultural practices are still underpinning pregnancy and childbirth thus, affecting pregnant women's choice of place of birth (Abbey, 2008) Inadequate knowledge and skills for health workers on management of obstetrics cases can be the barrier for delivery in health facilities (Adeyemi, 2007, Kabakyenga, 2012)

In Ghana, 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 effort to increase the proportion of institutional deliveries, and thereby, 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 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 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 Municipality indicated that 97% of antenatal clinic attendance was achieved, however, only 64% supervised deliveries were attained with the remaining 36% having unsupervised deliveries. This 36% 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, few researchers in the country including Bassoumah Bougangue (2010), Emmanuel Akafo Ameyah (2014) and Kombian Bisianin (2013) have conducted researches 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 choice of place of delivery were left out. Therefore, this study seeks to bring all these stakeholders on board and examine the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality. The findings of this research will bridge the existing gap in literature on factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality.

1.3 Research questions

- a) What are the social and cultural beliefs and factors underpinning pregnancy and child birth by women in the Savelugu/Nanton Municipality?
- b) Are there any economic, geographic and bottlenecks that influence the choice of place of birth of women in the Savelugu/Nanton Municipality?



- c) What are the risks and challenges associated with care provision that bother on the choice of place of delivery of women in the Savelugu/Nanton Municipality?

1.4 Objectives of the study

1.4.1 Main objective

The main objective of the study is to examine the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality.

1.4.2 Specific objectives

Specifically, the study sought

1. To examine the social and cultural beliefs and factors underpinning pregnancy and child birth by women in the Savelugu/Nanto Municipality
2. To explore the economic, geographic and bottlenecks that influence the choice of place of birth of women in the Savelugu/Nanton Municipality
3. To examine the risks and challenges associated with health care provision that bother on the choice of place of delivery

1.5 Significance of the study

The output of this study would contribute to knowledge and literature in the research topic under investigation. It would be immensely useful as a source of reference material for researchers, academicians, students, policy makers and other stakeholders interested in factors associated with choice of places of delivery of women especially in Ghana. The study conducted in the Northern region specifically would serve as a reference material and create a platform for further study into this area since no empirical studies has been done on factors associated with choice of place of delivery in the study area.



Governmental organizations such as Ministry of Health (MOH), Ghana Health Service (GHS) and non-governmental organization would find information emanating from this research useful in the design, planning and delivery of information on factors influencing women's choice of place of delivery in Ghana especially in Northern Ghana where issues of abuse and disrespect among pregnant women in health facilities still continue to be a major worrying phenomena. Other researchers interested in assessing factors influencing choice of delivery place among women in Northern Ghana would find this piece of work useful. Health facilities interested in quality surveys especially for expectant mothers would also find this research work useful with regards to women's choice of place of delivery.

1.6 Definition of terms

To guide the study there are key terminologies or concepts that have been explained. These are defined as below

- ✓ **Skilled attendant:** An accredited health professional – such as a midwife or doctor who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and immediate postnatal period, and in the identification, management and referral of complications in women and newborns (WHO, 2004a). For the purposes of this study a skilled attendant meant a trained nurse, midwife, clinical officer or a doctor.
- ✓ **Traditional birth attendant:** Independent (of health system), non-formally trained and community-based providers of care during pregnancy, childbirth and the postnatal period (WHO, 2004a). This study employed the WHO definition of a traditional birth attendant as its operational definition



- ✓ **Maternal mortality:** The study considered maternal mortality to be death of a woman as a result of; being pregnant, management of labour or postnatal period (GHS, 2008b)
- ✓ **Childbirth complications:** These are either maternal or neonatal morbidity states that occur as a consequence of the process of childbirth or its management
- ✓ **Institutional delivery:** The study upheld the definition of institutional delivery as defined by the Ghana Health Service, that this is childbirth that occurs at any recognised birth site where there is a skilled attendant to deliver pregnant women (Ghana Health Service, 2008)



Conceptual framework

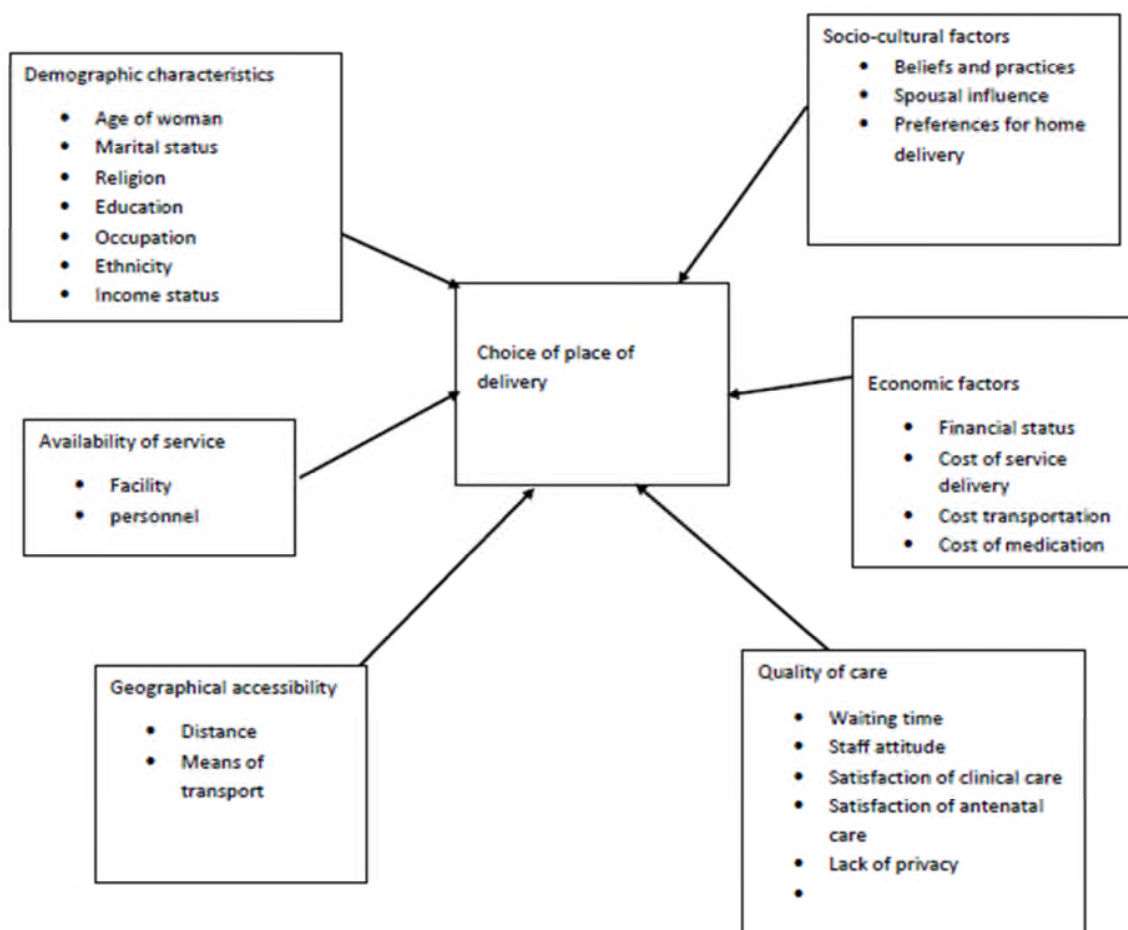


Figure 1.1: Conceptual Framework on factors associated with choice of place for delivery

(Source: Adopted from Emmanuel, 2014)

1.7 Narrative on Conceptual Framework on factors associated with the choice of places of delivery

The conceptual framework is the graphical presentation of independent variables considered to be factors associated with the choice of place of delivery by women in the Savelugu/Nanton Municipality. The conceptual framework was adopted from Emmanuel





A. A. (2014) and modified. It seeks to link up the various factors that lead to the choice of place of delivery. These include demographic characteristics of women (age, level of education, marital status, religion, ethnicity, and occupation). Age is often presented as a proxy for accumulated experience, including the use of health services. Older women are also possibly more confident and influential in household decision-making than younger women, and then adolescents in particular. This may influence the choice of place of delivery.

Marital status may influence the choice of delivery place, probably via its influence on female autonomy and status or through financial resources. Single or divorced women may be poorer but enjoy greater autonomy than those currently married. Young single mothers may be cared for by their natal family, which may encourage skilled attendance, especially for a first birth. On the other hand, single mothers may be stigmatised and prefer to deliver at home because they anticipate a negative provider interaction. Ethnicity and religion are often considered as markers of cultural background and are thought to influence beliefs, norms and values in relation to childbirth and service use and women's status. Moreover, certain ethnic or religious groups may be discriminated against by staff, making them less likely to use services. Women who are working and earning money may be able to save and decide to spend it on a facility delivery. Therefore women's occupation may influence their choice of delivery place.

Quality of Care: Perceived quality of care, which only partly overlaps with medical quality of care, is thought to be an important influence on choice of place of delivery.

Geographical accessibility: Distance to health centers exerts a dual influence on use, as a disincentive to seeking care in the first place and as an actual obstacle to reaching care after a decision has been made to seek it. Many pregnant women do not even attempt to

reach a facility for delivery since walking many kilometers is difficult in labour and impossible if labour starts at night, and transport means are often unavailable. The effect of distance is stronger when combined with lack of transport and poor roads. This may influence where women choose to deliver.

Affordability of service: The cost of care-seeking may include costs of transportation, medications and supplies, official and unofficial provider fees as well as the opportunity costs of travel time and waiting time lost from productive activities. This may influence the choice of place of delivery.

Socio- cultural factors: Women in some cultures may avoid facility delivery due to cultural requirements of seclusion in the household during this time of "pollution" or because of specific requirements around delivery position, warmth, and handling of the placenta. In some cultural groups in Africa, the belief that obstructed labour is due to infidelity and this hinders care-seeking. Beliefs that birth is a test of endurance, and care-seeking a sign of weakness may be another reason for delivering alone in some context.

Availability of service: Having access to health care facilities and health care professionals could influence women's choice of delivery. There are instances in which the health care facilities may be available and health care professional may not be there or vice versa. Both instances can influence where women choose to deliver.

The quality of antenatal clinic care as well as the satisfaction of care women derive from health facilities determine the place they would choose to deliver during labour. Women who are satisfied with care rendered to them at the health facility are more likely to deliver in this health facility than their counterparts who are not satisfied with the care rendered to them at the health facility. Constraints like cost of delivery, non-availability



of transport, cost of transportation and distance to the health facility determine where a woman will deliver when in labour.

1.8. Organization of the research work

The study is divided into six chapters: Chapter one contains the background of study, statement of the problem, research questions, objectives of the study, significance of the study, definition of key concepts and conceptual framework.

Chapter two focused on literature review and chapter three contains the methodology which focused on introduction, profile of study area, research design, study population, determination of sample size, sampling techniques, sources of data, data collection instruments, limitations of the study, quality assurance, methods of data analysis and ethical considerations.

Chapter four deals with the research findings and analysis of the data gathered whiles chapter five looks at the research findings in relation to the reviewed literature. Chapter six entails the summary, conclusions and recommendations of the research.



CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter presents a review of related literature concerning factors associated with choice of places of delivery by women. Literature review has always provided the foundation upon which a research confirms an existing situation, compliment an existing issue, counter or establish any new trends that possibly might have emerged in the field of study particularly as they relate to the issue under investigation. Globally, obstetric care is the services given to a pregnant woman until six weeks after delivery (Acharya & Cleland, 2000; Adam and Salihu, 2002). These services include antenatal services, management of labour and delivery and post-natal care (Abrahams, 2001; Adam & Salihu, 2002 Hulton, 2007).

The aim of obstetric care is for women to give birth to alive, normal and healthy babies, for the mother to be mentally, physically, and psychologically well and to able to breastfeed successfully (Hulton, 2007). Effective obstetric care is the key to reducing maternal deaths to the barest minimum leading to safe motherhood (Olatunji & Sule-Odu, 1997; Hulton, 2007). Safe motherhood is defined as “creating” the circumstances within which a woman is enabled to choose whether she will become pregnant, and if she does, ensuring she receives care for prevention and treatment of pregnancy complications, has access to emergency obstetric care if she needs it, and care after birth, so that she can avoid death or disability from complications of pregnancy and child birth (GHS, 2010). Every woman needs an essential care at the health facility.



Basic essential care is the minimum package of services provided at the health centre level without the need of an operating theater, to manage complication during pregnancy, labour, delivery and post-delivery (Cotter, Hawken and Temmerman, 2006). Comprehensive essential obstetric care services (CEOC) include in addition to the availability of caesarean section and safe blood transfusion (Kamga *et al.*, 2012).

2.2 Antenatal care

Antenatal care (ANC) is the health care and education given to women during pregnancy. Ante-natal services are important part of preventive and promotive health care (Babalola & Fatusi, 2009; Kabakyenga *et al.*, 2012). Ante-natal care has a beneficial impact on pregnancy and birth outcomes through early diagnosis and treatment of complication as well as promoting the health of the pregnant women (Khalid *et al.*, 2006; Kabakyenga *et al.*, 2012). ANC services create the opportunity, for service providers to establish contact with the pregnant women to identify and manage current and potential health risks and problems during pregnancy (Marjolein *et al.*, 2006; Mahdi and Habib, 2010).

Ante natal services also create the opportunity for the woman and her care provider to establish a delivery plan based on the needs of the woman, resources and circumstances (Olatunji & Sule-Odu, 1997). In addition, ANC provides the opportunity for screening and detecting of conditions such as breast cancer, HIV-and sexually transmitted infections (STIs) and other reproductive issues (Babalola & Marjolein *et al.*, 2006; Fatusi, 2009). For effective ANC, it is ideal that services are initiated early in pregnancy and adequate number of visits made for the women to enjoy the full package of services delivered. A range of packaged services is provided at ante-natal clinics.



Currently, some of the services provided include; nutrition education, laboratory investigations, family planning education, education on breast feeding and care of the newborn. The current strategy for delivering ANC services is geared towards promoting individualized, client centered and comprehensive services for women (Kamga *et al.*, 2012). It is also for disease detection and risk assessment. The strategy also aims at improving the skills and boosting the morale of service providers to deliver effective ANC services, taking cognizance of individual needs of the pregnant woman (Envuladu *et al.*, 2012).

In Ghana ANC services are provided by both public and private care facilities. Trained birth attendants also provide services in some communities in Ghana (GHS, 2007). The following indicators are usually considered in measuring ANC utilization

- ✓ Proportion of women accessing ANC service
- ✓ Proportion of women making adequate number of visits (4+)
- ✓ Timing of initiation of ANC
- ✓ Services received

Some factors known to be adversely affecting the utilization of ante-natal care include; long distance to health facilities, cost of services at the health centres, socio-economic and cultural barriers and quality of care of services provided, including service provider attitude (GHS, 2007; Mahdi & Habib, 2010; Marjolein, 2003; Maureen & Peter, 2008)

2.3 Childbirth complications

Globally, an estimated 904,400 newborn babies die in the first few days of life as a consequence of complications in childbirth, and a further 1.02 million babies die during labour (Mulusew, 2003 Mesko, 2004;). According to Mahdi & Habib, (2010) newborn



complications include asphyxia and birth hypoxia, umbilical cord entrapment, brain damage, shoulder nerve damage and stillbirth. According to Mulusew (2003) the most immediate maternal complications during child birth include; retained placenta, general tiredness and exhaustion, perineal tears, haemorrhage and death.

Maternal complications can also arise during or in the post-partum period. This sometimes leads to caesarian birth, puerperal infection, mastitis, breast engorgement, depression, psychosis and death (Berman, 2000; Maureen & Peter, 2008). In Kenya, maternal health is recognized by the Kenya's Constitution as a fundamental right hence the goal to have a country where every pregnancy is wanted, every birth is safe, every newborn is healthy and no mother dies while giving life (Mulusew, 2003 Wanjira & Mwangi, 2011).

The six pillars of maternal and newborn health in Kenya include: pre-conceptual care and family planning (Mulusew, 2003), focused antenatal care (Singh, 2004; Tukur *et al.*, 2008), essential obstetric care, essential newborn care, targeted post-partum care and post-abortion care (Wanjira & Mwangi, 2011). These services are underpinned by the foundation of skilled birth attendance and a supportive and functional health system (Babalola & Fatusi, 2009). This way all births will be conducted by skilled birth attendants in an enabling environment leading to better maternal and neonatal outcomes (Cotter, *et al.*, 2006).

2.4 Social and cultural beliefs and factors underpinning pregnancy and child birth

In a cross-sectional survey conducted by Institute of Public Health (2006) in Uganda, concerning pregnant women's knowledge of cultural factors affecting pregnancy and child birth, it was discovered that 90% of the pregnant women stated that they were aware



that cultural factors affect pregnant women's place of choice of birth while 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)

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 new born 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. According to 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 seen by everybody and husband sometimes technically discourages their wives from going to hospitals to deliver for fear of paying high medical bills should surgery arise (Adeyemi, 2012)

2.4.1 Factors affecting women's choice of place delivery

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 hospital to deliver (Mbaruku and Msambichaka (2009). In a study to assess social factors influencing pregnancy and child birth in Zaria, Nigeria, it was discovered that community norms, beliefs and personal likes and dislikes of pregnant woman, availability of TBAs and long distance to health facility 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 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 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 child birth (Amooti & Nuwaha, 2000 Adam & Salihu, 2002; Mbaruku *et al.*, 2009) Hospital delivery was only resorted to in cases of emergencies (Mbaruku *et al.*, 2009). A similar study was carried out in rural Kano, Nigeria, to find out the barriers to the use of ANC and obstetric care among pregnant women. It was revealed that most of the women who did not attend ANC services said they did not need it, majority of the women who had made more than two visits to the clinic stated that the distance to the health facility was too far for them while few



admitted that they only go to ANC when they were about to deliver for fear of been shouted at by the health workers that day (Adeyemi, 2007; Issah, 2010).

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 by 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).

2.4.2 Demographic factors affecting women's choice of places 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 choice of place of delivery for pregnant women in Southern part of Ethiopia, Abyot & 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 have 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, 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 number of antenatal visits before childbirth (Amooti & Nuwaha, 2000; Adeyemi, 2007; Abyot & Asres, 2010).

While in Nepal, Acharya and Cleland (2000) followed 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, across-sectional survey 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 a 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 cost of hospital bill (50%), 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 home as a place to deliver.

In a study on how Fulani pregnant women access health during pregnancy in Northern Ghana. It was discovered that most Fulani pregnant women (80%) preferred to deliver at home instead of health facility because according to them they were not treated properly at health centres while 20% respondents however, mentioned that their preferred place of birth would have always been health centres but because of the long distance to the health



centres do sometimes prevent them from walking to the place especially if they are in labour (Issah, 2010).

In rural Orissa, 51% of families did not have enough cash for a normal delivery and 74% did not have enough for a caesarean 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 the 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 presence of TBAs in the community who were competent and provided friendly services to pregnant women in the community (Idris *et al.*, 2006).

Similar studies have also been carried out with health workers to assess their views on why pregnant women deliver at home instead of health facility. Twenty two percent respondents gave reasons to emphasis long walking distance to the nearest health facilities, 12.5% respondents mentioned that negative attitude of health workers deterred pregnant mothers from coming to the health facility to deliver and 6.3% respondents of the health workers said they could not tell why women were not delivering in health facility (Cotter, *et al.*, 2006; Ogunlesi, 2005; Idris, *et al.*, 2006; Adeyemi, 2007; Kyomuhendo, 2009)

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 health facility or at home (Kyomuhendo, 2009). Few studies reported some traditional belief that affect the choice for place of delivery of women in the world. A study in northern part of Tanzania, found that women belief that normal delivery should be conducted at home and



delivery at health facilities were beneficial for those with complications only (Adeyemi, 2007; Mpembeni, *et al.* 2007; Ochako, 2011).

The issue of TBAs in communities also motivates women to deliver at home with their assistance. One predictor of women's choice of place of delivery has been the availability of TBAs. The presence of TBAs in their area makes women to deliver at home. They believed that they are capable of conducting delivery very normal and very successful (Kowalewski, *et al.*, 2002; Birungi & Ouma, 2006). Most other studies have tried to link socio demographic factors, socio economic factors, availability of health services, accessibility, behavior and attitudes of health care providers and socio cultural issues to be the major predictors of women's choice of place of birth (Adeyemi, 2007; Maureen, Mpembeni, *et al.*, 2007; Hazemba & Siziya, 2009; Kyomuhendo, 2009;, Ochako, 2011). And assessing all these variables has proven that there is always a link between one variable and women's choice of place of birth. It is argued that differential access to health care facilities between the rural-urban areas is an important factor for lower maternal healthcare services particularly for institutions delivery assistance by health personnel in rural areas (Maureen & Peter, 2008; Ochako, 2011; Kirigia; 2011).

2.4.3 Education and choice of place delivery

Several studies have indicated that for pregnant women in developing countries to delivery in health facilities, there should be sensitization programs to increase their level of knowledge on the dangers of home delivery as well as how safe it is to deliver at health centres. Also women should be empowered socio-economically so they can stand better chances of taking care of medical and other bills that may be incurred when they seek health care at the health facilities. There is the need to also enlighten women that though,



they cannot do away with their cultural beliefs and practices completely, it is important to adhere to those that will impact positively of them and nib those that affect them negatively in the bud. When an effort is made to demystify some of the beliefs and practices women hold onto and prefer home delivery, they may resort to seeking skilled care at the health facilities (United Nations 2007; Kyomuhendo, 2009; Kirigia *et al.*, 2011; Kabakyenga et al., 2012).

In a cross sectional study to suggest ways of improving health delivery among women in the world, Campbell & Graham (2006) suggested that health care providers in hospitals, polyclinics, clinics and maternity homes not only in rural areas but also in urban areas, should work with relevant stakeholders and embrace health education programs to provide more information on ANC to women in community programs, markets, radio stations through the appropriate communication channels so as to ensure that all women are prepared for safe deliveries.

Women in most developing countries perceive and believe that pregnancy and child birth is a natural gift of God and there no need to seek any additional help during pregnancy and child birth. Luck most often shine on some of these women because they may experience sudden labour and delivery follows suit without any complications (Olatunji & Sule-Odu, 1997; Kabakyenga, 2012). It is reported that in some studies that most pregnant women do not disclose their pregnancy to people, even those in their neighborhood. In most instances, it is after the woman delivers successfully that her neighbours will be informed to now come and congratulate her. (Adeyemi, 2007Maureen and Peter, 2008; Kyomuhendo, 2009). In Tanzania, women and people have believe regarding pregnancy. There is a cultural belief regarding pregnancy as a gift from God and therefore the challenges that come with it should be seen as a blessing. According to



this belief, “God makes women’s labour like stone that falls from the mountain” (Kyomuhendo, 2009). Believing a stone that falls from a mountain needs no force to bring it down, women in labour can deliver without assistance from anybody. Therefore, many a time in certain communities in rural Tanzania it is not surprising that pregnant women sometimes deliver in the night even without the support of their husbands (Birungi, & Ouma, 2006; Borghi et al.,2006 Kabakyenga, *et al.*, 2012; Ochako, 2011). This practice of woman being silent when they are in labour has the tendency of women delivering without any qualified skills attendants (Kyomuhendo, 2009). Similar studies on the choice of women place of birth have been identified to include; other factors such as the decision power of the man and friend influence (Olatunji & Sule-Odu, 1997; Adeyemi, 2007; Hiluf & Fantahun, 2007; Ochako, 2011;; Ochako, 2011; Kabakyenga, 2012)

In a qualitative survey of women aged 20-35 years carried out by Idris, et al., (2006) using a focus group guide. The FGDs findings 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 majority 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 (Idris, *et al.*, (2006).

The participants also stated that unless labor is complicated and decided by TBA, their husbands would not allow them to go to health facilities to deliver (Ochako, 2011). This finding has also been described in many studies like studies conducted in Tanzania and studies conducted in Uganda and Ghana where women have to still depend on their husbands for support in the form of transportation to the nearest health facility in the



event of sudden onset of labour (Sule-Odu, 1997; Adeyemi, 2007; Hiluf & Fantahun, 2007; Ochako, 2011; Kabakyenga, 2012; Olatunji)

In a cross sectional studies conducted by Kyomuhendo, (2009) in rural Uganda to examine the relationship between women's ANC attendance and choice of place of delivery it was revealed that women who were educated on the benefits of antenatal care and skilled delivery by skilled care provider were more likely to be influenced to regularly attend ANC and to choose health facilities as delivery place (Olatunji & Sule-Odu, 1997; Adeyemi, 2007). Women who got health information about the benefit of institutional deliveries increase the probability of choosing health institution by 3.6 times higher than those who did not get the information. The finding appeared to be similar to other study done in Debre Markos town by Maureen and Peter (2008) Birungi & Ouma (2006) where women who attended ANC regularly stated that they were going to deliver at the health centre.

2.4.4 Abuse and choice of places of delivery

In the field of maternal and newborn health, there have been calls to prioritize the intra-partum period and promote facility delivery to meet maternal and newborn mortality reduction goals (Ogunlesi, 2005 Adeyemi, 2007). This aim is based on a decade of epidemiological work identifying causes of death, systematically reviewing effective interventions, and modelling the impact of intervention coverage on mortality (Maureen & Peter, 2008; Kyomuhendo, 2009; Ochako, 2011;). Yet increases in facility delivery and in known effective interventions provided in those facilities have not always had the expected impact on women in rural communities (Hiluf & Fantahun, 2007; Kirigia *et al.*, 2011).





This has led to growing concern about the quality of care that women are experiencing during labour and delivery in certain public and private health facilities in developing countries (Birungi & Ouma, 2006; Filippi *et al.*, 2006; Kabakyenga *et al.*, 2012) and in most health care centres in the world. Women abuse, disrespect and what constitute abuse by women have also been linked to women not opting for health centres to deliver (Filippi *et al.*, 2006). In a landscape survey conducted by Kyomuhendo (2009) in Uganda concerning abuse and disrespect among post-partum women revealed that the most common abuse experience described across respondents entailed feeling ignored or neglected during labour at the health centre.

Verbal abuse by health workers at the labour ward was also common, but appeared to be less disconcerting among respondents. Physical abuse was rarely mentioned as it was discussed by women only (Filippi *et al.*, 2006). In Adigrat Town, North Ethiopia, studies conducted by Hiluf and Fantahun (2007) indicated that 79% post-partum women identified insulting as a common abuse and disrespect in the hospital facilities, 16% stated being shouted at during labour while 5% postpartum women mentioned non-dignified care. This, they said had the tendency of not allowing them to come back to the hospital to deliver again provided there would be no complications during labour, during birth and after birth. Similarly, the WHO multi-country Survey on Maternal and Newborn Health (2012) revealed that post-partum women were commonly abused and disregarded. The results shown that post-partum women mentioned shouting at, non-dignified care, buying of things for hospital staff and being insulted as the frequently reported cases of abuses and disrespect in hospitals.

This attitude of health workers most especially midwives could influence women negatively to deliver at home or opt to deliver at home for fear of being abused again. In a

land mark study to assess the perception of post-partum women on abuse and disrespect during child birth and women's choice of place of delivery all the respondents admitted that abuse and disrespect during child birth is bad and could influence women negatively to deliver at home (Birungi & Ouma, 2006; Ochako, 2011; Kabakyenga *et al.*, 2012;).

According to Mrisho *et al.* (2010) despite improvements in the quality of care at the health centers, hospital staff continued providing disrespectful and poor healthcare in the form of abuse and disrespect to pregnant women during labour which in a way is discouraging women from coming to the health centre to deliver for fear of being abused or disrespected. In Nepal several studies related to pregnant women and post-partum women perception of quality of health care have shown that most post-partum women interviewed perceived proper communication from health care providers, absent of abuse and disrespect and good friendly attitudes as best way to render proper care to women and this would encourage more women to come to the health centre to deliver (Kowalewski, *et al.*, 2002; Filippi *et al.*, 2006).

In rural Nepal, a cross sectional survey conducted by Maureen and Peter, (2008) revealed that all the post-partum women interviewed in the health centres admitted having been abused before and during child birth. The perceived quality of care at the health facility is reported as the most important factor for accessing and utilizing hospital services among pregnant women (Ogunlesi, 2005; Adeyemi, 2007; Maureen & Peter, 2008;). In a qualitative focus group discussion conducted by Campbell and Graham, (2006) on perception of pregnant women on the choice of delivery place, it was revealed that all the participants unanimously agreed that pregnant women who reported negative experiences in the health facilities either during pregnancy or during previous births often decided to give birth at home for fear of humiliation, bad treatment and for not being respected by



health care providers (Campbell & Graham, 2006).

It is thus very much important that all health workers in hospitals and maternity homes should have necessary knowledge, and skills, commitment and the ability to support woman and the family, in order to take care of the woman in totality (Olatunji & Sule-Odu, 1997; Adeyemi, 2007). Totality means to meet the physical, psychological and social needs and to help women to choose their own ways and make own decisions also on their health issues. Health workers should take up the role model in providing nursing care to the woman during the laboring process so as to encourage them to deliver at health centres (Adeyemi, 2007; Olatunji & Sule-Odu, 1997).

It has been observed that traditional birth attendants are old, mature, respected women within the community, with the necessary experience in dealing with birth cases and in most cases conduct deliveries to women within their community (Birungi & Ouma, 2006; Kyomuhendo, 2009; Ochako, 2011;).

According to Filippi et al., (2006), TBA's are considered essential in the society, thus they should be regarded as part of the maternal service plus the maternal team so as to be able to train them up to carry out well conducted deliveries to safe lives (Kowalewski, Mujinja & Jahn, 2002). However, most TBA's are not always well equipped with modern instruments for delivery and are mostly conducting deliveries without proper hands gloves. TBAs should be adequately prepared for their role in the community and properly supervised and encouraged to work in close relationship with qualified midwives, to enable them to refer cases which they cannot handle (Birungi & Ouma, 2006; Hiluf & Fantahun, 2007; Kabakyenga *et al.*, 2012;).

Some women would also choose other alternatives, including home birth with a skilled birth attendant, relative or spiritual centres, particularly where there are strong beliefs in



the normality of childbirth or cultural preferences for certain practices or delivery environments (Adam & Salihu, 2002). Given women the right to choose what's good for her making the options available with good health education would make it possible for women to make informed choices about the most suitable place for them to deliver and so the decision for them to deliver at home or at health centres would remain largely in their own initiative (Beth & Robert, 2001)

2.5 Economic, geographic and bottlenecks that influence the choice of place of birth of women

Studies have shown that pregnant women's knowledge of factors influencing the choice of places of delivery is substantially encouraging in the world (WHO, 2010). In a research to assess pregnant women's knowledge on factors influencing women's choice of place of delivery, it was revealed that all the women who were used as respondents knew at least one factor (Singh, 2004). Few of the factors identified included; low income, long distance to health facility and lack of means of transport. In a cross sectional survey conducted by Mulusew (2003), in Shebe town, South –Western Ethiopia, on pregnant women choice of place of delivery, it was discovered that the delay in recognizing the onset of labour especially among primigravidae and the decisions to act rather than the cost of transportation or institutional factors were causing pregnant women to deliver at home.

2.5.1 Economic and geographic factors and choice of place of delivery

Economic and geographic factors have been identified to play a major role in women's choice of place of delivery. In several studies assessing women's choice of place of delivery, it was discovered that economic and long distances to health facilities especially



in rural communities prevented women from going to the health centre to deliver (Olatunji & Sule-Odu, 1997). Similarly, in a cross sectional study to assess why women chose to deliver at home instead of health facilities in Zambia, Kenya and Uganda, some of the reasons given by those who chose home as a preferred place of delivery included cost of hospital bill, unfriendly attitude of health care workers and unexpected labour. Others mentioned distance to the health facilities, failure to book for ANC early and bad road network linking health centres from their homes as reasons for choosing home as a place to deliver (Khalid, *et al.*, 2006; Adeyemi, 2007;

Envuladu *et al.*, 2012)

High economic status is associated with greater wealth, making it easier for the family to pay costs associated with skilled delivery care. A limited ability to pay high hospital costs have been identified as the major barrier for the rural poor women wishing to access health care, due to economic difficulties in rural areas women are not able to afford costs related to deliveries even if the services in some places are free of charge they are unable to pay for transport in case of referral or if the facility is away from their homes (WHO, 2007, Mrisho *et al.*, 2007).

High socio economic status is associated with delivery in health facility and sometimes is confounding with level of education as those with higher education have better jobs and earning higher, so women are encouraged to participate in income generating activities in order to raise their economic status (Olatunji & Sule-Odu, 1997; Adeyemi, 2007). Household financial capacity is one of the major factors in the determination of places of delivery, and this depends on mother's occupation and husband's occupation (Adam & Salihu, 2002). Women who are working and earning money may be able, to save and decide to spend it on a facility delivery as compared to those not working (Adam &



Saliyu, 2002). Several studies found that women in farming occupation were less likely to have skilled attendance at delivery than women in more lucrative occupations as such salaried workers (Hazemba, & Siziya, 2009) partly due to limited financial resources and limited health services in rural areas. Wives of husbands with higher status occupations were more likely to pay for transportation to health centres and seek proper health care at health centres than the rural poor (Adeyemi, 2007; Olatunji & Sule-Odu, 1997)

2.5.2 Bottlenecks affecting choice of place of delivery

Informed choice of birthplace is fundamental principle of midwifery care in Ontario (Hiluf & Fantahun, 2007). Midwives facilitate the collaborative process of informed decision-making and recognize clients as primary decision-makers about their care, including where they choose to give birth (e.g., at home, in birth centres, hospitals, midwifery clinics, and remote health centres). The College of Midwives of Ontario requires registered midwives to provide choice of home and hospital birth; Aboriginal midwives practice under the exception clause in the Midwifery Act and provide choice of home or other out-of-hospital birth. While all midwifery clients in Ontario would ideally have equal access to birth settings, choice of birthplace is sometimes limited (Hiluf & Fantahun, 2007).

Several factors have been identified as barriers to access skilled care by women especially in developing countries; these include unavailability of the services, inadequate number of skilled personnel in rural areas, geographical inaccessibility and poor quality of care. In developing countries, most women deliver at home for some reasons including having to walk long distance before accessing health care (Alastair & Pepper, 2005; Birungi & Ouma, 2006). In a cross sectional study conducted by Cotter, *et al*, (2006) it was revealed



that the reasons for non-utilization of obstetric services by women in health centres especially in rural areas included: financial constraints, lack of awareness of services at maternity homes, no perceived need for such services, preference for home delivery because it was much less expensive and cultural factors.

In a cross sectional study conducted in Tanzania to investigate factors influencing women's choice of place of delivery, it was indicated that the perceived key determinants of selection of places of delivery for women were low socio economic status, lack of transport, sudden onset of labor, short labour duration, staff attitudes, lack of privacy, reproductive behaviour, traditions and cultures and the patterns of decision making power within the household (Kanga *et al.*, 2012; Khalid & Daniel, Lale, 2006; Olatunji & Sule-Odu, 1997)

In a study conducted in Chongwe district, Zambia by Hazemba *et al.*, (2010) concerning the relationship between pregnant women's level of education and choice of places of delivery of next child, the findings showed that there was a strong association between education and health facility delivery as educated pregnant women made the choice of delivering in health centres as compared to home (Hazemba *et al.*, 2010). It was shown that educated women had a better understanding of issues of obstetric complications and were able to make their own decisions on matters concerning their health. For any woman to make an informed decision about choice of delivery site and also to be able to recognize complications or illness, she needs adequate information which is normally given by the health worker at health centres (Olatunji & Sule-Odu, 1997). The low health worker influence in women's decision making could possibly be the reason why there is under utilisation of health facilities for delivery among women globally (WHO, 2010).





Several studies have been conducted worldwide on factors affecting delivery in health facilities and the following has been observed. The issues of risk and vulnerability, such as lack of money, lack of transport to health centres, sudden onset of labour especially in the night, short labour period, bad health staff attitudes toward pregnant women, lack of privacy during delivery, geographical location of the health centre, perception of poor quality of health services, tradition, cultures and the pattern of decision-making power within the household were perceived as key determinants of the place of delivery by women (WHO, 2010)

Similarly, a study by McDonagh, (1996) identified the following factors such as frequent antenatal attendance, health facility being near to home of the woman, health centre offering friendly services and health centre having affordable services to be significant determinants of women's choice of delivery site. The major perceived barriers to women access to health care services were lack of money (24%), long distance to health facilities (19%), not willing to go alone (11%) while only 2% of women cited obtaining permission from their parents as big problem (TDHS, 2010).

In many studies done in the African continent, most women expressed their wish to deliver in a health unit (McDonagh, 1996) but ended up delivering at home due to factors they could not control. However, majority of them end up either not being attended to or attended by non-trained people during delivery. Although most pregnancy and delivery related complications cannot be predicted, high quality antenatal care (ANC) and receiving counseling on birth preparedness during antenatal care appeared to strongly influence women's use of skilled care during delivery (WHO, 2012).

According to Marjolein (2003) 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 less visits. Similarly, women who make more visits to ANC also were more likely to deliver in health facilities as compared to those who never did (Mesko, 2004). 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, researchers observed that over 90% of pregnant women do attend ANC at least once during pregnancy, ANC attendance has only been linked to help pregnant women to make appropriate birth plans but does not necessarily attract them to come to have childbirth in the same health centre as it would be expected (WHO, 2010). Despite the high number of pregnant women who attended ANC in Kenya, a lot still preferred home delivery, 74% of pregnant women attended ANC and yet up to 39% chose home delivery in the index pregnancy.

This finding was not different from 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).

Personal income of women has been linked to be a key determinant of women opting to go to health centres to deliver. According to Hulton (2007) women with a personal source of income were more likely to deliver in a health facility and be assisted during delivery by a skilled birth attendant as compared to those with no income. This might be related to the fact that women with a personal source of income have better power to make their own decision in matters related to their health and the expected expenses could be paid by them as compared to women with less power in terms of income (Hiluf & Fantahun, 2007; Ochako, 2011; Kabakyenga, 2012)



In a similar development, cross sectional survey conducted by Cotter et al., (2006) indicated that long distance to health centres and the lack of means of transport to carry laboring women to the nearest maternity homes were factors that affected the choice of delivery site and utilisation of maternity services among pregnant women in Kenya. In a survey to assess economic factors influencing women's choice of place of delivery, it was revealed that most of the women identified lack of income, cost of transportation to health facility, absence of medications at health centres and charges on RCH services as factors influencing the choice of women's place of delivery in Niger (Olatunji & Sule-Odu, 2001).

According to Mbaruku *et al.*, (2009), lower educational status, marital status and low income were factors found to be strongly associated with option of home delivery as against hospital delivery by pregnant women in Kenya. Some studies in developing countries have shown that the decision to deliver at home is related to socio-demographic and economic factors such as income, educational status and marital status (Beth & Robert, 2001; Mesko, 2004).

Married women were more likely to ask permission from their husbands before going to the health centre to deliver as against single women. In most cases women unnecessarily delay at home leading to home delivery when they could have made the effort to deliver at the health centre. According to Maine (1997) one of the major causes of maternal mortality in developing countries is the delay at home by women to make a decision on where to go for delivery. Maine (1997) summarizes the causes of morbidity and mortality in developing countries as the three delays. Delay at home by women to make decisions to seek appropriate care, delay during the journey to reach the health facility from where to get the necessary care and the third delay is by the health facility to offer adequate and



appropriate services and treatment. All these delays before seeking proper health care could influence women's childbirth either negatively or positively.

Sometimes, the decision by women to choose a particular place for delivery is also largely influenced by the health care provider, the husband of the woman and the personal decision of the woman. In a study to assess who had the greatest influence on a woman concerning the place of child birth, findings revealed that women were not always given enough opportunity to help them make reasonable decisions. Women who testified that health workers had a role in their decision making process to deliver at health centres in Uganda were (11%). Husbands' influence was reported by (57%) while self-decision making was done by the 11% of the women. Seven percent however, said decision on site of delivery was determined by the situation that prevailed at the time (Amooti & Nuwaha, 2000).

Pregnancy and child birth process put every woman at risk of complications but 99% of the maternal complication/deaths that occur in developing countries are avoidable or preventable (Adeyemi, 2007; Olatunji & Sule-Odu, 1997). Amooti and Nuwaha, (2000) asserted that midwives were in the best position to empower pregnant women by giving them adequate information about all services and choices that were available so that women could make an informed decision concerning the right place of delivery. But sometimes, health education at health centres is rarely organized and women are left on their own to make their own choice concerning the right place of child birth.

2.5.3 Transport

Unreliable transport is also a barrier to access skilled delivery in rural areas. Failure by pregnant women to plan in advance for proper means of transport cause higher number of



women to deliver in their homes even if they had planned to deliver in health facilities (WHO, 2010). Similar findings have been documented by study done at Nigeria where by women who planned to deliver in health facilities 18% delivered in home due to lack of transport (Acharya et al., 2000). In rural Tanzania for instance 34% of women who gave birth at homes were actually intended to deliver in health facility but due to transport problem and long distance to health facilities they ended up delivering at home (Hazemba *et al.*, 2010).

In most other cases, poverty makes it difficult for women to pay for transportation cost even in areas where the road network is very good. Wives of husbands with higher status occupations could be more able to use facilities for delivery than home delivery because they may be in an advantageous position to pay for transportation cost as compared to wives from low socio-economic status (Adeyemi, 2007; Kabakyenga, 2012;).

High status occupations of husbands are associated with greater wealth, making it easier for the family to pay costs associated with transport charges (Abyot & Asres, 2010). A limited ability to pay high transport costs have been identified as the major barriers for the rural poor women wishing to access health care, due to economic difficulties in rural areas women are not able to afford costs related to deliveries even if the services in some places were free of charge they were unable to pay for transport in case of referral or the facility was away from home (WHO, 2010; Kabakyenga, 2012; Adeyemi, 2007).

Most transports from home to hospital are not emergencies and generally take place by private cars. In emergency situations, transport most often takes place by ambulance. Midwives are experts in normal birth. In British Columbia, women can choose to give birth at home or in a hospital with a midwife as the caregiver (Hazemba & Siziya, 2010). Informed choice means that they have the right to receive information and to make



decisions about their care. Informed choice is a fundamental principle of midwifery care in British Columbia. Midwives have a responsibility to inform women about their care options and to support them in making decisions about their care

2.5.4 Health care and choice of places of delivery

A brief history of the trends in the place of birth since the Second World War shows a rapid decline of non-institutional births in the world (Birungi & Ouma, 2006; Borghi, Nauman & Thomas, 2006). Whilst the drop was slower in Britain, it was slowest in the Netherlands and the rest of the world. The historical account shows that the decline in the home birth rate was a result of successive government reports. A discussion of the reports thus follows, which exposes the origins of assumptions and misconceptions that have influenced thinking about the place of birth (Borghi, Nauman & Thomas, 2006; Cotter, Hawken & Temmerman, 2006). The report goes on to express that many of the witnesses were concerned about risk of infection to mother and baby, and considered that the risk might be higher in hospital than home confinement (Hawken & Temmerman, 2006). Some of the witnesses felt that beds in general hospitals were provided for sick persons and should be used for that purpose rather than to meet the convenience and preferences of women, who could safely be delivered at home (Hawken & Temmerman, 2006).

Inadequate knowledge and skills for health workers on management of obstetrics cases can be the barrier for delivery in health facilities (Adeyemi, 2007 Kabakyenga, 2012). Studies have found that health workers sometimes tend to unnecessarily refer pregnant mother to higher level for management because they do not know how to manage complicated labour and women end up delivering normally on the way (Olatunji & Sule-Odu, 2001). This situation may compel woman to encourage their colleagues not to come



back to such facility due to unnecessary referral to other health facility (Olatunji *et al.*, 2001).

Lack of privacy during delivery is also documented as a barrier for delivery in health facilities because some older women do not want to be attended by younger midwives at health facilities who they think they are like their daughters or younger (Adeyemi, 2007; Kabakyenga, 2012). In other health facilities there is no special room for delivery; women are just delivering on the floor. This condition hinders women to deliver in health facilities (Adeyemi, 2007; WHO, 2010; Kabakyenga, 2012). In many cases, the medical 'culture' may clash with the woman's, for example, when family members are not allowed to be present, supine birthing position is imposed or privacy not respected, this may lead to perceptions of poor quality (Adeyemi, 2007; Thind *et al.*, 2010; Kabakyenga, 2012;).

Health provider behavior and attitudes are also determinant factors for a choice of place of delivery for pregnant mother. It has been argued that some of the health workers are very rude, using abusive language and refusing to assist women in times of needs, these attitudes prevent pregnant women from delivering in health facilities (Adeyemi, 2007; Tukur, Jido, Awolaja, 2008; Kabakyenga, 2012;).

It has been observed that positive attitudes of health workers attract women to deliver in health facilities (Adeyemi, 2007; Kabakyenga, 2012). For example in a study conducted by Hazemba *et al.*, (2010) concerning why women deliver at home, one woman during focused group discussion said “*When I went to the health facility (A) for delivery, I was badly treated by the midwife who cared for me. She was so inhumane, impolite and unsympathetic*” (Hazemba *et al.*, 2010; p23-5).

Improving skills and knowledge among health providers and increase access of health services in rural areas will increase access to pregnant mothers to deliver in health facility



as compared to other places (Adeyemi, 2007; Hazemba *et al.*, 2010; Kabakyenga, 2012). Perceived quality of care, which only partly overlaps with medical quality of care, is thought to be an important influence on health care-seeking and place of delivery among women. Assessment of quality of services is largely depends on personal experience with health system (Olatunji *et al.*, 2001; Cotter *et al.*, 2006; Adeyemi, 2007; Kabakyenga, 2012). Elements such as less waiting times, satisfaction with the service received including staff friendliness, availability of supplies and prompt attention during visits were perceived as good quality of health care by women (Adeyemi, 2007; Thind & Mohani, 2010; Kabakyenga, 2012;).

The involvement of TBAs in conducting deliveries by women in most cases has been noted to be good since these people are directly involve with the women in their communities. The availability of deliveries assisted by TBAs has been reported to be associated with non-utilization of a health facility for delivery in rural areas (Kabakyenga *et al.*, 2012). A study conducted in northern part of Tanzania showed that traditional births attendants are the ones who determined the place of delivery among Masai tribe and they also arrange for the kind of diet required by the women after delivery (Kowalewski *et al.*, 2002). In order to improve health facilities deliveries TBAs must be involved, well informed and fully participated in modern type of delivery (Ogunlesi, 2005).

Most women believe that TBAs and relatives are affordable and able to meet their expectation during delivery and postpartum period these services cannot be provided at health facilities (Ogunlesi, 2005). Another findings by Ogunlesi, (2005) in Tanzania shows that labour is kept secret because any complications develops means the women is



adulterous and remedy for that is to mention all men who have slept with her (Ogunlesi, 2005).

In Zambia it is believed that placenta must be buried in certain manner for a women to continue bearing children, this is contrarily to health facilities where placenta is burned by incinerator (Adeyemi, 2007; Hazemba, 2010; Kabakyenga, 2012). Different ethnicities have different cultural values and these cultural values may prevent women to access health facility for delivery (Ogunlesi, 2005; Hazemba, 2010). Lack of knowledge about pregnancy related complications may lead to having low skilled birth attendant. In spite of having high antenatal care at health post at community level and health centres and hospitals, majority of focus group participants didn't make mention about pregnancy related complications. It showed that as health service provider did not provide proper information on regular bases on pregnancy related complication, the need of having skilled attendant at delivery, birth preparedness and emergency readiness at the community and health institution level is critical to enhance proper care of women. A health survey in Ethiopia showed that women who did not deliver at a health facility were asked the reasons they did not deliver in a health facility and 61 percent stated that a health facility delivery was not necessary and 30 percent stated that it was not customary (Borgh, Nauman & Thomas, 2006).

2.6. Risks and other challenges associated with health care provision that bother on the choice of place of delivery

Researchers have compared the outcomes of mothers and babies from planned home births with those from planned hospital births. They found that when a woman has a healthy pregnancy and has access to skilled attendants, there are no significant differences



in the health outcomes of mothers and babies between settings (Hodgkin, 1996). When home birth services are well integrated into the health care system, as they are in hospital setting, all low-risk women should be given the option to choose either home or hospital birth (Hodgkin, 1996). Research shows that home birth is as safe as hospital birth, where there is screening, planning, trained professional midwives and a health care system that supports midwifery and home birth (Hazemba & Siziya, 2010).

For midwives, safety is the central issue in every birth. Midwives are trained to manage maternal and newborn emergencies in the home and in the hospital (Hazemba & Siziya, 2010).

Studies concerned with reducing maternal mortality in the world have constantly advocated that every woman in the world needs access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the postpartum period (Olatunji & Sule-Odu, 1997; Ogunlesi, 2005; Wanjira & Mwangi, 2011;). In Mali, a study carried out by Marjolein *et al.*, (2006) revealed that timely management of pregnancy and treatment of certain obstetric complications can save a woman's life (Olatunji & Sule-Odu, 1997). In that study, the researchers stated that most women who preferred choice of place of birth of next pregnancy as the home identified inadequate ANC services provided to them during their last pregnancy.

In Japan, most pregnant women who expressed dissatisfaction of ANC services preferred to deliver at home instead of at health facility (Olatunji & Sule-Odu, 1997; Mahdi et al., 2010;). In a cross sectional study carried out by Abbey (2008) in Ghana, the results showed that most rural women who risked giving birth at home said health workers were not at post during the night and women in labour who were not attended to in time may die. Most women preferred to deliver at home as against health facility delivery for fear



of being left there alone. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death (Olatunji & Sule-Odu, 1997; Abbey, 2008; Mahdi *et al.*, 2010). While researchers have stated that in some developed countries, women may decide to deliver at home safely with minimal support, this cannot be said in developing countries where conditions are not safe adequate to motivate women to deliver at home even though most women preferred to deliver at home especially in remote hamlets and rural communities still conservative to traditions and cultures (Abbey, 2008; Mahdi *et al.*, 2010).

In most rural communities, home delivery is usually the cheapest option, but is associated with challenges since the birth attendant is at risk of infection. There are also no equipment to deal with complications, should they occur. In developing countries, specifically in Sub-saharan countries, many women do not have the good fortune to be attended by skilled personnel during childbirth and this poses a greater risk to their survival during child birth largely due to what they perceived as the bad nature of health workers (Abbey, 2008; Hazemba, 2010; Mahdi *et al.*, 2010)

It is an undeniable fact that there are risks and several challenges associated with pregnancy and how women most especially pregnant women seek health care during pregnancy (Hazemba, 2010; Kyomuhendo, 2009). According to Olatunji & Sule-Odu, (1997), pregnancy is a result of conception and ought to be a normal health experience for a woman and for the whole family. Pregnancy ends when woman gives birth to her baby (Hazemba & Siziya, 2010; Kyomuhendo, 2009). For a woman, pregnancy is a time of great change and adaptation of her body and mind. These changes are caused by physiological process in the body and can affect the way the mother is experiencing the



birth of the baby (Eric, 2007; Hazemba, 2010; Mahdi & Habib, 2010). It is therefore, important that all women who are pregnant seek health care at a recognized health facility for proper treatment. Most women who refused treatment at health centres mentioned dissatisfaction of services they have received.

Women's satisfaction has been identified as one of the major indicator of healthcare outcomes and a measure of healthcare quality of health care by women (Mahdi & Habib, 2010). Research suggests that satisfied women were more likely to comply with prescribed treatments, provide information to healthcare providers, and continue using medical services (Eric, 2007; Hazemba, 2010; Mahdi & Habib, 2010). Women's satisfaction of health care is likely highly dependent on a number of factors including women's expectations, demographics, and psychosocial traits as well as healthcare worker traits and the hospital environment (Olatunji & Sule-Odu, 1997)

That notwithstanding women's satisfaction of health care may be influenced by cultural background, self-interest, gratitude, and even the Hawthorne effect which postulates the additional attention implicit in patient satisfaction which data-gathering leads to a more positive perception of services (Olatunji and Sule-Odu, 1997). The Ghana Health Service (GHS) as part of its re-organization processes took some proactive measures by introducing important regulatory documents like, code of ethics for staff, patients charter, code of conduct and disciplinary procedures for staff to improve their behaviour (Eric, 2007; Abbey, 2008; Hazemba, 2010). These are all in an attempt to address the perceived poor patients' satisfaction in public healthcare facilities. In spite of these measures and despite media criticisms, the attitudes of some health workers towards their patients are often negative (Eric, 2007; GHS, 2007). Patients often complain about poor quality of services in public health care facilities and these are mostly centered on waiting time,



unhealthy hospital environment, abuse and disrespect and apathy of health service providers (Amooti & Nuwaha, 2000; Abbey, 2008;).

Health centres have been described as the best place or environment, where special delivery can be conducted (GHS, 2007). Health centres can sometimes create a perception of a cold sterile atmosphere, especially if it is the women's first contact with a health care delivery unit. It is totally an unfamiliar and scaring environment to those who think that deliveries at health centres can cause death (Khalid, & Daniel, Lale, 2006; Envuladu *et al.*, 2012). This causes women to be scared and insecure because they don't know what the purpose of all the equipment and procedures is. The type of environment which create tense and uneasiness, should be overwhelmed by a kind, calm and supportive attitude and not for the health care providers control the women's actions (Ogunlesi, 2005; Hazemba, & Siziya, 2009; Kanga *et al.*, 2012).

2.6.1 Risks of childbirth

It has been argued that women use rules of thumb or heuristics by which they arrive at their assessments of risk (Berman, 2000; Birungi & Ouma, 2006; Cotter, Hawken & Temmerman, 2006). The heuristics involve simplifications of information by comparison of new risk information with other more familiar risks to assess the severity of the risk. The significance of the heuristics is that they involve consistent biases away from what is known to be objective facts about the extent of the specific risk (Cotter, Hawken & Temmerman, 2006). The result of this is that for different individuals, certain kinds of risk appear to be more likely to happen than they actually occur. They see other kinds of risk as less probable than would otherwise be predicted by the experts (Birungi & Ouma, 2006).





Risk perception in childbirth may similarly be influenced by the way information is presented by caregivers as well as by the interests and cultures of those concerned. For example, women looked after by obstetric consultants may tend to view childbirth as pathological and may be more likely to accept that they need interventions during labour (Beth & Robert, 2001). Those cared for by midwives, on the other hand, may tend to see childbirth as a natural process (Beth & Robert, 2001). Additionally, it is also proposed that women are unlikely to consider the risk or safety of an option that is not explicitly made available to them (Hazemba & Siziya, 2010). The thesis considers childbirth risk to have two dimensions. The first concerns the uncertainty of the process itself as problems could develop at any time. For example, a woman who did not have any problems at all during the first stage of labour may suddenly develop postpartum haemorrhage and collapse in shock during the third stage. It is possible that women who plan a hospital birth will be concerned about the uncertainty of the process. The other dimension could be risk due to technology, and modern medicine.

For example, a woman who labours in hospital might be given an epidural for pain relief, which might then be followed by a caesarean section because she was not able to push when required to give birth. If the same woman had laboured at home, she may possibly have avoided the operation. Women who plan to have their children at home might be more concerned about the risks of the hospital. An important factor in the differences could be the perception of benefits (Hazemba and Siziya, 2010). If women perceive the benefits of their decision as great, their tolerance of risk is higher (Hazemba & Siziya, 2010). It has been argued that factors such as personal relationships, control over events, and the importance of general happiness may also influence how women perceive risk (Borghini, Nauman & Thomas, 2006). For example, a woman who desires to have a family

experience of childbirth, where she is also in control, might worry less about the risk of childbirth.

In developing countries, millions of women and newborns die or experience serious health problems related to pregnancy and childbirth each year. Maternal mortality has been difficult to measure accurately in resource-poor settings and maternal mortality ratios in most Sub-Saharan African countries range from 600 to 999 per 100,000 live births (WHO, 2010). Researchers in Tanzania, revealed that women whose choice of place of birth was the home mentioned poor health care which they identified as being shouted at during weighing and delay in receiving care at the hospitals a motivating factor influencing women from delivering at health centres (Berman, 2000). Because the reaction of women surrounding pregnancy and labour vary from excitement to fearful expectations, the nursing care that is provided to them is so important (GHS, 2007). It is thus the responsibility of midwives to inform and educate them 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, Het al., (2006) further emphasized that clients must freely give informed consent before any invasive treatment or procedure conducted, to protect the autonomy of the client. Each client needs full explanation of the benefit and risks to herself and to her unborn baby, in a language she understands most.

According to Maureen and Peter (2008) health workers in urban and rural settings can play a significant role in helping women to achieve healthy successful pregnancies and labour by supporting, nurturing, educating and caring for the pregnant women and their



families, depending on the kind of obstetrical care available, where the midwife can either assist or take carefully. The issue of health workers attitude towards women has been a major obstacle to women seeking health care. In many studies, women have identified rude behavior of health workers as a major contributory factor for women delivering at home. Most women in surveys revealed that until health workers become friendly in providing health care and not being rude to women in Tanzania, women would continue to deliver at homes (Kyomuhendo, 2009; Ochako, 2011; Kabakyenga *et al.*, 2012). Some women recounted instance where during ANC visits health workers said that they were wasting their time or that they were not sitting properly as directed when waiting for assessments (Berman, 2000; Ochako, 2011).

A woman noted how she would be treated during labour if this was just a normal hospital visits (Berman, 2000). This attitude and behavior of health workers could pose the greatest threat to achieving zero home delivery as more women may prefer to deliver at home instead of going to the hospital (Berman, 2000; Ochako, 2011). In a survey carried out by Berman (2000) & Ochako, (2011) concerning how health workers attitude could influence women's choice of place of birth using focus group discussions. Most women who took part in the survey some expressed their opinions such as *"The health workers' attitude towards us is so bad and this discourages us from coming to the health center to deliver remarked by woman X"*. Another woman (G) stated; *"the kind of treatment the health workers give us when we come for antenatal clinic, how would it then be when we come to deliver? Won't they insult us more or even beat us?"* (Kowalewski *et al.*, 2002 p12)

Another concern women expressed was delay in the provision of health care to pregnant women in ANC clinics in the hospitals (Berman, 2000; Kirigia *et al.*, 2011). Women did



not like being kept waiting at the antenatal clinic when it was opened late. They also disliked when they were not attended to when they went to the health facility (Marjolein, 2003). A woman who was admitted after presenting with malaria in pregnancy was not happy with how she was managed. She went to the health facility but was not cared for as had been promised (Berman, 2000). They gave her medicine the next day in the morning. She felt they did not show her kindness and she remarked as follows: *“It is 12 midday already and we are tired. The workers for the morning shift said, I will be taken care of by those for the afternoon shift. I ended up sleeping in the hospital till the next day. I was hurt by the kind of treatment I received from the care givers”* (Berman, 2000; p45)

The consequences of poor health worker attitude have always been the results of risks associated with pregnancy and childbirth. In a study to examine women’s knowledge on risks associated with pregnant women delivering at home, it was revealed that 56% of the women mentioned that it was risky because the woman may die, 20% said the placenta may remain in the womb for long time while 24% of them mentioned that the baby and the mother may die during child birth (Bashour and Abdul Salam, 2005). In Africa, the lack of skilled attendance could be considered as one of the major factors in maternal and infantile mortality (WHO, 2010). Nigeria has continued to witness a high maternal-mortality ratio, with substantial variation across its regions (Olatunji & Sule-Odu, 2001)

Despite this, the use of reproductive health services remains low, and home delivery among women of child bearing age is widespread, hence maternal morbidity and mortality remains a public health problem (Olatunji & Sule-Odu, 2001). It is therefore, widely advocated that health sectors reforms should reform to meet the needs of their growing clients. Health sector reforms involve significant and purposive effort to improve the performance of a health-care system. There are five goals of health sector reforms



namely: efficiency, quality, equity, client responsiveness and sustainability. In a comparative study in 2001-2002, it was showed that the structure and operation of a health system influence maternal health care provision and outcomes in Bangladesh. The report indicated that outcomes of pregnancy were linked to health care system structures such as health centre environment which motivated women to come, health providers' attitude and availability of medication for pregnant women were all identified as enabling factors which made women patronize health centre for delivery. Improving upon the services of health sector could reduce maternal mortality ratio in the world.

Maternal mortality is the highest by far in sub-Saharan Africa, where the life time risk of death from pregnancy related conditions is 1 in 16, compared with 1 in 2800 in rich countries (WHO, 2010). According to EDHS (2005) and (2011) the levels of maternal and infant morbidity and mortality in Ethiopia, are among the highest in the world. There are 673 and 676 maternal deaths for every 100,000 live birth and the infant mortality rate was 39 and 37 per 1, 000 live births but the rate of institutional delivery, ANC follow up and MCH have remained lower even though they are major indicators of health service utilization in the country.

2.6.2 Other variables associated with women's choice of places delivery

Several factors have been identified as barriers to skilled care by women especially in developing countries; these include unavailability of the services, inadequate number of skilled personnel, geographical inaccessibility and poor quality of care which could result in risk associated with pregnancy outcome (Adeyemi, 2007; Kabakyenga, 2012;). In developing countries, most women deliver at home for some reasons. A study on the use of obstetric services in rural Nigeria shows that educational level, occupation of women,



and occupation of the spouse were found to be the most consistent associated factors with the use of health facilities for delivery (Adeyemi, 2007; Kabakyenga, 2012;)

In addition to these, lower educational status, marital status and low income were factors found to be strongly associated with option of home delivery as against hospital delivery (Adeyemi, 2007; Kabakyenga, 2012). Some studies in developing countries have shown that the decision to deliver at home is related to socio-demographic and economic factors such as income, educational status and marital status (Adeyemi, 2007; Kabakyenga, 2012;). The result of the study that was conducted in Enugu, Nigeria also found factors like maternal educational level among other socio-demographic characteristics to be highly associated with home delivery (Ogunlesi, 2005; Idris, Gwarzo & Shehu, 2006; Adeyemi, 2007;)

At the same time, maternal age and parity were not significantly associated with women's choice of place of delivery according to a study in Kenya (Ochako, 2011).

Recent demographic and health survey (DHS) data from more than 50 developing countries shows that women with the limited education, knowledge of health service are less likely to use basic health services such as immunization, maternal care and family planning leading to greater risk associated with pregnancy (Olatunji & Sule-Odu, 1997; Adeyemi, 2007; Kabakyenga, 2012). Improving the knowledge of women through information, education and communication has been found to increase obstetric service utilization leading to low risk associated with pregnancy outcome (Olatunji & Sule-Odu, 1997; Adeyemi, 2007).

According to the WHO (2010) one of the problems affecting the health sector in Africa is the lopsided distribution of health professionals in favour of urban centres. It is noted that some categories of health manpower are in short supply in the rural areas while they are



in excess supply in the urban areas. It has also been confirmed that wealth status influence the use of medical facilities, the positive relationship between the use of the facilities and wealth index is an indication that poverty is also the leading cause of maternal and infant mortality in most countries in the world (Ogunlesi, 2005). Maternal mortality is an indicator of how well a health system functions, as it encapsulates a substantial part of both primary and secondary health care. All countries where maternal mortality is high, the size, skills and infrastructure of the workplace are inadequate (Hiluf & Fantahun, 2007). The true constraints to improving care in developing countries are with the health systems and health sector reforms. They include lack of human resources, poor infrastructure, inadequate financial protection and non-evidence based medical practices (Adeyemi, 2012; Hiluf & Fantahun, 2007).

Majority of the maternal deaths that occur especially in developing countries are avoidable or preventable (Adeyemi, 2012). Studies have shown that the health, reproductive behaviour and socio economic status of women are among the important determinants of maternal mortality (Hiluf and Fantahun, 2007). Delivery in health facilities is still challenging in developing countries in which higher number of women attend antenatal clinic but about half of them mostly deliver at home without assistance of skilled professional (Adeyemi, 2012). It has been observed that low delivery in health facilities is as a result of many factors which lead to high morbidity and maternal mortality. Therefore proper interventions must be taken to increase women delivery in health facilities (Idris *et al.*, 2006; Hazemba, & Siziya, 2009; Cotter *et al.*, 2006). Home delivery are mostly conducted by TBAS and relatives which turn to increase the risk of transmission of diseases to relatives or traditional birth attendants who conduct deliveries without protective equipment.



The determinant of maternal mortality include the health and reproductive behaviour of the woman, her health status, access to health services as well as her socio-economic status. It is important to identify the factors which influence women to deliver at home so as to develop strategies to motivate women to deliver at health centres (Olatunji & Sule-Odu, 1997). Information on why mothers choose to deliver at home in preference for institutional (hospital) delivery is very vital for health planners and managers in order to design the appropriate health education which could motivate and encourage women to deliver at health centres. Other variables influencing women choice of place of delivery include income level of the women and parity of the woman. A study conducted by Cotter *et al.*, (2006) indicated that the perceived key determinants of selection of place of delivery for women were lack of socio economic status/money, lack of transport, sudden onset of labor, short labor duration, staff attitudes, lack of privacy, reproductive behaviour, traditions and cultures and the patterns of decision making power within the household.

Husband's occupational status has also been found to be so much having an influence on the place of delivery as wives of employed husbands tend to deliver at the hospital. Among 137 mothers who delivered in the hospital, in Nigeria, 126 of them (92%) mentioned that, their husbands were engaged in one occupation or the other (Cotter *et al.*, 2006). Other studies have documented the role of socio-economic status as an important determinant of women's place of delivery (Ochako, 2011). In contrast, however, a study conducted in Kenya showed that the most important significant predictors of women choosing a place to deliver was the distance from the nearest maternity centre to the home of the woman (Kowalewski *et al.*, 2002; Ochako, 2011).



2.7 Summary of the literature review

There is limited evidence to guide discussions on choice of birthplace with midwifery clients who have conditions or factors that may increase risk of adverse health outcomes. Best available evidence related to birthplace is informed by studies that involve participants at low risk of complications (defined similarly in different jurisdictions). Many midwives appeared to have had very little discussion about place of birth with women and, in the absence of such discussion; information alone did not appear to enable women to make an informed choice. Evidence from studies about women who experienced a high level of continuity of care (Hazemba and Siziya, 2010) suggests that in these contexts a much higher percentage of women are given a choice of birth location and feel more involved in the decision about where to have their baby. It is worth noting that adequate ANC attendance during pregnancy did not significantly influence hospital delivery based on the findings of this study. Other equally significant factors influencing women choice of places of delivery includes; socio-cultural factors, cost of health care, attitude of health care providers and the quality of institutional deliveries. The age at first pregnancy was found to be another determinant as more women who had their first pregnancies before the age of 18 years delivered at health facilities with their parents. This finding may not be related to the common cultural practice in the other areas where newly married young girls are taken to their parent's homes to have their first deliveries. This study have highlighted some of the factors affecting the choice of place of delivery among women in settlements in Savelugu/Nanton namely women's educational level, occupation, marital status, distance, quality of care. Few of the deliveries took place at home and unsupervised by a skilled attendant thus aggravating the risk of the relatives around them.



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter contains the research methodology that was used to conduct the study. It comprises of a profile of the study area, research design, study population, determination of sample size, sampling techniques, sources of data, data collection instruments, quality assurance, methods of data analysis and ethical considerations.

3.2 Profile of study area

The study was conducted in the Savelugu/Nanton Municipality. 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 being 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 °C at night and 40 °C 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 28° C (December - mid-April) to about 38 °C (April - June) while the mean night temperatures range from 18°C (December) to 25°C (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. Eidul-Ahda and Eidir-fitir are equally celebrated by the Muslims (GSS, 2010).

The males are mostly engaged in farming while the female assist the men with the farming activities. Polygamous marriages are common among the people. There is high illiteracy rate among the people. There are currently functioning government and private health facilities in the Municipality providing health care for all manner of persons. The Savelugu municipal hospital serves as a referral center for the rest of the health facilities. There are eight operational CHPS compounds, at Dipale, Kundanali, Guntingli, Nanton-kurugu, Fazihini, Nambagla, Pigu, and Nyolugu.

There are three (3) Health Centres and these are located in Nanton to the East and Pong Tamale and Diare to the north. Five clinics located at Moglaa, Janjori-Kukuo, Tampion and Zoggu. Bruham clinic and Modern Surgical center are privately owned and operates 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.

Majority of the females in the Municipality are within the age range of 15-49 years representing women in the fertile age (WIFA). The Municipality recorded a Total Fertility Rate (TFR) of 3.5, General Fertility Rate (GFR) of 101.9 and a Crude Birth Rate (CBR) of 24.0. The Municipality has a crude death rate (CDR) of 5.7. (GSS, 2010)

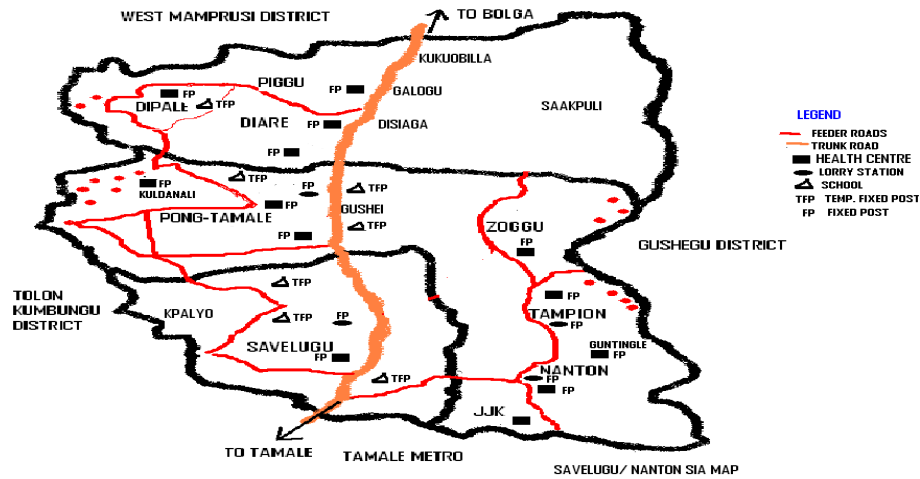


Figure 3.1: Map of Savelugu/Nanton Municipality

3.3 Research design

Descriptive cross-sectional study design was used for the study to examine the factors that are 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 provides 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 place 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.

3.4 Study population

The study population included women in fertility age in the Savelugu/Nanton Municipality. They included women who delivered with the assistance of both skilled or unskilled birth attendant and expectant mothers. Also included in the study were married men, health workers and opinion leaders who were willing to participate in the research. Their inclusion was appropriate because they are considered as key stakeholders as far as the choice of place of delivery is concerned. Also these wide range and different category of respondents was considered appropriate in view of the multi-faceted nature of factors influencing women's choice of places of delivery in Ghana.

3.5 Sample size determination

The study involved 250 women who were sampled from selected communities and health facilities in the Savelugu/Nanton Municipality at the time of the study.

A formula adopted by Varkevisser, et al was used to determine the sample size

$$n = p (1-p)/e^2$$

Where n = sample size

P = population of women of child bearing estimated to be 23%

e = estimated error at 2.5%

z = confidence interval at 95% = standard value of 1.96



$$n = 23(100-23) / (2.5)^2 = 283$$

A 10% non-response rate was added it summed up to 311 respondents. However, 250 respondents were used for the study because of the resource constraints as well as the how wide apart the selected communities were from one another. It made movement from one community to another a bit difficult. The data collection was also done in the farming season and this made a bit difficult getting the respondents at home.

3.6 Sampling technique

The sampling procedure used for the study was multistage. This method involved the drawing of a sequence of samples from already selected samples, so that only the last sample of subjects is studied. Savelugu/Nanton Municipality was purposively chosen for the study because of its demographic characteristics such as high poverty rate, high fertility rate, adherence to religious and socio-cultural practices which largely affect health delivery in the municipality. According to the Savelugu/Nanton Municipal Assembly's Report (2014), the Municipality is clustered into five sub-municipalities and out of these, three (including Savelugu, Pong-Tamale and Nanton) were selected using simple random sampling technique by labeling and balloting. The choice of the technique was to afford each sub-municipality an equal chance of being selected for the study.

A similar sampling technique was adopted in the selection of three communities from the Savelugu sub-municipality and two communities each from the Nanton and Pong-Tamale sub-municipalities. From the Savlugu 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. Systematic sampling technique was then used to select houses for the study; hence the first house was selected by taking a spin from any relevant landmark. Every third house was considered.

In the chosen houses, the simple random sampling technique was further used to select a respondent and if there were more than one eligible respondents in a household to respond to the quantitative data (questionnaire). “Yes” and “No” were balloted for the selection of the respondents. Simple random sampling was again used to select respondents for focus group discussions. The focus group involved two groups of respondents which comprised of women in their reproductive ages. It was conducted at Libga and Laligu. These groups were homogeneous in terms of sex and with a range of 7-10 subjects. Besides the written documentation of responses from study subjects, voice recorder was used after obtaining a verbal consent to ensure that all feedback was rightly captured for analysis. This was conducted by the principal investigator himself with support from four (4) research assistants who were good at the popularly spoken local languages.

The moderation of the discussion by the research assistants and feedback from participants was done in the languages best spoken by the participants. The feedback in the local languages was then translated to the principal investigator in English by research assistants who were well versed with both respective local languages. The principal investigator and the research assistants took time and reviewed the translations to ensure that the meaning of responses of study participants had not been misunderstood.



Table 3.1: Number of respondents sampled for the study

Where sampled	Category of respondents	Number sampled
Savelugu hospital	Pregnant women	20
Pong Tamale health center	Pregnant women	10
Nanton health center	Pregnant women	10
Nakohigu west	Women	52
Libga	Women	32
Bunglung	Women	21
Laligu	Women	25
Tibali	Women	17
Nanton Nayilifong	Women	38
Chamkpem	Women	25
Total		250

(Source: Field survey, 2015)

Respondents were randomly selected from selected communities within the sub-municipalities in the study area. The names of the communities from each sub-municipality were written down and mixed thoroughly. Picking without replacement probability sampling technique was used to select three communities from Savelugu sub-municipality and two communities each from Nanton and Pong-Tamale sub-municipalities for the study. Respondents were selected from the health facilities and the communities proportionate to size.



3.7 Sources of data

The sources of data for the research were gotten mostly from primary and secondary sources. The primary source of data was collected from the respondents using questionnaires. The research tool was divided into sections to enhance effective data collection. The secondary data sources however, was obtained from the review of relevant materials such as; books online, periodicals, journals, annual reports of World Health Organizations and Ghana Health Service Reports. Some secondary data was obtained from the Savelugu/Nanton Municipal Health Directorate and Savelugu/Nanton Municipal Assembly. All researched materials were duly acknowledged in the appendix of this research work.

3.8 Data collection techniques

3.8.1 Questionnaire administration

A questionnaire comprising of both close and open ended questions were employed to collect primary data from the respondents. Close ended questions were accompanied with very possible responses to allow respondents easily select the most applicable to them while open ended questions were left open to allow respondents to feed in their own responses.

3.8.2 Focus group discussions

Focus group discussion (FGD) was conducted to solicit information on experiences, thoughts, feelings, attitudes and ideas of participants on determinants of choice of places of delivery by women. 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



inclusion criteria of the research work. Before the FGDs, the moderator introduced all the team members, explained the general purpose of the study and 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 child birth by women in the Savelugu/Nanton Municipality.

3.8.3 Key informants

Key informants from the Savelugu/Nanton Municipality were contacted to assist in providing responses on social and cultural issues influencing women's choice of place of delivery. These key informants were mostly traditional leaders, opinion leaders and health workers. These people provided information on cultural, social and geographic factors influencing women's choice of place of delivery specifically as they relate to the study area. The information solicited from the key informants was to answer questions on objectives one and two.

3.9 Data analysis

The field data collated was edited in order to address questions that have been answered partially or not answered by respondents. After editing, both closed ended and the open-ended questions were coded (i.e., the assignment of numbers and key words as codes to responses to make them computer readable). After editing and coding, the data was entered into the computer using the Statistical Package for Social Sciences (SPSS) software version 20.0 and transposed using word excel 2013. Before performing the desired data transformation, the data was cleaned by running consistency checks on every variable.



Corrections were made after verification from the questionnaire and the database was generated. The data was presented using basically descriptive statistics involving mainly frequency distributions. The demographic variables were summarized using descriptive summary measures: expressed as mean (standard deviation) for continuous variables, and percent for categorical variables. Thematic analysis was done for the qualitative data generated. Qualitative data was analyzed manually by coding and making thematic and content analysis.

Besides the written documentary during focused group discussions, the audio-visual voice recordings by the mobile phone were reviewed by playing over and over to facilitate comparison across different themes and sub-themes.

3.10 Quality control

The questionnaire was first pretested using a sample of five respondents at Ying community, in the Savelugu Municipality. After the pre-test, the necessary corrections were made after which the final data collection began at the field. Four research assistants who have in-depth knowledge in the research topic under investigation and have done similar data collection before were contacted to assist in the data collection. The criteria used for the selection of the research assistants were based on their ability to speak and understand the local language (Dagbani). Training was provided to the research assistants to enhance their data collection skills. The questionnaires were well explained to the research assistants before data collection to avoid large missing data gaps in the questionnaires. The researcher also made sure that all the respondents who were contacted provided the needed information relevant to the research study. After the data collection, the final data was cleaned before the entry and analysis.



3.11 Ethical considerations

Ethical issues that were considered in this study included ethical clearance from the University for Development Studies. Permission was sought from opinion leaders resident in Savelugu/Nanton Municipality. For primary data that were collected in the health facilities using health workers as study respondents, permission was obtained from the Director of Ghana Health Service in the Savelugu/Nanton Municipality and from the Hospital administration before administering the research tool. Permission was also sought from all the married men, the expectant mothers, health workers, women after the purpose of the research was explained to them.

All the respondents were informed that their participation in the research work was voluntary and that they have the right to withdraw from the study if they wished to do so any time. The anonymity and confidentiality of respondents were ensured once respondents did not indicate their names or other forms identification on the questionnaire that were likely to be used to trace them.

3.12 Study limitations

The study was constrained by many factors among which were; inadequate access to previous data related to the research topic because of extreme data gap situation in the country. To overcome this limitation in the study, the research reviewed extensively relevant literature pertaining to the research topic including broader consultations with friends and health workers. The study was also constrained by the uncooperative attitude of some respondents because they felt information solicited from them could be used to victimize them. The researcher assured respondents that information taken from them was



confidential and was not meant for victimizing them. However, these limitations did not affect the interpretation of the research findings nor interfere with the entire study.



CHAPTER FOUR

RESULTS

4.1 Introduction

This section contains the findings of the study based on statistical analyses and are presented in tables where appropriate. A p value of < 0.05 was used as the criterion for statistical significance. All statistical tests were performed using two-sided tests at the 0.05 level of significance.

4.2 Socio-demographic data of respondents

A total of 250 respondents were assessed during the study period. Also, married men, health workers, traditional birth attendants and opinion leaders who are considered to be key stakeholders on choice of place of delivery were involved in the study. The category of health workers sampled included community health nurses (3), public health nurses (2), midwives (3) and general nurses (2). The mean (standard deviation) of the ages in years is 25.4 (10.1) years. With regards to the age groups of respondents, the modal age group was (25-35) years as majority, 125 (50%) of them were within this age range. The analysis indicates that those who were engaged in the formal sector of the economy such as public servants represent 68 (27%) whereas, those who were engaged in the informal sector of the economy such as petty trading were 137 (55%) while 45 (18%) were unemployed. The economic variable assessed in the research which could have an impact on choice of places of birth was their income level based on their occupation.

The analyses also showed that most of the respondents 155 (62%) were of the Islamic faith with 85 (34%) and 10 (4%) of them being Christians and Traditional worshippers respectively. With regards to the educational status of the respondents, it was shown that



60 (24 %) had tertiary education while 50 (20%) had SHS/Vocational training. Majority of the respondents 140 (56%) had no formal education. Majority of the respondents representing 230 (92%) were married, 8 (3%) respondents were separated from their husbands at the time of the research while 12 (5%) respondents were single or co-habiting. The results are shown in Table 4.1



Table 4.1: Demographic characteristics of respondents

Socio-demographic variables		Frequency (n) and (%)
Sex of respondents	Female	250(100)
Age of respondents in years	25-35	125 (50)
	36-45	99 (40)
	45+	26 (10)
Occupational status	Housewives	45 (18)
	Trading	137 (55)
	Salaried workers	68 (27)
Religious affiliations	Christians	85 (34)
	Muslims	155 (62)
	ATRs	10 (4)
Marital status	Married	230 (92)
	Single	12 (5)
	Separated	8 (3)
Educational level	No formal education	140 (56)
	SHS/ Vocational	50 (20)
	Tertiary	60 (24)

(Source: Field survey, 2015)



On assessing the associations between the socio-demographic variables and the choice of places of delivery by women (which in this survey is defined as predictors of place of birth), the following findings were made as tabulated in Table 4.2. The findings from the survey revealed that those who were married were 2 times more likely to make the choice to deliver at a health centre as compared to those who were not married (OR =2.0; 95% CI: 0.9– 4.2; P= 0.089)

Table 4.2: Binary logistic regression on predictors of place of birth

Independent variables	Dependent variables	p-values	Odds Ratio (OR)	95% Confidential interval
Sex (male ; female)	Place of birth	0.036	1.0	0.1- 1.6
Occupation (formal sector; informal sector)	Place of birth	0.017	17	1.7- 7.8
Education (educated & non-educated)	Place of birth	0.068	2.2	0.7-7.0
Marital status (married; single)	Place of birth	0.015	2.4	0.9- 7.0
Distance to health centre (at least 2 km)	Place of birth	0.005	5.2	0.5- 2.2

(Source: Field data, 2015)

4.3 Ethnicity and place of delivery

Majority (75%) disagreed with the statement that ethnicity influences where a woman chooses to deliver while 25% of the respondents agreed with the statement that there was a correlation between ethnicity and women's place of birth. A further probe from those who agreed that there correlation between ethnicity and place of delivery to determine whether a specific ethnic groups could be mentioned, most (23%) of that category identified the Fulanis who according to them taboo allowing people to see their private parts during delivery.



4.4 Social and cultural beliefs and factors underpinning pregnancy and child birth.

Social and cultural beliefs and practices are still traditionally rooted in the minds of most people living in rural communities in Ghana which is negatively influencing access to basic maternal health care, yet little is known about these factors even when they influence a woman's choice of places of birth. Understanding of variables surrounding availability of these social and cultural beliefs and practices in these communities would remove the bottlenecks. In order to establish cultural factors affecting choice of places of birth, respondents were asked whether there were cultural factors affecting women's choice of places of birth and most, 160 (64%) of the respondents said "Yes" while 90 (36%) said "No".

4.4.1 Knowledge on social and cultural factors underpinning pregnancy and child birth

The analyses revealed that 160 (64%) respondents said they knew some examples of cultural beliefs affecting child birth, 50 (20%) of the respondents did not know any cultural beliefs affecting child birth while 40 (16%) of them had no idea on what cultural factors influence child birth in the study area.

4.4.2 Home delivery means woman was faithful to the husband

Among respondents who knew the cultural beliefs affecting child birth, 62.5% stated that safe home delivery means the woman was faithful to the husband while 37.5% indicated that home delivery is not attributed to women being faithful to their husbands. Respondents maintained that married women were more likely to uphold cultural practices so they could have the trust from their husbands.



4.4.3 Home delivery means bravery

It is worth noting that home delivery has been attributed to bravery by the people in the study area. According to them, women who deliver in the house are considered brave. It was revealed by majority of the respondents (62.5%) that women who made the effort to deliver at home means those women were brave whereas 37.5% think otherwise.

4.4.4 New born baby is not to be seen by everyone

Few (25%) of the respondents mentioned that not everyone is supposed to see the child when newly born so this would necessitate that women make frantic effort to choose home as their preferred place of birth while 75% think otherwise.

4.4.5 Placing “black medicine” on the baby’s forehead

Furthermore, 20 (12.5%) of the respondents mentioned that placing of black medicine on the forehead of the baby when delivered prevents women from going to the health facility to deliver as they would not be allowed to place any black medicine on the forehead of their babies while 140 (87.5%) think otherwise. They believe that this medicine will protect the baby from harm and grant the child long life.

4.4.6 Prolonged labour means woman was not faithful to the husband

On the issue of prolonged labour being associated with unfaithfulness on the part of the woman, analyses revealed that majority (73%) of the respondents did not consider prolonged labour to be culturally related to unfaithfulness on the part of the woman, 12% of them mentioned that their culture supported the assertion that prolonged labour means the woman was not faithful to the husband while 15% could not tell whether prolonged labour has any cultural connotation with unfaithfulness on the part of the woman.



4.4.7 Woman's health seeking behaviour

Seeking health care during pregnancy has been linked to how women perceive their health condition as being critical or not. Culturally, most women consider pregnancy as a disease and when pregnant, they find it very difficult to do any work including having to travel to seek health care. Findings from the survey revealed that 70 % of the respondents mentioned that they go to the health centre when their condition was getting critical, 20 % of the respondents said women they have been going to the hospital always even if their condition is not getting worse while 10 % of the respondents said they rarely go to hospital except on ANC visits.

4.4.8 Previous successful home delivery means subsequent ones will be successful

Findings further revealed that Majority (75%) of the respondents believe that previous successful home delivery was a factor influencing women to deliver at home while 25% did not believe successful home delivery was a factor that could influence women's choice of places of child birth.

4.4.9 Community norms and place of delivery

Community norms were also assessed to know the extent to which these could influence a woman's choice of places of delivery, 90% of the respondents mentioned that community norms could influence a woman's choice of place of birth while 10% respondents said they do not believe community norms could influence a woman's choice of place of birth. It was considered not a norm for a man in the study area to accompany the wife to a health centre as majority (88%) of the men who were interviewed mentioned that they have never accompanied their wives to the health centres while 12% respondents of the men said they have ever accompanied their wives to the health centre before. According



to the respondents, men who accompany their wives to the health centre to deliver are considered being weaker and are controlled by their wives. Some men may therefore have the zeal to send their wives to the health facility for skilled health care but for fear of being tagged as weaker men, they relent in doing so. It is therefore not surprising that majority of the male respondents affirmed that they have never accompanied their wives to the health centre.

4.4.10 Personal likes and dislikes and place of delivery

Findings also revealed that (76%) of the respondents mentioned that personal likes and dislikes of women about a place of delivery could influence a woman's choice of places of delivery while 24% of the respondents said they do not believe personal likes and dislikes of a woman could influence her choice of places of childbirth.

4.4.11 Fear of operation

It was also revealed that all the 250 respondents affirmed that the fear of death while being operated upon was a major cause of women making the choice to deliver at home. Respondents believe that the fear of operation was a major factor influencing women to deliver at home even though they go for ANC services at the health centres.

4.4.12 Preferred place of delivery

All the 250 respondents stated that their preferred place of delivery was the health centre. They mentioned some reasons that informed their preferred place of delivery. According to them, they prefer delivering at health centers because when complications arise during child delivery, the health care professionals will be able to provide skilled assistance for



them compared to home delivery. Furthermore, they are enlightened on how to cater for themselves and their new born babies.

Majority of the respondents (90%) of the health staff category interviewed revealed that women prefer to deliver at the health centres centre while 10% of the respondents indicated otherwise. However, they mentioned that despite that fact that women prefer to deliver at the health facilities, the skilled delivery rate does not commensurate the rate of ANC attendance because certain factors like distance to the health centers, poverty and poor road networks prevent women from seeking skilled delivery from them.

4.4.13 Modernization and place of delivery

Analyses also revealed that, majority (70%) of the opinion leaders said modernization has now changed the deep rooted cultural practices making way for women to deliver at health centres while (30%) of the respondents said modernization has not affected the cultural beliefs of the people. Among the former, some identified reasons to include; advent of religion has changed some of the cultural practices liberating women to deliver at their preferred places of choice. Respondents also mentioned that education has also altered women's perception about traditions as education on radio and at health centres have changed the perception of women on facility-based delivery. As a result of modernization, some of the misconceptions women held about child delivery in the health centers have ben demystified.

4.4.14 Availability of TBAs and place of delivery

In the study area respondents believed that the availability of TBAs culturally influenced women to deliver at home. Most (65%) Of the respondents stated that Traditional Birth Attendants influence where women choose to deliver since they live with them in the



same community and conduct deliveries in the absence of health workers while 35% of the respondents think the availability of TBAs does not influence where women choose to deliver.

4.4.15 Lack of Privacy

This study revealed that 75% of the respondents expressed the view that lack of privacy during delivery could influence women's choice of place of delivery while 25% of them stated that privacy during delivery may not influence women to deliver at home. The huge percentage of women who said lack of privacy influences where they choose to deliver suggests why many women would attend ANC and end up delivering at home.

Table 4.3 illustrates cultural beliefs and places of child birth.

Table 4.3: Cultural belief and places of child birth

Variables	Response	N (%)
Cultural belief	Yes	160 (64)
	No	50 (20)
	Don't know	40 (16)
prolonged labour	Yes	30 (12%)
	No	183 (73%)
previous successful home delivery	Don't know	37 (15%)
	Yes	120(75%)
	No	40(25%)
home delivery means bravery	Yes	100(62.5%)
	No	60(37.5%)
New born baby is not to be seen	Yes	40(25%)
	No	120(75%)
	No	

(Source: Field data, 2015)



Analysis of predictors of certain cultural and social factors associated with choice of places of delivery by women after having tried to control for confounding factors by matching and randomization are shown in Table 4.4. Logistic regression analysis and Chi-square test (X^2) were used to test for significant relationships. The independent variables were simultaneously introduced into the model in order to control for the effects of the other variables. Analyses revealed that those who were employed in the informal sector were 13 times more likely to be influenced by certain perceived cultural and social factors especially when it comes to the choice of places of birth compared with their colleagues employed in the formal sector (OR=13.0; 95% CI: 1.7-7.8; P=0.017). The study also revealed that those who did not know of any cultural and social factors associated with choice of places of delivery were 8 times more likely to ignore such cultural practices and make the effort to deliver at health centres compared with those who knew such cultural practices (OR=8.0; 95% CI:1.9-32.8; P=0.004).

The analyses also showed that women who were married were 2 times more likely to conform to certain social and cultural factors as compared with their counterparts (OR=2.0; 95% CI: 1.0-20.1; P= 0.089). The analyses further revealed that, in the communities where TBAs are highly patronized, women were 17 times more likely to deliver at such places as compared to places where their services are not needed (OR=17.0; 95% CI: 0.0-0.7; P= 0.012).



Table 4.4: Binary logistic regression on socio-demographic factors and place of delivery

Independent variables	Dependent variables	P –values	Odds ratio	95% confidence Interval
Male involvement in pregnancy	Place of birth	0.071	1.8	0.3 -1.9
Marital status (married; single)	Place of birth	0.081	2	1.0-2.0
Family support (yes; no)	Place of birth	0.012	1.3	0.5- 2.9
Knowledge of cultural factors (yes; no)	Place of birth	0.004	8.0	1.9- 2.2
Availability of TBAs in community (yes; no)	Place of birth	0.012	17.0	0.0-0.7
Occupation (formal; informal)	Place of birth	0.017	13.0	1.7-7.8

(Source: Field data, 2015)

4.5 Economic, geographic and other Bottlenecks that influence the choice of place of birth of women

4.5.1 Cost of transportation and medical bills

All the 250 respondents stated that cost of transportation to health centres and medical bills influence women’s choice of places of delivery. This suggests that though women may have the zeal to deliver in the health facility, their inability to foot transportation and medical bills may compel them to deliver at home.

4.5.2 Financial status of the family

All the 250 respondents affirmed the assertion that financial status of a family influenced where women would choose to deliver. As indicated in the socio-demographic characteristics, majority of the respondents are engaged in petty trading. This does not generate enough revenue for them to be financially sound so that they will be able to cater for the expenses that may arise when seeking health care from skilled providers. Women



may therefore have the zeal to deliver in the health facility but their inability to foot their bills may compel them to resort to home delivery. It is therefore not surprising all the respondents affirmed the assertion that the financial status of a family can influence where women would choose to deliver.

4.5.3 Distance and places of delivery

Findings revealed that 75% of the respondents stated that long distance to health centres compelled women to make the choice of delivering at home while 25% of them stated otherwise. The analyses revealed that women who were staying very far away from a health centre were 5 times more likely to deliver at home if occasioned by sudden onset of labour as compared to those who were staying very close to a health centre (OR=5.0). 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. 158 (63%) of the respondents indicated they were staying above 5 km from the nearest health centre while 92 (37%) respondents said they were staying between 0-5 km.

4.5.4 Cheap services rendered by TBAs

Finding from the study revealed that 35% of the respondents mentioned that cheap services provided by TBAs mostly in the same communities with women influenced them to choose the home as their preferred place of delivery while 65% respondents did not think cheap services provided by TBAs influenced choice of places of delivery by women.



4.5.5 Poor road networks

Findings revealed that, 37% of the respondents were of the opinion that poor nature of the roads linking communities to health centre influenced women's choice of places of delivery while 63% of them stated that poor roads may not necessarily influence a woman's place of birth.

4.5.6 Attitude of health care professionals

The analysis of the results revealed that most (86%) respondents stated that poor attitude of health workers affects women's choice of places of birth while 14% respondents said the attitude of health workers could not influence women to deliver at home. The huge percentage of women who have indicated the attitude of health care professionals can determine where women will opt to deliver suggests that these women in one way or the other might have not been handled well by the health care professionals during their previous visits.

4.5.7 Quality of services rendered

The quality of services rendered in the health facilities can influence where women would choose to deliver. Majority (85%) of the respondents identified poor health service provided at health centres as a factor that determines where women will opt to deliver while 15% of them held a contrasting view.

4.5.8 Husband's influence

Findings from the study revealed that (80%) of the respondents identified husband's influences to be associated with choice of places of delivery by women while 20% of



them stated that husband's position does not influence women's choice of places of delivery.

4.5.9 Level of education

Analysis revealed that 87% of the respondents said that the educational level of women could influence where they would choose to deliver while 13% of them said educational level of women was not associated with choice of places of delivery by women. According to them, women with higher education were more likely to deliver at health centres with the belief that they would be taken care of at the health centres as compared to less educated women who may not make the effort to deliver at health centres. The huge percentage of respondents who agreed to this assertion suggests that the educated women are more enlightened about the benefits of delivering at the health centers compared to their counterparts.

4.5.10 ANC Visits

Findings from the research revealed that majority of the respondents (55%) said that they attended ANC during their last pregnancy four times while 25% attended two times and 20% attended once. It is important to note that the number of times women go for ANC can influence where they choose to deliver. In some instances, the more women attend ANC, the higher the chances of delivering at the health center and vice versa. However, in some instances too, the more women attend ANC, the higher their chances of delivering at home because they feel they have acquired enough knowledge and experience to cater for the child delivery processes at home.



4.5.11 Level of satisfaction

Majority (85%) of the respondents indicated that they were not satisfied with the health care services they had ever received from the various health centres they had visited while 15% respondents however, stated that they were satisfied with the services they had received at the various health centres.



Table 4.5: Bottlenecks associated with places of delivery

Variables	Response	N (%)
Distance	0-5 km	92 (37%)
	5+ km	158 (63%)
Risks of home delivery	She may lose the baby	30(12%)
	Retention of placenta	33(13%)
	Woman may die	187(75%)
Attitude of health care professionals	Yes	215(86%)
	No	35(14%)
Level of education	Yes	218(87%)
	No	32(13%)
Poor communication	Yes	215(85%)
	No	35(15%)
Level of satisfaction	Satisfied	37(15%)
	Not satisfied	213(85%)

(Source: Field data, 2015)



Analysis of independent and dependent variables of some factors modeled after controlling for confounding factors revealed that there was no association between women's age and how often they seek health care at the health Centre when pregnant (X^2 , 1.334; $P=0.365$). There was also no association between respondents' occupation and how often they attend clinic to assess health care (X^2 , 2.314; $P= 0.311$). The study revealed that education was associated with where women could make the effort to deliver (X^2 , 0.003; $P=0.001$). The modeling also showed that respondents who went to ANC often were more likely to deliver at the health centres as compared to their counterparts (X^2 , 0.001; $P= 0.005$). It was also revealed that distance to the health centre was also related to where women could make the choice to deliver (X^2 , 0.004; $P= 0.112$).

4.6 Risks and other challenges associated with health care provision that bother on the choice of place of delivery

4.6.1. Risk of death

The study assessed risks associated with pregnancy and childbirth. Majority of respondents (75%) identified the fact that women may die as a risk factor associated with pregnancy, 12% respondents mentioned that pregnant women may lose their baby while 13% respondents said the placenta may be retained in the womb of the woman leading to birth complications.

4.6.2 Unsuccessful delivery at the health centre

It was noted by 55% of the respondents 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 them to make the choice to deliver at home instead of going to the health centres to deliver while 45% held a contrasting view.

4.6.3 Absence of health care professionals

It was revealed by 68% of the respondents that health workers may not be available at the time of labour at the health centres to assist the women and this may lead to death while 32% stated otherwise. The huge percentage 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 post as at the time their clients come.

4.6.4 Poor communication

Most (85%) of the respondents were of the view that poor communication by health workers may compel women to deliver at home or at TBAs home while 15% held a contrasting view.

4.6.5 Inadequate knowledge on the part of health care professionals

Other risk factors identified by respondents which bother on the choice of places of birth by women were perceived inadequate knowledge by health workers when managing pregnant women. Majority (75%) of the respondents indicated that inadequate knowledge on the part of health care professionals can influence women's choice of places of delivery whereas 25% think otherwise. It is an undeniable fact that some people may choose certain professions not because they are passionate for the job but because of financial gains associated to it. We are also living in an era where priority is placed so much on academic excellence which is usually manifested in the 'grades and classes' students obtain at the end of their course of study. Many professionals may therefore



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employ route learning and come out with excellent results but they may not be well equipped with the requisite skills to perform up to expectation in the field of work.



CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter discusses the main findings of the study and relates them to the appropriate literature. The main aim of the study is to examine the factors associated with choice of places of delivery by women. This study explores social, economic, geographic, cultural beliefs and risk factors underpinning pregnancy and child birth by women.

5.2 Socio-demographic characteristics and choice of place of delivery

5.2.1 Marital status and place of delivery

The findings from the study revealed that women who were married were 2 times more likely to make the choice to deliver at a health centre as compared to those who were not married (OR =2.0; 95% CI: 0.9– 4.2; P= 0.089) This could suggest that married women could have been receiving some form of social and financial support from their partners and that could account for their comparative advantage of being more likely to deliver at a health centre over their single counterparts. Furthermore, the unmarried women may also fear the stigma of single parenthood and therefore tend to stay at home to deliver. This finding from the study supports the study done by the following researchers Kabakyenga (2012) & Adeyemi (2007). These researchers in their separate findings revealed that women who were married and were staying with their husbands were more likely to make the choice to deliver in a health centre as compared with women who were not married but got pregnant. Their findings showed that married women were more likely to be assisted by their husbands in terms of transporting them to the nearest health



centre in times of need and were more likely also to be assisted by the husband's family members even in the absence of the husband. However, this finding, did not support the findings by Berman (2000) where marital status of a woman did not influence women's choice of places of delivery. His findings indicated that the most important factor influencing women's choice of places of delivery was the personal likes of the woman which would determine where she chooses to deliver.

5.2.2 Age and choice of delivery place

Analyses revealed no statistical relationship between respondents' age and their choice of places of birth ($P=1.36$; $X^2=1.23$). This finding from the study supports the findings presented by Ochako (2011) in Kenya where age of women was not considered significant when it came to where they wanted to deliver their next child. Even though the study could not establish any correlation between age and the choice of places of delivery, older women were more likely to deliver at home especially if they have had previous home deliveries successfully as compared to the younger women who perhaps would be afraid to make the choice to deliver at home. Since some of these older women might have had successful home delivery previously, they may claim they have enough experience in home delivery. Another reason for this could be because many older women regard themselves as experts in matters concerning childbirth. It may therefore seem ridiculous for them to go to the healthcare facilities to be aided in child delivery by staff they consider far younger and less experienced than themselves. However, we cannot run away from the fact that some of the elderly women may opt to deliver at the health facility due to the fact that they consider themselves weak and will need assistance from skilled care providers, should complications arise during labour and child delivery.



The young women may also consider their exuberance and opt for home delivery. These young ones may think they have enough energy to endure pain and contain any eventuality that may arise.

5.2.3 Occupation and choice of place of delivery

The analyses however, revealed a strong statistical relationship between respondents' occupation and their choice of places of birth. It was revealed from the survey that those who were employed in the formal sector were 13 times more likely to make the choice to deliver at health centre as compared to their counterparts who were not employed. (OR=13.0; 95% CI: 1.7-7.8; P=0.017)

This could be accounted for by the fact that most respondents in the formal sector have better working conditions and are assured of regular income at the end of the month as compared with those in the informal sector. These women who are employed and probably earning income regularly are more likely to make their own decision concerning where they preferred to deliver, and were also more likely to be able to transport themselves to health centres to seek health care. Besides, these gainfully employed women could bear the cost of the necessary items the health care providers usually request during labour and child delivery. For example, expectant mothers are usually required to bring specific quantities of items like Dettol, soap, sanitary pads, clothes, pampers, just to mention but a few. This finding from the study supports the findings made by Kabakyenga (2012) and Adeyemi (2007) where income level of women was considered as the most significant factor associated to where women could deliver their next child. The results indicated also that women who were employed were more likely to finance their own cost of health care if their partners were not in agreement to support



them. Personal income of women has been seen to be a key determinant for them opting to go to health centres to deliver. Findings are similar to Hulton (2007) where women with a personal source of income were more likely to deliver in a health facility and be assisted during delivery by a skilled birth attendant as compared to those with low or no income. According to Hiluf and Fantahun, (2007); Ochako, (2011); Kabakyenga, (2012) women with a personal source of income have better power to make their own decision in matters related to their health and the expected expenses could be paid by them as compared to women with low or no income.

Findings from Cotter *et al.*, (2006) also indicated that husband's occupational status has also been found to have an influence on the place of delivery as wives of employed husbands tend to deliver at the hospital. Among 137 mothers who delivered in the hospital, in Nigeria, 126 of them (92%) mentioned that, their husbands were engaged in one occupation or the other.

5.2.4 Ethnicity and place of delivery

As to whether ethnicity has anything to do with a woman's choice of place of birth, majority of the respondents representing 75% disagreed with the statement while 25% of them agreed with the statement, indicating that there was a correlation between ethnicity and women's place of birth. Further interrogation to know if specific ethnic groups could be mentioned, most (23%) of that category identified the Fulanis who according to them taboo allowing people to see their private parts during delivery. This is similar to was discovered by Issah, (2010) that most Fulani pregnant women (80%) preferred to deliver at home instead of health facility because their culture does not permit their private parts to be seen during child birth and they were not treated properly at health centres while



20% respondents however, mentioned that their preferred place of birth would have always been health centres long distances to the health centres do sometimes prevent them from walking to the place especially if they are in labour. The Fulanis are pastoral people, making them the largest nomadic pastoral community in the world and inhabit several territories. They herd cattle, sheep and goats. In virtually every area of West Africa where nomadic Fulanis reside, there has been an increasing trend of conflicts between them and farmers. These conflicts might have created some kind of bad relationships between the Fulanis and other tribes. It might be as a result of it they claim the health care professionals do not treat them well when they go to the health centre to deliver.

5.3 Social and cultural beliefs and factors underpinning pregnancy and child birth by women

5.3.1 Knowledge on social and cultural factors underpinning pregnancy and child birth

Results of the study indicated that 64% of the respondents said there were cultural and social factors underpinning pregnancy and where women should go and deliver their babies. The implications of such a huge number of respondents affirming the belief that cultural factors influence choice of places of birth is mind boggling as this may influence women to make their choice of places of delivery based on these cultural beliefs. This finding agrees with the findings made by Abbey (2008) that certain cultural practices were still underpinning pregnancy and childbirth in Ghana especially in rural communities. For instance, it is believed in the study area that pregnancy is considered as secrete between the pregnant woman and her close family. It is not supposed to be





disclosed to anybody outside the marital home until it attains a certain stage and rituals performed to outdoor it. This particular belief by the people in the study area affects the time pregnant women commence ANC attendance. Antenatal care is an essential part of pregnancy as should commence as you as a woman is expecting. Early commencement of antenatal care allows for early detection of certain complications such as hypertension and diabetes so they can be properly monitored and treated. Besides, it helps expecting mothers to gain insight and get fact-based information on pregnancy, birthing options, breastfeeding and caring for new born baby so they can make informed choices. However, the late commencement of ANC sometimes paves the way for expecting mothers to suffer complications that could have been avoided. Furthermore, it is believed that during pregnancy, the woman has to stay away from certain foods in order to sustain the pregnancy as well as delivering a child with the desired character. During pregnancy, women are therefore prohibited from consuming some foods such as eggs. The practice of making pregnant women refrain from eating eggs can be injurious to the health of the mother and baby. Eggs are good sources of calories, high quality protein and fat, many vitamins and minerals. They are also great source of choline which is vital for many processes in the body including brain development. Low intake of choline during pregnancy may increase the risk of neural tube defects and possibly lead to decreased brain function. It is worth noting that the myth behind denying pregnant women from eating eggs is to prevent them from giving birth to thieves. However, it has been established that low intake of choline may lead to decreased brain function hence a gateway to giving birth to children who may eventually become thieves. If their brains do not function well and they are not able to excel academically, they may resort to armed robbery and other vices. Another belief upheld by the people in the study area is that,

during pregnancy, women are expected to avoid looking at scary creatures or carvings in order to reduce the chances of the baby looking like those creatures. Despite the fact that this is also a cultural belief, it does not impact negatively on the woman and the baby. It is therefore important to let the people who still hold onto to their cultural beliefs to understand that, though, they may not be able to do away with these practices completely, it is advisable to practice those that impact positively on them and relegate those that impact negatively on them to the background. A similar result was obtained from a survey conducted by Institute of Public Health (2006) in Uganda, concerning pregnant women's knowledge of cultural factors affecting pregnancy and child birth. It was discovered that 90% of the pregnant women stated that they were aware that cultural factors affect their choice of place of birth while 10% stated otherwise.

This finding from the study is also similar to the findings presented by Adam and Salihu (2002) where it was revealed that women would choose home as a preferred place to deliver particularly where there were strong beliefs and cultural practices on pregnancy and childbirth. Furthermore finding collaborates with the findings by Maureen and Peter (2008) where women in Tanzania were so much adhered to cultural beliefs that they did not want to go to a health centre to deliver because health workers were seen as strangers and conducted deliveries in a manner they were not used to. A study conducted in Nigeria, by Abyot and Asres, (2010) showed haemorrhage was considered normal for cleansing the mother after delivery. Such a practice prevented women from seeking health care in the health centre even if they had successfully delivered at home with any recognized complications. Once these women considered haemorrhage as a natural cleansing mechanism, they could bleed and become anaemic or even die but would not make any conscious effort to seek health care at the health centers.



5.3.2 Home delivery means woman was faithful to the husband

Among respondents who knew the cultural beliefs affecting childbirth, 62.5% stated that safe home delivery means the woman was faithful to the husband. According to them, this motivated women to deliver at home to prove that they have been faithful to their husbands. This finding from the study is similar to the findings made by Mpembeni, *et al.* (2007) & Ochako, (2011) where in northern part of Tanzania, women believed that those who are faithful to their partners can have normal delivery at home instead of the health facility. Delivery should only be conducted at health facilities when complications set in.

5.3.3 New born baby is not to be seen by everyone

Few (25%) of the respondents mentioned that not everyone is supposed to see the child when newly born. This makes women to choose home as their preferred place of birth. This finding from the study is similar to the finding made by Borghi *et al.*, (2006); Birungi, & Ouma, (2006) where women in Tanzania believed that not everyone was supposed to see the newly born child for fear of bad people casting their evil or bad eyes on the child. This compelled many women with such cultural beliefs to deliver at home to prevent people from coming to see the baby early. It is even stated that sometimes neighbours were not informed of it until a period of time that they would be informed to now come and congratulate the woman. This belief by these respondents would necessarily compel them to deliver at home so they could have the opportunity to prevent people from coming into contact with the baby during the early days. This attitude and belief of these respondents could have a lasting effect on maternal and child health since these periods usually marked a time of seclusion from the public. Once, the baby and the mother are not usually allowed to be seen in public, it implies that any complication that



may set in during this time, will not receive attention from any skilled personnel. This finding from the study supports what Bolam *et al.* (1998) found in Tanzania that cultural factors were making it difficult for women to deliver at health centres as they would not be allowed to do certain rituals in the health centre environment. It also similar to the findings that certain cultural practices were common among Ghanaians especially in rural communities where a newly born child has to be anointed with oil from a cow horn to prevent witches and bad people from harming the child. In certain communities in Northern part of Ghana, these rituals are so pronounced that even if a woman delivers in the health centre, these rituals would usually be performed in the health centre secretly or given to the woman to do if the health workers were preventing family members from coming to see the woman. They mentioned that women do so with the intention of protecting their babies from witches, fear of losing their babies, for spiritual protection and at most times to dedicate their babies to God.

5.3.4 Prolonged labour means woman was unfaithful to the husband

According to the research findings, respondents did not believe prolonged labour by women was a sign of unfaithfulness on the part of the woman since majority (73%) of the respondent did not agree with this assertion. According them, many factors may account for a delay in delivering and not merely based on the fact that women were unfaithful to their partners. Prolonged labour can stem from inexperience on the part of the women who are delivering for the very first time (the primigravidae). These women may not have in-depth knowledge on the signs of labour and may complain of labour pains earlier than expected meanwhile they may not be due. However, those who think prolonged labour is due to unfaithfulness attributed this as a form of punishment by the gods to women who



engaged in extra marital affairs. Besides, they mentioned that the duration of labour can sometimes depend on the age of the expectant mother. Labour can be prolonged in older women because their system have become weaker than the younger ones and not necessarily that they were unfaithful to their husbands. The health care professionals also indicated that prolonged labour may not necessarily mean that women were unfaithful to their husbands. They enumerated possible causes of prolonged labour such as the baby being too big and cannot move through the birth canal, the baby assuming an abnormal position, usually head-down facing the expectant mother's back, the birth canal being too small and the baby cannot move through it, the expectant mother's pelvis being too small and the contractions of the woman being very weak. The findings collaborate with a study conducted by Adeyemi (2012) among women in Kenya which 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. However, finding from the study is at variance with the findings made by Mbaruku and Msambichaka (2009) where women in Thailand who were sampled as study participants did not know of prolonged labour associated to woman's unfaithfulness and choice of places of delivery.

5.3.5 Home delivery means bravery

It was revealed by majority of the respondents (62.5%) that women who made the effort to deliver at home means those women were brave while 37.5% Of the respondents held a contrasting view. They held onto the belief that only weaker women who could not endure pain went to the health facility to deliver. This finding from the study agrees with the study done by Hazemba and Siziya (2010) where women stated that home delivery was a sign of bravery on the part of the woman. Culturally, most women in certain



communities today still hold onto the belief that women who make the effort to deliver at home exhibit bravery. The brain behind this is that labour pains and child delivery act as a test that women must endure to prepare for challenges of motherhood. Furthermore, polygamous marriage is practiced in the study area and rivalry among women tends to gain grounds. Women prove their ability to endure pain by choosing to deliver at home. They consider other women who opt to deliver at the health centre as weaker ones. This compels a lot of women to opt for home delivery since they don't want to be tagged as such. It is worth noting that sometimes when misunderstanding ensues between rivals, one can even insult the other as being coward and weak if she has ever delivered at the health facility. Apart from the fact that women who deliver at the health facilities are considered weak, the children who are born at the health facilities are also considered weaker than their colleagues born at home. The belief held by them is that during delivery, the child will have to fall to the ground and this is what will harden his or her body and head and will in turn make him or her a strong man or woman when they grow. During a focus group discussion, one of the women stated that *“a child born a health facility will grow to be weak, a child must hit the body to the ground during delivery so that nature will confer strength on him or her for the rest of his or her life”*

5.3.6 Personal likes and dislikes and place of delivery

Findings also revealed that (76%) of the respondents mentioned that personal likes and dislikes of women about a place of delivery could influence a woman's choice of places of delivery while 24% of them said they do not believe personal likes and dislikes of a woman could influence a woman's choice of places of childbirth. “Probing further, respondents mentioned things they classified as personal likes as, squatting to deliver,





delivering in the privacy of only family members, administering local medicine popularly known as “kalgu tim” to facilitate the delivery process. Findings revealed that women were much happy, being surrounded by their family members at home to deliver. Women see the hospital setting as a new environment and therefore, do not feel comfortable in the presence of new faces especially during labour and child delivery. They feel the presence of family members boost their morale and confidence and therefore eases the delivery processes at home than in the hospital setting. According to them, squatting to deliver affords them an opportunity to push with ease as compared to when they are made to lie down. Furthermore, they mentioned that when you allow many people to see the new born baby, there is a likelihood that the baby will die because some people will cast ‘evil eyes’ on the child. They also held the view that the local medicine they administer during labour eases their pain and make them deliver easily and quickly. They mentioned the following as personal dislikes such as regular vaginal examination by nurses and midwives, the posture the nurses let them assume, which is the supine position (lying flat on their backs during delivery), bad smell in the labour ward/hospital setting and delivering in the presence of many people in the labour ward.” This finding from the study supports the study done by Idris et al., (2006) where women in Zaria, Nigeria stated that the personal likes and dislikes were factors influencing where women could make their choices to deliver their next child. A study to ascertain why pregnant women in Syria were delivering at home, it was observed that most of them liked being surrounded by family members and friends during labour. However, they did not like the vaginal examination by health workers (Bashour & Abdul Salam, 2005).

5.3.7 Woman's health seeking behaviour

Seeking health care during pregnancy has been linked to how one perceives the health condition as being critical or not. Culturally, most women consider pregnancy as a disease and when they are pregnant find it very difficult to do any work including having to travel to seek health care. Findings from the survey revealed that 70 % of respondents mentioned that they usually go to the health centre when their condition was critical, 20 % of them said women have been going to the hospital always even if they were not in critical condition while 10% of respondents said women rarely go to hospital except on ANC visits. This finding from the study disagrees with the report made by Cotter, *et al.* (2006) where it was revealed that all pregnant women went to health centres regularly in Kenya to assess the state of their health and their baby.

5.3.8 Community norms and place of delivery

Community norms were also assessed to know the extent to which these could influence a woman's choice of place of delivery, 90% of the respondents mentioned that community norms could influence a woman's place of birth while 10% respondents said they do not believe community norms could influence a woman's place of birth. The huge percentage of the respondents who agreed that community norms can influence where a woman chooses to deliver suggests that the traditional practices of the people in the study area are still rooted deeply in them. Among the former, respondents mentioned that women are made to deliver at TBAs houses due to the fact that others had successfully delivered at such places as compared to the health facilities. This finding from the study supports the study done by Idris *et al.*, (2006) where community norms motivated women to deliver in the confines of their homes with assistance from TBAs. It is also similar to the findings



made by Abbey (2008) where women in Uganda and Kenya thought that home delivery was just normal and saw nothing wrong with women delivering at home. It is worth stating that home delivery may present complications such as prolonged bleeding after delivery which may lead to death of the woman.

5.3.9 Preferred place of delivery

All the 250 respondents stated that their preferred place of delivery for women is the health centre. They mentioned some reasons that informed their preferred place of delivery, the health centre. They believe that when a woman delivers at the health centre, management of any complication would be done effectively by the nurses and midwives as they are trained to do as compared to the home where a woman may not get the proper care after delivery and this may lead to death. They also said when a woman delivers at the hospital, she is given advice on postnatal practices on nutrition for the mother and the baby, care of the mother and the baby. According to them, when they deliver at the health centre, they are also given education on common signs of infections in the mother and the baby and this enables them to seek early attention when these signs occur. This finding from the study supports the study done by Mbaruku *et al.* (2009) where most women preferred to deliver at the health facilities. According to them most people strongly advocate that women should be encouraged to deliver at health centres to prevent any birth complications which may lead to death.

It is important to note that 90% of the health staff category interviewed revealed that women prefer to deliver at the health centres centre while 10% of them indicated otherwise. However, they mentioned that despite that fact that women prefer to deliver at the health facilities, the skilled delivery rate does not commensurate the rate of ANC



attendance because certain factors like distance to the health centers, poverty and poor road networks prevent women from seeking skilled delivery from them.

5.3.10 Availability of TBAs and place of delivery

In the study area respondents believed that the availability of TBAs culturally influenced women to deliver at home. Most (65%) of the respondents stated that the presence of Traditional birth attendants in their communities influenced their choice of delivery places while 35% had a contrasting view. The TBAs understand the norms and cultural beliefs and practices of the women and this makes most of them patronize their services. Besides, they indicated that the TBAs give them better treatment since they do not shout at them during labour and childbirth. Also, they said the TBAs know the norms and cultural practices and do not violate them when they are assisting them to deliver. This finding from the study supports the findings made by Kowalewski *et al.*, (2002) and Birungi and Ouma (2006) where the presence of TBAs in communities motivated women to deliver at home with their assistance. They believed that they are capable of conducting delivery very normal and very successful.

TBAs have traditionally been assisting women during child birth for centuries in Ghana here. They do not only give community members delivery services, but with emotional support and practical assistance before, during and after the birth. TBAs are cherished members of the community and can be more influential than health care professionals in terms of where women would choose to deliver. It is vital to note that in most of the rural communities the only time some women would resort to delivering at the health facility is when a TBA gives a recommendation.



5.4 Economic, Geographic and Bottlenecks that influence the choice of place of birth of women

5.4.1 Cost of transportation and medical bills

All the 250 respondents stated that cost of transportation to health centres influence 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 from the study supports the study done by (Khalid, *et al.*, 2006; Adeyemi, 2007; Envuladu *et al.*, 2012) where income status of women was a major factor influencing women's choice of places of birth. This finding from the study is also similar to the findings made by Olatunji and Sule-Odu (1997) where women with high income would choose to deliver at health facility because they could afford to pay costs associated with skilled delivery care. Less advantaged women with low income who could not afford transportation cost were more likely to deliver at home.

5.4.2 Financial status of the family

Respondents stated 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. Respondents also 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 lack of money. This finding from the study supports the study done by the following researchers (Amooti & Nuwaha, 2000; Adeyemi, 2007; Abyot & Asres, 2010) where 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, 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 bill had to rely on friends and family members for assistance and most were compelled to deliver at home (Abyot & Asres, 2010). Furthermore finding from this study is in line with what was found by Kabakyenga, (2012) & Adeyemi, (2007), where 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 occupations of the husband and wife. Women who are working and earning money may be able, to save and decide to spend it on a facility delivery as compared to those who are not working

5.4.3 Distance and place of delivery

Long distance 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 the home because of long distance to the nearest health centres. The analyses revealed that women who were staying very far away from a health centre were 5 times more likely to deliver at home if sudden labour occurred as compared to those who were staying very close to a health centre (OR=5.0). Findings revealed that 75% of the respondents stated that long distance 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 car 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 car or motorbike to the health centre. Others held the view that women sometimes deliver on their way to the health facility due to a 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 distance to health centres negatively influenced choice of places of child birth. This finding from the study supports the study done by Olatunji and Sule-Odu (1997) where long distances to health facilities especially in rural communities prevented women from going to the health centre to deliver. It also supports the study done by (Khalid, et al., 2006; Adeyemi, 2007; Envuladu et al., 2012) where 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 play a major role on where women choose to deliver. When the health facility is located far away from the residence of women, they 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 on motorbikes and bicycles. Sometimes women deliver on their way to the health facility because of long distance. 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 going there at that time of the night. Unreliable transport system especially at rural communities is a serious barrier to access 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

5.4.4 Cheap services rendered by TBAs

Cheap services rendered to women by TBAs have an impact on where they choose to deliver. Though majority of the respondents (56%) indicated that they 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, 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. Most women rely on the services of traditional birth attendants simply perhaps they are readily available, affordable and accessible. Traditional birth attendants have been identified 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 from the study supports the study done by Ogunlesi, (2005) where 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.



5.4.5 Attitude of health care professionals

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

This finding from the study supports the study done by (Olatunji, & Sule-Odu, 1997 Khalid & Daniel, Lale, 2006 Kanga et al., 2012) where the perceived poor attitude of health workers were preventing 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' attitude towards women has been a major obstacle to women seeking health care. In many studies, women have identified 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 health care delivery unit. It is totally an unfamiliar and scaring environment to those who think that deliveries at health centres can cause death (Khalid, & Daniel, Lale, 2006; Envuladu *et al.*, 2012).



This causes women to be scared and insecure because they don't know what the purpose of all the equipment and procedures are. Kamga *et al.*, (2012); Hazemba, & Siziya, (2009); Ogunlesi, (2005) indicated their separate researches that since the hospital environment may create some form of uneasiness to 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.

Therefore, health workers' interpersonal relationships with women is important factor influencing women's choice of places of delivery. The huge percentage 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 during pregnancy and child birth 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 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 of the pregnant women consider to be abuse by the health care providers is not really so. The nurses and midwives have various ways of motivating the woman to deliver as labour progresses. One of the strategies they employ especially when the woman is 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 the health care providers, this is done just to save the lives of the baby and the mother. Unfortunately the women describe the acts as 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.

5.4.6 Quality of services rendered

It was also revealed that 85% of the respondents identified poor health service provided at health centres while 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 one researchers 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 health care 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); Amooti and Nuwaha, (2000) where patients often complain about poor quality of services in public health care 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”.

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, prefer to deliver at home instead of delivering at health facility (WHO, 2004)

5.4.7 Level of education

The level of education attained by women can influence where they will choose to deliver. It is therefore not surprising that majority (87%) of the respondents said the educational level of women could motivate them to deliver at health centres and only few (13%) of them think otherwise. The greater percentage of respondents who agreed that educational level of women influence 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 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 sudden onset of labour at home. Furthermore, the 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 last



successful home delivery. This finding is similar to that those found by Abbey, (2008); Olatunji and Sule-Odu, (1997); Hiluf and Fantahun, (2007) which indicated that women with higher education have strong desire for choosing a health facility to deliver as compared to those with less education. This finding from the study also supports the study done by Adeyemi, (2007); Olatunji and Sule-Odu, (1997) where educational level of women was a strong factor which motivated them to seek ANC services regularly and possibly made the effort to deliver at health centres. It is vital to note that these educated women are enlightened on the effects of some of social and cultural practices on their health. They would therefore 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 & Siziya, (2010) & Kabakyenga, (2012) where they argued that education has no link with where a woman chooses to deliver.

5.4.8 ANC Visits

Furthermore, it was also revealed by the respondents 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 remedy as and when the need arises. They are sensitized on the dangers associated with home delivery. Findings from the research revealed that majority of the





respondents (55%) said they attended ANC during their last pregnancy 4 times. This finding from the study supports the opinions expressed by most of the women during focus group discussion that they have attended ANC at least four times during their previous delivery. It 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 antenatal 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 long distance to health facility and lack of money to transport themselves to health centres. The findings of this study is similar to those of Marjolein (2003) where 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 less visits, & (Mesko, 2004) where 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. Researchers observed that over 90% of pregnant women do attend ANC at least once during pregnancy. ANC attendance has only been linked to help pregnant women to make appropriate birth plans but does not necessarily attract them to come and have childbirth in the same health centre as it would be expected (WHO, 2010). Despite the high number of pregnant women who attended ANC in Kenya, a lot still preferred home delivery. 74% of pregnant women attended

ANC and yet up to 39% chose home delivery in the index pregnancy. 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 and 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).

5.4.9 Husband's influence

Result from the study affirms the view that (80%) respondents identified husband's influences on 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 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' decision and had to always listen to their husbands before they would act. Respondents 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 caesarian section is to be conducted or when there is 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 majority 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 most key person in the decision-making process.

5.5 Risks and challenges associated with health care provision that bother on the choice of place of delivery

5.5.1 Risk of death

The study also assessed risks associated with pregnancy and childbirth. Majority of respondents (75%) identified the fact that women may die as a risk factor associated with pregnancy, 12% respondents mentioned that pregnant women may lose their baby while 13% respondents said the placenta may be retained in the womb of the woman leading to birth complications. The finding is line with what found by Bashour and Abdul Salam, (2005) The study was to examine women's knowledge on risks associated with pregnant women delivering at home, it was revealed that 56% of the women mentioned that it was risky because the woman may die, 20% said the placenta may remain in the womb for long time while 24% of them mentioned that the baby and the mother may die during child birth. In a related studies (WHO, 2010) indicated that in developing countries, millions of women and newborns die or experience serious health problems related to pregnancy and childbirth each year and this sometimes result in permanent disability or death. Other known risk factors associated to places of delivery is the issue of prolonged bleeding which is usually considered as a natural way of cleaning the woman especially if the woman delivers at home.



5.5.1 Unsuccessful delivery at the health centre

There are instances where child delivery in the health facilities may not be successful and result to either the death of the mother, child or both. 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. 45% of the respondents think otherwise. It is an undeniable fact that we are recording a lot of maternal and child deaths in our health facilities. Sometimes, negligence on the part of the health care 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 the health facilities. Surprisingly, when complications arise, there may not be 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 expectation 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 of what accounted for the unsuccessful delivery. This finding from the study supports the study done by (Olatunji & Sule-Odu, 1997; Khalid *et al*, 2006; Kamga *et al.*, 2012) where most women opted for home delivery because health centres were seen providing poor services to women which led to loss of lives.



5.5.2 Absence of health care providers

It is an undeniable fact that sometimes, clients may go to the health centers and there may be no health care 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 by either the mother, child or both. One of the women remarked during 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 which may be new to them and there is no one to assist them. The huge percentage 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 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 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 post or get there late. Women may therefore go to some health facilities and nobody may be present to attend to them. Other times, they may wait for longer periods before the arrival of the health care professionals. Women therefore consider this phenomenon to be risky. Findings from the study supports a study carried out 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 and Sule-Odu, 1997; Mahdi et al., 2010; Abbey, 2008) indicated that it is particularly important that all births are attended 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.

5.5.3 Poor communication

Majority of the respondents (85%) were of the view that poor communication by health workers may compel women to deliver at home or at TBAs' home. The Ghana Health Service recognizes this and indicated that because the reaction of women surrounding pregnancy and labour vary from excitement to fearful expectations, the nursing care that is provided to them is so important (GHS, 2007). Researchers have therefore advocated that it is the responsibility of midwives to inform and educate them 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 procedure conducted, to protect the autonomy of the client. Each client needs full explanation of the benefit and risks to herself and to her unborn baby, in a language she understands most. More often than not, some of the health care providers do not communicate properly with the expectant mothers and they do not usually understand why certain procedures are to be carried out on them. Some of these health care 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 care givers if they fail to involve them.

Poor communication can take various forms ranging the instructions health workers give to clients and even among themselves. Patients' perception 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 for their clients before carrying out certain operations on them. Once clients are not given 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 way of administering the medications that may be given to them and they see it as risky. Furthermore, healthcare professionals sometimes do not properly keep records on their clients and any other person who takes over may find it difficult to continue with the remaining procedures. This is equally seen to be risky.

5.5.4 Level of satisfaction

Results from the study revealed that 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 were receiving from the various health centres, it could influence them to make the voluntarily choice of delivering at home with assistance from TBAs. This finding from the study supports the study done by the WHO (2010) where 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, can be attributed to the work load that health workers have to deal with daily.

These observations suggest the existence of factors that do 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 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 establishment of more health training institution 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.

Respondent mentioned long waiting time before being attended to by health workers at the health centres especially on ANC days as a factor influencing their level of satisfaction. It was also indicated that sometimes inadequate medications were given to them while 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 and may substitute a particular drug to them which may affect their health.

5.5.5 Lack of privacy

This study revealed that 75% of the respondents expressed the view that lack of privacy during delivery could influence women's choice of place of delivery while 25% of the respondents stated that privacy during delivery may not influence women to deliver at home. One of the respondents remarked during focus group discussion that "*All pregnant*



women need 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 child birth” This finding collaborates with what Cotter *et al.*, (2006), Abyot & 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.



CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter, constitutes a summary of the finding from the study, conclusion and recommendations.

6.2 Summary of findings

This study revealed that all the respondents chose hospital as their preferred place of. Respondents mentioned that the selection of choice of place for delivery by women is influenced by a number of factors including: social and cultural beliefs, inadequate finance to pay for transportation to health centres, fear of operation at the health centre, repeated vaginal examination, level of education, parity, age of the mother, long distance to health centres and availability of TBAs in the communities.

From the study also, poor roads linking communities to health centres, poor attitude of health workers towards clients, cultural practices and inadequate knowledge of health care providers on management of birth complications were also contributory factors to women delivering at home. It was indicated that modernization has changed the perception of respondents concerning certain beliefs and cultural practices related pregnancy and childbirth. Furthermore, 37% of the respondents stated that the nearest health centre to their homes was estimated to be between 0-5 km while majority (63%) of respondents estimated the distance to be above 5km.

The study also assessed risks associated with pregnancy and childbirth. Majority of respondents (75%) identified the fact that women may die as a risk factor associated with pregnancy and child delivery, 12% of the respondents mentioned that pregnant women



may lose their baby while 13% of the respondents said the placenta may be retained in the womb of the woman leading to birth complications. Respondents mentioned TBAs, spiritual camps, health centres and home as places women go to deliver.

6.3 Conclusion

The main objective of the study is to assess the factors associated with choice of places of delivery by women. Findings from the study suggest that social and cultural beliefs and practices were still traditionally rooted in the minds of most people living in rural communities the study area which is negatively influencing women to make the choice to still deliver at home. The study also revealed that those who did not know of any cultural and social factors associated with choice of places of delivery were 8 times more likely to ignore such cultural practices and make the effort to deliver at health centres compared with those who knew such cultural practices.

The findings also showed that women who were married were 2 times more likely to deliver at the health facility compared to the unmarried ones. The analyses showed that communities where TBAs are highly patronized women were 17 times more likely to deliver at such places as compared to places where their services are not needed. The analyses revealed that women who were staying very far away from a health centre were 5 times more likely to deliver at home if occasioned by sudden onset of labour as compared to those who were staying very close to a health centre. There was also no association between respondents' age and choice of place of delivery. The study revealed that there was statistical significance between education and place of birth. The study also showed that respondents who went to ANC often were more likely to deliver at health centres as compared to their counterparts.



Even though respondents stated that their preferred place of delivery is the health centres, certain social and cultural beliefs underpinning pregnancy and childbirth, socioeconomic and geographic factors still make them deliver at home and spiritual centres. If these issues are not addressed, they could still have negative impact of maternal and child health in the study area.

6.4 Recommendations

Based on the findings from the study, the following recommendations are made to assist the authority, policy makers, health workers and organizations interested in improving women's delivery in health centres especially in rural communities in Northern region and in Ghana.

To the Ministry of Health/ Ghana Health Service

Organize programmes to sensitize health workers on positive behavioral attitudes towards their clients. Since quality of care, support, privacy and comfort were the major issues that motivated women to deliver at the health facilities, stringent efforts should be put in place to ensure that health care providers at all levels improve on their attitudes right from the entry point to exit point so that their client will be satisfied always and be willing to come back when they want to deliver and again as well as, advice others who for some reasons or due to their previous experiences would not want to come to the health facility rescind their decision and visit the health facility for care.

Health authorities should continuously monitor the health workers' professional conduct and disciplinary procedures for staff should be instituted to improve their behaviour.



To the Municipal/ District Health Directorate

Intensify education aimed at increasing family involvement in selecting the right place for women to deliver with minimal risk. There should be robust public health education in the rural communities of the Savelugu/Nanton Municipality to build up the confidence of the people in the institutional health care system. This will go long way to inculcate some sense of ownership in the people to own and as well patronize the health facilities, where obstetric complications could be diagnosed early enough for the necessary interventions. Public health education is vital, giving the low literacy rate in Savelugu/Nanton Municipality which affects choices and preferences for quality of care.

The district planners for health services should focus on ensuring that drugs and supplies that are required for pregnant women to deliver well are always sufficiently stocked. The necessary infrastructure meant to cater for issues of women should be improved upon to meet their expectations whenever they visit the health care facilities.

Organize frequent in-service training for the staff of health facilities on communication and good interpersonal relationship with their clients and endeavour to provide services that meet the expectations of these clients.

6.5 Research gap

A study should be conducted to evaluate the causes of unethical and unprofessional behaviours of trained health workers in public health facilities, in order to suggest appropriate ways and means of effectively dealing with these unethical and unprofessional behaviours.



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APPENDIX I: Questionnaire for Expectant Mothers and women

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF ALLIED HEALTH SCIENCES

Questionnaire for Expectant Mothers: examining the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality

Informed consent

My name is ----- I am a student of University for Development Studies. I am conducting a study on examining the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality. I would very much appreciate your participation in this study. This information will help the government and other decision making bodies in the country enact policies that will help improve this situation.

The discussion will take between 10 to 20 minutes usually to complete. Whatever information you provide will be kept strictly confidential. In this survey, participation is voluntary and you can choose to answer any/some or all the questions or withdraw at any point in time should you decide to do so without any consequences. However I hope that you will participate in this study since your views are important.

Section A: Socio-demographic characteristics of respondents

1. Age (years).....
2. Marital status (A) Single () (B) Married () (C) Cohabiting () (D) Widow () (E) Divorced () F. others (specify).....
3. Religious status (A) Islam () (B) Christian () (C) Others (specify).....
4. Educational qualification (A) BSc. () (B) Masters () (C) PhD () (D)



Others (Specify).....

5. Ethnicity (A) Dagomba () (B) Gonja () (C) Konkomba () (D) Others (specify).....
6. Occupational status (A) Traders () (B) Public servant () (C) others (specify).....
7. Where did you deliver your last child? (A) home () (B) Hospital ()
8. Where do you prefer to deliver your next child? (A) Home () (B) Hospital () C. others (specify).....
9. If any why.....

Section B: Social and cultural beliefs and factors underpinning pregnancy and child birth

10. Do you know cultural beliefs and practices that affect pregnancy and child birth in your place? a. yes () b. no ()
11. If yes can you mention them
12. Will you consider the following as major social and cultural beliefs and factors underpinning pregnancy and child birth in your community?
 - a. Prolonged labour means unfaithfulness a. yes () b. no ()
 - b. Home delivery means the woman is brave a. yes () b. No ()
 - c. Successful previous home delivery means subsequent ones will be successful a. yes () b. no ()
 - d. Relatives' influence a. yes () b. no ()
 - e. Community norms and beliefs a. yes () b, No ()
 - f. Personal likes and dislikes a. yes () b. no ()
 - g. Location of the health facility a. yes () b. No ()



- h. The ethnic background of the woman a. yes () b. no ()
- i. Marital status of the woman a. yes () b. no ()
- j. Attitude of the woman towards others a. yes () b. no ()
- k. Fear of death a. yes () b. No ()
- l. Fear of operation a. yes () b. no ()

Section C: Economic, geographic and other bottlenecks that influence the choice of place of birth of women

13. Do you know factors that influence pregnant women's choice of delivery?

a. yes () b. no ()

14. If yes can you mention them.....

15. Will you consider the following as economic factors that influence pregnant women's choice of delivery place?

- a. Financial status of the family a. yes () b. no ()
- b. Poor quality of services provided in health facilities a. yes () b. no ()
- c. Cost of transportation a. yes () b. no ()
- d. Type of occupation a. yes () b. no ()

16. Which of these are geographic factors affecting pregnant women's choice of place of delivery?

- a. Long distance to health facility a. yes () b. no ()
- b. Availability of TBA a. yes () b. no ()
- c. Nature of roads leading to health Facility a. yes () b. No ()
- d. Nature of building of the health Facility a. yes () b. no ()
- e. The scent in the health Facility a. yes () b. No ()



f. How long (estimate) do you walk to the health facility a. 0-5 km () b. 6-10 km ()
c. above 11km ()

g. Does distance affect your choice of place of delivery a. yes () b. no ()

h. If yes how

17. Can these factors affect pregnant women's choice of place of delivery

a. Poor attitude of health workers towards clients a. yes () b. no ()

b. If yes how.....

c. Inadequate access to maternity services a. yes () b. no ()

d. If yes how.....

e. Presence of spiritual centers in the communities a. yes () b. no ()

f. If yes how.....

g. Preference for TBAs a. yes () b. no ()

h. If yes how.....

i. Experience of previous abuse during labour and child delivery

a. yes () b. no ()

j. If yes how.....

k. cultural barriers a. yes () b. no ()

l. If yes how.....

m. Religious affiliation a. yes () b. no ()

n. If yes how.....

o. Husband's position on choice of place of birth a. yes () b. no ()

p. If yes how.....

q. Level of education a. yes () b. no ()

r. If yes how.....



- s. Inability to recognize onset of labour on time a. yes () b. no ()
- t. If yes how.....
- u. Delayed labour at home a. yes () b. no ()
- v. If yes how.....
- w. Payment for reproductive and child health services a. yes () b. no ()
- x. If yes how.....

Section D: risks and other challenges associated with health care provision that bother on the choice of place of delivery

- 18. Are you satisfied with services provided at the health facility you attend? a. yes () b. no ()
- 19. If no why.....
- 20. During your last pregnancy how many times did you go for ANC?
 - a. 1-4 times () b. 5-10 times () c. Others (specify).....
- 21. Were you satisfied with services provided? a. yes () b. No ()
- 22. Do you consider the following as factors that could influence the place where a woman would choose to deliver?
 - a. Inadequate knowledge and skills of health care providers?
 - a. yes () b. no ()
 - b. If yes how.....
 - c. Absence or late reporting to work by health care providers at the health facility
 - a. yes () b. No ()
 - d. If yes how.....



- e. Provision of certain items such as Dettol, soap to health care providers a. yes () b. no ()
- f. If yes how.....
- g. Long waiting time at the health facility a. yes () b. no ()
- h. If yes how.....
- i. Abuse and disrespect during labour and childbirth a. yes () b. no ()
- j. If yes how.....
- k. Absence of medications in facility a. yes () b. no ()
- l. Lack of privacy during labour and child delivery a. yes () b. no ()
- m. If yes how.....
- n. Absence of health care providers at the health facility a. yes () b. No ()
- o. If yes how.....
- p. Attitude of health workers towards their clients a. yes () b. no ()
- q. If yes how.....
- 23. What are the risks associated with pregnant women delivering at home? Tick as many as applicable a. woman may die () b. she may lose the baby () c. Retention of placenta () d. others (specify).....
- 24. Do you think poor health service delivery can influence women's choice of place of delivery? Yes () No ()
- 25. In which ways can poor health service delivery affect pregnant women? a. leads to home delivery () b. leads to poor ANC attendance () c. leads to poor post-natal attendance ()
- 26. Can the following affect the attitude of women positively towards health care?
 - a) Quality of health care provided a. yes () b. No ()



- b) Effective Nurse-patient communication a. yes () b. No ()
- c) Availability and provision of good medications a. yes () b. no ()
- d) Provision of privacy during labour and child delivery a. yes () b. no ()

27. How would women be motivated to deliver in health facilities?

.....

Thank you for your time



APPENDIX II: Questionnaire for Health Care Providers

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF ALLIED HEALTH SCIENCES

Questionnaire for Health Care Providers: Examining the Factors Associated with choice of Places of delivery by women in the Savelugu/Nanton Municipality

Informed consent

My name is ----- I am a student of University for Development Studies. I am conducting a study on examining the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality. I would very much appreciate your participation in this study. This information will help the government and other decision making bodies in the country enact policies that will help improve this situation.

The discussion will take between 10 to 20 minutes usually to complete. Whatever information you provide will be kept strictly confidential. In this survey, participation is voluntary and you can choose to answer any/some or all the questions or withdraw at any point in time should you decide to do so without any consequences. However I hope that you will participate in this study since your views are important.



Part I

1. Age (years).....
2. Marital status (A) Single () (B) Married () (C) Cohabiting () (D) Widow () (E) Divorced () F. others (specify).....
3. Religious status (A) Islam () (B) Christian () (C) Others (specify).....
4. Educational qualification (A) Certificate () (B) Diploma () (C) Degree () (D) Others (Specify).....
5. Ethnicity (A) Dagomba () (B) Gonja () (C) Konkomba () (D) Others (specify).....
6. Category of staff (A) General Nurse () (B) Public health nurse () (C) midwife () D. Doctor () E. community health nurse () F. others (specify).....
7. Sex A. male () B. female ()

Part II

8. How often do women visit the health centre when ill? a. always () b. rarely () c. when condition is serious () d. others (specify).....
9. How often do pregnant women attend ANC clinic in this health centre? a. always () b. rarely () c. when condition is serious () d. others (specify).....



10. How often do pregnant women deliver in the health centre?
a. always () b. rarely () c. when complications arise () d. others
(specify).....
11. Do pregnant women prefer to deliver in this health centre?
a. yes () b. no ()
12. If yes/no why?.....
13. What factors motivate women to deliver in this health
centre?.....
14. What factors motivate women to deliver at home?.....
15. Do you think there are economic factors influencing women's choice of place
of delivery in this community? a. yes () b. No ()
16. If yes mention them.....
17. What are the main financial problems women in this community encounter with
respect to seeking health care?.....
18. What other challenges confront women in this community with respect to the
choice of place delivery?.....
19. What steps are you taking to encourage more women to always come to the
health centre to deliver?.....

Part III

20. Do women who come to this health facility get satisfaction from the services
rendered to them? A. yes () b. No ()
21. If yes/ no why?.....
22. Do women come with pregnancy related complications to this health centre? A.
yes () b. no ()



- 23. If yes can you mention them?.....
- 24. And how are those complications managed?.....
- 25. What steps are always taken to ensure that women presented with pregnancy complications are attended to immediately?.....
- 26. What can be done to improve health care provision in this health facility to encourage more women to seek health care?.....

Thank you



APPENDIX III: Questionnaire for Married Men
UNIVERSITY FOR DEVELOPMENT STUDIES
SCHOOL OF ALLIED HEALTH SCIENCES

Questionnaire for Married Men: Examining the Factors Associated with Choice of Places of delivery by women in the Savelugu/Nanton Municipality

Informed Consent

My name is ----- I am a student of University for Development Studies. I am conducting a study on examining the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality. I would very much appreciate your participation in this study. This information will help the government and other decision making bodies in the country enact policies that will help improve this situation.

The discussion will take between 10 to 20 minutes usually to complete. Whatever information you provide will be kept strictly confidential. In this survey, participation is voluntary and you can choose to answer any/some or all the questions or withdraw at any point in time should you decide to do so without any consequences. However I hope that you will participate in this study since your views are important.

Section A: bio-data of respondents

1. Age (years).....
2. Marital status (A) Single () (B) Married () (C) Cohabiting () (D) Widow () (E) Divorced () F. others (specify).....
3. Religious status (A) Islam () (B) Christian () (C) Others (specify).....
4. Educational qualification (A) BSc. () (B) Masters () (C) PhD () (D) Others (Specify).....



5. Ethnicity (A) Dagomba () (B) Gonja () (C) Konkomba () (D) Others (specify).....
6. Occupational status (A) Traders () (B) Public servant () (C) others (specify).....

Part B

7. Do you know factors influencing women's choice of place of delivery in your community?
a. yes () b. no ()
8. If yes can you mention them.....
9. Do you know cultural factors affecting women's choice of place delivery in this community? a. yes () b. no ()
10. If yes mention them.....
11. How can women be encouraged to deliver at the health facility in your community? a. attitude of health workers must be kind () b. there should more education on advantages of delivering at the health facility () c. Avoiding negative cultural practices () d. others (specify).....
12. Where will you prefer your wife to deliver? A. hospital () b. Home () c. Others (specify).....
13. If any why?.....
14. Do women in this community deliver at home a. yes () b. No ()
15. If yes what factors motivate them to deliver at home?
16. Do women in this community deliver at the health centres? a. yes ()
b.no ()



17. If yes what motivates them to deliver at the health centres?
18. Do you know any other places women in this community go to deliver? a. yes ()
b. no ()
19. If yes mention them.....

Part C

20. Which of the following barriers in this community influence women's choice of place birth? (Tick as applicable) A. unemployment () b. Religion () c. Financial constraints () d. others (specify).....
21. What other challenges do women in this community face with regards to their choice of place of delivery?.....
22. Can you throw light on them?
23. Do think distance to the nearest health facility in your community can affect women's choice of place of delivery? a. yes () b. No ()
24. If yes how?.....
25. Is there a health centre in this community? A. yes () b. No ()
26. Have you ever gone there with your wife to deliver? a. yes () b. No ()
27. If yes what means of transport did you use to carry your wife to the health facility? a. on foot () b. Bicycle () c. Motorcycle () vehicle () Others (specify).....
28. How will you rate the hospital staff in your previous attendance? a. Rude () b. Kind () c. Sympathetic () d. skillful ()
29. Do you think the attitude of health workers can affect women's choice of place of delivery in this community? a. yes () b. No ()



30. Did your wife attend ANC services during the last pregnancy? a. yes ()
b. No ()
31. If yes how many times did your wife attend ANC during the last pregnancy? a.
Once () b. twice () c. Three times () d. Over 4 times () e. others
(specify).....
32. Do you think a man has a role to play when it comes to selecting a place for the
wife to go and deliver? a. yes () b. No ()
33. If yes why?.....
34. Where will be your preferred place of delivery for your wife? a. home () . b.
TBAs () c. Hospital () d. others (specify).....
35. If any why.....

PART D

36. Do you think pregnancy is a risk? a. yes () b. no ()
37. If either why?.....
38. What are the risks associated with pregnancy?.....
39. How can the risks associated with pregnancy be reduced?.....
40. What are the major challenges the health care providers encounter that may
impede health care provision to pregnant women in this
community?.....



Thank you for your attention

APPENDIX IV: Questionnaire for Opinion Leaders

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF ALLIED HEALTH SCIENCES

Questionnaire for Opinion Leaders: Examining the Factors Associated with choice of Places of delivery by Women in the Savelugu/Nanton Municipality

Informed Consent

My name is ----- I am a student of University for Development Studies. I am conducting a study on examining the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality. I would very much appreciate your participation in this study. This information will help the government and other decision making bodies in the country enact policies that will help improve this situation.

The discussion will take between 10 to 20 minutes usually to complete. Whatever information you provide will be kept strictly confidential. In this survey, participation is voluntary and you can choose to answer any/some or all the questions or withdraw at any point in time should you decide to do so without any consequences. However I hope that you will participate in this study since your views are important.

SECTION 1

1. Age (years).....
2. Marital status (A) Single () (B) Married () (C) Cohabiting () (D) Widow ()
(E) Divorced () F. others
(specify).....
3. Religious status (A) Islam () (B) Christian () (C) Others
(specify).....
4. Educational qualification (A) BSc. () (B) Masters () (C) PhD () (D)



Others (Specify).....

5. Ethnicity (A) Dagomba () (B) Gonja () (C) Konkomba () (D) Others (specify).....

6. Occupational status (A) Traders () (B) Public servant () (C) others (specify).....

Section 2

7. How long have you been in this community?.....

8. What are the places in this community that women can go to deliver? A. TBAs () b. Hospital () c. Home () D. Spiritual centres ()

9. Which place is your preferred choice? A. TBAs () b. Hospital () c. Home () D. Spiritual centres ()

10. If any why?.....

11. Do men in this community accompany their wives the health centers during pregnancy and child delivery? a. yes () b. no ()

12. What are the cultural beliefs and practices influencing women's choice of place of delivery in this community?.....

13. How are those cultural beliefs and practices affecting women's choice of place of delivery in this community?.....

14. Has modernization affected the change of these traditions in this area? a. yes () b. no ()

15. If yes how?.....

16. What can be done to alter the culture to favour women to deliver at places of their own wish?.....



Section 3

17. What factors compel women to choose a place to deliver in this community?
(Tick as many as possible) a. economic factors () b. attitude of health workers () c. Geographic factors () d. others (specify).....
18. Do you know economic factors that affect women in this community towards child birth? a. yes () b. no ()
19. If yes can you identify them?.....
20. Do you know geographic factors affecting women choice of place of delivery in your community? a. yes () b. No ()
21. If yes can you mention them?.....
22. What do you think can be done to reduce the impact these factors in this community?.....

Section 4

23. Is there a health facility in this community? a. yes () b. no ()
24. If yes, how will you rate the health care provision at the health facility here? A. poor () b. Good () c. others (specify).....
25. What do you think can be done to improve upon health care for women in this community?.....
26. If women have pregnancy related complications what should be done? A. taken to hospital immediately () b. taken to the shrine () c. taken to the spiritualist ()
27. If any why?.....

Thank You



APPENDIX V: Focus Group Discussion

UNIVERSITY FOR DEVELOPMENT STUDIES

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Focus Group Discussion on Examining the Factors Associated with choice of places of delivery by women in the Savelugu/Nanton Municipality

Informed Consent

My name is ----- I am a student of University for Development Studies. I am conducting a study on examining the factors associated with choice of places of delivery by women in the Savelugu/Nanton Municipality. I would very much appreciate your participation in this study. This information will help the government and other decision making bodies in the country enact policies that will help improve this situation.

The discussion will take between 30 to 60 minutes to complete. Whatever information you provide will be kept strictly confidential. In this survey, participation is voluntary and you can choose to answer any/some or all the questions or withdraw at any point in time should you decide to do so without any consequences.

- 1) State three places where women prefer to deliver in your community.
- 2) Mention five reasons why women choose to deliver in such places in your community.
- 3) Mention five reasons why women prefer to deliver in the house.
- 4) State five risks associated with women who choose to deliver at home.
- 5) State five reasons why women prefer to deliver in the health centre.
- 6) State five risks associated with women who choose to deliver at health facilities.
- 7) Mention five reasons why women prefer to deliver in spiritual centres in your community.



- 8) State five risks associated with women who choose to deliver at spiritual centres in your community.
- 9) State five economic factors affecting women's choice of place of delivery in your community.
- 10) State five geographic factors that can influence women choice of place of delivery in your community.
- 11) State five risks associated with pregnancy.
- 12) Mention five cultural beliefs and practices that can influence women choice of place of delivery in your community.
- 13) Mention five roles of husbands towards women's choice of place of delivery in your community.
- 14) State five measures that can be instituted t to encourage women to deliver at health centres in your community.

Thank you

