World Journal of Public Health
2017; 2(3): 102-110
http://www.sciencepublishinggroup.com/j/wjph
doi: 10.11648/j.wjph.20170203.13

An Assessment of Factors Influencing Access to Skilled Delivery in the Sunyani West District in the Brong Ahafo Region of Ghana

Awuni Prosper Mandela Amaltinga[1], Ninsawu Nicholas Nakpan[2], Narh Vanessah[3], Mary Osei Bonsu[4], Abrefa Bridget[4]

[1]Institute of Preventive Medicine and Public Health, Hanoi Medical University, Hanoi, Vietnam

[2]Department of Clinical Medicine, Mili Med Hospital, Techiman, Ghana

[3]Faculty of Public Health and Allied Sciences, Catholic University, Fiapre, Ghana

[4]Department of Nursing, Korle Bu Teaching Hospital, Accra, Ghana

Email address:
mandelaprosper@yahoo.com (A. P. M. Amaltinga), nakpan4@gmail.com (N. N. Nakpan)

To cite this article:
Awuni Prosper Mandela Amaltinga, Ninsawu Nicholas Nakpan, Narh Vanessah, Mary Osei Bonsu, Abrefa Bridget. An Assessment of Factors Influencing Access to Skilled Delivery in the Sunyani West District in the Brong Ahafo Region of Ghana. *World Journal of Public Health*. Vol. 2, No. 3, 2017, pp. 102-110. doi: 10.11648/j.wjph.20170203.13

Received: March 26, 2017; **Accepted**: March 18, 2017; **Published**: June 15, 2017

Abstract: Maternal morality has long been an Achilles heel for many developing nations due to lack of adequate health care and family planning services, near absence or minimal access to skilled labour and emergency care, pregnancy complications such as haemorrhage and sepsis. With the Millennium Development goals fast approaching, most developing nations are still in a race to meet set targets. In this study, the objective is to ascertain factors influencing access to skilled delivery in the Sunyani West District of the Brong Ahafo region of Ghana. We specifically sought to assess the relationship between antenatal clinic attendance and use of skilled delivery, identify socio- cultural barriers impeding pregnant women from accessing skilled delivery and know if "task- shifting" and use of alternative cadres to provide skilled delivery is feasible. As an explorative cross-sectional case study design, the study was conducted among pregnant women in the Sunyani West district. Questionnaires were the instruments for data collection. Analysis was done with the Statistical Package for Social Sciences (SPSS) version 20 for windows. There was a relationship between awareness of antenatal services and attendance of Antenatal services. Also, a relationship between attendance of antenatal before childbirth and the places that the women in the district usually deliver their children was established. In addition, there was a relationship between the respondents' family having a tradition of giving birth at the hospital and the choice of the places that the women in the district usually deliver their children. The study recommended that in order to solve the challenges associated with skilled delivery a multifaceted approach need to be adopted.

Keywords: Skilled Delivery, Labour, Antenatal Care, Task Shifting, Pregnancies, Traditional Birth Attendants

1. Introduction

In 1987, the International Safe Motherhood Conference was convened in Kenya. The goal was to reduce maternal mortality by 50% by the year 2000, and announce to the global community the plight of the pregnant woman. Initially, donors, United Nations (UN) agencies, and governments focused on 2 strategies to reduce maternal mortality: increasing antenatal care and training for traditional birth attendants. By the year 2000, the goal was far from been realized. The global community reaffirmed its commitment in 2000, and the United Nations issued 8 Millennium Development Goals (MDG); the fifth goal (MDG-5) stipulated a reduction of the maternal mortality rate by 75% by 2015 [1]. One of the United Nations' Millennium Development Goals is to reduce the maternal mortality rate by 75% by 2015. The causes of maternal mortality include postpartum haemorrhage, eclampsia, obstructed labour, and

sepsis. However, as these MDGs are almost catching up with us, the dream seems far from been reached. In Sub-Sahara Africa, maternal mortality contributes to 57% of the 358, 000 global maternal deaths while having only 17% of the global births [2]. In Ghana, the maternal mortality ratio (MMR) remains high at 350 maternal deaths per 100,000 live births and under-five mortality is estimated at 82 deaths per 1000 live birth [3]. In order to curb the problem of maternal mortality, the WHO has decided to intensify the role of skilled delivery globally.

Delivery or labor is the process by which the fetus and the placenta leave the uterus, this can occur in two ways either vaginally or cesarean section [4]. Skilled delivery is a situation in which women have access to skilled attendant, namely Midwives or doctors during child birth. A skilled attendant refers exclusively to health professionals with midwifery skills (for example, Doctors, midwives, nurses) who have been trained to proficiency in the skills necessary to manage normal pregnancies, deliveries and diagnose and refer medical and obstetric complications [5]. According to the WHO, the aim is to have a skilled attendant present at 90% of all births by 2015 [6]. Globally, number of studies have shown a correlation between an increased proportion of births attended by skilled birth attendants and a reduced maternal mortality ratio skilled birth attendance-lessons learnt. In Ghana, surveys carried out showed that, 57% of women had an institutional delivery and only 59% delivered with a skilled attendant present [7, 8]; similar findings were in the 2011 Multiple Indicator Cluster Survey [8, 9]. In rural communities in Ghana, despite the introduction of the national health insurance which has made delivery free to all women, most women still deliver at home without skilled delivery. To combat this disparity, the Millennium Villages Project (MVP) designed a strategic model targeted at deprived communities to mitigate some of these inherent problems unique to rural areas [7]. The MVP sought to improve the living standards of rural communities through the coordinated and simultaneous delivery of proven package of interventions in health, agriculture, infrastructure and education which the Sunyani Municipality is a part, though a commercial town, most of its citizens are farmers.

As the nation strives to meet these targets, this research aims to determine the relationship between Ante Natal Clinic attendance and use of skilled delivery, identify socio- cultural barriers impeding pregnant women from accessing skilled delivery and to know if "task- shifting" and use of alternative cadres to provide skilled delivery is feasible.

2. Methods

2.1. Setting

Sunyani West District is in the Brong Ahafo Region of Ghana and shares boundaries with Wenchi Municipality to the north-east, Tain District to the north, Berekum and Dormaa East to the west, Sunyani Municipality to the south-east and to the eastern boundaries of the District is Tano. This study was carried out in 2013.

2.2. Study Type and Design

Having adopted a case study design, the researchers adopted a descriptive study type for this cross section survey. This is based on its ability to use data from surveys and case studies and other qualitative methods for gathering relevant information with which conclusions and recommendations can be drawn for the study. Three important uses of descriptive studies include trend analysis, planning, and hypothesis generation. A frequent error in reports of descriptive studies is overstepping the data: studies without a comparison group allow no inferences to be drawn about associations, causal or otherwise.

2.3. Study Variables

The research used both dependent and independent variables that were noted from the objectives of the study. The independent variables being variables that are constant and do not change included the demographic and personal characteristics of the respondents like age, educational status and marital status. The avenues of skilled delivery were also noted. The dependent variables that are noted to change as a result of the nature of the independent variables included rates of skilled delivery, perceptions of skilled delivery, and adequacy of health professionals as well.

2.4. Study Population

The population that was considered for this study included pregnant women and people who have given birth the last year. Some major stakeholders in the community like the municipal health director and traditional birth attendants who conduct delivery were given special consideration for in-depth knowledge on the issue of skilled delivery in the district but access to these people was often difficult.

Inclusion in the study is based on the presence of the respondents in the study area at the time of the study. Being pregnant or having given birth within the last year was a prerequisite for one to be a part of the study. The respondents should be at least 18 years and above and should not have an obvious mental challenge in other to respond to questions in the study. Women who have given birth more than a year ago and are not pregnant were left out of the study. Those who are just passing through the town and are not permanent residents were not considered either.

2.5. Sample Size and Sampling Techniques

The study used purposive sampling method to choose the traditional birth attendants and the municipal director in charge of reproductive health as samples for informant interviews. Purposive sampling was used to choose the target population (Pregnant women and those who have given birth within a year). Through a convenience sampling technique, the researchers chose a sample size of 400 respondents for

the study. In choosing the 400 respondents, the study used simple random sampling. The district was stratified into groups, made up of the various sub-communities in the municipality. From these communities respondents were selected with 'yes' and 'no' cards. Those who chose the 'yes' cards become part of the study.

2.6. Data Collection Tools and Techniques

The study utilised both primary and secondary data to find answers to the research questions. The data was both qualitative and quantitative in nature. The instrument for primary data collection was by way of questionnaires and interviews. The questionnaire was structured with both open and close ended questions. The questions in the questionnaires were grouped under the objectives of the study. For the secondary data collection, the study reviewed relevant literature from journals, peer reviews and published articles of all forms.

2.7. Data Analysis

SPSS software version 20.0 for windows was used for the analysis of data that was collected with the questionnaire. To enable the analysis to be done, the software was used to code the questionnaire. From the dataset, charts and tables were generated with their corresponding frequencies and percentages. Inferential statistical analysis was done with Pearson Chi-square test.

2.8. Ethical Considerations

The study in the first instance was approved by the faculty and supervised from the beginning till the end. Clearance was sought from all appropriate authorities before data collection. Data was collected with informed consent and confidentiality ensured. Verbal consent was sought from the respondents before data collection. All the secondary data that was used for the research was cited in order to prevent plagiarism.

3. Results

3.1. Personal Characteristics

Table 1. *Descriptive statistics of the demographic characteristics of respondents.*

	N	Mean		Std. Deviation
	Statistic	Statistic	Std. Error	Statistic
Age	400	1.9000	.04450	.88993
Period of Pregnancy	400	2.7500	.07058	1.41155
Religion	400	1.2500	.02168	.43355
Ethnicity	400	1.9000	.05461	1.09224
Income	400	2.1500	.04270	.85400
level of Education	400	2.7500	.05221	1.04414
Marital Status	400	2.4500	.06023	1.20463
Number of Children	400	2.0000	.03878	.77557
Valid N (list wise)	400			

Table 1 gives the descriptive statistics that characterize the demographic and personal characteristics of the respondents. The table gives the mean and standard deviation distributions of the data collected.

When respondents were asked of their age, 40% (160) are between 18-29 years, 35% (140) are between 30-39 years, 20% (80) are between 40-49 years and 5% (20) are 50 years and above. In terms of religion, 75% (300) are Christians and 25% (100) are Muslims, When respondents were asked they come from, 55% (220) said they are Akans, 25% (100) said they come from the northern region, 10% (40) are Ga and 10% (40) are Ewes.

Assessing the income level of respondents, 55% (220) earn between GH¢100 -GH¢500, 20% (80) earn less than GH¢100, 15% (60) earn between GH¢600- GH¢1000, and 10% (40) earn more than GH¢1000. In relation to the level of education, 45% (180) attended secondary school, 25% (100) had tertiary education, 20% (80) had no formal education and 10% (40) had basic education. In terms of marital status of respondents, 70% (280) are married, 15% (60) are co-habiting, 10% (40) are single and 5% (20) are separated. When respondents were asked of the number of children they have, 55% (220) said 1-2, 25% (100) said none, 15% (60) said 3-4, 5% (20) said 5 and above.

3.2. The Relationship Between Ante Natal Clinic Attendance and Use of Skilled Delivery

Table 2. *Relationship between Awareness of Antenatal Services and Attendance to Antenatal Services.*

	Place of delivery			Chi-Square Test				
	Yes	No	Total		value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Awareness of Antenatal Yes	380	0	380	Pearson Chi-Square	400.000[a]	1	.000		
Services No	0	20	20	Continuity Correction[b]	379.224	1	.000		
				Likelihood Ratio	158.812	1	.000	.000	.000
Total	380	20	400	Fisher's Exact Test					
				Linear-by-Linear Association	399.000	1			
				N of Valid Cases	400	1	.000		

a. 1 cell (25.0%) have expected count less than 5. The minimum expected count is 1.00.
b. Computed only for a 2x2 table

In identifying whether there is a relationship between the awareness of antenatal services and attendance of ANC services. The chi-square value of 400.000awas noted with a p-value of.000. This indicates that there is a very strong relationship to contradict the null hypothesis that there is no relationship between the two independent variables.

Table 3. *Relationship between Attendance of Antenatal Services and Place of Delivery.*

	Place of delivery					Chi Square			
	No response	Hospital	TBA	Unskilled Delivery	Total		value	df	Asymp. Sig. (2-sided)
Attendance of antenatal service	100	220	60	0	380	Pearson-Chi-Square	400.000[a]	3	.000
Yes						Likelihood Ratio	158.812		
No	0	0	0	20	20	Linear-by-Linear-Association	140.000	3	.000
Total	100	220	60	20	400	No of Valid Cases	400		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 1.00.

The study sought to identify whether there is a significant relationship between attendance of women in ANC services and the place they deliver their children. The Pearson Chi-Square value for the test was 400.000. The P-Value on the other was.000. This shows a very significant relation between the variable.

Table 4. *The Relationship between Poor Work Attitude in the Health Facility and Place of Delivery.*

	Place of Delivery					Chi-Square Tests			
	No response	Hospital	TBA	Unskilled Delivery	Total		Value	df	Asymp. Sig(2-sided)
Poor Work Attitude in Health Facilities	40	100	40	0	180	Pearson-Chi-Square	28.773[a]	3	.000
Yes						Likelihood Ratio	36.363	3	.000
No	60	120	20	20	220	Linear-by-Linear Association	.000	1	1.000
Total	100	220	60	20	400	No of Valid Cases	400		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 9.00.

The Table 4 above illustrates a Pearson Chi-Square analysis testing the relationship between poor attitude of health workers in health facilities and the choice of place women in the district usually deliver their children. As noted earlier, while the first table indicates the cross tabulation of variables, the second table gives various chi-square tests. Of much significant to the study is the Pearson Chi-Square. The Pearson Chi-Square value for the analysis is 28.773[a] with a p-value of.000. This indicates a significant relationship between the variables under study.

The frequency and percentage distribution of the questions under the relationship between ANC attendance and the use of skilled delivery are as follows in figure 1 below: Assessing awareness of antennal service, 95% (380) said yes and 5% (20) said no. In relation to attendance of antenatal services, 95% (380) said yes and 5% (20) said no. In terms of services delivered at antenatal, 50% (200) said yes to in relation nutritional services, 45% (180) said no, and 5% (20) gave no response. When respondents were asked of the central theme of health education, 70% (280) said exclusive breast feeding and complementary feeding, 25% (100) said need for skilled labor, and 5% gave no response. In terms of satisfaction with service delivery, 75% (300) were satisfied, 20% (80) were neutral and 5% (20) were dissatisfied.

When women were asked whether they attended antenatal service before childbirth, 70% (280) said yes, 25% (100) gave no response and 5% (20) did not give any response. In terms of benefits associated with skilled delivery, 75% (300) answered yes that there is the need to receive skilled services because of possible complications that may arise during child birth to prevent maternal mortality and quality service, 25% (100) answered no since TBAs attended to them during their previous birth. In relation to whether there is a relationship between ANC and skilled delivery, 80% (320) said yes and 20% (80) said no.

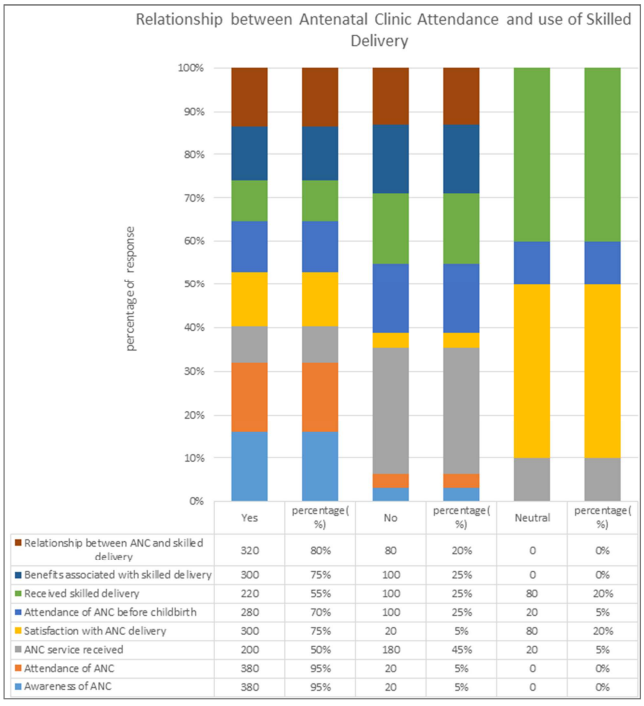

Figure 1. *Relationship between Ante Natal Clinic attendance and use of skilled delivery.*

3.3. Sociocultural Barriers Impeding Pregnant Women from Accessing Skilled Delivery

Table 5. *Relationship between family tradition of giving birth in hospital and place of delivery.*

	Place of Delivery					Chi-square Test			
	No response	Hospital	TBA	Unskilled Delivery	Total		Value	df	Asymp. Sig. (2-sided)
Family Mostly Tradition of Giving Birth sometimes at the Hospital Rarely	60	160	20	0	240	Pearson Chi-Square	235.152[a]	6	.000
	0	60	40	0	100	Likelihood Ratio	249.553	6	.000
	40	0	0	0	40	Linear-by-Linear Association	.000	1	1.000
						No of Valid Cases	400		
Total	100	220	60	400					

a. 1 cells (8.3%) have expected count less than 5. The minimum expected count is 2.00.

In analyzing the sociocultural factors that affects the choice of delivery, some assumptions were tested. The Table 5 above illustrates a Pearson Chi-Square analysis testing the relationship between the respondents' family having a tradition of giving birth at the hospital and the choice of place women in the district usually deliver their children. As noted earlier, while the first table indicates the cross tabulation of variables, the second table gives various chi-square tests. The Pearson Chi-Square value for the analysis is 235.152 with a *p-value* of.000. This indicates a significant relationship between the variables under study.

Table 6. *Relationship Between Affordability of Healthcare and Place of Delivery.*

Affordability Of health serv.	Place of delivery				Total	Chi-Square Test			
	No response	Hospital	TBA	Unskilled Delivery			Value	df	Asymp. Sig. (2-sided)
Yes	100	180	60	0	340	Pearson Chi-Square	143.316[a]	3	.000
						Likelihood Ratio	129.546	3	.000
No	0	40	0	20	60	Linear-by Linear Association	52.157	1	.000
						No of Valid Cases	400		
Total	100	220	60	20	400				

a. 1 cells (12.5%) have expected count less than 5. The minimum expected count is 3.00.

The Table 6 above illustrates a Pearson Chi-Square analysis testing the relationship between the ability of respondents to afford the health services delivered in the health facilities in the district and the choice of place women in the district usually deliver their children. As noted earlier, while the first table indicates the cross tabulation of variables, the second table gives various chi-square tests. The Pearson Chi-Square value for the analysis is 143.316 with a p-value of.000. This indicates a significant relationship between the variables under study.

3.4. "Task- Shifting" and Use of Alternative Cadres to Provide Skilled Delivery Is Feasible

Table 7. *The Relationship between Adequacy of Health Staff and Place of Delivery.*

	Place of delivery				Total	Chi-Square Test			
	No response	Hospital	TBA	Unskilled Delivery			Value	df	Asymp. Sig. (2-sided)
Adequacy Of Health Staff in The District No						Pearson Chi-Square	17.225[a]		
Yes	0	20	0	0	20	Likelihood Ratio	24.772	3	.001
	100	200	60	20	380	Linear-by-Linear Association	.000	3	.000
Total	100	220	60	20	400	N of Valid Cases	400	1	1.000

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 1.00.

The Table 7 above illustrates a Pearson Chi-Square analysis testing the relationship between the adequacy of health staff in the district and the choice of place women in the district usually deliver their children. While the first table indicate the cross tabulation of variables, the second table gives various chi-square tests. The Pearson Chi-Square value for the analysis is 17.225 with a p-value of.001. This indicates a significant relationship between the variables under study.

The figure 2 below is a histogram that indicates the responses recorded on whether the health facilities in the district have adequate staffing. From the figure the response had a mean value of 1.95 with a standard deviation of.218. The frequencies and percentages indicated that 95% (380) said no and 5% (20) said yes. Women were of the view that more health workforce was needed to augment the current

staff. Most especially they emphasized the need for more midwives and more Doctors since most of them had to travel long distance if they needed to see a gnaecologist.

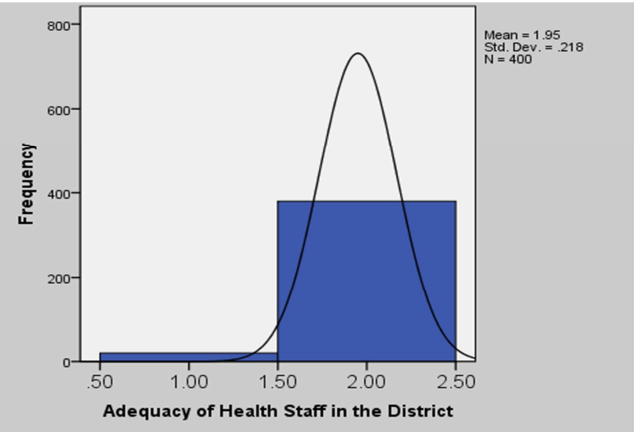

Figure 2. *Adequacy of Health Staff in the District.*

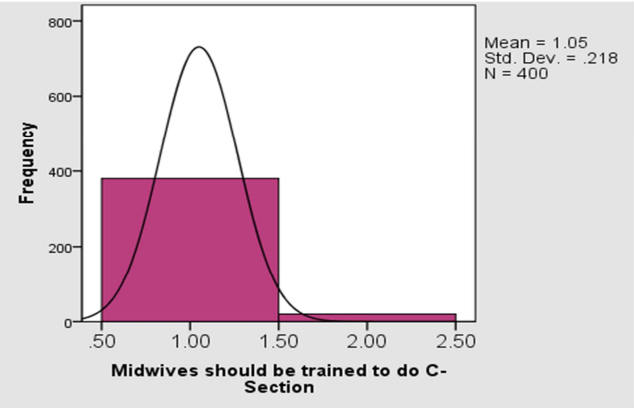

Figure 3. *Midwives should be trained to Perform Caesarean Section Apart From Medical Doctors.*

The figure 3 above is a histogram illustrating the response on whether midwives need to be trained in order to perform C-section in the absence of a medical doctor. The responses had a mean of 1.05 and a standard deviation of.218. The frequency and percentage distribution indicated that 95% (380) said yes and 5% (20) said no. Though the women were not knowledgeable in health issues, they also said if there is a possibility to train more midwives to preform Caesarian section on women who cannot deliver per vagina. Most of the young educated ladies were very instrumental in referring us to other African countries were the practice has been a success and wished midwives should be trained to perform C- section due to low health workforce. Some even suggested medical assistants as alternative since they almost perform similar functions as the medical Doctors in the community.

With reference to distance between residence and health facility, these were the findings from respondents, 55% (220) said normal, 25% (100) said not far, 10% (40) very close, 5% (20) said very far and 5% (20) said far. In terms of easy access to transportation, 90% (360) said yes and 10% (40) said no. In terms of affordability of health facilities, 85% (340) said yes and 15% (60) said no. In terms of poor work attitude in health facilities, 55% (220) said no and 45% (180) said yes. In terms of presence of people who can assist with skilled delivery, 100% (400) said yes. With regards to other non- professional health workers assisting in skilled delivery, 100% (400) said yes.

4. Discussion

4.1. Relationship Between Ante Natal Clinic Attendance (ANC) and Use of Skilled Delivery

The first relationship to be tested was the relationship between the awareness of antenatal services and attendance of ANC services. The chi-square value of 400.000 was noted with a p-value of.000. This indicates that there is a strong relationship between awareness of ANC service and women attending ANC. This calls for some form of health education or awareness creation to meet the challenges that might be associated with low patronization of ANC services. The rate at which women utilized ANC services can be translated into some effectiveness of antenatal care in preventing maternal deaths similar to a cross sectional studies suggestions [10]. The research identified a strong relationship between women patronizing ANC services and the places that they deliver their children. The cross tabulation of results noted that in most of the cases, those who had attended ANC services delivered in health facilities and the vice versa. This statistical analysis had a Pearson Chi-Square value of 800.000 with a P-Value of.000 which shows a significant relation between the two variables. This result calls for availability of more avenues for ANC services in the district. For places that lacked clinical service, the Community Health Initiative Projects (CHPS) compounds can be established to ensure that women have access to ANC services. This primarily falls in line with the executives' pay-cut of central government to ensure that more of such compounds are built to serve the needs of women in such deprived communities in the country as a whole. Contrary to the notion that ANC can fail to improve maternal health care in some cases as noted by some social movements [11], in this case however, is an outlier with massive improvement. The services in the facilities however need not compromise on quality, since women can by-pass the nearest health facility largely because of quality of care delivered in another health facility [12].

The type of services that are delivered in the facilities do have some significance as to where women would seek clinical service with regards to delivering a baby. In the findings of the study, ANC services were mainly about breastfeeding, complimentary feeding and the need for skilled delivery. This to a very large extent influenced the choice of respondents in choosing place of delivery. In the analysis, the Pearson Chi-Square value was 621.091 with a p-value of.000. This seems to suggest that in order to improve patronization of ANC services, the service providers need to consider the quality of ANC services delivered. Efforts should be put in place to address issues pertaining to skilled delivery and the benefits it presents to women. Attitude of

health workers exhibit in health facilities was noted to have some level of significance to the choice of place a woman decides to go for delivery. The Pearson Chi-Square value for the analysis was 28.773[a] with a p-value of.000. A number of scholars have indicated the role health worker attitude plays in ensuring that clients patronize services. In most of the cases, if health workers treat clients in a positive manner the clients become comfortable when seeking health services and vice versa. A survey done in Malawi noted that, the participants perceived the care they received during antenatal was largely good which positively influenced their attitude towards skilled delivery [13]. Similar results were noted for this case. The study is in line with previous survey which show that the shift in place of delivery from home to health facilities is seen as an important strategy for improving neonatal outcomes [14]. However, it is not only availability of health facilities for deliveries that is important, but also the quality of care provided. From the results the satisfaction levels of the respondents with the health service delivery was noted to be very high. The study in Malawi also noted that, for people who were satisfied and utilized skilled delivery, the delivery process went well and they had healthy babies [13]. Participants rated care as being good when they were warmly received and not treated harshly at the clinic. Considering the significant relationships that have been identified in the study it may come as no surprise that most of the respondents have delivered in health facilities, followed by trained TBAs and unskilled attendant. This results seem to indicate that skilled labor has not only increased over the years in developed countries, but developing countries are also making some strides [15].

The respondents rightly identified the benefits associated with skilled delivery. The most common benefit was to avoid complications and secondly prevent maternal and child mortality. The findings of the study were confirmed by the respondents when most of them 80% (320) noted that there is a relationship between ANC and skilled delivery in the district. There is the need to enhance this as noted earlier since skilled birth attendant at delivery, timely emergency obstetric care, provision of immediate newborn care and postnatal care are essential in promoting neonatal health [16].

4.2. Socio - Cultural Barriers Impeding Pregnant Women from Accessing Skilled Delivery

In analyzing the social and cultural factors that affects the choice of delivery, some assumptions were tested. The analysis testing the relationship between the respondents' family having a tradition of giving birth at the hospital and the choice of the place women in the district usually deliver their children was significant. The family background and practices of women has been noted to have some level of influence on the maternal and child health choices of women. This study confirms these earlier assertions. In this study, the families of the respondents seem to have bought into the idea of skilled or hospital delivery. This invariably might have influenced the high rate at which the women resort to skilled delivery in the case of those who have given birth before. As many as 90% of the respondents also indicated that their families encourage them to attend ANC in their communities. The husbands of the women rather need encouragement to be a part of ANC practices associated with pregnancies. From the findings, most husbands in the district do not take part in the ANC visits to the clinics with their wives. Healthcare and affordability was also assessed. There was a significant relationship between the ability of respondents to afford the health services delivered in the health facilities in the district and the choice of the place women in the district usually deliver their children. This analysis had a Pearson Chi-Square value of 143.316 with a p-value of.000. The challenges associated with cost of maternal and child healthcare was partly addressed with the introduction of free maternal and child healthcare policy under the National Health Insurance Scheme. With this policy, women and children stand a greater chance of enjoying the best of healthcare in order to ensure its primary purpose of curbing maternal and child mortality is attained. It might probably not to be out of place to indicate that this might have contributed to the responses by the respondents to the effect that the cost of healthcare is cheap so to speak. It might imply that they are registered users of the NHIS. Although the cost component can increase outcome, emphasis need to be placed also on the quality of care, not only on availability of services [17-19]. This is vital because lack of quality care at health facilities limits women's access to quality care [20, 21].

Aside the cost, another factor that sometimes impedes access to healthcare is access. In this regard, the issue of transportation and distance between the residence of the respondents and the health facility in the district were assessed. In both cases, a significant relationship was noted to exist between them and the place that women chose for delivery. The distance that was noted between the health facility and the residence of the respondents was noted to be 'normal'. There was also the indication that there is some form of easy access in terms of transportation to and from the health facility. This is similar to other studies that indicate that when women have a choice, they will go to health facilities where they perceive better quality of care in terms of physician centered and midwife led psychosocial care exist [22], regardless of distance. This confirms the assertion of some scholars that that in some regard multiple factors contribute to skilled and unskilled delivery. This can be social, economic and cultural in character. Ability to find effective solutions to these challenges would to a very large extent ensure some level of success with addressing maternal and child health issues. This confirms findings that several socio-economic, cultural and religious factors play a significant role in the use of Skilled Birth Attendance for delivery as it was identified in the case of Naples [23].

4.3. "Task - Shifting" and Use of Alternative Cadres to Provide Skilled Delivery is Feasible

Generally it was identified that the health workers in the district were lacking. The role that health workers play in ensuring that there is skilled delivery cannot be underestimated [16]. With a shortage in staff, its associated

challenges might be realized in the district. A significant relationship was identified between the adequacy of health workers and the place of delivery. This goes to prove that when the health staff in the district is adequately distributed it can enhance the skilled delivery rates in the district. This to a large extent can also be influenced by the staff attitude that is exhibited by the health workers in the district. From the results it was noted that generally the health workers in the district exhibit some level of professionalism in the discharge of their duties. The role of TBAs in the maternal and child healthcare in the district is dully recognized by the respondents of the study although most of them seem comfortable delivering in health facilities. From the results of the study it was noted that the respondents have a positive attitude towards TBAs in the communities. This offers a strong case for the issue of "task-shifting". In the wake of an apparent inadequate staffing of health workers, TBAs can take up the role with some training to ensure that much is achieved. This is similar to findings in cases where midwife-directed prenatal and labor care results in equal or improved maternal and infant outcomes [24].

The respondents of the study did identify that there are competent people in the communities in which they live who can adequately handle or take up the role of health staff to deliver some of the needed services. This will entail some form of training. This 'task shifting' practices can adequately take care of the shortage or inadequate staffing that was identified in the study. Aside recognizing that there are competent people in the community to assist in healthcare delivery, all did agree that these competent non-professionals should be included in the healthcare system to assist in matters that pertain to skilled delivery. This confirms the point that in countries facing a critical shortage of physicians, task shifting may be used to train alternate health care workers or laypersons to perform tasks generally considered to be within the purview of the medical profession [25].

5. Conclusion

From the study, it is worth stating that, the staff strength of the district need to be increased. Being a deprived district, incentives can be an added advantage that will attract more health workers. This can be both monetary and infrastructure in nature. While the role of government in this regard is noted, the role that the community also play in ensuring that health workers are comfortable and ready to give off their best is also recommended.

The free maternal and child healthcare in place by way of the NHIS need to be enhanced by the stakeholders of the NHIS. From the analysis, it contributes positively to the ability of women to afford services that are delivered in the health facilities in the district.

More health education should be directed at families of women in the districts to ensure that they give their support to ANC services in the municipality. This can enhance the utilization of skilled delivery in the district. Husbands can be encouraged to see the need to be part of the antenatal visit of their wives, this can improve ANC attendance because they are heads of families and usually their words are taken seriously by their spouses.

In solving the issues associated with inadequate staffing, the 'task shifting' strategy is recommended. Midwives and physician assistants should be equipped with surgical skills to manage obstetric complications and possibly caesarean section. They are often the majority at communities where there are no medical doctors. Community Health Nurses should be trained to manage all stages of labour since they often provide delivery services where midwives are lacking. TBAs in the various communities can be trained to provide basic ANC services. Others can be trained in basic obstetric emergency management and proper referral methods. This will help ensure increase in skilled delivery.

References

[1] United Nations. UN Millennium Development Goals. The Millennium Development Goals Report 2013. 2013; New York.

[2] UNICEF W. Countdown to 2015 decade report (2000–2010) with country profiles taking stock of maternal, newborn and child survival. Geneva; New York: World Health Organization; UNICEF WHO2010Countdown to 2015 decade report (2000–2010) with country profiles taking stock of maternal, newborn and child survival Geneva; New York: World Health Organization; UNICEF. 2010.

[3] UNICEF WA. Accountability for Maternal, Newborn and Child Survival. The 2013 Update. Geneva: WHO; 2013.

[4] Health NIo. Eunice Kennedy Shriver National Institute of Child Health and Human Development. 2013: www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/Pages/labor.aspx.

[5] (WHO) WGWHO. Department of Reproductive Health and Research (RHR); 2004. Making pregnancy safer the critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO.

[6] WHO Press WHO, 20 Avenue Appia 1211. Proportion of births attended by a skilled health worker. Accessed on 03 March 2012. 2008: Available online at: http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/200_skilled_attendants/en/.

[7] Doku D, Neupane S, Doku PN. Factors associated with reproductive health care utilization among Ghanaian women. BMC Int Health Hum Rights.. PMC. 2012; 12: 29. Doi: 10.1186/472-698X-12-29.

[8] Ilene S Speizer, William T Story, Kavita Singh. Factors associated with institutional delivery in Ghana: the role of decision-making autonomy and community norms. BMC Pregnancy Childbirth. 2014; 14: 398 doi: 10.1186/s12884-014-0398-7.

[9] Service GS. Ghana Multiple Indicator Cluster Survey with an Enhanced Malaria Module and Biomarker, 2011, Final Report. Accra, Ghana: 2011: http://www.unicef.org/ghana/Ghana_MICS_Final.pdf Accessed 2012.

[10] Manas P. Roy, Uday Mohan, Shivendra K. Singh, Vijay K. Singh, Annand K. Srivastava. Determinants of Utilisation of Antenatal Care Services in Rural Lucknow, India. Journal of Family Medicine and Primary Care. 2013; 2 (1): 55-9 doi: 4103/2249-4863.109946.

[11] Group SMI-A. The safe motherhood action agenda: Priorities for the next decade (PDF). Colombo, Sri Lanka. Inter-Agency Group for Safe Motherhood. 1997.

[12] Kruk ME, Mbaruku G, McCord CW, Moran M, Rockers PC, Galea S. Bypassing primary care facilities for childbirth: a population-based study in rural Tanzania. Health Policy Plan. 2009; 24: 279-88.

[13] Lily Kumbani, Gunnar Bjune, Ellen Chirwa, Address Malata, Jon Oyvind Odland. Why some women fail to give birth at health facilities: qualitative study of women's perceptions of perinatal care from rural Southern Malawi. BioMed Central Reproductive Health. 2013; 10: 9 doi: 10.1186/742-4755-10-9.

[14] Spector JM, Agrawal P, Kodkany B, Lipsitz S, Lashoher A, Dziekan G. Improving quality of care for maternal and newborn health: prospective pilot study of the WHO Safe Childbirth Checklist Program. PLoS One. 2012; 7: 3515.

[15] Judith A. Levine, Clifton R. Emery, Harold Pollack. The Well-Being of Children Born to Teen Mothers. Journal of Marriage and Family. 2007; 69 (1): 105-22 doi: 10.1111/j.741-3737.2006.00348.x.

[16] Bhutta ZA, Chopra M, Axelson H, Berman P, Boerma T, and Bryce J. Countdown to 2015 decade report (2000–10): taking stock of maternal, newborn, and child survival. Lancet. 2010; 375: 2032-44.

[17] Graham WJ, Ahmed S, Stanton C. Measuring maternal mortality: an overview of opportunities and options for developing countries. BMC Med. 2008; 6: 1–8.

[18] Van den Broek NR aGW. Quality of care for maternal and newborn health: the neglected agenda. BJOG. 2009; 116 (Suppl 1): 18-21.

[19] Kinney MV, Kerber KJ, Black RE, Cohen B, Nkrumah F, Coovadia H. Sub-Saharan Africa's mothers, newborns, and children: where and why do they die? PLoS Med 2010; 7 (6): e1000294 doi: 1371/journal.pmed.

[20] Linda Vesel, Alexander Manu, Terh J. Lohela, Sabine Gabrysch, Eunice Okyere, Augustinus H. A ten Asbroek, et al. Quality of newborn care: a health facility assessment in rural Ghana using survey, vignette and surveillance data. BMJ Open Disease in Childhood. 2009; 3 (5): http://dx.doi.org/10.11336/bmjopen-2012-002326.

[21] Olsen OE, Ndeki S, Norheim. Human resources for emergency obstetric care in northern Tanzania: distribution of quantity or quality? Human Resource Health. 2005; 3: 5.

[22] Pitchforth E, Van Teijlingen E, Watson V, Tucker J, Kigler A, Ireland J, et al. "Choice" and place of delivery: a qualitative study of women in remote and rural Scotland. PubMed. 2009; 18 (1): 42-8 doi: 10.1136/qshc.2007.023572.

[23] Baral YR, Lyons K, Skinner J, van Teijlingen ER. Determinants of skilled birth attendants for delivery in Nepal. Kathmandu University Medical Journal (KUMJ). 2010; 8 (31): 325-32.

[24] Benatar S, Garrett AB, Howell E, Palmer A. Midwifery care at a freestanding birth center: a safe and effective alternative to conventional maternity care. PubMed. 2013; 48 (5): 1750-68 doi: 10.111/475-6773.12061.

[25] Larry W. Chang. Task shifting: A solution for the health worker Human Resource Crisis? Medscape July 14 2009.