

**UNIVERSITY FOR DEVELOPMENT STUDIES**

**HIGH ANTENATAL ATTENDANCE, LOW SKILLED DELIVERY: ASSESSMENT  
OF FACTORS INFLUENCING DECLINE IN SKILLED DELIVERY IN TOLON  
DISTRICT IN NORTHERN REGION**

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**NOVEMBER, 2016.**



UNIVERSITY FOR DEVELOPMENT STUDIES, TAMALE

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DISTRICT IN NORTHERN REGION**

**BY**

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**A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH,  
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AWARD OF DEGREE OF MASTER OF PHILOSOPHY IN COMMUNITY HEALTH  
AND DEVELOPMENT**

**NOVEMBER, 2016.**



**DECLARATION**

**STUDENT**

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

APRAKU VIVIAN

(STUDENT)

Date .....

Signature.....

**SUPERVISOR**

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

DR. VIDA YAKONG

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Date .....

Signature.....



## ABSTRACT

Skilled delivery has become an essential subject of discussion in recent times. Though figures on ANC indicate high attendance, skilled delivery does not match with the ANC attendance as may be the perception of health professionals. It was this impairment on the MDG5 that prompted this study in the Tolon district to assess the factors contributing to high ANC attendance and low health facility or skilled delivery. The study employed a mixed research method of adopting both quantitative and qualitative approaches to research to sample 423 women for quantitative study. Health workers and community men from 4 communities were studied qualitatively in a focus group discussion. The selection criteria were basically purposive. Both primary and secondary information was used in the study. It was found that, the district lacks far behind on the global target for maternal health care and the MDG5. This was because hidden traditional beliefs were traced to the people's high use of the health facility for ANC (85.8%) but low use for delivery (57.1%). Husbands (74.6%) and mother-in-laws (20.8%) were the major influence in the decision to place of delivery and have often opted for TBAs and prayer camps. Though there was a high preference for health facility delivery (83.4%), there was a low usage among the women (57.1%). There was absolutely high knowledge of the relevance of skilled delivery (95.2%). Healthcare worker attitudes that were expected to ensure access to delivery center and service were found to have existed. There was, however, an issue of transportation to the center for skilled delivery service (29.1%). The study, therefore recommended ambulance service and intensified education targeting not only the women, but their families and community members as well. The study also suggested the conversion of TBAs into skilled birth attendants through training.



## DEDICATION

This work is dedicated to my late husband Mr. Gabriel Kofi Adu-Daasebere, my children; Kwasi and Serwah.



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## LIST OF ABBREVIATIONS

ADP-	Automatic Data Processing
CHPS -	Community-Based Health Planning and Services
FGD -	Focus Group Discussion
GDHS -	Ghana Demographic and Health Survey
IDI -	In-Depth Interview
IMF -	International Monetary Fund
MDGs	Millennium Development Goals
MCHS -	Maternal Health Care Services
MMR -	Maternal Mortality Rate
NORSAAC-	Northern Sector Action on Awareness Center
PMTCT	Prevention of Mother-to-child Transmission
SAFE -	Skilled Attendance for Everyone
TBA -	Traditional Birth Attendant
TD	Tolon District
UN -	United Nations
UNEPA -	United Nations Population Fund
UNICEF -	United Nations Children's Fund
WHO -	World Health Organization



ANC -	Antenatal Care
DHD -	District Health Directorate
DHIMS -	District Health Improved Management System
NHIS -	National Health Insurance Scheme
EMOC -	Emergency obstetric Care



## CHAPTER ONE

### 1.0 Introduction

Safe-motherhood is a worldwide effort that aims to reduce the number of deaths and illnesses associated with pregnancy and childbirth (Mustafa & Alsiddiq, 2007). The Safe Motherhood Newsletter in 2013 reported that, safe motherhood can be achieved through regular antenatal care, skilled attendance at all births, access to quality emergency obstetrical care, access to quality reproductive health care, including family planning and safe post-abortion care. This chapter presents background information on the factors influencing the decline in skilled delivery in the Tolon District of the Northern Region of Ghana.

The chapter again presents the problem statement, research objectives, research questions, and the scope of the study, significance of the study and limitations of the study. The chapter again presents an overview of the research methodology and outlines how this study will be organized.

### 1.1 Background of the Study

Safe motherhood is an essential component of maternal health which advocates for quality maternal health services from antenatal care to care after delivery. It ensures that pregnant women stay healthy during the period of their pregnancy, delivery and after delivery complications (Khalil & Roudi-Fahimi, 2002). Access to emergency obstetric care and skilled attendance at birth are three key interventions that have been implemented globally to reduce maternal mortality (PATH, 2012).

The world health organization in 2003 established that, antenatal care is of utmost importance to ensuring that pregnant women and newborns are physically and emotionally healthy. The WHO maintained that, antenatal care is a period in which the pregnant woman receives a





range of health education and services including health promotion and preventive health care services, nutritional support, immunizations and prevention and treatment of common related diseases such as Pre-eclampsia and eclampsia.

The 2003 maternal health report of the WHO and UNICEF indicated that, antenatal is a period in which healthy maternal and child health is determined. It is during this period that antenatal screening will unravel some sickness and diseases such as STI's and HIV/AIDS for clinical attention.

The findings of the WHO in 2001 on maternal health established that, efficient and effective healthcare systems can help address the life threatening complications of pregnancies and childbirth. WHO maintained that, skilled delivery by qualified midwives can help save the life of mother and child. Unfortunately, skilled delivery is not given the much needed attention in developing countries including Ghana. This could be blamed on some socio-cultural practices and the attitude of some health professionals towards pregnant women during antenatal visits (WHO, 2001).

The inability to address these concerns can lead to infant morbidity and mortality. It is possible that maternal and infant morbidity and mortality would continue to increase if such complications are not identified early, managed and handled by trained personnel.

Between 1990 and 2010, the global maternal mortality ratio (i.e. the number of maternal deaths per 100 000 live births) declined by only 3.1% per year, this is far from the annual decline of 5.5% required to achieve MDG5 (UNICEF Statistics, 2014). Over 99 percent of maternal deaths occur in developing countries, with nearly half of this taking place in Sub-Saharan Africa of which Ghana is not an exception (UNICEF/WHO/UNFPA, 2010). Women



living in Sub-Saharan Africa have a higher risk of dying while giving birth than women in any other region of the world. At the global level, maternal mortality decreased by less than 1 percent per year between 1990 and 2005, far below the 5.5 percent annual improvement needed to reach the MDG target (UNICEF, 2009).

In Ghana, the skilled delivery stands at 49.1%, 55.1% and 54.5% in 2011, 2012 and 2013 respectively. In the Northern Region of Ghana, Tamale, skilled delivery for 2011-2013 stands at 39.4%, 47.3% and 51.2%, respectively (Regional Health Directorate Annual Report, 2014). This shows a decline in the skilled delivery as compared to antenatal attendance within the same period. The WHO report of 2004 asserts that many more women in sub-Saharan Africa attends antenatal care than receiving skilled delivery at birth.

### **1.2 Statement of the Research Problem**

In Ghana, several interventions targeting improving skilled delivery and reducing maternal and infant mortality have been initiated. The free maternal health policy, quick and subsidized ambulance services and refresher training for midwives are all strategies geared towards enhancing improved maternal health (Witter et al., 2007)

All of the above measures are targeted at promoting skilled birth attendance. Most health care professionals, usually midwives and community health nurses are well trained to give health education, manage labour and its complications so as to provide quality care to their clients and prevent deaths and disabilities

The Ghana Demographic Health Survey reports (2008) indicate that, women who received antenatal care from health professionals. It is expected that the number of women who attended ANC should be equal to the number who will deliver at the health facilities.



However, this has not been the case since the ANC for the period 1988 to 2008 stands at % 82%, 86%, 89%, 92% and 95%, whereas skilled delivery within the same period indicates 40%, 44%, 44%, 47% and 59% respectively.

The Tolon District has satisfactorily ANC attendance and registered poor health facility delivery over the years. The poor attitude towards skilled delivery can affect maternal and health outcomes (Tolon Annual District Report, 2013). Adam and Salihu, (2002): Mwaniki et al, (2002) established that the low patronage of health facility delivery in most rural communities in Ghana includes; long distance from home to the health facility, the cost of service, perceived poor quality of services and the poor attitude of some health professionals.

The situation in the Tolon District is not different from several governmental and non-governmental organizations such as the World Vision Ghana, ADP, NORSAAC, Baptist Child Development initiative on ANC, facility delivery, newborn care, family planning, and reward for Traditional birth attendants for timely referral of cases to health facilities has still not yielded the desired results.

The Tolon DHD annual report of 2013 indicates ANC attendance for the period at 76% (2011), 82% (2012) and 92% (2013) as against skilled delivery of 28% (2011), 27% (2012) and 27% (2013). This indicates skilled delivery has not yielded the desired attention despite the interventions in place.

Literature has far demonstrated poor attention given to skilled delivery as a component of maternal health care in rural districts and virtually no study so far has delved into finding out the state of maternal health in the Tolon District with particular reference to skilled delivery. It is within this context that this study seeks to assess the ANC attendance of the District and



juxtapose that to skilled delivery in the District and make recommendations for policy framework.

### **1.3 Research Questions**

The following research questions aided the researcher to find answers to the study

1. What are the socio-cultural factors affecting access to skilled delivery in the Tolon District of the Northern Region of Ghana?
2. Do women in the Tolon District has adequate access to deliver services?
3. What is the attitude of health professionals towards women in labour in the Tolon District of the Northern Region of Ghana?
4. What is the level of knowledge of women on the significance of skilled delivery?
5. What are the views of women on how to improve skilled delivery?

### **1.4 Objectives of the Study**

#### **1.4.1 General Objective of the Study**

The general aim of the study is to assess the factors contributing to the high ANC coverage, but low skilled delivery in the Tolon District of the Northern region.

#### **1.4.2 Specific Objectives**

To achieve the main objective of this study, the following specific objectives are outlined;

1. To assess the socio-cultural factors influencing skilled delivery in the Tolon District of the Northern Region of Ghana.
2. To access whether women have adequate access to delivery services in the Tolon District of the Northern Region of Ghana.



3. To find out the attitudes of health staff towards clients during delivery services in Tolon District.
4. To assess women's knowledge level about the significance of skilled delivery in Tolon District.
5. To elicit mothers views on ways to improve skilled delivery in the Tolon District.

### **1.5 Significance of the Study**

The result of this study is expected to inform the national, regional and District Health Management Team (DHMT) of Tolon in designing maternal and child health programs especially on ANC and facility delivery. The findings of this is also expected to inform the non-governmental organizations working in the district in the area of maternal health The study would also help improve the health of women and infants/children before, during and after delivery, hence reduced complications and deaths associated with childbirth in the national, regional and the Tolon district.

The results of this study would also serve as baseline information for future researchers to explore reasons for low skilled delivery in the district. Again, the findings of the study would inform policy makers' decisions on policies related to skilled attendants in order to improve access and promote maternal health.

### **1.6 Limitations of the Study**

A major limitation to this study was that, it involved convenient selection of four sub-districts, bias might have therefore set in. As the researcher might have unconsciously approached some respondents and avoided some others, even within the selected sub-districts. This phenomenon, therefore placed limits on issues of generalization of the findings and the application of the recommendations to similar issues elsewhere.



### **1.7 An Overview of the Research Methodology**

The study employed a mixed method by which both quantitative and qualitative approaches to research were used. A sample size of 380 plus 10% drop-out given a total sample size of 418 women were used.

The questionnaire was administered to these sample populations. Midwives and nurses as well as male counterparts were interviewed through focus group discussion in four communities of the Tolon district. Both primary and secondary sources of information were used with structured questionnaires forming the tool for primary data collection. The selection of the participants of the study was purely purposive. Appropriate data management and research ethics were upheld in this study.

### **1.8 Organization of the Study**

This study is made up of in five chapters.

**Chapter One** of the study outlined the background to the study, the statement of the research problem, the research objectives, research questions and a justification for the study. It also highlights the scope and limitations of the study as well as an overview of the methodology employed in this study.

**Chapter Two** of the study is basically a review of existing but relevant literature of the subject matter.

**Chapter Three** of the study is a presentation of methodological procedures employed in the course of the study.

**Chapter Four** of the study present the field data with its analysis with the researcher's intuition guided by existing literature reviewed.



**Chapter Five** of the study is the discussion of the research results.

**Chapter Six** of the study is the summary of the findings of the study, the conclusions and suggestions towards improving the situation of high ANC coverage and low skilled delivery in the Tolon District of the northern region.



## CHAPTER TWO

### LITEERATURE REVIEW

#### 2.0 Introduction

This chapter of the study reviews existing but the relevant literature on the subject under study. Concepts such as antenatal care and skilled delivery are also explained in the chapter. The objectives of the study are also used as themes in discussing the literature related to ANC and Skilled delivery.

#### 2.1 Operational Concepts of Key Terms

##### 2.1.1 Antenatal Care (ANC)

According to Bulatao and Ross (2000), antenatal care (ANC) coverage is a success story in Africa, since over two-thirds of pregnant women (69%) have attended ANC at least once. However, to achieve the full life-saving potential that ANC promises for women and babies, four visits are recommended.

Essential interventions in ANC include identification and management of obstetric complications such as preeclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy (IPTP), and identification and management of infections including HIV, syphilis and other sexually transmitted infections (STIs). ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behaviors such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing.

It has been estimated that 25 percent of maternal deaths occur during pregnancy, with vary between countries depending on the prevalence of unsafe abortion, violence, and disease in the area. Between a third and a half of maternal deaths are due to causes such as hypertension





(pre-eclampsia and eclampsia) and antepartum hemorrhage, which are directly related to inadequate care during pregnancy. The World Health Organization in its study in six West African Countries in 2007 established that, a third of all pregnant women experienced illness during pregnancy of whom three percent

Also, an estimated 900,000 babies die as stillbirths during the last twelve weeks of pregnancy. It is estimated that babies who die before the onset of labor, or antepartum stillbirths, account for two-thirds of all stillbirths in countries where the mortality rate is greater than 22 per 1,000 births-nearly all African countries. Antepartum stillbirths have a number of causes, including maternal infections-notably syphilis-and pregnancy complications, but systematic global estimates for causes of antepartum stillbirths are not available.

The goal of the ANC package, therefore, is to prepare for birth and parenthood as well as to prevent, detect, alleviate, or manage the three types of health problems during pregnancy that affect mothers and babies such as complication of pregnancy itself, pre-existing. It is believed that screening for health and socioeconomic conditions such as education likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for a safe birth, emergencies during pregnancy and how to deal with them (Villar *et al.*, 2001; Spyridou *et al.*, 2016; Muyunda *et al.*, 2016).

In the Sub-Saharan Africa, many more women attend antenatal care clinics than seek skilled attendants' delivery services, although the magnitude of this differential varies from country to country and regionally within the border areas of countries (WHO/UNICEF, 2005). Attending antenatal and postnatal clinics are viewed by women as empowering because these



are rare opportunities to leave the household on their own accord and take control of their own health (Magoma *et al.*, 2010).

### **2.1.2 Skilled Delivery**

Skilled delivery can be explained in terms of a pregnant woman given birth under a supervision of a qualified health professional more often than not a midwife. The professional who conducts the delivery is termed the birth attendant. A birth attendant, also known as a skilled birth attendant (SBA), is a midwife, physician, obstetrician, nurse, or other health care professional who provides basic and emergency health care services to women and their newborns during pregnancy, childbirth and the postpartum period.

The World Health Organization (2004) defines skilled birth attendant as an accredited health professional e.g. midwife, doctor or nurse specifically educated and trained to expertise in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

Carlough and McCall (2005) illustrated that, the presence of a skilled birth attendant at delivery is important in averting maternal and neonatal mortality and morbidity. It has now shown that even trained traditional birth attendants (TBAs) cannot, in most cases, save women's lives effectively because they are unable to treat complications, and are often unable to refer. Qualified midwives and doctors are often not available in the rural areas and community settings where most women in developing countries deliver.

The WHO, UNICEF, UNFAPA and World Bank reports in 2005 on maternal health identified skilled birth attendance role as vital to preventing maternal death. Hussein *et al.*



(2004) and Safe Motherhood Inter-Agency Group (2000) put it that, SBA is characterized by two criteria: the attendant and environment. The attendant must be present during labor, delivery and postpartum, and be trained to manage normal deliveries and refer complications.

Literature according to Magadi *et al.* (2000), Mills *et al.* (2008), Mpembeni *et al.* (2007) and Hounton *et al.* (2008), numerous barriers to SBA at deliveries have been reported.

Chief among these are the shortage of SBA personnel and the inaccessibility of emergency obstetric care in rural areas. Numerous studies have explored “determinants” of childbirth location quantitatively by retrospectively analyzing the association of demographic factors with the location of a woman’s last birth. In Sub-Saharan Africa, home birth has been associated with the following: increasing parity, lack of formal education, poor accessibility of facilities, rural residence, low socioeconomic status, traditional religions, and lack of female autonomy (Magadi *et al.*, 2000). Additionally, the environment must be “enabling,” such that the women in labor gets the necessary support and access to health care services and qualified health professionals (Bell *et al.*, 2003).

Skilled care during and after delivery as well as emergency obstetric care (EmOC) aimed at reducing maternal and neonatal mortality (Starrs, 1997; WHO, 2009). This is because, most of the morbidity and mortality that occurs among women and newborns occurs during labour or delivery or shortly after childbirth usually the first 24 hours (Campbell *et al.*, 2006; Penn-Kekana *et al.*, 2007 Lawn *et al.*, 2010).

Adegoke and Van Den Broek (2009) have demonstrated that the use of skilled attendance at birth could potentially reduce maternal mortality rate by a range of 13% to 33%. However, many Countries within Sub-Saharan Africa still registers more women at ANC than receiving



skilled delivery under a qualified health professional (WHO and UNICEF, 2003; Stanton et al. 2007). The use of skilled attendance at birth is also considered as a cost saving intervention not only related to number of deaths averted but also reducing incidence of morbidity (Adegoke and Van Den Broek, 2009).

Skilled attendance at birth requires two key components: an SBA and an enabling environment that includes drugs and equipment, a functional referral system and enabling policies (Koblinsky *et al.*, 2006). Studies have demonstrated a positive correlation between the proportion of deliveries taking place with an SBA and a reduction in maternal deaths (Graham *et al.*, 2001). For this reason, an SBA is defined as an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (WHO, 2004). Therefore, the availability of a Skilled Birth Attendant (SBA) during childbirth is a key indicator for MDG5 and a strategy for reducing maternal and neonatal mortality in Africa.

## **2.2 Socio-cultural and Economic Factors affecting Skilled Delivery**

According to the United Nations (2014), maternal deaths vary across regions and continents and are more pronounced in Sub-Saharan African and Southern Asia plausibly due to the social, cultural and economic settings surrounding these societies. Because Pregnancy and childbirth is social responsibility and often involve significant family and community participation which is an important strategy geared to influence mothers' awareness about skilled delivery care during routine ANC, especially in many developing countries (MOH, 2002; WHO, 2001).



In Sub-Saharan Africa, females does not get into the necessary basic rights such as access to better education and training coupled with some traditional and religious belief as well as domestic violence, such as rape, early marriage, no member of decision-making at the household level often limit their ability to access maternal health services including skilled delivery (Esen & Sapporo, 2013).

The inability of women to mobilize financial resources and poverty, especially in rural agricultural communities of Sub-Saharan Africa contributes to the limited patronage of skilled delivery services by women (Witter *et al.*, 2007). This is because skilled delivery involves costs that mothers have to bear, but often times majority of them are unable to afford (Esen & Sapporo, 2013). Mpembeni *et al.* (2007) established that the advice given to women during antenatal care, distance to the health center and knowledge of pregnancy risk factors have significant influence on the use of skilled care at delivery in Kenya.

### **2.3 Women Access to Delivery Services**

According to Perkins *et al.* (2009), many studies, largely focus on the factors surrounding health systems that affect utilization of skilled birth attendants; user fee, physical access to health facilities including distance, and transport to the health facility. Cotter *et al.* (2006) also reported that, in sub-Saharan Africa, although women attend antenatal clinics (ANC) yet they do not seek skilled attendance when they are in labor. This however means that a significant number of even those who received health services during the antenatal period still deliver without an adequate obstetric care.

Thaddeus and Maine (1994) showed that distance to health services exerts a dual influence on use by serving as a disincentive to seeking care in the first place, as well as an actual obstacle to reaching care after a decision has been made to seek it. Due to this, many pregnant



women do not even attempt to reach a facility for delivery since walking many kilometers is difficult at labour and impossible if labour starts at night, and transport means are often unavailable.

Stekelenburg (2004) also revealed that, the majority of women would want to deliver at the health facilities, few of them are able to do so because of distance from home to health facilities and inadequate means of transport. Because of these, there is still low utilization of skilled attendance at birth in many low income countries, which is still a challenge to improving better maternal health conditions. Studies have shown the utilization of skilled delivery at birth is slightly above or below 50% (Kongnyuy et al., 2009; Bisika, 2008; Navaneetham and Dharmalingam, 2002). In Africa, the overall utilization of skilled attendance at birth stands at 45.7% (Campbell et al., 2006), but the figure is even lower for sub-Saharan Africa.

With the global effort and commitment to reduce maternal mortality rates by 75%, the use of skilled attendance at birth was set at the following standards; 80% by 2005, 85% by 2010 and 95% by 2015 (United Nations, 2010).

#### **2.4 The Healthcare Staff during Delivery**

Many other studies that showed negative interactions between health professionals and women as one of the causes of women's poor attitude towards seeking skilled delivery. D'ambrosio *et al.* (2005) mentioned poor staff attitudes as one of the reasons for non-acceptability and low utilization of delivery care services. Further, their respondents (women) confirmed that they expected a humanist, professional and courteous treatment from health professionals as well as a reasonable standard of the physical environment as they



consciously change their place of delivery and make the same recommendations to others if they experience degrading and unacceptable behavior from health professionals.

Kyomuhendo (2003) found that, a lack of skilled staff at the primary health care level, verbal abuse, neglect and poor treatment in hospital and poorly understood reasons for procedures, plus health workers' views that women were ignorant, explained the unwillingness of women to deliver in health facilities. Koblinsky *et al.* (2006) filed a report of women preferring to deliver at home because health personnel use offensive and demeaning language, ridicule women because of their faded old clothing, high purity and poor personal hygiene. The study of Esena & Sappor (2013) found that there were a few cited poor attitudes of health workers and poor quality care as some of the challenges of the respondents' non-seeking of skilled delivery. They found that, majority 188 (60.1%) rated the health provider's attitude as well, 36 (11.6%) as excellent; while 71 (22.8%) rated as 16 (5.1%) average and poor respectively.

Studies from different developing countries have shown that negative attitudes like rudeness, shouting during labor, lack of empathy, refusal to assist, and lack of moral support, making patients wait and giving priority on the basis of links to staff, caste and ethnic, language and religion all discourage the use of SBAs (Kamwendo & Bullough, 2005).

## **2.5 Significance of Education on Skilled Delivery**

Literature confirms that, high formal education and maternal education have positive associations with improved accessibility of skilled delivery by mothers (Kalule-Sabiti *et al.*, 2014; Collin *et al.* (2007)). This is because knowledge of pregnancy-related complication such as depends on formal and informal education of women on maternal health. Education is also likely to influence women's knowledge of skilled delivery services and service providers (Sakeah *et al.*, 2014).



In most West African countries, the majority of women prefer skilled birth health professionals at government and private health facilities as a result of higher educational attainment (Iyaniwura & Yussuf, 2009; Sakeah *et al.*, 2014). Esena & Sappor (2013) reported that the majority of mothers with low levels of formal education did not accessed skilled delivery.

Evidence provided by Gitimu *et al.* (2015) indicated that, women with a higher level of formal education, especially at the tertiary level are more likely to access skilled delivery. In the findings of Worku *et al.* (2013), higher levels of education could not only be a significant factor in improving attendance of skilled delivery of women, but also providing maternal education for both educated and not educated mothers could significantly in their patronage of skilled delivery services. Ahmed *et al.* (2010) also found a positive relationship between maternal education and the utilization of skilled delivery services by mothers

## **2.6 Improving Skilled Delivery: The Women's Perspective**

Around the world, people celebrate the birth of a new baby, societies expect women to bear children, and honor women in their role as mothers, yet in most of the world, pregnancy and childbirth is a perilous journey. In less developed countries, more than half a million mothers die from causes related to this life-giving event each year. The period when mothers are most at risk of death, however, is during pregnancy, delivery, and the 42-day period following childbirth (Moucheraud *et al.*, 2015).

Evidence shows that motherhood can be safer for all women. Over the past decade, experts have largely come to agree on a set of lifesaving strategies that can work even in low-resource settings. Governments around the globe have signed international conventions that advocate significant reductions in maternal mortality. The rules and regulations can seem strange or





frightening and the health personnel may do things that are not comfortable with women as they may be compatible with their beliefs (Arkutu, 1995).

A study conducted by Palmer (2007) at the Kintampo Hospital to find out why some women deliver outside health facility revealed that there was a poor interpersonal relationship, especially the utterances or careless derogatory statements such as “when she was enjoying with her husband, I was not there”. Such irresponsible and unethical comments must be shunned by all health workers (Myles, 1975). If the health workers are capable with a calm, optimistic temperament, they will be eminently suited from the psychological point of view for the job (Myles, 1975).

In Ghana, several interventions targeting improving skilled delivery and reducing maternal and infant mortality have been executed (Witter *et al.*, 2007). For example, free exemption policy instituted in 2003, ambulance service, refresher trainings for midwives and the introduction of free maternal health care service under the national health insurance scheme (NHIS) save motherhood initiative revealed that 529,000 mothers die annually worldwide as a result of not having access to proper care during delivery (Safe Motherhood Newsletter, 2013).

The strategies to address the problems of maternal mortality include one proven effective strategy which is the provision of access to basic emergency obstetric services by employing lifesaving skills such as assisted deliveries (Paxton *et al.*, 2005). Access to these services is a key element in meeting the global target for skilled delivery of 80% by 2010 and 90% by 2015. It is, however worthy, nothing that in addressing the issue of expectant mothers having access to skilled attendants, it is important that there is provision of easy to reach health



facilities with the necessary motivated workforce, equipment and drugs and enabling environment as well as adequate referral systems.

It is also worth noting that, efforts have been taken in Ghana and for that matter the study area to train more midwives to replace the large numbers of midwives going on retirement, new midwifery schools are being put up with some existing health assistant schools being upgraded to midwifery schools as well as the placement of non-practicing midwives to maternity units. Both local government and the Ministry of Health (MOH) have collaborated to put up or expand existing health facilities to create space for more maternity units. In order to bring health services to the doorstep of the communities, the CHPS program is being implemented in both rural and urban settlements although the implementation strategies vary slightly.

From the view point of the women, their perception of skilled delivery care can also influence their tendency to utilize skilled deliver services. For example, most women may pay attention to quality of health care services, so they rate on satisfaction or dissatisfaction with the skilled delivery care according to a variety of factors. They feel satisfied if their personal preference, values and expectations increases (Bazant and Koenigvan, 2009; Teijlingen et al., 2003; Nilses et al., 2002; Lule et al., 2000). They tend to be dissatisfied with the services due to long waiting time, poor facilities, lack of confidentiality and poor provider versus client interaction. This is because, always the women knows what know what care is expected through past experience, knowledge from health talks and from peers; they will always seek alternative better care if available (Bisika, 2008; Seljeskog et al., 2006; Lule et al., 2000). It suggests that, health facilities should be revised looking at what better suit women or discourage them from accessing the skilled delivery services.



The National Health Insurance Scheme (NHIS) and the Free Delivery Service concepts are also being implemented in all public health facilities as well as some accredited private clinics. A suggested approach towards increasing coverage of skilled delivery service is the inclusion of birth plans (birth preparedness and complication readiness plans) in routine ANC (WHO, 2006). A number of countries in Sub-Saharan Africa have adopted WHO's focused antenatal care model (WHO, 2008) which promotes birth plans as a strategy for improving women's health seeking behaviours for timely and appropriate care during pregnancy, labour, delivery and the postnatal period (WHO, 2006).

### **2.7 Barriers to Skilled Delivery Services**

Cotter et al. (2006) have reported that, in sub-Saharan Africa, although women attend antenatal clinics, yet they do not seek skilled attendance when they are in labour. Some authors have argued that, inadequate access to and underutilization of quality maternal health care services could be major reasons for poor health of the women as well as high mortality among women and newborns (Campbell and Graham, 2006). Skilled delivery, however, reduces mortality among women and babies (Crissman et al., 2013), but there are still barriers that prevent pregnant women from accessing the services (Tsegay et al., 2013).

The barriers that prevent pregnant women from accessing skilled delivery services include socio-economic and cultural factors, physical and institutional factors. For example, Onta et al. (2014) revealed that distance to health centers, inadequate transport services, poor availability of skilled birth attendance, poor infrastructures especially in remote, inadequate information about the services prevent pregnant women from accessing skilled delivery services. A similar study conducted by Esena and Sappor (2013) in Ghana found that most women access skilled delivery services. However, they identified that, transportation



difficulties, high cost of care, poor attitude of health workers and poor quality were some of the challenges in accessing skilled delivery services among women in Ga West municipality.

Katenga-Kaunda (2010) observed that, women were usually dissatisfied with the quality of care they received during their periods of pregnancy and childbirth. This turn to prevent them from accessing skilled delivery services. Also, he identified that this problem arises due to weak administration and poor management of the services. Crissma et al. (2013) also found that, maltreatment by some health professionals, the need for a support person for HCF delivery and precipitous labor remains the barriers to skilled delivery services among women. The sociocultural and economic issues that prevent women from accessing skilled delivery services include; cultural and traditional practices, family education, lack of decision making power, educational level, marital status, cost associated with HCF delivery prevent women from accessing skilled delivery services (Onta et al., 2014; Esena and Sappor, 2013; Tsegay et al., 2013). Onta et al. (2014) for instance identified that, some families can exert pressure on the women upon their traditions and customs to seek traditional birth attendance rather than skilled birth care.

## **2.8 Conceptual Framework**

This study sees skilled delivery service as a function of increased antenatal care service, people's socio-cultural intuitions, access to delivery centers and service, healthcare provider attitude and quality of delivery service, and women's knowledge on the significance of skilled delivery. These factors are expected to shape the decision to seek skilled delivery or otherwise.

Thinking out of the box, economic and geographical spread of the people may also have stakes in the decision to seek skilled delivery. This function is represented below. As a

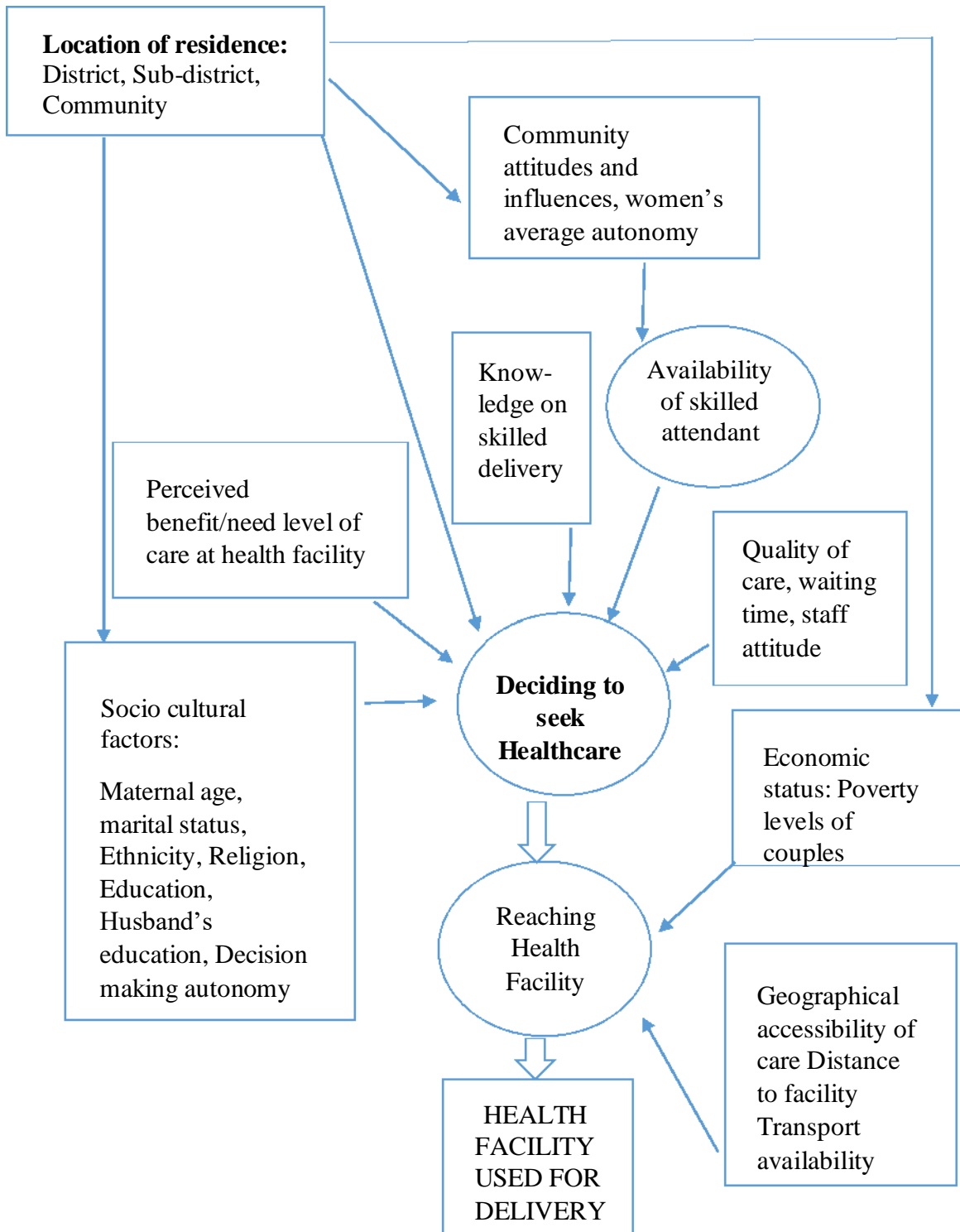


parachute, when there is a good balance between the various components, there is the possibility of a good and a controlled landing, but where such components fail to agree among one another, the incident of home or unskilled delivery becomes the result.

The framework according to Gabrysch *et al.* (2011) considers person related factors as well as health facility factors. The person related factors include the mother's socio-demographic characteristics as well as social - cultural factors and the perceived benefits and need of facility user. It also considers how community attitudes influence family decision making with the location of residence influencing most other factors. Knowledge on skilled birth attendance is also an important factor and all these together have an influence on the decision to seek care.

Economic and geographical accessibility mainly influence whether the woman actually reaches the facility. The health facility factors are related to availability of skilled delivery services as well as the quality of care rendered in terms of waiting time and staff attitude (Gabrysch *et al.*, 2011).





**Figure 2. 1: Decision to Seek Skilled Delivery by Women (adopted from Esena and Sappor (2013))**

## CHAPTER THREE

### METHODOLOGY

#### 3.0 Introduction

In this chapter is the methodological procedures employed in the course of the study. It highlights the study area, the research design, the population under study, the sampling procedures and sample size, data collection tools, analysis and tools of presentation as well as ethical considerations.

#### 3.1 The Study Area

Tolon District is one of the 45 districts created by the erstwhile Provisional National Defense Council (PNDC) Law 207 in 1988 with Tolon as its capital. The District comprises 61 members, of which 42 are elected, 19 appointed, the District Chief Executive and the two (2) Members of Parliament who are non-voting members of the Assembly.

The land is generally undulating with a number of scattered depressions. There are no marked high elevations throughout the district. The District is drained by a number of rivers and streams, most prominent being the White Volta, which almost divides the District into two equal halves. Among the major tributaries of the White Volta are Kulabong, Koraba, Salo, and Bawa Winibo, to mention just a few.

The major rivers and their tributaries exhibit dendrite drainage patterns. Most of these tributaries dry up during the dry season. . There exist 48 smaller dams and dug-out (26 dams-14 dugouts) in some communities in the District.

The vegetative cover is basically Guinea Savanna interspersed with short drought resistant trees and grassland. The land is generally undulating with a number of scattered depressions.



The soil is generally of the sandy loam type except in the lowlands where alluvial deposits are found. Major tree species include the Shea nut, dawadawa, mango, which are economic trees and form an integral part of the livelihood of its people.

The District has Shea nut tree plantations and other economic trees like mangos, dawadawa trees and cotton production. Other economic undertaken include inland fishing and rice cultivations/fields in large areas. There are also a number of income generating groups who have been trained in various skills to undertake small-scale business activities so as to generate income for their families.

But the Scarcity and the cost of credit or loan facilities to assist them yield good fruits from the skills and knowledge acquired has been a limiting problem. Given the unpredictable nature of the weather and unpredictable incomes from farming, many young people migrate to down south known as (Kayaaye) for economic reasons. The females especially migrate to Accra and Kumasi for survival and greener pastures, but are usually unable to be employed because they lack relevant employable skills.

The total population, according to the 2000 Population and Housing Census, stands at 122,550. The 2010 population is estimated at 161,160 with the growth rate of 3%. Population density is approximately 50 inhabitants per square Kilometer. The current population stands at 249,691 according to GWEP TKDA January 2009 update.

About 45% of the population are within the ages of 14 and 30 which indicate that the population is largely youthful. The district is made up of 237 settlements, most of which are farming communities with a population below 500. Using a population of 5000 as the threshold for Urban-Rural dichotomy, the district has about two (2) Urban Centre's. This





includes Tolon, and Nyankpala. It, therefore, implies that a greater percentage of the population lives in the rural areas. The current demographic data of the District have the population at about 249,691 and Two Hundred and Twenty-Six (226) communities of the 12 Area Councils in the Tolon District (GWEP/UNICEF, 2009).

Generally the standard of living is very low as compared to the National average as indicated in the District poverty mapping. The people mean very little and cannot save to build up capital for development. The average income per month for a household is about GH¢20.20. Nationally, the Northern regions are classified as the poorest regions in Ghana. In the northern region, among the numerous poor districts, Tolon is not an exception as the majority of its inhabitants are peasant and subsistent farmers who farm on a subsistence basis making it difficult to even offer some of their produce for sale.

These have culminated into most of the youth travelling to the South for non-existing jobs. The District is well known as contributing significantly to the incidence of 'Kayayee' which is a national canker. This, among other issues like malnutrition and unemployment, can testify for the poor standard of living in the District.

The Tolon/ District has a lot of opportunities awaiting private investment and joint venture partnership between the private and the public sector. In Agricultural sector, studies have indicated that along the banks of the White Volta, irrigation farming is feasible and can take place throughout the year.

The majority of the population is engaged in the cultivation of different crops ranging from Vegetables to cereals. Available records show that the Tolon District has a comparative advantage over the other districts in the northern region due to its numerous potential. The



District Assembly really encourages this dry season farming through its National Youth Employment Program (NYEP). It is worth noting that vegetables produced from these two (2) dams keep Tamale flooded with vegetables throughout the year, the district is also noted for the production of industrial crops like cotton. The District is endowed with a vast track of pasture suitable for livestock production. The District is blessed with a good breed of cows, sheep, goats, and pigs. Another area of investment yet undeveloped is the poultry industry.

The indigenous people are Dagomba; however, one can still find other tribes like Gonja and Ewes who do fishing along the White Volta. Dagombas constitute more than 80% of the district population. Islam and Traditional Religions are the predominant religions of the people. However, it is worth mentioning that there are pockets of Christians across the broad spectrum of the population especially in the urban settlements.

There are also some Non-Governmental Organizations and other Donors in the District who have been assisting the District in terms of Socio-economic activities such as: World Vision; District Wide Assisted Projects; UNICEF-I-WASH; CBRDP; NORPREP; Baptist Child Development Program; GDCA; NNED; WFP; LSGDP; Youth Empowerment for Life(YEFL); CAMFED; BIDO (Behisung Integrated Development Organization); NORSAAC- Northern Sector Action On Awareness Centre; Amaschina Self Help Association; and New Energy.

## HEALTH

The district has twelve (12) Health Facilities: three (3) health centers and seven (7) CHPS, one community hospital, and one clinic hospital.



Table 3. 1: Number of Health Facilities in the District

NO. SUB-DISTRICT COMMUNITIES			FACILITIES
1	Tolon	66	Tolon H/ Centre Kpendua CHPS Gburimani CHPS Yoggu CHPS Afreakmed Comm.Hosp.
2	Nyankpala	34	Nyankpala H/ Centre Gbulahagu CHPS UDS Clinic
3	Wantugu	24	Wantugu H/ Centre Kasuyili CHPS
4	Lingbunga	33	Lingbunga CHPS Zantani CHPS
Total		157	12



Table 3. 2: Population Distribution among Sub-district and Health Facilities

Sub- Distric	Population Children		15-19 ys				WIFA MTMSG TTBA CBS Outreach Comm.			
	>11m	>5ys								point
	4.0%	20.0%	10.6%	23.5%						
<b>Tolon</b>	28,211	1,128	5,642	2,990	6,630	4	32	132	52	66
<b>Nyankt</b>	17,632	705	3,526	1,869	4,143	5	11	68	20	34
<b>Wantu</b>	14,105	564	2,821	1,495	3,315	1	8	48	11	24
<b>Lingb.</b>	10,579	423	2,116	1,121	2,486	1	1	66	15	33
<b>Total</b>	70,527	2,821	14,105	7,476	16,574	11	52	314	98	157

District Health Directorate Tolon (Population Indices for 2014).

### 3.2 Research Design

The study employed a mixed research approach so that, both quantitative and qualitative designs was being used. Creswell (2007) distinguished between quantitative and qualitative research methods stating that, quantitative approach is one in which the investigatory primarily uses postpositive claims for developing knowledge (i.e., cause and effect thinking, reduction to specific variables and hypotheses and questions, use of measurement and observation, and the test of theories), employs strategies of inquiry such as experiments and surveys, and collect data on predetermined instruments that yield statistics data.

Buber, Gardner and Richards (2004) also noted that, if a researcher uses numbers in a research, interpretation would still be needed and if the data gathered are texts, counting may still be appropriate. Therefore variables do not necessarily have clear-cut meanings since processes can be revealed through numeric analysis as well as through narratives. This inability to



definitively separate one approach from another has implications for the acceptability of mixing methods in that “lines of conflict” cannot be clearly drawn.

The above assertions justify the writer’s choice of mixed methods as the design for the study, since the study entails inquiring about the cause and effects of high staff turnover in the banking sector.

### **3.4 Population of the Study**

The main population of the study were women in their reproductive age (WIFA) that is, women between the ages of 15-49 years who have children 0-12 months and pregnant women. Key informant interviews by purposive selection of health staff who conduct deliveries and have in depth knowledge on skilled delivery care and services were conducted. Similar interviews were conducted among traditional birth attendants with the aim of obtaining all-round information on the subject.

Also, focused group discussion with married men between the ages of 20-49 and with children was conducted in four (4) communities. The selection of the men was randomized. Each group contained 10-15 men so as to gather varied views from across the men and the communities. Therefore, four categories of people were considered for relevant data in this study. They include the principal respondents who were women of reproductive stage and who should be pregnant or had given birth in the last one year; birth attendants (i.e. skilled health workers and traditional birth attendants) and men (husbands in the communities).



### 3.5 Sampling Procedures

Purposive sampling technique was employed to select the four (4) sub-districts for study. The choice of the technique was to ease access to the four sub-districts. In each of the four sub-districts, a list of all communities was made. Ten (10) communities were purposively selected under each of the four sub-districts making 40 communities in all. The selected communities were on purpose that they rank high in issues of home delivery per the researcher's observation. This was done to ensure the quick location and access to the required number of respondents for the study considering the time frame for the study.

A sample size of 423 was considered worthy for this study. This target was reached using the simple random sampling. By this method, the researcher wrote 'yes' and 'no' so that, anyone who picked 'yes' was considered for the study. This was made possible by the assistance of the local chiefs and leaders of the various communities sampled. These chiefs sent out announcements to summon all women within their reproductive age for education on some pressing maternal health issues facing their communities and the District as a whole. This assistance made the collection of data quite easy for the researcher and her team of assistants. This however, was the main respondents who were studied quantitatively with questionnaires.

The study also sampled some midwives, general health workers who conduct delivery and traditional birth attendants for further information in support of the information from the main respondents. From the four Sub-Districts (i.e. Tolon, Nyankpala, Wantugu and Lingbunga), focus groups were formed from the ten communities for the purpose of the interview. In all, there were ten focus group discussions, each with a membership size of 10-15 people including men (husbands in the communities), healthcare workers, and traditional birth



attendants. All the four health centers and the CHP compound were visited to invite the midwives or health workers who conduct regular delivery from these facilities for the interview. The discussion grounds were the CHP compounds. The women who were the main respondents were met at the health centers and CHP compounds, though a good number of them were met in their homes.

### 3.5.1 Sample Size Determination

According to the 2013 district annual report in Tolon District, 27% out of the total delivery were skilled delivery and the population for women in their reproductive age stands at 16,106 (DHD Annual Report, 2013). With this definite population of target respondents to draw from, the sample size of the study was determined as follows.

$$n = \frac{z^2 p (1-p)}{e^2}$$

Where,

n = the sample size

z = the z-score of the confidence level (95%) = 1.96

p = the proportion of skilled delivery in the Tolon District as at 2013 (27%)

e = the desired precision = 0.05

Therefore, substituting the values in the formula gives the following:

$$\begin{aligned} n &= \frac{1.96^2 \times 0.27(1-0.27)}{0.05^2} \\ n &= \frac{1.962 \times (0.27)(0.73)}{0.0025} \\ &= \frac{(3.8416) \times (0.1971)}{0.0025} \end{aligned}$$



$$\begin{aligned} & 0.0025 \\ = & 0.7572/0.0025 \\ = & 302 \end{aligned}$$

A 40% provision was made for dropouts in the study. This was because, the area under study is a farming area and conducting a survey during the raining season requires a provision for the possibility of high dropouts. Turn out at the meeting points were expected to be low due to the fact that, the target respondents might have been busy with their farm activities and assisting their husbands at the farm. Widening the sample size was also on purpose of including some other varied views for a more representation of the population under study. Therefore the sample size studied was:

$$\begin{aligned} 40\% \times 302 &= 120.8 \\ 120.8 + 302 &= 422.8 \\ &= 422.8 \text{ i.e. approximately } 423. \end{aligned}$$

Hence, the sample size for the study was 423.

### **3.6 Data Sources, Tools of Collection and Analysis**

Data for the study was obtained from two main sources namely: primary and secondary sources.

#### **3.6.1 Primary Data Sources**

Primary data for the study took the form of firsthand information gathered from among the respondents. It includes the information gathered from the interaction with all the individuals visited or encountered in the course of the study. Specifically, they were women in reproductive age, men in the communities, and general health workers especially midwives and nurses who conduct deliveries. These data were collected with the aid of questionnaires



and through focus group discussions with interview guides. Sindhu (2012) defined that, primary data are information collected by a researcher specifically for a research assignment.

### **3.6.2 Secondary Data Sources**

Secondary data for the study took the form of a review of existing but relevant literature. Literature was therefore sourced from textbooks, journals, organizational profiles and other printed materials on the subject matter. The essence of it is to help situate the study into the context existing studies relating to the subject matter and to obtain a wide view of the subject. The use of secondary data also guided the flow of the work towards achieving its objectives.

### **3.6.3 Data Collection Tools**

The basic tool for collecting the field data was a carefully designed questionnaire. The questionnaire was a structured one and was featured with close-ended questions to help guide the responses. However, it was not self-administered since majority of the people could not read and write. The researcher with the aid of a team of assistants administered it on the respondents in an interview.

There were also a few open-ended questions to allow respondents to freely express their opinion on the subject matter where necessary. There were sections in the questionnaire designed to reflect the sub-topics being studied. There were also interviews structured and guided by well-designed interview guides.

### **3.6.4 Data Analysis and Presentation**

The field data was analyzed using SPSS (Statistical Package for Social Sciences, Version 20). The researcher ensured quality of the data by first of all assessing the accuracy and the manner in which the questions were answered by the respondents to ensure that, only answers



appropriate to the questions were collected. Extraneous variable found as response to any question(s) were edited before the questions are coded into the software for processing. Self-discipline and data management ethics were strictly adhered to thereby ensuring that only responses collected from the field were coded and entered into the system and the analyst's own judgment does not come into play in the process of the data entering.

A descriptive analysis of the field data was made with logical deductions made with reference to existing literature reviewed. Histograms, pie charts, bar graphs and frequency distribution were employed to enhance interpretations where necessary.

### **3.6.5 Dependent Variable**

**Skilled Delivery:** Delivery by a qualified health provider is the dependent variable.

### **3.6.6 Independent Variables**

**Socio-Cultural Factors:** This includes men and in-laws as decision makers on the place of delivery; burial rites of the placenta; perceptions of unfaithfulness of women due to delayed delivery or complications; non-involvement of men and other family relatives in maternal issues.

**Access:** This includes distance to delivery or healthcare center; Means of transport; Availability of 24 hours service.

**Knowledge on Skilled Delivery:** Community members' knowledge on the relevance of skilled delivery.

**Healthcare Provider Attitude:** Attitudes of healthcare providers towards pregnant women and nursing mothers.



### **3.7 Reliability and Validity of Data**

Towards collecting a valid and reliable data, the researcher relied on existing literature to ensure that the questions constructed are accurate regarding their possibility of confirming existing findings or otherwise. The questionnaires were subjected to careful evaluation by some data experts and tutors with gross examination from the supervisor.

For reliability and consistent test, the Cronbach Alpha which ranges between 0 and 1 was used. The decision thumb is that of 0.6-0.7 indicate acceptable reliability, =0.8 or higher indicate good reliability. The sections of the questionnaire used in the analysis showed a of 0.8 which indicated good reliability suggesting a high internal consistency in the variables making up the questionnaire.

### **3.8 Ethical Considerations**

A letter of introduction was written indicating the essences of this study to participants and institutions concern. Appropriate consultations were made with chiefs and community leaders for access to members of their communities. This aided access to translators who assisted the researcher with translation of the languages. The study also followed a sequential layout as acceptable in the field of research and employed appropriate research procedures and conducts. The study also allowed for voluntary participation among the target respondents (expectant mothers and nursing mothers) and also midwives and identified husbands of the women. This helped to prevent the possibility of induced responses from the staffs and enhance the validity of the findings.



## CHAPTER FOUR

### RESULTS AND ANALYSIS

#### 4.0 Introduction

This chapter of the study presents the results and analysis of the field data collected through quantitative and qualitative means. It is presented in such a manner as will reveal the major themes making the objectives of the study. The results are categorized under the headings: Socio-demographics of the respondents; Knowledge of the essence of skilled delivery; Past pregnancy experience of the respondents; Knowledge on the danger signs of pregnancy, labour and health seeking behaviour among the respondents; and interview responses from the Focus Group Discussions.



#### 4.1 Socio-Demographics and Knowledge of Skilled Delivery

Table 4.1: 1 Socio-Demographics and Knowledge of Skilled Delivery

Demographics		Knowledge of skilled delivery		
		Yes	No	Total
<b>Age</b>	15-20	47 (11.5%)	8 (2.0%)	55 (13.5%)
	20-25	147 (35.9%)	8 (2.0%)	155 (37.8%)
	25-30	130 (31.7%)	13 (3.2%)	143 (34.9%)
	30-49	51 (12.4%)	6 (1.5%)	57 (13.9%)
<b>Total</b>		<b>375 (91.5%)</b>	<b>35 (8.5%)</b>	<b>410 (100.0%)</b>
<b>Religion</b>	Christian	109 (26.6%)	9 (2.2%)	114 (27.8%)
	Islam	265 (64.6%)	26 (6.3%)	290 (70.7%)
	Traditional	1 (.2%)	0 (0.0%)	1 (0.2%)
<b>Total</b>		<b>375 (91.5%)</b>	<b>35 (8.5%)</b>	<b>410 (100.0%)</b>
<b>Marital statue</b>	Married	345 (84.9%)	30 (7.3%)	375 (92.2%)
	Single	23 (5.6%)	5 (1.2%)	28 (6.8%)
	Separated	7 (1.0%)	0(.0%)	7 (1.0%)
<b>Total</b>		<b>375 (91.5%)</b>	<b>35 (8.5%)</b>	<b>410 (100.0%)</b>



Table 4. 2: Socio-Demographics and Knowledge of Skilled Delivery (Continuation)

<b>Demographics</b>	<b>Knowledge of skilled delivery</b>			
		<b>Yes</b>	<b>No</b>	<b>Total</b>
<b>Marriage Type</b>	Monogamous	194 (48.3%)	7 (1.7%)	201 (50.0%)
	Polygamous	175 (43.5%)	26 (6.5%)	201 (50.0%)
<b>Total</b>		<b>369 (91.8%)</b>	<b>33 (8.2%)</b>	<b>402 (100.0%)</b>
<b>Ethnicity</b>	Dagomba	301 (74.9%)	25 (6.2%)	326 (81.1%)
	Gonja	44 (10.9%)	10 (2.5%)	54 (13.4%)
	Akan	22 (5.5%)	0 (.0%)	22 (5.5%)
<b>Total</b>		<b>367 (91.3%)</b>	<b>35 (8.7%)</b>	<b>402 (100.0%)</b>
<b>Education</b>	Primary	66 (16.3%)	23 (5.7%)	89 (21.9%)
	JHS	47 (11.6%)	1 (0.2%)	48 (11.8%)
	SHS	15 (3.7%)	1 (0.2%)	16 (3.9%)
	Tertiary	14 (3.4%)	0 (0.0%)	14 (3.4%)
	Others	1 (0.2%)	3 (0.7%)	4 (1.0%)
	Nil	230 (56.7%)	5 (1.2%)	235 (57.9%)
<b>Total</b>		<b>373 (91.9%)</b>	<b>33 (8.1%)</b>	<b>406 (100.0%)</b>
<b>Occupation</b>	housewife only	220 (54.5%)	27 (6.7%)	247 (61.1%)
	Petty trader	68 (16.8%)	5 (1.2%)	73 (18.1%)
	Farmer	66 (16.3%)	3 (0.7%)	69 (17.1%)
	Others	1 (0.2%)	0 (0.0%)	1 (0.2%)
	Student	3 (0.7%)	0 (0.0%)	3 (0.7%)
	Gov't employee	11 (2.7%)	0 (0.0%)	11 (2.7%)
<b>Total</b>		<b>369 (91.3%)</b>	<b>35 (8.7%)</b>	<b>404 (100.0%)</b>

Source: Field Survey, May 2015



From the data collected regarding the ages of the respondents, it was observed that the proportion of the respondents between the ages of 15-20, 20-25, 25-30 and 30-49 years who indicated their knowledge on skilled delivery were 13.5%, 37.8%, 34.9% and 13.9% respectively. It thus suggests that, majority of the sections of the women were aged within 20-30 years.

Regarding the women's knowledge of skilled delivery, 91.5% of the women have knowledge on skilled delivery. The findings of the study established that women within the age range of 20-30 had adequate knowledge of skilled delivery. The general level of knowledge on skilled delivery was very adequate among the women. However, 8% of the women indicated having little knowledge on skilled delivery.

With regards to the results of religious affiliations of the respondents, the majority of the women representing 70.7% belonged to the Islamic religion, 27.8% and 0.2% of them belonged to the Christianity and traditional religions. Regarding knowledge in skilled delivery, 2.2% of the women who were Christians did not have adequate knowledge on skilled delivery and 6.3% of the women who were Muslims also had insufficient knowledge on skilled delivery.

The results of the study also reveal that, (92.2%) of the women interviewed were married, 1.0% were married, but separated at the time of the study while 6.8% were still single but with children or pregnancies.

In the type of marriage engaged in by the women, the survey found that 50.0% of the women were into monogamous marriages (meaning one man to one woman marriage type), while

another 50.0% of the women were into polygamous kind of marriage (meaning one man to more women marriage).

The study also found that the majority (81.1%) of the women were Dagombas, 13.4% Gonja while 5.5% were Akans. Knowledge of skilled delivery among the Dagombas was highest, yet, they recorded low attendance of skilled delivery. All the Akans included in the study had knowledge of skilled delivery while the Gonjas recorded a few (2.5%) cases of ignorance among them.

The survey with regards to the women's education discovered that, 21.9% of the women had only primary level of education, 11.8% had up to Junior High School level education, 3.9% attained Senior High School level education while 3.4% of them hold up to the tertiary level of education. About 1.0% of the women had other forms of education (non-formal, apprenticeship, etc.). Unfortunately, 57.9% of the women had no form of education. That is to say, they have never been schooled in any form and therefore, have very lean chances of reading and writing the English language and perhaps, their local languages.

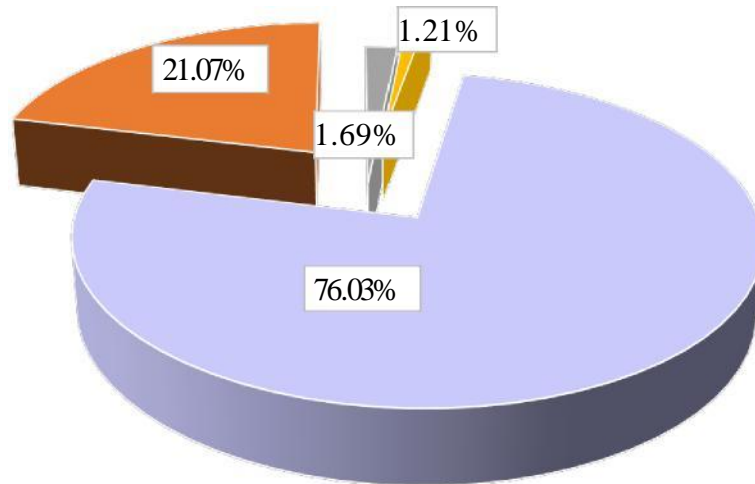
With regards to occupation, the majority (61.1%) of the women were housewives only and had no business or work doing apart from taking care of the house. About 18.1% of the women were petty traders, 17.1% were farmers while 0.7% were students. Also, 0.2% of them noted to have been engaged in other activities other than petty trading and farming. However, 2.7% were government employees.





#### 4.2 Knowledge of Importance of Skilled Delivery among the Women

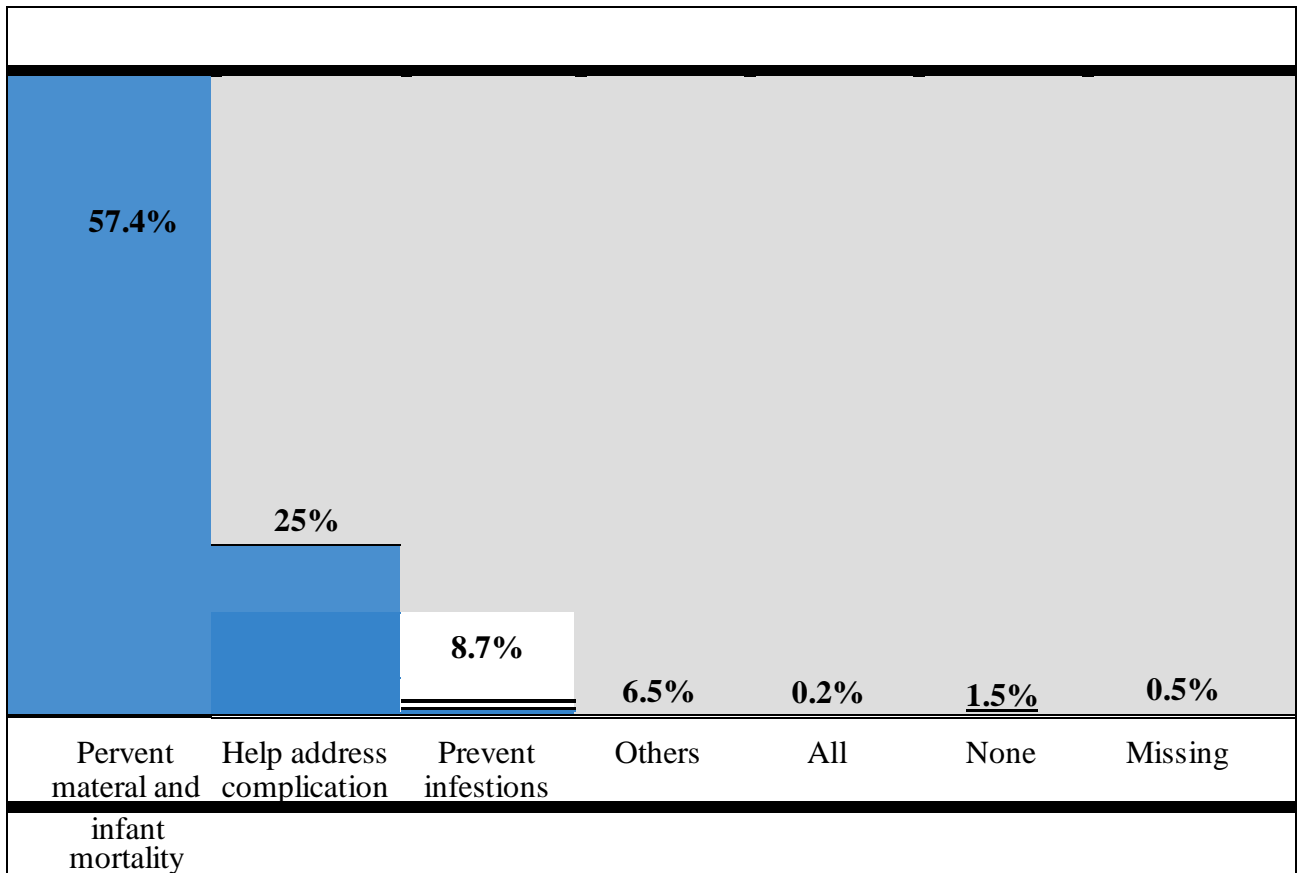
- Nurse/midwife attending to pregnant women
- Trained TBA attending to pregnant woman
- Untrained TBA attending to pregnancy
- Missing



**Figure 4. 1: Women’s Perception Definition of Skilled Delivery Source: Field Survey, May 2015**

Having noted about 91.5% of the women reporting to have known about skilled delivery, the survey inquired about their perceived meanings of the concept. The results of the study reveals 76.03% of the women stating that skilled delivery means a nurse/midwife attending to a pregnant woman. About 21.07% of the women noted that skilled delivery also implies that a trained Traditional Birth Attendant assisting a pregnant woman who is on labour to deliver. About 1.7% of the women also held that when an untrained Traditional Birth Attendant attends to a pregnant woman, it is regarded as skilled delivery. It is worth noting, however the 1.21% of the women did not respond to this question as a way of indicating their

ignorance of skilled delivery. It can be held from the submissions as a confirmation of the earlier position of the women that, majority of the women really understands and know about skilled delivery.



*Figure 4. 2: Women's Perceived Relevance of Skilled Delivery*

Source: Field Survey, May 2015

Also, the study enquired from the women, their perceived importance of skilled delivery and this revealed 57.4% of the women mentioning that skilled delivery prevents maternal and infant mortality. Also, 25.2% of the respondents held that skilled delivery help address complications before, during and after birth, whereas 8.7% of the women noted that skilled delivery prevents infections before, during and after delivery. Interestingly, 6.5% of the women mentioned that skilled delivery has some other relevance to maternal health as 0.24%

of the respondents noted that all of the above stated facts make up the relevance of skilled delivery. Unfortunately, 1.45% of the women could not associate any importance to skilled delivery. This perhaps may be due to their lack of knowledge on the subject. It implies that, most of the women in the Tolon District acknowledged the essence of skilled delivery among reproductive mothers.

#### 4.3 Past and Present Pregnancy Information of Women in Tolon

Table 4. 3: Past and Present Pregnancy Information of the Women

Number of Pregnancies	Frequency	Percent
1-2	132	32.0
2-3	192	46.5
3-4	65	15.7
5-6	20	4.8
7& above	4	1.0
<b>Total</b>	<b>413</b>	<b>100.0</b>

Source: Field Survey, May 2015

After obtaining some past and present pregnancy information of respondents, it was revealed that 32.0% of the respondents have had not more than two (2) pregnancies while 46.5% have had up to three (3) pregnancies at the time of the study. It was further found that 15/7% of the women had up to four (4) pregnancies while 4.8% of the women have had up to the tune of 6 births or pregnancies. Women who had more than seven (7) pregnancies were represented by 1.0% of the women.



### 4.3.1 Attendance to Antenatal Care

Table 4. 4: Number of ANC Attendance

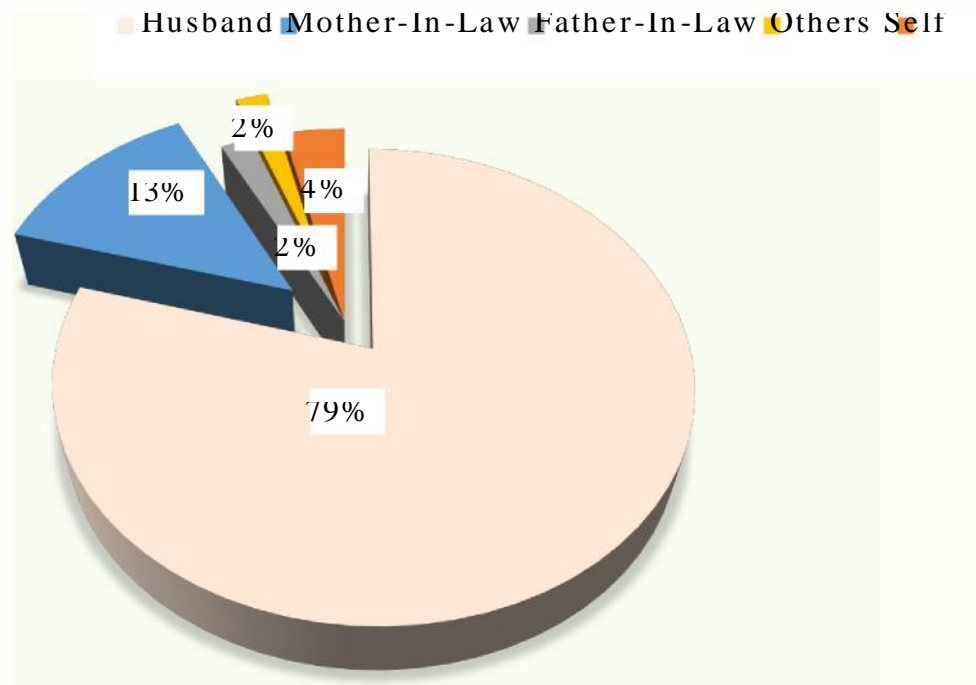
No. of Times Attended		Frequency	
Yes	1-2	111	( 2 8 . 2 % )
	3-4	117	( 2 9 . 7 % )
	4 plus	110	( 2 7 . 9 % )
No		56	( 1 4 . 2 % )
<b>Total</b>		<b>394 (100.0%)</b>	

Source: Field Survey, May 2015

The survey attempted to ascertain whether they attended antenatal care and how frequently the women attended antenatal care and this revealed that, 85.8% of the women attended antenatal care while 14.2% of the women did not. By the number of women who attended ANC during their pregnancies, 28.2% visited once or twice while 29.7% visited about 3 times or four times. About 27.9% of the women also noted to have attended ANC for more than 4 times.



### 4.3.2 Source of Influence for ANC Attendance



*Figure 4. 3: Source of Influence for ANC Attendance*

Source: Field Survey, May 2015

A further inquiry among the women revealed that, 79.4% of the women were influenced by their husbands while 13.08% were influenced by the mothers-in-law to attend ANC meetings with their nurses. About 1.9% of the respondents each were also influenced by their father-in-laws and other family members while 3.6% of the women advised themselves to attend ANC meetings. In some other cases, Traditional Birth Attendants advised the women to attend ANC meetings.

### 4.3.3 Information on Place of Delivery from Healthcare Staff during ANC

Table 4. 5: Delivery Place Information from Healthcare Staffs

Information form Healthcare Staffs	Percentage
It prevents infections	56(15.5%)
It prevents maternal and infant mortality	58(16.0%)
It prevents complication	59(16.3%)
Gives advises on good diet	45(12.4%)
Importance of skilled delivery	144(39.8%)
No	31(8.6%)
<b>Total</b>	<b>362(100.0%)</b>

Source: Field Survey, May 2015

As to whether the women received information on the place of delivery during their routine ANC sessions, the survey found that 91.4% of the women were informed about a place of delivery while 8.6% of the respondents reported that they were not informed about where to visit for delivery. Of the number of respondents who reported to have been informed, the majority (39.8%) of them reported to have been told the importance of skilled delivery or the

relevance of health facility delivery. Also, 14.4% of the women were told that skilled delivery prevents infections, 10.8% were also told that skilled delivery prevents maternal and infant mortality. A section of the respondents (15.2%) was also told that skilled delivery prevents complications associated with delivery while 11.3% of them were given information on good dietary practices.

#### 4.3.4 Place of Deliveries Already Made and Preferred Place of Delivery

Table 4. 6: Number and Place of Delivery among the Women in Tolon District

Number of Deliveries	Place of delivery		Total
	Health facility	Home(TBA)	
1-2	70	57	127
	17.9%	14.5%	32.4%
2-3	119	53	172
	30.4%	13.5%	43.9%
3-4	23	43	66
	5.9%	11.0%	16.8%
5-6	11	14	26
	2.8%	3.6%	6.4%
7 and above	1	1	2
	.3%	.3%	.5%
<b>Total</b>	<b>224</b>	<b>168</b>	<b>392</b>
	<b>57.1%</b>	<b>42.9%</b>	<b>100.0%</b>

Source: Field Survey, May 2015

Regarding past pregnancy experience of the women, it was discovered that 32.4% of the women have had up to two (2) deliveries already, 43.9% of them have had up to 3 deliveries while 16.8% of them have had 4 deliveries before the time of the study. About 6.4% have had up to six (6) deliveries before the time of the study. A few women (0.5%) have had seven and above deliveries before the study. A further probe revealed that 57.1% of the women made their deliveries at the health center or the hospital/clinic facility in their communities while 42.9% of the women made their deliveries at the home or with the Traditional Birth Attendant.





Table 4. 7: Preferred Place of Delivery and Reasons

Reasons for Preference	Where do you prefer to deliver			Total
	Health facility	Home (TBA)	Prayer camp	
It prevents infections	42 12.0%	12 3.4%	0 0.0%	54 15.4%
Prevent maternal and infant mortality	62 17.7%	11 3.1%	4 1.2%	77 22.0%
It addresses complications	83 23.7%	4 1.1%	4 1.2%	91 26.0%
Sense of save delivery	97 27.7%	6 1.7%	0 .0%	103 29.4%
peoples acknowledgements of the place	7 2.0%	7 2.0%	0 .0%	14 4.0%
Its closeness	1 .3%	10 2.9%	0 .0%	11 3.1%
Total	292 83.4%	50 14.3%	4 2.4%	350 100.0%

Source: Field Survey, May 2015

In the inquiry about the preferred place of delivery among the women, it was found that majority of the women (83.4%) preferred to deliver at the health facilities provided in the



district and their communities. However, 14.3% of the women have their preference for home or with TBAs.

Interestingly, about 2.4% of the women prefer delivery at the prayer camp. A further inquiry showed that, of the women who preferred the health facility for delivery, 12.0% knew it prevents infections, 17.7% knew it prevents maternal death and infant mortality, 23.7% knew it addresses possible complications with childbirth.

Also, 27.7% of these women knew that delivery of the health facility ensures a sense of safe delivery, 2.0% of them believed many people acknowledge the health center as the right place of birth while 0.3% of the women reported that the health center is close to them. Interestingly, these same knowledge and beliefs rests with the 14.3% of the women who prefer the home or the TBA for delivery.



#### 4.4 Knowledge on Danger of Pregnancy, Labour and Health Seeking Behaviour

Table 4. 8: Knowledge of danger signs during pregnancy and delivery

Symptoms	Frequency	Percent (%)
<b>Dangerous signs/symptoms during pregnancy</b>		
Swollen/puffy face	45	10.9
Swollen legs	112	27.1
Raised B/P	128	31.0
Dizziness	65	15.7
Seeing water before delivery	32	7.7
Others	25	6.5
<b>Total</b>	<b>413</b>	<b>100.00</b>
<b>Dangerous signs/symptoms during labour/delivery</b>		
Seeing water before delivery	33	8.0
Fitting	199	48.2
Raised B/P	47	11.4
Dizziness	30	7.3
Bleeding before delivery	74	17.9
Others	30	7.3
<b>Total</b>	<b>413</b>	<b>100.00</b>

Source: Field Survey, May 2015

Regarding the women's knowledge on the dangers of pregnancy, labour and health seeking behaviours especially during pregnancy, the women were asked to indicate the signals and/or symptoms that mean danger to them during pregnancy and 10.9% of them noted swollen or



puff faces during pregnancy while 27.1% mentioned swollen legs during pregnancy. Also, 31.0% of the women noted raised BP as a signal of danger during pregnancy, 15.7% of the women mentioned dizziness while 7.7% identified the seeing of water before delivery as a sign of danger. About 6.5% of the women also identified some other unusual features as signals of danger during pregnancy.

On a similar note, the women were asked to identify the symptoms perceived as a danger during labour/delivery and it was found that, 8.0% of the women perceived seeing water before delivery as a danger to the delivery process. To this query again, 48.2% of the women perceived fitting as a signal of danger during delivery, 11.4% of them considered raised BP as a danger to the delivery process while dizziness before or during delivery was also considered dangerous among the women. To about 17.9% of the women, excessive bleeding prior to delivery is a danger of complications during the delivery process. About 7.3% of respondents also mentioned other signals.



#### 4.4.1 Decision-making, Funding and Factors Considered for Place of Delivery

Table 4. 9: Decision-Making, Funding and Factors Considered for Place of Delivery

<b>Response</b>	<b>Frequency</b>	<b>Percent(%)</b>
<b>Decision Maker</b>		
Husband	308	74.6
Mother-In-Law	86	20.8
father-in-law	7	1.7
Others	2	.5
Self	10	2.4
<b>Total</b>	<b>413</b>	<b>100.00</b>
<b>Fund Provider</b>		
Self	62	15.0
Husband	298	72.2
Mother-in-law	39	9.4
Others	14	3.4
<b>Total</b>	<b>413</b>	<b>100.00</b>
<b>Other Factors</b>		
attitude of health staff	117	28.3
Time spent in health facility	119	28.8
type of facility	42	10.2
Transportation cost	115	27.8
Quality of services	12	2.9
Nil	8	1.9
<b>Total</b>	<b>413</b>	<b>100.00</b>

Source: Field Survey, May 2015



With regards to who makes the decision on the place of delivery, it was found among 74.6% of the women that their husbands make the decision to place of delivery while 20.8% of such decisions come from the mothers-in-law of the women. In some cases (1.7%), the father in-laws of the women makes such decisions while other family members have 0.5% influence in the decision on a place of delivery for pregnant women in the family.

A further inquiry also showed that, 72.2% of the women were funded by their husbands to seek healthcare while 15.0% of the women funded themselves to seek healthcare during pregnancy. Unfortunately, mothers-in-law who have about 20.8% influence in the decision to place of delivery have only 9.4% funding for the women. Other family members who have a lesser influence rather make 3.4% funding towards health care needs of the women.

On the factors usually considered when deciding on the place of birth, 28.3% of the women mentioned the attitude of health staffs, 28.8% mentioned the time spent in the health facility while 10.2% considered the type of facility closest to them. Also, 27.8% of the women considered transportation cost as 2.9% of the women looked at the quality of service that comes out of the facility or the place of delivery. Unfortunately, 1.9% of the women do not look out for anything when considering the place of delivery, so they walked into any place once it has been tagged as a place of delivery.



#### 4.4.2 Commitment, Friendliness and Cleanliness of the Health Facility

**Table 4. 10: Commitment, Friendliness and Cleanliness at the Health Facility**

<b>Variables</b>	<b>Frequency</b>	<b>Percent (%)</b>
<b>Perceived features of Quality Healthcare</b>		
Availability of equipment/supplies	240	58.1
Type of staff	122	29.5
Availability of ambulance	51	12.4
<b>Total</b>	<b>413</b>	<b>100.00</b>
<b>Level of Staff Commitment</b>		
Committed	328	79.4
Uncommitted	38	9.2
Fairly committed	47	11.3
<b>Total</b>	<b>413</b>	<b>100.00</b>
<b>Friendliness of Staff</b>		
Very friendly	235	56.9
Friendly	160	38.7
Unfriendly	18	4.4
<b>Total</b>	<b>413</b>	<b>100.00</b>
<b>Level of cleanliness of the Health Facility</b>		
Very clean	202	48.9
Clean	189	45.8
Not clean	22	5.4
<b>Total</b>	<b>413</b>	<b>100.00</b>

Source: Field Survey, May 2015



Talking about quality of service as one of the factors considered for a place of delivery, the study enquired about the features of quality service among the women. This inquiry reveals 58.1% of respondents saying the availability of equipment/drugs/supplies adds quality of a service while 29.5% of the women mentioned that the type of staff rendering the service could make a difference between quality service and poor service. About 12.4% of the women stated that the availability of ambulances, etc. can also make a quality service. While these perceptions may hold true, it sends signals of woman's expectation of service from the health facilities, if they must utilize them.

A further inquiry on the commitment of health staffs in ensuring quality service to pregnant women laboring women in the Tolon district revealed 79.4% of women stating that health professionals within the district are committed to their work. About 11.3% of the women ranked the health staff as being fairly committed while 9.2% of the women said health professionals in the Tolon district are not committed to their calling. While it is obvious that, health providers in the Tolon district shows remarkable commitment to the course of their works, it is also worth saying that there are still traces of uncommitted workers in the health sector of the district.

With regards to the friendliness of health staff in the Tolon district, 56.9% of the women noted that health professionals in the district are very friendly while 28.7% of the women mentioned that, the health workers are friendly towards their patients. Only 4.4% of the women identified unfriendly health staffs in the Tolon district. This again confirms that, the





district has a great number of committed health workers who relate friendly with their patients except a few uncommitted ones who treat patients in an unfriendly manner.

On the cleanliness aspect of the health facility, 48.9% of the women held that the facility was very clean while 25.8% of the women said the facility was clean. About 5.4% of the women, however, did not see the facility to be clean. It suggests that, the district has clean facilities, except that further efforts need to be employed to keep the facility clean at all times of patients' visit.



#### 4.4.3 Relevance of Health Facility Delivery

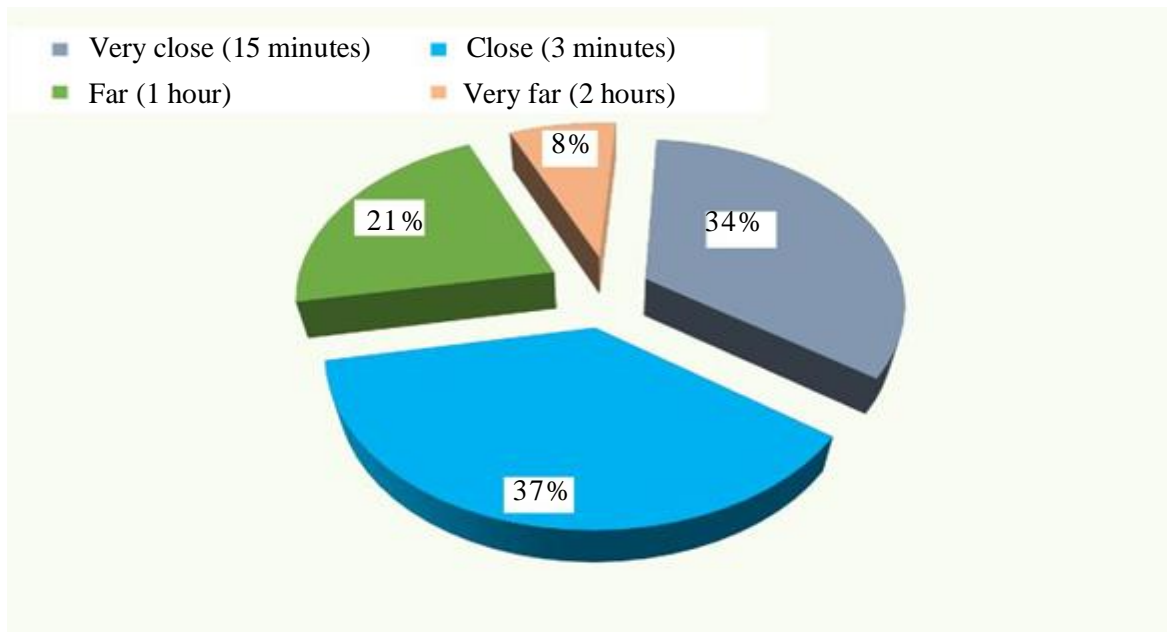
Figure 4. 4: The Relevance of Skilled Delivery to the Respondents

Source: Field Survey, May 2015

While asked to identify the relevance of delivering at the health facility, 34.6% of the women noted that delivering at the health facility makes it possible for complications to be managed. Also, 23.7% of the women indicated that skilled delivery or delivering at the health facility paves way for delivery to be done with less bleeding and pains while 16.7% of the women noted that, delivery at the health facility is faster. About 20.1% of the women also realized that proper care is given to both the mother and child to prevent death. While 0.7% of the women acknowledged that skilled delivery offers many more significance to the delivery process, 4.1% of the women could not identify any good thing with going to the health facility to deliver.

#### 4.4.4 Health Facility Distance from the Mothers/Women

Figure 4. 5: Travel Distance to Health Facility

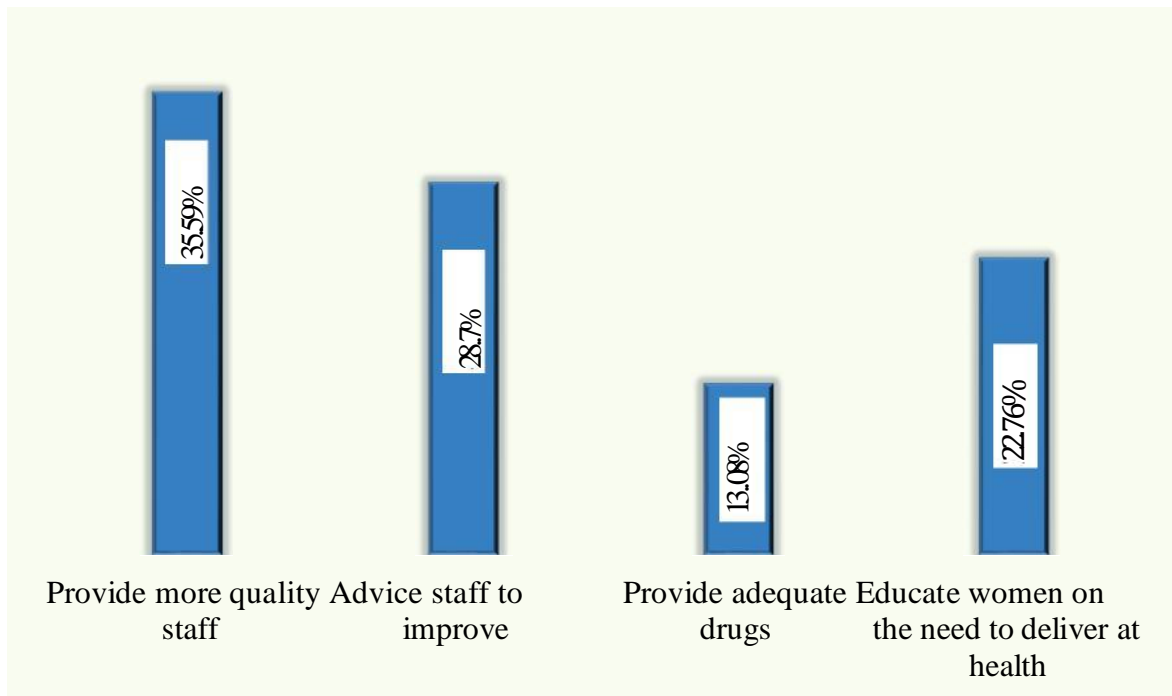


Source: Field Survey, May 2015



With transportation distance was mentioned as a challenge to the women’s access to skilled delivery, the study found that 33.7% of the women travel 15 minutes from the place of residence to the facility. It was also held between 37.3% of the women that, they must have to travel close to 30 minutes to access the health facility. Also, 21.3% of the women reported that they travel closed for one hour to access health care facility for skilled delivery.

Other women represented by 7.8% of the respondents must have to travel 2 hours to access the health facility for delivery. It thus suggests that, about half of the respondents could access the health facility in a maximum of 30 minutes’ drive from their residence while the other half must have to use a minimum of 1 hour to access the facility.



#### 4.5 Improving the Use of Skilled Delivery in the Tolon District

*Figure 4. 6: Improving the Use of Skilled Delivery in the Tolon District*

Source: Field Survey, May 2015

Towards improving the situation of low rates of skilled delivery among pregnant women in the Tolon district, the survey asked the women to make suggestions and this reveals 35.6% of the women, suggesting that more qualified staff should be provided for the health facility in the district. To this same query, 28.6% of the women proposed that health care staff at the facility should be advised to improve their attitude towards patients. About 13.1% of the women also mentioned that drugs should be adequately supplied to the facility and to the patients while 22.7% of the women held that, education to women on the need to deliver at the health facility should be encouraged especially during their ANC visits. These suggestions from the women are expected to motivate their use of the health facility for delivery and not just for the ANC.

#### **4.6 Focus Group Discussion Results**

The results of the qualitative data were evaluated according to the common themes that were identified during the discussions. This was done by going through the interviews to understand some of the issues that were raised. The interview was conducted for Men, Traditional Birth Attendants (TBAs), Midwives and Nurses.

##### **4.6.1 Importance of Skilled Delivery**

During the focus group discussion, a midwife established her understanding of significance of skilled delivery as

*“Complications are managed there, delivery is done with less bleeding and pains, delivery is fast and safe as well as proper care is given to both mother and child to prevent death”.*

In a follow-up to these responses this is what a man said about the importance of skilled delivery or why his wife/relative must have to make delivery of the health facility:



*“The facility/clinic is the safest because delivery is done with less bleeding and pains, especially, after delivery which was not the case when my wife delivered our first born at home” (FGD, man, Tolon).*

In conjunction with the importance of skilled delivery, another man testified by saying that:

*“I have observed that complications, especially, Postpartum Hemorrhage (PPH) are managed effectively after delivery in the health centers unlike when women deliver at home” (FGD, Man, Tolon).*

#### **4.6.2 Challenges Encountered at the Health Centers**

On the other hand, some of the men enlisted reasons why their wives/relative will not deliver at the health facility as:

*“When women are pregnant and we take them to the facility for Antenatal Care services, they tell them to visit the facility regularly and should try to deliver at the health facility, but at times when they are in labor and you send them to the facility, there is no staff at the health facility to help especially in the night and weekends” (FGD, men, Kpendua).*

Other men also gave reasons why their wives/relatives do not deliver at the health facility.

They said:

*“Our houses are far from the health facility and also, the attitude of the health staff towards our wives, where they shout at them unnecessarily, when we send them to access healthcare center delivery, they snob, insult and beat them when in labor at times” (FGD, 2 men, Kasuyili).*



This is what health workers had to say in line with the above statements raised by the men;

*“At times it is true that they come and do not meet us and this is due to lack of accommodation to health staff at the facility level where we have to move from Tamale to work every day” (In-depth Interview, health staff, Wantugu).*

*“A few health workers do shout, snob, insult mothers, especially when the life of the mother or the baby is in danger and this is due to the anger as a result of the ignorance or carelessness of the mother or the families of the matter about the danger that has accumulated” (In-depth Interview, health staff, Nyankpala).*

A man (a husband of a mother) narrated their encounter with a health worker;

*“We those who didn't attend school, if we go there, they treat us like useless human beings, they look down upon us, what they are not supposed to tell us, they told us because we have not been to school” (FGD, man, Tolon).*

A TBA also narrated how she was treated when she referred and escorted a woman to a facility at one night:

*“We went there in the night and they said they won't come, we begged them before one of the health workers came, checked her and asked us to go to Tamale for drips and that we will spend a lot of money and see how it is whiles we went with a motorbike. Then, the other nurse told the colleague that, it is too late to move with a bike to Tamale so calm down and attend to them” (In-depth Interview, TBA, Wantugu).*



Also, some men complained about the waiting time and this is what one said:

*“We took our wives to the facility and waited for the health workers for a very long time and when they came, they were just looking through some papers for a long time till we became fed up with them” (FGD, man, Kpendua).*

Most of the men lamented about the absence of health workers at the post during the weekends:

*“In our community, health workers do not work on weekends. So on weekends, no one will be there to attend to labour issues and that is not safe for the women, therefore it is rather safe to make up your mind that you are delivering at home or with the aid of a traditionalist” (FGD, man, Chirifoyili).*

#### **4.6.3 Reasons for Preference for TBAs**

When asked what factors attract their women to the TBAs, one man said;

*“The women in the Traditional homes (TBAs) do not demand so many things as they do at the hospital, the TBAs even helped the women with some local drinks hot water, and local porridge, and the women really liked this, (In-depth Interview, man, Tolon).*

Another man also mentioned that:

*“Giving birth at the hospital is not free, there are too many demands which their economic status could not meet ((In-depth Interview, man, Tolon).*



**A TBA also confessed that:**

*“Sometimes, the situations and conditions within which the women find themselves while in labour makes them to opt for the local delivery, for instance, when a woman did not expect delivery on a particular day and it starts, she just must have to accept anything possible within her reach to get the baby out and be free (In-depth Interview, TBA, Tolon).”*

#### **4.6.4 Cultural Factors leading to the Preference for TBAs**

With regards to the cultural factors, a number of the men had a same view which goes that:

*“(i). It is only women who are weak that deliver at the hospital. (ii). Women who did not conduct themselves well while with their husbands fear to deliver at home due to fear of confession. (iii) Women who deliver at the hospital are not allowed to give birth to many children and this does not qualify them and their children to much inheritance in case their father passes away (In-depth Interview, men- Tolon).”*

Another man quickly added that:

*“Even at the hospital, people are not allowed to perform the traditional rite for the burial of the placenta, they are not even given to the women, and meanwhile, the TBAs help to organize a befitting burial rite for the placenta because they know the traditions of the community”.*



#### 4.6.5 The Way Forward

Some TBAs also think that the delivery of the health facility was only necessary for women with complications as a TBA expressed:

*“Only young ones have problems and can go to the facility to deliver, but elderly and experienced ones do not have problems because they know how to control themselves and have easy delivery” (In-depth Interview, TBA, Tolon).*

Another TBA, while laughing saying that:

*“Then government should send people to come and teach us how to address the complications when they come, because we are already in the delivery work, only we do not have the capacity and equipment to face it when it gets complicated (In-depth Interview, TBA, Tolon)”*

From these narrations, it could be held that the continuous act of home delivery is as a result of several factors touching all other stakeholders such as nurses, the women and their families and also other difficult-to-control situations such as transportation and distance, as well as waiting time. Addressing the issue must therefore consider every other factor so as to ensure a lasting solution the canker of low skilled delivery.

## CHAPTER FIVE DISCUSSIONS

### 5.0 Introduction

This chapter of the study presents the discussions of the results of the field study. It highlights the issues such socio-demographics of the respondents, knowledge of the essence of skilled delivery, past pregnancy experience of the respondents, and also knowledge of the danger signs of pregnancy, labour and health seeking behaviour among the respondents. It also presents interview responses from the focus group discussions among the men and health workers as well the traditional birth attendants.

### 5.1 Socio-Demographics and Knowledge of Skilled Delivery

With regards to the demographics of the respondents, the survey took a look at the age, religious affiliation or faiths, marital status, the type of marriage, ethnicity, education and the occupation of the respondents. Most women in the Tolon district in the past of adolescent (especially 20 years and above), tend to secure knowledge of skilled delivery. The implication is that women are active examined their reproductive roles. It is therefore important that, maternal and reproductive education be geared towards women with the ages of 15-20 years to help address issues of limited knowledge of skilled delivery. If these necessary provisions are ignored forerunners in the provision of health services to the age group identified can lead to poor maternal and child health outcomes. In the context of knowledge of skilled delivery of women, marriage plays a very role in improving the knowledge levels of skilled delivery. In the specific context of the study, the majority of the informed decisions regarding the place and type of delivery services is highly influenced by husbands. In addition, this assertion may, however, depend on the socio-cultural and economic settings of households, especially



in the Tolon district where the majority of the household decisions and assets are controlled by husbands.

While the polygamous kind of marriage may be frowned upon by the Christian faith, there have been just a little of women and perhaps, community members with the Christian faith, therefore most community members could be seen within this kind of marriage as it was not prohibited by the dominant religious faith of the district. Only a few men and women would decisively not engage in the polygamous kind of marriage in the district. It is therefore worth mentioning that, with the polygamous marriage, the delivery trend of earlier wives has the tendency to influence the delivery activities of the new wives and if the trend is unskilled or home delivery, more of the new wives are likely to be influenced to follow this line of delivery instead of skilled delivery. It is not to say that, the trend of unskilled delivery or home delivery may not be found among the women with the monogamous kind of marriage. However, knowledge of skilled delivery was higher among women with monogamous marriage type than women with polygamous marriage type.

Typically, ignorance of skilled delivery was higher among women with primary level of education than women with JHS and SHS levels of education. Interestingly, there was no ignorance recorded among women with tertiary level of education. Most of the women who had no formal of education were noted to have knowledge of skilled delivery. This however is a more basis for inquiry into their practice of the level of awareness shown in this study.

The findings on the socio-demographics of the women suggest that the majority of the women depend largely on the economic positions/situations of their husbands or families and this may not pave way for the autonomy of decisions regarding their maternal health. Financiers

may have a keen interest in their place of health care considering their sponsorship. This further suggests that knowledge of skilled delivery may be hampered by the inability to access services due to inability to completely afford the decision to seek skilled delivery. This finding explains more clearly the assertion of Ministry of Health (2002) and WHO (2001) that, because pregnancy and childbirth are events charged with social meaning and often involved significant family and community participation, inclusion of family members in discussions about skilled delivery care during routine ANC should be a strategy promoted in many developing countries.

## **5.2 Knowledge of Importance of Skilled Delivery among the Women**

Regarding the women's knowledge on the importance of skilled delivery, the definition obtained from the respondents is most comparable to that given by WHO (2004) that, a skilled birth delivery attendant is someone trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. Therefore, if a traditional birth attendant receives appropriate training, he/she is capable of attending to such calls but ensure referrals where necessary or complicated. This confirms the position of Mpenbeni et al. (2007) that, lack of knowledge about pregnancy-related risk factors can be a reason of not perceiving the need of a skilled attendant at delivery. With this level of knowledge among the women, it is expected that, the use of skilled delivery would be high among the women. Figure 4.2 below shows data on the women's perceived relevance of skilled delivery.



### **5.3 Past and Present Pregnancy Information for Women in Tolon**

The information gathered in the past and present pregnancy information about reproductive mothers in the Tolon district revealed that, both experienced and new mothers were studied towards ascertaining the determinants of high ANC coverage and low skilled delivery in the Tolon district. There were, however, more experienced pregnant women and mothers than the first timers and/or the inexperienced ones. This may have a negative effect on the extent to which pregnant women seek skilled delivery, especially, when the experienced mothers and pregnant women have not used skilled delivery in their encounters. They are likely to advise the first timers or the new mothers to visit the TBA. Table 4.2 gave a detailed data on the past and present delivery information on the women.

#### **5.3.1 Attendance to Antenatal Care**

Approximately, ANC visits should be made once every month from the time of the first visit to the clinic or the hospital. These visits were supposed to have been used as an opportunity to educate pregnant women about the risks associated with childbirth, especially where skilled professionals are unavailable to attend to the pregnant woman. This is because, ANC is an opportunity to promote the use of skilled attendance at birth and healthy behaviors such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing. It thus suggests that, there exists a gap somewhere in the system, either from the ANC providers in the form of not communicating the needed information to the women or the women themselves who have made up their minds to only make ANC and deliver at TBA. This was shown in Table 4.3.



### **5.3.2 Source of Influence for ANC Attendance**

With inference from the responses on the source of influence for the attendance of the ANC, it is worthy of saying however, that, the community members understand the relevance of ANC treatments and have not relented on embarking on such visits to the clinics and the health centers. Yet, this is not enough to ensure safe delivery and safe maternal health. This is because, the increased ANC visit is expected to be finalized with skilled delivery in order to ensure safe maternal health. This aspect of the effort is lacking among the people and has to be emphasized regularly, especially during ANC meetings with the pregnant women. Data regarding this inference is shown in Figure 4.3

### **5.3.3 Information on Place of Delivery from Healthcare Staff during ANC**

The submissions regarding whether the women received information on the place of delivery during their routine ANC sessions suggest that, health attendants put up their efforts to caution, advise and educate the women on safe delivery through skilled delivery at the health facilities, yet, the women do not often regard this cautions. Perhaps, the influence of family members, husbands, TBAs and the people's beliefs should be responsible for this level of disregard for health cautions from the health care providers. The information herein is presented in Table 4.4.

### **5.3.4 Place of Deliveries Already Made and Preferred Place of Delivery**

Regarding the past pregnancy experience of the women, the submission from the women confirms the problem identified by the researcher that, skilled delivery stood very low compared to ANC attendance among the women. ANC attendance among the women stood at 85.8%, while skilled delivery recorded 57.1% among the women studied. Despite the improvement against the figures stated in the problem statement of this study, the number of



deliveries through TBAs is still great and could cause harm to maternal health in the district. It is therefore not out of place to think that, the women believe if they attend ANC meetings, they can make delivery wherever they desire (even outside the provided health facility). It is no surprise that, even the TBAs advise the women to attend ANC meetings prior to delivery. Table 4.5 shows this data as gathered from the women. Inferences drawn from some of the qualitative data gathered from the focal groups also depicted these facts.

In the inquiry about the preferred place of delivery among the women, it was found that majority of the women (83.4%) preferred to deliver at the health facilities provided in the district and their communities. However, 14.3% of the women have their preference for home or with TBAs. About 2.4% of the women, however, prefer delivery at the prayer camp. With the women who preferred the prayer camp for delivery, they ascribe to the conception that prayer camps help prevent maternal and infant mortality and also help to address complications of delivery. It implies therefore, that, a good number of the people (women) believe that the individuals at the prayer camp and the TBAs have some special powers beyond science and medicine hence, their preference for those places for delivery. These findings concur with that of Gabrysch and Campbell (2009) that, sociocultural factors, primarily influence decision-making on whether to seek care, rather than affecting whether women reach a facility. Therefore, there could be a conceptual distinguishing between the mother's own motivation to use skilled services and her act on her wishes. Yet, Gabrysch and Campbell espoused that, consideration should be given to decision-making of both mother and her family and therefore include women's autonomy and husband's education towards the freedom from these cultural beliefs. Table 4.6 shows data to this effect.



## **5.4 Knowledge on Danger of Pregnancy, Labour and Health Seeking Behaviour**

Without doubt, knowledge of dangers during pregnancy, and labour helps to shape the decision to seek skilled healthcare and more so, skilled delivery. On this note, the submissions suggest that, through education of skilled health providers during ANC meetings, the majority of the women got to be aware of what signals to look out for as dangerous during pregnancy and delivery. Yet this extent of knowledge needs to be met with the appropriate health care treatment and when this is not met, the unexpected happens and mortality due to unskilled delivery processes keeps increasing. Table 4.7 shows data on this discussion.

### **5.4.1 Decision-making, Funding and Factors Considered for Place of Delivery**

The submissions regarding who makes the decision on place of birth, who funds the decision and the final place of birth indicate that, inasmuch as the health facilities are expected to be the best if not the only place for delivery, the women who seek healthcare considers a number of factors as a composition of influence from their husbands, mothers-in-law, father in-laws and also other family members. This was also partly so, because majority of funding for the health care came from the husband, the mother-in-laws and other family members with the women themselves having little or no influence in the matter. Paramount among the factors considered were the attitude of healthcare workers towards the women, the time spent on service delivery and the transportation cost of the place. It thus suggests that, significant number of the women and their families ranked the TBAs and the prayer camps higher in terms of these factors as they consider placing for delivery.

This finding, however sends a caution to the health facilities as D'ambruoso et al. (2005) put it that, poor staff attitudes served as one of the reasons for non-acceptability and low utilization of delivery care services in the rural areas. This is because, the women and their





families expected a humanist, professional and courteous treatment from health professionals as well as a reasonable standard of physical environment as they consciously change their place of delivery and make the same recommendations to others if they experience degrading and unacceptable behavior from health professionals. The findings of this study also affirm the words of Kyomuhendo (2003) that, verbal abuse, neglect and poor treatment in hospital and poorly understood reasons for procedures, plus health workers' views that women were ignorant, explained the unwillingness of women to deliver in the health facilities. Also worth mentioning in this light is the distance traveled by the women to receive healthcare in the health facilities. Thaddeus and Maine (1994) showed that distance to health services exerts a dual influence on use by serving as a disincentive to seeking care in the first place, as well as an actual obstacle to reaching care after a decision has been made to seek it. As a result, 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. Relevant data relating to this discussion are presented in Table 4.8.

#### **5.4.2 Commitment, Friendliness and Cleanliness of the Health Facility**

From the responses, it can be conceived that the respondents' perceptions of service quality hold true and it is one of the major factors that influence people's decision to seek healthcare. This is what Esena and Sappor (2013) espoused that, poor attitude of health workers and poor quality care are some of the challenges contributing to the respondents' non-seeking of skilled delivery. However, the case in the Tolon district seemed contrary to the view of Esena and Sappor, though it is a prerequisite for health care. This is because, every necessary provision in terms of quality of service regarding the commitment of a friendly health worker, the

service facilities and the environment can be said to have been provided, yet, unskilled delivery stands high among the people. Table 4.9 shows data as discussed herein.

#### **5.4.3 Relevance of Health Facility Delivery**

On the note of relevance of health care delivery facility, it was observed that the education and sensitization on skilled delivery had not reached every woman in the district. However, it is worth saying that most of the women had head knowledge of the relevance of skilled delivery, but have not acted on their knowledge, hence, the high rate of deliveries with the Traditional Birth Attendants. Figure 4.4 below shows data gathered from the women in a field survey.

#### **5.4.4 Health Facility Distance from the Mothers/Women**

The survey as presented in Figure 4.5 revealed that, about half of the respondents could access the health facility in a maximum of 30 minutes' drive from their residence while the other half must have to use a minimum of 1 hour to access the facility. This could be a justification for the 57.1% of the women who used the health facility for their deliveries while about 42.9% of the women used the TBAs. It thus suggests that, time and cost of transportation could be the underlying circumstance for the women's use of TBAs for deliveries. This finding concurs with that of Thaddeus and Maine (1994) that distance to health services exerts a dual influence on use and due to this influence, 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. Borghi et al., (2006) also mentioned that, transport costs may also have a similar effect in the decision to seek skilled delivery. This may also be responsible for why 83.4% of the women preferred

the health facility for delivery, but 57.1% of women actually used the place. Figure 4.5 shows data to this effect.

### **5.5 Improving the Use of Skilled Delivery in the Tolon District**

Towards improving the situation of low rates of skilled delivery among pregnant women in the Tolon district, the survey asked the women to make suggestions and this saw 35.6% of the women, suggesting that more qualified staff should be provided for the health facility in the district. To this same query, 28.6% of the women proposed that health care staff at the facility should be advised to improve their attitude towards patients. About 13.1% of the women also mentioned that drugs should be adequately supplied to the facility and to the patients while 22.7% of the women held that, education to women on the need to deliver at the health facility should be encouraged especially during their ANC visits. These suggestions from the women are expected to motivate their use of the health facility for delivery and not just for the ANC. (See Figure 4.6).



## CHAPTER SIX

### SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

#### 6.0 Introduction

This chapter of the study presents the findings, conclusions and the recommendations of the study.

#### 6.1 Summary of Findings

The following are the key findings of the study;

The study found that, the Tolon district still lacks behind with regards to the global target for skilled delivery of 80% by 2010 and 90% by 2015 (Paxton et al., 2005). This was due to the revelation that, majority of the people studied only had head knowledge of skilled delivery and did not take the necessary steps toward practicing it. The reproductive age group studied was the range of 15-49 years and people within the range of 20-30 years were found to be dominant with high knowledge among the women. The dominant religious faith among the women was Islam while polygamous marriage was widely practiced among people making it easier for a first wife who delivered through the TBAs to advise a second wife to follow the trend. The people were largely Dagombas and Gonjas with a few mixes of the Akans with very low levels of education. The majority of the women had been also midwives with just a few of them engaged in petty trading and farming.

The study found that, the women understood the concept of skilled delivery as a health worker attending to a pregnant woman. Also others understood skilled delivery as a trained TBA attending to a pregnant woman. The women recognized skilled delivery as essential in preventing maternal and infant mortality. They also consented that skilled delivery helps to address complications, and to prevent infections during delivery.



Majority of the women have had past experience(s) of child delivery with a few women having more than seven deliveries. It was also found that attendance to the ANC was very high among the women, yet, not all the women studied attended ANC sessions. The principal source of influence for ANC sessions was the husband with a little influence from mothers-in-law. The women noted to have received sufficient information on the place of delivery during the ANC sessions. Only about 8.6% of the women claimed not to have been given information on the place of delivery. Among the Information receive at the ANC sessions is the fact that skilled delivery prevents infections, maternal and infant death and complications, as well as advices on diets.

The study also discovered that only 57.1% of the women used skilled delivery as against 83.4% of women whose preference place for delivery is the health facility. The rate of delivery at the Traditional Birth Attendants' place stood at 42.9% despite the preference.

At the ANC sessions, the women were taught the signs and symptoms of danger during pregnancy and during delivery. Some of the signs learnt includes swollen legs and faces, raised BP, bleeding before delivery, among others. It was also found that, the decision on the place to seek health care and delivery is mainly made by the husband of the pregnant woman and also some other family members. This was because the husband provides the fund to seek healthcare.

Among several other factors, the women and their families consider the attitude of healthcare workers towards patients, the time spent in the health facility, the type of facility, transportation time and cost and also the quality of service provided the facility to make decisions in the place of delivery. The features considered for a quality service among the

women include the availability of equipment/drugs and supplies and also the availability of Ambulance.

The professionals of the health facilities in the district were seen to be committed and friendly with a clean hospital environment except a few cases of non-commitment and unfriendliness among the health workers. The women identified the health facility as where complications are managed, delivery is done with less bleeding and pains, delivery is done faster and also where proper care can be taken from the mother and the child. The study discovered that about half of the women needed to travel for a maximum of 30 minutes to access the health facility while others had to travel at a minimum of one hour to access delivery care or service.

The suggestions towards improving skilled delivery among the women are provision of more qualified staff, improved attitude of staff, adequate drugs, and education of women on the need to deliver at the health facility.

## **6.2 Conclusions**

The national skilled delivery rate stands at 49.1%, 55.1% and 54.5% in 2011, 2012 and 2013 respectively. The regional delivery rate for the northern region was 39.4%, 47.3% and 51.2% in 2011, 2012 and 2013 respectively. The northern region has recorded far reduced rates of skilled delivery compared to the national levels and the underlying causes are not far-fetched. The people have had head knowledge of the concept of skilled delivery and its significance, but were not prepared to practice it. Many preferred the health facility for their delivery just as they attended ANC sessions there, but influences from husbands and mother in-laws and some other family members have not paved way for the choice of skilled delivery, rather, the TBAs. It suggests that, traditional beliefs have dominant roots in the decision making process



for the place of delivery, especially where the same people complaining of transportation and quality of service have travelled a couple of times to the same facility for ANC sessions.

Again, access to the health facility and for that matter skilled delivery had been created through a well-functioning health facility with committed and friendly health workers who worked in a cleaned environment. However, there is the need for a more pronounced commitment among the health workers. Thus, access to delivery service was compromised with long hours of transportation before delivery. The people also believed that the Traditional Birth Attendants and the prayer camps use special powers to help the delivery process against complications and maternal and infant mortality.

It is thus concluded that, skilled delivery is a result of the people's (women, husbands, and family members) increased knowledge through good health care worker attitude, quick and reliable access to the quality service with well-defined quality of service, using good quality equipment and improved facilities. This knowledge, not only through ANC sessions is expected to prompt the decision to seek quality health care and at the health facility. Despite the significant upward shift in support of health care facility delivery by the government through free delivery strategies, people's mind has been tuned to the traditional system of delivery, given the influential nature of the community and family members with husbands in the lead.

### **6.3 Recommendations**

First and foremost, efforts should be made the Ghana Health Service and its development partners such as health, training schools to convert the TBAs to modern delivery attendants who would be taught the ways of the modern SBA in order to forget the old ways of delivery which are associated with mortality, complications and infections. Hygienic technique, such



as HDK, could be made available to such centers, for use on the women to prevent infections. In this regard, therefore, the converted TBAs will be taught signals of possible complications and the need to refer those cases to the health center. The motivation to refer possible complicated cases to the health facility would be based on the remuneration of the converted TBAs. Once they are well paid as staff of the Ghana Health Service, they would not see the need to retain complications while their referral would not make any difference in their pay.

Also, governmental policies on awareness of delivering care plays a vital role in perceiving the need for skilled delivery care among women. Therefore, an intervention consisting of awareness programs promoting delivery care should be formulated and implemented by the Health Directorate and its implementing partners such as musicians and other celebrities, targeting the women, their families, mothers-in-law, and husbands. It is also suggested that, more skilled health workers should be made available in the villages, especially in the CHPS centers to assist the women with delivery issues.

The study also suggests that, as part of curbing or eliminating transportation barriers, a reliable ambulance service should also be made available to all communities while at the same time general improvements of the roads would help reduce transport time. The transport department of the District Assembly and the Department of Feeder Roads could be called to task to help lessen transportation challenges of the district. Further, the issue of transportation distances and the associated cost even when the means are getting may be reduced by taking advantage of the presence of ‘Motor Kings’ in the villages. This could be done by converting a number of the ‘motor kings’ into a kind of ambulance equipped with bed and well covered with a canopy or tent to convey the women to the health center when due for delivery.



Alternatively, the issue of transportation distance and the consequent cost can be curbed by involving Assemblymen, Unit Committee Members and various transport unions, for instance the GPRTU if in the district to help support expectant mothers in labour with arrangements for transport in terms of the areas where the people had to travel more than an hour to access healthcare facility for delivery. Provisions should be made for night labour events as well. This arrangement could include drivers and car owners of the need for social responsibilities as business owners in the community in order to reduce the associated cost of transport in such moments. This would help remove the transportation barrier and to motivate the expectant mothers to willingly opt for healthcare facility delivery.

Also, birth plans may be an effective strategy for improving women's utilization of health units for delivery and postnatal care without negatively affecting care satisfaction of women or providers. A cost effectiveness study of civil society groups, academic institutions for health training and/or NGOs/individuals, comparing different ways of making birth plans such as community vs. antenatal care would be useful too.

Towards attracting the women and their deciders to accepting the skilled delivery system and as part of respecting some of their traditions which do not contravene any skilled delivery procedures, it is recommended that, the women and their families should be given the placenta rather than disposing it off within the hospital for which no rituals are performed. Once the people have special burial rituals for the placenta with the belief that it eases the next birth for the women, this has to be valued even if it makes no scientific meaning to the healthcare centers. However, gradual education and sensitization activities should be directed towards making the people see the reality of healthcare systems as against traditional values.

The study, however recommends follow-up studies involving larger samples to further develop the evidence base on the effectiveness of ambulance service and antenatal birth plans to increase utilization of health units for delivery care in the district and its surroundings.



## References

- AbouZahr, C. (2003). Global burden of maternal death and disability. *British Medical Bulletin* 67.1-11.
- Adegoke, A. A., & Van Den Broek, N. (2009). Skilled birth attendance-lessons learnt. *BJOG: An International Journal of Obstetrics & Gynaecology*, 116 (s1), 33-40.
- Ahmed, S., Creanga, A.A., Gilliespie, D.G, Tsui A.O. (2010). Economic status, education and empowerment: implications for maternal health service utilization in developing countries. *PLoS ONE* June 2010, 5 (6): e11190.
- Amooti-Kaguna, B., Jordan, B. & Nuwaha, F. (2000). Factors influencing choice of delivery sites in the Rakai district of Uganda. *Social Science & Medicine*, 50, 203e213.
- Arkutu, A.A. (1995). Health, women mother's health: an information guide. (2nd edition).New York: FCI.
- Bell, J., Hussein, J., Jentsch, B., Scotland, G., Bullough, C., and Graham, W. (2003). *Improving skilled attendance at delivery: A preliminary report of the SAFE strategy development tool*. *Birth* 2003; 30:227-234.
- Bisika, T. (2008). The effectiveness of the TBA programme in reducing maternal mortality and morbidity in Malawi.
- Borghi, J., Ensor, T., Somanathan, A., Lissner, C., et al. (2006). *Mobilising financial resources for maternal health*. *Lancet Maternal Series* 2006; 368: 1457–65. Published Online September 28, 2006 DOI: 10.1016/S0140-6736(06)69383-5.



Buber, R.S. Gadner, B. and Richards, F.K. (2004). Total Quality Management in Service and Understanding and Classifying Services. *International Journal of Quality and Reliability Management*, 11, (3). MCB University Press, 21-48.

Bulatao, R.A. & Ross, J.A. (2000). *Rating maternal and neonatal health programs in developing countries*. MEASURE Evaluation Working Paper No. 26. Chapel Hill, North Carolina, USA: Carolina Population Center, University of North Carolina.

Caldwell, P. (1990). Gender implications for survival in South Asia. Health Transition Working Paper No. 7. Canberra. *National Center for Epidemiology and Population Health*, Australian National University.

Campbell, O. M., Graham, W. J., & Lancet Maternal Survival Series steering group. (2006). Strategies for reducing maternal mortality: getting on with what works. *The lancet*, 368(9543), 1284-1299.

Carlough, M., and McCall, T.M. (2005). Skilled birth attendance: what does it mean and how can it be measured? A clinical skill assessment of maternal and child health workers in Nepal. *International Journal of Gynecology Obst.* 2005; 89:200-8.

Collin, S., Anwar, I., and Ronsmans, C. (2007). A decade of inequality in maternity care: antenatal care, professional attendance at delivery, and caesarean section in Bangladesh (1991–2004); *International Journal for Equity in Health*.

Conference Center, Arusha.



- Creswell, J. (2007). *Research Design. Qualitative, Quantitative, and Mixed Methods Approaches*. 3<sup>rd</sup> Edition. Sage Publications, California, U.S.A.
- Crissman, H. P., Engmann, C. E., Adanu, R. M., Nimako, D., Crespo, K., & Moyer, C. A. (2013). Shifting norms: pregnant women's perspectives on skilled birth attendance and facility-based delivery in rural Ghana. *African journal of reproductive health*, 17 (1), 15-26.
- D'Ambruso, L., Abbey, M., Hussein, J. (2005). Please Understand When I Cry Out in Pain: Women's Accounts of Maternity Services during Labour and Delivery in Ghana. IMMPACT, University of Aberdeen, Aberdeen, UK. *BMC Public Health* 2005, 5:140doi:10.1186/1471-2458-5-140.
- District Health Directorate, Tolon (2013). Health Statistics. An Annual Report to the Ghana Health Service.
- District Profile, Tolon District Assembly. (2007). Annual Report. Tolon-Ghana.
- Ensor, T, and Cooper, S. (2004). Overcoming barriers to health service access: influencing the demand side. *Health Policy and Planning* 19 (2): 69-79.
- Esen, R. K. and Sappor, M. M., (2013). Factors Associated With the Utilization of Skilled Delivery Services in the Ga East Municipality of Ghana Part 2: Barriers to Skilled Delivery. *International Journal of Scientific & Technology Research*: Vol 2, Issue 8, August 2013.



- Gabrysch S, Cousens S, Cox J, Campbell O.M.R. (2011). The Influence of Distance and Level of Care on Delivery Place in Rural Zambia: A study of Linked National Data in a Geographic Information System. *PLoS Med* 8(1): e1000394. doi: 10.1371/journal.pmed.1000394.
- Gabrysch, S., and Campbell, O.M.R. (2009). Still too far to walk: Literature review of the determinants of delivery service use. *BMC Pregnancy and Childbirth*, 9:34.
- Garge, A.J. (2006). Barriers to the utilization of maternal health care in rural Mali. *Soc Sci Med*, 65(8): 1666-1682.
- Gitimu, A., Herr, C., Oruko, H., Karijo, E., Gichuki, R., Ofware, P., & Nyagero, J. (2015). Determinants of use of skilled birth attendant at delivery in Makueni, Kenya: a cross sectional study. *BMC pregnancy and childbirth*, 15 (1), 1.
- Government of Kenya (GoK-2012). *Accelerating attainment of Health Goals: The First Kenya Health Sector Strategic and Investment Plan – KHSSP July 2012 – June 2018*. Afya House, Nairobi. In.; 2012.
- Graham, W., Bell, J.S, and Bullough, C.H.W. (2001). Can skilled attendances at delivery reduce maternal mortality in developing countries? *Stud HSO&P* 2001; 17:97– 129.
- Hounton, S., Chapman, G., Menten, J., De Brouwere, V., Ensor, T., Sombie, I., Medi, N., Ronsmans, C. (2008). Accessibility and utilization of delivery care within a skilled care initiative in rural Burkina Faso. *Tropical Medicine and International Health*, 2008; 13(Suppl1):44-52.



- Hussein, J., Bell, J., Nazzar, A., Abbey, M., Adjeu, S., Graham, W., (2004). The Skilled Attendance Index: Proposal for a new measure of skilled attendance at delivery. *Reproductive Health Matters*, 2004; 12:160-170.
- Iyaniwura, C. A., & Yussuf, Q. (2009). Utilization of antenatal care and delivery services in Sagamu, south western Nigeria. *African journal of reproductive health*, 13(3).
- Kalule-Sabiti, I., Amoateng, A. Y., & Ngake, M. (2014). The Effect of Socio-demographic Factors on the Utilization of Maternal Health Care Services in Uganda. *Etude de la Population Africaine*, 28(1), 515.
- Kamwedo, L.A. and Bullough, C. (2005). Insights on skilled attendance at birth in Malawi- The findings of a structured documents and literature review. *Malawi Medical Journal*, 16:40-2.
- Khalil, K. and Roudi-Fahimi, F. (2002). Making Motherhood Safer in Egypt. MENA Policy Brief. *Population Reference Bureau (1): 1-8*.
- Koblinsky, M. A., & Tinker, A. (1994). Programming for safe motherhood: a guide to action. *Health Policy and Planning*, 9(3), 252-266.
- Koblinsky, M., Matthews, Z., Hussein, J., Mavalankar, D. et al. (2006). *Going to scale with professional skilled care*. Lancet Maternal Series 2006; 368:1377-86  
Published Online September 28, 2006 DOI:10.1016/S0140-6736(06)69382-3
- Kongnyuy, E. J., Hofman, J., Mlava, G., Mhango, C., & Van Den Broek, N. (2009). Availability, utilisation and quality of basic and comprehensive emergency



obstetric care services in Malawi. *Maternal and child health journal*, 13 (5), 687-694.

Kyomuhendo, G. (2003). Low use of rural maternity services in Uganda: impact of women's status, traditional beliefs and limited resources; *Reproductive Health Matters*, 11(21):16-26.

Magadi, M., Diamond, I., Rodrigues, R. (2000). The determinants of delivery care in Kenya. *Social Biology*, 2000; 47(3- 4):164-188.

Magoma, M., Requejo, J., Campbell, O.M.R., Cousens, S. &Filippi, V. (2010). High ANC coverage and low skilled attendance in a rural Tanzanian district: a case for implementing a birth plan intervention. *BMC Pregnancy and Childbirth*, 10, 13.

Mills, S., Williams, J., Adjuik, M., Hodgson, A. (2008). Use of health professionals for delivery following the availability of free obstetric care in Northern Ghana. *Maternal and Child Health Journal*, 2008; 12:509-518.

Ministry of Health, (2002). *Focused Antenatal care, Malaria and Syphilis in Pregnancy. Orientation package for Service Providers*. Reproductive and Child Health Section, Dares salaam, Tanzania 2002.

Moucheraud, C., Worku, A., Molla, M., Finlay, J. E., Leaning, J., & Yamin, A. E. (2015). Consequences of maternal mortality on infant and child survival: a 25-year longitudinal analysis in Butajira Ethiopia (1987-2011). *Reproductive health*, 12(1), 1.





- Mpembeni, N.M.R., Killewo, J.Z, Leshabari, M., Massawe, S., et al. (2007). Use pattern of maternal health services and determinants of skilled care during delivery in Southern Tanzania: implications for achievement of MDG-5 targets. *BMC Pregnancy Childbirth*. PMID, 18053268 [PubMed -indexed for MEDLINE].
- Mpembeni, R. N., Killewo, J. Z., Leshabari, M. T., Massawe, S. N., Jahn, A., Mushi, D., & Mwakipa, H. (2007). Use pattern of maternal health services and determinants of skilled care during delivery in Southern Tanzania: implications for achievement of MDG-5 targets. *BMC pregnancy and childbirth*, 7 (1), 1.
- Mustafa, S. M., and Alsiddiq, A. Z., (2007). Poverty and the Millennium Development Goals (MDGs) in Sudan: Current status, achievement and prospect; *Sudanese Journal of Public Health*, Vol.2 (4)
- Muyunda, B., Makasa, M., Jacobs, C., Musonda, P., & Michelo, C. (2016). Higher Educational Attainment Associated with Optimal Antenatal Care visits among childbearing women in Zambia. *Frontiers in Public Health*, 4, 127.
- Myles, M.F. (1975). Textbook for midwives with modern concepts of obstetric and neonates care. Great Britain, Churchill Livingstone.
- Nepal report (1997). Understanding improvements in maternal health. Development Progress. Overseas Development Institute. London.
- Nepal, (1998). *National Planning Commission Secretariat. Care during pregnancy and delivery: implications for protecting the health of mother and their babies*

(*final report*). NMIS, fifth cycle (1997). Kathmandu: National Planning Commission Secretariat, 1998:47-9.

Onta, S., Choulagai, B., Shrestha, B., Subedi, N., Bhandari, G. P., & Krettek, A. (2014). Perceptions of users and providers on barriers to utilizing skilled birth care in mid-and far-western Nepal: a qualitative study. *Global health action*, 7.

Palmer, M.A. (2007). Exercise during pregnancy and its association with Gestational Weight Gain. *Maternal and Child Health Journal*, (19): 528-537.

Paxton, A., Maine, D., Freddman, L., Fry, D., Lobis, S. (2005). The evidence for emergency obstetric care. *International Journal Gynaecology& Obstetrics* 2005.

Perkins, M., Brazier, E., Themmen, E., Bassane, B., Diallo, D., Mutunga, A. et al.(2009).Out-of-pocket costs for facility-based maternity care in three African countrie.*Health Pol Plann.* 2009; 24(4):289-300.

Polit, D. F., & Beck, C. T. (2010). *Essentials of nursing research: Appraising evidence for nursing practice* (7th ed.). Philadelphia: Wolters Kluwer Health, Lippincott Williams & Wilkins.

Program for Appropriate Technology in Health (PATH). (2012). Basic Emergency Obstetric Care: First Response: Technology Opportunity Assessment Prepared for the Merck for Mothers [Program. www.path.org](http://www.path.org).

Safe Motherhood Inter-Agency Group, (2000). *Skilled Care during Childbirth*. Information Booklet. New York.

Safe Motherhood Inter-Agency Group, (2010). *Skilled attendance at delivery: a review of the evidence*. New York.

Safe Motherhood Newsletter, (2013). The Safe Motherhood Initiative and Beyond. Volume 120, Issue 3, Pages 312–313.

Sakeah, E., Doctor, H. V., McCloskey, L., Bernstein, J., Yeboah-Antwi, K., & Mills, S. (2014). Using the community-based health planning and services program to promote skilled delivery in rural Ghana: socio-demographic factors that influence women utilization of skilled attendants at birth in Northern Ghana. *BMC Public Health, 14*(1), 1.

Seljeskog, L., Sundby, J., & Chimango, J. (2006). Factors influencing women's choice of place of delivery in rural Malawi-an explorative study. *African Journal of Reproductive Health, 10* (3), 66-75.

Sindhu, F. (2012). Customer care: the neglected domain, *Irish marketing Review, 4*(3): 2950.

Spyridou, A., Schauer, M., & Ruf-Leuschner, M. (2016). Prenatal screening for psychosocial risks in a high risk-population in Peru using the KINDEX interview. *BMC pregnancy and childbirth, 16*(1), 1.

Stanton, C.Chou, D., Ahmed, S. (2007). Skilled care at birth in the developing world: progress to date and strategies for expanding coverage. *Journal of Biosocial Science, 39*:109–120.



- Starrs, A. M. (1997). *Safe motherhood initiative: 20 years and counting*. *Lancet*: 368(9542):1130-2.
- Stekelenburg, J., Kyanamina, S., Mukelabai, M., Wolffers, I., & van Roosmalen, J. (2015). Waiting too long: low use of maternal health services in Kalabo, Zambia. *Tropical Medicine and International Health*, 9(3), 390e398.
- Tawiah E.O. (2007). Maternal health in five Sub-Saharan African countries. Poster presentation at The Fifth African Population Conference, 10–14 December 2007, Arusha International
- Teijlingen, E. R., Hundley, V., Rennie, A. M., Graham, W., & Fitzmaurice, A. (2003). Maternity satisfaction studies and their limitations:“What is, must still be best”. *Birth*, 30 (2), 75-82.
- Thaddeus, S., Maine, D. (1994). Too far to walk: maternal mortality in context. *SocSci Med*, 38(8):1091-1110.
- Tolon District Health Directorate Annual Report, (2013). District Report, 2012Tolon, Ghana.
- Tsegay, Y., Gebrehiwot, T., Goicolea, I., Edin, K., Lemma, H., & San Sebastian, M. (2013). Determinants of antenatal and delivery care utilization in Tigray region, Ethiopia: a cross-sectional study. *International journal for equity in health*, 12 (1), 1.
- UNICEF, (2008). The State of the World’s Children 2009, *Maternal and Child Health Journal*. New York; 2008.



UNICEF, (2009). *Analysis based on data provided by the Mailman School of Public Health AMDD program*, July 2009.

UNICEF, WHO, and UNFPA, (2010). *Maternal Mortality in 2000*. Estimates developed by WHO, UNICEF and UNFPA. *Geneva*.

United Nations (2010). Millennium Development Goals Indicators.

United Nations, (2011). Millennium Development Goals Report 2011, June 2011, ISBN 97892-1-101244-6, Retrieved 19 March 2015. Available at: <http://www.unhcr.org/refworld/docid/4e42118b2.html>

Villar J., Ba'aqeel H., Piaggio G, Lumbiganon P., Miguel Belizán J., Farnot U., Al-Mazrou Y., Carroli G., Pinol A., Donner A., Langer A., Nigenda G., Mugford M., Fox-Rushby J., Hutton G., Bergsjø P., Bakketeig L., Berendes H., Garcia J., (2001). WHO antenatal care randomised trial for the evaluation of a new model of routine antenatal care. *WHO Antenatal Care Trial Research Group Lancet*. 2001 May 19; 357(9268):1551-64.

WHO, (2000). Reproductive health indicators for global monitoring; Report of the second interagency meeting 2001. WHO/RHR/01.19. Geneva: World Health Organisation.

WHO, (2004). *Road Map for Accelerating the Attainment of the MDGs Related to Maternal And Newborn Health in Africa*. African Regional Reproductive Health Task Force Meeting. In. Harare; 2004.



WHO, (2007). *Maternal Mortality in 2005*. Estimates developed by WHO, UNICEF, UNFPA and the World Bank, Geneva.

WHO, (2009). Unicef; AMDD. *Monitoring emergency obstetric care: a handbook*. Geneva, Switzerland; pp.1-164.

WHO, UNICEF, UNFPA, & the World Bank, (2005). *Maternal Mortality in 2005: estimates developed by WHO, UNICEF, UNFPA, and the World Bank*. Geneva: WHO; 2005.

Witter, S., Arhinful, D., Kusi, A., Zakariah-Akoto, S. (2007). *The experience of Ghana in implementing a user fee exemption policy to provide free delivery care*. *Reproductive Health Matters*. 15(30):61-71.

Worku, A. G., Yalew, A. W., & Afework, M. F. (2013). Factors affecting utilization of skilled maternal care in Northwest Ethiopia: a multilevel analysis. *BMC international health and human rights*, 13(1), 1.

World Health Organization (2006). *Coverage of maternity care: a listing of the available information*. Fourth Edition. Geneva: World Health Organization.

World Health Organization (WHO)/United Nations Children's Fund (UNICEF) (2003). *ANC in developing Countries: Promises, Achievements and Missed Opportunities – An Analysis of Trends, levels and differentials 1990 – 2001*. WHO: [Geneva.www.accesstohealth.org](http://Geneva.www.accesstohealth.org)



World Health Organization, (2010). *Trends in maternal mortality: 1990 to 2008: Estimates developed by WHO, UNICEF, UNFPA and The World Bank*. Geneva: World Health Organization; 2010.

World Health Organization-WHO, (2001). *Antenatal care randomized trial: manual for the implementation of the new model*. Geneva (document no WHO/RHR/01.30) 2001.

Yanagisawa, S., Oum, S. and Wakai, S. (2006). *Determinants of skilled birth attendance in rural Cambodia*. *Tropical Medicine and International Health* (2006), 2(2):238251.



**Appendix A (Questionnaire)**

**INTERVIEW GUIDE**

I am conducting a research on the topic “**Reasons for High ANC coverage but low Skilled Delivery**” in Tolon District of the Northern Region. Your effective contribution will lead to the success of the study. Information given will be treated as confidential.

**IDENTIFICATION**

Name of Community: ..... Serial number.....

**Section A: Demographic Data**

1. Gender

(A) Male  (B) Female

2. Age

(A) 18-19  (B) 20-29

(C) 30-49  (D) 50-69

(E) 70 years & above

3. Religion

(A) Christian  (B) Moslem

(C) Traditional  (D) others (please specify) .....

4. Marital status

(A) Married  (B) Single

(C) Separated  (D) Widowed

(E) Divorced

5. Ethnicity

(A) Dagomba  (B) Gonja





(C) Akan [ ] (D) others (please specify) .....

6. Education

(A) Primary [ ] (B) JHS [ ]

(C) SHS [ ] (D) Tertiary [ ]

(E) Others (please specify)

7. Occupation:

(A) Housewife only [ ] (B) Petty Trader/business [ ]

(C) Farmer [ ] (D) others (please specify) .....

**KNOWLEDGE OF SKILLED DELIVERY IMPORTANCE**

8. Are you aware of skilled delivery?

a. Yes [ ] b. No [ ]

9. In your view, what is skilled delivery

a. Nurse/midwife attending to pregnant woman [ ]

b. Trained TBA attending to pregnant woman [ ]

c. Untrained TBA attending to pregnant woman [ ]

d. O t h e r s ( p l e a s e s p e c i f y )

10. What do you think are some of the importance of skill delivery?

a. Prevent maternal and infant mortality [ ]

b. Help to address complication [ ]



- c . P r e v e n t i n f e c t i o n s [ ]
- d . O t h e r s ( s p e c i f y )

**SECTION C: PAST PREGNANCY INFORMATION**

11. Number of pregnancies:

- (A) 1-2 [ ] (B) 2-3 [ ]
- (C) 3-4 [ ] (D) 5-6 [ ]
- (E) 7 & above [ ]

12. Did you attend ANC during your last pregnancy

- (A) Yes [ ] (B) No [ ]
- ( C ) I f N o w h y ?

13. If yes, how many times?

- (A) 1-2 [ ] (B) 3-4 [ ]
- ( C ) 4 P l u s [ ]

14. Can you please state what motivated you to attend antenatal care

.....

15. During your routine ANC, did you receive any information on place of delivery?

- (A) Yes
- (B) No

16. If yes, what information was given? .....



17. Number of deliveries:

- (A) 1-2  (B) 2-3   
(C) 3-4  (D) 5-6   
(E) 7 & above

18. Place of Delivery

- (A) Health facility  (B) Home (TBA)   
(C) Prayer camp  (D) others (please specify).....

19. Where do you prefer to deliver?

- (A) Health facility  (B) Home (TBA)   
(C) Prayer camp  (D) others (please specify) .....



20. Why do you prefer that place?

.....

**SECTION D: KNOWLEDGE ON DANGER SIGNS OF PREGNANCY, LABOUR AND HEALTH SEEKING BEHAVIOUR**

21. What signs/symptoms do you perceive as dangerous during pregnancy?

- (A) Swollen/puffy face  (B) Swollen legs   
(C) Raised B/P  (D) Dizziness   
(E) Seeing water before delivery  (F) others (please specify)

.....

22. What signs/symptoms do you perceive as dangerous during Labour/delivery?

- (A) Seeing water before delivery  (B) Fitting   
(C) Raised B/P  (D) Dizziness   
(E) Bleeding before delivery  (F) others (please specify)

.....

23. Who makes decision on your place of delivery?

- (A) Husband  (B) Mother In-law   
(C) Father In-law  (D) others (specify) .....

24. Who provides the fund to seek health care?

- (A) Husband  (B) Mother In-law   
(C) Father In-law  (D) others (please specify) .....

25. What factors do you consider important in deciding which place to deliver?



- (A) Attitude of Health staff
- (B) Time spent in health facility
- (C) Type of facility
- (D) Transportation Cost
- (E) Others (please specify) .....

26. Perceived Quality of care

- (A) Availability of equipment/drugs/supplies
- (B) Type of staff
- (C) Availability of ambulance etc.
- (D) Others (please specify) .....

27. In your opinion, how committed are the staff to their work?

- (A) Committed
- (B) Uncommitted
- (C) Fairly committed
- (D) Others (specify)

28. How friendly is the staff toward their client?

- (A) Very friendly
- (B) Friendly
- (C) Unfriendly

29. How do you assess the cleanliness of the health facility?

- (A) Very clean
- (B) Clean
- (C) Not clean



(D) Very dirty.

30. What are the importance of delivery at the health facility?

(A) Complications are managed there.

(B) Delivery is done with less bleeding and pains

(C) Delivery is faster

(D) Proper care is given to both mother and child to prevent death.

(E) I don't know.

(F) Others (specify) .....

31. How many minutes will you take to the health facility?

(A) Very close (15 minutes)

(B) Close (30 minutes)

(C) Far ( 1 hour)

(D) Very far (2 hours)

32. What do you think can be done to help influence mothers to deliver at the health facility?

(A) Provide more qualified staff.

(B) Advise staff to improve attitude toward clients.

(C) Provide adequate drugs

(D) Educate women on the need to deliver at health facility during ANC

(E) Others (specify).



**THANK YOU FOR YOUR TIME**

**Appendix B (Interview Guide)**

**INTERVIEW GUIDE FOR INDEPTH INTERVIEWS WITH TRADITIONAL  
BIRTH ATTENDANTS (TBAs)**

1. What are some of the reasons the women give for refusal to go to the health facility when they come to deliver with you?
2. Do you refer women to health facility when they come to deliver with you?
3. What are the religious, traditional and cultural practices of the community during labour?
4. How do you help a labouring mother when a complication arises during the delivery process?
5. What do you think can be done to encourage women to seek skilled delivery care during delivery?

***THANK YOU FOR YOUR TIME***

**INTERVIEW GUIDE FOR IN-DEPTH INTERVIEWS WITH HEALTH  
WORKERS**

1. What are some of the likely reasons why women will refuse to take formal care during delivery?
2. Do you think there are some specific procedures or activities that are carried out in the health facility that prevents women from delivering in a health facility?
3. What factors affect easy accessibility to delivery care?



4. What are some of the measures that are being put in place to increase skilled birth attendance at child birth in your health facility/area?

***THANK YOU FOR YOUR TIME***

**Appendix C (Other Relevant Tables)**

Table B: Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.772	.629	15

Source:



**RELIABILITY**

/VARIABLES=b8 b9 b10 c11 c12 c13 c14 c19 c20 d21 d22 d23 d24 d25 d26

/SCALE ('ALL VARIABLES') ALL

/MODEL=ALPHA/STATISTICS=CORR.

**Other Relevant Tables on Population and Status of Facilities**



-----

■

		<i>Chn 0-11</i>							







- 
- 
- 
- 
- 

■

- Weak vehicles leading to constant breakdowns and high fuel consumption.

■

~~BMET~~

3  
8  
8

**Table 1: Sub Districts and Health Facilities**

NO	SUB-DISTRICT	COMMUNITIES	FACILITIES.
1	<input type="checkbox"/> Ninkr <input type="checkbox"/> Ninkr <input type="checkbox"/> Ninkr	= = =	<ul style="list-style-type: none"> <li>• Scarce funds preventing scheduled PPM on</li> <li>• Poor road network turns to</li> <li>• Aged motor-bikes turn to</li> </ul> Tolon H/ Centre Kpendua CHPS Gburimani CHPS Yoggu CHPS AfreakmedComm. Hosp.
2	Nyankpala	34	Nyankpala h/centre, Gbulahagu CHPS UDS Clinic
3	Wantugu	24	Wantugu h/center Kasuyili CHPS



4	Lingbunga	33	Lingbunga CHPS Zantani CHPS
	District	157	12

## APPENDIX D

### CONSENT NOTE FOR PARTICIPANTS IN THE QUANTITATIVE

#### SURVEY INTRODUCTION

I am a student from university for development studies, Tamale and I am conducting a research in your community to find out the factors according for low uptake of skilled deliveries. I would therefore like to invite you to participate in the study.

#### RECRUITMENT PROCEDURES

You are being invited to answer few questions concerning factors accounting for low uptake of skilled care in your community. The interview will last 25 minutes.

#### BENEFITS

There are no benefits to you in your participation in this study. We however hope that the knowledge and views gotten from this study will help us in widening coverage of skilled delivery services in our quest to advert maternal mortality in the country.



## **RISK TO PARTICIPANTS**

The risk that you will encounter in taking part in the study are minimal. They include the time that you will spend in answering the questions and the inconvenience it may cause you. Some questions may also be personal and thus cause some embarrassment. Our field staffs however, have been well trained to conduct the interviews so as to minimize these risk.

## **CONFIDENTIALITY**

All information that will be provided will be protected to the best of our ability. No names shall be recorded when conducting the interview. All completed questionnaires' will be kept in a locked cupboard and only the study team will have access to your information. If the results of this study are made public, neither your name nor any identifying personal characteristic about you or others who participate in this study will be revealed.

## **CONTACTS**

If you have any questions on this study, you may contact Apraku Vivian, university for development studies, Graduate School Tamale or call 0249990919,

[email:aprakuvivian@yahoo.com](mailto:aprakuvivian@yahoo.com)

## **UNIVERSITY FOR DEVELOPMENT STUDIES**

Tel:0372093295 P.O. Box 1883

28/04/2015

Our Ref:

Your Ref:



Tamale, Ghana

Date:



/01/2015

School of Allied Health Sciences

The District Health Director

Tolon District Health Directorate,

Northern Region

Dear Sir/Madam,

**LETTER OF INTRODUCTION**

I write to introduce to you Ms. Apraku Vivian (UDS/CHD/0128/13), a graduate student pursuing her studies in MSc/Mphil in the community health and development at the school of Allied Health Sciences, University for Development Studies. She has been scheduled to carry out her field research in your district as part of the partial fulfillment of her degree.

Her research is titled: “High antenatal attendance, low skilled delivery: A study to assess factors influencing decline in skilled delivery in Tolon District in Northern Region”.

Thank you.

Yours faithfully,

Dr. Vida N. Yakong

(For Dean, School of Allied Health Sciences)

Cc: District Chief Executive Tolon District.

