

BARRIERS TO THE UTILISATION OF SKILLED BIRTH CARE SERVICES PROVIDED BY HEALTHCARE PROFESSIONALS IN BONGO DISTRICT, GHANA

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ABSTRACT

Maternal mortality rates are still alarmingly high in Sub-Saharan Africa. Skilled delivery care during childbirth is the most critical intervention for improving maternal health. Despite the importance of skilled delivery services, performance of skilled delivery care is still low in the Bongo District. The researcher, being an indigene of this district, and a professional nurse, observed that skilled birth care during pregnancy, labour and childbirth has been low within the Bongo community and its environs. The study aimed at determining the barriers to utilisation of skilled birth care services provided by healthcare professional from the perspective of mothers in the Bongo District of Upper East Region of Ghana. A descriptive study with cross-sectional design of 610 mothers, selected through simple random sampling technique was conducted. Data were collected using a structured interviewer-administered questionnaire, and analysed using SPSS statistics. The study identified women's age; education; marital status; religion; husband's education; parity and health insurance status as the socio-demographic characteristics of women that were significantly associated with utilisation or non-utilisation of skilled delivery services. The study also identified lack of money to pay for transportation and cost of treatment; poor quality of services and poor attitudes of health personnel; availability and influence of TBAs; long distance and lack of means of transportation; and cultural reasons as the major barriers to the utilisation of skilled delivery services. The recommendations emerging from the study reinforce the importance of skilled attendants' awareness regarding attitude, and the need for development of interpersonal communication skills into education and training that women are treated with respect, understanding and dignity. It is also recommended that midwives and other skilled attendants in deprived areas should reorient their caring practices to more culturally appropriate and evidenced- based maternity care. Further research on women's experiences of care received, and health care delivery in rural areas is needed.

BACKGROUND TO THE STUDY

Maternal mortality rates are still alarmingly high especially in rural communities. In Sub-Saharan Africa, maternal mortality rate stood at 510 maternal deaths per 100,000 live births in 2010 (WHO, 2014). Globally, recent reports from the UN indicate that, an estimated 289,000 women in 2013 died due to pregnancy and childbirth complications with Sub-Saharan Africa noted as the riskiest region in the world for maternal and child deaths from complications in pregnancy and childbirth (World Health Organization [WHO], 2014:1). Thus the sub-Saharan Africa region has the highest MMR of 510 deaths per 100,000 live births in 2013, accounting for 179,000 (62%) of global maternal deaths (WHO, 2014).

In West Africa, The WHO reports indicate that five West Africa countries are among the eight countries with the highest maternal mortality rates including; Sierra Leone with maternal mortality rate of 110 deaths per 100,000 live births (WHO, 2014). In Ghana, maternal mortality ratio is still on the increase and remains as high as 380/100,000 live births (Ghana Statistical Service, 2012), despite integrated efforts to improve maternal health; this is particularly true in rural settings. On a regional basis, the Upper East Region—where this research will be conducted reported 124 actual institutional maternal deaths from 2007 to 2010 (Yakong, 2013). Indications are that if the current trends continue, it will be unlikely for Ghana to meet the MDG target of 185 per 100,000 by 2015 unless steps are taken to accelerate the pace of maternal health interventions (GSS/GHS/ICF MACRO, 2009).

According to WHO (2005), inadequate utilisation of skilled delivery services in Sub-Saharan Africa is a major hindrance to efforts aimed at improving the health of women, especially during delivery. The exposure of women to crude means of delivery at home and by untrained Traditional Birth Attendants (TBAs), poses a great danger to the health of women and yet it is estimated that in Sub-Saharan Africa about 45 million births occur at home without the assistance of skilled attendants (WHO, 2008). Moreover, skilled attendance at delivery is one of the key indicators to reflecting progress towards the Millennium Development Goal of improving maternal health. Globally, the goal is to have 80% of all births assisted by skilled attendants by 2005, 85% by 2010 and 90% by 2015 (Stanton et al., 2006).

Empirical studies (Carlough and McCall, 2005; WHO, 2008) have shown that the presence of a skilled birth attendant at delivery is important in averting maternal mortality and morbidity. Most maternal deaths occur close to the time of delivery, underscoring the need for timely interventions. In China, Honduras, Indonesia, Jamaica, Jordan, Mexico, Mongolia and Tunisia, maternal deaths have been reduced significantly over the past decade by encouraging health facility delivery (WHO, 2010). Dramatic reductions in maternal mortality in Sri Lanka (by half in three years) and Malaysia (by three-fourths in 20 years) resulted from the training and appropriate deployment of professional midwives, and with closely linked backup emergency obstetric services (UNFPA, 2004). In Ghana, empirical information from several studies (Adetunji, 1994; Buor, 2003, 2004, Adjei, 2008; Obeng 2008; Abor et al., 2008; Amankwah,

2008) have shown that hospital delivery have been noted to contribute to decrease maternal mortality in urban communities in Ghana. According to Amankwah (2008), measures that encourage facility-based delivery among women, where assistance is sought from skilled health care providers in developing countries is the surest way to reduce maternal mortality and infant mortality.

PROBLEM STATEMENT

Maternal health care is a top priority for health intervention in Ghana, yet the researcher observed that few women seek it. As a healthcare professional and a nurse, the researcher has realised that several initiatives and programmes have been introduced by government and other stakeholders to reduce maternal and child mortality in Ghana. The Ghana government has since 2005 put in place a policy that makes maternal health services free of charge in all health institutions. Furthermore, the introduction of a National Health Insurance Scheme in all districts in Ghana was expected to reduce the financial burden on pregnant women in order to increase access to skilled birth care services (Ghana Health Service Report, 2007).

In spite of these efforts, low utilisation of maternal health services especially making use of skilled birth care services still persist. The researcher observed that women, especially those from rural and deprived communities such as the Bongo District in the northern part of Ghana continue to deliver at home without the assistance of skilled birth attendants. It is for this reason that the researcher plans to investigate into the utilisation and non-utilisation of skilled birth care services in the Bongo District. The researcher being a native of the area and having worked in that district close to five years observed that there could be some socio-cultural factors regarding the beliefs, practices, customs, and norms surrounding childbirth that contribute to the utilisation or non-utilisation of skilled birth care services.

To date, there is paucity of literature in the utilisation and non-utilisation of skilled birth care services in the Bongo District of Ghana. The study therefore sets out to investigate women's experiences and perspectives on the utilisation or non-utilisation of skilled birth care services in this district. In the light of the above, the understated question has been asked.

RESEARCH QUESTION

- What factors prevented mothers from utilising skilled delivery services in Bongo District?

RESEARCH OBJECTIVE

- To identify the reasons that made women to utilise skilled delivery services in Bongo District.

CONCEPTUAL FRAMEWORK

The decision to use maternal health services is mostly an individual choice (Adai, 2000). The utilization of health services is a complex behaviour phenomenon (Chakraborty et al, 2003). The conceptual framework used in this study is based on the health-seeking behaviour model developed by Andersen (1995). This behavioural model proposes that the use of health care services is a function of three sets of individual characteristics. These are: predisposing or individual characteristics, enabling characteristics, and need characteristics. Taking the conditions in the study area into consideration, and the entire developing nations into context; and bearing in mind that other variables need to be tested to discover any possible emerging trends in developing countries, a hypothetical model for the study (figure 2.3) has been adapted from Andersen (1995) model.

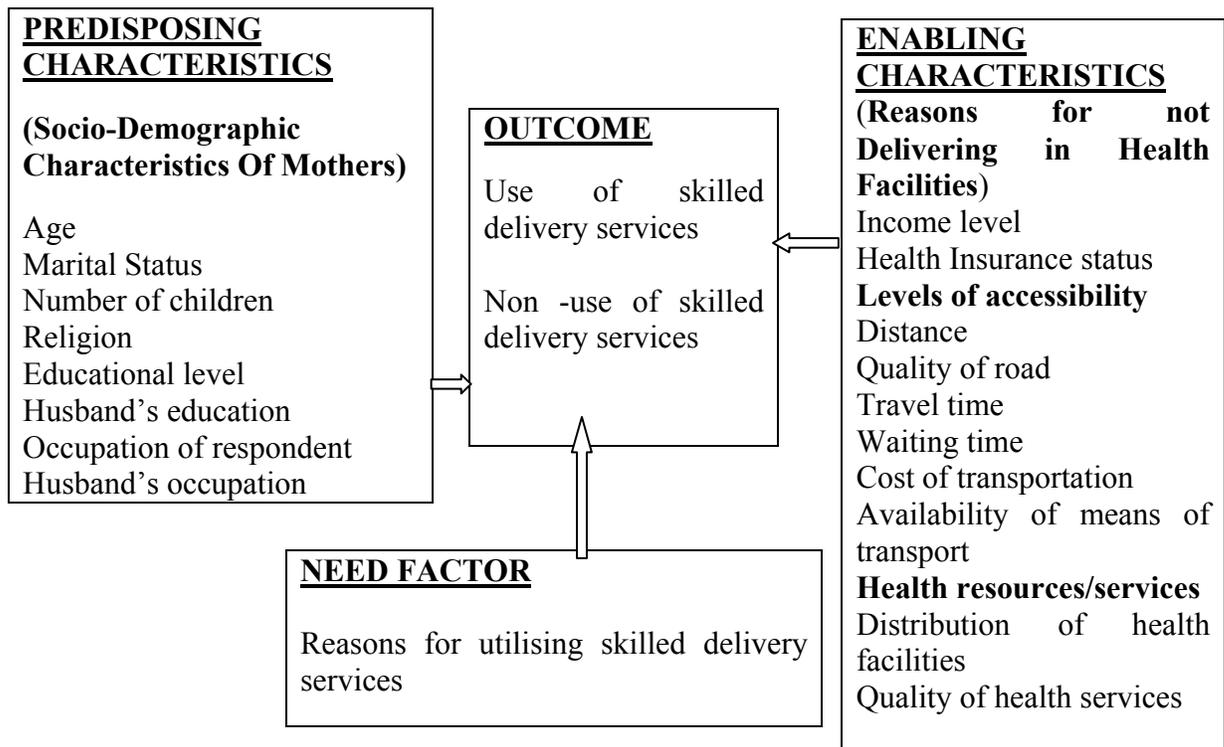


Figure 1: A Conceptual Model for the Study of Utilisation of Skilled Delivery Services

Source: Adopted from the Behavioural Model of Health Service Utilisation (Andersen, 1995)

The model seeks to explain the factors influencing the utilisation or non-utilisation of skilled delivery services. The model has *use of skilled delivery services* at the centre, being the

dependent (outcome) variable. It is the aim of policy makers that health facilities are used for delivery when necessary, to ensure sound health which is a *sine qua non* of development. The *predisposing characteristics*, *the enabling resources*, and the *perceived need factors* are the factors influencing the choice of place for delivery by mothers.

Health policy is very important in the use of health services in developing countries, since it is the policy makers who determine cost, where to locate health facilities, and also who initiate insurance policies. These are critical factors of utilisation. Levels of physical accessibility play a crucial role in utilisation in developing countries that are plagued by poor roads and poor transport network. All individual characteristics: *predisposing*, *enabling* and *need* are crucial to utilisation in developing countries, even though enabling factors rank very high. There tends to be a low perception of the need for modern health care among some primitive and rural communities that are taboo inclined. Social enlightenment plays a role in evaluating the need for health care. Financial constraints are, however, about the most important hindrance.

In developing countries, there is a dichotomy in the distribution of health facilities, with the urban areas having the lion's share (Buor, 2004). Even within the urban setting, there is a dichotomy between the periphery and core. The periphery, mostly marked by slums, tends to be deprived of important social services.

RESEARCH METHOD AND STRATEGY

RESEARCH DESIGN

The research methodology is designed to answer the question: What factors influence the utilisation of skilled care birth services in Bongo District? The researcher undertook a retrospective study design using women who gave birth within one year (12 months) prior to the survey in the study area.

RESEARCH CONTEXT

The Bongo District is one of the nine (9) districts in the Upper East Region of Ghana, with Bongo Township as its district capital. This district was chosen for the study because it recorded the lowest performance of skilled delivery services from 2008 to 2012 in the Upper East Region. This situation led to reported cases of four maternal deaths in 2008, five in 2009 and 3 in 2012 (Upper East Regional Health Directorate, 2012).

The district lies between longitudes 0.45'W and latitudes 10.50'N to 11.09'N and has an area of 459.5 square kilometres. It lies within the onchocerciasis-free zone of Ghana. The district shares boundaries with Burkina Faso to the North and East, Kassena-Nankana District to the West and Bolgatanga District to the South. Bongo District as a whole had an estimated population of 77,885 in 2000 and a population density of 183 people per sq. km (Ghana Statistical Service, 2005). This relatively high mean figure for the district implies that there is increasing pressure on

land for farming and other purposes. This situation is further worsened by the rocky nature of the district thus putting extra pressure on land. The relief of the area is related to the geology. The topography of the area is relatively flat, with occasional rocky outcrops, at an altitude of about 200m above sea level. Viewed at the end of the dry season, the area seems to epitomise the hazards of desertification. Most trees have been removed and grass cover is sparse. There is serious vulnerability to water and wind erosion.

STUDY POPULATION

The research population for this study will consist of women from Bongo District in the Upper East Region of Ghana. The research population and inclusion criteria are described in the table below.

Table 1: Summary of the research population

POPULATION	INCLUSION CRITERIA
Group 1	<ul style="list-style-type: none">• Mothers who delivered in health facilities assisted by skilled attendants within six (6) months and either married or unmarried prior to the study and are living in the rural communities in Bongo District• Women who delivered life babies and whose babies at the time of study are alive and well• Women who are above eighteen years
Group	INCLUSION CRITERIA
	<ul style="list-style-type: none">• Mothers who delivered at home within six (6) months attended by a traditional birth attendant or family relatives and either married or unmarried prior to the study and are living in the rural communities in Bongo District• Women who delivered life babies and whose babies at the time of study are alive and well• Women who are above eighteen years

SAMPLE SIZE

A sample size of 610 mothers selected from the target population was used for the study. The total number of women who delivered in Bongo district was 3476 (Bongo District Health Annual

Report 2011). Out of a total of 3476 mothers, 1791 (51.5%) of them delivered at health facilities, whereas, 1685 (48.5%) mothers delivered at home or by a TBA. Using a Statcalc Programme in Epi Info Version 6, with a population of 1685 (48.5%) of home deliveries, assuming expected frequency of 50% + 5% and a 95% confidence level, the required sample size of mothers who delivered at home or by TBA was 274. Furthermore, with a 95% response rate the adjusted minimum sample size was 279. Also, with a population of 1791 (51.5%) of women who delivered at health facilities, assuming expected frequency of 50% + 5% and a 95% confidence level, the required sample size of mothers who delivered at health facilities was 310, with a 95% response rate the adjusted minimum sample size was 331. Therefore, a total of 610 participants were determined to be adequate for the study.

SAMPLING AND SAMPLE SIZE

A simple random sampling technique was employed to select 610 mothers who delivered in Bongo District between January and December, 2010 for the study sample. The *lottery method* under the simple random sampling technique was employed in the selection of respondents. Names and addresses of mothers who delivered in the health facility within one year were written on pieces of papers and folded. They were put in a bowl and thoroughly shaken. With the *sampling by replacement technique*, the folded papers were picked one after the other until a sample size of 331 was gotten for mothers who delivered in a health facility. With regard to the selection of mothers who delivered home, a similar sampling technique was used until a sample size of 279 was obtained to represent the sample size for mothers who delivered at home. In all, 610 mothers were selected for the study.

DATA COLLECTION

Data were collected between December 2011 and January 2012. A total of twelve (12) research assistants who have ever participated in a similar exercise in the district were employed to collect data over a period of six weeks. The skills of the interviewers were improved and consolidated by a training section that was organised. Criteria for selection of interviewers included ability to understand, speak, read and write the local dialect of the study area fluently, were born in, or have spent a fair amount of time in the study area and be conversant with the local traditional practices and geographical conditions. Respondents were visited in their homes by the researcher and his twelve research assistants using respondents' house addresses taken from Bongo District Health Administration antenatal care attendance register. The researcher made sure that questions were well explained to research assistants. This exercise was undertaken after permission was granted by the various community and household heads and the purpose for the research was well explained to respondents. All interviews were conducted in the local language (Frafra) which was largely spoken in the area.

RESEARCH INSTRUMENT

The data gathering method was self administered questionnaires. Data was collected by means of a self-administered questionnaire designed to give satisfactory answers to the main research questions of the study. Two sets of questionnaires were used to gather data from the two groups of mothers: mothers who delivered at home or by a Traditional Birth Attendant (TBA) and mothers who delivered in the health facility.

DATA ANALYSIS

Filled-in questionnaires were checked for completeness and consistency of the responses. Specific data was entered into Statistical Package for Social Sciences (SPSS) computer software package (Version 16.0) and univariate analysis was carried out. Inferential statistics, in particular the Chi-square (χ^2) test was applied to analyse the data in order to provide answers for my specific objectives. In these tests, a p-value of 0.05 was used. The data were analysed and organised into frequency tables. Barriers to utilisation of skilled delivery and reasons associated with utilisation of skilled delivery services were computed and presented in tables in a ranked order.

RESULTS

DEMOGRAPHIC CHARACTERISTICS OF WOMEN THAT ARE ASSOCIATED WITH THE UTILISATION OF SKILLED DELIVERY SERVICES

The study identified the demographic characteristics of women that are associated with the utilisation or non-utilisation of skilled delivery services. A Chi-Square test was carried out to identify the demographic characteristics of women associated with the use or non-use of skilled delivery service. Table 2.0 shows that *age* as a demographic characteristic was significantly ($p=0.004$) associated with utilisation or non-utilisation of skilled delivery services. Table 4.15 showed that majority 93(85.5%) of respondents who aged ranging between 15-19 utilised skilled delivery services followed by mothers 158(72.5) who aged ranging between 30-39. However, majority 174(64.7%) of age groups of the mothers ranging between 20-29 recorded the highest number of home deliveries followed by mothers who aged 40 and above, which constituted 4(28.6) of home deliveries. The percentage of women delivering in health care facilities decreased with age from 85.5% at 15-19 years to 28.6 % at 40 years and above. Older women prefer to deliver at home than younger ones. As shown in table 2.0 above, the educational level of mothers also influences ($p=0.000$) the choice of skilled attendant for delivery. In the basic level of education, more than 70.0% of the respondents used skilled attendants. In fact among the SHS, college, and tertiary educated respondents, none of them delivered at home. For mothers who had no education, many of them (30.7 %) did not utilise skilled delivery services. Religious affiliation was also observed to influence ($p=0.002$) the choice of skilled attendant for purposes of delivery. The data indicate that majority of Christians (72.5%) and Muslims (86.7 %) utilised

skilled delivery services while 77.8% of respondents who are traditional believers delivered at home. Marital status of respondents was not associated ($p=0.152$) with the use or non-use of skilled delivery services and a similar ($p=0.140$) observation was made in respondents partners' occupation and the use or non-use of skilled attendants at delivery. Women's occupation was also observed to be significantly associated ($p=0.000$) with skilled delivery utilisation or non-utilisation. Majority of Teachers 38(82.6), Traders and Vocational workers 143(67.8) utilised skilled delivery services. However, about 212 (62.7) of women who were farmers did not utilise skilled delivery services.

The data showed that women whose husbands had higher educational level had greater chances of using modern health facilities for their delivery compared to women with lower education (Table 4.3).The number of children the women had also significantly associated ($p=0.002$) with mothers' choice of place for delivery. Table 2.0 showed that women with lower parity 1-4(65.4) utilised skilled care than those with high parity of 5-9 (15.4%). Majority of mothers with parity 9 and above (83.3%) did not deliver in a health facility. Finally, the Chi-square test showed a statistically significant relationship ($p=0.000$) between membership of health insurance scheme and utilisation of skilled delivery services. Table 2.0 showed that out of 279 women who delivered at home, 176 (88.9%) of them are not members of the NHIS, and 309 (75%) of those who delivered in a health facility are members of the NHIS.

Table 1.1: Socio-Demographic Factors and the Use of Skilled Delivery Services Place of Delivery

Variables	Home (n=279)	HF (n=331)	X²	DF	P
Age					
15-19	16(14.7)	93(85.3)			
20-29	174(64.7)	95(35.3)			
30-39	60(27.5)	158(72.5)			
40+	4(28.6)	10(71.4)	140.95	3	0.004
Educational Status					
No formal education	114(30.7)	258(69.4)			
Primary	60(75.0)	20(25)			
Middle/JHS	90(98.9)	1(1.1)			
SSS/Tech.	47(100.0)	0(0.0)			
Univ./Poly./College	20(100.0)	0(0.0)	227.00	4	0.000
Religion					
Traditional	182(77.8)	52(22.2)			
Christian	91(27.5)	240(72.5)			
Muslim	6(13.3)	39(86.7)	160.39	2	0.002
Marital status					
Married	264(50.4)	260(49.6)			
Divorced/Separated	5(62.5)	3(37.5)			
Widowed	1(10.0)	9(90)			

Never Married	61(89.7)	7(10.3)	56.73	3	0.152
Husband's Education					
No formal education	238(75.1)	79(24.9)			
Primary	7(8.5)	75(91.5)			
Middle/JHS	2(2.7)	71(97.3)			
SSS/Tech.	1(1.3)	75(98.7)			
Univ./Poly./College	2(7.4)	25(92.6)	236.99	4	0.000
Woman's Occupation					
Farmer	212(62.7)	126(37.3)			
Trader/Voc.Worker	68(32.2)	143(67.8)			
Teacher	8(17.4)	38(82.6)	1.259	2	0.003
Parity of Respondents					
1-4	164(34.6)	310(65.4)			
5-8	110(84.6)	20(15.4)			
9+	5(83.3)	1(16.7)	177.55	5	0.001
Health Insurance					
Insured	103(25.0)	309(75.00)			
Uninsured	176(88.9)	22(11.11)	219.94	1	0.000

BARRIERS TO UTILISATION OF SKILLED BIRTH CARE SERVICES

This section presents the factors that prevented mothers from utilising skilled delivery care services. It specifically presents findings on reasons why mothers delivered at home, choice of place for future delivery, and reasons accounted for the choice of home for future delivery. The study identified the major reasons why mothers delivered at home in order of ranking from the most important barrier to the least important barrier. These include lack of money to pay for transportation and cost of treatment 98(35.1%), poor quality of services and poor attitudes of health personnel 64(22.9%), availability of Traditional Birth Attendant (TBA) 37 (13.3%), long distance and lack of means of transport 29(10.4%), to enable child's placenta to be buried at home and to be given hot millet flour immediately after delivery 15(5.4%), onset of labour in the night 13(4.7%), home delivery is comfortable and convenient 10 (3.6%), husband and family members preference for home delivery 8(2.9%) and fear of hospital environment and surgical operations was the least important barrier 5(1.8%).The results are shown in Table 3.0 below.

Table 1.2: Reasons that Made Women to Deliver at Home

Reason	n (%)	Rank
Lack of money to pay for transportation and cost of treatment	98(35.1)	1 st
Poor quality of service and poor attitudes of health workers	64(22.9)	2 nd
Availability of Traditional Birth Attendant (TBA)	37(13.3)	3 rd

Long distance and lack of means of transport	29(10.4)	4 th
To enable child's placenta to be buried at home and to be given hot millet flavour water immediately after birth	15 (5.4)	5 th
Onset of labour in the night	13(4.7)	6 th
Home delivery is comfortable and convenient	10(3.6)	7 th
Husband and family members prefer home delivery	8(2.9)	8 th
Fear of hospital environment and surgical operations	5(1.8)	9 th
Total	279(100.0)	

DISCUSSION

Demographic characteristics of women investigated in this study include *mother's age, women's education, marital status, religion, parity, husband's education and occupation, NHIS status*. In the *Health-Seeking Behaviour Model*, predisposing characteristics conceptualise the factors such as demographic factors, social structures and health beliefs that are present preceding the ill health and need for care. The model suggests that individual socio-demographic characteristics such as age, educational status, marital status, occupation and parity play a significant role in influencing the use or non-use of health services and in particular, skilled delivery services (Andersen, 1995). Review of empirical literature (Abor et al., 2011; Adjei, 2008; Amankwah, 2008; Mengsteab 2010; Obeng, 2008; Adjei 200 ; Buor, 2004) showed the effects of demographic characteristics on the utilisation of skilled delivery service. In this study it was observed that all the demographic characteristics with the exception of the marital status of mothers' and husbands' occupation affected the utilisation of skilled delivery service.

BARRIERS TO THE UTILISATION OF SKILLED DELIVERY SERVICES

The study identified a number of reasons as to why women do not deliver in health facility assisted by skilled attendants. The barriers to the utilisation of skilled delivery services identified in this study were: *lack of money to pay for transportation and cost of treatment, poor quality of services and poor attitudes of health personnel, availability of Traditional Birth Attendant, long distance and lack of means of transport, to enable child's placenta to be buried at home and to be given hot millet flour immediately after delivery, onset of labour in the night, husband and family members preference for home delivery and fear of hospital environment and surgical operations was the least important barrier*. The finding of this study is in line with the theoretical framework underpinning this work, the *Behavioural Model of Health Services Use* developed by Andersen (1995). The model suggests that personal health practices and people's use of health services is a function of the predisposition to use the services, factors that enable or impede use and need for the service. In the model, health beliefs conceptualise the decision to seek health care as a rational balance between perceived susceptibility, barriers, and benefits. Health beliefs also refer to attitudes such as values and knowledge that women have about health

and health services that might influence their subsequent perceptions of need and use of the services. Health beliefs provide one means of explaining how social structure might influence the ability to meet the costs i.e. enabling resources, perceived needs, and subsequent use of the health service. While cultural influences refer to the health beliefs and attitudes of the mothers in relation to child bearing (Andersen, 1995).

One most important reason identified in this study as a major barrier to utilisation of skilled delivery services was *lack of money to pay for transport and cost of treatment*. It was the most important barrier to the utilisation of skilled delivery services. Review of the literature on current studies (Nketiah, 2009; Obeng, 2008; GHS, 2007; Buor, 2004) has shown comparable results with this study. A study from Tanzania to assess barriers to utilisation of maternal healthcare services found that lack of money to pay for cost of treatment was ranked as the first factor for home delivery. Similarly, the finding of the study conforms to the *Behavioural Model of Health Services Use*, which suggests that enabling resources, for instance money, health insurance which provide patients with the means to make use of the services can be a barrier to the utilisation of skilled delivery services (Andersen, 1995). Community and personal enabling resources therefore play important role in skilled delivery services utilisation. People must have the means (money) to get to those services and make use of them (Andersen, 1995). The findings of this study confirm the above findings as majority (34%) of the mothers mentioned lack of money to pay for transportation and cost of treatment. Nearly all quantitative studies mention cost as an important barrier to formal care. TBAs are usually deemed affordable for poor families since their payment is negotiable in terms of amount and timing and can be in kind.

Also, one interesting thing about the findings of this study is that, one would have expected that due to the free maternal health care policy introduced in Ghana in 2003 and subsequently included in NHIS in 2008, money to pay for cost of treatment would not have been ranked the first reason for non-utilisation of skilled delivery services. A possible explanation to this finding is that poor mothers are unlikely to afford the cost of transport and other medical costs. Even though, the skilled delivery services in the health facilities are given free of charge, it incurs costs when complicated delivery is referred to health facility is necessary coupled with other indirect expenses associated with transporting the woman to the health facility to deliver. Another crucial finding of this study is *poor quality of skilled delivery services and poor attitude of health staff* was identified in this study as the second most important barrier to utilisation of skilled delivery services. Few quantitative studies assess quality of care. A Vietnamese study (Gabrysch and Campbel, 2009) found that women who delivered in a facility give a significantly higher average quality score for health care delivery, but not for communication and conduct of personnel as compared to women who delivered at home (and who judged these quality aspects from others' experience or earlier contacts with the facility). Another study (Stekelenburg et al., 2004) in a rural district of Zambia found no effect of perceived quality of care on service use, however, service satisfaction levels were 96%.

One interesting major barrier to utilisation of skilled delivery that was identified in this study was the *influence and availability of Traditional Birth Attendants*. This was identified and ranked the third most important barrier to utilisation of skilled delivery services. This finding of this study is not surprising in the sense that in Ghana, most women in rural communities prefer to deliver at home by a family relative or a TBA because they are culturally acceptable and widely available, affordable and accessible at all times (Abor et al., 2011; Buor, 2004 and Senah, 1997). Moreover, women place value on delivery by a Traditional Birth Attendant (TBA). Throughout history Traditional Birth Attendants (TBAs) have been the main human resource for women during childbirth. Their role varies across cultures and at different times, but even today, they attend the majority of deliveries in the rural areas of developing countries. There is little doubt that they have a significant role when it comes to cultural competence, consolation, empathy and psychosocial support at birth with important benefits for the mother and also for the new-born child. In many countries, the contribution of TBAs has been an important component of strategies to improve maternal and neo-natal outcomes. However, recent analyses have come to the conclusion that the impact of training TBAs on maternal mortality is low. Society respects and recognizes the role played by TBAs in communities and their attendance is highly valued. The TBAs provide services that the formal health system does not, including postpartum care in the home. Some of the women believe that childbirth-related complications are caused by witchcraft, and the TBAs are perceived as better equipped to intervene in such cases UNFPA (2004). In a related finding, Abor et al., (2011) indicated that traditionally, Ghanaian children are often given birth to at home with the assistance of Traditional Birth Attendants or elderly women in the community. Women's choice of home delivery could therefore be attributed to the presence of Traditional Birth Attendants and elderly women in most Ghanaian communities.

Distance to health services exerts a dual influence on use of skilled delivery services; as a disincentive to seeking care in the first place and as an actual obstacle to reaching care after a decision has been made to seek it. Many pregnant women do not even attempt to reach a facility for delivery since walking many kilometers is difficult in labour and impossible if labour starts at night, and transport means are often unavailable. Studies (Obeng, 2008; WHO, 2008; Sepehri, Sarma, Simpson and Moshiri, 2008; Gage, 2007; Mills, and Bertrand, 2005; Buor, 2004; Stephenson and Tsui, 2002, Chakraborty et al., 2002) have shown from a wide range of countries across the globe that physical accessibility; poor road, and inaccessibility of public transports was an important barrier to utilisation of maternal and child health services. Findings in the study are consistent with the above studies as long distance to health facility is one of the major reasons cited by women for delivering at home in this study. Long distances to health facility limit women's willingness and ability to seek healthcare, particularly when appropriate transportation is scarce, terrain and climate are harsh. The distance factor is especially significant in Third World settings where the density of modern health facilities in rural areas is low, where the majority or patients are likely to make the journey on foot (WHO, 2005). Therefore it was not surprising to have found that long distance and transportation difficulties cited as major barriers to skilled delivery service utilisation were not unusual given that the road networks in

the district which consists largely of unmotorable feeder roads are poor particularly during the rainy seasons. The non-existence of access roads by vehicles to some communities still militates against achieving 100 percent deliveries at health facilities or ensuring Skilled Attendant at Birth by the citizenry and TBAs across the rural parts of the country.

Additionally, this study identified other barriers to the utilisation of skilled delivery services to include: *onset of labour in the night, comfortable delivering at home, my husband and family members' preference to home delivery and fear of hospital environment and surgical operations*. These findings are consistent with previous studies conducted in Ghana and other developing countries. The GHS (2007) reports indicated that most mothers delivered at home because of onset of labour in the night, husband and family preference for home delivery, fear of hospital and operation, and inconveniences in hospital delivery. GHS (2007) reports indicate that most mothers deliver at home because of sudden onset of labour at odd hours, inconveniences in hospital delivery and long waiting hour. One important thing to note is that most mothers usually have the fear that once you are pregnant and you go to deliver in the hospital you would be operated upon. This misconception has led many women deliver at home in an attempt to avoid the surgeon's knife. These however, constituted the least important barriers to the utilisation of skilled delivery services in this study.

CONCLUSION

The findings of this study demonstrate that rural women in Ghana face many barriers in seeking skilled delivery services. The findings suggest that barriers such as lack of money to pay for transportation and cost of treatment; poor quality of services and poor attitudes of health personnel; availability and influence of TBAs; long distance and lack of means of transportation; and cultural reasons are the major reasons accounting for the low utilisation of skilled delivery services.

The recommendations emerging from the study reinforce the importance of midwives and other skilled attendants in deprived areas in reorienting their caring practices to more culturally, appropriate and evidenced- based skilled birth care. Moreover, it is necessary midwives should use antenatal attendance by pregnant women as an opportunity to give appropriate counselling, health education on the importance of skilled delivery services for women to seek skilled delivery services during childbirth. Also, the husband or a family member should be encouraged to accompany a woman during labour since that might be a possible intervention to overcome the cultural need of family to be around and witness the delivery and as well reduce the barrier of unfamiliar environment.

Traditional practices in the district like giving warm water with millet flour should be encouraged by midwives to motivate women to deliver in health facilities. Further, skilled birth attendants can mobilise community members to collaborate with Ghana Private Transport

Unions to ensure a sustainable public transport system in the rural areas to address geographic inaccessibility of skilled delivery services.

Further, a qualitative research on women's experiences of care received, and health care delivery in rural areas is needed.

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