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TOWARDS THE MILLENIUM DEVELOPMENT GOAL 5: ASSESSING THE QUALITY OF SUPERVISED DELIVERY IN THE GA WEST DISTRICT, GHANA.

BY

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CHAPTER ONE

INTRODUCTION

1.1 Background

1.1.1 Overview

Childbirth is of special value to men and women in Ghana, whether they are married or not (Dolphyne, 1991). A woman needs to have children to ensure the continuity of her own lineage in a matrilineal society, or that of her husband, in a patrilineal society. Meanwhile, child bearing in the country has its age-old problem, that of maternal mortality. This has been a source of great worry to the health authorities in Ghana, women advocacy groups and other stakeholders, including the country's development partners. The maternal mortality remains high in the country, estimated as 204/100,000 life births in 2002 and 187/100,000 life births in 2006 (UNDP, 2007).

It must be stressed here though that Ghana is not an exception to the maternal mortality phenomenon, but a general health problem across the developing world, particularly sub-Saharan Africa and Southern Asia (UN, 2007). Each year, more than 500,000 women die from treatable or preventable complications of pregnancy and childbirth. In Sub-Saharan Africa, a woman's risk of dying from such complications over the course of her life time is one in 16, compared to one in 3,800 in the developed world.

This being the case, maternal health has over the years emerged as a topical issue at international fora and even on conventions. For instance, the Convention on the elimination of all forms of Discrimination Against Women (1979) and the platform for Action of the Fourth World Conference on Women held in Beijing (1995) viewed maternal health as an important guarantee of the health of children (UNICEF, 2001). Similarly, the United Nations Millennium Summit in September 2000 made a major pronouncement on it. The fifth of the millennium development goals (MDG5) is on "improving maternal health". The MDG5 aims at reducing maternal mortality by three-quarters from 1990 figures by 2015 (Nanda et al 2005; WHO, UNFPA, World Bank 1999).

Tew (1990) argues that birth is an important physiological event by which the human race has perpetuated itself and that it must take place in a medical institution or environment.

Continuing, Tew (1990) states that research has shown that most maternal deaths and disabilities can be prevented if women have access to good quality services during pregnancy and delivery. Unfortunately, most women do not receive these care, just about half of all deliveries in the developing countries are seen by a skilled attendant, with low rates in some countries (Rizzuto and Rashid 2002).

Furthermore, Tew asserts that quality health care during labour and delivery will prevent women from injury and infections ensure a safer childbirth and minimize maternal death. The first few hours after birth are also crucial to the newborn and there is the need to provide adequate care for the baby as well. On the other hand, lack of quality health care at this crucial moment has serious implications for the mother and the new born. For instance, poor health care can lead to prolong labour, infection for the mother and the baby and even maternal and child deaths. Delvaux and others in 2007 on quality normal delivery found that over all quality of care was poor, although most women were attended to by professional midwife.

Skilled attendance at delivery is, therefore necessary to reduce maternal mortality and the survival of the newborn (WHO, 2006). Ghana is one of the countries that had signed up the MDGs. It has, therefore, adapted the MDG5 target of reducing maternal mortality by three-quarters from the 1990 figures. This means that the country is expected to reduce the 1993 figure of 214/100,000 live births to 56/100,000 by 2015(UNDP, 2007). If, indeed, Ghana has pledged to reduce maternal mortality ratio in the coming years, then it behooves on public health providers to improve on the quality of maternal health care to clients.

This must involve introducing appropriate reproductive health services before, during and after pregnancy, and through life saving interventions should complications arise (UN, 2007). Quality supervised delivery as used in this study embraces the health facility which under takes infection prevention, use of partograph, timely referrals, good interpersonal relationship, have trained staff and with adequate resources for maternal care.

1.1.2 Partograph use

The patograph is a simple tool used to assess the progress of labour, yet is a critical tool for labour and delivery. It is a paper form designed to facilitates accurate, recording and interpreting signs of maternal and foetal well beings (http: www infanticide-org, accessed 3rd February 2008). Partograph use in labour and delivery is important as it saves lives by allowing doctors, midwives to monitor labour and intervene appropriately when the need arise**.** Studies have shown that partograph use was highly effective in reducing complications from prolong labour for the mother (PPH, uterine rupture and sepsis) (Ganesh Dangal, 2007).

1.1.3 Infection Prevention

The main aim of infection control is to minimize nosocomial infections. Infection control is a quality standard of patient care and is significant for the patients well being and the safety of both patients and staff. (IFIC 2000). Infections transferred from patients to staff are through hands contaminated from patients infected body fluids, excretions, secretion or from contaminated items that are brought into contact with skin lesion or mucous membranes of staff or vice versa. Large droplets from respiratory tract often contaminate the environment close to the patient or staff and infection is transmitted by contact.

Blood from the patient reaches the blood of staff through cuts or sharp injuries for instance during suturing of episiotomy or vice versa. (From staff to patients).

According to A Hand Book on Nursing Protocol (2005) and GHS Training Manual (2003); the standard precautions in all patient care, should be avoidance of transfer of potentially harmful microorganism between patient and staff. With these, general precautions should be taken:

- Washing of hands immediately after touching infective material for instant blood, secretions, body fluids, and contaminated articles used for patients care such as delivery instruments and mackintosh.
- Gloves must be worn when in contact with blood, body fluids and contaminated items.

- Ensure patient care equipment supplies are sterilized for each patient use.
- Prevent injury with sharps.
- Keep the facility clean and properly dispose of waste

1.1.4 Interpersonal Relationship Among Mothers And Staff During Labour

The relationship between midwives and women in labour needs to be cordial. Nurses need to educate the women during the antenatal period on the process of labour and delivery. They need to establish relationship that conveys concern and care. Women in labour should be informed about progress of labour and allow them to participate in decision making.

Caring behaviour is a simple action that maternity health service providers can take to show women kindness, respect, give them privacy, and make them feel comfortable. Women receive good care and feel assured when providers respond to their needs promptly, give reassurance and provide information on how to help themselves and what to expect during labour and child birth. Women in labour have better birth outcome and a decrease in labour when they have a supportive person with them during labour. (Family Care International, 2002).

1.1.5 New Born Care

Newborn care is examined to ascertain the actual care given to babies in the maternity wards. Issues on any gap detected in the newborn care will be raised and, appropriate measures taken for improvement. This will be done by observations carried out during delivery and after care. New born care after delivery includes;

- Drying thoroughly and wrapping baby in a dry cloth to prevent heat loss.
- Cord clump after delivery to prevent blood loss.
- Infection prevention measures help prevents cord infection which can be fatal.
- Ensuring baby is put to breast within half an hour
- Ensuring the airway is patent and baby breathing well.
- Also physical examination of the newborn.

The aim is to ensure live and safe babies void of infection. (*Kinzie and Gomez 2004).*

1.1.6 Resource Availability

Availability of resources is significant in the provision of good quality service to clients in health facilities. Resources such as equipment, instruments, transport, infrastructure and most important is human resource and water without which the services rendered will be poor. And health care providers especially those dealing with child birth will find it difficult to execute their function.

Policy makers and managers (directors of health services) must ensure resources needed are provided. Oduro, J. (1997) in his study at Dormaa said that, to the manager and care provider, quality of services refers to what is actually provided at the service delivery point and determined by how policy makers and managers convert their resources into services.

1.1.7 Category Of Staff In Labour

The category of staff rendering maternal and child health services in the wards is a contributing factor to the outcome of delivery and the state of health of mother and baby after delivery. The well trained midwives acquire knowledge and skills to better manage labour and there after. The presence of a trained midwife or skilled birth attendant at delivery is essential in averting maternal and neonatal morbidity and mortality. Skilled attendant is a trained personnel and has the requisite skill required to render appropriate maternity services. They are capable of recognising onset of complications and assess risk factors. Skilled staffs observe the women in labour; monitor the foetus during child birth. They are able to perform essential basic interventions should any problem arise. Clients however are referred to higher level of care if complications require interventions beyond their realm of competence (WHO 1999). It was realized that trained traditional birth attendant in most cases cannot save women's live due to their inability to treat complications. Moreover they are unable to refer their clients (Carlough, and Mc Call, 2005). Increasing access to skilled attendant especially at birth is not only a legitimate demand and clinical knowledge but it is cost effective and feasible in resource poor countries.

1.2 **Statement Of The Problem**

Maternal and child health is of much importance to all stakeholders. The Ga West district has much concern about provision of quality maternal and child health care. The maternal care in the health setting is expected to embrace all areas such as antenatal, supervised deliveries, postnatal and post abortion care services. Annual reports of the reproductive and child health unit of the Ghana Health Service show that supervised deliveries are not encouraging as expected (Annual RCH report 2005, 2006). Research findings in the report indicate that cost of delivery, distance to service delivery point and quality care were identified as the main hindrances of access to supervised deliveries. In the Greater Accra Region, out of the six (6) districts, Ga West appears to be one of the worst districts with low supervised delivery, the others being Dangbe East and Dangbe West. In the Ga West district in Ghana, the ante natal coverage is encouraging on viewing the trend from the annual RCH reports. However, this does not go along with the supervised delivery. Most of the pregnant women that report for antenatal services within the district do not report for supervised delivery. The report is as follows, antenatal registrants from 2004- 2007 were 16323(103%), 2005; 14117(106%), 2006; 14324(81%), 2007; 15010(81.1%). Whiles the supervised deliveries from 2004 - 2007 were 6225(39.5%), 5077(38.1%), 4930(28.0%) and 5595(29%) respectively.

What one can infer from this high antenatal coverage and low supervised deliveries is that most of the women deliver at home, probably through traditional birth attendants. Women delivering at home are often brought to the health centre with life threatening complications like severe haemorrhage and puerperal sepsis which could have been detected early and better managed if delivery was under professional care. These warrant concern on the part of the DHMT.

In addition the district has no records of maternal and infant mortality as it refers all serious and complicated cases to other hospitals. However there is the feeling that the district health services are not providing the best quality of care to the women. This requires an assessment of the current situation to identify the problem in the health system. It is therefore important that the quality of maternal care especially supervised delivery be assessed and the view of

the mothers be explored in order to develop strategies to enhance the performance of care and improve on maternal health.

1. 3 Objectives Of The Study

The study has its general objective of assessing the quality of maternal and newborn care during labour and delivery.

1.3.1 Specific objectives

The specific objectives of the studies are as follows;

i. To examine the use of partograph during labour delivery.
ii. To compare infection prevention practice to standard protocol.
iii. To assess interpersonal relations of staff towards mother in labour and delivery.
iv. To examine the care rendered to the newborn immediately after delivery in terms of standard protocol.
v. To assess resources available to ensure quality supervised delivery.
vi. To determine the type of service provider in the labour ward.

1.4 Research questions

This study also embodies the following research questions:

i. Are partographs used during labour and delivery?
ii What goes into infection prevention during birth?
iii What is the nature of nurse- mother relationship during labour and delivery?
iv What are the cares given to the newborn after delivery?
v What type of care is being given to mothers during labour and delivery?
vi Are there resources for the provision of quality maternity service?
vii What category of staff renders service in the maternity?

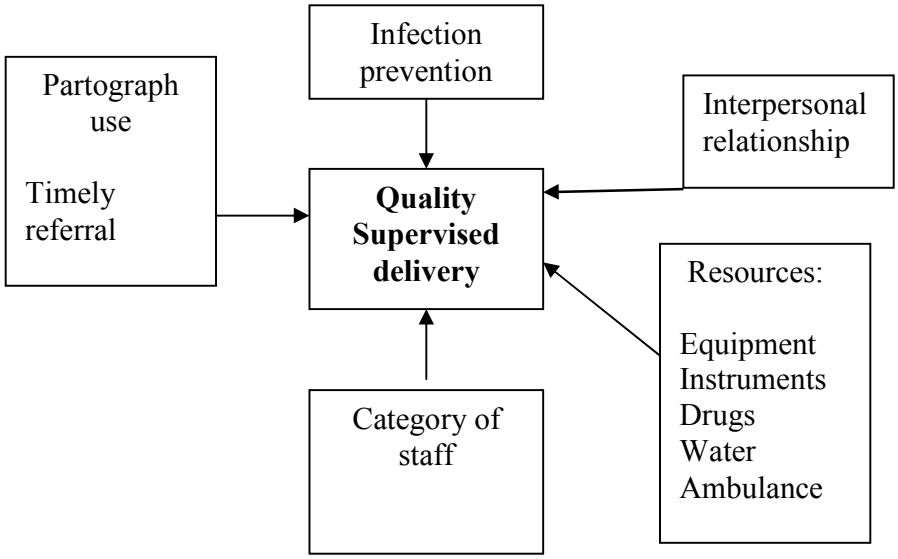
1.5 Conceptual Framework

The conceptual framework, Figure 1, for the study is quality maternal health care.

One of the most important issues confronting the health sector today is the provision of quality care to clients, because it virtually determines their success. This statement equally applies to maternal health care, and the critical part of this is supervised delivery.

With the issue of supervised delivery in the health sector, there is the need to ensure that certain important measures are in place and services rendered as expected. For instance, the use of partograph, infection prevention, availability of resources, and skilled staff are essential for its success.

Figure 1
Conditions For Quality Supervised Delivery



Partograph, a management tool use to monitor labour is vital in the detection of progress of labour. This was lauded and promoted by WHO in 1987 with the view of promoting labour management and in order to reduce maternal and foetal morbidity and mortality.

According to Kinzie (2004), the patograph aid the skilled provider in decisions about a woman's care by furnishing a visual representation of the conditions of both woman and foetus. This enables the skilled provider to determine when to intervene if labour is not progressing normally. In addition partograph keeps ensuring that women and foetus health are carefully monitored in labour, and unnecessary interventions are avoided, and complications recognized and responded to at the appropriate time (Kinzie and Gomez , 2004).

The effective use of partograph promotes confidence, and has reduced both prolonged labour (from 6.4% to 3.4% of labours). The outcome was more marked with caeserean sections fell (from 9.9 to 8.3%) like wise intrapartum still births (from 0.5 to 0.3 %) (*WHO, 1994).*

Infection prevention in the maternity unit especially during labour and delivery is highly essential as its negligence may result in puerperal sepsis and various infections to the mother and baby. Infection prevention in the health set up contributes tremendously to patient's quality care and safety. And for affective infection prevention there is the need for provision of resources (Gerberding, 2001). According to Gerberding, infection prevention should be in the interest of both patients and staff to protect patients and heath care personnel, and promote health care quality.

A high standard of hygiene and sensible infection control practice is the best way to protect workers and reduce the risks of transmission of infections. Hand washing with soap and water after all patient contacts should be standard infection control practice for all staff (Demmler and others, 1986). It is only through standard infection prevention precaution that staff will be safe and mother and baby safe and discharged home healthy without complications.

In addition interpersonal relationship among women and health staff during childbirth need to be cordial to enhance fruitful outcome as women are under emotional stress at this crucial period. D' Ambruoso and others (2005) in their study found that interpersonal aspect of care is the key to woman's expectations and this governs their satisfaction. More over it influence their health seeking behaviour and utilization of health facility. Midwives therefore need to

understand women during childbirth and give them encouragement and support for better outcome. Consequently availability of resources is essential in the provision of quality supervised delivery. The absence or inadequacy of resources, for instance, equipment, instruments, drugs and water will jeopardize the effort of the health staff and will lead to provision of substandard care. Graham and others (2001) specify that skilled attendants cannot function effectively unless attached to a care system.

Category of service provider during childbirth is important to the health and safety of mother and the baby. Skilled attendant at labour will be able to manage labour successfully. The attendant can identify, treat and refer complications beyond her ability. Therefore there is the need for every woman to have skilled attendant at delivery and the post partum period, also timely referral in complications of pregnancy for emergency care. (Campbell O.M.R et al 2006). Quality cares promotes confidence, improves communication and foster a clear understanding of community needs and expectations. If health providers do not offer quality services, they will fail to earn the population trust, and clients will come to the health system only when they are in dire need of curative care. Quality care therefore should be available and affordable (Brown et al, 2000).

1.6 **Rationale For The Study**

An investigation by the researcher showed that no study had ever been undertaken on maternal health care delivery in the Ga West district. Therefore, this study is the first of its kind. Secondly, the study will provide comprehensive information about the state of supervised delivery in the target district and highlight on its major challenges. Thirdly, the findings will assist policy makers, DHMT and other stakeholders to fashion out appropriate interventions to improve further supervised delivery in the district. Lastly, the study will add to the body of literature on quality health care delivery in the Greater Accra Region, and specifically with regards to MDG5.

1.7 **UNIQUENESS OF THE STUDY**

Unlike previous studies which were done in hospitals with unspecified locations, this study was done based upon the location of the health facility which is urban, peri urban and rural in the Ga West district in the Greater Accra Region.

Three data collection instrument were used, namely questionnaire, interview and observation Analysis and interpretation was done appropriately to arrive at valid conclusions.

1.8 **OPERATIONAL DEFINITION OF TERMS**

- **Skill attendant:** A health professional such as midwife, doctor or nurse who has been trained and acquire skills needed to manage normal pregnancies, childbirth and immediate postnatal period and to identify, manage or refer women and newborn with complications.
- **Supervised Delivery:** Delivery conducted by midwife, nurses or doctor with the required skill.
- **Quality Health Care:** Health care services that meet the expectations of an individual or community, and delivered in accordance with professional standard.
- **Partograph** A management tool use to monitor labour which shows the graphical presentation of the progress of labour
- **Maternal Mortality:** Death in women related to pregnancy up to forty two days after delivery.
- **Safe Motherhood:** A woman's ability to have a safe and healthy pregnancy and child birth.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter reviews the available literature relating to maternal health services. The information has being organized in line with the objectives of the study. The following terms will therefore form the basis of the literature review: partograph; infection prevention; mother to child transmission of HIV/AIDS; interpersonal relationship; health workers behaviour; resources; skilled attendant; maternal care; and observation.

2.1 The use of Partograph

The use of partograph is essential for the successful outcome of labour and delivery. This serves as a monitoring tool for the assessment of the progress of labour and the condition of mother and the unborn child. (WHO, USAID, JHPIEGO 2004). During childbirth the mother and baby's state of health may be normal at the initial assessment, but the condition of the woman and her baby can change suddenly during labour, childbirth and the immediate postpartum or newborn period (JHPIEGO 2006). Hence monitoring during labour and delivery should be ongoing and done properly at the correct interval appropriate to the stages and phases of labour. This is important in ensuring the well being of both mother and babies, and also, aid in detection of any abnormalities. (JHPIEGO 2006).

The partograph aids in early detection of abnormal progress of labour and effective prevention of prolonged labour. The risk of infection and postpartum haemorrhage is therefore reduced (WHO/ UNPF 1994). Partograph is not meant to replace adequate screening of women on arrival in labour that exclude conditions of urgent attention or immediate transfer, rather is to detect deviation from the normal as labour progresses (WHO/ FHE). In other words, patograph clearly differentiates normal from abnormal progress of labour and identifies those women who likely require intervention. (Lancet 1994 Jan 4;).

A study done on the use of partograph in labour as an indicator of hospital's quality of care reveal that partograph is being used in majority of labours and that most of the partographs were completed correctly (Nakkazi 2001).

2.2 Infection Prevention

Postpartum infection (or puerperal Sepsis) is one of the causes of maternal death. This infection causes about 15% of maternal death in developing countries. The newborn babies have higher risk of infection due to their immune system not mature (low immunity level). Hence, they are liable to die from tetanus infection. Approximately about 2.5 million newborns die from tetanus and other infections every year. The care attendant there needs to be cautious to prevent such occurrences (Tietjen et al, 2003).

The health staffs are equally at risk of infection as they care for mothers and newborn throughout the reproductive cycle. Through exposure to contaminated body fluids and instruments, healthcare workers and clients are at increased risk to blood born diseases. Infection prevention (IP) practices should aim at preventing infection to both clients and health staff. Precautions such as hand washing before procedures and disinfections will interrupt the cycle of transmission; hence transmission of diseases will greatly decrease.

According to Tietjen and others, hand washing with soap and water is the most practical procedure for preventing the spread of infection and disinfect using antiseptic hand rub. This should be done before and after examining clients and even if gloves were worn especially after contact with blood and other body fluids because gloves may have invisible holes in them. Puerperal infection is still a cause of maternal death, hence must be prevented with strict cleanliness. The skilled attendant must ensure safe delivery and avoid tears and abrasions as these reduces the tissues resistance to infection and any ascending infection may affect the uterus and placental site (Fraser & Cooper , 2003).

Staff with common cold should not work during the most acute phase of their condition, if need be, they should wear face masks whiles attending to the women to avoid them

contracting upper respiratory tract infection. Women should be encouraged to change vulva pads frequently. Vulva cleanliness must be ensured to prevent urinary tract infection. A septic technique practiced when preparing sterilized equipments for the delivery process. Sterile surgical gloves should be used during this time to protect mother and the midwife.

2.2.1 Mother To Child Transmission of HIV/AIDS.

Pregnant women infected with HIV virus have possibility of transferring the virus to their new born. The risk of mother to child transmission of HIV virus during childbirth is estimated at 10-20% if no preventive measures were taken (MNH program) JHPIEGO.

The chances of transmission of the virus are great if the newborn is exposed to maternal fluids and HIV infected blood. To assure quality healthcare the attendant during labour and delivery should avoid:

−Artificial rupturing of the membranes (amniotic sac).

−Giving routine episiotomy.

Instrumental delivery and lacerations should be minimized and effort put in to prevent post partum haemorrhage (Engenderhealth 2007).

The risk of mother to child transmission increases by 2% hourly after the membranes have ruptured (MNH program). Skilled attendant who assist HIV positive women during labour should take care to gently clean the newborns face and body. Extra care should be taken to disinfect all instrument and sheets used during childbirth and to disinfect all surfaces exposed to blood and body fluids (HNCP, USAID.2002).

Caesarean section prior to the onset of labour may reduce the risk of mother to child transmission of HIV as it minimizes the risk of child to maternal body fluids. However, this may increase maternal morbidity and mortality due to possible infection and blood loss. In addition giving a single dose of neverapine to the mother during labour and a dose to the child 48hrs after have been found to reduce the HIV transmission by 50% at a very low cost (Engenderhealth 2007).

2.3 Interpersonal Relationship (Staff Attitude)

Good emotional and physical support during labour shortens the use of analgesics as well as reducing operative deliveries. Even labour that is progressing normally can be stressful and exhausting for women hence the importance of the skilled staff, birth companion to remain encouraging throughout the progress of labour. In caring for women in labour, the attendant should take into consideration the woman's physical needs, her desires, comfort and emotional wellbeing. The level of emotional support to the woman in labour need to be increased when there is growing intensity of labour as this places greater demand on the woman. (Kinzie, 2004)

According to Kinzie continuous care by the same skilled provider throughout the childbirth is associated with reduction in the need of pain relievers, caesarean sections and other inventions in labour. Effective communication among staff present (in the labour ward) should include the mother in labour, and paying attention, listening to her view and responding to her questions makes the labour ward environment safe and secure for the women. They added by saying that physical and emotional comfort measures such as massage, a cold cloth on the forehead helps the woman to cope with labour and the postpartum depression at six (6) weeks incidence is less. Good communication skills are essential in providing high quality service to the women and their newborns. As the woman will feel comfortable to discuss her concerns and feelings and ask questions about any doubt for clarification. It also helps build the confidence and trust in the skilled staff (service provider) and make her more likely to seek care for herself and the baby and return for follow up visits. With good interactions, women may recommend facilities that have this mother baby friendliness to friends and family members.

2.3.1 Health Workers Behaviour

The behaviour of health workers plays a role in woman utilization of skilled care. The perception that the service providers are uncaring or abusive has greater influence on the use of skilled care than other well known factors such as access and cost of service. (Tarnpol, 2005; D'Ambruoso et al., 2005).

A study done on women accounts of maternity services during labour revealed that women expect humane and courteous treatment from health professionals, and have a change in their minds about place of delivery and recommendation to others if they experience degrading and unacceptable behaviour (D'Ambruoso et al.., 2005). In addition findings reveal that patient's satisfaction with care is an important element of quality care, and there is growing evidence that patient perceived quality of maternal health services particularly provider attitudes has a significant influence on the women's willingness to use skilled childbirth services. (Family care int. 2002)

In Kenya, about 65% of respondents expressed their dissatisfaction with delivery in health facilities due to provider's attitude towards them. Women spend long waiting time even with emergency cases. About two thirds complained about their dissatisfaction with their case related to poor attitudes of health staff (baseline survey 2005). Helping health workers to be more caring in their behaviours towards client is a way to make skilled care more appealing to women (Tarnpol 2005). Giving birth is an emotional experience as it is the culmination of many hopes and fears. Mothers need emotional support and encouragement to adjust to this experience. Women need to be assured by service providers' attitude and support (Fraser and Cooper 2003)

Service providers need to build their workers confidence by giving clear and careful instruction and allow women to ask questions and discuss any anxiety. Encouraging them, make them feel accepted and loved.

Providers caring behaviour towards women in labour is the simple action that maternity health care providers can express their kindness and respect to these women. Attending to

them in privacy makes them feel comfortable. Women receive caring behaviour when the midwife and doctors respond to their needs promptly and provide re-assurance and information on ways to assist themselves and make them aware of what to expect during labour and delivery.(Family Care Int., New York accessed at www. Familyint.org. on 2nd February 2008).

According to Fraser and Cooper (2003), women in labour have better birth outcome and a decrease in the labour when they have a supportive person with them, or an encouraging and family member or friend. Ultimately having good interpersonal relationship with a woman means treating the woman in labour as "you" would wish to be treated if you are in that situation. According to a study done in the U.S, reveal that continuous presence of the midwife improves women's relationship with carers. This can reduce the length of labour, and can also affect the need for pain relief, oxytoxic augmentation and operative delivery(Mugford, 1993).

In a study conducted in Chile using open ended questions "being treated as human being" was how many of the women judged if services were of high quality. Cleanliness at facility, having adequate time with a staff and being encouraged to learn about their own health were among other attributes that clients were concern with (Vera H. 1991).

2.4 Availability of Resources

Availability of resources in the provision of maternal health services are basic necessities. Equipment, instruments and supplies such as drug, oxygen and water are essential for proper functioning of any maternal and child health unit.

The presence of qualified and skilled staff becomes inefficient without the basic resources. As such one cannot function properly, putting the precious life of the women and the child to be born at stake. Resources have been identified as important consideration in providing quality services to mothers. Basic amenities, such as water and sanitation should be provided; this will improve the utilization of the services. (Oye-Ita et al 2007). It has been confirmed by researches that to provide good quality obstetric care, it needs building, trained staff,

equipment and drugs. They indicated that making clinical policies more evidence based will improve on the care quality, and will improve the health outcome in women and their babies. (Smith and Garner, 2001).

2.4 Skilled Attendant

The presence of skilled attendant during childbirth and the immediate postpartum newborn period is essential in saving the lives of women and their babies. They have the skills necessary to deliver essential maternal and newborn care in any setting (including the home, the community health post and the hospital). (Kinzie and Gomez .2004).

Access to skilled birth attendant is one of the most important intervention for reducing maternal death.(D'Ambruoso et al, 2005). This is in relation to availability of enabling environment, such as provision of drugs, supplies of other logistics, referral facilities, supportive management and supervision. These will enable the attendant to perform efficiently to reduce maternal morbidity and mortality.

Maternal mortality is generally lower in countries where mothers have skilled professional care attendant during childbirth (WHO, 2005). Postpartum haemorrhage(PPH) which is excessive blood loss within 24hours after delivery is the single most important cause of maternal death worldwide and account for about 50% of postpartum maternal deaths in developing countries. According to Sanghvi et al JHPIEGO corporation, about two- thirds of postpartum haemorrhage occur in women without any identifiable risk factors, hence every woman must be observed closely after childbirth for signs of PPH which require the presence of a trained skilled attendant. They added that active management of third stage should be routinely used by skilled providers at all birth to help prevent the occurrence

In a study done at rural Malawi on reproductive health services, it was found that maternal mortality and peri natal mortality is high. It was said that skilled assistance at delivery can result in improve pregnancy outcome (Van den Broek, White et al 2003). Delvaux and others 2007 in their work on quality normal delivery found that over all quality of care was poor, although most women were attended to by professional midwife.

2.6 **Newborn Care**

Assessing the health of the newborn is very important for detecting any problems in their earliest, most treatable stages. Congenital anomalies, major and minor occur in 3-4% of births. Some are recognized at birth and others become obvious later. Two-thirds of neonatal deaths occur during the first week. These can be prevented by early detection and treatment when babies are thoroughly examined after birth and observed during the postnatal period (Tamil, 2004).

WHO (1996) guidelines on essential newborn care emphasizes on cleanliness, thermal protection, eye care, immunization, initiation of breastfeeding, early and exclusive breast feeding and management of illnesses. Midwives carry out initial examination of the newborn infant to rule out any abnormalities.

Babies are covered with clean cloth, breathing is assessed and baby observed for passing of first stool. Skin to skin contact with mother ensured and initial breastfeeding initiated (Kinzie and Gomez (2004). The newborn care was judged against the standard. (See appendix V).

2.7 **Maternal Care**

To assess quality in reproductive health service means, measuring the gap between the quality of care perceived by the providers, and as perceived by the client or women (expectations). Thus quality service should have special emphasis on women's experiences and expectations and the women's level of satisfaction with the service as compared with the views of the care providers.

According to Bergstrom (2003), good quality maternal care should fulfill the criteria;

- Involve the women in decision making and regard her as partner in health care.
- Care should be available and at close proximity as possible to the women and at a health facility providing safe and effective service.
- Be equipped with essential supplies for example drugs and equipment.
- Be staffed by care providers that are non judgmental, respectful and responsive to women's needs.
- Give comprehensive care and linkage to other reproductive health services.

More over Bergstrom suggested its important to recognize quality maternity care not as a luxury but rather a way of making the services cost efficient by meeting the women's needs in an appropriate way. Donabedian (1979) defines quality of care as "the extent in which actual care given is in conformity (line) with the present criteria for good care"

To assess the quality of care of an institution, one needs to consider

The quality of the provision of care (care provided)

The quality of care as experience by users (clients)

2.8 Observation Method

Observation techniques are essential in assessment of the care given to women which relate to cleanliness, provider client relations, and the equipments available for rendering the proper services and so on. Observation helps as it's an effective way of verifying aspects of care described in provider and client interviews.

The frame work presented in this paper on the quality of supervised delivery viewed has adopted elements from Donabedien quality assessment framework using the structure, process and outcome.

Structure	**Process**	**Outcome**
Staff, building	partograph use	client satisfaction
Equipments, drugs	infection prevention	morbidity
Transport	interpersonal relations	mortality
	Maternal and new born care	Healthy mother and baby

Structure

The structure deals with the tools and resources at the disposal of the service providers as well as the physical setting in which the service is provided.

It includes the human, financial and physical resources used in the provision of services in the maternity unit.

Process

This is made up of the set of activities and interactions that went on between the provider and client during the transaction of the actual care. With this the structural demands are used to provide the service.

Outcome

The outcome includes the indirect impact on the client satisfaction with the services offered (she received) and her health seeking behaviour (during such periods). In the case of direct impact of the delivery outcome, these are changes (both desirable and undesirable) expected. This means, whether or not, the delivery process was successful and baby and mother healthy and cheerful.

For the purpose of this study the measurement scale is drawn to assess the care rendered to the women. See appendix. IV

2.9 **Knowledge Gaps**

A lot is known about supervised delivery but not much emphasis has been placed on quality. This study attempted to assess the quality of supervised delivery and has added the following:

- Supervised deliveries being carried out in the private clinics but not known to the district health administration hence do not reflect in their reports.
- Midwives are friendly and caring. Hence, clients come from other places outside the district to seek care.
- Majority of women who visit the health facilities for maternity services are traders and artisan. Civil servants are very few, approximately 6%.
- Little was known about the situation in the health facilities in terms of resources but now we know they lack resources to work with for example no vehicles for referral services.
- About 50% of women still deliver at home in the rural areas assisted by grandmothers and relatives.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter discusses on the methodology for the study and gives insight into the study design, profile of the study area, target population, sampling, data collection and analysis, as well as the limitation of the study.

3.1 Study Design And Type

This was descriptive cross sectional study involving the use of questionnaire. The questionnaire was administered on three categories of clients within the district; classified as urban, peri-urban, and rural. These locations may have influence on the healthcare seeking behaviour of clients due to differing amenities and socio-economic statuses.

3.2 Profile Of The Study Area

Ga west district is the third largest district in Greater Accra region with Amasaman as its district capital. It has a population of 462,382. The district is bordered on the west by Awutu-Afutu-Senya district, Akwapim South district to the North, to the south –East by Accra Metropolis and the Atlantic ocean to the south. It has over 300 scattered communities. Thirty percent of the communities are peri-urban and urban with relatively high population density. The remaining is rural. The rural settlers are farmers, of which majority are peasant farmers who grow crops such as okro, pepper, onion and few commercial farmers who cultivate pineapple, pawpaw, water melon, mango and pepper, for export. There are also fishermen in the coastal area along Densu River.

Women are involved in cassava and gari processing and fish mongering in the coastal communities. A number of people, mostly young men are engaged in sand winning.

In the urban and sub urban areas are artisans, traders, civil servants and industrial workers.

The urban and some peri-urban communities have potable water supply. The rural communities depend on water from bore holes, rain harvest and streams. Those who can afford pay for water supplied by tankers. Roads connecting the communities are unpaved and in poor condition hence public transport is scarce and expensive. Train transport is used by the villages along the rail lines that cross the district. The district is divided into three sub districts (Health zones) namely: Amasaman, Weija and Obom.

The Ga west district has eight functional public health facilities: 3 health centres and five community initiated clinics. Private and maternity homes total 71 with 35 clinics and 36 maternity homes. The number of traditional birth attendants (TBAS) is forty two (42).

3.3 Study Population

The study populations were the women with children from day one to three months who attended child welfare and post natal clinics in the district. Midwives, nurses and doctors working in district health facilities. The mothers included deliveries from both maternity home and government facilities.

3. 4 Sampling

Since it is impossible to elicit information from the entire study population, samples were selected.

3.4.1 Sample Method

Respondents were sampled as follows. The seven health facilities with labour ward facilities in the district were sampled from the three sub districts. Two large sub districts which had total of six labour ward facilities in different communities and a third sub district has only one health centre with labour ward which were selected. A systematic sampling was used to select respondents among clients. The expected delivery from these facilities were estimated to be about 18,495 from which a sample of 325 respondents were to be selected given a sampling interval of about 57 (that is 18945 / 325). Due to time factor and the flow of clients through the facilities, using a sample interval of 57 would have been impractical.

Consequently, after a random start of the first respondent, sampling interval of three was used until a sample size of 325 was obtained. Every third mother at the facility at the time of the interview was selected. Purposive sampling was used to select staff. Purposive sampling means that, in the judgment of the researcher, those selected were in a better position to provide information on the subject of research. All available staff on duty in the labour ward during the period of study were administered with questionnaire.

Exclusion Criteria

- Mothers who delivered their babies outside the district.
- Mothers with babies above 3 months were not included.

3.4.2 **Sample Size**

According to the 2000 population census the population of Ga West stood at 462,382.
Since the expected pregnancy is 4% of the total population in Ghana, the number of expected pregnancy was 18495. Using EPI INFO software version 6, expected frequency of 30%, worse accepted frequency of 25%, confidence interval of 95%, gave a computed sample size of 317, rounded up to 325.

3.4.3 Study Variable

For this study, the dependent variable was supervised delivery. While independent variable were as follows:

- Partograph use
- Infection prevention
- Interpersonal relations
- Resource availability
- Category of staff

These variables and how they were measured are explained in the appendix (see appendix IV).

3.5 Data Collection

Pre-testing

Before the questionnaire could be taken to the field, it was pre-tested, the essence of which was to see if the questionnaire would elicit the appropriate responses.

Pre-testing of questionnaire was done in one health facility with labour ward and a child welfare clinic by asking some service providers to fill them.

Tools

Three types of data collection instruments were used and these were:

1. Questionnaire
2. Interview guide
3. Observation (checklist)

The questionnaire was used to elicit information from the service providers, mainly midwives. The questionnaire was designed taken into consideration the study objectives. It incorporates both open-ended questions and close-ended questions. (see appendix l)

An exit interview was carried out with mothers who visited the child welfare clinics because the women seemed not to be conversant with filling a questionnaire. An interview schedule was used for this purpose. (See appendix ll). Observation of labour wards was done by the researcher to see at first hand prevailing conditions and, also to ascertain the truthfulness or otherwise of information provided by the service providers. Checklist was used for this purpose. (See appendix lll)

Ethical Consideration

Before data collection began, the regional director of health services, the District Director of health services and the district management team were briefed about the study and permission sought to proceed.

A community entry was done in areas with health facilities where data were collected. All participants were informed about the purpose of the study the benefit and risk their rights to refuse or withdraw from the study. Informed consent was obtained verbally after needed information and explanation.

In order to gain access to the labour ward, permission was obtained from the principal nursing officer of the maternity unit, medical assistants and midwifery superintendents of the various health centers, where the participants were recruited from and observations done in the labour wards. The women were talked to so that they could feel free to take part in the study. They were therefore encouraged to express their views and concerns.
All interviews of clients were done in privacy, confidentially and anonymity was assured hence, names were not required from participants. The use of camera and taking of notes were explained to participants. The picture below shows a client being interviewed

Picture 1

The researcher interviewing a client

Data was collected from women at the postnatal clinics and child welfare clinics at seven health facilities. Women met in the post natal wards were followed to their home and interviewed after discharged. A total of 325 clients were interviewed. The providers view was also elicited by administration of questionnaire to 50 staff (ward manager inclusive) working in the labour wards throughout the districts. The wards in charges were directly interviewed to obtain information on their wards capacity to provide quality services. Observation was done in the labour wards and lying in wards to obtain information on the manner in which services are provided as information from providers on the care delivered to the woman could be subjective.

Likewise the women as they may only dwell on staff attitude and not seeing other things that goes on during the care delivery at that special moment.

3.6 **Quality Control Measures**

Adequate time was spent reviewing the questionnaires to ensure they were clear and ambiguous in local languages. Each day's work was reviewed and potential problems were addressed on the field. Researcher was on the field with research assistants to ensure constant supervision of data collection. Completed questionnaire from the field were checked for completeness and numbered accurately before storage.

3.7 **Data Management And Analysis**

Data from completed questionnaire were coded and data entered into computer for analysis using EP1 INFO version 6. Other information obtained from client during interview and response to open questions in the structured interview were analysed manually. Descriptive analysis were mainly done; frequencies,

3.8 **Limitations**

Observations of staff in the labour wards was done only in the Government health facilities although some clients interviewed delivered at private health institutions within the districts. Those women who loss their babies before the study were not included since they did not attend the post natal and child welfare clinics. Due to lack of time and resources, household survey could not be done to include them.

CHAPTER FOUR
RESULTS

This chapter presents and analyses data collected from clients and service providers by way of interviews and the use of questionnaires respectively. In addition, the observations made by the researcher is also presented and analyzed here. Importantly, the data gathered from the respondents and through observations have been analyzed. Further more, some of the data collected will be presented in tables, together with frequencies to enhance easy analysis. It must be recalled that the interviews with clients were from three district areas, namely: rural, peri-urban and urban. The analysis of responses from clients will reflect this distinction.

4.1 **Background Characteristics Of Respondents**

Table:1 Age distribution-*clients*

Age category	**Urban**		**Peri-urban**		**Rural**	
Client	**Frequency**	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
15- 20	5	4.90	13	9.78	11	12.22
21 - 25	18	17.65	23	17.29	20	22.22
26 - 30	43	42.16	67	50.38	39	43.33
31 - 35	27	26.47	23	17.29	9	10.00
36 - 40	9	8.82	6	4.51	7	7.78
41 and above	0	0	1	0.75	4	4.45
Total	102	100.00	133	100.00	90	100.00

The modal age class of urban, peri-urban and rural areas is 26 – 30 years with 42.16% of the respondents in this range coming from urban, 50.38% in the peri-urban and 43.33% in the rural areas and the least age class is 41 and above as shown in the Table above**.**

Table:2 ***Education of clients***

Education	Urban		Peri urban		Rural	
	Frequency	percent	frequency	Percent	frequency	percent
No education	17	16.7	18	13.5	26	28.9
Primary	59	57.8	86	64.7	46	51.1
Secondary	16	15.7	20	15.0	17	18.9
Tertiary	10	9.8	9	6.8	1	1.1
Total	102	100.0	133	100.0	90	100.0

The highest educational attainment of most clients is primary education with 57.8% in urban, 64.7% in peri urban and 51.1% in rural areas, followed by secondary education and the least educational level attained is tertiary across all the areas within the district. Client's education helps to understand situations and influence their understanding of questions asked and their responses.

4.2 The use of Partograph

Partograph is being used in all the health facilities throughout the districts. Only one of the rural health facilities has no evidence of partograph use. This is due to the fact that she has no delivery records and no client was met in labour in that facility.

However, although the partographs are being used, in most cases the observations charted are incomplete. Following are tables on tools use in monitoring labour.

Table:3 ***Tools use to monitor labour***

What tool do you use to monitor labour?	frequency	percent
Partograph	39	95.1
Partograph and labour chart	2	4.9
Total	41	100.0

The table above indicates the tool used by midwives (respondents) in monitoring labour.

It shows that 39 respondents making 95.1% used partograph to monitor labour and 2 respondents totaling 4.9% used both labour chart and partograph for monitoring labour.

Table :4 ***Impressions about the quantity of tools (partograph)***

What are your impressions about the quantity of these tools	frequency	percent
Very sufficient	6	14.63
Sufficient	34	82.93
Insufficient	1	2.44
Total	41	100.0

The table above indicates the impressions about the quantity of the tools used for monitoring labour.14.63% representing 6 respondents said the tools were very sufficient.34 respondents representing 82.93% replied that the tools were sufficient and 2.44% representing 1 respondent responded that the tool used were not sufficient.

4.3 **Infection Prevention**

Generally all the labour wards visited were clean and things well arranged when no client is in labour. Delivery instruments were clean, sterilized and in a sterile tray with cover. Sterile gloves were used during deliveries and disposable gloves used for other duties. A septic technique was practiced by midwives using chisel forceps to pick items from sterile drum. 5% chlorine is being used in all the labour wards to disinfect soiled equipments and instruments before sterilizing. Same solution is use to clean other soil surfaces and floors.

Hand washings done under running water using soap and single hand towels.

The urban centre uses running tap with sink whiles peri -urban and rural health facilities use veronica bucket over sink or bowl. In all water supply is sufficient for smooth running of the labour wards as tanker services, bore hole and rain harvest is being used at places without tap water. Hand washing is done after every procedure; meanwhile alcohol hand rub is not practiced. No staff with common cold or other virus infection was met in the labour ward

attending to client. With all the above well done according to standard. However in some peri urban facilities, when the ward is busy with several clients reporting in labour instruments are hurriedly sterilized for use, since delivery sets are insufficient. Clients are transferred soon after delivery to post natal ward to make way for others. Delivery beds are hurriedly cleaned to receive the next client. In some occasions, for vagina examination to assess progress of labour for new arrivals, clients on delivery couch are excused to get down making way for vagina examination for their counter parts. At times couch are not cleaned after use, and client is asked to get back to bed. Deliveries are at times done on the floor in case of emergency. These are not good practices and do not augur well for standard infection prevention.

In other peri urban facilities, the staffs are not under pressure as clients in labour are received once in a while, hence services are provided accordingly and infection prevention quiet better at these places. The same applies in rural health facilities. Artificial rupturing of membrane are not practiced, rather it was allowed to rupture spontaneously.

Table: 5 ***Condition of ward environment***

Condition	Urban		Peri urban		Rural	
	Frequency	percent	Frequency	percent	Frequency	Percent
Very clean	8	8.4	6	5.4	-	-
Clean	82	86.3	102	91.07	44	97.8
Dirty	5	5.3	4	3.6	1	2.2
Total	95	100	112	100	45	100

86.3% of mothers said that the ward environment was clean, 8.4% indicated that it was very clean whiles 5.3% from the urban setting complained of it being dirty. In the peri urban areas 91.07% of clients rated the ward as clean, very clean 5.4% and dirty 3.6%. The rural facility had single client (2.2%) responding that the ward was dirty and about 98% responded the

ward was clean. Further inquiries from client who complained about the state of the ward, mainly refer to the wash rooms. Critical examination of the data and notes taken reveal that clients who complained are mostly from the category of tertiary education, and are from the urban and peri urban areas.

Table:6 ***How equipment/items are sterilised for use***

How items are sterilised	Frequency	Percent
Autoclave after soaking in chlorine solution for 10 mins	3	7.3
Boiling after soaking in chlorine solution	31	75.6
Autoclaving and boiling	7	17.1
Total	41	100.0

Three(3) people representing 7.3% of respondents used autoclaving for sterilizing equipment.75.6% representing 31 people used boiling whiles 7 representing 17.1% used both boiling and autoclaving.

Table :7 ***Care of soiled equipment***

How soiled equipments are cared for	Frequency	Percent
Soak in 5% chlorine for 10 minutes	40	97.6
Soak in dettol solution for 10 minutes	1	2.4
Total	41	100.0

From the table above, 97.6% of respondents cared for their soiled equipment by soaking it in 5% chlorine for 10 minutes whiles only 2.4% soaked their equipment in dettol solution for 10 minutes.

4.4 Nurse Mother Relationship

Some midwives give words of encouragement to clients in labour, others do not. Observations carried out in the six effective functioning labour wards reveal that midwives in the rural health facilities have a better relationship with their clients than those in the urban and peri urban setting. Only few midwives inform clients about progress of labour and congratulate them after delivery. Most midwives relate to clients nicely and speak kindly to clients, however few are those who shout on clients for little mistakes done, and some at times go to the extreme. Thus agrees with the clients view that some of the staffs are abusive hence their decision to visit other places. Here come the results on their relationship.

Table:8 ***How staff welcomes clients to the ward***

Responses	Urban		Peri urban		Rural	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
With a smile & encouraging words	90	94.7	98	87.5	44	97.8
With discouraging words	5	5.3	14	12.5	1	2.2
Total	95	100.0%	112	100.0%	45	100.0%

About 95% of clients who receive care from the urban health facility indicate they were welcome well into the ward; same applies to 87.5% and 97.8% of clients from peri urban and rural areas, respectively.

However, 5.3%, 12.5% and 2.2% of urban, peri urban and rural clients respectively complained of being welcomed with words that are discouraging.

The one client from the rural area indicate that the staff was not nice to her and she was left in the darkness alone with a watchman, and told to send for the midwife when the need arise.

Peri urban: Observation carried out in the ward recall that some of the bad attitude show up when the staff over worked and are under pressure.
Majority of midwives welcome the women into the ward, and direct them on what to do.

Table:9 ***Do midwives answer your questions?***

Responses	Urban		Peri urban		Rural	
	Frequency	percent	Frequency	Percent	Frequency	Percent
No	22	23.2	15	13.4	5	11.1
Yes	73	76.8	97	86.6	40	88.9
Total	95	100	112	100%	45	100%

On enquiring from clients, whether their staff responded to their questions asked while in labour? Most said they had responded to their questions and request.

Majority of women's questions were answered by midwives. 76.8%, 86.6% and 88.9% of women from urban, Peri – urban and rural respectively had response from the service providers attending to them. Those who had no responses were in the minority. Some of these were people who were not even sure if they asked any question at all whiles in labour.
This group constitutes 23.2% from urban, 13.4% from peri – urban and 11.1% from rural areas.
Responding to a persons question is a good way of encouraging communication flow and promoting support. These also make the client relaxed and have assurance of good care.

Table:10 ***Relationship between women and midwives during labour and childbirth***

Nurse mother relationship	Urban		Peri urban		Rural	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Excellent	13	13.7	2	1.8	-	0%
Good	78	82.1	95	84.8	41	91.1
Bad	4	4.2	15	13.4	4	8.9
Total	95	100%	112	100%	45	100%

About 82% of women from the urban areas, 85% from peri urban and 91.1% from rural areas indicated that the relationship between them and midwives during childbirth was good. 13.7% from urban area and 1.8% from peri urban describe the relationship as excellent as they stated the midwives who attended to them did well. Meanwhile 4.2%, 13.4% and 8.9% of client from urban, peri urban and rural areas indicated that the relationship between them and midwives were bad.

Some of those clients went on to say that such midwives must be counseled on how to relate to mothers. Others said they would seek care at other places for future care.

Table:11 ***Women view about service provider***

Responses	Urban		Peri urban		Rural	
	Frequency	percent	Frequency	percent	Frequency	percent
Very friendly and caring	5	5.3	6	5.4	3	6.7
Friendly and caring	79	83.1	79	70.5	37	82.2
Not friendly, but cares at times	9	9.5	21	18.7	5	11.1
Abuses and shout at mothers, not caring	2	2.1	6	5.4	-	-
Total	95	100	112	100%	45	100

From the table above 83.1% responded the midwives who attended to them were friendly and caring. 70.5% and 82.2% of service providers were friendly and caring as stated by women from to peri-urban and rural areas respectively. Midwives that were very caring constituted 5.3%, 5.4% and 6.7% from urban, peri – urban and rural respectively.

The urban had 9.5% of midwives not friendly but cares at times, 18.7% and 11.1% of such midwives are from the peri urban and rural areas.

Clients as well indicated that 2.1%, 5.4% of midwives from urban and peri -urban are those who abuses and shout on them. These shows that about 83% of midwives in the district are caring, however, the midwives from the peri urban facilities are in the majority in terms of abusing and shouting on women in labour.

4.5 Maternal And Newborn Care

Actual nursing care rendered is quiet good. It is observed that midwives explain procedures to their clients and seek their concern before carrying out their duties. Midwives are only interested in the foetal heart beat and the rhythm to detect the state of the baby in utero. Time is not taken to count fully for a minute. Other vital signs are not checked hence no records

are documented after the initial records at the time of admission. Only one or two midwives carry out subsequent observations on the mother.

Babies delivered in the heath facilities are all wrapped in cloth to give them warmth, and kept by their mothers. It was observed that babies are not put to breast after delivery.

In addition observation in the ward reveal that babies after delivery are put in cot and left alone, attention is paid more to mothers first, before attending to babies. Privacy is rare; relatives are at times allowed in to encourage their people, mainly in the busy labour wards.

Table:12 ***Place Of Antenatal Care***

Responses	Urban		Peri Urban		Rural	
	Frequency.	Percent	Frequency.	Percent	Frequency.	Percent
Health Centre	78	76.5	19.8	88.7	85	94.5%
Maternity Home	20	19.6	14	10.5	3	3.3%
TBA	4	3.9	1	0.8	2	2.2%
Total	102	100	133	100	90	100%

On finding out where women had their antenatal care before delivery; in the urban facility, 76.5% received ANC at the health centre, 19.6% at private maternity home and 3.9% from traditional birth attendants (TBA).

Peri – urban client's revealed 88.7% from health centre, 10.5% from maternity homes and 0.8% from TBA. Rural clients revealed 94.5% had ANC from the health center, 3.3% from maternity home and the remaining 2.2% from traditional birth attendants.

Table:13 ***Place Of Delivery***

Responses	Urban		Peri Urban		Rural	
	Frequency.	Percent	Frequency.	Percent	Frequency.	Percent
Health Centre Facility	95	93.14	112	84.2	45	50%
Home	1	0.98	15	11.3	24	26.7%
TBA	6	5.88	6	4.5	21	23.3%
Total	102	100	133	100	90	100

The data above shows that in the urban area 93% of clients delivered at the health facilities, which was attended to by doctors and midwives, 0.98% delivered at home probably by grand mothers and relatives and 5.88% were with traditional birth attendants.
In peri-urban areas, 84.2% delivered in the health facilities, 11.3% at home and 4.5% had their babies with the TBAs. With rural health clients 50% had their babies at the health centre 26.7% at home, and 23.3% with traditional birth attendants.

4.5.1 Reasons For Place Of Delivery

When asked the main reasons for their choice of place of delivery, about 74%, 83% and 91% from urban, peri – urban and rural responded that is safer and this are mainly people who delivered at the health facility. The other group who had delivery at home and with TBA from the peri-urban which constitutes TBA 9(6.8%) grandmother 12(9.0%) and rural TBA 21(23.3%), grand mother 24(26.7%).
Women who delivered at home and with TBA gave variety of other reasons. These include, lack of transport, non availability of relatives to send them to the health centre, bad attitude of staff and family tradition. Some also indicated that they are not actually aware that they were in labour, and that it was sudden.

Table:14 ***Waiting Time***

Time spent before attended to	Urban		Peri urban		Rural	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
5 Minutes	86	90.5	75	66.9	34	75.6
10 Minutes	4	4.5	26	23.2	9	20
20 Minutes	3	3.3	5	4.5	2	4.4
30 Minutes	2	2.1	6	5.4	-	-
Total	95	100%	112	100%	45	100%

From the table above 90.5%, 66.9%, 75.6% of clients from urban, Peri – urban and rural respectively are attended to within five minutes on reporting at the Labour ward.

This shows that the majority of clients are attended to immediately they report at the Labour ward. Clients who waited for about 30 minutes before attended to are the least seen, this are 2.1% from urban and 5.4% from peri- urban.

The reason given according to clients who gave those responses is that, the midwives were busy hence they were not attended to on time.

Reasons given by clients;

Urban: Midwives were busy attending to other clients

Peri urban: - Ask to wait until they transfer one client to post natal ward and get the couch ready for use.

- staff busy attending to bleeding case
- the midwife was not available on time

Rural: Midwife not available, have to call her from her residence.

Table:15 ***Were you provided with privacy?***

Responses	**Urban**		**Peri - urban**		**Rural**	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	71	73.7	49	43.75	29	64.4
No	25	26.3	63	56.25	16	35.6
Total	95	100%	112	100%	45	100%

Urban: About 74% of clients from urban facility indicated they had some privacy during childbirth. Meanwhile 26.3% from the same urban area said they were not given privacy.

They indicated that the delivery room is only one and they are two women in labour at the same time. Those who had privacy claim there were in labour alone.

Peri urban: The clients who indicated they had privacy were less than those who had no privacy. About 44% had privacy while 56% were not given privacy.

Some alleged there were other people who enter the labour ward. Meanwhile, they were about two or three in labour at the same time.

Those who had privacy were alone in the labour ward

Rural: About 64% of client indicated they had some privacy whiles in labour; whiles 36% said they were not given privacy.

Majority had privacy in the rural health facilities because they were alone at the time in labour.

Table:16 ***Reason For Place Of Choice***

Responses	Urban		Peri Unban		Rural	
	Frequency.	Percent	Frequency.	Percent	Frequency.	Percent
Its safer	70	73.7	93	83.1	41	91.1
Cost affordable	1	1.0	2	1.8	0	0
Closer to the house	24	25.3	17	15.1	4	8.9%
Total	95	100	112	100	45	100

On finding from clients their reason of choice of place to have their babies, 73.7%, 83.1% and 91.1% of clients from urban, peri urban and rural areas fells its safer for them to deliver at the health facility. Meanwhile 25.3% 15.1% and 8.9% of urban, peri urban and rural clients said is because the health facility are closer to their houses and easily accessible whiles 1.0% and 1.8% of client from urban and peri – urban said to them its because the cost is affordable.

Table: 17 ***Assistance At Delivery***

Delivery Assistant	Urban		Peri Urban		Rural	
	Frequency.	Percent	Frequency.	Percent	Frequency.	Percent
Doctor	4	3.9	5	3.7	1	1.1%
Midwives	91	89.2	107	80.5	44	48.9%
TBA	7	6.9	9	6.8	21	23.3%
Grandmother	-	-	12	9.0	24	26.7%
Total	102	100	133	100	90	100%

From the above table, it was clear that majority of deliveries in the district are done by midwives. 91 (89.2%), 107(80.5%) and 44(48.9) from urban, peri urban and rural

respectively are deliveries conducted by midwives. 4(3.8%) 5 (3.7%) 1 (1.1%) are caesarean section from urban, Peri urban and rural respectively it must be said that, the one client for rural is a referred case to the district hospital for caesarean section

Deliveries, by TBA constitutes 6.9%, 6.8% and 23.3% for urban, peri urban and rural respectively.

Finally are the Deliveries by grand mothers which constitute 9.0% and 26.7% from peri urban and rural areas.

Table: 18 ***Client Impression About Way Treated***

Responses	**Urban**		**Peri Urban**		**Rural**	
	Frequency	Percent	Frequency	Percent	Frequency	Rural
With Much Respect	5	5.3	4	3.6	3	6.7
With Respect	87	91.6	98	87.5	41	91.1
With Disrespect	3	3.1	10	8.9	1	2.2
Total	95	100%	112	100%	45%	100%

From table above, about 97% of client in the urban health are had the perception of being treated with respect and 3% said they were treated with disrespect.

Some of the reasons for perception of being disrespectful to clients are,

- staff shouting on clients
- Talk to them as though they do not know any thing or know their aim

Peri – urban: About 91% of client indicated they were treated with care and respect, however 9% said staff met did not give them due respect.

Some actions mentioned as being disrespectful to them are;

Midwives were rude, arrogant and shout on them and at times some talk to client any how as they will do to their children at home.

Rural: About 98% of client claimed they were treated nicely with care and given due respect. 2% claimed the midwives did not give them any due respect.

Table:19 ***Client satisfaction with care received***

Client satisfaction	Urban		Peri urban		Rural	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very satisfied	9	9.5	10	8.9	1	2.2
Satisfied	80	84.2	94	83.9	43	95.6
Dissatisfied	6	6.3	8	7.1	1	2.2
Total	95	100%	112	100%	45	100%

From figures above; in urban areas about 93.7% of clients indicated they were satisfied with the care received, whiles 6.3% said they were dissatisfied.

Peri urban – About 93% indicated they are satisfied; however 7% are dissatisfied with the care given by the mid wives.

Rural: About 98% claimed they are satisfied with care received and 2% dissatisfied

Table: 20 ***Would You Like To Visit Again?***

Response	Urban		Peri urban		Rural	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
No	15	15.8	14	12.5	2	4.4
Yes	80	84.2	98	87.5	43	95.6
Total	15	100%	112	100%	45	100%

On asking clients whether they would like to visit again for their next child, these are the responses;

Urban: approximately 84% said they will visit again for their next child, even those who claim this is their last child said they will recommend the health facility to others. 16% said they will not visit again.

Peri – urban: 85.5% indicated thy will visit for their next baby, however 12.5% still want to try other facilities, probably hospitals springing up.

Rural: 95.6% indicated, they will visit for their next baby, but 4.4% said they will not visit again.

Table: 21 ***Care Of Babies Cord***

Person responsible	Urban		Peri urban		Rural	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Midwives	7	6.96	5	4.5	-	-
Self	83	91.2	98	87.5	36	80%
T BA	2	1.96	9	8.0	9	20&
Total	102	100	112	100	45	100%

Source: Field data

Care of babies cord is important and if not properly done can be a source of infection to the babies. From the above table; about 7% of babies cord is cared for by midwives in the urban area. Data collected shows that these were all done by private maternity homes. 91% are done by the client's them-selves and about 2% cared for by Traditional Birth attendants.

Peri urban- 4.5% are cared for by midwives, 87.5% by baby mothers or close relatives and 8% by traditional birth attendants.

Rural – In these areas 80% of babies cord is cared for by their mothers, or close relations and 20% is by traditional birth attendants.

Table: 22 ***Any Education And Counseling On Self/Child Care Before Discharge?***

Response	Urban		Peri urban		Rural	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
No	9	9.5	16	14.3	5	11.1
Yes	86	90.5	96	85.7	40	88.9
Total	95	100%	112	100	45	100

On the question of whether mothers were counseled on care of the baby and self care before discharge, 90.5% of mothers from urban facility indicated they had some counseling before leaving for the house, whiles 9.5% said they had no counseling.

In the Peri – urban facility about 86% were counseled before discharge and 14% claimed there were not counseled on how to care for the child.

The rural clients, had about 89% who were counseled on child and self care before discharged home, whiles 11% said there were not counseled.

4.5 Availability Of Resources

Availability of resource is essential for smooth running of labour wards. In general observation reveals that the needed resources are not sufficient for rendering required services in the wards. Upon observation most of the facilities do not have delivery tray set ready for use, they only set it when client is in labour. Only two facilities which are the urban health and the district hospital have tray ready for any emergency.

The urban and the three peri urban health facilities had oxygen available but the three rural facilities do not. When the need arise they make use of ambubag, Delivery attire and boots were used only in the urban facility where they have changing rooms as well. The peri urban and rural health facilities do not have hence deliveries are conducted in uniforms. Protective cloths for instance, mackintosh apron was in the wards but insufficient. Observation in the district hospital shows that apron have to be quickly removed from one midwife who had almost finished delivery to be used by another.

The picture below shows a midwife performing her duty.

Picture 2

A midwife in uniform tidying up a client just after delivery.

Drugs such as oxytoxin, infusions, and pain relievers are available in all facilities. Ambulance service is available for the urban facility and the district hospital on call. All others make use of taxis. Sterilizer is available in all facilities those without electricity facility use gas stove to sterile their instruments. Suction machine is used in the urban and district hospital. Other facilities use mucus extractor for the babies. Other equipments, such as sphygmomanometer, thermometers, and drip stand are available in all health facilities.

In general resources are insufficient for use by staff in all the health facilities, to render quality service to clients.

Thus have agreed with most of the staff information gathered that the resources were not sufficient for smooth running of the ward. Deliveries are at times conducted on the floor in the busy labour ward due to insufficient delivery beds and inadequate space.

The picture below is a delivery bed in one of the labour wards.

Picture 3

A delivery bed in a rural health facility.

Below are tables showing results from the field.

Table: 23 ***Do you have oxygen cylinders in the ward?***

Do you have oxygen cylinders in the ward	Frequency	Percent
No	7	17.1
Yes	34	82.9
Total	41	100.0

82.9% had oxygen cylinders in the ward whilst 17.1% did not have.

It was realized that this 7 respondents (17.1%) are all from the three rural communities in the district. This shows that rural health facilities do not have oxygen available for use in the labour wards and that all the urban and peri urban facilities have one oxygen cylinder each.

Table: 24 ***Do you have ambulance service/vehicle to transport women referred to next level of care?***

Ambulance/Transport service for referral	Frequency	Percent
No	17	14.6
Yes	24	85.4
Total	41	100.0

Looking at the table above 58.5% (24) respondents responded that they had access to ambulance service and 41.5% (17) did not have access to ambulance service. From observation the facilities that did not have access to ambulance service were mostly from the rural areas and part of the peri – urban health facility.

Table: 25 ***Availability of resources for smooth running of ward***

Are the resources sufficient?	Frequency	Percent
No	29	70.7
Yes	12	29.3
Total	41	100.00

From the chart above, 70.7% of respondent responded that the resources provided for safe delivery in the wards were not sufficient whiles 29.3% said the resources provided were sufficient.

4.6 Category Of Staff On Duty

Labour wards throughout the districts, are mounted by trained midwives. Only the district hospital had one doctor working at the hospital. The urban and district hospital had sufficient midwives to manage the wards. However the rural health facilities lack midwives as there is no midwife or only one on duty at a time.

Table:26 ***Average no. of midwives on duty in the Labour ward***

No. of midwives on duty at a time	Frequency	Percent
One	10	24.4
Two	15	36.6
Three	13	31.7
Six	3	7.3
Total	41	100.0

Looking at the table above, 36.6% of respondents responded that two midwives are present on duty everyday. 31.7% indicated they had three on duty, 24.4% had one midwife on duty and 7.3% had six midwives on duty.

On observation in the labor ward, for the 7.7% that responded six midwives on duty, only two or three out of the six are actually on duty in the labor ward, all others are assigned other duties.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 *Introduction*

This chapter discusses the results of the survey as gathered from the field.

This will be done using the objectives of the study as sub-headings.

Before this is done, a brief discussion of the background characteristics of the respondents (i.e., service providers and clients) will be made.

5.1 *Background Characteristics Of Respondents*

5.1.1 Clients

The ages distributions of respondents who are clients show that majority of them are below 40 years.

One interesting development is the low level of women with tertiary education, 20 (6.1%) was sampled within the district.

Also women with no education constitute 18.8% of which those from the rural areas are in the majority.

5.1.2 Service Providers

Respondents who are staff are mainly trained midwives who work in the maternity specifically labour wards in the three sub districts covering urban, peri – urban and rural health facilities in the district.

5.2 The Use Of Partograph During Labour

The first objective of this study was to find out the extent of patograph usage during labour. The data from service providers and observation by the researcher was used to discuss.

In assessing the quality of service rendered to mothers during labour demand that partograph be captured during this study. As partograph help to ascertain the state of mother and foetus, also aid to detect abnormal progress of labour.

The surveyed midwives across the urban, peri – urban and rural areas generally indicate that partographs are most commonly used for monitoring labour in the wards. From the survey findings 95% of midwives use partograph, whiles 5 % use partograph and labour chart. About 97.5% of staff indicates that they have sufficient quantity of this tool for use.

This gives the opportunity to midwives to use it on every labouring woman however, observation carried out in seven (7) labour wards in the district reveal that, even though partograph is being used throughout the district in the labour wards, in practical terms the chart is not fully utilized and completed.

This can mean that the observations scheduled were not carried out and might be due to negligence and pressure of work in some places. This puts the mother and the unborn baby at risk and may lead to delay in taking decision to take action.

This confirms a study by Sarah Nakkazi (2001), that partograph is being used in majority of labour and were completed but, the latter part disagree with her findings as in this research most of the partographs are not completed.

5.3 Comparing Infection Prevention

The second objective of the study was to compare infection prevention to standard

Infection prevention is essential in heath care and must be taken into consideration in all heath facilities.

5.3.1 Cleanliness Of Ward Environment

Observing cleanliness in the ward and its environment is important in health facilities, not only that it can cause infection but also can leave a bad impression in the minds of clients, and make then seek care at other places that is presumed as cleaner.

In general, client indicated that the wards are clean as seen in the data analyzed from the field as 86.3%, 91.07%, and 97.8% from urban, Peri – urban and rural. This shows the effort of the health staff to maintain the wards. However some few clients complained about the ward environment which they stated the state of the washrooms as dirty with the urban facility being the dirtiest.

With 5.3% of respondents from urban, 3.6% peri – urban and 2.2% from rural indicate that. This might be attributed to the level of education of clients as the rural and peri urban have lesser client with higher education and the client do not see much problem with the ward.
This was confirmed on observation in the wards and might be due to the over usage of the washrooms by clients due to the number. The staff therefore has to ensure frequent thorough cleaning to prevent infections to users.

5.3.2 Sterilisation And A Septic Technique Practices In The Labour Ward.

Infection prevention is not a problem as all soiled items are disinfected with 5% chlorine, all items and instruments are well sterilised either by autoclaving or boiling before use. This is done according to standard.
Sterile gloves are mainly use on clients with aseptic practices in procedures across the urban, peri urban and rural facilities according to data from field.

However, observation in the peri urban setting reveals instruments are being hurriedly sterilized and deliveries conducted on the floor occasionally. Couch used are not properly cleaned before next client is received after vagina examination.
This did not agree with HNCP, USAID (2002), which stated that all instruments should be well disinfected during child birth and surfaces exposed to body fluid well disinfected.
These developments mar the whole infection prevention process in the busy labour wards rendering it poor. This may lead to infections and hence impeach on the MDG 5. This may be due to lack of insufficient resources, and inadequate space in the labour ward. These can be easily reversed when the infrastructures are expanded and needed resources provided, without which the problem may persist and staff always under pressure. These confirms what is said by Oye- lta and others (2007) that skilled staff becomes inefficient and cannot function without the basic resources.

Also Gerberding (2001) stated that for infection prevention to be effective there is the need for provision of resources.
Meanwhile hand washing facilities are well in place and utilised properly by the midwives to prevent any infection to clients. This is in agreement with Fraser and Cooper (2003) that hand washing is the most practical procedure to prevent spread of infection, and that puerperal sepsis is still a cause of maternal death, hence must be prevented with strict cleanliness.

The policies on health should be made flexible to enable every health centre to purchase items needed for effective functioning of their facilities from their BMC (Budget management centre) funds.
With these there will be sufficient instruments, infrastructure and other items for effective infection prevention.

5.4 Nurse Mother Relationship During Labour

Midwife relationship with women in labour is very crucial during labour and the new born period. It does not indicate the success of labour but influences the perception of women towards the midwives and general staff. To ascertain the relation, one initial information was on how clients were received into the ward, the result shows that majority of midwives receive clients nicely with encouraging words. Averagely about 93% across all areas of urban, peri-urban and rural had a form of welcoming women into the ward.

One interesting observation from the analysis is the generally good relationship among women and midwives a cross the urban, peri urban and rural areas.
In the urban area out of 95 women sampled, 91 representing 95.8% indicate they have good relationship with midwives. The trend is however not different in the peri urban and rural areas. In the peri urban as well 97 out 112 representing 86.6% and rural 41 out of 45 sampled representing 91.1% also expressed good relationship with midwives

Peri urban women are more (13.4%) in expressing their view that they had bad relationship with midwives which is higher than 4.2% in the urban areas expressing having bad relationship with midwives. The higher bad relationships in peri urban areas between midwives and women might be attributed to the high low level of education of women in most peri urban and rural areas, who may perceive midwives at the health facilities as people of a higher social class of whom they are inferior to and cannot be free with them. Another observation which supports the idea that education might be a major contributor to relationship of midwives and women is revealed in the excellent relationship in urban and peri urban areas which does not exist at all in the rural areas. Because in the urban areas people are better educated and more enlightened, they might perceive midwives attending to them as colleagues who they can interact with and as well be friends which results in about 13.7% in urban and 1.8% in peri urban with excellent relationships. As shown in table 10.

In order to gain much insight about the kind of relationship that exist between midwives and the women during labour and after child birth requires that information should be ascertained about the response of midwives to questions asked and specific request made by women. The responses indicate that midwives on most occasions answered their questions as shown by 76.8%, 86.6% and 88.9% from urban, peri urban and rural areas respectively. This information is in support with Kinzie and Gomez (2004) which state that paying attention and responding to women's questions makes the labour ward safe and secure for the woman.

On the view of women about the midwives who attended to them, majority about 86% averagely indicated they were friendly and caring. This is encouraging and will enhance utilization of the services. This friendly nature might be in response to the complained from most women that midwives have bad attitudes towards women.

5.5 Maternal And Newborn Care After Delivery

Maternal and newborn care which is the centre of attraction for the maternity unit service must be carried out effectively with efficiency.

The findings reveal that majority of clients (77.6%) were attended to within five (5) minutes, hence waiting time is not a problem. Few clients complain about the waiting time. Notes taken from those same clients reveal that the midwives were busy. This can be corrected, when the busy health facilities have sufficient staff and spacious delivery room to attend to clients on time.

Lack of privacy and the general impressions of client about the treatment such as shouting and abusive words are identified as the reason for some client's unwillingness to patronize the facility again.

Although privacy is important in health care, as it makes women feel comfortable, it is difficult to provide complete privacy to women in labour in our developing countries as the resources are not adequate and infrastructure is lacking. And this must be explained to all women during the antenatal period to enable them adjust to the situation, however allowing relatives to enter into the labour ward whiles two or more clients are in labour should be discouraged. Though it agrees with what Fraser and Cooper (2003) stated that women have better out come and decrease in labour with a family member or friend with them.

Clients indication of change of mind and place of delivery is in line with D' Ambruoso and others (2005) finding, that women have a change of mind about place of delivery when they do not receive humane and courteous treatment.

Meanwhile majority, about 89% were client who said they are satisfied and would visit again, with these one can confidently state that the care given is good and can be said to be quality. This is in line with the care as stated by some research findings which stated that patient's satisfaction with care is an important element of quality care. And there is evidence that perceived quality of maternal health services especially provider's attitude influences women's willingness to use skilled services. This confirms Tarnpol (2005) finding that when health workers are more caring in their behaviour towards clients is a way of making skilled care more appealing to women.

Another finding from observation is that newborns are neglected immediately after delivery although all other cares are given and warmth provided latter after the midwife have finished with the mother. This might be due to lack of adequate staff to carry out the activities as required.

5.6 Resources Available For Safe Delivery

Health services especially childbirth are very important to the general public hence health professionals must be equipped with necessary resources to enable them carry out quality supervised delivery. In the discussion of this the data from staff and observation made by the researcher was used.

Some of the resources needed for midwives to render their services include, delivery couch, delivery sets, disinfectants, sterilizers, suction machine with catheters, spacious delivery room, mackintosh sheets and aprons, supplies, ambulance, appropriate drugs, B/P apparatus and finally staff (midwives).

The study reveals that although staffs agree that they have resources, 70.7% complain that resources are not sufficient for the work. With the issue of delivery sets, observation shows that some busy labour wards do not have sufficient set, which under mines infection prevention process as delivery sets are at times hurriedly sterilised.

Infrastructure at the urban and peri urban in terms of the size of labour ward is too small to accommodate the clients received at a time.

This put the midwives under pressure and might be the cause of their reactions and displacement on some of the clients, resulting in shouting on some clients.

Observations in the ward agree perfectly with the staff that the resources are not available for the midwives to carry out their activities smoothly.

For instance, a busy labour ward with only one mackintosh apron, which have to be quickly switch over in case of emergency is just not appropriate. This does not augur well for provision of quality service during labour and delivery.
This confirms Smith, Garner (2001), who said that to provide good quality obstetric care, it needs, buildings, drugs and equipments. It means that without sufficient resources for the staff to do effective work, the care rendered can not be said to be of good quality. Providing all the resources for the midwives in the district will aid them to perform better and relieve them off some pressure.

More over the rural health facilities do not have oxygen cylinders, suction machine, ambulance or vehicle to transfer clients. The non availability of transport or ambulance services in the peri-urban and rural health facilities, poses many challenges to the health staff. This may cause delays in referred clients reaching the next level for urgent care, and can be a cause for maternal death. This may not help the country to achieve the MDG, 5 (improve on maternal health). The interesting thing is that all the labour wards claim they have the drugs needed for use in the labour wards.

Hope that when sufficient resources are supplied to all the health facilities, it will reflect on the equipments situation; avoid delays in transfer of clients to the next level and aid to improve on maternal health care.

5.7. Category Of Staff In The Labour Ward

5.7.1 *Service Providers In The Ward*

The staff working in the health set up is relevant for its performance; more importantly is the maternal and newborn care. Skilled attendant at service delivery point in the obstetric unit enhances the effective and efficient service and outcome.

The research findings from the data collected from clients and observation carried out by the researcher shows that all staffs working in the labour wards throughout the district are trained midwives. However the skilled midwife can only put up her best performance when resources are made available for their use.

Most of the midwives, about 26 (63.4%) percent had 10 (ten) years working experience such experiences and the skills acquired come into play when the need arise and have much bearing on the care given. The skilled attendant at delivery confirms what Kinzie and Gomez. (2004), said that the skilled attendant has skills necessary to deliver essential maternal and newborn care in any setting.

This might have resulted in no maternal death in the district as the skilled staff work effectively and refer their clients on time for better outcome. As there was no maternal death recorded in the district. This means mother and baby leaves, the facility safely. Thus confirms what white et al (2003) said that skilled attendance results in improve pregnancy outcome.

Moreover is worth to conclude that despite all the short falls, the midwives are putting in their maximum effort, in care given to the women.

Although quality care was poor in terms of partograph use, infection prevention, and considering the resources available to render the service to women, the over all quality of care was good. As greater percentage of women stated that the midwives were friendly to them and all facilities had skilled attendants in the labour wards. Also care given to women was good and there was no record of maternal death.

This disagrees with Delvaux and others (2007) finding that the over all quality of care was poor.

5.7.2 Assistance At Delivery

The service providers who render service to women in labour ward are an issue of importance to ensuring safe delivery and after delivery care. The type of service provider can also influence the education or counseling given to women during labour and after birth. The

type of service providers for clients interviewed includes doctors, midwives, grandmothers and traditional birth attendants depending on places of delivery. In comparing the service at child birth to women across urban, peri urban and rural areas table17 shows that most of the service were rendered by midwives across urban 89.2%, peri urban 80.5% and rural 48.9%. This is due to their specialty training to assist women at birth.

Interesting information from the research is the featuring by grandmothers in the service delivery and this is mostly in the rural areas which was 26.7% and TBA'S 23.3%. Grandmother's deliveries decrease to 9.0% in the peri urban and none was captured in the urban. This might be due to the fact that in these places there are a lot of hospitals and health centers which are easily accessible in times of labour.
The rural areas there fore need more education and counseling on safer childbirth as well as additional health facilities and staff to render the service.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter draws conclusions from the analysis of objectives and gave some recommendations.

6.1 Conclusions

This study has sought to assess the quality of maternal and new born care in the Ga West district. These were the main conclusions for the study.

Generally the quality of care was good in the urban health setting with some few short falls.

There is good interpersonal relationship between providers and clients in the rural, peri urban and urban health setting.

Generally assessing quality in terms of availability of resources and supplies, facility size, and the state of over crowding, partograph use and infection prevention, then the service is poor (sub standard).

On the part of nurse client relationship and the maternal and new born care rendered, then service quality is good.

6.1.1 The Use Of Partograph

All the health facilities use patograph but the observations on the client are in complete in all health facilities in the district.

6.1.2 Comparing Infection Prevention

Infection prevention is good in the urban and some peri-urban facilities that are not busy. However infection prevention is poor in the busy and overcrowded labour wards. This can be solved when the labour wards are expanded and basic resources provided.

6.1.3 Nurse Mother Relationship During Labour.

Generally the nurse mother relationship is good as indicated by clients and confirmed by observation.

Majority (95%) of clients are satisfied with the services rendered to them.

Meanwhile areas of dissatisfaction should be addressed to improve on the care to women during child birth.

General care is good, although there are few short falls.

Causes of dissatisfaction as stated were;

- long waiting time
- shouting and abuses from midwives

6.1.4 Newborn Care After Delivery

Newborn care is quiet good, although observations proved that they are neglected at the initial stage, they are however cared for, given warmth and breastfeeding initiated. Meanwhile assigning a nurse to care for the newborn will enhance the care given.

Maternal care is generally good in all the health settings throughout the district.

6.1.5 Resources Availability

In general resources are lacking in terms of provision of good quality service. For instance, midwives in the rural facilities are inadequate. And no ambulance service or transport is available for these facilities to render their services. With these things available services will improve.

The peri urban and urban have insufficient resources, but they are doing their best. Meanwhile the urban stand in better position in terms of resources and ambulance service hence better care rendered and their infection prevention is better.

6.1.6 Staff In The Labour Wards

The labour ward staffs through out the district are qualified midwives who had much experience. Their skills made them able to render services required even though the whole district had only one doctor at the district hospital

Major findings

URBAN: Partograph usage is poor, observation on partograph not completed.

- Resources insufficient
- Infrastructure to small
- Clients have more privacy in urban than other facilities

PERI URBAN: Partograph usage and infection prevention is poor and did not conform to standard.

- No privacy, labour wards busy most of the time and relatives allowed in at times.
- Staff become abusive and shouts on clients when there is heavy work load and they are under pressure.

RURAL: Nurse-mother relationship good

- About 50% of clients had home delivery.
- Patograph use and infection prevention is poor.
- Lack of midwives hence needs more midwives to do the work.
- Most resources are lacking.
- Majority had privacy in the rural health facilities because clients are alone in labour. Due to this they had more attention from the midwife. Hence the care is good and relationship more cordial.

General Findings

- Partograph usage is poor. Observations are not completed.
- Provision of privacy is a problem as they have no curtains and have one labour ward with more than one client at a time.
- About 83% of staff is friendly and caring.
- Nurse mother relation ship was good. However few midwives are rude and this mar the care given.
- Newborn care is substandard as newborn are neglected at the initial stage after delivery.
- Trained midwives are working in all the labour wards throughout the district
- Waiting time is good, most clients are attended to within 5-10 minutes
- Resources not sufficient for running the services in the labour wards.
- Infrastructure too small to accommodate clients.
- Infection prevention poor in peri-urban especially the busy labour wards but good at other places. The washrooms are over used and are not cleaned properly.
  Complains are mainly from the highly educated women.

6.2 Recommendations

In the light of the above conclusions and other problems identified in the course of the study, the following recommendations are being made:

6.2.1 The district health administration should;

- Open more CHPS compound in rural comminutes and to be headed by midwives
- Carry out in service for nurses on how to have patience and accommodate women in labour.
- Carry out monthly or quarterly monitoring and supervision on the use of partograph during labour.
- Organize workshops for staff on human relationships and client care.
- Inservice training on infection prevention in the health facilities.

- Workshops on the use and importance of partograph.
- The DHMT and policy makers must carry out in service training and counseling of midwives on their relationship towards clients. Meanwhile areas of dissatisfaction should be addressed to improve on the care to women during child birth.
- MOH, DHMT should post more midwives to rural areas to enable midwives to be at post all the time.
- Infrastructure should be expanded to make more room for delivery beds and provide first stage room.
- Midwives in the rural centre should be accommodated closer to the health centre.
- More midwives should be posted to peri urban health facilities with few midwives.
- Educational campaign should be organised in the rural and peri – urban areas on safe delivery at the health centres.
- A good referral system should be put in place and ambulance services made available for the rural and peri urban health facilities.

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6.2.2 The Ghana health service should;

- Post more obstetrician gynaecologists to the district to assist the only doctor at post.

- Train midwives in Emergency obstetric care & newborn care to take charge of the newborn immediately after delivery.

- Sufficient resources and instrument should be supplied to every health facility for smooth discharge of duties and rendering of quality service.

6.2.3 The district Assembly and NGOs should;

- Assist to expand the infrastructure for the maternity units in the district to create more room for delivery beds
- .Assist in building accommodation for midwives in the rural communities.

6.3 Concluding Remarks

The healthcare system in the country aspires to meet very high standards with respect to MDGs. Generally quality of care at the study area is done well in the urban as against the peri urban and rural. This is because the urban area is well resourced than the peri-urban and the rural areas. Therefore, to improve quality of care at all levels there should be equitable distribution of resources, both human and material, at all levels in order to meet the MDG 5 that is Improvement in Maternal Health.

From the study, it becomes quite clear that the Ga West District, especially the rural and peri urban areas are facing numerous problems with quality maternal care. However, if it can be argued that the target district is very close to the national capital, Accra, where one expect a high level of maternal care, then it means that other districts away from Accra or regional capitals are having more of such maternal health care problems. There is the need, therefore, to carry out more studies in such districts to ascertain their state of maternal health care delivery and find solutions to them. When problems are identified, it is then possible to come up with appropriate interventions.

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APPENDICES

APPENDIX I

QUESTIONAIRE

DEPARTMENT OF COMMUNITY HEALTH

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

TOWARDS THE MDG 5: ASSESSING THE QUALITY OF SUPERVISED DELIVERY IN THE GA WEST DISTRICT.

Name of sub district/ health facility……

Questionaire serial number……..

Interviewer code…….

I am a student from the above named institution undertaken a study into maternal health services rendered during labour and delivery.

The aim is to make recommendations to improve on maternal care.

We will like you to spare 10 minutes of your time to answer some questions for us.

Your participation will be of immense help.

You are free to be part of the study and you may withdraw when you feel like.

However confidentiality of any information provided and anonymity is assured.

STAFF INTERVIEW

SECTION A: BACKGROUND CHARACTERISTICS

1. Age……. 2. Sex……

3. Occupation…….. 4. Rank/category……..

5. Years in service

6. What tool do you use to monitor labour?

a) Labour chart b) Partograph c) None d) other (specify)……

7. What are your impressions about the quantity of these tools (partograph)?

(a) Very sufficient (b) Sufficient (c) Insufficient (d) Very insufficient

SECTION B: INFECTION PREVENTION

1. Is infection a problem in this facility? Yes No

2. How do you sterilize your equipments/items for use?

a) Autoclave after soaking in chlorine solution for 10 minutes

b) Boiling after soaking in chlorine solution

d) No sterilization in Emergencies

3. What types of gloves do you use in your facility?

a) Sterile surgical gloves b) Re usable gloves (boil and use)

c) Disposable gloves d) others (specify)

4. How do you care for your soiled equipment?

a) Soak in 5% chlorine for 10 minutes b) Soak in dettol solution for 10mins

c) Others, specify…….

5. Where do you get your disinfectants?

(a) From district store (b) From district head

(c) Bought from the market (d) From the clients

RESOURCES AVAILABLE

1. What resources do you have for delivery?

2. Are these resources sufficient for smooth running of ward services?

   Yes No

3. Do you have delivery set?

   Yes ☐ No ☐

4. If yes how many delivery set?

   a) One set b) Two sets c) Three sets d) Others (specify)

5. Do you have oxygen cylinders in the ward?

   i) Yes ☐ ii) No ☐

6. If yes how many?

   a) One b) Two c) Three d) Others (specify)……..

7. If no, how do you cope with the situation?.....

8. Do you have emergency drugs available for the use in the labour ward/dispensary

   Yes ☐ No ☐

9 On average, how many midwives are on duty in the Labour ward everyday?

   a) One b) Two c) Three d) Other specify ……

10. Are the midwives adequate to attend to clients who visit?
    i) Yes ☐ ii) No ☐

11. On average, how many clients do you receive in a day? …….

12. Do you have ambulance service/vehicle to transport women referred to next level of care?
    i) Yes ☐ ii) No ☐

13. If no, how do you send emergency cases to the next level?
    (a) use taxi (b) GPRTU support (c) client family arrangement

14. At what stage (level) do you refer the women in labour?
    a) When condition is beyond our level
    b) Contractions sluggish
    c) Do not refer, we have all the expertise and facilities available for care.
    d) Other , specify…….

APPENDIX II

CLIENT INTERVIEW QUESTIONNAIRE

DEPARTMENT OF COMMUNITY HEALTH
KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

A student in the above named institution is under taking a study into maternal health services rendered during labour and delivery.
The aim is to improve on maternal health care in the district.
We are inviting mothers with babies 0-6months to be part of this study. We will like you to spare part of your time to answer some question for us. You are free to associate or withdraw. Confidentiality of any information provided and anonymity is assured.

Sub district /Facility……. Date…….
Research Assistant code…….

SECTION A

1. Study number…… Age……. Residence …….

2. Number of children ☐ Age of last child

3. Occupation: Civil Servant ☐ Trade ☐ Farmer ☐
   Others……specify

4. Ethnic origin: Ga ☐ Akan ☐ Ewe ☐ Hausa others……..

5. Educational level: Tertiary ☐ Secondary ☐ Primary ☐ No Education ☐

6. Where did you receive antenatal care?
Hospital ☐ Health centre ☐ Maternity home ☐ TBA ☐ others ☐

7. Where did you deliver your baby?
Health facility ☐ TBA ☐ Home ☐

8. Reason for place of choice
It's safer ☐ cost affordable ☐ closer to the house accessible ☐

9. If TBA why?
Closer home ☐ Attendant more friendly ☐
Feels comfortable and relax than health facility ☐ heavy staff abusive ☐
Cost affordable other specify……

10 What were your impressions about the way you were treated?
(a) With much respect (b) with respect (c) with disrespect

11 How did the staff welcome you into the ward?
(a) With a smile and encouraging words
(b) with discouraging words
(c) with very discouraging words

12. In your opinion, were you provided privacy whiles in labour ?

Yes ☐ No ☐

13. How would you grade your satisfaction with the care received?

a) very satisfied b) satisfied c) dissatisfied d) very dissatisfied

14. Would you like to visit there again?

Yes ☐ No ☐

15 why would you visit again? .....

16. Who assisted you during childbirth?

Doctor ☐ midwives ☐ TBA ☐ Grandmother ☐ other specify…….

17. How would you describe the ward environment?

a) Very clean b) clean c) dirty d) very dirty

SECTION C: INTERPERSONAL RELATIONSHIP

18. How was the midwives/relationship with you during labour and after childbirth?

i) Excellent ii) Good iii) Bad iv) Other, specify……

19. Did the midwives/health staff answer your questions?

i) Yes ☐ ii) No ☐

20. What will you say about the midwives/service provider who attended to you?

a) Very friendly and caring ☐

b) Friendly and caring ☐

☐

c) Not friendly, but cares at times

d) Abuses and shout at mothers, not caring ☐

21. What were your expectations concerning staff relations towards you before going to the facility?

Responses ……

22. Were you congratulated after delivery of the baby?

i) Yes ☐ ii) No ☐

23. Were you encouraged on the care of the new born and breastfeeding?

i) Yes ☐ ii) No ☐

24. If yes, what were you told/taught? ……..

25. Who cared for the baby's cord after discharge?

i) Midwives ii) Self iii) TBA

26. Were you in given any form of education/counseling on self/child care before discharge home?

Yes ☐ No ☐

27. If yes on what were you counseled?

a) Exclusive breast feeding and nutrition b) hygiene and immunization

c) Breast feeding only d) All

28. How long did you wait to receive care?.....

29. Was the waiting time acceptable?

Yes ☐ No ☐

30. If no, what do you think can be done to improve on it?

……

31. Were you referred for continuity of care for the baby?

Yes ☐ No ☐

32. If yes to where?

a) To public health nurses for growth and monitoring and immunization

b) For family planning

33. Do you prefer one midwife attending to you in labour?

a) Yes ☐ b) No ☐

APPENDIX III

CHECKLIST FOR ASSESSING MATERNAL CARE DURING DELIVERY (OBSERVATION IN THE LABOUR WARDS)

Sub district/health facility……..

Code of observer……

Date of observation…….

SECTION A: PARTOGRAPH USAGE

1. Is partograph being used?

   Yes ☐ No ☐

2. If yes, were the observations done and plotted correctly?

   Yes, ☐ No ☐

SECTION B: INFECTION PREVENTION

1. Is the labour ward clean and things well arranged?

   Yes ☐ No ☐

   i) Is the floor clean? Yes No

   ii) Equipments – i), clean Yes No

   ii) sterilized Yes No

iii) Use of sterile gloves Yes ☐ No ☐

iv) Aseptic technique provided Yes ☐ No ☐

v) Do they have a delivery tray set for emergency use? Yes No

vi) How do they pick items from sterile drum? (a) use scissors b) chisel forcep?

vii) Any emergency obstetric care set/corner

i) Oxygen available ii) Emergency drugs available

2. Are staff well dressed?

i) In boots Yes No

ii) Delivery attire Yes No

iii) Protective clothes, eg) apron/mask Yes No

iv)Use of bleach for soiled linen, Yes No

3. How do they manage 3rd stage of labour to prevent PPH?

Response……..

4. Is water supply sufficient with available hand washing facilities?

Yes ☐ No ☐

5. If yes what type of hand washing facilities do they have?

a) Running water with under sink/soap and small towels

b) Veronica bucket/bowl and soap and small towels

c) Two hand washing basin/soap and towel

d) Are alcohol hard rub in use (in between patients)

e) Other specify……

6. Do staff wash hand before and after every procedure or after discarding used glove/alcohol hand rub use?

   Yes ☐ No ☐

7. Are there staff with common cold attending to clients in labour/delivery?

   Yes ☐ No ☐

8. Are aseptic technique used when preparing equipment for delivery process?

   Yes ☐ No ☐

9. Are Artificial rupturing of membranes carried out (HIV transmission prevention)

   Yes ☐ No ☐

10. Is the available chlorine of required strength? Yes No

Observe the chlorine preparation and the strength of chlorine available.

Formula

N- number of part of water required

X – given strength

0.5 – required strength

$N = \frac{X}{0.5} - 1$ for example $\frac{3.5}{0.5} - 1 = 7 - 1 = 6$ 1 part chlorine 6 parts water

$\frac{5}{0.5} - 1 = 10 - 1 = 9$ 1 part chlorine 9 parts water

SECTION C: <u>INTERPERSONAL RELATIONSHIP</u>

11. Does service provider/midwife remain sensitive to women discomfort and emotional state? Yes No

12. What emotional support did she give?

a) Words of encouragement

b) Congratulate client with each effort made

i) Made woman comfortable in bed. Yes No

ii) Give analgesics/rub her back. Yes No

13. Do they inform client about progress of labour?

Yes ☐ No ☐

14. Do midwives communicate effectively with client and attend to their needs.

Yes ☐ No ☐

i) If yes what did she do for the client? Ans……

ii) If no, what was the her reaction (midwife) Ans……..

15. Are clients questions answered during labour/delivery?

☐

Yes ☐ No

16. Are women congratulated after delivery ?

Yes ☐ No ☐

17. Do midwives/doctors give the women privacy (use of screen)?

Yes ☐ No ☐

18. Are mothers given any education in the newborn period (after delivery)?

Yes ☐ No ☐

19. If yes, what are the contents of the education?

i) care of the baby ii) Feeding/Nutrition iii) rest and sleep iv) hygiene

STAFF INTERACTION WITH PATIENTS

20. Are clients crying out in pain visited by midwives to provide comfort or give advice on comfort measures? Yes No

21. Are clients spoken to kindly by the midwives/physician? Yes No

22. Do midwives respect clients dignity by explaining procedures before touching her (e.g vagina examination abdominal exam, Blood). Yes No

23. How many midwives are on duty at a time?.....

24. What category of staff is in the maternity ward?

a) Midwives b) nurses c) ward aids d) Other specify……..

SECTION D NEWBORN CARE

25. Are babies kept warm after delivery? Yes ☐ No ☐

26. Where do they keep the babies? a) With mother b) Separate room

27. Are babies put to breast by midwives/health staff? Yes ☐ No ☐

28. How is the cord cared for? (a)Use methylated spirit
(b)Mercurochrome (c)Gention violet

SECTION E: EQUIPMENTS

29. Is there sterilizer in the ward?
Yes ☐ No ☐

30. Suction machine with catheters in stock
Yes ☐ No ☐

31. BIP apparatus Yes No

32. Thermometer Yes No

DRUGS AVAILABLE

33. Pain relievers Yes No

34. Oxytoxin/intravenous infusions Yes No

35. Staff trained in emergencies obstetric care. Yes No

36. Manual removal of placenta