FACTORS AFFECTING A WOMAN’S CHOICE OF DELIVERY PLACE IN WELLEMBELLE

A qualitative study conducted by IMCC and SAVE-Ghana

Tumu, Upper West Region, Ghana
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## List of Abbreviations

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<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>BP</td>
<td>Blood Pressure</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>DHA</td>
<td>District health administration</td>
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<td>CHN</td>
<td>Community Health Nurse</td>
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<td>CHV</td>
<td>Community Health Volunteer</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>FGD</td>
<td>Focused Group Discussion</td>
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<td>GHS</td>
<td>Ghana Health Service</td>
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<td>HSAO</td>
<td>Health Sector Advisory Office</td>
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<td>Hgb</td>
<td>Haemoglobin</td>
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<tr>
<td>IMCC</td>
<td>International Medical Corporation Committee</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>PHN</td>
<td>Public Health Nurse</td>
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<tr>
<td>PNC</td>
<td>Post Natal Care</td>
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<td>PF</td>
<td>Family Planning</td>
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<tr>
<td>RPA</td>
<td>Rural Participatory Approach</td>
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<tr>
<td>SEDA</td>
<td>Sissala East District Assembly</td>
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<td>SAVE- Ghana</td>
<td>Sustainable Aid through Voluntary Establishment-Ghana</td>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>UWR</td>
<td>Upper West Region</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Acknowledgment

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We owe a great debt of appreciation to Madam Sophia Nyireh, Public Health Nurse of the Sissala East DHA, Mr. Robert Juah the In-charge of Wellembelle and Madam Ruth, midwife of Wellembelle. All Wellembelle health staff should accept our sincere thanks for the great support that they have given us during the study.

We are equally grateful to all interviewees, for making time for us out of their busy schedules at the many times that we called for their help.
Abstract:

**Background:** In northern Ghana maternal mortality is high. The midwife of Wellembelle health centre in Sissala East District, UWR has expressed concern that the women in Wellembelle won’t deliver at the clinic though they come for ANC. The aim of the study is to investigate the reasons behind the women’s choice of delivery place. Furthermore the aim is to make recommendations that are operational in the setting of a deprived area such as Wellembelle.

**Method:** The study has been conducted after the principles of RPA. The gathered information is from interviews, observations and review of current data and statistics for the area and Ghana as a whole. Semi-structured interviews have been conducted as individual interviews with stakeholders in health and in focus group discussions with key-informants from the community and staff at the health centre. Observations were made during the interview sessions on participants’ behaviour and relevant statistics were collected from DHA, national statistics were obtained from GHS, MoH and WHO. Data collection has been done during the period from October 2008 till May 2009.

**Results and findings:** The findings were grouped into six categories, which were thought to have an influence on the women’s choice: 1) Logistics at the clinic; one delivery-bed, only one midwife, two CHN can conduct deliveries, but are often not used, no supply of water, no basic life saving equipment like laboratory. 2) Circumstances when delivering at the clinic; staff behaviour, the technical issues e.g. giving injections and medication are considered a motivational factor, the possibility of monitoring the delivery, time spend at the clinic. 3) Circumstances when delivering at home with the TBAs; TBAs not always contacted early, they are highly respected in the community, possibility of giving concoctions, often not a direct contact between the TBAs and the health staffs. 4) Socio-cultural aspect; proving to be a real woman by delivering alone, the men are considered lucky if they don’t have to go to the clinic, delay in contact to the clinic if it is thought the woman is unfaithful, prolongation of the delivery when many people are aware of it, some religions don’t allow others to see your nakedness, the general acceptance that some children will live and some will not. 5) Economic factors; cost of items for delivery and the fear of the cost of transportation when referred. 6) Knowledge; a gap between knowledge and behaviour.

**Discussion:** In general the community and the health staff are concerned with many of the same issues concerning the delivery situations. Due to different backgrounds in terms of education and different insight to how the system works their solutions however differ. The community is much focused on the issues of logistics at the clinic and the economic aspects, the health staffs also see these to be major problems but acknowledge that it is difficult to change these, so their focus is on education and community dialogue especially on the socio cultural aspects. Many community members express an interest in changing some of the traditional beliefs.

**Conclusion and recommendations:** Communication between health staff and TBAs and health staff and the community should be enhanced, there is a need of more education of the women on pregnancy and delivery related issues and forums for community dialogue, community ambulance systems and savings are to be created, the water situation and the possibility of getting basic laboratory equipment are to be looked into. Stakeholders in health and CSOs have a shared responsibility to act together.
Introduction
In northern Ghana women are dying as a result of childbirth and pregnancy every year, this situation is more serious within the poor rural communities with few health facilities, poor patronage to the facilities etc. As part of the Sissala East District Health Administration (DHA) effort to improve the health status monitoring and supervision of the health facilities within their catchment area is one of their regular activities. In one of their visits to Wellembelle health clinic the midwife expressed concern that the women come for the ANC and PNC, but for the most crucial aspect of pregnancy being delivery they have a very low attendance. This information is of great concern to the staff of the clinic, DHA and some CSOs in the district.

It is in the light of this, that SAVE-GHANA; a women and children centered local NGO in the Sissala districts, has gone into a partnership with IMCC, a Danish NGO working in primary health care. Together the two NGOs have conducted a research to explore the reasons for this problem.

Background:
National:
Ghana has subscribed to adopt the United Nations Millennium Development Goals, which is to be achieved by 2015\(^1\). The Goal 5 focuses on improving maternal health. Along with other low- and middle income countries Ghana is having difficulties in achieving this goal. According to data from GHS the institutional maternal mortality-ratio is 230.2 per 100,000 live births in 2007 – realistically the number is even higher considering all the maternal deaths occurring outside health facilities. In its effort to improve this situation Ghana introduced free health care for all pregnant women in the country to increase health facility attendance but in some parts of the country including Northern Ghana there is still a low rate of facility deliveries, which goes a long way hindering the achievement of the MDGs.

Few years ago MoH and development partners trained a number of women in the communities who were to become TBAs in order to reduce maternal mortality. Each TBA was given certain skills and basic equipment to perform deliveries in a safe way. Since the maternal mortality hasn’t dropped accordingly afterwards, the MoH and stakeholders have changed their strategy from promoting deliveries by TBAs to encourage skilled deliveries by trained health staff at a clinic.

Locally:
Sissala East District is in Upper West Region. The District capital is Tumu, where the district hospital is situated. According to the Sissala East DHA yearly report from 2008 the district has a low population density of about 12/ km\(^2\) and all roads in the district are dirt roads except from a few in the district capital. The rainy season lasts from March to September and affects the condition of the roads. Many inhabitants are subsistent farmers rearing livestock and poultry. The population practice Islam, Christianity and traditional religion. Literacy level in the district is low and higher with males than females\(^2\).

Wellembelle is the second largest village in the district with a total target population in the catchment area of 10163\(^3\). It is considered safe to assume that the profile of the district matches the profile of Wellembelle.

In 2008, 2072 women were registered for receiving ANC at the health facilities in the whole district. 23 % of these were delivered by skilled personnel, 39 % by TBAs and the rest must be assumed to deliver alone or with family members. 27 stillbirths were registered and 3 maternal deaths.
For the Wellembelle catchment area the total number of ANC registrants was 290 women. Of these 66 (23 %) were registered as skilled deliveries, 195 (67 %) as TBA conducted. Two still births were recorded and 0 maternal deaths.

The recorded deaths are institutional deaths, meaning that those dying at home without contact to health facilities are not captured in these numbers.

**Study aim:**
The aim of the study is to investigate the reasons behind the women’s choice of delivery place. Furthermore the aim is to make recommendations that are operational in the setting of a deprived area such as Wellembelle.

**Methods:**

**Data collection:**
It was decided to keep this study as simple, unacademic and feasible as possible for the health staff and other stakeholders in health. We chose to conduct the study using the principles of RPA\(^iv\) which is a method for obtaining information about a specific subject in a quick and cheap way with regards to the time spend and the monetary expenditures. One of the cornerstones in RPA is to pay no attention to time-consuming unnecessary information and instead just keeping a focus on what the actual situation is in the study-area according to those affected by the situation.

The gathered data for the study can be categorized into three categories: Interviews, observations and review of current data and statistics for the area and Ghana as a whole. According to the above most emphasis was put on the interview-part. The interviews were conducted as semi-structured interviews in focus group discussions with key-informants from the community and stakeholders in health, and individual interviews. The majority of the participants in the focus groups from the community were identified by the health staffs and few were selected directly by the interviewers. The participants were sampled into groups of young women in the fertile age, husbands, mothers-in-law, opinion leaders like traditional and religious leaders, and TBAs. Focus group discussions were also conducted with health staff at the clinic. Individual interviews were conducted with the in-charge of the clinic, the district PHN and the district Medical Director. The interviews with the community members were conducted in the local language “Sissali”. For these interviews members from SAVE–Ghana were the facilitators and afterwards the translators. The interviews were conducted outside the clinic area.

During the interviews, observations were made and noted concerning the behaviour of the participants, how they felt and reacted about specific issues etc. Also we witnessed four cases of labour during our visits. Statistics about the attendance and performance in Wellembelle were collected from DHA. Further data on maternal health and the specific situation in Ghana were gathered from WHO, Ghana MoH and GHS and HSAO in Accra. Data collection has been done during the period from October 2008 till May 2009. The data collection period was delayed due to administrative problems.

**Data analysis:**
For this session we didn’t use a specific theory. The analysis however has been done systematically: first, the interviewers individually read through all the interviews, noticing which statements had several
occurrences; afterwards we gathered and grouped the repetitive findings from the interviews and observations into overall categories that were further subdivided into single statements.

Validation:
After the data collection and the analysis, the interview team went back to Wellemelle to discuss the preliminary findings, first with the health staff at the clinic and the next day with some of the community members. 20 community members participated in the discussion; they were a broad range of opinion leaders, men, young women, older women, and TBAs. Information was triangulated during the focus group discussions.

Ethical approval:
Ethical approval was applied for and granted by the district- and regional directors of health services.

Results and findings

Logistics at the clinic:
The logistics at the clinic are of great importance to the community. It was mentioned at several occasions that there is only one delivery-bed at the clinic; “In fact we only have one delivery bed in the clinic and if two women come at the same time what will happen to the other woman?” (Mother in laws). They found it made it difficult for the midwife in case there is more than one delivery case at a time. It was also found that the clinic has only one midwife, this seems to be inadequate for the sub-district. Above this, she sometimes has to attend to family problems or official duties in Tumu or elsewhere taking her out of the clinic. This was confirmed during our interview sessions when we encountered four delivery cases in the clinic three in her absence. Though there are two CHNs that are trained to conduct deliveries, they are often not performing the task, since the community prefer deliver with the midwife. At the discussions it was even revealed that some women in labour send people to find out whether the midwife is at the clinic before deciding whether actually to come in for delivery.

It was also found that there is no supply of water at the clinic and this was considered to be an issue by both community members and service providers. “Water is also an important issue. We do not have water at the clinic, so if someone delivers at the clinic, her people have to bring water to the clinic” (Mother in laws). The women saw this as a discouraging factor for using the clinic.

The clinic has no basic life saving equipment like laboratory equipment for measuring Hgb, examine urine etc. or blood bank. As a result of this, situations occurring during pregnancy or delivery were these services are needed are referred to either Tumu or Wa.

Circumstances when delivering at the clinic:
During our interviews, it was said that the health staff sometimes has a rough behaviour towards the women e.g. slapping their thighs during labour, yelling at them when they come in a late stage of labour or do something wrong etc. The women said this keeps them away from coming to deliver at the clinic. “I will not go to the clinic because of the nurses there. They are not kind to pregnant woman and so if I can go to the TBA to get the same treatment why should I go to the clinic?” (Mother in laws). However these kinds of sentences were often supplemented, by stating that this was the fact in the old days and not now: “Over here it is not always that” (pregnant woman’s answer to whether the midwife beats them). Later
discussion with the health staff revealed that actually the midwife sometimes slaps the thighs of the women during labour if the woman is pulling her legs together so the baby cannot come out. It was not possible to determine to what extent this is a problem today.

The clinic offers the possibility of giving injections and medication, taking the blood pressure of the women, and registering the birth weight and the birth date. The women see this as a motivation in coming to deliver at the clinic.

Our discussions with the health staff revealed that the midwife uses a partograph to monitor the delivery situation. This helps to monitor the delivery situation to ensure that the foetus is not being stressed up by the interval of contraction of the uterus; therefore she will be able to determine whether an emergency situation is rising and referral is needed. The other health staffs that are also trained in conducting deliveries have been taught to use this in school, but say that since they don’t use it regularly they have forgotten how to use it. They have not received any refresher training in this.

The pregnant women think that the health staffs sometimes disregard their views and choices. For instance, the pregnant women said that when they report for labour early at the clinic, they are made to stay longer at the clinic than they find necessary. “In some cases you may begin to fell minor pains in the womb. If you rush to the clinic taking the pains for labour you may spend five or six days there. But the day the pains get really deep then I know it is really labour and then it is time to go to the clinic” (pregnant woman). The health staffs say that they are only keeping the women admitted the absolute minimum of time.

The community revealed that they were really concerned about another issue, that young women are sometimes being rejected at family planning because they are considered too young. “Young women in school when they are pregnant will not go to the clinic for delivery but will go to their friends who will give them some concoctions in the name of aborting the pregnancy, most times they die in this village. The day before yesterday a young woman passed away like that. When they go to the clinic for family planning they will say that they are too young for that, so I think that this is an issue that should be addressed” (Mother in laws).

Circumstances when delivering at home with the TBAs:

The community says that the TBAs are the first point of contact with health service providers during labour. “When you start to feel labour pain, you gather all the materials you bought for delivery and call for the TBA and possibly go to the clinic” (pregnant woman). The TBAs examine the pregnant woman and decide whether she should deliver at home or at the clinic. But the TBAs state that when they are called to examine a woman in labour, most of the time, the labour is already in the second stage and as a result, it makes it difficult for them to refer to the clinic and then they have to perform the delivery. However the health staff stated that two of the TBAs were actually referring labour situations to the clinic.

It was clear from the interviews that the TBAs are much respected in the community. They both conduct deliveries and serve as a link between the pregnant women and the clinic. The community members don’t distinguish between TBAs and the formal health sector “The TBAs have been trained and they do what the clinic people do so why do you have to send your wife to the clinic?” (Opinion leader, male).
On the issue of concoctions, we found out during our interviews and discussions that some of the TBAs give concoctions. “Sometimes they can even give some concoctions to make them deliver early which the clinic people cannot give.” (Opinion leader, male). In the discussion on the preliminary findings, it was said that it is not always the TBAs that do so.

Socio cultural:
The society is built up in a way that men are the decision makers. However when it comes to pregnancy and delivery the mother in laws have the largest mandate “all we know about pregnancy and delivery is that when our wives are pregnant, the first person to know is the mother in law, and if possible the husband is also made to know that the wife is pregnant. It is the mother in law that takes charge of her until she gives birth” (opinion leaders, male).

A woman will have to prove herself to a “real” woman by delivering alone. This is thought to be a sign of true womanhood. “Women who do not patronize the facility for delivery they use that as a way of proving their true women status and try to look down upon those who patronize the facility and consider them as very lazy and inferior. Some men also consider women who deliver at the facility as inferior” (Health staff at the clinic). This was later confirmed “For my wife,…, when she is in labour she will not want someone to know that she’s in labour, that makes her a woman” (Opinion leader, male). A staff from the health centre even confirmed this “As a result I did not come to the facility for my first delivery.” (Health staff at the clinic)

It was also realized that the men think that they are lucky if their wives deliver at home: “But if you are lucky you get there, she gives birth so you don’t go to the clinic” (Husbands).

When the women come to the clinic they often are in a late state: There is a perception that when a woman’s delivery is being prolonged, it’s an indication of unfaithfulness, thus she has to confess first before the baby comes and before she is taken to the TBA or the clinic “but during the labour time when the child was not coming, people in my husband’s family were accusing me of sleeping with other men and that was why the baby was not coming. Because I was in pain and I thought, that if I said it was true then the baby would come out, I said it and yet the baby never came. I was finally taken to Tumu for operation” (mother in laws). During our discussions with the health staff, the midwife said that on some occasions, women are brought in late to the clinic in the second stage of labour because the family have demanded them to confess first. Besides that there is a belief that when many people know of a woman’s labour situation the delivery prolongs. As a result they prefer staying at home as long as possible where nobody apart from relatives knows of the labour, rather than going to the clinic where other people might know and thereby prolong the delivery.

During our interviews, we found out that in certain religions strangers e.g. another person than the husband, mother in-laws etc are not allowed to see ones nakedness. “For my religion it influences some of the options; unless we can do without, it is not allowed for someone you do not know to see your nakedness” (opinion leaders, male). As a result of this, the pregnant women won’t come to clinic to be assisted in delivery by strangers. During our discussions with the health staff, the in charge of Wellemelle confirmed that, sometimes when he is to conduct a delivery, the woman is not comfortable and shows signs of unwillingness to cooperate.
The society structure necessitate that there is a general acceptance of the fact that out of the many children a woman will give birth to, some will live and some will die. In one FGD it came out that all the women had at least lost one child, when asked how it had happened the answer was “For me it is the work of God” (mother in laws), and this was being confirmed by the other women. As a result they don’t see the outcome of their choice of delivery as an influencing factor. They believe there is nothing to be done to change or prevent this outcome.

Economic
On the items for delivering such as clean clothes, disinfectants etc, we found out during the interviews and discussions with the health staff that, the health staffs are afraid to tell women to bring these items as it may further make them stay away from delivering at the clinic. However, discussions with the community show that, they prefer to know exactly what they are expected to bring.

The fear of possible referral to Tumu or Wa in a case of complication during delivery, keeps some pregnant women from frequenting the clinic. “I would prefer to go to the clinic because they have everything to make your delivery easy. The only reason why I will not want to go to the clinic, is that they will transfer me to Tumu” (mother in laws). During our discussions with the health staff they even said that on a particular labour situation, a woman was referred to Tumu, and actually refused to go. The negative aspects of possible referral occurred several time during the different interviews in relation to cost, inconvenience etc.

Knowledge:
The women seem to have a good basic knowledge when it comes to pregnancy signs, what to eat, the importance of ANC etc ”Over here we eat dawadawa and fish but in the absence of fish the dawadawa act as a good substitute as well as green vegetables” (pregnant women). The women have been told to give birth at the clinic and theoretically they support this idea;” When you are in labour you consider it that it is the work of god and so as an enlightened person you go to the clinic for help” (pregnant women). There seems however to be a gap in what they know and their behaviour, in that their behaviours do not reflect this knowledge, e.g. few delivers at the clinic. When it comes to the delivery situation the women lack knowledge on what actually happens and complications like illness and personal hygiene, signs of commencing labour, danger signs in pregnancy etc.

Discussion
In general the health staffs have knowledge on the system they work in and they are well aware of the possibilities and limitations. E.g. when discussing the issue of getting another midwife to Wellembelle, they express that even though this of course would help them a lot, they are well aware that it’s simply not a possibility considering the fact that many of the other clinics in the district don’t even have a midwife. This resulted in them having a focus on the more intangible issues like education and dialogue besides material things as way forward.

Since the community comprises of a different range of people in terms of educational level, religion, knowledge and usage of the health system etc. their views on the way forward were focused mainly on tangible issues like extra beds, extra midwives, water etc. Discussing the issues like education and dialogue they didn’t oppose it they just didn’t think that these are the most important interventions.
Logistics
For the community this area was a major issue, while the health staff had a slightly different point of view. The community saw the solutions to be extra beds, more midwives, laboratory equipment and a borehole at the clinic, while the health staff found that though it would be a great advantage to have a basic laboratory and water, but that the absence of all these should not be what keep patients away.

A way to meet the situation about logistics is to make better use of what they actually have. The limitation in numbers of staff could be dealt with by making better use of the two CHNs. When we discussed this possibility with the health staff, they promised to try to sensitize the community during ANC on the possibility of being attended by a CHN during delivery. The community actually expressed that they were aware that the CHN could assist them through delivery, and that they tried to cope with the situation.

The laboratory and the water are playing roles on different levels. Basis laboratory like examination of a pregnant woman’s urine or measuring Hgb can determine danger signs in a pregnancy and by that help to reduce mortality. Now the women have to go to Tumu for this. However they do not always follow the instruction and go to Tumu, resulting in them being in greater risk. This sometimes discourages them from frequenting the Wellemelle clinic because when they are asked to go on referral, and they don’t do so, they are afraid to be blamed by the health staff. The overall result of this is that the women don’t frequent the Wellemelle clinic.

With the water it’s the same situation; having water at a clinic means you are able to conduct a clean and hygienic delivery, something very essential in the reduction of maternal and neonatal deaths. At the same time not having the water discourages the women from going to the clinic since they will have to get their relatives to carry water to the clinic.

The clinic:
The unpleasant treatment at the clinic was a source of great debate and it remains unclear what is actually happening. In general the community is talking about bad treatment, like being slapped during labour, yelled at and being forced to run around the clinic but then they mention the past, and say that it’s different these days, that this midwife is pampering them and giving them injections and so on. But still it’s something that all the interviewees mentioned, meaning that it’s important to them. It doesn’t seem as if it’s the present midwife’s behaviour that is discouraging the community from going to the clinic, but it is clear that the past is still affecting the women’s choice of going to the clinic or not. The society structure allows the mother in laws to take major decisions concerning pregnancy and labour. Since they have experienced bad treatment in the past, they will not advise their daughter in laws to go to the clinic.

The community are comfortable with this midwife and see it as a major problem that they too often go in vain, because she is not at the clinic. The midwife expresses that sometimes she feels uncomfortable being the only one to conduct deliveries. Her behaviour when slapping the thighs could be due to the fact that she is stressed by being alone in the labour ward and patients coming in late so they are difficult to assist in delivery. When discussing with one of the stakeholders in health in the district, he expressed concern of the midwife situation in the district. There are only a few midwives and many of them will soon go on retirement. He had a fear that this will result in a serious lack of midwives in a few years to come and now it’s causing a situation where the midwives are stressed because of workload. All this probably doesn’t encourage the midwife to stay more than what is absolutely necessary in Wellemelle.
In the interviews the community pointed out that the good aspect of the clinic is their possibility of taking the BP, giving injections, weighing the child etc. This is mentioned as a great motivation for coming to the clinic. In our discussion with the community they were more focused on what needed to be changed than what actually worked well. But considering their emphasis on the how important a motivational factor a laboratory would be. Then it’s obvious that taking of BP, injections etc. are presently seen as a great motivation for choosing the clinic. The health staffs are already aware of this and to make more people frequent the clinic, a way could be to put even more emphasis on promoting what the clinic actually offers a woman in labour.

Surprisingly the issues of abortion came up when we were trying to find out what the women know about pregnancies and deliveries. The fact that it is difficult for the young girls to assess FP-services results in unwanted pregnancies and when the young women are afraid of going to the clinic, they instead choose to get an unsafe abortion and this is in the end contributing to maternal mortality. When this was revealed to the health staff they agreed to look in to this issue.

TBA:
The TBAs are highly respected in the community, and the community members didn’t differentiate much between the TBAs and the clinic, since the saw the TBAs to be an integrated part of the system. Though some interviewed said that the TBA is the first point of contact for women when they go into labour, it was however in later discussions with the community and health staff revealed that only a few actually contact the TBA early. Many of the women give birth alone or with some few family members and only few are assisted through delivery by the TBA. Even fewer are then likely to be referred to the clinic by the TBA. In the end this means only a small fraction of the women giving birth will actually give birth at the clinic. To get more women to frequent the clinic it would be of great benefit to further strengthen the link between community and TBAs and then between TBAs and the clinic.

The clinic and the TBAs have limited cooperation. A CHV explained that often they serve as an intermediary between the clinic and the TBA. In fact there is only two of the TBAs that transfers labour cases to the clinic. It didn’t seem as if they disliked or disrespected each other they just don’t collaborate. A lot of information is lost when it has to pass through an extra person and thereby information that could save life is lost or never generated. E.g. the dialogue between the health staff and the TBA about why a child died during delivery or how the TBA should have reacted when the women suddenly started to complain about headache during labour.

From the interview it appeared as if the TBAs are giving concoctions and that was a motivation for going to the TBA. But when we returned to validate our findings we found out that this is not the correct picture, some TBAs use concoctions, but often it is given to the women by their mother in laws, elderly women in the villages or bought at the local market. To stop the use of concoctions it might be necessary to deal with it from a different perspective. The TBAs are aware they should not use it. Now the women need to understand the dangers in the usage, since they are the ones to refuse it.

Knowledge and socio-cultural:
The aspect of knowledge and socio-cultural behaviour are closely linked. And obviously there is a great difference between the opinion of health staff and the community to these issues since they have very different background. While a few from the community attributed behaviour to lack of knowledge, most of them thought that the “gap between knowledge and behaviour” is due to poverty, and by this
classification they don’t see there is anything to do about it (e.g. they don’t go to the clinic, because they cannot afford the cost of transportation if referred). The health staffs find that the women don’t practise according to the knowledge on the issues that are costless. They think that the major problem is getting the women to prioritise spending the time at the clinic getting sensitized on matters concerning pregnancy, delivery etc. The women are often in a hurry, since they have to go home to take care of the other children, cook, work in the farm etc. This means the knowledge is not being fully developed and not being utilised in a way so it results in the correct behaviour.

The community and the health staff agree that the socio-cultural beliefs have a major impact on the choices concerning delivery. The health staffs find these beliefs to be important in their own life too and that it all comes down to education. But when even the educated people like the health staffs tell that traditional beliefs are having a major impact on their own decisions it is obvious that the impact on the community at large is even greater. From the discussion with the community a few of the members saw the beliefs to be a problem, and they encouraged more usage of the clinic in order to deal with specific traditional practices. But judging from the fact that most women don’t use the clinic, this must mean that they are accepting the traditional believes and living their lives according to them. If it all comes down to education, the men and the traditional leaders together with the mothers in laws must be considered just as important partners in order to address the issues effectively and holistically.

The economic:
Both the staff and the community confirmed that the cost of transportation in the case of referral has a major impact on the women’s choice of going to the clinic or not. Often they will chose not even going to the clinic because of the fear of referral and the associated costs. The health staffs acknowledge that this is how the situation is and it’s not possible to change the cost, so the solution for the community is for them to be mobilised and together create a community ambulance system, but they don’t believe that the community is interested. The community acknowledge that the GHS cannot bear the cost and that they themselves should find a solution where they help each other, but they see this to be the actual problem, since they don’t know how to carry this out.

Coming to the issues raised concerning the economic factors, it actually turned out that the community and the health staffs were agreeing on the problems and even on possible solutions, but the problem is that they don’t communicate well about this. They don’t think they will be able to solve the problem together if they are of different opinions and the result is that they just accept the situation as it is. When it now turns out that they are actually agreeing they might now be able to work towards a solution together.

Discussion on methodology:
The fact that SAVE-Ghana was both doing the facilitation of the FGD and afterward the translation and transcription is a possible source of error. But since we have a genuine interest in revealing the causes of low attendance at the clinic in order to make interventions that could help increase the attendance, we believe that our personal interest will not influence our facilitation or transcription and should therefore not be questioned as a source of error.

Most of the participants in the focus group discussions were identified and selected by the Wellembelle Health Centre. This might cause some biases of our findings. Of course they have a better contact with those in the community that use the clinic, and therefore these are the ones that are most likely to be invited for the discussion groups. We are well aware of this, which is why we tried to put our major focus
on what good experiences they had, in order to later on get these disseminated to the whole community and when discovering their negative views on the clinic, we have put emphasis on sharing this information with the health staffs in order for them to change it.

Another problem in our data collection was the range in the data collection period. When conducting the interviews and the analyzing with such a delay things might already have changed and the information might no longer be valid. We take our chance and believe that the situation has not changed dramatically and the information can still be regarded as valid, this was even confirmed when we went back to the community to discuss and validate our findings.

**Conclusion and recommendations:**

In general it has been realised that the causes for the low utilisation of the clinic are very different in terms of underlying reasons and possible solutions; some causes are due to misunderstandings and inadequate communications which are easily addressed, while others are more difficult to reach and need support and interventions from other stakeholders.

Finally it is necessary to understand the society structure is the context within which we work. We need to put our focus on the aspects in the society that support facility-delivery and we need to realise that the society cannot be changed from outside neither by NGOs nor health staffs but we can try to facilitate the processes that will lead to change from inside the community. This is why it is so important to bring all opinion leaders and decision makers on boards.

From the above findings and discussions we recommend the following:

The **communication** on all the levels is not efficient enough. This counts for both the communication between the community and health staff, and between health staff and TBAs. We recommend an enhanced focus being put on communication. Instead of having a link through the CHV, direct communication between TBAs and health staff should be established in order to improve on maternal health and enhance facility-deliveries. E.g. this could be done by inviting all the TBAs to a yearly review and discussion on delivery situations in the sub-district, or by visiting the TBAs in their compounds to meet them, acknowledge them and establish a direct link to them.

Sometimes the health staffs are taking decisions they think is the best for the community, while the community is of a different opinion (like not asking them to bring specific items, or not giving a young girl FP). Enhanced communication on needs, wishes and opinions will reduce this issue and lead to health services that match the needs of the community, enhance the usage of the clinic and in the end this will even make the job more satisfactory for the health staffs.

The knowledge on what is happening during pregnancy and child birth e.g. basic anatomy, physiology, diseases, danger signs etc. could be expanded through **education**. There is already knowledge on some of the aspects, but this could be improved with more education which would lead to a better and more rational behaviour. This would have to be based on what the women already know and their perception on these issues, for it to be a useable knowledge that they can put into practice. Both the health staff and CSOs have a role in the educational aspects.
Since some of the major reasons for low utilisation of the clinic are concerning socio-cultural causes, we recommend that a forum for **community dialogues** is created. Discussing this recommendation with the health staff they expressed that they found this to be very important but as service providers in the official system they found this very difficult to do. Therefore we further recommend that the CSOs in the district take this important challenge up. This could be done though maternity durbars, paternity durbars, durbars at schools on reproductive health and safe sexual behaviour. Furthermore these sessions are excellent forums for sensitizing the populations on their rights and responsibilities with regards to health issues in general and reproductive health in particular. This is also a possibility to sensitize the community on the advantages of making good use of available resources e.g. better use of CHN. Dialogue will also tackle the problems with the gap between knowledge and behaviour. The durbars need to empower the community members in order for them to understand that, they themselves have a role in reducing maternal mortality, instead of the present belief that the deaths are an unchangeable fact. This could be done with role plays, active discussions etc.

Transportation when referred is a problem for the community both in terms of the expenditures and as a demotivating factor for going to the clinic, this could be dealt with through creation of **community ambulance system** or a **community saving system**. The community have expressed the wish for creating this, but also their concerns on how to do it. We recommend that the CSOs take up this challenge and help mobilize the community.

**Water** at the clinic and **basic lifesaving laboratory equipment** has been identified as some of the most important way forwards by the community. The health staffs agree that these are important matters. Since this is an expense that the Wellemelle Health Centre cannot afford to bear alone, we recommend that stakeholders take the initiative to act on this and try to find money in their tight budgets to prioritise this important matter. Furthermore an extra **bed** in the labour ward was of great importance to the community. Though we know an extra bed is not the item that will save a woman’s life, it might be a motivational factor towards actually use the clinic, especially if they feel that they are involved in the process of making the labour ward more attractive.

The **midwife situation** is disturbing not only to Wellemelle Health Centre but to the whole district. The stakeholders need to take up this issue. A possible solution is for stakeholders to sponsor young students who are interested and prepared to go into midwifery and later return to the district. If nothing is done about this issue the whole district is most probably facing a serious situation in a few years from now. Furthermore **refresher training** on the issues of reproductive health, patient-health staff communication etc. will benefit the service deliveries. This will give the currently available staff the capacities, placing them in a better position to serve the community, and by that increase the attendance at the community and reduce maternal mortality. After a staff has gotten refresher training it is crucial that they pass on their new knowledge to their colleagues. Training on the ground by the midwife to the other staff when she is conducting a delivery is also a possible solution. By that the women will even get more comfortable with the other staffs assisting them in deliveries.

Concerning the issues raised by the community members on teenage pregnancy and unsafe abortions should be further investigated to find out the extent of this problem and impact it has on maternal mortality.
The risks associated with pregnancy and child birth are of great concern to the Wellembelle community, to the health providers and to CSOs. As we have looked into in the above there are several causes to the low attendance for delivery and possible solutions to increase the attendance. In order to improve this situation and to achieve the MDG 5 in the area of Wellembelle, it’s most crucial that all stakeholders join in collaboration and put in all their effort to increase facility deliveries, which is the key to reducing maternal mortality.

\[\text{WHO} \]
\[\text{ii} \] SEDHA Yearly Report 2008
\[\text{iii} \] SEDHA Yearly Report 2008
\[\text{iv} \] Rapid Participary Appraisals; Guidelines for RPA to assess community health needs.

\[\text{v} \] A local nut-extract rich in protein
References:
1) Hugh Annett and Susan B.Rifkin: *Guidelines for rapid participatory appraisals to assess community health needs*. WHO publication 1995

2) Sissala East District Health Administration-Yearly Report 2008

3) National Health Policy. MOH/PPME, Ghana 2007


5) [http://www.who.int/making_pregnancy_safer/topics/mdg/en/](http://www.who.int/making_pregnancy_safer/topics/mdg/en/)

6) [http://www.moh-ghana.org/moh/docs/pub_health/INSTITUTIONALMATERNALMORTALITYRATIO.pdf](http://www.moh-ghana.org/moh/docs/pub_health/INSTITUTIONALMATERNALMORTALITYRATIO.pdf)

7) [http://www.moh-ghana.org/moh/docs/pub_health/SUMMARYOFREPRODUCTIVEHEALTHSERVICES.pdf](http://www.moh-ghana.org/moh/docs/pub_health/SUMMARYOFREPRODUCTIVEHEALTHSERVICES.pdf)

Appendix 1

SSI guide (Semi Structured Interview) for traditional leaders at W’belle subdistrict

Intro

- Traditional greetings
- Introduction – interview team + project
- Introduction – men

Knowledge

- What do they know about pregnancy and delivery (risks etc.)
- What are the options for the women regarding pregnancy, delivery and health services

Personal Opinion

- What do they think about the women’s options regarding delivery
- Does their religion influence their opinion
- How does your opinion influence the community (in general, when choices are to be taken)
- Perception on home delivery, TBA delivery and delivery at health facility

Ways forward

What they think should be done to achieve safe delivery
Appendix 2

SSI guide (Semi Structured Interview) for husbands at W’belle subdistrict

Intro

- Traditional greetings
- Introduction – interview team + project
- Introduction – men

In general:

- What do they do for a living?
- Wife?
- Children?
- Born where? What happened?

The pregnancy/delivery

- Who makes the decisions about pregnancy and delivery?
- What happened when the wife went into labour?
- What are in their opinion good conditions for giving birth?
- Opinion about delivery: At home with the mother in law? With the TBAs? At the health facility? Explain why.
- What do they know about giving birth – the risk associated, the possibilities for help etc?

Way forward

- What do they think is the ideal situation for giving birth?
- How are we going to get that situation?
Appendix 3

Semi structured interview guide (SSI) for mother in laws

Introduction

- Traditional greetings
- Introduction of interviewer team
- Introduction of interview group (women)

Their own experience with delivery

- How many?
- Where? What happened?
- Why did they do as they did?
- If they were to deliver again, then how and where?
- What do they know about giving birth – the risks? Their possibilities? Etc.

Daughter in laws

- How many?
- How many grandchildren?
- Where have they delivered?
- Why?
- What are they (the mother in laws) expected to do when their daughter in law are to deliver?

Way forward

- What do they think is the ideal situation for giving birth?
- How are we going to get that situation?
Appendix 4

Semi structured Interview guide with the pregnant women in W’belle subdistrict

Introduction
- Traditional greetings
- Presentations of interview group and the project
- Presentation of the women

The Pregnancy
- How did they find out they were pregnant
- What did they do after finding out

The perception on the pregnancy
- Changing your life, your daily routines still working as normally,
- The future.
- What preparation / ANC

Knowledge on Pregnancy and delivery
- The risks associated with pregnancy
- The risks associated with delivery

The delivery
- What will happen when they find out that they are in delivery
- The choices to be taken
- What is important for them in the delivery situation
- Their expectations regarding the delivery situation
- Anybody with previous experience of delivery

Way forward
- Their wishes regarding making delivery easier (Drugs and so on)
Appendix 5

Semistructured interview guide

Introduction
- Traditional greeting, state that the interviewer is here to learn

Who are you?
- How did they become a TBA?
- What else do you do?

What are you doing?
- Apart from them who else do delivery?
- Is there a difference between what they do and what others do?
- How is your perception of women who do not come to you but rather seek help from else where
  (this could be mother in laws, the health clinic)

How are doing it?
- What happens when a woman calls you?
- What is important when a woman has to deliver?
- What type of deliveries do you take care off?
- Are there any deliveries that you will have to transfer? Why?
- What happens when you have to transfer? (optional)
- What do you offer that others do not?

Why are you doing it?
- How many deliveries did all of you conduct last month?
- Did the people call you or you called them? Who called you?
- How did they know that they could call you?
- Responsibility/Role in the society
- Payment from women?
- Do you encourage the pregnant women to call you?
- Why do you want to be a TBA?
Appendix 6

SSI with Medical Director at Tumu District Hospital

Introduction

- Greeting
- Purpose with the interview

How does the health system manage to take care of a woman who is in labour?

- What works well/what does not?
- At the grass root level? (HC / TBA)

Delivery?

- In your opinion – why is MMR high?
- Why skilled delivery instead of TBA?
- Home delivery and maternal deaths? How is it registered?

Transferral?

- The women they receive that have been transferred from the health centers – why have they been transferred?
- Collaboration? Positive and not?
- Complicated deliveries/transferral – how do they come to THD?

What happen during delivery and TDH?

Beating of the women by the midwives?

Challenges - deliveries?

Way forward