KWAME NKRUMAH UNIVERSITY OF SCIENCE AND

TECHNOLOGY

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

LATE ARRIVAL OF WOMEN WITH PREGNANCY RELATED COMPLICATIONS TO MAMPONG DISTRICT HOSPITAL-GHANA

THE UNDERLYING FACTORS

BY

FOSTER NYARKO

SEPTEMBER 2004

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FOSTER NYARKO

A DISSERTATION IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE MASTER OF SCIENCE HEALTH SERVICES PLANNING AND MANAGEMENT DEGREE.

SEPTEMBER 2004

DECLARATION

I, Foster Nyarko, hereby declare that this is the result of my own work and no previous submission for a degree has been done here or elsewhere. Also work by others that served as sources of information have been duly acknowledged by making references to the authors.

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DEDICATION

This dissertation is dedicated to my lovely wife Birago Wiredu, my parents Mr. and Mrs. Nyarko and my siblings Cecilia, Salomay, Rita and Daniel whose support, hard work and care has brought me this far.

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Profound gratitude goes to the Lord Almighty for the enormous mercy he has granted me. Special appreciation to the head of department, Dr.E.N.L Browne, Dr Easmon Otupiri my academic supervisor and Mr. Amoah my field supervisor for their useful advice and constructive criticisms which guided me through this work.

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Finally this work would not have been complete without the rich experience and friendly academic atmosphere created by my course mate

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DEFINITION OF TERMS

Abortion	Emptying of the pregnant uterus before the end of the 28th weeks.
Bleeding	Escape of blood from the uterus when no organic lesion is present
Cost	Fee paid for receiving healthcare services which includes transportation and drugs bought.
Eclampsia	A severe condition in which convulsion may occur as a result of an acute toxaemia of pregnancy
Hyperemesis	Excessive and uncontrollable vomiting during pregnancy
Knowledge	Knowing, familiarity gained by experience.

LIST OF ABBREVIATIONS

ANC	Antenatal clinic
APH	Antepartum Haemorrhage
DHS	Demographic and Health Survey
DHMT	District Health Management Team
GDHS	Ghana Demographic and Health Survey
PPH	Postpartum haemorrhage
PMM	Prevention of Maternal Mortality Network
PRC	Pregnancy related Complication
MOH	Ministry of Health
MCH	Maternal and Child Health
NGO	Non Governmental Organization
TBA	Traditional Birth Attendants
UNFPA	United Nations Population Funds
USAID	United State Agency for International Development
WHO	World Health organization
ZDHS	Zambia Demographic and Health Survey

ABSTRACT

Maternal mortality is the result of complex interaction between biological and socioeconomic factors, which should be organize in a meaningful way. An estimated 75% of maternal death result from direct causes such as haemorrhage, infection/sepsis toxemia and unsafe abortion.(WHO, 1995) Most of these deaths could have been prevented with timely medical intervention.

Delay in reporting PRC emerge as the pertinent factor contributing to maternal death.

This study was conducted in Sekyere West District in Ashanti region to ascertain what factors are contributing to the late reporting to the District Hospital by pregnant women with complications.

In all, 150 women who have had pregnancy related complications within the last five (5) years (1999-2004) and six health personnel were interviewed. The multistage sampling approach was used in the selection of respondents. The sample methods used were convenient and simple random sampling in the communities and purposive sampling for the health professionals. Questionnaire and interviews were the main methods for data collection. Epi info was used to analyze the results.

The study identified lack of knowledge on what constitute pregnancy complication as one of the causes of delayed reporting to the hospital. Most respondent (50.0%) did not know what is termed as the danger signs of pregnancy, thereby making it difficult for them to report early to the hospital.

The study revealed that the mean distance from the health facility and place of residence was 5.2km.And most of the respondents used public transport as a means of transport to

the hospital which delays their arrival to the hospital. They spent an average of 16.14 minutes in traveling to the hospital.

The cost (70,000-150,000) of receiving treatment during pregnancy was high compared with the monthly income of the respondents.

The study showed that the respondents were very much satisfied with the conduct of the staff in the hospital.

From the findings of this study it was concluded that certain factors such as

high illiteracy rate among pregnant women, high parity, delayed referral from peripheral clinics, unsafe abortion, poverty, gender discrimination and high cost of seeking health care were some of the reasons why most pregnant women reported late to the hospital.

Recommendation was therefore made to the effect that health education given to pregnant women at ANC should be intensified.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Childbirth is generally characterized by joy and merrymaking for many Ghanaians but for some families this sometimes turns out to be a period of pain and misery. Many women have lost their lives, sometimes together with their babies, due to pregnancy and childbirth complications.

The complications arising during pregnancy and childbearing cause death of half a million women every year. Over four million unborn babies also die each year as a result of pregnancy related complications and million more women suffer debilitating and life-long consequence of ill health. (WHO, 1995)

It is estimated that about ninety-nine percent of all deaths due to pregnancy related complications occurs in developing countries. Studies have found out that the lifetime risk of women dying from pregnancy and childbirth causes can be as high as 1 in 20 in developing countries to 1 in 10,000 in developed countries. (WHO, 2000)

The safe motherhood initiative program was launched in Nairobi, Kenya in 1987 at the First International Conference to focus specifically on the health of women. Since then there has been a dramatic increase in attention to the problem of maternal mortality, including research and programs by developing country governments, international agencies, and non-governmental organizations.

Out of the safe motherhood initiative concept the prevention of maternal mortality (PMM) program was born to specifically address the issue of maternal deaths.

However, the maternal death rate in Ghana ranges between 214 and 714 per 100,000 live births with disparities in the 10 regions of the country.

The figure may be higher, given that these were the reported cases.

This situation is most unfortunate because maternal deaths can be prevented.

It is noteworthy however that reduction in maternal mortality has been one of the major goals of several recent international and local conferences and has been included in the Millenium Development Goals.

Despite the fact that the country is implementing the Safe Motherhood Programme — a global initiative aimed at making childbirth safe for women — maternal mortality continues to be quite high due to the delayed arrival of women with pregnancy complications to healthcare facilities.

The prevention of maternal mortality Network (PMM) had identified three forms of delay.

- Delay in seeking medical care which is influenced by factors like socio-cultural, accessibility and perception or previous experiences about the health facility (ies).
- Delay in reaching the health facility after decision is made due to lack of communication and transportation.
- Delay in receiving appropriate care at the health facility due to staff insensitivity, lack of appropriate resources or poor organizational setups that is not conducive for emergency care.

Some of the contributing factors are socio-economic, inadequate knowledge on pregnancy related complications, lack of funds, lack of transport, poor road, poor staff attitudes to patient and their relations. This study therefore seeks to establish the underlying factors that prevent mothers from seeking health care in the Sekyere West District.

1.2 PROBLEM STATEMENT

Women of Sub-Saharan Africa face the highest risk of maternal mortality and morbidity of any region in the world. At least 150,000 African women will die of pregnancy-related complications every year in Africa, and the number of maternal deaths continues to rise each year in many countries. The population of women of childbearing age is now larger than it was five years back, and the number of women who die each year from pregnancy-related causes has increased even though there may have been a slight decline in the risks of pregnancy.

Some of this mortality is caused by avoidable factors such as staff shortages, staff errors, transport difficulties, bad attitude of health staff and other socio-economic factors.
In Sekyere West district, failure on the part of pregnant women to report pregnancy related complication early to the hospital was identified as a major cause of maternal death.

This late reporting might result from a combination of factor such as poor roads, lack of decision making power, lack of finance, and lack of knowledge on what constitute PRC.

bad attitude of health workers and the distance between where the women are residing and where the hospital is located. Even though these factors have been identified as the main cause of the delay, no evidence exist to prove which of these factors affect pregnant women in the Sekyere West.

The study therefore seeks to find out what major obstacles are faced by pregnant women in their bid to seek healthcare in the Sekyere west district and suggest possible means of addressing these problems.

1.3 JUSTIFICATION

The district has a maternal mortality rate of 159 per 100,000 live births, which is high compared to that of developed countries (District profile, Sekyere West 2003). If factors contributing to the delayed arrival of women with pregnancy related complications are identified and properly managed this will lead to reduction of maternal mortality in the district.

The Ministry of Health has the objective of reducing maternal mortality ratio from 214 to 100 per 100,000 live births by the year 2005.

World Health Organization (WHO) in collaboration with government of developing countries and other agencies are encouraging research and studies to embark on epidemiological research with the aim of reducing high incidence of maternal mortality and morbidity.

Most deaths related to pregnancy and childbirths in the Sekyere West District occurred as a result of late reporting to the healthcare facility.

The study seeks to identify the factors that lead to the delay and suggest possible solutions to address such problem.

1.4 RESEARCH QUESTIONS

The study intended to find answers to the following questions…

- What do women know about PRC?
- How much does it cost to treat PRC?
- How does a woman with PRC get to the hospital?
- How long does it take women with PRC to arrive at the hospital?
- What is the attitude of health personnel towards women with PRC?

1.5 OBJECTIVE

1.5.1 MAIN OBJECTIVE OF THE STUDY

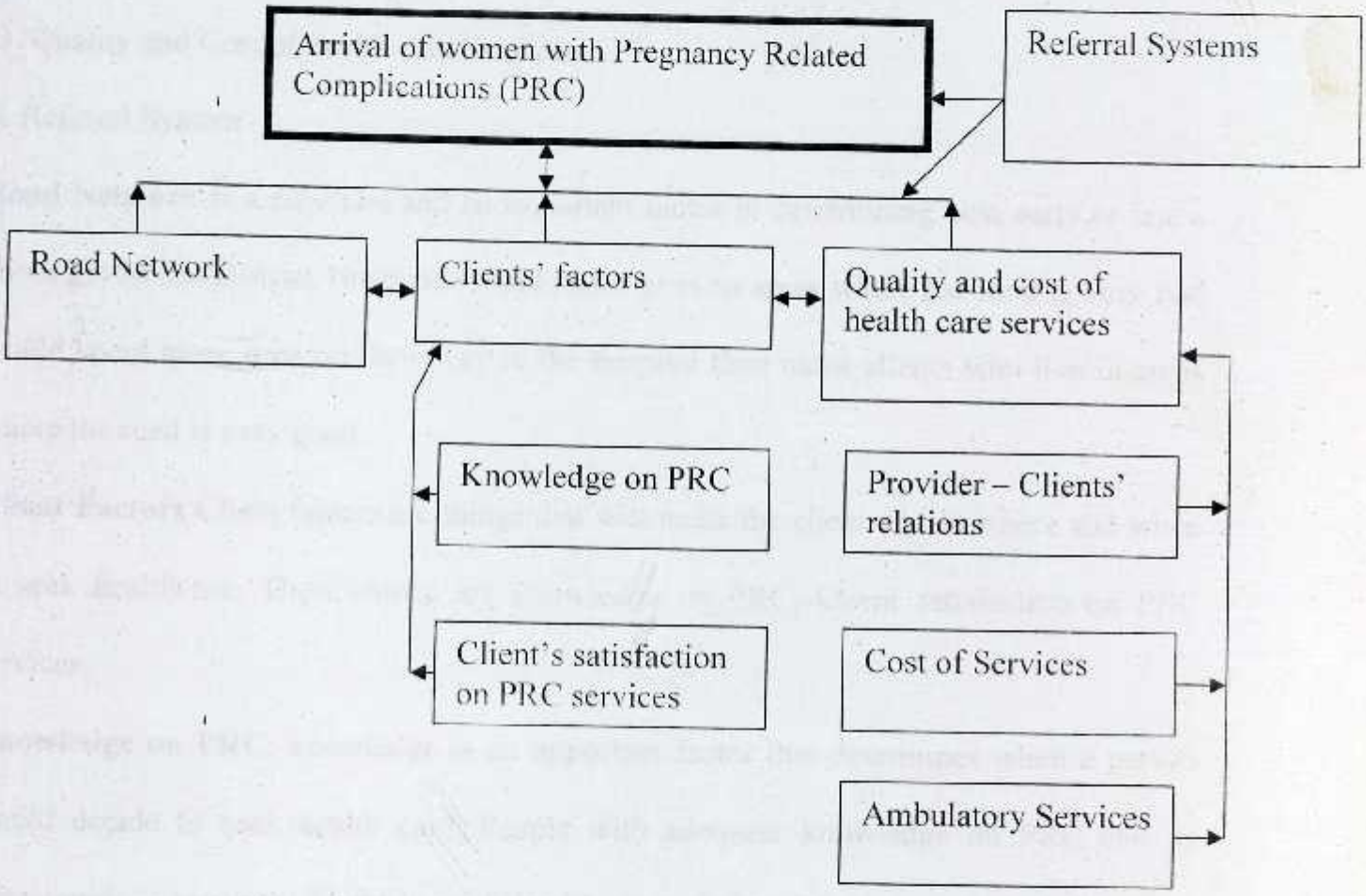
The main objective of the study was to determine factors which contribute significantly to the delayed arrival of women with pregnancy related complications to health care facilities in the district and give recommendations on the appropriate strategies to help improve the situation.

1.5.2 SPECIFIC OBJECTIVES

1. To determine the knowledge, attitude and perceptions related to complications of pregnancy and childbirth.
2. To determine the distance between places of residence and nearest health care facility and waiting time for transport.
3. To determine the cost of health care service and the quality of care provided at the health facilities.
4. To identify the attitude of staff towards pregnant women with pregnancy related complication.
5. To make recommendations to Government, Ministry of health, donor agencies, and other non-governmental organization towards reducing maternal death through early reporting of complications.

1.7 CONCEPTUAL FRAMEWORK

Fig 1: Conceptual framework showing the factors influencing arrival of women with pregnancy related complications



Source: Authors construct, 2004

There are Four (4) major interrelated factors that combine to give rise to late arrival of women with PRC.In order to solve the late arrival these factors need to be carefully studied. These factors are;

1. Road Network
2. Client factors
3. Quality and Cost of health care Services
4. Referral System

Road Network is a powerful and an important factor in determining how early or late a client get to the District Hospital. Clients who lives in areas where the road is very bad would spent more time on their way to the hospital than those clients who live in areas where the road is very good.

Client Factors Client factors are things that will make the client decide where and when to seek healthcare. These things are knowledge on PRC. Client satisfaction on PRC services.

Knowledge on PRC; knowledge is an important factor that determines when a person would decide to seek health care. People with adequate knowledge on PRC and its consequences are more likely to seek health care earlier than those who have little or know knowledge on the effect of PRC on their life.

Satisfaction with PRC services; Services that are being offered to pregnant women with complications at the hospital also help clients to make a choice on where to seek help in

an event of complications.Availability of personnel,good reception,effective treatment and facilities at the hospital are important factors that client consider before reporting to the facilities. Client are more likely to go to places where facilities are modern, reception is good. gets effective treatment and have good reception.

Client provider relation; also help client to report early to hospital. It is believed that women who visit TBA do so because of the inhuman treatment at hour health care institutions. Thus an improve human relation would encourage more women with complication to report early to the hospital

Cost of health care; Cost of health care service has been a major obstacle that prevents women from seeking assistance from our health institutions. Client may go to TBA or use herds to treat pregnancy related complications because of high cost of treatment at our health care institutions. There is therefore the need to make obstetrics services free of charge.

Ambulatory services; standby vehicle that would transport patients in emergency conditions also help to reduce the hour that patients spent on their way to the hospital. If there are ambulances in each health center, it would make traveling easier for those in critical condition.

Referral System; Improved referral system will facilitate early treatment at the hospital. Districts that are network with a two-way communication system would help the staff to prepare adequately to receive and give early treatment to their clients.

1.8 PROFILE OF STUDY AREA

1.9 LOCATION

Sekyere West District is one of the 18 districts of Ashanti Region, which has Mampong as its district capital. The district capital is about 57km from the regional capital, Kumasi. It is bounded on the south by Afigya Sekyere, the north by Brong Ahafo region, the East by Sekyere East and the North West by Ejura Sekyedumasi Districts.

The district forms 5.2% of total land area of the Ashanti Region.

The major towns in the southern semi-urban portion of the district are Mampong, Krobo, Dadiase, Asaam, Kofiase, Nsuta, Beposo and Kwamang. The Northern part of the district has Birem, Asubuasu and Oku as the major towns. Access is generally difficult during the wet season to the Northern part, which is in the Afram Plains.

1.10 TOPOGRAPHY

The Northern part of the District is generally low lying with few scattered hills. There is a scarp, which runs westwards from the south. Access to the district capital from regional capital is via the scarp.

1.11 ECONOMIC ACTIVITY.

The district is predominantly an agricultural one with about 51% of the people engaged in subsistence farming. Agriculture is mainly rain fed since there are no irrigation facilities. Petty Trading is the other main economic activity.

Some of the major market days in the district include Wednesdays in Mampong, Thursdays in Nsuta, Fridays in Kofiase, and Tuesday in Jeduako.

The Queen of Mampong market still wields a lot of power and does not allow people from other parts of the region and the country to sell their foodstuffs directly in the market. This makes the cost of foodstuffs quite high in the district capital. This has negative implications for availability of food in households, which in turn can negatively influence the nutritional status of community members.

For ease of administration, the district has been divided into seven sub-districts namely:

- Mampong
- Nsuta
- Kofiase
- Kwamang
- Birem
- Asubuasu
- Oku

TABLE 1.1 PATTERN OF POPULATION GROWTH: 2001-2004

	2001	2002	2003	PROJECTED 2004
District Population	137,603	153,110	158,315	163,698
0-11Months	5,504	4287	4,433	4,584
Under 5		23,425	24,143	24,964
WIFA	13,624	35,522	36,729	37,978

(Source; Sekyere West DHMT Annual Report. 2004)

Mampong the district capital forms the largest portion of 37.4% of the total population. This is followed by Nsuta with difference of about18%. Activities would need to be intensified especially in area of family planning coverage in these large subdistricts..

TABLE 1.2 SUBDISTRICT CHARACTERISTICS

NO.	SUBDISTRICT	OUTREACH POINTS	NO. OF COMM.	CBS	NO.OF TBAs	
					Trained	*Untrained*
1	Mampong	22	44	24	16	44
2	Nsuta	17	31	34	17	-
3	Kwamang	21	39	24	12	-
4	Birem	11	20	14	11	-
5	Oku	12	18	9	17	-
6	Asubuasu	25	35	22	26	5
7	Kofiase	15	20	14	16	11
TOTAL		123	207	141	117	55

(Source; Sekyere West DHMT Annual Report, 2004)

Asubuasu Subdistrict is a hard to reach area which had the highest number of outreach points as compared to Mampong subdistrict with the larger population. The scattered settlements in Asubuasu needed more outreach points to increase accessibility to healthcare to these communities.

The total number of untrained TBAs formed a third of the total number of TBAs. Training of the untrained ones was ongoing.

TABLE 1.3 DISTRIBUTION OF HEALTH FACILITIES

SUB-DISTRICT	HOSPITAL	H/CENTER	CLINICS	
			GHS	PRIVATE/MISSION
Mampong	1	1	1	5
Nsuta	-	2	0	1
Kwamang	-	2	1	0
Birem	-	1	0	0
Oku	-	-	0	1
Asubuasu	-	1	0	1
Kofiase	-	4	0	0
Total	1	11	2	8

(Source; Sekyere West DHMT Annual Report. 2004)

A health center was reopened in the course of the year in the Mampong sub-district to improve geographical accessibility to health care.

TABLE 1.4 DISTRIBUTIONS OF KEY HEALTH STAFF

SUBDIST.	DOCTORS	PHARM	MEDICAL ASSISTANTS	NURSES/ MIDWIVES	CHN	PHN	TECH OFF/FT
Mampong	0	0	0	1	2	1	0
Nsuta	0	0	1	3	1	1	1****
Kwamang	0	0	1	2	2	0	0
Asubuasu	0	0	0	1*	1	0	0
Birem	0	0	0	0	1	0	1
Oku	0	0	1**	1**	0	0	1
Kofiase	0	0	3	2	0	0	0
DHA	1	0	0	0	0	1	3
Hospital	6	1	2	48	0	0	7****
Total	7	1	8	58	6	3	12

(Source; Sekyere West DHMT Annual Report, 2004)

**Staff in Missions Institution *Staff serves as CHN and Midwife

***Staff serves as Medical Assistant and midwife ****Dispensing technicians

Inadequate staff strength especially midwives and CHN impaired geographical accessibility to health care.

1.10 PROPORTION OF STAFF TO CLIENTS

Patient to Doctor Ratio was 12,000:1

Population to Doctor Ratio was 22,616:1

Patient to Nurse Ratio was 1,448:1

Population to Nurse ratio was 2,729:1

TABLE1.5 TOP TEN CAUSES OF MORBIDITY 2001-2003

2001

	DISEASE	%
1	Malaria	38.2
2	Preg.& Related Disorders	16.9
3	Gynaecological Services	8.3
4	Acute Eye Infection	3.9
5	Dental Carries	3.6
6	Diarrhoea	2.6
7	RTA	2.1
8	Home/Occup. Accidents	1.9
9	Hypertension	1.8
10	Skin Disease	1.7

2002

	DISEASE	%
1	Malaria	31.1
2	Preg.& Related Disorders	17.6
3	Gynaecological Disorder	8.7
4	Acute Eye Infection	6
5	Other URI	3.9
6	Dental Caries	3.8
7	Malaria in Pregnancy	3
8	Diarrhoea	2.4
9	RTA	1.6
10	Skin Disease	0.4

2003

	DISEASE	%
1	Malaria	21.4
2	Preg.& Related Disorders	12.5
3	Gynaecological Disorders	6.8
4	Acute Eye Infection	4.7
5	Dental Carries	3.2
6	Diarrhoea	2.1
7	Pneumonia	1.6
8	Anaemia	1.4
9	RTA	1.1
10	Intestinal Worms	

(Source: Sekyere West DHMT Annual Report, 2004)

Malaria continues to be the highest cause of morbidity in the three-year pattern. Education on use of insecticide treated bed-nets and reduction of breeding sites for mosquitoes was ongoing.

TABLE 1.6 TOP TEN CAUSES OF ADMISSIONS 2001-2003

2001

	DISEASE	%
1	Malaria	30.4
2	Preg. & Related Disorders	22.4
3	Gynaecological Disorders	14.4
4	Typhoid Fever	8.1
5	Pneumonia	4.6
6	RTA	4.4
7	Anaemia	4.1
8	Hypertension	1.8
9	Diarrhoea	1.6
10	Hepatitis	0.9

2002

	DISEASE	%
1	Malaria	24
2	Preg.& Related Disorders	23.1
3	Gynaecological Disorder	13.7
4	Pneumonia	5.3
5	RTA	3.5
6	Typhoid Fever	3.2
7	Anaemia	2.8
8	Hypertension	2.2
9	Diarrhoea	1.7
10	Hepatitis	1.4

2003

	DISEASE	%
1	Pregnancy & Related Disorders	33.4
2	Gynaecological Disorders	14.6
3	Malaria	13.7
4	Anaemia	5.1
5	Pneumonia	4.5
6	Typhoid Fever	4.4
7	RTA	2.5
8	Hypertension	2.4
9	Diarrhoea	2.2
10	Hepatitis	1.5

(Source Sekyere West DHMT Annual Report ,2004)

Pregnancy related diseases continue to be on the increase. The maternal deaths also continue to rise though care at the facility is rising. Regular in-service training sessions for staff need to be intensified.

Admissions due to malaria reduced and formed only 13.7% of the total admissions in 2003. Home management of fevers could further reduce complicated forms of malaria, which were admitted.

Road traffic accident, being on the top ten causes of admissions requires emergency preparedness plan which was put in place at the district hospital

TABLE 1.7 TOP TEN CAUSES OF DEATH 2001-2003

2001

	DISEASE	%
1	Malaria	19.5
2	Anaemia	14.8
3	Pneumonia	13.2
4	Typhoid Fever	8.2
5	Septicaemia	5.4
6	Hepatitis	4,6
7	C.V.A	2.7
8	Hypertension	1.5
9	HIV/AIDS	1.1
10	T.B	1.1

2002

	DISEASE	%
1	Malaria	10
2	Anaemia	8.7
3	Pneumonia	8
4	Septicaemia	5.9
5	C.V.A	5.2
6	Typhoid Fever	4.9
7	Cancer of Liver	4.2
8	Diabetes mellitus	2.8
9	Hypertension	1.7
10	HIV/AIDS	1.4

2003

	DISEASE	%
1	CVA	13
2	Malaria	10
3	Anaemia	8.3
4	Pneumonia	6.9
5	Cardiac Disease	5.5
6	Septicaemia	5.1
7	Typhoid fever	4
8	Liver Cirrhosis	4
9	Viral hepatitis	3.6
10	Diarrhoeal diseases	3.2

(Source; Sekyere West DHMT Annual Report, 2004)

The highest cause of mortality was cerebrovascular accidents which formed 13% of the total deaths. Seventy-five percent (75%) of the deaths due to stroke were above the age of 60years.An intensive health education on proper eating habits and lifestyles such as reducing high cholesterol food intake, alcohol consumption, smoking as well as undertaking regular exercises were essential to help reduce the incidence. Health

providers also needed improvement managing hypertension, diabetes mellitus and cerebrovascular accidents.

Anaemia ranks third on the cause of morbidity and a critical look at the need to provide logistics to keep blood bank running is essential.

TABLE 1.8 SURGICAL OPERATIONS

	CONDITION	TOTAL CASES
MAJOR	Emergency Caesarian section	325
	Hysterectomy(c/s=btl)	84
	Hysterectomy(fibroid)	23
	Hysterectomy(PPH)	20
	Repair VVF(vaginal)	2
	Laparatomy	30
	Right Sapingectomy	11
	Elective C/S	22
	Myomectomy	4
	Others	11
	Total	557
MINOR	EOU for abortions	248
	Hydrotubation	44
	Manual removal of placenta	42
	EOU for criminal abortions	25
	EOU for sepsis POD	20
	EOU for PPH	19

(Source: Sekyere West DHMT Annual Report, 2004)

The high number of unplanned pregnancies led to many evacuation of uterus. This had serious implications on the rate of increasing sexually transmitted diseases including HIV infection. Management for infertility also was high and this reflected on the effect of the unwanted pregnancies and as many as 25 patients reported with criminal abortions.

Effort to encourage the use of family planning methods as well as education could curb the situation

1. 12 REPRODUCTIVE AND CHILD HEALTH

Table 1.9ANTENATAL CARE COVERAGE 2003

Indicators	**District Total achieved**	**Percentage Coverage**
Antenatal Registrants	6852	154.5
ANC Attendance	19,777	
Average Number of Visits	2.8	43.5
TT2 Coverage	3673	82.8
Teenage Pregnancy	914	13.3
Supervised Deliveries		
Midwives	3253	64.1
Traditional Birth Attendants	1819	35.9
Total	5072	100

(Source; DHMT Annual Report, 2004)

Teenage pregnancy formed 13.3 % of total deliveries. Mampong and Nsuta towns showed very high cases of teenage pregnancies. Intensified health education on Sexually transmitted diseases especially HIV/AIDS was ongoing. Special teenage antenatal clinics would be held to address their peculiar health needs and also to counsel them.

Table1.10 POST-NATAL CARE

Indicators	District Total	Remarks
Number Still Birth Deliveries	141	2.7% of deliveries stillbirth
Babies weighing Below 2.5kg	277	5.5% of deliveries below weight
Maternal Death	8	MMR-157 per100,000 live births
Infant Mortality	15	IMR – 8.5 per1000 live births
Under five Mortality	39	UFMR- 7.7 per1000 live births
Post-Natal Registrants	5066	114.2% coverage
Family Planning Acceptors	3886	10.6 %
Couple Year Protection	2814.1	

(Source; Sekyere West DHMT Annual Report, 2004)

TABLE 1.11 REPRODUCTIVE AND CHILD WELFARE 2001-2003

INDICATOR		2001		2002		2003	
		No.	%	No.	%	No.	%
CWC	0-11	8256	150.0	7649	178.4	10,925	103
	12-23			1867	31.3	1444	10.6
ANC		7151	129.9	6733	157	6852	154.5
SUPERVISED DELIVERIES		4138	75.0	4360	101.7	5072	100
PNC		4242	77.0	4196	97.9	5066	114.2
FAMILY PLANNING		4572	16.6	5806	16.3	3886	10.6 %
TT2				4435	12.2	3714	83.7
SCHOOL HEALTH		16816	125.0	3725	26.2	12320	56.1
MAT. DEATHS.		9	*244.5	5	114.6	8	157/100,000
TEENAGE PREGNANCY		787	11.0	795	11.8	914	13.3

(Source; Sekyere West DHMT Annual Report, 2004)

TABLE 1.12 FAMILY PLANNING METHODS UTILIZATION

COMMODITY	NO DISPENSED	C.Y.P.
LO-FEM	2432	187.0
OVRETTE	298	22.9
CONDOM	26788	267.8
FEMIDOM	233	2.3
CU'T	35	14
M-G	700	53.8
MICR-N	24	1.8
CONCEPTRO	520	5.2
DEPO	3853	963.2
MINI/LAP	60	4.8
NORIGYNON	684	57
NORPLANT	91	26

(Source; Sekyere West DHMT Annual Report, 2004)

The family planning method utilization for condom was found to be the highest, followed by the use of injectables.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The World Health Organization (WHO) defines maternal death as "the death of a woman while pregnant, or within 42 days of the completion of the pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by pregnancy or its management".

Maternal mortality rate measures the risk of women dying from complication related to pregnancy, labour and puerperium per 100,000 live births. This usually is measured in an area and during a giving period.

2.2 Overview

Worldwide statistics show that 585,000 women die annually from pregnancy and child birth.99% of these deaths occur in developing countries, in Africa, south of the Sahara. In Europe and America about 20 women die out of 100,000 live births. This is against the statistic in developing countries where it is recorded at 300 per100, 000 live births. (WHO 1995)

Statistics on maternal mortality worldwide shows that those who are least able to afford proper care have the worst obstetric outcomes.

Statistics from Europe North America and Australia show that maternal mortality rate in recent years have been brought down to 5-10 per 100,000 live births (Maine1995). World Health Organization (WHO) estimated that at least half a million women die each year, around, the world as a result of pregnancy, labour and puerperal problem. According to these estimations over 60% of maternal deaths occurs in Asia especially in south East Asia, 30% in Africa and 7% in Latin America. Only 6000 of such deaths were recorded in developed countries. (WHO, 1995)

Abouzahr (1997) reported that there are some 585,000 maternal deaths, 99% of them in developing countries. This is around 80,000 deaths more than earlier estimates have suggested. One woman in 50 is still dying as a result of pregnancy related complications and the figure rises to 1 in 10 in many parts of Africa.

By contrast, the figure for developed countries can be as low as 1 in 8,000.

Agbogboba (1997) enumerated that the major causes of death were abortion, eclampsia, and puerperal sepsis. Majority of the patients were unbooked and they presented late to the hospital, they either received no antenatal care or their care were sub standard, being provided by poorly trained medical staff and sometimes by untrained persons including spiritual healers, native doctors, medical auxiliaries and traditional birth attendants.

2.3 CAUSES OF MATERNAL MORTALITY

Almost all deaths from pregnancy and childbirth are related to such factors as; Hypertension disease in pregnancy, Eclampsia, Obstructed labour, Hemorrhage, Sepsis due to unskilled TBAs, Heart disease in pregnancy and Sickle cell disease in pregnancy. UNICEF and WHO estimates, based on a new approach to data collection, show that in 1990, 585 000 women died from causes related to pregnancy and childbirth. This is in excess of one death per minute. Over 140 000 died from hemorrhage; about 75 000 died from attempting to abort themselves; another 75 000 died from the brain and kidney damage of eclampsia; 100 000 died of sepsis; and about 40 000 died from obstructed labour. Eighty-seven per cent of births occur in developing nations, and these births account for 99% of maternal deaths (UNICEF, 1998)

For every woman who dies from a pregnancy-related condition, about 30 more (i.e., over 15 million women per year) sustain a severe and permanent injury, such as chronic pelvic inflammatory disease, vaginal, rectal and perinea tearing leading to urinary and faecal incontinence, or Sheehan's syndrome (excessive blood loss causing pituitary gland necrosis and thus ovarian, adrenal and thyroid insufficiency).

WHO (1995) reported that that the causes of maternal deaths are essentially the same around the world. It is estimated that 25%women die due to haemorrhage, 15% due to sepsis, and 12% due to hypertensive disorders of pregnancy, 8% due to obstructed labor and almost 13% due to abortion. Around 20% of women die as a results of a disease, which is aggravated by pregnancy, such as malaria, iron deficiency anaemia, hepatitis, tuberculosis and heart diseases.

2.4 A. KNOWLEDGE, ATTITUDE & PRACTICES

A study conducted in Pakistan in 2003 by Pakistan National Commission for Human Development (NCHD) reveals that most pregnant woman who has had intermittent breeding (fortnightly) for some years normally visit the chemist for treatment. The study also indicated that 70% of birth took place at home, without any antenatal care. The percentage of birth with no antenatal care increase with birth order of the mother was higher for those >35 years of age. None of the patients studied availed any antenatal care. The causes of lack of antenatal care are multifactoral including lowest gender ratios, illiteracy, teenage marriage, frequent pregnancies and poor access to health facilities.

Another study at Kalomo in Zambia found that very few pregnant women were able to recognize obstetric complications and many traditional beliefs and practices delayed patient's decision to seek healthcare. (ZDHS, 1988)

A research conducted at Navrongo in Ghana revealed that traditional medicine is the first source of care sought by most people and hospital is frequently seen as the last resort. Consequently delays in seeking health care at fixed health facilities are compounded by

the lack of affordability, immediate transport and then the delay at the health facilities themselves. (GDHS, 1998)

The 1988 Ghana Demographic Health Survey found that 87% of all pregnant women received antenatal care at least once. Despite the relatively high antenatal coverage, only 44.3% of the pregnant women had delivered with a nurse, midwife or a doctor in attendance.

Institutional delivery rate varied greatly by district. Studies have established institutional delivery ranges from about 20% in Bolgatanga to over 75% in Kumasi.

In kassena-Nankana, 70% of women attended antenatal care clinic but only 21% delivered in a health institution. Various studies have identified a range of social, cultural and economic factors as contributing to high maternal deaths. Specifically, lack of knowledge on pregnancy and childbirth as well as prevalence of traditional beliefs and practices.(GJA,15 January 2004)

A study conducted in Mozambique by the US Agency for International Aid, the UN Population Fund and UNICEF, showed that about 72 percent of women aged 24 years or below gave birth at home compared to the national average of 45 percent. According to UNFPA, only 71 percent of pregnant women in Sudan receive antenatal care, 57 percent of deliveries are attended by skilled providers and only 13 percent receive postpartum care during the first six weeks following delivery. (MDHS, 2001)

The 2003 Ghana demographic and health survey (GDHS, 2003) indicates that a relatively high percentage of women received antenatal care from a trained health professional, that

is a doctor, nurse, midwife or auxiliary midwife. Only 1 % mothers receive antenatal care from traditional birth attendants (TBA) and 6% received no antenatal care.

It also revealed that older women are less likely to receive antenatal care from a trained health professional than younger women. Women are also less likely to obtain care from a trained health professional for births of order six or higher.

It also established a strong association between women's education and receipt of antenatal care from a health professional. As a woman's education increases, the likelihood that she will receive antenatal care from a health professional increases from 86 percent among women with no education to 100 percent among women with at least some secondary education. More than half (54 %) of women with secondary and higher education saw a doctor for antenatal care compared with 11% of women with no education.

It also revealed that most women (69%) have made at least four ANC visits for their most recent births. Three in five women (61%) are informed about the signs of complications during pregnancy. The 2003 GDHS also revealed that first births are more likely to be delivered by a medically trained provider than those of second or higher order. (GDHS 2003)

2.5. The Distances between places of residents and nearest healthcare facility.

Distance separating clients from the nearest health facility has been shown to be an important barrier particularly in rural areas. Distance can act as an actual obstacle to reaching the health facility. These can influence one's decision to seek care or the length of time the person takes to reach the nearest healthcare facility.

Fawcus (1996) reported that many of the cases of maternal deaths arrived in hospital after many hours and sometimes days of commencement of labour with excessive blood loss. ruptured uterus overwhelming sepsis and eclamptic fit.34% of the deaths occurred in emergency unit from irreversible disease process and 78% of all deaths occurred within 24 hours of admission. The prevailing economic hardship, high hospital charges, poor quality services, transportation problems, illiteracy, ignorance and bad cultural practices are some of the factors that affect the utilization of maternal services.

Studies show that many women have limited access to skilled professionals for maternal care. For example, the 2001/2002 ZDHS shows that only 43 percent of mothers deliver with the assistance of skilled professionals, compared with 48 percent in 1996. In a report on research priorities and recommendations for action for 1999-2001, the Central Board of Health of Zambia noted a tendency among women to deliver at home as they got older. The report suggested that long distances to health centers might be a major reason for this. Others have also reported the trend.

One study in Katete district in the Eastern Province of Zambia said that as women grow older and have more children, long distances and the cost of care may become bigger concerns:(ZDHS 2001) "There seems to be a tendency among women as they grow older

and with high parity to deliver at home without any assistance, maybe because of the long distance and the costs associated with a hospital delivery".

People living in provinces and large towns along the railway line have better access to health centers. In urban areas, 99.0 % of households are within 5 kilometers of a health facility, compared with only 50.0% of households in rural areas, according to the ZDHS 2001. (ZDHS, 2001)

Midwife Naphira Sichale agrees that distance and the cost of care are major issues. "People just do not have the money to pay the user fees or transportation costs, and it is usually too far to walk to the health center," she says, noting that women prefer to be delivered by their friends and relatives who charge nothing or by traditional healers who charge in kind.

Indeed, surveys show that the vast majority of women who die from obstetric causes in Zambia are in the middle- to poor-income groups. Only 3% of maternal deaths occur among women in high-income categories, according to the ZDHS 2001/2002.

2.6 The cost of healthcare services, and quality of healthcare

The cost of receiving care, which includes transportation cost, physician and facility fee and the cost of medication and other supplies, may also act as a barrier to the utilization of obstetric care. In many parts of the world prospective patients, especially women, do not travel alone to a health facility. They may be accompanied by other adults, and by their children. These additional people swell the cost of transport.

A woman's risk of dying during or soon after pregnancy increases the poorer she is, according to a study published in the Jan. 3 issue of the Lancet, Reuters Health reports (Reuters Health, 1/2).

Dr. Wendy Graham and colleagues from the University of Aberdeen in the United Kingdom examined data from 11 household surveys in 10 diverse developing countries to formulate percentage distributions of women according to their poverty-related characteristics and survival status. The researchers used a new method called the "familial technique" to analyze the responses. The analysis showed significant association in the countries between women's poverty status and maternal survival. As poverty increased, the percentage of women dying from non-maternal causes increased generally and women dying from maternal causes increased consistently. In Indonesia one of the countries studied, about one-third of all maternal deaths occurred among women in the poorest fifth of the population, and the risk of maternal death was three to four times greater among women in the poorest group, compared with women in the richest group (Graham et al., Lancet, 1/3). "Our findings have shown the magnitude

of the poor-rich gap in maternal mortality through a new method, and should be a stimulus to setting and monitoring poverty-relevant development goals," the researchers said, according to Reuters Health.

Adrienne Germain of the International Women's Health Coalition said that the international community needs to recognize women's reproductive and health rights and needs to establish gender equality to reduce maternal mortality, according to Reuters Health (Reuters Health, 1/2).

John snow international, UK (JSIUK) concluded that it is generally clear that poor women are more likely to die of maternity related conditions. However improving economic status alone will not bring down maternal mortality rates. Health systems providing good quality care as well as the availability of skilled outreach workers are also required. In low-income countries, poverty is a key problem when accessing patchy services, and is thus a major determinant of maternal ill-health.

2.7 Staff attitude towards pregnant women with pregnancy related complications.

It is true that most women prefer to use the services of traditional birth attendants and healers because of the rude, unsympathetic and uncaring attitude of health workers.

A study of 718 maternal deaths in Egypt found that 92% of them could have been avoided if good quality care had been provided.

- Improving the quality of existing maternal health services is the quickest, most cost-effective way to save women's lives. Good quality care aims at providing: Services should be provided in health facilities that are as close as possible to where women live and that can provide the services safely and effectively;
- Services should be sensitive to cultural and social norms, such as preferences for privacy, confidentiality and care by female health workers;
- Staff should be respectful, non-judgmental and responsive to clients;

According to the 1998 UNFPA supported study in Zambia it was found that many pregnant women fail to visit the health facility because of bad attitude of health care workers. Some say the nurses shout at mothers for not buying things like razor blade, baby cloth, and gloves. They also said that the presence of male nurses discourage them from seeking healthcare from the hospital.

According to them it is uncomfortable to have a man examine them. It is also culturally taboo for a man who is not your husband to see anything above the knee

The study also indicated that adherence to some tribal custom also increased the chances that a woman with complication will visit the health facility late. Among these customs, women drink herbs that they think will help them deliver quickly. Poor quality care

provided at health facilities, the lack of transport in emergency cases and long distances to health facilities have been identified as major factors contributing to the high maternal mortality in the Kassena Nankana District. The negative attitude of some health workers also keeps some pregnant women away from seeking medical help during delivery, research findings on: "The Prevention of Deaths During Child Birth" in the Kassena Nankana District, have shown.(Bolgatanga, Jan. 15, GNA)

According to the Djibouti government, maternal health can significantly be improved through better services in hospitals and increased numbers of trained birth attendants and midwives, Safia Elmi (Djiboutian national coordinator for reproductive health) said more women had died giving birth at home rather than in hospitals. Many of those who died in the hospitals, she added, had suffered haemorrhaging. (OCHA IRIN.htm. 1991)

In Africa, over 60 percent of women deliver with a family member, a traditional birth attendant, or even by themselves. (WHO, 1995)

In Rwanda, only 18% of all deliveries are attended by trained personnel. Although traditional birth attendants (TBAs) still have an important role during childbirth in Africa, studies to evaluate their contribution to reducing maternal morbidity and mortality have shown variable results: in Benin and Eastern Nigeria, trained traditional birth attendants with back-up support from health personnel have contributed to a reduction in maternal mortality, while in the Gambia trained traditional birth attendants without skilled back-up support did not decrease maternal mortality (Greenwood, 1991).

Burkina Faso: Maternal mortality remains high in Burkina Faso with maternal mortality rates ranging from 350 to 650 per 100,000 live births. Less than 23 percent of the

deliveries take place in a health facility and less than 30 percent of deliveries are assisted by a trained attendant (Greenwood, 1991).

According to Josephine Ouedrago (Senior Midwife) even those women who recognize the need to go to a health facility for antenatal care are often treated rudely and forced to wait for long periods of time before they are seen. Often women wait only to be told that there is no blood or drugs are lacking.

In Mali there is an insufficient supply of health manpower and existing staff are not adequately prepared to provide obstetric services. There is an oversupply of providers in Bamako and an acute shortage of primary health care providers at the periphery.

Health services are not fully utilized because of the poor quality of health care. Faced with long waits, staff who are not responsive to clients needs and a shortage of drugs, Malians are forced to use more expensive private clinics, where they exist, or traditional healers for care.

Studies in Senegal estimate the maternal mortality rate to be 933 deaths per 100,000 live births. Most births in Senegal take place at home and, as a result, it is estimated that three out of four maternal deaths are not registered.

Many women die on their way to a health facility or, once they reach the facility, obstetric care may be delayed due to the absence of qualified medical personnel or the lack of drugs and supplies. Because of these problems, Mrs. Therese King, former Minister of Health of Senegal, told the Group that the Government of Senegal has chosen a proactive strategy, which mobilizes both human and financial resources to reduce the levels of maternal mortality in the country. (Save Motherhood in Francophone Africa)

CHAPTER THREE

3.0 METHODOLOGY

3.1 STUDY DESIGN

A descriptive study type with a cross-sectional design was employed in this survey. Qualitative and quantitative methods were employed to identify, classify and describe relationships between variables. The study took place over a period of three months, July 26 - October 16, 2004

3.2 STUDY VARIABLES

The dependent variable is the delayed arrival of women with pregnancy related complications to the healthcare facilities.

The independent variable includes the socio-economic status of the women, cultural practices, poor road network, poor referral system, the distance between places of residence and the nearest healthcare facility and lack of transport.

Table 3.1 Study Variables

VARIABLES	OPERATIONAL DEFINITION/ INDICATOR	SCALE OF MEASUREMENT
Level of knowledge	Response to questions in the questionnaire.	Ordinal
Cost of healthcare services	Money to be paid in cedis for accessing healthcare.	Ratio
Cultural practices	Response to questions	Nominal
Roads	Quality of roads used in the district.	Ordinal First class roads Second class roads Third class roads
Attitude of staff	Response to questionnaire.	Ordinal Rudely, not friendly, don't care, cant tell
Referral System	No of patients questioned with a referred notes and follow-up.	Ratio

Source: Author's Construct, 2004

3.3 STUDY POPULATION

The study populations are pregnant women and health professionals in the Mampong District Hospital in the Sekyere West District

3.4 SAMPLING UNIT

The study population comprised females who had experienced pregnancy related complication within the last five years i.e. (1999-2004) and reported to the Maternity unit of Mampong district hospital.

3.5 SAMPLE SIZE: With a population of 37,978, Women in Fertility Age, a sample size of 150 respondents was determined using the StatCalc of Epi Info 2002 with the assumption that the expected frequency is 50% and the Worst Acceptable of 42.01% at the 95% confidence level. In addition, 6 health professionals were interviewed from the district hospital.

3.6 SAMPLING METHOD

The sampling method used was multistage. The district capital was conveniently selected for the study due to financial constraints. Out of the 44 communities in Mampong, the district capital, five were randomly selected for the study by simple random sampling. Thirty respondents (30) were by the common sense approach allotted to each community. Within each community, by a toss of a pen, the first and subsequent houses were selected. The respondent per house was selected based on the following selection criteria: have had a pregnancy complication in the past five years; and used the Mampong Hospital Maternity Unit.

Six health professionals were purposively selected from the maternity unit of the District Hospital.

3.7 DATA COLLECTION TECHNIQUES AND TOOLS

The technique used in collecting the data was mainly interview.

The interviewer-administered approach was employed for the collection of data.

A questionnaire, with open ended and closed ended questions was designed for the collection of data. The questionnaires captured information on demographic and socio-economic background of respondents, their knowledge on pregnancy related complications, cultural practices, their income levels and staff altitude towards them at the hospital. Also, an Interview guide was designed to collect data from health professionals who worked in the Maternity Unit of the District Hospital.

3.8 DATA ANALYSIS/PRESENTATION

The data collected was analyzed using the Epi Info 2002 version. The results were presented using tables, histograms and pie charts. Descriptive statistics were done on variable were appropriate.

3.9 PRE-TESTING

Questionnaires were pre-tested on 50 women at Kwame Nkrumah University of science and technology hospital. This was to ensure that errors would be reduced and corrected in the use of the tools.

3.9 ETHICAL CONSIDERATION

Permission was sought from the district health authorities detailing the objectives of the research and the methods to be employed in data collection. Individuals sampled to take part in the research were asked to give a written consent and advised to opt out of the research as and when they wish to do so.

3.10 LIMITATIONS OF THE STUDY

1. Some women who have had pregnancy related complication refused to participate in the study.

2. One major limitation was lack of funds.

3. Interpretation of the questionnaire into twi will be a difficult task since there are no twi equivalent for certain English words.

4. The time limit was not adequate for the study.

3.11 ASSUMPTIONS

-All the respondents have had PRC within the last 5 years (1999-2004)

-All the respondents reported late to the hospital.

-The cost of receiving treatment for PRC is relatively low.

-Women delay due to lack of knowledge on danger signs of pregnancy.

Chapter Four

4.0 Findings

4.1 Introduction

The findings of this study were based on the response gathered from 156 people made up of 150 women who have had PRC within five (5) years (1999-2004) and Six (6) health providers at Mampong District Hospital.

4.2 Socio-Demographic Data

Socio-Demographic Variables

Table 4.1

Background characteristic	Option	Frequency	Percentage (%)
Age	< 19	18	12.3
	20-34	105	70.4
	>35	14	22.2
Marital Status	Single	22	14.8
	Married	122	81.5
	Windowed	6	3.7
Educational Level	None	31	21.0
	Primary	4	3.5
	JSS	82	54.3
	SSS	31	21.0
	Tertiary	2	1.2
Occupation	Farming	28	18.5
	Trading	76	50.6
	Civil Servant	5	3.7
	Unemployed	41	27.2
Ethnicity	Akan	117	77.8
	Northern extraction	31	21.0
	Ewe	2	1.2
Religion	Christian	126	84.0
	Moslem	24	18.0

(Source Field data 2004)

Majority of the respondents43.2 % were between the ages of 26-32 years, while 27.2% were between the ages of18-25 years.12.3 % was between 12-18. Those between 33-39 years formed 18.5 %. 3.7 % were 40 years and above.

Out of the 150 respondents 81.5% were married and formed the majority.3.5% were either divorced or widowed and 14.5% were single and had never been married.

Majority of the respondent were traders and unemployed. They formed 50.6% and 27.2% respectively. Farming formed 18.5% and 3.7% was civil servant.

Most of the respondents (77.8%) were Akans, 21.0% were of northern extraction and 1.2 were Ewes.

Majority of the respondents were Christians and formed 84.0%. Moslems formed 16.0%

4.3 Knowledge, Attitude and Practices related to pregnancy and childbirth

Table 4.2 Ideal age to be pregnant

Options	Frequency (N=150)	Percentage (%)
14-20yrs	65	43.2
21-26yrs	63	42.0
27-33yrs	2	1.2
34-40yrs	4	2.5
>40yrs	0	0.0
Don't know	16	11.1
Mean	22.05	

(Source; Field Data 2004)

Most of the respondents (43.2 %) think that the ideal age for women to become pregnant is between 14-20 years.42.0 % also choose 21-26 year. 1.2 % belief that it is ideal for a woman to become pregnant for the first time between the ages of 27-33 years. 2.5 % also choose between 34-40 %.None of the respondent would not like to become pregnant for the first time at the age of 40 and above.11.5 % did not know an ideal age to become pregnant.

Table 4.3 Age at which a woman should stop childbirth

Options	Frequency (N=150)	Percentage (%)
30-34yrs	11	7.4
35-39yrs	20	13.6
>40yrs	82	54.3
Don't know	37	24.7
Mean	42.22	

(Source Field data 2004)

Majority of respondent (54.3 %) think that an ideal age for a woman to stop producing babies is 40years and above.24.7 did not know, while 13.6 choose between the ages of 35-39 years. Only 7.4 % said a woman should stop producing babies between 30-34 years of age.

Table 4.4 Age at which a woman is likely to develop pregnancy complications

Options	Frequency (N=150)	Percentage (%)
<17yrs	9	6.2
18-30yrs	2	1.2
>35yrs	91	60.5
Don't know	48	32.1
Mean	41.46	

(Source; Field Data 2004)

About 60.5% of the respondents said that women are at risk of pregnancy related complications at the age of 35 and above. 32.1% did not know, while 6.2% belief those women below the age of 17 are likely to get complications during pregnancy. Only 1.2 % respondents

think that women between the ages of 18-30 have high risk of developing complication during pregnancy.

Table 4.5 Mother's knowledge on pregnancy related complications.

Options	Frequency (N=>150)	Percentage (%)
Bleeding	73	48.7
Eclampsia / Fitting (PIH)	23	15.4
Obstructed labour	19	12.8
Don't know	75	50.0

Source: Field Data 2004

50.o % could not mentioned any pregnancy related complication, 48.7 % mentioned bleeding, while 15.4% mentioned pregnancy induced hypertension/ eclampsia, with only 12.8 % mentioning obstructed labour

Table 4.6 The need for pregnant woman to attend ANC

Options	Frequency (N=150)	Percentage (%)
Yes	150	100.0
No	0	0

(Source Field data 2004)

All the respondents (100 %) think that antenatal care is very important during pregnancy.

Table 4.7
The need for pregnant woman who is bleeding to seek immediate attention

Options	Frequency (N=150)	Percentage (%)
Yes	146	97.6
No	2	1.2
Don't know	2	1.2

Source: Field Data 2004

Majority of the respondents (97.6) think that pregnant woman who is bleeding needs immediate attention while1.2 %think otherwise. Another 1.2 %did not know whether immediate attention is needed or not.

Table 4.8 Places where pregnant women go in an event of PRC

Options	Frequency (N=150)	Percentage (%)
Home	4	2.5
TBAs/Herbalist	2	1.2
Maternity Home	5	3.7
Hospital	137	91.4
Don't know	2	1.2

(Source; Field Data 2004)

Majority of the respondents (91.4 %) think that a pregnant woman with complication needs to go to hospital first.3.7% think maternity home should be the first point of call while 2.5% would manage it in their home. 1.2 % thinks it is better to see the herbalist first while another 1.5 % did not know where to go.

Table4.9 Attendance at ANC during pregnancy

Options	Frequency (N=150)	Percentage (%)
Yes	126	84.0
No	24	16.0

(Source Field data 2004)

Majority of the respondents attended antenatal clinic and formed 84.0 %. Only 16.0 % did not attend antenatal clinic but were only admitted to when they had complications.

Table 4.10 Number of attendance at ANC during pregnancy

Options	Frequency (N=150)	Percentage (%)
1	34	22.8
2	42	28.4
3	15	9.9
4	30	19.8
5+	29	19.1
Mean	2.85	

(Source; Field Data 2004)

Majority of the respondent attended ANC at least twice and formed 28.4 %followed by those who attended ANC only once which formed 22.8 %.Those who attended ANC thrice formed 9.9% while 19.8% attended four times. 19.1 % attended five or more.

Table 4.11 First ANC visit.

Options	Frequency (N=150)	Percentage (%)
First trimester	91	60.5
Second trimester	43	28.4
Third trimester	16	11.2

(Source; Field Data 2004)

Majority of the respondents 60.5 % started ANC during the first three months of their pregnancy.28.4 came during the second trimester and 11.2 started during their last three months of pregnancy.

Table 4.12 Number of women who have had PRC before

Options	Frequency (N=150)	Percentage (%)
Yes	150	100
No	0	00

(Source; Field Data 2004)

All the 150 women interviewed have ever had pregnancy complication.

Table 4.13 Type of Complication experienced

Options	Frequency (N=150)	Percentage (%)
Bleeding	76	50.7
Eclampsia/Fitting	17	11.3
Obstructed labour	14	9.3
Others (anaemia, hyperemesis.)	43	28..7

(Source; Field Data 2004)

Out of the number interviewed 50.7 % had bleeding. 11.3% had eclampsia 9.3 % had obstructed labour and 28.3 % had others such as hyperemesis, anemia, and abortion.

Table 4.14 Stage of pregnancy at which complication was detected.

Options	Frequency (N=150)	Percentage (%)
First trimester	87	58.0
Second trimester	34	22.7
Third trimester	29	19.3

(Source; Field Data 2004)

Most of the respondents had their complications during the first trimester and form 58 %. 22.7% also detected the complications during the second trimester. The rest of the respondents (about 19.3%) detected it during the third trimester.

Table 4.15 First point of call

Options	Frequency (N=150)	Percentage (%)
Pharmacist	10	6.6
Midwife	75	50
Herbalist	5	3.3
TBA	33	22.0
Hospital	27	18.0

(Source; Field Data 2004)

Majority of the respondents 50.0 % visited midwife first while 22 % went to TBA first 6.6% had their medication from the pharmacist and 18 % called first at the hospital. Only 3.8 % of the respondents went to the herbalist first.

Table 4.16 Period of delay before reporting at a hospital

Options	Frequency (N=150)	Percentage (%)
1-3days	96	64.0
3-6days	16	10.7
1week	14	9.3
>1week	24	16.0

(Source; Field Data 2004)

64. 0 % of the respondents reported to the hospital within 1-3days, 10.7 % reported within 3-6 weeks with 9.3 coming to the hospital after a week. 16 .0 % visited the hospital after she has had the complication for more than a week.

Table 4.17 used or knowledge of someone using traditional method to manage Pregnancy complications?

Options	Frequency (N=150)	Percentage (%)
Yes	84	55.8
No	66	44.2

(Source; Field Data 2004)

About 55.8 % of the respondents either have knowledge or have used traditional method to manage pregnancy related complication while 44.2 % have not used or have no knowledge.

Table 4.18 Methods used by the women in treating PRC in the house

Options	Frequency (N=84)	Percentage (%)
Herb (enema and or drink)	71	84.0
Herb + palm nut soup)	11	13.6
Others	2	2.4

(Source; Field Data 2004)

84.0 % of the respondents said herbs are used for enema or drink while 13.6 % said herbs are used to prepare palm nut soup and drink. The remaining 2.4 % used other methods.

Table 4.19 Outcome of traditional management

Options	Frequency (N=84)	Percentage (%)
Death	0	0.0
Recovery	54	64.0
Don't know	30	36.0

(Source; Field Data 2004)

Majority of the respondents 64.0 % said either they have knowledge of someone who have recovered or have recovered themselves. None of them knew someone who has died after using traditional medicine 36.0 % of the respondent could not tell whether the users recovered or not.

4.4Geographical access to healthcare facilities

Table 4.20 Difficulty in locating services area

Options	Frequency (N=150)	Percentage (%)
Yes	20	13.6
No	130	86.4

(Source; Field Data 2004)

Majority of the respondents 86.4 % did not have any difficulty locating the facility, while 13.6 % had some difficulties.

Table 4.21 Distance to health facility.

Options	Frequency (N=150)	Percentage (%)
<1km	15	9.9
1-5km	74	49.4
>5km	61	40.7
Mean	5.12	

(Source; Field Data 2004)

Majority of the respondents (49.4 %) lives between 1-5 km away from the hospital. while 40.7 % of the respondents live more than 5km away from the hospital. Only 9.9 % of them live within 1km from the hospital.

Table 4.22 Means of locating the health facility

Options	Frequency (N=150)	Percentage (%)
Sign post	50	33.3
Information desk	9	6.2
Driver	91	60.5

(Source; Field Data 2004)

Most of the respondents (60.5 %) located the hospital through drivers, 33.3% also used the signpost while 6.2 % used information desk.

Table 4.23 Means of arriving at the hospital

Options	Frequency (N=150)	Percentage (%)
Public transport	126	84.0
Ambulance	2	1.2
Hire car	18	12.3
Walked	4	2.5

(Source; Field Data 2004)

Majority (84.0 %) of the respondents used public transport. 12.3% hired cars, 1.2% used ambulance and 2.5% walked

Table 4.24 Length of time spent before getting to facility

Options	Frequency (N=150)	Percentage (%)
<5min	30	19.8
5-10min	33	22.2
11-15min	35	23.5
16-20min	17	11.1
>21min	35	23.5
Mean	16.14	

(Source; Field Data 2004)

With regard to the length of time spent on the road before getting to the hospital 19.8 % spent less than 5 minutes, 22.2 % spent 5-10 minutes while 23.5 % spent 11-15 minutes. 11.1 % spent 16- 20 minutes.23.5 % spent more than 21 minutes.

Table 4.25 Delay at the hospital by the staff

Options	Frequency (N=150)	Percentage (%)
Yes	59	39.5
No	91	60.5

(Source; Field Data 2004)

Asked whether they were delayed by any staff. 60.5 % said no they were not delayed while 39.5 % said they were delayed by some of the staff.

Table 4.26 Cost of transportation

Options	Frequency (N=150)	Percentage (%)
<¢5000.00	118	78.5
¢5000 – ¢10,000	23	15.2
>¢10,000	9	6.3
Mean	8220.33	

(Source; Field Data 2004)

According to the survey 78.5% of the respondents pay less than 5000 cedis while 15.2 % pays between ¢5000-¢10000. Only 6.3 pay more than 100,000 Cedis as the cost of transport.

4.5 The cost of health care services & quality of health care

Table 4.27 Things required for delivery at the hospital

Options	Frequency (N=>150)	Percentage (%)
Soap	100	66.7
Bed sheet	91	60.5
Napkins	104	69.1
Antiseptics	91	60.5
Baby dresses	104	69.1

(Source; Field Data 2004)

Most of the respondents were required to bring along with them items like soaps, bed sheets Napkins, Antiseptics and baby dresses.

Table 4.28 Cost of items

Options	Frequency (N=150)	Percentage (%)
< ¢50,000.00	3	2.3
¢50,000-¢100,000.00	109	72.7
>¢100,000.00	38	25.0
Mean	83486.24	

(Source; Field Data 2004)

Items that are required of pregnant women during delivery cost 72.7 % an amount of between 50,000-100,000 Cedis while 25.0 spent over 100,000.Only 2.3 % paid less than 50,000 Cedis.

Table 4.29 Length of stay after delivery in hospital

Options	Frequency (N=150)	Percentage (%)
1day	57	37.9
2days	57	37.9
3days	23	15.5
>3days	13	8.6

(Source; Field Data 2004)

Most of the respondents spend between 1-2 days at the hospital, 15.5 % spent 3 days. Only 8.6 % spent more than 3 days at the hospital.

Table 4.30 Bill on discharge

Options	Frequency (N=150)	Percentage (%)
< ¢50,000.00	16	10.8
¢50,000-¢100,000.00	69	46.0
>¢100,000.00	65	43.2
Mean	93478.26	

(Source; Field Data 2004)

Majority of the respondent paid an amount ranging from 50,000-100,000 cedis and formed 46.0%.43.2 % paid over 100,000, while 10.6 % paid less than 50,000 Cedis.

Table 4.31 Those who were able to pay their bills

Options	Frequency (N=150)	Percentage (%)
Yes	107	**71.6**
No	0	**0.0**
Don't know	43	**28.4**

(Source; Field Data 2004)

About 71.6 % were able to pay their medical bills promptly while 28.4% did not know whetner they were able to pay promptly or not.

Table 4.32 Satisfaction with services provided at the hospital

Options	Frequency (N=150)	Percentage (%)
Yes	147	98.3
No	3	1.7

(Source; Field Data 2004)

Majority of the respondents were satisfied with the services rendered to them at the hospital. And formed 98.3 %. Only 1.7 % was not satisfied with the services at the hospital,

Table 4.33 women view on the affordability of their hospital bills.

Options	Frequency (N=150)	Percentage (%)
Yes	122	**81.4**
No	0	**0.0**
Don't know	28	**18.6**

(Source; Field Data 2004)

Most of the respondents (81.4 %) believe the cost of healthcare at the hospital was affordable while 18.6 % did not know whether the cost of healthcare at the hospital is affordable or not. None of the respondent was able to say that the cost is not affordable.

Table 4.34 Category of relatives who paid the bills for the women.

	Frequency (N=150)	Percentage (%)
Husband	138	91.7
Parents	12	8.3
Borrowed	0	0.0
From savings	0	0.0

(Source; Field Data 2004)

Majority of the respondents 91.7 % had their hospital bills settled by their husbands, while 8.3 % of them had their bills settled by their parents.

4.6 Staff Attitude towards pregnant women with complications

Table 4.35 Reception at the hospital

Options	Frequency (N=150)	Percentage (%)
Unfriendly	6	3.7
Friendly	107	71.6
Very friendly	37	24.7

(Source; Field Data 2004)

Majority of the respondents (71.6 %) said the staffs at the hospital were friendly, while 24.7 % said they were very friendly. Only 3.7 % said that the staffs were unfriendly to them.

Table 4.36 Quality of care

Options	Frequency (N=150)	Percentage (%)
Yes	146	97.5
No	4	2.5
Reason (yes)		
Options	**Frequency (N=146)**	**Percentage (%)**
Good relations	139	93.2
Competent	10	6.8

(Source; Field Data 2004)

97.5 % of the respondents liked the services rendered at the hospital, while 2.5 %did not liked the services.

Out of the number that likes the services 93.2 % sited good interpersonal relationship as their reason, while 6.8 % because of their competence.

Table 4.37 Distribution of respondent who did not like the services at the Hospital

Options	Frequency (N=4)	Percentage (%)
Only one Doctor	4	100.0

(Source; Field Data 2004)

Those did not like the services rendered at the hospital sited lack of enough doctors as their reason.

Table 4.38 competency of staff in handling maternal cases

Options	Frequency (N=150)	Percentage (%)
Yes	146	97.5
No	0	0.0
Don't know	4	2.5

(Source; Field Data 2004)

All the respondents (100 %) believed that the staffs at the hospital are competent enough in handling all obstetric cases.

Table 4.39 Considerations of client views during their management

Options	Frequency (N=150)	Percentage (%)
Yes	**150**	**100.0**

(Source; Field Data 2004)

All the respondents said that the personnel at the hospital consider patient concerns during their management.

4.5 Answers given by healthcare providers.

Table 4.40 Profession

Options	Frequency (N=6)	Percentage (%)
Midwives	4	66.6
Medical Assistant	1	16.7
Doctor	1	16.7

(Source; Field Data 2004)

The respondents were made up of 4 midwives, one medical assistant and a doctor

Table 4.41 Rank

Options	Frequency (N=6)	Percentage (%)
P. N. O.	1	10
S.N Midwives	2	40
E. N Midwife	2	40
C. M .A	1	10

(Source; Field Data 2004)

The nurses were made up of one P.N.O, two S.N. midwives and one E.N.midwive. There was one chief medical assistant and a medical doctor.

Table 4.42 Distribution of staff whose work involves the care of pregnant women.

Options	Frequency (N = 6)	Percentage (%)
Yes	6	100 %
No	0	00

(Source; Field Data 2004)

All those interviewed (100 %) had an important role to play in making pregnancy save.

4.43 First point of call of pregnant women with PRC

Options	Frequency (N=6)	Percentage (%)
District hospital	5	83.3
TBA	1	16.7
Maternity Home	0	0

(Source; Field Data 2004)

Majority of the respondents (83.3%) think that pregnant women in the district report to the hospital in an event of pregnancy related complication.16.7 % also think that pregnant women with complication report to the TBAs for treatment. But none of them made mention of the midwives as where pregnant women go in time of complication

Table 4.44 Cause of late reporting to the hospital

Options	Frequency (N=6)	Percentage (%)
Lack of transport	4	66.7
Lack of funds	6	100
Cultural belief	4	66.7

(Source; Field Data 2004)

Approximately 66.7 % attributed the late arrival of pregnant women to lack of transport, whereas the entire respondent sighted funds as a major cause. About 66.7 also think that cultural factors are also responsible for their late arrival to the hospital.

Table 4.45 Workers impression on the number of health professionals at the hospital

Options	Frequency (N– 6)	Percentage (%)
Yes	0	00
No	6	100

(Source; Field Data 2004)

All the respondents (100 %) think that they are understaffed and need more hands.

7. Most of the respondents believed that pregnant women with complications are treated effectively in the District hospital but will perform more effectively if more personnel are posted to the hospital to help them.

8. All the respondents believed that lack of funds was the main cause of the late arrival of pregnant women with complication to healthcare facility in the district. Other factors that were mentioned included cultural practices, lack of ambulance services, lack of decision-making power of women and poor road network.

Table 4.46 Number of respondents who have had In-service Training

Options	Frequency (N= 6)	Percentage (%)
Yes	6	100
No	0	00

(Source; Field Data 2004)

All the respondents have ever attended an in-service training.

Table 4.47 Distribution of respondents who have had training in life saving skills

Options	Frequency (N=6)	Percentage (%)
Yes	6	100

(Source; Field Data 2004)

All the respondents have had training in life saving skill

CHAPTER FIVE

5.0 Discussion

The discussion is a reflection on the analysis of the data and findings, personal observations and informal interactions during the data collection process.

5.1 Sociodemographic data

All the respondents were women of reproductive age who have had pregnancy-related complication within the last five years. Majority of the women were between the ages of 26-32 years.

With regard to education, those with educational level lower than or up to JSS/MSLC level formed the majority of the women with complication who reported late to the hospital. Thus their low level of education might have accounted for their late reporting. This finding supports that of Kenya's (KDHS, 2003) which revealed that as mothers education rises, so does the likelihood that she will see a health professional for care during pregnancy.

Matthew et al (2002) concluded in their study that apart from household wealth status, educational level of individual women have been shown to affect the uptake of maternal health delivery services. The prevalence of the PRC among the Akans are higher, this may be due to the fact that the study area was predominantly an Akan speaking one. The higher percentage (84.0%) of the respondents was Christians. This could also be as a result of the fact that the study was carried out in a predominantly Christian community.

Majority of the respondents (81.5%) were married and their main occupation were petty trading and farming with about 27.2% not working.

Most of the respondents (60.5%) have already had 4-5 children. This might have accounted for them developing complications since a woman chance of developing complication increase with higher birth order. This also accounted for their late reporting to the hospital, since they would not like to leave the rest of their children in the house alone.

5.2 Knowledge attitude and practices

Most of the women interviewed had some knowledge on pregnancy and childbearing. Out of the 150 respondents about 85.2% said it is ideal for a woman to be pregnant from the ages of 14-26 years. Only 2.5% of the respondents said it was ideal to be pregnant after 34 years. None of the respondent thought that it is appropriate to start giving birth at 40 years.

Ironically, their knowledge level on when a woman should stop producing children was inadequate as most of them said that women should stop producing babies after 40 years. However, majority of them knew that a woman's chance of developing complication during pregnancy increased after the age of 35 years. However a significant proportion 32.3% of respondents did not know that a woman chances of developing pregnancy related complication increases after 35 years. This lack of knowledge could be as a result of poor health education given to the women at antenatal clinic by the midwives.

With regard to knowledge on any pregnancy related complication it is surprising since approximately 50.0% could not mention any pregnancy related complication .The other 50% were able to mention at least one of the following, eclampsia/hypertension.

bleeding, and obstructed labour. This poor knowledge on what constitute pregnancy complication might have accounted for their late arrival at the hospital since they did not know that this complication could be live threatening. This poor knowledge can be blamed on the midwives at the antenatal clinic. This can also be attributed to irregular attendance at antenatal clinic by pregnant women and the fact that some of the pregnant women have never attended antenatal clinic.

The staff in general has a very good knowledge of pregnancy related complication and its effects, but although they organize antenatal care for their client most of them have poor knowledge on pregnancy and childbirth. During the data gathering it was realized that the nurse's focus was on the child more than the woman and spend more time educating mothers on breastfeeding. Another factor that needs to be considered here is inadequate staffing. This study supports a study conducted in Kolomol in Zambia (ZDHS2001) which found out that very few pregnant women were able to recognize obstetric complications and traditional belief and practices delayed patients' decision to seek healthcare.

Even thought 16% of the respondents have never attended antenatal clinic but only reported to the hospital with pregnancy related complications all the respondents knew that ANC is indispensable as far as pregnancy is concerned. Therefore their refusal to attend ANC may be due to other factors such as financial, family responsibilities and cultural beliefs.

It is also important to note that the majority of those who attended ANC do so during the first trimester. It is only about 11.2 % who started the ANC at the third trimester of their pregnancy.

All the women thought that a pregnant woman who is breeding needs immediate attention, 91.4 % thought the hospital should be the first place to visit whereas 3.7 %

thought that the person should visit the TBA/Herbalist first before reported to the hospital.

This findings do not support a research conducted in Navrogo in Ghana that revealed that the major cause of delayed was the fact that traditional medicine is the first source of care sough by most women and hospital is frequently seen as the last resort.

It was also revealed that breeding cases constitute more than half of all complications that report to the hospital. This includes spontaneous abortion, criminal abortion and infections. Most of these complications usually occurred during the first trimester. This may be due to the fact that most of these cases were bleeding which could result from attempted abortion. It is worth mentioning that most of the respondents (50%) visited midwives in the community before being referred to the hospital. This can result in a delay since there are no effective means of referral in the district. About 22.0% also report to the TBA first before reporting to the hospital thereby causing a delay. Almost 9.9 % also resort to self-medication either through drugs bought from chemical shops or by the use of herbs, and reports to the hospital only when the condition deteriorates.

It is only 18 % whose first point of contact was the district hospital. However, most of the respondent (64.0 %) reported to the hospital between the first day and the third day after the onset of the complication. 10.7 % reported to the hospital after three days whereas 9.3 % reported within one week. A significant number of 16% also reported after one week. This trend suggest that the decision to seek health at the hospital takes a very long time to be made because of other factors as social, financial and cultural practices.

With regard to their knowledge on traditional way of treating any of the complications, 55.8% said they have knowledge or have used traditional method to manage PRC with high percentage recovering. This knowledge in the traditional method of treating PRC in the house might have accounted for their late arrival at the hospital. This is because the traditional method is cheaper and until the condition gets out of hands they will not report to the hospital.

5.3 Geographical access to healthcare

Distance separating client from the nearest health facility has shown to be an important barrier particularly in the rural areas. Distance can either act as an actual obstacle to reaching the health facility or of transportation and poor road. (GDHS 1998)

According to the study approximately halve of the respondents live within 1-5 km from the hospital, which is not too far from the hospital. But a significant number (40 .7 %) also live at places more than 5km from the hospital. This includes people from Brong Ahafo and Afram plains where accessibility is a problem; therefore transportation might cause their delay.

Locating the district hospital was not a problem to most of them. Most (86.4 %) had no problem locating the place. Even those who had little problem was brought to the hospital by drivers. Thus locating the place cannot be said to be one of the reason for reporting late to the hospital.

Majority of the respondents (84.0 %) used public transport in coming to the hospital. Only 1.2 % came in an ambulance or hospital car and approximately 12.3 %came in a hired car.

Since majority of the respondent arrive at the hospital in public transport the tendency that they would be delayed is high because they have to wait for other passengers to join the car before starting the journey. In places where it is difficult to get a car one has to wait for longer time before getting a car. According to the study approximately 23.5%

spent more than 21 minutes waiting for a car. However, the meantime used in waiting for a car is approximately 16.14minuts, which is too much for a pregnant woman who is breeding. Only 19.8% spent less than 5 minute.

This findings supports that of a study conducted in Katete district in the eastern province of Zambia that revealed that long distances and cost of healthcare may prevent woman from arriving at the hospital in time.(ZDHS 2001)

This findings also supports that of Emuveyan study that concluded that many of the cases of maternal deaths arrived in hospital after many hours and sometimes days of commencement of labour with excessive blood lost, ruptured uterus and eclampsia fit.

5.4 The cost of healthcare services

The cost of receiving health care, which include transportation cost, physician and facility fee and other supplies, may also act as a barrier to the utilization of obstetric care.

In many parts of the world, prospective patient, especially women, do not travel alone to a health facility. They may be accompanied by other adult and by children these additional peoples swell the cost of transport.

According to a study published in the Lancet Reuter Health report of 3rd January 2004; a woman risk of dying during or soon after pregnancy increases the poorer she is.

According to this study the cost of transport, cost of items, and bill on discharge is excessively high compare with the monthly income of the women and the fact that most of them already have some mouth to feed. This might have accounted for their late reporting because they would like to use other cheaper means to treat the complication and only report to the hospital when the situation become critical.

According to the health care providers finance was the main obstacle that prevented pregnant women with complication from seeking healthcare early. From the study the mean monthly income of the women was ¢80,000 which is far below the hospital charge, cost of transport and cost of items that ranges from as much as¢70,000 –¢150, 000 Cedis The study also revealed that majority of women who deliver at the hospital spent between 1-3 days. Only few women (8.6%) spent more than 3 days.

Even though it is clear that the cost of seeking maternal health care was high compared to the income of the women, most respondents were able to pay for their bills promptly, but that does not mean that the women and their families did not encounter any difficulty in raising the money themselves. In rural communities it is not out of place to borrow money from other people to take care of the sick especially during delivery.

One of the revelations by the study was that all the women who had pregnancy related complications had their bills settled by either their husbands (91.7%) or parents (8.3%) and that most of them could not even remembered how the bills were settled.

This practice of having parents and husbands paying every medical bill for them has its effect on when a woman decide to seek healthcare. This is because the woman needs the consent of the husband and/or the mother to be able to decide when to seek healthcare. In effect the woman's level of autonomy was linked with healthcare seeking behavior during pregnancy and childbirth. At delivery care seeking decision are often not make by the women themselves in the context of low woman's status. It is also known that women themselves are reluctant to report "little little" problems either within their natal or marital home. (Jeffery & Jeffery 1989)

Although the relationship between women's autonomy and wealth status is not straightforward, the predominance of poor maternal health outcome in regions and

countries where woman's status is low often coincides with either a general level of poverty, or high level of economic inequality.

A study conducted in the United Kingdom concluded that, it is generally clear that poor women are more likely to die of maternity related conditions. However, improving economic status alone will not bring down maternal mortality rate. (Matthew John Snow International UK- JSINK)

5.5 Staff Attitude toward women with Pregnancy Related Complications.

There is an undeniable fact that pregnant women prefer to use other means such as self medication, and unskilled attendants because of the rude, unsympathetic and uncaring attitude of health workers.

The study revealed that the nurses and doctors at the hospital were friendly to their client .Almost all the women interviewed were satisfied with the conduct of the nurses and doctors at the unit. Out of 150 women interviewed about 24.7 % said the staff very friendly to them, 71. 6% saw the staff as being friendly to them. It was only 3.7 % who saw the staff as unfriendly. These findings would not have been taken as the true picture if the interview was conducted in the hospital premises only because most of them would have given opposite answers if they were interviewed in their own backyard.

But it was observed during a visit to the unit that there was a good interpersonal relationship between the workers and their clients, which confirm what the clients themselves, have said already.

Therefore workers attitude is not a factor that might have causes women in the district to delay in reporting to the hospital. This finding does not supports the UNFPA study in Zambia where it was found that many pregnant women fail to visit the health facility because of bad attitude of healthcare workers.

With regard to the services provision, majority (97.5%) did like the services being offered at the hospital because of the good interpersonal relationship and competent staff. Only 2.5 % did not like the services at the hospital because they were delayed before seeing the doctor who is the only doctor at the maternity unit. All the respondents also said that the workers are more responsive to the needs of patients.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

Maternal mortality remains an important indicator of the status of health care in the most modern world. Many different factors interact in complex ways to increase a pregnant woman's risk of death.

The study identified lack of knowledge on what constitute pregnancy complication as one of the causes of delayed reporting to the hospital. Most respondent (50.o %) also did not know what termed as the danger signs of pregnancy is, thereby making it difficult for them to report early to the hospital. The respondents (78.8%) were also deficient in knowledge on when to give or stop giving birth and when a woman stands a higher risk of developing complications.

The study also revealed that 55.8% of the respondents know a traditional way of treating pregnancy complications such as bleeding and eclampsia.

The study also found out that majority of them (91.4%) reports to the hospital in an event of complications.

Most of the respondents (84.6%) attended ANC with most of them making their first appearance during the first trimester. It was also found that the most frequently reported case was bleeding (43.6 %) followed by hypertension (12.8 %) Obstructed labor forms about 10.3% of the complication with others like anemia, hyperemesis constituting 33.3%.

The study revealed that the mean distance from the health facility and place of residence was 5.2km.And most of the respondents used public transport as a means of transport to the hospital which delayed their arrival to the hospital. They spent an average of 16.14minutes in traveling to the hospital. The cost of receiving treatment during pregnancy was high compared with the monthly income of the respondents.

The study showed that the respondents (97.5%) were very much satisfied with the conduct of the staff in the hospital.

From the findings of this study it can be concluded that certain factors such as

high illiteracy rate among pregnant women, high parity, delayed referral from peripheral clinics, poverty, and high cost of seeking health care were some of the reasons why most pregnant women reported late to the hospital.

6.2 RECOMMENDATION

Based on the strength of this study, these recommendations are enumerated here to improve upon the maternal services:

- Knowledge

The DHMT should ensure that Education and information which comprises community education about save motherhood, Danger signs of pregnancy and family planning information and services for adolescent and adult reproductive health should be intensified in the district to reach women in their reproduction age.

The District Assembly ensures that more girls are encouraged to go to school to know more about their reproductive right.

The DHMT should organize training programs for traditional birth attendants (TBAs) as well as other health professionals in rural areas to improve their knowledge on pregnancy and childbirth.

- Accessibility Improvement

The Ministry of health (government) must ensure that health facilities that are located close to where women live have adequate number of trained staff, a continuous supply of drugs and equipment and should be linked to the district hospitals by an emergency transport and referral system.

- Good referral system

The Ministry of Health (MOH) should ensure that district hospital and local health centers are linked by a two-way system of radio communication and transportation. A car equipped with a stretcher should be available to transport women from health centers to district hospital. This would drastically reduce the time require to transport the patient from up to a day to just a few minutes.

- Economic Empowerment

The District Assembly and non governmental Organizations in the district should give micro credit financial assistance to women who are willing to engage themselves in business ventures to help improve their economic status.

- Cost of maternal services

The Ministry of Health (MOH) should ensure that maternal services are provided free of charge to pregnant women with complications. This is to ensure that financial barrier do not impede emergency care.

- Gender empowerment

The District Assembly has to improve women's status and raise awareness about the consequences of poor maternal health. Families and communities must be encourage and enable women to receive proper care during pregnancy and delivery.

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APPENDIX I

QUESTIONNAIRE FOR HEALTHCARE PROVIDERS

1. Profession.....
2. Post/Position/Rank.....
3. Does your work involve the care of pregnant women with complication? Yes/No
4. Were do pregnant women who develop complications in the district (a)TBAs (b) Maternity home (c) District hospital (d) others specify

5. What do you think makes them report late to the hospital?(a)Lack of transport(b)Lack of money (c) cultural Beliefs (d) Staff attitude (d)Others specify.....

6. Do you think you have enough professionals to provide quality obstetric services? Yes/No

7.What are your impressions about the management of women with pregnancy related complication?.....
.....
.....
.....

8. What are some of the problems pregnant women with complications face in accessing treatment in the district.....

9. Have you ever had in-service training? Yes/No

10. Have you had training in life saving skills? Yes /No

QUESTIONNAIRE ON THE TOPIC:

DELAYED ARRIVAL OF WOMEN WITH PREGNANCY RELATED COMPLICATION TO HEALTHCARE FACILITIES I N SEKYERE WEST DISTRICT OF ASHANTI REGION OF GHANA: THE UNDERLYING FACTORS

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(The information from respondents will be kept secret and only be used for the purpose of this study; however respondents has the right to opt out at any stage of the study)

A. Background Information

1. Age (a) 12-18 yrs (b) 19-24 yrs (c) 25-31 yrs (d) 32-40 yrs (e) >40yrs

2. Marital status (a) Single (b) Divorce (a) Widow (C) Married

3. Educational Level (a) MSLC /JSS (b) Secondary/Technical (c) Tertiary (d) None

4. Occupation (a) Farming (b) Trading (c) Civil servant (d) Unemployed

(e) Others (specify).....

5. Ethnicity (a) Akan (b) Northerner (e) Ewe (d) others specify.....

6. Religion (a) Christian (b) Muslim (c) Traditionalist (d) others (specify).....

7. Number of children (a) 1-3 (b) 4-5 (c) >6 (d) no child

B. Knowledge, Attitude and perception related to pregnancy and childbirth

1. What is the ideal age for a girl to become pregnant for the first time?

(a) 14-20yrs (b) 21-26 yrs (c) 27-33 yrs (d) 34-33 yrs (e) 34-40 yrs (d)> 40 yrs (e)don't know

2. When should a woman stop producing babies? (a) 25-29 yrs(b) 30-34 yrs (c) 35-39 yrs(d)>40 yrs (e)don't know

3. At what age of a woman life is she likely to have complications during pregnancy?

(a) <17 yrs (b) 18-30 yrs (c) >35 yrs (d) Don't know

4. Did you attend ANC during your pregnancy? Yes/No

5. If yes how many times? (a) 1 (b) 2 (c) 3 (d) 4 (e) 5

6. When did you make your first visit?

(a) First trimester (b) second trimester (c) Third trimester

7 Is there any need for a pregnant woman to attend antenatal care (ANC)? Yes/NO

8. Give reasons for your answer.....

9. What are pregnancies related complications? (a)bleeding (b)eclampsia/fitting (c) Obstructed labour (d) Others specify.....

10. Do you know of any traditional way of managing the following?

(a) Profuse vaginal bleeding (b) Obstructed labour (c) eclampsia/fit (d) Others Specify.....

11. How was it managed and with what?.....

12. Have you or do you know of anyone who has used it before? Yes/No

13. What was the outcome? Death/Recovered

14. Have you had any pregnancy related complications? Yes/No

15. What was it ?(a)bleeding (b)obstructed labour (c)Eclampsia (d) Others specify.....

16. At what time of your pregnancy did you detect the problem?

(a) First trimester (b) Second trimester (c) Third trimester

17. Where did you go first for help?

(a) The pharmacist (b) Midwife (c) Herbalist (d) TBA

18. How many weeks or days did it take you to report to the hospital?

(a) 1-3days (b) 3-6days (c) One week (d) More than one week

20. Do you think immediate attention is necessary for pregnant woman who is bleeding, in labour or within 40 days of delivery? Yes/No /don't know

21. Where should pregnant women go in an event of pregnancy related complication? (a) Home (b) TBAs/Herbalist (c) Maternity home (d) Hospital

22. Do you have any cultural/religious practices that prohibit pregnant women from receiving medical care? Yes/No

23. What is it?.....

C. Geographical access to health care.

1. Did you have any difficulty locating service area? Yes/No

. 2. What is the distance between your house and the health facility? (a) < 1km (b) 1-5 km (c) > 5 km

Others specify.....

3. How did you locate the place finally? (a) Sign post (b) information desk (c) others (specify

4. By what means did you arrive at the hospital (a) public transport (b) ambulance (c) Hired car (d) walked (e) Others specified

5. How long did it take you to get a car from your house to the hospital? (a) < 5min (b) 5-10min (c) 11-15 min (d) 16-20min (e)>21 min.....

6. Were you delayed by any staff? Yes/No

7. What was the cost for the transportation? (a) < ¢5,000 (b) ¢5,000-¢10,000 (c) > ¢10,000

D. The cost of health care services & quality of Health care

1. What were you required to bring along for delivery in the hospital?(a) soap (b) bed sheet (c) napkins (d) antiseptics (e) baby dresses (f) others (specify).....

2. How much did it cost you?

.....

3. How long did you stay at the hospital after delivery? (a) 1 day (b) 2 days (c) 3 days (d) >3days

4. How much was your bill on discharge?

5. Were you able to pay all your bills promptly? Yes/No

6. Were you satisfied with the services provided at the facility? Yes /No

7. In your opinion will you say the cost of such treatment in the hospital is affordable? Yes/No Don't know

8. Who paid for the bill? (a) My husband (b) My parents (c) Borrowed (d) My savings

9. How much do you earn in a month?

E. Staff attitude towards pregnant women with complications.

1. How were you received at the hospital? (A) Bad (b) friendly (c) very friendly

2 Did you like the services provided at the facility? Yes/No

Give reason for your answer .....

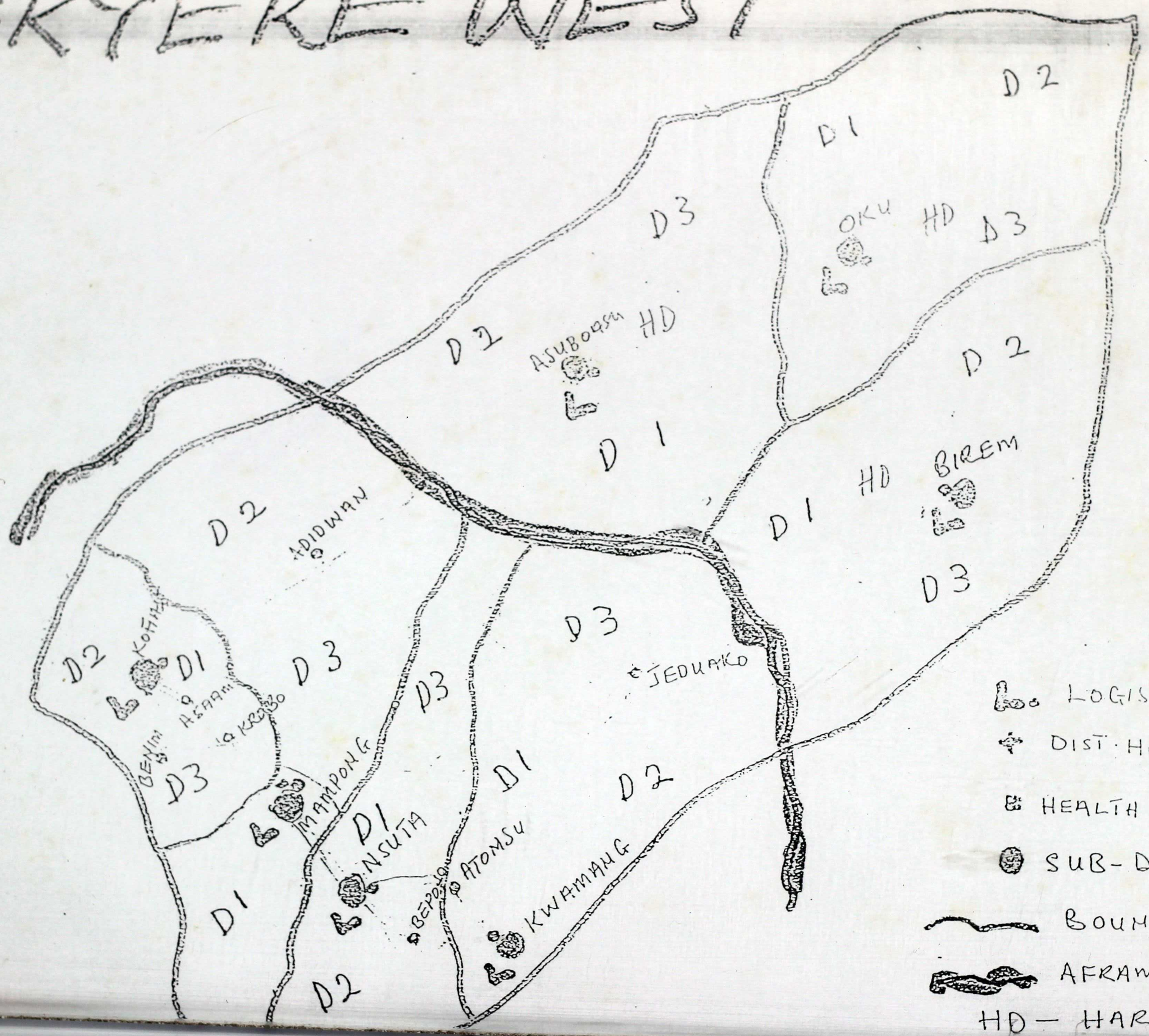
3. In your opinion are the nurses and doctors in the district hospital competent at handling obstetric complications? Yes/NO/Don't know

4. Are you happy with the services offered in the hospital to pregnant women with complications or women who have just delivered? Yes/No /don't know

5. Are concern of patience considered during their management? Yes/NO don't know

6. Would you use or recommend to others the emergency obstetric services at the hospital? Yes/No Don't know

SEKYERE WEST



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