

Research Article

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A Qualitative Study on Factors Contributing to Low Institutional Child Delivery Rates in Northern Ghana: The Case of Bawku Municipality

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Abstract

Introduction: Women's utilization of health care facilities for delivery is an important health issue with regard to the well-being and survival of both the mother and her child during childbirth which has implications on the maternal and child mortality rate in human society. However, in most of the third world countries including Ghana and Bawku Municipality in particular, there are certain factors that inhibit pregnant women in patronizing maternal health facilities during childbirth.

Main objective: The main objective of this study was to explore and describe factors hindering utilization of health care institutions for child delivery in the Bawku Municipality.

Materials and methods: A cross sectional design was used using one focus group discussions of Nine (9) women in each of the four (4) subdistricts to collect information on women who have just delivered to explore and describe factors hindering utilization of health care institutions for delivery in the Bawku Municipality.

Results: Four focus group discussions were performed; one in each of the four subdistricts selected. The study revealed that cultural factors, attitude of health care providers, previous experiences with the health system, long waiting time, negligence of health care workers, alternative delivery services, transport to service facilities and expectations are factors that influenced their utilization of health facilities for delivery. It is however established that since the introduction of the national health insurance scheme, there is no cost to maternal health services.

Conclusions: Cultural factors and health services factors which include staff attitude and lack of maternal education during ANC attendance were the most frequently identified contributing factors to the low Utilisation of health institutions for child delivery in this study.

Keywords: Maternal mortality; Institutional deliveries; Skilled deliveries; Bawku municipality

Abbreviations: ANC: Antenatal Care/ Clinic; BMHD: Bawku Municipal Health Directorate; CS: Caesarean Section; EMOC: Emergency Obstetric Care; FGD: Focus Group Discussion; FIGO: Federation of Obstetrics and Gynaecology; GDHS: Ghana Demographic and Health Survey; GHS: Ghana Health Services; GPRTU: Ghana Private Transport Union; GSS: Ghana Statistical Service; ICM: International Confederation of Midwives; MDGs: Millennium Development Goals; MMR: Maternal Mortality Rate; NHIS: National Health Insurance Scheme; PNC: Postnatal Care; TBA: Traditional Birth Attendant; UN: United Nations; WHO: World Health Organisation

Background

Maternal mortality is one of the most sensitive indicators of the health disparity between richer and poorer nations. Improving the health of women during pregnancy and childbirth is an international priority, with one of the United Nations' Millennium Development Goals to reduce maternal mortality globally by three-quarters by the year 2015, with much of this reduction expected across low income countries [1].

According to World Health Organisation, the estimated death per pregnant women or complications resulting from childbirth is 1,500 each day. In the same year, 536 000 maternal deaths were estimated worldwide [2]. Most of these deaths are occurring in developing countries partly because; the number of women becoming pregnant is many as compared to that of developed countries. While 450 maternal deaths per 100,000 live births occur in developing countries, a relatively low number of 9 maternal deaths per 100,000 live births occur in developed countries [2]. For instance, the risk of losing one's life through pregnancy in advance countries is 1: 7,300 as against 1: 75 in developing countries [2].

In 2000, the 193 UN member states agreed on eight international development goals called Millennium Development Goals (MDGs), and MDG 5 aims to improve maternal health, indicated through measures of the maternal mortality ratio and the proportion of births attended by a skilled health professional [1].

Pregnancy and childbearing have brought risks for women throughout history. Maternal mortality is seen as a key indicator of women's health status and shows differences between socio-economic classes.

This problem is strongly prevalent amongst rural Ghanaian women from low socioeconomic groups, resulting in low or incomplete uptake of maternal health care.

Ghana has seen mixed results with its efforts to address this goal. While the National Maternal Mortality Survey suggests that maternal deaths have been declining, results have been slow to appear. In 2005, the survey recorded 503 deaths/100,000 live births, which dropped to 451 deaths/100,000 live births in 2008 [3]. There are also significant geographic variations in these statistics, with the northern and rural areas of the country most affected [4]. While meeting MDG 5 requires

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Ghana to reduce the 1990 maternal mortality rate of 214 per 100,000 live births by 75% to 54 per 100,000 live births by 2015, the figures are still high and staggering.

This evidence suggests that improvement in Ghana's maternal mortality since 1990 has been negligible (Table 1 and 2, Appendix 1). Unfortunately, these figures must be regarded as optimistic as they likely underestimate the number of women from rural communities who die from maternal causes but are not reported [5]. A recent review of Ghana's MDG progress concludes that, "If the current trends continue ... it will be unlikely for Ghana to meet the MDG target of 54 per 100,000 by 2015" [3].

The other indicator for MDG 5-the proportion of births attended by a skilled health professional-has also experienced minimal progress. However, whilst antenatal care is nearly universal in Ghana, above 90% of pregnant women make at least one antenatal care visit; delivery and postpartum care are generally low. It is documented that only 49.50% and 52.23% of institutional deliveries achieved in 2010 and 2011 respectively, in the country takes place in health facilities [6]. The majority deliver at home attended to by a traditional birth attendant or a relative. This situation is worrying and poses a tough challenge to the attainment of the MDG focusing on maternal health.

Problem Statement

Maternal death worldwide is a critical issue which many countries with high rates are working vehemently to address. In northern Ghana in particular, pregnancy related death is seen as a major socio – cultural issue and even in most ethnic groups a taboo to accept the corpse to be buried within their homes. A woman who dies as a result of pregnancy related death is usually buried in valleys or bushes and the family seen by others as a "bad luck family or a curse meted to them as a result of a grievous crime that they might have committed" (Authors observation among the Kusasi tribe in Northern Ghana). This implies, maternal mortality is not only a developmental problem but also a socio – cultural issue and everyone is concerned.

In the Ghana, health facilities are relatively accessible, costs of health services are generally low and even covered by National Health Insurance Scheme (NHIS), with ANC coverage high but maternal mortality is unacceptably high. Delivery rate in health care facilities is

very low. In Ghana, national antenatal care coverage in 2011 was 91.3% and 111.9% (More than 100% due to influx women for neighbouring Togo and Burkina Faso accessing health in the Municipality) in Bawku municipality, implying that women are aware of the importance of attending clinic [7]. But only few deliveries take place in the health facilities. After delivery, they attend Infant welfare clinic, immediately after the naming ceremony. The national figure of skilled attendant at deliveries in 2011 was 52.23% and 66.3% in Bawku Municipality [7].

The main objective of this study was to explore and describe factors hindering utilization of health care institutions for child delivery in the Bawku Municipality.

Methodology

Study design

This is a descriptive study with cross-sectional design examining the factors that account for low rates of institutional deliveries in the Bawku Municipality. The study population were women who have just delivered and reported to the clinic for registration. This study was conducted in January and February 2013.

Study population

The target population for the study were women who had delivered and reported to the clinic for registration living within the Bawku Municipality both in peri-urban and urban settings. They form 4% (8,922) of the total population of the Bawku Municipality [7]. They were recruited from the maternal and child health clinics and followed lack in the community for a focus group discussion. As most women with babies do attend infant welfare clinics, the main group of women that this study did not capture are actually those that have died or are seriously ill. If the baby survived, some of these cases were captured when the relatives cared for the baby.

Sampling methods

The sampling technique used was multi-stage sampling. The Bawku Municipality consists of nine (9) subdistricts with a hospital, clinics or health centres. Four out of the nine (9) subdistricts were selected by simple random sampling.

	2007	2008	2009	2010	2011	2012
Ghana MMR (per 100,000 live births)	224	200	169.9	163.2	173.8	
ANC coverage	91.1%	97.4%	92.1%	93.3%	91.3%	
Ghana % Deliveries attended by a trained Health worker	32.1%	44.2%	45.6%	49.5%	52.23%	
Ghana PNC coverage	56.7%	57.5%	56.0%	61.6%	64.7	
Bawku Municipality MMR (per 100,000 live births)	241	113	232	81	208	126
Bawku Municipality % Deliveries attended by a trained Health worker Bawku Municipality	49.8	42.2	50.8	57.3	66.3	71.3

Table 1: Ghana Health Services Annual Report 2011/ BMHD Annual Report 2012.

	2007	2008	2009	2010	2011
Ashanti Region	26.7	35.0	42.4	53.4	52.0%
Brong Ahafo Region	34.5	49.8	53.7	54.0	63.2%
Central Region	22.3	56.3	52.5	51.6	59.7%
Eastern Region	43.1	48.0	52.1	48.2	52.8%
Greater Accra Region	43.1	50.2	47.9	54.4	56.0%
Northern Region	27.7	26.0	36.1 %	36.8%	31.2%
Upper East Region	43.5	40.4	52.6%	59.7%	67.3%
Upper West Region	32.9	40.6	36.7%	46.5%	53.3%
Volta Region	33.3	37.5	39.4	36.9	40.2%
Western Region	17.6	39.1	42.6	49.6	54.7%

Table 2: Skilled delivery by region (Source GHS annual Report 2011).

Many different types of clients as possible were recruited to get a variety of good representation (primigravida and multigravida, old and young, polygamous and monogamous, educated and uneducated).

A total of 36 women were selected to participate in the focus group discussions by convenience. A total of four (4) Focus Group Discussions (FGDs) were conducted with 36 recently delivered women who have reported for child welfare clinic registration. One discussion was held in each Subdistrict (Binduri, Mognori, Pusiga and Urban East). Each group consisted of 9 women within the ages of 16 – 43 years. The women were selected in the clinics and were followed into the communities where the health facilities are located and the focus group discussions were held. Permission to participate in the focus group was sought prior to the meeting. Each session lasted for 30-45 minutes.

Data collection and analysis

Primary data was collected through focal group discussions. The secondary data was collected from public and private organisations. For example, data on the profile of the area was collected from the Municipal Assembly, Ghana Health Service and other governmental and non-governmental organisations in the district. Other sources of information like reference materials were sourced from Textbooks, Magazines, and Journals such as the Population Reports and Ghana Demographic and Health surveys (GDHS) and the internet.

This was conducted to get a broader picture from people's experiences and knowledge. The rationale for using focus groups is that attitudes and perceptions are not developed in isolation but through interaction with other people.

A total of four (4) focus Group Discussions (FGDs) were conducted with 36 recently delivered women who have reported for child welfare clinic registration. One discussion was held in each Subdistrict (Binduri, Mognori, Pusiga and Urban East). Each group consisted of between 9 women within the ages of 16 – 43 years. The women were selected in the clinics.

Each session lasted for 30-45 minutes. The discussions were centred on different themes relating to factors inhibiting utilisation of health facilities for delivery care. These included; a) the women's previous experience with health facilities for labour and delivery care; b) attitude of health workers; c) perceived quality of care; d) negligence by the health care workers; e) preference for alternative services; f) expectations of women; and g) their satisfaction or dissatisfaction to services.

The assumption with the FGDs was that individual's attitudes, beliefs and actions do not form in a vacuum. People often need to listen to others opinions and understandings in order to form their own.

All data were transcribed verbatim, typed and stored safely. All data was stored in a lockable cupboard and was only accessible to the researcher. The transcripts were categorised into themes and analysed manually. At the end of the study, all tapes used for the focus groups were planned to be destroyed in accordance with the research ethics requirements.

Inclusion and exclusion criteria

All women who had delivered a live baby and are reporting at a clinic with the baby; for child welfare, registrations were included. As most women with babies do attend infant welfare clinics, the main group of women that this study did not capture are babies that have died or are seriously ill, and then the women will not report to the clinic.

Ethical consideration

Participation was completely voluntary. Verbal consent was sought from each individual participant before the commencement of each focus group discussions session. The study was cleared by the ethical review committee of the Bawku Municipal health Directorate.

Results

People's past experiences with the health system tend to influence future use of health care service. Women in particular openly talked and gossiped about their past experience with the health care system. These include their interaction with care providers, examinations subjected to, waiting time and other issues. They also get information from relatives and friends about their perceived quality of health services.

Examinations

Vaginal examinations women are subjected to during labour and delivery is often viewed and expressed as painful, frequent and often cited as a factor inhibiting the use of health facility for delivery.

"I do not like health facility delivery..... The vaginal examinations are frequent and painful. In my last pregnancy I delivered in a health facility.....they (nurses) kept on inserting their hands in my private part(vagina).....different persons examined me was very painful and embarrassing especially the male doctors. I wonder if they knew what they were looking for" (FGD 3, Para 3 woman).

"In my last delivery I was subjected to series of vaginal examination..... If it was my first delivery with the health facility, then I would never go there again". My religion (Islam) doesn't allow another man to insert his hands into a married woman's private parts (FGD 3, Para 2 woman).

Not being physically examined after reporting your ailment to a health care provider may also not go down well with some women. Women in labour generally expects to be examined at least e.g. blood pressure measurement, vaginal examination and etc. Not been examined is viewed as a departure from the norms. A woman who just had her fourth child narrated:

"I reported to the health facility with abdominal pains..... I was asked to go home and wait..... I was never examined. Immediately I arrived home, I delivered".

Waiting time

Long waiting time in clinics or health care facilities before being attended to has been consistently mentioned as a disincentive to use such facilities even for delivery. A woman who had just given birth to her sixth child narrated her frustration on long waiting time she was subjected to during her routine antenatal clinic attendance:

"We (pregnant women) go to the clinic as early as 8am..... We spend the whole day waiting to be attended to.....the nurses will not start work early" (focus group 3, para 6).

Attitude of health workers

Users of health care services often consider attitude of health workers when deciding where to seek care. Women often mentioned poor attitude of health workers as a major deterrent for the utilisation of health services particularly institutional delivery. The women reported varied testimonies. Poor reception, poor provider attitude, poor interpersonal relationship and not being attended to were highlighted. A Para 3 lady explained:

"My sister-in-law was in labour. We took her to the clinic where they asked her a few questions and gave prescription to collect medication the following day without examination. The moment we arrived home, she delivered whilst getting out of the tricycle" (focus group 1, para3 narrated)

Women in labour expect support and good care during that painful process. They also expect the care provider be it the nurse, midwife even the doctor to frequently check and monitor their progress.

"This is all because of lack of checking and help. If someone comes to you with pain and you asked her to go back home without checking her, you know that is not good" (FGD 1, Para 2 narrated). "I have experienced myself in the hospital in Pusiga Health centre. The nurses do not stand by your side till you deliver. You always have to call them when your baby is about to come. Sometimes they come when the baby has already delivered. So home and hospital delivery is the same..... Infact delivering at home may be safer as there you will always have someone by your side." (FGD 4, Para 4 woman)

Not been checked during labour may be viewed as poor provider attitude. A Para 4 woman explained: *"I have seen a woman who was in severe abdominal pain..... reported to the hospital... she was not examined but asked to go home because they (care providers) felt she was not in labour. As soon as she arrived home, she delivered."* (Focus group 1, para3) Poor provider attitude acted as an obstacle to the uptake delivery services in a health care institution. Shouting at patients or patient's escorts and exercise of impatience by the care providers was consistently echoed during the discussions.

"In my last pregnancy.....I delivered at home due to quick labour...I refused to report to the health centre immediately after to avoid embracing myself. If I go to the health facility the nurses will shout at me for delivering at home.....if you deliver at home and go and report to a health facility they (care providers) are angry.....if you opted to deliver in a health facility they (care providers) don't treat you well" (FGD 1, Para 3 woman).

A para 1 woman explained her ordeal she encountered in the labour room with a midwife *"I was severely beaten by a midwife with the claim that, I was going to girl my baby". The midwives like beating and I was not even the only one. Do you think I will again go back there next delivery? (FGD 2, para 1 woman).*

Women believe that health workers, particularly nurses and midwives should have more patience and understanding because they are trained on the work they do. Lack of patience and understanding among health care workers is an inhibiting factor to utilising health facility for delivery.

"Nurse should have patience and understanding. We (patients) can be very ignorant sometimes. I escorted a woman to the labour ward one night. The nurse on duty asked me to stay out. They (care providers) did not examine her..... and was left to lie down until the baby came they (care providers) started shouting at her that she should not have pushed. Just imagine that"

(FGD1, Para 5 woman)

Poor reception at a health care facility was another issue raised. A Para 3 woman narrated:

"One day I escorted my sister-in-law. The nurse we found on duty asked my sister-in-law to choose any bed she could lie in the labour ward. She(nurse) ordered me out in a way as if am not a human being..... she (nurse) shouted at me and pointed at the door for me to follow suit" (FGD 1, Para 3 woman).

A Para 1 woman narrated that: *" the midwives do not even tell as where to go and deliver and reasons why we should deliver in health facility during our ANC visits"* (FGD 3, Para 1 woman).

Negligence of health care workers

Negligence on the side of the nurses particularly those at the antenatal clinic, labour or delivery wards in performing their duties with diligence was also highlighted. Nurses' sleeping throughout the night while on duty or relying on the patient's call for help in determining that labour is eminent. Negligence of care providers was in one case blamed for a woman to undergo a caesarean section (CS) because to them (women) the nurse they met on duty at the labour ward send her to the theatre even without examining her. A Para 2 women said: *"I was operated due to the negligence of the nurses. I was not even examined... the moment I entered the labour ward ...she (nurse) said you (referring to me) move over there you are going to be operated. All they (nurses) kept on saying was that you cannot deliver because your last delivery was CS. They took me to theatre by force. Having an operation (caesarean section) in your previous delivery does not mean you must be operated again"*

The woman concluded (FGD 4) lateness on the side of the care providers in reporting to work resulting in long waiting hours; engaging in personal duties for survival were issues raised by women.

A woman said: *"The nurses do not have any regard for their patients..... We (patients) come to the health centre very early in the morning but we spent long hours waiting. Nurses spend a lot of time doing other things – eating, chatting and going up and down rather than attending to the patients"*(FGD 3, Para 6).

Use of mobile phones while attending patients particularly when conducting a delivery was strongly criticised. A woman asserted that during her last delivery her baby nearly fell off the bed.

"I nearly lost my baby the nurse placed her at the edge of the bed which she (the nurse) was rushing to answer to a call in the mobile cell phone" (focus group 3, para1).

Alternative delivery services

Women have alternative places to seek health care including delivery for varied reasons. The options mentioned were delivery at home, public health facility (health centre or hospital) or a private health facility (for-profit or otherwise).

Home or private maternity clinics are alternative places women resort to. The choice of place of delivery is dictated by many factors ranging from personal, socio-cultural to health service related factors. Quaran are concoctions administered during labour to drink. These as well are believed to fasten and make the labour process safe and without event.

A testimony of Para 3 woman was: *"I have never delivered in a hospital..... my mother- in- law is a TBA..... She gives herbs to help me deliver early..... rub my stomach, gave me some to drink and in the process praying when my baby is not well positioned.....this is very helpful.....such care you know I will not get it in health facilities"* (FGD 4, Para 3) *"I have not delivered in the health facilities before, I do not know why but know that I have a woman at home who helps me a lot during labour and delivery"* (FGD 4, Para 5).

Traditional and cultural practices

Inability to use traditional things (herbs or concoctions) during labour and restrictive policies in health care facilities and not being

culturally sensitive or competent were viewed by women as deterrent to using medical facilities for delivery.

A woman with 4 children narrated: *"I always used my traditional things during labour.....these are very helpful to me especially the concoctions we use to sprinkle on our babies immediately after delivery to prevent their death if widows who have had sex before the performance of the final rites of their late husband's see our babies. Whenever I use them I have an event free labour.....but these are not allowed in the health facility..... because of that reason I prefer to deliver at home"* (FGD 4, Para 4).

Support and care

Support, care and companionship during labour and delivery are highly cherished and valued. Unfortunately these were not always obtained in health facilities. As these were always assured for home deliveries women opt to deliver at home as oppose to a medical facility.

A testimony of a woman: *"In the health facility, the nurses do not stand by your side; they only come when the baby comes if you are lucky."* (FGD 4, Para 3)

Transport and cost

Utilisation of health services has generally been influenced by many factors including distance to a facility, availability of transport and cost of receiving care. Lack of readily availability of a means of transport bars some women from visiting health facilities even during delivery. *"I planned to deliver in the health facility, but when labour started and I look for a taxi, I delivered before it came or you will not get at all"* (FGD 3, Para5)

Some women because of lack of transport facility resort to alternative ways of reaching a medical facility. *"I have to walk for long distance when I was in labour.....there was no transport"* (FGD3, Para 2).

In some settlements or rural villages transport is available but only at certain periods, Example in the mornings or evenings. *"We live in a place where transport is hard to come by. When you are in labour and need it, you find it difficult to get one especially now that there is a ban by the security on motor cycle riding in the Bawku Municipality due to protracted ethnic conflict. The available transport ply the road only twice in a day. So it is not possible to get one after they have left and also very expensive to hire a taxi or motor King (Tricycle)"* (FGD 3, Para 3).

User-fees prevent use of health facilities not only for delivery but for other services. In Ghana Maternal health care is being taken care of by the National Health Insurance Scheme (NHIS). From ANC, delivery to postnatal care is free. A woman who had 6 deliveries explained: *"Most women who could not afford for antenatal and delivery services are able to go for these services now with no cost. Thank God for the implementation of NHIS, money is no more a problem."* (FGD 3, Para 6)

Satisfaction with health services

Women also have positive experiences with the health system and viewed as encouraging factors to use health facilities for delivery. Furthermore, the perceived associated benefits of giving birth in a health facility were also highlighted and were mentioned as motivating factors too. Some of the issues raised included:

"Hospital or health centre (meaning any medical facility) delivery is the best..... You can be helped to deliver quickly" (FGD2, Para 1)

Perceived availability of life-saving interventions or facilities

(blood transfusion, caesarean section, infusion) in a medical facility was mentioned as a reason to deliver in a health facility.

"In health facilities, there are people with expertise who can help you to deliver safely even when you have a difficult labour.....at times you are taken to theatre" (FGD 2, Para 2).

"Blood and water (infusion) can be given when you need them. All these can save live..... these cannot be done if you deliver at home In my last delivery in the hospital as I was going to the toilet, feeling dizzy, I fell down. They (nurses) immediately saved my life by putting up water (infusion) for me. If that occurred at home, then by now am dead" (FGD 2, Para 2). *"It's important to deliver in hospital in case there are problems..... Small and short women like me who may need operation should delivery in a hospital"* (FGD3, Para 2) *"I met a nurse at the hospital who was very polite, helpful and patient..... She assisted me throughout labour and delivery..... She comes to see me at my bed whenever I need her"* (FGD 4, Para 1)

Expectations

Expectations were generally governed by experience of the women which influenced their future expectations. All women expressed a desire to have staff with a positive attitude. Some women expressed positive staff attitude they would expect. These included encouragement, politeness, giving reassurance, available by the bedside and exercising patience and tolerance.

A woman with 2 children narrated: *"In all my previous deliveries in the hospital I always met good nurses..... they helped me a lot during my last delivery. One of them was with me until I delivered that's was the time she left for home"* (FGD 4, Para 2)

"I do not think that all nurses are bad..... Some will leave you to lie down on the bed unattended when you are in pain or need their help... but some will do all they can to help and make you comfortable before they go home" (FGD 1, Para 3)

Women expected the nurses attending to them to be knowledgeable and competent and apply their skills when providing care, guidance and talk to them during labour and delivery.

"Hospital delivery is very important and the best..... but we have lots of problems..... Sometimes we do not get what we expected..... We are not given chance to ask questions" (FGD 4, Para 4).

Women also expressed that everybody including the nurses has social problems but further asserted that such problems should not be transport to the workplace. *"They should leave their problems at home when coming to work. They displace their personal problems on us (patients)"* (FGD 4, Para 4). *"The nurses should know that they were employed because of us..... They should have patience and understanding. If it was not us (patients) then they (nurses) will not have jobs to be paid salary"* (FGD 4, Para 5)

Availability of drugs and supplies in health facilities is a high expectation among the women. Lack of drugs and being given empty prescriptions only to buy the drugs in a private drug store is an issue that concerns them too.

"We are receiving good care at the health centre..... but drugs should be made available. Not everyone can afford to buy drugs at the pharmacies.....they are expensive.....those who can afford it do not visit the health facility (public health facilities) but rather go to the private health facility" (FGD 2, Para 3).

What women hear about the health system also raised or lowers

their expectations. Thus if their expectations are not met future use of health care facilities may be affected. *"We always hear that drugs are available, but when we visit the health facilities we are given prescriptions to buy from the pharmacies"* (FGD 2, Para 2).

Discussions

The low proportion of institutional deliveries that obtains in the Bawku Municipality can be associated with poor attitude of health care providers, lack of reliable means of transport and strong cultural adherence. Women in Bawku Municipality perceived pregnancy, labour and delivery as a secret and prefer to deliver quietly without the knowledge of many for fear of being bewitched. Witch craft is associated with pregnancy, labour and delivery.

Health workers attitude, which was consistently mentioned, is associated to low health institutional delivery. The acute shortage of trained health personnel may be a factor contributing to poor staff attitude; the available ones are over worked and demotivated.

Previous experience

Interplaying health systems, social and economic factors are thus responsible for the low utilisation of health facilities for delivery despite the high awareness of its importance. Past experiences of the women with health facilities (interaction with care providers, examinations subjected to, long waiting hours and other issues) were health services factors raised.

These factors have considerable influence on acceptability and utilization of services. Similar studies done in Malawi to look into factors influencing choice of place of delivery, also expressed similar issues. The women reported varied experiences at different health facilities when they reported for delivery ranging from not been examined during labour and after delivery, poor reception at the labour ward, left alone not assisted and sometimes no midwife to deliver [8].

Attitude of health workers

The attitude of the health care providers also contributed as the women were sent home when they report in labour. This is done mostly when there is lack of space to accommodate everyone who report with labour and the cervix is not yet dilated. Some maternity rooms are very small to include everyone. It is also done when health workers are about to close and do not want to attend to new clients. It is bad though as it contributes to the usage of health facilities for delivery. The attitude of staff towards the women comes out throughout the studies. It is true that the nurses are over worked coupled with poor working conditions, but a study that was done in Nigeria to study the pattern of utilization of antenatal, delivery and postnatal care services in the community shows that utilization of ANC to be relatively high but most of the respondent delivered at home without the supervision of trained personnel. This was attributed to advanced labour and perceived poor staff attitude towards the women [9].

It is true that the nurses are over worked coupled with poor working conditions, but that should not reflect on their relationship of care seekers. The services offered should be accessible in terms of quality offered and time required to receive the services. The women should be treated with respect. They should be treated as women that leave with us.

Negligence of health workers

Negligence on the side of the nurses particularly those at the antenatal clinic, labour or delivery wards in performing their duties

with diligence was also highlighted. Nurses sleeping throughout the night while on duty or relying on the patient's call for help in determining that labour is eminent.

Alternative delivery source

Preference for alternative services was influenced by quality of care from the perspective of the service provider's behaviour. TBAs (in the community) were preferred as they are considered to be more empathetic and caring. TBAs allowing women more liberty on birthing positions was also cited as a preference for home deliveries.

Longer waiting time reported from public facilities discourage women from delivering in health facilities. Confined to bed the whole labour and delivery period were issues that send women away from delivering in health facilities.

Health facilities in Ghana the women are only delivered in the lithotomy position. Therefore if other alternative is being offered, then those who do not prefer the lithotomy position will not visit the health facilities. More birthing positions should be employed, but through the midwifery training schools so that midwives are used to it before graduation. Facilities to cater for other positions also should be provided.

A similar study conducted in a rural Nigeria to assess maternal health seeking behaviour indicated that pregnant women prefer TBAs and the private clinics were considered to be more affectionate and caring compared to public facilities. Waiting time was also considered to be longer in the government facility compared to other alternative source of care [10].

Another study done in Zambia to describe the routine care of women during normal labour and delivery, and the immediate care of newborn babies also shows that women were confined to bed during the whole labour and delivery period. All women were delivered in lithotomy positions and primiparae were fixed in stirrups during the second and third stages of labour [11]. A study done in Bangladesh also shows how women's active participation in their own birthing experience can be taken away from them. Most women greatly preferred the squatting or kneeling position when giving birth, which has been used for generations and which was more comfortable [10].

Cultural and spiritual sensitive care

The values of cultural and traditional preference were important to Northern Ghana women. The present study reveals how women resort to delivering at home just to be able to practice and use their cultural believes (herbs or concoctions).

The health facilities are only resorted to, when complications arises which in most cases is late because it's always the last option. People in Northern Ghana are known to their cultural believes and stick to it at all times. There are so many cultural believes that are done for women who are in labour and most women adhered to it. Even when women are facing difficulties, these believes are practiced first, and if failed they resort to the health facilities which in most cases is late. Formal health services can conflict with ideas about what is normal and acceptable including preferences for privacy, modesty and female attendants.

A study that was conducted in Uganda to look into why women when faced with complications of pregnancy or delivery, still continue to choose high risk options leading to severe morbidity and even their own death. The finding demonstrates that adherence to traditional birthing practices and believes that pregnancy is a test of endurance and maternal death sad but normal event are important factors [12].

Skilled attendant can only be available in the health institutions. To reduce maternal mortality and morbidity, and to attain the millennium development goal that Improving Maternal Health is outlined as one of them which set a target of maternal mortality ratio reduction by three-quarters of the 1990 levels by the year 2015 [1].

Critical in the attainment of the above goal is availability, utilization and quality of maternity care services – antenatal, delivery and postpartum care.

Of the global maternal deaths over 70% occur during delivery or shortly after thus making skilled attendance during pregnancy but most importantly during delivery and the postpartum period key intervention in reducing maternal mortality and morbidity [13].

Home births remain a strong preference, and often the only option, for many women in the developing world. A large proportion of these home deliveries take place without skilled attendants.

The women should therefore be encouraged to use the health institutions and delivered by a skilled attendant.

Why focus on skilled attendant now? Well intended efforts to reduce maternal and new born mortality and morbidity have been underway for more than a decade. These efforts have resulted in success in a few countries, but regrettably, progress in most countries has been unacceptably slow. Experience from past projects and on-going research, point to the importance of access to a functioning health care system as a key factor in reducing maternal mortality. Currently, as part of economic development support linked to MDG targets, health systems are being reformed and strengthened in many developing countries. WHO, ICM and FIGO believes that this is an opportunity moment to push the case for skilled attendant with view to ensuring that this vital function is institutionalized in the newly reformed developing health systems [14].

Over the last decade many traditional birth attendants have been given midwifery training as part of the Safe Motherhood strategy. Their training appears, however, to have had little impact on maternal mortality.

Provision of a health worker with midwifery skills at every birth place, plus access to emergency hospital obstetric care, is considered the most crucial intervention for safe motherhood.

The required skills and ability of a midwife includes being able to communicate effectively, need to cultivate effective interpersonal communication skills and an attitude of respect for the women's right to be a full partner in the management of their pregnancy, child birth and the post natal period [15]. The midwife should be able to perform vaginal examination; ensuring the woman's and her/his own safety. Identify the onset of labour and monitor maternal and foetal well-being during labour and provide supportive care [15].

The majority of maternal and perinatal deaths could be avoided by access to basic maternity care; which is supported by adequate medical and surgical care. The medical staff should realised and recognised that their health services are in competition with alternative health systems which are wildly used and often perceived to be better. The people we serve do not think in terms of what is medically sound, but what is culturally appropriate. Their medical decisions are often based on non-medical rationales.

Maternity care can be disrespectful and inhuman or even exploitative [16].

Offensive and demeaning language by health personnel, and

ridiculing of women's poverty, clothing, parity, smell, hygiene, cries of pain, or desire to remain clothed is not only disrespectful, but abusive [17].

The maternity services need to be made more culturally and socially relevant to be able to save lives. Procedures during labour can be undertaken with little discussion, but might be considered shameful or disgusting to women, and unnecessary by international standards, including episiotomies, perineal shaving, and enemas [18].

A poor reputation of staff attitude means that the women will less likely use health services for delivery. They will only come when it is too late. Providers need to improve the acceptability of care provided, and communities should be encouraged to help with transportation for their women to go to a health facility when they are in labour. Referral is another important aspect of quality maternal care as it improves the efficiency of services facing resource constraints.

In summary, the qualitative data has described and give an insight of the contributing factors that influence the women not using the health institutions for delivery. There was a high preference for delivering by TBAs who lack skills to respond to emergency obstetrical conditions.

Satisfaction with health services

Perceived quality of care was mentioned in all the subdistricts as the most prominent issues as it satisfies clients if the quality is perceived to be good. It is important to encourage them to use the health facilities for delivery where they perceived quality of care, followed by the attitude of staff towards them and the availability of equipment, drugs and supplies in the facilities. The perceived quality of care is very important in making sure that women utilize the health institutions for delivery. Therefore, the services should be made friendly for users and optimum care given at all times.

Expectations

The expectation of the women on the health systems was not to their satisfaction. They expected a great deal of interpersonal relationship; on the contrary they viewed health care providers as rude, unsympathetic and uncaring, and thus prefer to use the services of traditional birth attendants and healers. Women who are in labour needs constant support and motivation until the delivery of the baby which they think they cannot get from the health facilities. It is well to mention that in the health facilities; more than one woman in most cases is in labour, so it will be difficult to concentrate on all at the same time especially with the shortage of staff. Unlike in the community where only one person will be in labour and all the attention is given to her. In the study, negative attitude of the health care providers was explicitly mentioned, a situation which health workers can and should try to change.

Attitudes towards patients are a critical element of care offered to the patients. The clients should be governed by policy to help them in this regard.

This was also found in studies conducted in Bangladesh [19].

Conclusion

This qualitative study has revealed that, the low rate of deliveries taking place in health care facilities in Bawku Municipality is as a result of interplay of both health service and socio-cultural factors. The prominent health service factors identified are: attitude of health staff, previous experience of the women, lack of information given on place of delivery during ANC, negligence of the health care workers, lack of care and support during labour, alternative delivery services, and

low expectations of the women when they visit the health facilities. The socio-cultural factors are adherent to cultural and spiritual care which will not be allowed in the health facilities, distance to the health facilities, and lack of transport especially during labour. These are generally the factors identified in the study that deterred women from using health facilities for delivery. The popularity, which is also reflecting in the study, shows that women believe that health facility delivery is beneficial.

The recommendations emerging from the study reinforce the importance of provider awareness regarding attitude, and the need for development of interpersonal communication skills into education and training. The means to address the factors relating to good delivery care practices are therefore to ensure a high level of awareness amongst practitioners. Sitzia and Woods describe several mechanisms by which patient views might be communicated to the health system from patient-provider discussions, patient advocates, patient comment boxes in hospitals, patient committees, focus groups, public meetings and surveys [20].

Recommendations

There should be a system in place for rewarding service providers with good incentives, better working conditions and satisfactory accommodation facilities especially for those working in the rural areas to motivate them to stay and work. Staff should be increased to meet the staff patient ratio and strategies put in place for retention. Quality assurance system should be introduced within the health system to protect the rights of the women.

The managers of health facilities should make sure that services are friendly for the users. Adequate staff should be available in health facilities to meet the demand of patients especially in the rural area.

The health management teams should continue to support health care providers through continuous supervision, monitoring and evaluation. If they know that they are continuously monitored, then it will influence their attitude towards work. Thus, the services will be improved and user friendly.

Since the ANC clinic is the first contact with the women, it is necessary for the midwives to seize the opportunity and spend more time than is currently done on each patient to give appropriate counselling, health education and discussion of plans for delivery. This will not only provide knowledge, but also trust.

Community mobilization and sensitization targeting women and men who provide finance for seeking care and are involved in decision making in the community.

Both the community and ANC clinics should be targeted for health education on dangers signs of pregnancy, labour and after delivery to reach as many people as possible. If the women know the danger signs that are leading causes of maternal mortality and morbidity, then they will report early to health facilities. It should target both men and women especially those who are involved in making decision. The information should provide where care is available. Community needs to understand that women can survive pregnancy and that the thorns and other hazards on their paths can and should be removed as a community obligation. Active community participation in such education, including that of men as leaders and as partners, is required.

To assure the continuation of the health facilities for delivery by the women, action is needed to improve providers' attitudes towards the women and their relatives. The women should be treated with respect, understanding and dignity. Midwives should reorient their caring practices to more culturally, appropriate and evidenced-based

maternity care. Traditional views on pregnancy and motherhood are important cultural factors influencing health care-seeking behaviour that must be kept in mind and made a subject for further research. Allowing a family member or husband to accompany a woman during labour might be a possible intervention, to overcome the cultural need of family to be around and witness the delivery. It may also reduce the barrier of unfamiliar environment.

The Ministry of Health should post midwives in every health facility and strategies to maintain midwives in the field especially in rural areas should be improved.

Improving the road conditions/network and putting in place a sustainable public transport system in particular in the rural areas. Continuous and Strong collaboration with Ghana Private Transport Unions (GPRTU), Ghana Health Services and Communities should be encouraged for them to help in the evacuation of their women to the nearest health facility.

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