

Access vs. Traditional Beliefs: Use of Health Professionals for Obstetric Care in the Kassena-Nankana District of Northern Ghana

Abstract. This study explores the role of access vs. traditional beliefs in decision-making to seek obstetric care with health professionals. 18 purposively sampled homogenous groups in 15 communities participated in focus group discussions on traditional beliefs, barriers to the use of health professionals, and ways to improve obstetric care. All the groups were knowledgeable about life-threatening signs and symptoms of pregnancy and labor complications. Decisions on the place of delivery were made after the onset of labor. Accessibility (cost, distance, transport, availability of health facilities, and attitude of nurses) were major barriers, whereas traditional beliefs were reported to be less significant barriers. Informants made pertinent recommendations on how to improve obstetric services in the district. These findings demonstrate that even in this district where African Traditional Religion is the religion of a third of the population, compared to a national average of 4 percent, access was perceived as the main barrier.

As of 1996, the demographic surveillance estimate of Maternal Mortality Ratio (MMR) in the Kassena-Nankana district of northern Ghana was 637 per 100 000 live births (Ngom et al. 1999). Increasing the proportion of births assisted by health professionals (doctors, nurse midwives and nurses with midwifery skills) to 80% is the current main recommendation of the United Nations General Assembly to reduce the high maternal deaths in developing countries (UN General Assembly 1999). In Sub-Saharan Africa, the proportion of pregnant women who attend prenatal care is disproportionately higher than those whose deliveries are assisted by health professionals (Stewart et al. 1997) and this disproportion vary by geographical area. In Ghana, as of 1998, the proportion of deliveries supervised by health professionals was 76 percent in urban areas compared to only 34 percent in rural areas (Ghana Demographic and Health Survey 1998). A household survey in the Kassena-Nankana district (Mills 2004), carried out concomitantly with this study, reports that 94 percent of pregnant women attended prenatal care whereas 44 percent delivered with a health professional in attendance.

Previous studies have highlighted several factors including access (cost, distance, transport and availability of health facilities) and traditional beliefs, which account for the low levels of utilization of health professionals for obstetric care. In this paper, traditional beliefs and practices, which can be categorized as psychosocial accessibility (Bertrand et al. 1995) are described separately from access to care. In Sub-Saharan Africa, where almost all the deliveries attended to by health professionals take place in health facilities (Stewart et al. 1997), a major barrier to the use of health professionals is the lack of adequate obstetric facilities. Long distances to the health facilities and lack of transportation also discourage the use of health professionals (Thaddeus et al. 1994). Available evidence suggests that women who live closer to health facilities are more likely to use health professionals for obstetric care (Rose et al. 2001). Another barrier is the low quality of care (such as long admission-to-treatment time intervals, lack of drugs and supplies) at the health facilities (Ifenne et al. 1997; Opoku et al. 1997; Sabitu et al. 1997). Women recognize the risks associated with home delivery but

sometimes have no other alternative if they consider obstetric facilities to be inaccessible or of poor quality (Obermeyer 2000).

Several studies in Nigeria have reported traditional beliefs and practices as major barriers to the use of health professionals. A previous study in Zaria, Nigeria, revealed that majority of the women who died during childbirth had ready access to transportation and were within two kilometers of all-weather roads, but the decision to seek care was delayed when the husband was not available (Wall 1998). A study in the Borno state of Nigeria also revealed that eclampsia was perceived to be caused by evil spirits and that traditional medications were required for treatment (el Nafaty et al. 1998). Bleeding in pregnancy was also attributed to supernatural powers and could only be stopped by diviners (Okolocha et al. 1998). Further, Hausa women in Northern Nigeria did not utilize health professionals because they disliked episiotomies and did not want to expose their genitals to strangers (Wall 1998). However, these traditional beliefs and practices cannot be generalized to all the diverse ethnic groups in Nigeria (Okafor 2000).

Thus the above-mentioned barriers to the use of health professionals for obstetric care have to be placed in local context. The reasons for high maternal mortality levels may differ from one region to another (Miller et al. 2003). This calls for context-specific interventions to reduce maternal mortality (Allotey 1999). In one report, a tertiary obstetric facility was upgraded, and more obstetric staff trained, but utilization decreased partly because pregnant women could not afford the services (Ifenne et al. 1997). Maternity waiting homes that offer temporary place of stay for women who live far away from health facilities have been successfully implemented in some countries (Figa'-Talamanca 1996; Poovan et al. 1990; Chandramohan et al. 1995) but one established in Ghana was poorly patronized partly because it did not meet the needs of the local populace (Wilson et al. 1997). In addition to ascertaining the barriers to the use of health professionals, researchers must ask communities which interventions will meet their needs to enlist their support.

A 1993 review of traditional birth attendants (TBA) training in the Kassena-Nankana district of northern Ghana indicated the populace also strongly adhered to traditional beliefs related to pregnancy and delivery (Allotey 1999). The question is whether the populace still adheres to these traditional beliefs associated with obstetric care, considering that the proportion of women in the reproductive age in this district who profess African Traditional Religion has decreased from 69% in 1993 to 31% in 2002 while the proportion of Christians has increased from 27% to 62% in the same period (Akazili et al. 2003). Previous studies on obstetric care in parts of Sub-Saharan Africa, where African Traditional Religion predominate, have not described changes in traditional practices in favor of delivery with health professionals.

This paper presents the findings of focus group discussions, which explored 1) the role of access vs. traditional beliefs in decision-making to seek obstetric care with health professionals in the Kassena-Nankana district and 2) why majority of women use health professionals for prenatal care but not for obstetric care. Informants' recommendations on how to improve obstetric services in the district were also addressed. Focus group research is appropriate for this subject matter because group interaction elicits rich information on beliefs, opinions and perceptions (Carey 1994).

METHODS

Setting

This focus group research was conducted in the Kassena-Nankana district in November/December 2002. This remote district is one of 110 districts in Ghana and shares borders with districts in the three northern regions of Ghana. It has guinea savannah vegetation and 2 main seasons: rainy (May - October), and dry (November - April). It is a scattered settlement with a typical compound housing an extended family, surrounded by a field where farming and cattle raising is done. The district is 10% urban and 90% rural. The population is approximately 142,000, with 30,000 women in the reproductive age group (15 – 44 years) (Debpuur et al. 2002). About 60 % of women in the reproductive age are married and over a half

of the population (aged 6 years and above) have no primary education (Nyarko et al. 2001). There are two main ethnic groups, namely the Kassenas and Nankanas. The Kassenas make up 54% of the population whereas the Nankanas, 42%. The remaining 4% are Builsa and other minority tribes (Nyarko et al. 2001). The Kassenas occupy the northwestern and central parts of the district while the Nankanas are in the eastern and southern areas. African Traditional Religion accounts for a third of the religion in this district (Akazili et al. 2003), compared to the national average of 4% (Ghana demographic and Health Survey 1998), while over half of the population is Christian (Akazili et al. 2003).

The district has a hospital, three health centers and five health posts but no private obstetric facility. In addition, the Navrongo Health Research Center (NHRC), an internationally recognized center in northern Ghana that conducts decision-linked research for the Ministry of Health, is situated in the district. The Institutional Review Boards of the Johns Hopkins School of Public Health and the NHRC granted approval for the study.

Recruitment of informants and sampling

Prior to the study, the first author accompanied by a principal field supervisor at the NHRC, met with each of the 10 paramount chiefs in the district to discuss the background and objectives of the focus group research. The chiefs in turn informed their respective communities about the study. The investigator employed purposive sampling to select 18 homogenous groups (described in Table 1) from 15 communities covering all ten paramount chiefdoms (Mensch et al. 1999) in the district. The investigator enlisted different community contact persons in a sampled community to recruit informants who were eligible for a designated homogenous group. The groups had different characteristics but the composition within a group was homogenous. Sampling diverse groups allowed the perspectives of different groups (women, men, TBAs, traditional healers and community leaders) on the use of health professionals for obstetric care to be captured. Further, for each Kasem speaking group there was a corresponding Nankam speaking group (except for the last 2 in Table 1) to allow

comparison of the findings. There were 9 – 12 informants in each homogenous group with an average of 10. The informants were selected from households that were not sampled for a concomitant household survey (Mills 2004). The first author, who is a physician with the Ghana Ministry of Health, assisted in setting up the place for each session but was not present during the discussions to reduce deference effect.

Recruitment of moderators and discussion guide

One male and one female social science researcher from the NHRC who have experience in the handling of focus groups and speak the local dialects were recruited and trained as moderators for the focus groups. One male and one female assistant moderator were recruited for note taking.

The focus group guide covered the following topics: symptoms and complications of pregnancy; pros and cons of using a TBA vs. health professional for prenatal care; signs, causes and treatment of labor complications; cultural beliefs associated with pregnancy and delivery; birth preparedness; pros and cons of using a TBA vs. health professional for obstetric care; decision-making on place of delivery during pregnancy and labor; role of the vuru (soothsayer) in decision-making; community support for transport and referral; and ways to improve obstetric care service in the community.

Procedure of the focus group sessions

Separate sessions were held for each of the 18 homogenous groups noted earlier. The discussions were held in nearby local primary schools when classes were over or any other location in the community where an outsider could not hear the discussions. None of the discussions was held in a health facility to reduce deference effect. In each focus group, the moderator and assistant were of the same sex as the informants. Each session began with the exchange of greetings between the moderator and the informants followed by a consent process. The moderator read aloud the consent in the local language to the informants; expressly stating that participation was entirely voluntary. The informants signed or thumb

printed the consent forms to indicate consent. Parental consent was sought in cases where the informant was between 15 – 17 years and not married.

The moderator then led the discussion using the guide noted earlier but followed up leads. Each session lasted between 45 – 90 minutes with the majority lasting for about an hour. The sessions were audio recorded with a digital voice recorder. The assistant took notes on the setting, content of the discussion, and nonverbal communication. After the discussion, the moderator thanked them and presented them with bars of soap. The audio files were later downloaded to a computer. The moderator and assistant debriefed the investigator immediately after each session to discuss emerging themes. The age group for the Nankam young women was changed from 15-29 years to 15-19 years when it was realized that the women aged over 20 years dominated the 15-29 year old Kasem group discussion.

Data Management

The audio files were fully translated and transcribed verbatim into English by a transcriptionist at the NHRC using Olympus DSS Pro transcription software with a foot switch. The transcriptions were carried out concurrently with the fieldwork. The investigator and one moderator later reviewed the transcripts to check for accuracy and completeness.

Data analysis

The investigator created initial topical codes by reading through the 18 transcripts for themes. He then applied the topical codes to all the transcripts using ATLAS.ti software (ATLAS.ti 2003).

All texts containing each selected code in all the transcripts were generated and printed. Comments on the coded text were then written while comparing the various groups of informants and looking for unanimity and negative cases. Illustrative quotes from informants were noted and reported.

At dissemination seminars held in the district in January 2004, the first author discussed the findings and policy implications with the Ministry of Health, NHRC staff, Paramount Chiefs and other community leaders.

RESULTS

In general, the health professionals conducted deliveries in the health facilities and not in the individual homes of pregnant women. In this district, nurse midwives ran prenatal clinics and referred to doctors when necessary. The findings of the 18 focus group discussions are presented below.

Knowledge of labor complication

By and large, all the groups were knowledgeable about the signs and symptoms of pregnancy and labor complications. The labor complications discussed include prolonged labor, big baby, malposition, antepartum hemorrhage, postpartum hemorrhage, anemia, severe vaginal tears, retained placenta, umbilical cord round fetal neck, maternal exhaustion and uterine prolapse. Most of the groups indicated that when such problems cropped up they preferred to go to the hospital. The TBAs and traditional healers indicated that when they realized they were not able to handle some of these complications, they referred the women to the health facilities. A few of the groups, including the male opinion leaders and heads of households, explained that caesarian section was the only way out for complications such as obstructed labor as illustrated in the following quote.

If the baby grows fat in the womb, she can labor for long without giving birth. In the olden days, there were herbs that were used but now we go to the hospital for an operation if the baby can't come out. (Untrained TBA, Nankam)

Traditional beliefs and practices

Traditional beliefs and practices associated with pregnancy and labor were discussed at length, but the majority of groups indicated that most of these were no longer practiced. Some of the traditional beliefs and practices associated with pregnancy were as follows: in some households pregnant women (as well as other members of the household) were forbidden to visit the hospital, so only the TBAs were allowed to attend to them in labor; pregnant women were not allowed to sit on stones or wood which were believed to harbor bad spirits; eating of food rich in protein such as meat, fish, and fresh milk was forbidden to prevent the fetus from

becoming overweight and prolonging labor; and special herbs in boiling water were used to determine the time of the day that a woman would deliver.

Traditional beliefs and practices associated with labor include the following: women who engaged in extramarital affairs could have prolonged labor; special herbs were given to women when the umbilical cord entangled around the neck of the baby and for breech presentation; hot water was poured on the abdomen and okra smeared on the vagina to expedite delivery; women with retained placenta were given a bottle into which to blow air to force the placenta out; the placenta was always buried outside the house to indicate the ancestors had accepted the baby; and a calabash of hot water was placed on the abdomen of women who experienced postpartum hemorrhage to stop the bleeding.

After delivery, women were expected to be indoors and not lift cooking utensils for three days if the baby was a boy and four days if a baby girl, otherwise the navel of the baby would get infected; women were given hot water containing herbs to drink to prevent blood clots in the uterus; and breast milk was tested before being given to the baby– breast milk was expressed in a calabash and an ant was put into it, if the ant died then the milk was considered unwholesome.

In general, there were no differences in the traditional beliefs and practices discussed among the Kassenas and Nankanas. Some of the informants indicated that it's been a long time since they heard of some of the traditional beliefs mentioned by other informants in the group and that most of them were no longer practiced. This was buttressed by the following quote:

In the olden days pregnant women were not allowed to go to their fathers' houses when pregnant, and if they did, there were problems. This was a local belief and a certain herb was used under this situation. But now we have forgotten of our herbs because there are hospitals around. Most of the herbs can't even be found today and we don't even know the laws of the herbs too. The hospital is good but most of us can't afford to go there. (Head of household, Kasem)

Informants were aware of the adverse effects of some traditional practices. For example, a male opinion leader (Nankam) spontaneously explained that female genital cutting could partially seal

the vaginal opening and cause problems during delivery. However, the male groups including the traditional healers, emphasized the need for women to be faithful and that extramarital affair could lead to prolonged labor as illustrated in the following quote:

A promiscuous woman would definitely have problems if she is giving birth. She would have to tell everybody present the number of men who have slept with her apart from her husband before she would be able to give birth. (Male opinion leader, Kasem)

The women countered this claim as indicated in the following quote:

If the soothsayer knows you and doesn't like you, he can lie to the compound head that you are suffering because you have been sleeping with other men and that is what the compound head would take. (Female opinion leader, Kasem)

The female opinion leaders, compared to the other groups, were more averse to harmful traditional beliefs such as not allowing pregnant women to eat meat. The trained TBAs made it clear that after undergoing TBA training, they realized that some of these traditional beliefs and practices were a source of punishment to women. Despite these beliefs and practices, all the groups, including the traditional healers, indicated that the hospital was the ultimate place for obstetric care, reflected in the quote below:

I remember when I gave birth, the placenta would not come out. They gave me all the local treatment and medicine but it would not come out. In the end I was taken to the hospital. The placenta came out only after I received an injection. (Woman aged 30-44 years, delivered in last five years, Kasem)

Although the traditional healers pointed out that they referred pregnant women to the health professionals, they were of the opinion one could not completely do away with spiritual healing in one's daily life.

Decision-making and the role of the soothsayer

Decisions on the place of delivery were made after the onset of labor and not during pregnancy.

I think we don't normally talk about those things during pregnancy. It is only when she is in labor, and the time that it takes, and the suffering that she goes through, that help us to decide where she should deliver. Some women go to the

well (to fetch water) and end up giving birth there, so why do we have to decide where she should give birth when she is not in labor. (Head of household, Kasem)

Although the decision to deliver in the hospital was made after the onset of labor, during pregnancy the health professional could advise the woman to deliver at the hospital especially when the pregnancy was considered to be of high risk. In these instances, arrangements were made to go to the hospital as soon as labor sets in:

Sometimes during the prenatal clinics the nurses would advise some women never to attempt delivering at home so those ones will go to the hospital as soon as they are in labor without the consent of their husbands (Trained TBA, Kasem)

During labor, the husband usually made the decision because it was believed that a woman in labor was in pain and did not have the clear thinking to make a decision. However, where the husband was not the compound head, the latter had the final say. In all the groups it was stated that the compound head usually had the final say as illustrated in the quote below:

It is only the compound head who can give you the go ahead to go to the hospital or ask you not go depending on what the gods have asked him to do. He has the final say. There are instances where they refuse to allow the woman to go to the hospital because the gods did not allow them to go but later allow the women when things become worse. (Woman aged 30-44 years, delivered in last five years, Kasem)

Some household heads made the final decision in consultation with a soothsayer. Libations were then poured if recommended by the soothsayer to ensure safe delivery of the baby. Soothsayers played very important roles in the lives of some members of the district. The soothsayer could also predict complications and once the right rituals were performed, the woman was expected to have a safe delivery:

The soothsayer helps in several ways. For instance if you want your wife to have safe delivery, you can go and plead with your ancestors through the soothsayer. The soothsayer would only give you sacrifices to go and perform and if you do everything right, the woman would actually have safe delivery. (Male, traditional healer, Kasem)

All the same, there were divergent views on the edicts of the soothsayer in the various communities. There were some who did not depend on the soothsayer to make decisions in labor while others do:

It depends on the compound. Those who don't believe in traditional things will act fast upon hearing that the woman is in danger, but those who believe in them will first have to send somebody to the soothsayer and until the person returns, no decision will be taken. (Trained TBA, Kasem)

I also went to (community A) for some registration and I saw a woman in labor and I advised them to take her to the hospital. Not knowing that was even her second day in labor, and I was told that the compound had gone to consult a soothsayer and until he is back she can't be taken to the hospital. So I called the husband of the woman and spoke to him and they took the woman to the hospital where she delivered safely. (Male opinion leader, Nankam)

As a norm, women did not consult with the soothsayer and only got information on the edicts of the soothsayer from the men. Some women did not concur with the decisions made by the soothsayer and indicated that it could be harmful to depend on their advice.

I don't waste time at home if a woman is in labor. It is always by coincidence that the soothsayers say things and they happen but I don't think they are helpful. (Untrained TBA, Kasem)

It was in the olden days that people worked with the soothsayers and acted on their advice. (Untrained TBA, Kasem)

People have relied on the advice of the soothsayers and lost their wives or the babies. (Untrained TBA, Kasem)

Most of the compound heads are old man who were not born at the hospital and believe in the advice of the soothsayer and that is why if there is any problem they consult the soothsayer before telling you what to do. (Woman aged 30-44 years, delivered in last five years, Kasem)

The soothsayer is only there to tell compound heads to pour libations for women in labor to deliver well. (Woman aged 30-44 years, delivered in last five years, Kasem)

Further, after much deliberation about the role of the soothsayer in one of the male groups, it was explained that with respect to illness, the soothsayer was not always right as indicated in the quote below:

It is not that we don't believe what the soothsayer says but in terms of illness I will never keep a sick person in the house because of what the soothsayer says. In terms of illness, the soothsayers have no truth. If someone runs short of blood, for instance, the soothsayer can't give the person blood - it is only in the hospital. (Head of household, Nankam)

In addition, even after performing all the recommended rituals one might end up losing the baby:

Sometimes also, the soothsayers can advise you to come and perform so many rituals and if you actually do everything you might end up losing your baby (laughter). (Head of household, Kasem)

This delay in decision-making was what sometimes led to the death of the woman and the baby.

I have seen a woman who has died as a result of that. The compound head delayed before allowing them to take the woman to the hospital and at the time that he permitted them there was no car and the woman died. (Woman aged 30-44 years, delivered in last five years, Kasem)

In such critical situations, the compound head sometimes followed the TBA's advice on the best course of action. The cost involved with seeking care from health professionals was sometimes the overriding reason men did not allow their wives to deliver in the hospital as illustrated in the quote below:

The husbands of some women do not allow them to deliver at the hospital. They prefer that the women deliver at home and that is why some of us bear it until we deliver at home and not that we like it. It isn't that it is forbidden for them to deliver at the hospital but the money isn't there. If there is only one goat in the house, your husband wouldn't sell it for you to go to the hospital. (Untrained TBA, Kasem)

Some women made their own decision and did not wait for the household head especially when the women could afford to go to the health facility:

Yes, it is those who are fools that will wait for their husbands to decide for them. But the wise ones will start getting their money ready during the pregnancy and go to the hospital during labor without telling their husbands. (Trained TBA, Kasem)

I don't even wait for them to tell me what to do because I'm carrying the pregnancy and know what it means. Therefore, if there is any problem I go to the hospital. (Woman aged 30-44 years, delivered in last five years, Kasem)

Once you have the money, you go to the hospital when you are due after discussing with your husband. (Woman aged 30-44 years, delivered in last five years, Kasem)

A few of the groups explained that women who have expedited labor sometimes delivered by the time they get to the hospital, so those women had better deliver at home. In addition, those who have had normal pregnancy do not necessarily have to deliver at the hospital unless complications arise.

Reasons for prenatal care with health professionals

All the groups indicated that prenatal care with a health professional was necessary for safe delivery. The following quotes illustrate the traditional healers' explanations for the need for prenatal care:

I don't think there is any reason for not attending prenatal care. It was in the olden days that they had beliefs but everybody is enlightened now, and we have seen the benefits of going for prenatal care and would always encourage our pregnant women to go for prenatal care. (Male, traditional healer, Kasem)

The main reasons for attending prenatal care were to check the pregnancy was normal and the fetus was well positioned in the womb. Other reasons for attending prenatal care were: to find out the expected date of delivery, for tetanus immunization, for diagnosis and treatment of illnesses associated with the pregnancy, for nutritional advice and multivitamins, for registration of the pregnancy so that during labor the nurses would give them the necessary attention, and for those who would need caesarian section to be informed beforehand.

However, informant gave a few reasons for not attending prenatal care. The main reasons for not attending prenatal care were distance to the health facilities, the high cost and unavailability of transportation. Other reasons for not attending prenatal care were: drugs not available at the health facilities, short hours of operation of the clinics since some had to get there on foot, some nurses gave wrong expected date of delivery, and in some families it was forbidden to seek care from hospitals. Further, women who did not want others to know they

were pregnant usually waited until the pregnancy was over three months old before starting prenatal care.

Reasons for prenatal care with TBA

Trained TBAs provide routine prenatal care but the untrained TBAs and traditional healers usually did not. The main reasons for consulting the TBAs were to notify them of the pregnancy, for treatment of minor ailments and because their services were cheaper. In all the groups, informants pointed out that it was preferable to consult the health professional but then the TBAs would also have to be consulted since the TBAs live in the communities and were the ones who were called upon especially at night to conduct the delivery. The informants considered the TBAs to be less skilled and not well equipped compared to the nurses. The TBAs explained that their services were complementary to those of the health professionals and that they referred women who were at high risk of developing delivery complications (such as those with anemia, swollen hands and feet, jaundice, and short stature) to the health professionals.

Birth preparedness

The groups unanimously explained that making preparations for delivery was essential. The heads of household group (Kasem) explained that in the past, women were discouraged from making preparations for delivery but that has changed since 'everyone' has been enlightened. At the prenatal clinics, the nurse midwives advise the pregnant women to get ready items such as soap, baby clothes, clean old clothes, and to set money aside for the delivery. However, arrangements for blood transfusion were not made during pregnancy except during labor when the doctor requested it. In addition, plans to get community support for transport to the health facility during emergencies were not in place in any of the communities. The male groups pointed out that saving money for delivery was the most important preparation but lamented that some of them could not afford.

Pros and cons for obstetric care with health professional

The two main reasons cited for not using health professionals for obstetric care were the attitude of the midwives at the health facilities and poverty. Although all the groups acknowledged the efficacy of modern obstetric care, the attitude of the nurse midwives was a source of concern. It was explained that the midwives shouted at them for presenting late, looked down on some of them especially those who were poor, embarrassed the women by insulting them that they were dirty, slapped them when they delay in pushing during the second stage of labor, left them alone in bed unattended and sometimes they ended up delivering by themselves. The following quote illustrate some of the sentiments the informants expressed about the nurses:

Some of them (the nurses) are so irresponsible. Times that the baby is even coming out, you would call them and they wouldn't mind you. Some of them don't sit in the ward, they leave us alone on the bed. We even deliver sometimes without them being around and you just feel that it would have been better to deliver at home and get all the care. (Female opinion leader, Nankam)

A few of the informants however, acknowledged some of the midwives were sympathetic and also appreciated that the hospitals were short-staffed and the nurses burned out.

The other main reason for not delivering at the health facilities was because of the cost involved. Some informants complained the hospital charges were high and that they could not afford items such as soap, baby cloths, clean cloths and rags, and blade for cutting the umbilical cord, which they explained, were necessary for hospital delivery.

There is no woman who will not like to go to the hospital when in labor but the problem is when they deliver at the hospital the husbands are always called upon to pay some money and most of the time the husbands cannot afford and that is why most of them deliver at home. And when they deliver at home safely the money that would have been used to pay for the hospital bills can then be used to buy things for her to use (laughter). (Head of household, Kasem)

Some women were embarrassed to go to the hospital because of they did not have nice clothes for themselves and the newborn. They would rather deliver at home where nobody would know they were poor. The high costs of transportation also hindered women from delivering at the

health facilities. In communities where there were no health facilities, getting to the hospital in emergency was always a problem. There were no vehicles in most of the communities, so they had to use a bicycle to get to the nearest town (which could be 40 kilometers away) to fetch a commercial vehicle. The process is so long that sometimes by the time the vehicle was available it was too late:

There is one woman who stays near my house that my mother took to the hospital after my mother had tried and the lady could not give birth. They boarded a taxi which charged ₱15,000.00 (\$2) from here to X health center, and we wanted him to reduce the charge and he refused and the life of the baby was in danger. When he finally agreed to reduce the fare we got to the hospital late. (did the baby die?). Yes. (Male, traditional healer, Kasem)

The cost of transportation could be as high as ₱100,000.00 (\$12). Vehicles were easier to get if it was a market day. The communities usually provided support in times of emergency. In instances where they were unable to get a vehicle or a motorcycle, the women were pushed on a bicycle or truck. This problem of cost involved in delivering with a health professional manifested itself in several ways in decision-making when a woman went into labor as noted earlier.

Less frequently mentioned reasons for not delivering at the health facilities were: the hospitals lacked supplies such as needle and syringe, some women have acquired infection as a result of delivering at the hospital, and some of the doctors performed caesarian sections at the slightest indication.

In spite of the above-mentioned negative reasons, the groups unanimously acknowledged that delivery was best conducted by a health professional. It was believed the health professionals were capable of doing the following: management of retained placenta, induction or acceleration of labor, caesarian section for prolonged labor, blood transfusion for postpartum bleeding, and detection of dead fetus. The following quotes illustrate the perception that the health professionals were capable of handling labor complications:

The old ladies force us too much at home to push even if the baby is not coming, all these because they don't know the time that you would give birth. But in the hospital they know when you would deliver and would only allow you to lie on the bed until that time. (Woman aged 30-44 years, delivered in last five years, Nankam)

Some women bleed a lot after delivery and the nurses can stop it if only you go there. (Woman aged 30-44 years, delivered in last five years, Nankam)

Further, those who have had complications with previous deliveries were expected to deliver in the hospital:

Any woman who went through bad experience during delivery and was saved at the hospital will always want to deliver there even if there is no imminent danger. (Female opinion leader, Kasem)

As expected, the younger women's group explained that primipara have to deliver at the hospital:

If it is also your first time giving birth you would like to deliver at the hospital even if there is nothing wrong with the pregnancy. (Woman aged 15-29 years, delivered in last five years, Kasem)

It is interesting to note that others preferred to deliver at the hospital because only the midwife would see the woman's private part unlike at home where several people delivered them.

It is only the nurse who sees your private part at the hospital but in the house the TBA and all the old ladies who conduct deliveries in the area would see it. That is why others prefer to deliver at the hospital. (Female opinion leader, Kasem)

The heads of household (Nankam) reiterated that many women saw the expectant mother's private part when she delivered at home.

Reasons for obstetric care with TBA

The majority of women delivered at home with the assistance of the TBAs because of the above-mentioned constraints in delivering with a health professional. The following quote from a young woman summed it up:

It is just because of the money that most prefer to deliver at home and only pray that the TBAs would be able to help them deliver safely. (Woman aged 15-29 years, delivered in last five years, Kasem)

Given the opportunity they would have preferred to deliver at the hospital:

There are also instances where you labor throughout the night hoping that at day break you would be taken to the hospital and at that time you are almost giving birth and they are the only available people who can help. (Woman aged 15-29 years, delivered in last five years, Kasem)

The majority pointed out that TBAs were the first point of contact in the community during labor since the TBAs lived with them and were always ready to help. The other reasons for delivering with the TBAs were: TBAs assisted in bathing the newborn, gave advice on breastfeeding and the care of the newborn, and their services were cheaper. The TBAs were particularly helpful in cases where there were no complications but referred to the health facilities when complications arose. The following quote explains the place of TBA in the obstetric care system:

It is good for women to deliver with the TBAs because it is not every woman who would like to deliver at the hospital or it is not every woman whose delivery has complications. Some women normally need just assistance when in labor and don't have to go to the hospital. The TBAs are there to help this type of women. (Male opinion leader, Nankam)

All the same those who delivered with the TBA expected to be promptly referred in the event of a complication:

A young lady in this community suffered this type of thing in the hands of a TBA. She was in labor for three days and was not taken to the hospital. The TBA later took her to the hospital when she was so weak and at the hospital she was given infusions and she recovered and delivered safely, so I think everything has its own limitations. (Male opinion leader, Nankam)

When the trained TBAs (Nankam) group was asked specifically whether some women complained when the health professionals did not give the placenta to them to take home, they answered in the negative.

Relationship between traditional attendants and health professionals

The traditional healers and TBAs indicated that their relationships with the nurses were cordial and that sometimes the health center staff assisted them in arranging transport for referred patients to the hospital. They made it clear that it was when they delayed in sending

pregnant women to the health facility that the midwives got angry with them. As to whether the midwives allowed them into the labor ward, the responses were mixed.

Informants' recommendations

All the groups, excluding the TBAs and traditional healers, were specifically asked whether they would prefer a midwife to conduct deliveries at the health facility or at home. As expected, in communities close to a health facility, the informants indicated delivery should be conducted in the hospital whereas those whose communities were far from a health facility preferred deliveries to be conducted at home. The reasons put across for the preference for midwives conducting deliveries in the health facility were: blood and intravenous fluids could only be administered at the health facility and that midwives could not carry equipment home. On the other hand, other groups preferred the midwives to assist in the communities because of the high cost of transportation, difficulty in getting transport in emergency, and long distance to the nearest health facility. The male opinion leaders (Nankam) suggested the nurses should be stationed in the communities and not necessarily to conduct deliveries in their individual homes since the nurses were few and could not come to their individual homes. Further, the female opinion leaders suggested that the nurses posted to the communities should be experienced in conducting deliveries and not require much supervision. They explained that some of the community health nurses posted to the communities did not have midwifery skills. In the long run, informants from communities without health centers suggested the putting up of health facilities and that they were prepared to provide labor, sand and stones.

The informants suggested the nurses should be encouraged to be more understanding since some pregnant women cannot read and did not understand the procedures at the health facilities. Nurses should not discriminate and demand deposit in emergency.

Some informants suggested the District Health Management Team (DHMT) should upgrade the skills of TBAs because of the difficulty in getting to the health facilities. The TBAs wanted to be consulted first before women went to the health facilities; otherwise it made them

feel their services were not valued in the community. Also, TBAs needed more referral cards to give to pregnant women and soap to wash their hands. The traditional healers also wanted more attention to be paid to herbal medicine and wanted the DHMT to provide them items such as raincoats, torchlights and identification cards.

With respect to the transportation difficulty, informants suggested provision of vehicle or ambulance for referral, delegation of some community members to arrange transport for pregnant women, and rendering the roads motorable to encourage commercial drivers to ply the routes.

Informants suggested regular meetings with the health care staff to discuss how to address relevant health issues and also wanted researchers to share findings with them. The informants indicated that the Navrongo Health Research staff, unlike the hospital staff, discussed health issues with them and that has enlightened them as illustrated in the quote below:

It is really the NHRC people who do that (involving community in discussions related to health) but we have never seen someone from the hospital coming to talk to us. (Head of household, Kasem)

NHRC has really enlightened most of us. They talk to our pregnant women often, and this did not happen in the past. (Head of household, Kasem)

The NHRC together with the DHMT has an on-going Community Health and Family Planning project (Debpuur et al. 2002) in the district but it appeared the populace was not aware the DHMT was involved.

DISCUSSION

The objectives of this study were to examine 1) the role of traditional beliefs vs. access as barriers to the use of health professionals for obstetric care and 2) why majority of women use health professionals for prenatal care but not for obstetric care.

There are a few limitations to the findings. First, deference effect is a potential source of bias in interviews or focus group discussions. Nevertheless, steps were taken in this study to reduce this effect. Staff of the NHRC, who were not health professionals, moderated the discussions. This allowed informants to discuss freely any misgivings they had about the obstetric staff and services provided at the health facilities. Moreover, none of the discussions was held in a health facility. Second, probability sampling would have made the sample representative of the study population. However, purposive sampling, which was more appropriate for focus group research, ensured that informants who were knowledgeable about obstetric care in both major and remote communities in this district were selected for the discussions. The selection of diverse groups of informants enhanced the internal validity of the findings. Further, recruitment of informants was done by different community contact persons and not by the research team. This reduced the tendency by the research team to select only informants who would give data to support the views of the research team.

Traditional beliefs and practices were not the main reasons that the majority of pregnant women in this district did not seek obstetric care from health professionals. Although a 1993 review of TBA training indicated that the populace in this district strongly adhered to traditional beliefs (Allotey 1999), informants in this study repeatedly explained that some of the traditional beliefs and practices associated with delivery were observed in the olden days. All the groups unanimously acknowledge the essence of birth preparedness unlike the 1993 study that indicated making preparations for delivery was a taboo. Indeed, a recent report revealed that the predominant religion in the district has changed from African Traditional Religion in 1993 to Christianity in 2002 (Akazili et al. 2003). The trained TBAs explained that TBA training had

demystified some of the traditional beliefs, which hitherto discouraged delivery with health professionals. In addition, some women believed soothsayers victimized them and so did not always accept the edicts of the soothsayer. Further, the NHRC that has conducted a number of operations research in the district since 1989 may have also enlightened the populace on harmful traditional practices: the NHRC has an on-going project to eradicate female genital cutting (Akazili et al. 2003). A formative research prior to the implementation of the Community Health Family Planning project in the district in 1994 showed that all the communities requested the establishment of clinics (Health on Wheels 2001). Thus, traditional beliefs may no longer be major barriers to the use of health professionals for obstetric care in this district. In all the groups, informants were knowledgeable about the signs and symptoms of the pregnancy and labor complications, as was also observed by the Prevention of Maternal Mortality network in West Africa, (Maine et al. 1992) and accepted modern interventions such as caesarian section and blood transfusion as appropriate.

All the groups emphasized their preference for delivery with health professionals but the major obstacle was accessibility. First, many women did not access the health facilities because they could not afford the hospital bills, and the high cost of transportation. Second, the long distances to the health facilities and the poor conditions of the roads were other barriers cited. Third, some informants pointed out that essential drugs and supplies were lacking in some health facilities. Fourth, all the groups were critical of the unfavorable attitude of nurses during labor. This finding has been observed in other places (Amooti-Kaguna et al. 2000; Senah et al. 1997; Oyesola et al. 1997; Chukudebelu et al. 1997). The foregoing access factors, rather than traditional beliefs, were repeatedly emphasized in all the discussion groups as the major barriers.

With respect to the second objective, several factors explained why a high proportion of pregnant women sought prenatal care from health professionals but not for obstetric care. First, majority of the criticisms of the unfavorable attitude of nurses were more associated with labor

than with prenatal care. The focus groups revealed that pregnant women were concerned about malposition of the fetus and believed the health professionals could correct them. Although this perception that the health professionals could correct malposition was erroneous, it was one of the reasons women attended prenatal care. They misinterpreted abdominal palpation as a procedure for correction of malposition although in reality, health professionals in this district do not practice external version. Knowledge of the expected date of delivery was another reason why women went for prenatal care, thus making some of them critical when the expected date of delivery turned out to be inaccurate. In practice, it is difficult to estimate the expected date of delivery since over half of the women in the district have had no formal education (Nyarko et al. 2001) and did not accurately know their last menstrual period. Further, ultrasonography was not used routinely in the district to accurately date pregnancies. Thus, when the nurses inform them of the expected date of delivery they would have to explain to them the date was not foolproof. All the same, perception that the nurses were capable of correction of malposition and estimation of the expected date of delivery motivated women to go to prenatal clinics.

Second, women who were informed at prenatal clinics that their pregnancy was normal expected the delivery to be also normal and did not deliver with a health professional especially if the problems with access noted earlier were prominent.

Third, the informants explained that those who have had a previous expedited delivery should deliver at home since they would deliver on the way to the hospital anyway considering the long distances.

Fourth, some of the women go to prenatal care for registration as a precaution so that the nurses will not shout at them if they came in labor (Amooti-Kaguna et al 2000). If they did not develop labor complications, they did not deliver with a health professional.

Fifth, prenatal care has been free of charge in the district for several years whereas obstetric care became free three months prior to the study. Probably, as more women get to

know there were no charges for obstetric care, women who were previously put off by the high hospital bills may begin to deliver with health professionals.

Sixth, unlike labor that cannot be scheduled, women can arrange to attend prenatal care to coincide with a market day when transport is available.

These access barriers need to be urgently addressed to facilitate the decision by women to seek obstetric care with health professionals (Obermeyer 2000). It is interesting to note that the diverse recommendations made by the informants, reported earlier, reflected the needs in their respective communities. This underscores the need not to implement the same intervention in all the communities in the district. In general, while it is expedient to draw on findings from studies in similar settings in designing programs, it is important to tailor them to suit the needs of a particular community. The policy implications of the findings are as follows:

1) The Ministry of Health will have to motivate and provide health professionals with skills to improve health professional-patient relationship so that pregnant women become more satisfied with obstetric services. At prenatal clinics, health professionals must emphasize that every pregnancy is at risk of developing life-threatening complications.

2) The quality of care at the existing health facilities must be improved to meet the needs of pregnant women. While arrangements are made to put up health facilities in the remote communities, the midwifery skills of the community health nurses posted to the communities will have to be upgraded.

3) The community leaders will have to improve the roads and make arrangements for emergency transport.

4) While the head of household had the final say on the place of delivery, lack of funds underpinned the decision not to deliver with health professionals. This decision was made after the onset of labor, as observed elsewhere (Obermeyer 2000), so empowering women through the provision of employment opportunities may provide them with the needed cash to facilitate

the decision to deliver with health professionals, should the head of household decide otherwise (Rizzuto 1997).

The findings of this study demonstrate that even in this district where African Traditional Religion is the religion of a third of the population, compared to a national average of 4 percent, access was perceived as the main barrier. A similar study in other districts of northern Ghana will indicate whether the finding that traditional beliefs are no longer major barriers compared to access to the use of health professionals, are applicable to the other ethnic groups of Northern Ghana.

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Table 1. Description of the groups purposively sampled for the focus group discussions

Group	language
1. Women aged 15-29 years who have delivered in last five years	Kasem
2. Women aged 15-19 years who have delivered in last five years	Nankam
3. Women aged 30-44 years who have delivered in last five years	Kasem
4. Women aged 30-44 years who have delivered in last five years	Nankam
5. Trained traditional birth attendants (females)	Kasem
6. Trained traditional birth attendants (females)	Nankam
7. Untrained traditional birth attendants (females)	Kasem
8. Untrained traditional birth attendants (females)	Nankam
9. Traditional healers (males)	Kasem
10. Traditional healers (males)	Nankam
11. Female opinion leaders	Kasem
12. Female opinion leaders	Nankam
13. Heads of households (males)	Kasem
14. Heads of households (males)	Nankam
15. Male opinion leaders	Kasem
16. Male opinion leaders	Nankam
17. Female opinion leaders	Kasem
18. Heads of households	Kasem