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Contextualising Women Decision Making during Delivery: Socio-Cultural Determinant of Choice of Delivery Sites in Ghana

Adadow Yidana*, Mustapha Issahaku

Department of Community Health and Family Medicine, School of Medicine and Health Sciences, University for Development Studies, Tamale, Ghana

Abstract The welfare of women and children continue to be at the forefront of national and global millennium health policies. Though these programs and initiatives have been put into place, maternal mortality is still a challenge in many developing countries including Ghana. In many rural communities across the country, quite a number of deliveries still take place at home without skilled supervision. This paper sought to establish sociocultural impediments to the use of health facility as the most ideal place of delivery among a cross section of women in the northern part of Ghana. Using a purposive sampling method, a total of 120 nursing mothers were interviewed. The results suggest a positive relationship between increasing maternal formal education, household income and possibility of delivering at a health facility. However, social and cultural factors have been noted to exert a greater impact on the choice of delivery sites. In view of this, the paper suggests a modification of traditional practices to suite current happening. In addition to the above, there is also the need for deployment of resources needed to combat home delivery, or even if at, make it safer.

Keywords Delivery, Health facility, Tradition, Women, Midwives

1. Introduction

The health and general wellbeing of women during childbirth plays a critical role in the improvement of reproductive health. The desire to improve reproductive health globally has generated an ongoing debate in parts of the developed world, especially with regard to the right of women to decide whether to deliver at a health facility or at home [15]. Studies on maternal and child health have generated quite a number of useful data in developing countries, majority of which are related to undesirable outcome of home delivery amongst women [22]. The rate at which women receive antenatal care and its quality is very important in predicting the outcome of choice of delivery sites in many developing countries [1]. Thus, policy makers have instituted timely and supervised skilled delivery as a right of every woman, putting the welfare of women at the forefront of national and global health policies [17]. It has often been argued that many of the deliveries still take place at home instead of health care facilities. This situation, it is argued, could lead to loss of lives during delivery, resulting from hitherto preventable causes if not managed well. It is on the bases of this that [11] have indicated many maternal deaths could be prevented if all deliveries are managed by skilled personnel.

In situations where deliveries take place outside health care facilities, tracking and correcting complications becomes a daunting task. It is here that [5] are right in their observation that pregnancy related complications cannot be reliably predicted. It is against this challenge that, attempts to address women's needs and health problems have become a major focus globally [17]. Available statistics at the global stage suggest that more than 60 million women deliver at home without skilled care, and about 530 000 die from pregnancy related complication, with 3 million babies coming out as stillbirth [18].

Individual choice for location of childbirth is embedded in society's conceptualisation of the situation, often seen as a social process. Cultural diversity often leads to differences in the conceptualisation of childbirth in parts of the developing countries, creating a platform where expectant mothers feel reluctant to use health care facilities in times of pregnancy related complications. Consequently, some expectant mothers have developed the penchant of observing normal home births, often surrounded by their families as a normative activity [6]. In a traditionally oriented society, most newborns are delivered at home with the assistance of traditional birth attendants [10], majority of who are not trained. To encourage deliveries at health care settings, and

* Corresponding author:
adadowy@yahoo.com (Adadow Yidana)
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to ease the economic burden of expectant mothers, the government of Ghana passed a policy in 2003 to improve access to health service for the poor and the vulnerable, by putting into place universal exemption from payment of user fees for all delivery care [3], though many still prefer home delivery, usually without the assistance of skilled attendance [17]. In most traditional societies, the moral status of a woman is raised when she delivers successfully at home [5].

Delivery behaviour of women in this context is not governed by causal factors operating behind their backs, but they are seen as conscious decision makers whose actions are significantly influenced by the costs and benefits of different action alternatives [19]. On this note, women who deliver at health facilities are often believed to have cheated, but are prevented from the consequences of their actions through the intervention of medical technology [5].

As [24] indicates, the increasing rate of maternal mortality in Sub-Saharan Africa is very tragic, and improving the health of mothers continues to be a challenge because women in the developing nations have a 1 in 31 chance of dying during pregnancy or childbirth, as against 1 in 4,300 in developed countries. It is on the basis of this that few countries in sub-Saharan Africa are committed to achieving the Millennium Development Goal 5 target of reducing maternal mortality ratio by 75% by the end of 2015. The 2008 Ghana Demographic and Health Survey shows that in almost 6 out of 10 births in Ghana, fifty-seven per cent (57%) of them occur in health facilities and forty-two per cent (42%) of births occur at home. In the rural communities however, home delivery is as high as fifty-eight per cent (58%). The 2012 report in the Nanumba North District in the Northern Region of Ghana (a rural district) shows that unsupervised delivery continues to be higher with over fifty per cent. This thus suggest that with the over fifty percent of Ghana's population living in rural communities, home delivery is likely to be higher than imagined. This study sought to explore the socio-cultural determinants of the choice of place of delivery in the Nanumba North District in the northern region of Ghana.

2. Methodology

A descriptive cross-sectional study was carried out from May to July 2013 in the Nanumba North District in the Northern Region of Ghana. The selection of respondents was done at a child welfare clinic within the Nanumba North District. The total number of nursing mothers was 5100 for the district using population data projected by the Ghana Health Service (GHS) from the 2010 population census. The sample size was estimated using Yamane's Equation: n = N/[1+N(e)^2], where 'n' is the sample size, 'N' is expected nursing mothers and 'e' is level of precision at 7%, using 95% confidence interval. Thus, an approximate value of 120 sample size was gotten. Using both purposive and systematic sampling techniques, the 120 women were selected and interviewed at the child welfare clinic. To minimize bias in the selection, every third woman who visited the facility was selected for interview, and the process continued for several days until the required number was achieved. It is worth noting that only women who agreed to be interviewed were interviewed.

Four focus group discussions was also organised to get an additional insight into reasons for the choice of delivery sites. This was deemed necessary because it was thought that the questionnaire alone will not provide all the facts needed for the analysis. Four final year nursing students were trained to administer the questionnaire and the focus group discussion. An informed consent was sought from all participants in interviews and focus group discussion (FGD). Information gotten through informal conversation was noted to enrich the data. Each interview administered questionnaire lasted between 25 to 35 minutes. The data from the FGD was later transcribed for analysis. The research language for the research was English language and Dagbani precisely because the indigenous dialect in the area is Dagbani.

Permission and approval was sought from the District Health Directorate of the Nanumba-North District as well as the heads of the Child Welfare Clinic before the commencement of the research.

3. Results and Discussion

Choosing an appropriate delivery site for women has a potentially critical role to play in enhancing the health and wellbeing of mothers and babies. Results from the field gives home delivery as high as (52.6%) in the Nanumba North District, with an inverse relationship between increasing maternal educational level and home delivery. There was a positive relationship between household wealth and health facility delivery and vice versa, as well as linear relationship between increasing physical distance to the nearest facility and home delivery.

4. Does Antenatal Visits Guarantee Delivery at Health Facility?

The main purpose of women attending antenatal clinic was for a routine check up to guide against possible complication, and sometimes for confirmation of pregnancy. From the field data, antenatal attendance was relatively high among all the respondents, with each one attending at least once during pregnancy and before delivery. In an ideal situation, women who attended antenatal clinic, all things being equal, will delivered at a health facility. It is worth noting that there was no established correlation between antenatal attendance and the choice of place of delivery. In situations where antenatal attendance was twice, home delivery was about 40% as against 60% hospital delivery. In the same vein, when attendance rate was three times, home delivery was 62.5% whereas hospital delivery was 37.5%. What this means is that attending antenatal twice does not allay an individuals' fear of complications during childbirth.

However, attending thrice without any warning sign in relation to any complication presupposes that they can deliver safely at home. Additionally, there was 42.2% home delivery with 57.8% hospital delivery among those who attended more than four times. This suggests that antenatal attendance does not have much influence on the choice of delivery site. These results appear to be consistent with [1] study in rural northern Ghana, which suggest that though antenatal visits have increased over the years, deliveries at health facilities have not increased substantially. This information is shown on table 1 below. One therefore cannot use antenatal visits to conclude that once they attend the clinic, they will deliver at a health facility.

Table 1. Antenatal attendance

Number of attendance	Frequency	Place of delivery		Place of delivery	
		Health facility	%	**Home**	%
0	0	0	00	0	00
1	2	0	00	2	100
2	5	3	60	2	40
3	8	3	37.5	5	62.5
4	15	6	40	9	60
5+	90	52	57.8	38	42.2
Total	**120**	**64**	-	**56**	-

Though the choice of delivery site is usually made for, or on behalf of women in some communities, it is important to indicate that many women in urban settlements often walk to the nearest health care settings upon the experience of signs of labour. The case as pertains in the rural communities is different. Data from the field revealed that home delivery was still very high. This situation however varied, depending on which part of the district one is looking at. Whilst home delivery was very low among women in the district capital (31%), it was very high (81%) among rural dwellers. This reflects the dichotomy between urban and rural settings. Even within the same rural sub-district, some communities recorded 100% home delivery. An important observation with regard to this revelation is that, many of the respondents who delivered at home grew up in farming communities, quite far from health facilities. These communities are much scatted with no health care facilities. This observation is thus consistent with [8] report which found home births to be common in rural areas.

There was also an observed positive relationship between the choice of delivery sites among women and their educational status. Mothers education was found to be a key indicator of household socioeconomic status, and a strong predictor of mortality [1]. In line with this, there was an observed inverse relationship between increasing maternal educational level and home delivery. For women with high level of education, home delivery was observed to be decreasing progressively from primary to tertiary while health facility delivery increased. Home delivery was 25% among women with tertiary education as against 75% health facility delivery. Maternal formal education, no matter how low it is, may enhance health facility delivery while reducing home delivery. This apparently is consistent with [4] study which found maternal education as predictor of choice of place of delivery place.

5. Plausibility Structures as Predictors of Delivery Sites

The use of health facility during delivery is a complex behavioural phenomenon among many women in Ghana. Utilization of delivery facility is often determined by the availability, quality and cost of services. In many developing states, the social structure, health beliefs and personal characteristics of women [2]. There are also psychological factors that have been noted to predict behaviour intensions with regard to choice of delivery site. These include among others attitude, social influence, and self-efficacy. The behaviour of a person can be changed through modification of attitude, perception of social norms and support as well as self-efficacy [2]. Among factors observed to be responsible for choice of delivery site include; tradition, lack of access to health facilities, trust, convenience, decision of husband / in-laws or parents. This is shown on table 2 above.

Table 2. Decision making during delivery

Reasons for choice of delivery site	Frequency	Place of delivery	Percentage
		Home	
Tradition	26		40.6
Trust	6		9.3
Convenience	3		4.8
Lack of access to service	18		28.1
Family decision	2		3.1
Need as a woman	1		1.6
Others	8		12.5
Sub total	64		100
		Health facility	
Safety	47		83.9
Access to health facility	4		7.1
Convenience	2		3.57
Family decision	2		3.57
Others	1		1.79
Subtotal	56		100
Total	**120**		--

5.1. Communities and Their Belief Structures

In many instances, cultural factors are tied to traditional

practices. These practices are very essential for health seeking behaviour of most communities, especially Africa. These practices are social norms that are followed by almost all members. About 40% of women who delivered at home stated that their actions were informed by tradition. In their view, home delivery is something they came to meet. To indicate that they are conscious about what they do, one of them indicated:

We only come to hospital when the labour becomes difficult (prolonged), my mother gave birth to me at home, why do I have to rush to the hospital to deliver my child if there is no problem?

There were others who believed that women who deliver at the health facilities are weak women who cannot deliver on their own. This view is consistent with [21] finding in Indonesia, where similar opinions were raised to explain why they deliver at home. Table 2 above explains how the belief systems influence their actions.

5.2. Access to Health care Facilities

Access to health facilities is a major challenge facing many communities across Africa. Among those who delivered at home, 28.1% of them mention access as a major reason why they deliver at home, bringing to light two issues in the explanation of access. One was the physical distance and the other was in relation to the availability of health care provider. One of the respondents was emphatic on these issues:

The hospital is far from my village. The road from my village to the hospital is very bad, cars do not come there and in labour it is unsafe to ride or be carried on bicycle. In the night we cannot move from our village to where the hospital is. The midwife was not at the hospital so I was asked to go to the district capital, but because of the nature of the road, I had to go home and deliver.

From the above statement, one can speculate that several factors impede access to health care facilities. These include poor roads, which often result in high transportation cost. Others include unequal distribution of both health care facilities and the experts needed to manage these facilities. As [23] study in Ghana indicated, economic ability and access to health care is a daunting task for most women

5.3. Issues of Trust

Developing confidence about another person could be taken as trust. Trust in social science is the optimistic acceptance of a vulnerable situation which is based on positive expectations of the intentions of the trusted individual [7, 9]. Trust functions to reduce complexity in society, and act as a medium of interaction between social systems and the representatives of those systems [14]. There is trust when delivery is conducted by a relative or a same tribe mate than 'stranger' at the hospital. These trusted persons include grandmothers, mother-in-laws and mothers and in some cases traditional birth attendants. Trust is a social phenomenon because it occurs as a result of communication within and between individuals. The decision to place (dis) trust reduces complexity in society because decisions making function as a means for rational action. Some of the respondents indicated that:

Your own relative will not harm you, reduce your fertility or give your child something bad when they assist you to deliver. If there is the need to perform some rituals during the delivery they can easily alert the one responsible. Besides, we believe if a woman commits adultery she will die during labour unless she confesses for some rituals to be performed. This confession is kept as a secret in the family with home delivery but at the hospital it becomes known to strangers and one responsible for performing rituals may not be around.

The above statement suggests that the reason for not delivering at any health care facility is embedded in traditional belief systems. Others were of the opinion that one stand the risk of losing her baby through theft. One of the respondents was emphatic that: 'A nurse can swap your baby with a different baby. They do this for women who may be looking for either a male or female.' Whether this is a perception or real, the fact that they harbour these feelings, discourages them from utilizing health care facilities during child birth. Apart from trust, it must be noted, delivering within one's own premises relieves them from buying many hospital delivery kits. These women generally felt that seeking assistance in childbirth waste other people time. Similar findings were found by [5]. Other women believe their delivery at home is a natural rite of passage for women, and is preferred at home unless complications occur. This go to suggest that if enough education goes down, they may change some of their behaviour tendencies.

6. The Decision of Significant Others

Giving the opportunity, many of the respondents would wish to deliver at health facilities. However, the decision to seek care in most rural communities in northern Ghana is usually not the decision of the individual women. In societies across Africa, issues of pregnancy and delivery are conceptualised as women domain. Consequently, most men are often not expected to accompany their wives to the antenatal clinic or be present during delivery [16, 20]. As decision makers in families, decisions about where, when and even if, a woman should go to hospital for delivery often fall to men and mother-in-laws. In this study, respondents stated that they had to deliver at home because it was simply the decision of their in-laws. These women, some of who were teenagers, explained that though it was the decision of their parents to deliver at home, it protected them from becoming a source of public ridicule since outsiders do not have to ask them questions about the father of the child. For the married women, the most common explanation was that other women in the house delivered at home so their family heads /in-laws did not see the reason for them going to the hospital.

7. Preferred Mode of Delivery

Many of the women (83.9%) stated safety as the main concern that influences delivery at health care centres. They were of the view that at the hospital, doctors and nurses are there to help when complications are detected. When the child is known to be too big to be delivered naturally, the doctors will conduct caesarean operation. While some praise their husbands for asking them to deliver at the hospitals, others put the blame on their husbands. These respondents were located within the district capital, suggesting that many of them might have been given education on maternal health.

Table 3. Preferred mode of delivery

Preferred mode	Person who conducted delivery	Place	Frequency	Percentage
		Home		
Spontaneous vaginal delivery	Mother –in-law		33	**27.5**
	Grandmother		13	**10.8**
	Mother		7	**5.8**
	Trained TBAs		3	**2.5**
	Untrained TBAs		0	**00**
	Alone		3	**2.5**
	Others		6	**5**
	Subtotal			
		Hospital		
	Midwife		44	**36.7**
	Doctor		4	**3.3**
	Nurse		3	**2.5**
	Subtotal			
Caesarean section	Doctor		4	**3.3**
	Total		**120**	

As shown on table 3 above, 96.7% of respondents stated that they delivered via the spontaneous vaginal delivery (SVD). According to some of them, they are often made to stay in bed and when the baby is about to come out; their feet are put in stirrups. This is probably done to enable the health worker to have easy access and a clear view of the delivery process. However, what seem to be good for the health workers is not necessarily so good for the expectant mother who feels uncomfortable and humiliated to push their babies without the helpful force of gravity. This perceived uncomfortable state discourages women from delivering at health care centres. About 27.5% of women who delivered at home were assisted by their mother-in-laws, 10.8% by their grandmothers, and 5.8% by mothers while 2.5% were attended to by trained traditional birth attendants. The above statistics suggest that apart from the trained traditional birth attendants, woman will normally not allowed individuals who are not close relatives to assist them during delivery. It is worth noting that though the trained traditional birth attendants live with the people, they work in close collaboration with the health care staff. Quite a number of the SVDs that took place at the health centres were supervised by nurses, doctors and midwives.

8. Nurse's Attitude towards Expectant Mothers

The way health workers relate to expectant mothers during delivery plays a crucial role in the determination of an appropriate delivery site. This often forms the basis of nurse's attitude towards expectant mothers when they go into labour. An attitude here refers to a relatively enduring predisposition to respond in a reasonably consistent manner towards a person, situation, or idea. To ensure a balanced attitude from both the nurses and expectant mothers, nurses tasked to ensure safe delivery of women have to respond in a reasonably caring manner when they go into labour [12]. In many societies especially in the developing world, women choose not to give birth in a hospital because of fear of being treated badly by nurses [13]. From the field, it was observed that poor attitude and human relation on the part of some health workers who deal directly with expectant mothers influenced their choice of place during delivery. Women with good experience were motivated to deliver at the health facilities. One of the respondents indicated that:

The nurses treated me well. It is not true that the behaviour of health workers make us deliver at home, if the nurse beats you because they want you to push and deliver your child safely, is it bad?

As the above statement shows, the conceptualisation of been beating vary from one person to another, whiles some saw it as an effort on the part of midwives to help them deliver, others described it as wickedness. These sentiments were re-echoed in a statement made by one of the respondents:

The nurses were inpatient; they wouldn't mind you when you are crying for help and even shout at you. In the night, the nurses will not be around, so I chose not to go there at all.

From this, it is clear that health workers attitude can either attract or scare expectant mothers from delivering at the health facilities. While it is not all of them who may be labelled as being hostile towards women in labour, it has the tendency to stifle the achievement of the millennium development goals 5.

9. Conclusions

This paper sought to contextualize the socio-cultural factors that determine women delivery at health facilities using a cross section of mothers in the northern region of Ghana. As far as home delivery is concerned, 52.6% of the women still practice it. An important observation is also that there was a disparity in terms of location and availability of midwives, which tend to determine people choice of delivery sites. An important revelation is that, women who are

educated showed a positive effect in the utilization of health care facilities as against those who had little or no education. The most important issue that also came up has to do with the belief structure of the local people. The beliefs, norms and traditional practices and perception play a great role in the determination of place of delivery. Interestingly, there was no direct influence of antenatal care attendance in the reduction of home delivery, a situation that could lead to the achievement of millennium goal 4 and 5. In view of this, it is necessary that education on the modification of cultural practices and beliefs to meet present challenges. There is also the need for governments and stake holders to step up the knowledge base of women in remote parts of the country on maternal health. Continues improvement on the knowledge and skills of traditional birth attendants is also important since they are the only experts in very remote communities.

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