

Barriers to Accessing Maternity Care among Expectant Mothers at Tamale Teaching Hospital

¹Solomon Suglo, ²Jerry P K Ninnoni, ³Boakye Yiadom, ⁴Janet Gross, ⁵Agani Afaya, ⁶Susana Achaab

¹Tamale Teaching Hospital, Department of Neuro-surgery

²University of Cape Coast, School of Nursing and Midwifery, Ghana

³Department of Community health, University for Development Studies-Tamale

⁴Morehead State University, USA.

⁵University for Health And Allied Sciences-Ho

⁶Seventh-Day Adventist Hospital, Tamale. Ghana.

Abstract: Maternal mortality remains a major challenge to developing countries. Access to maternal health services is crucial to ensuring safe motherhood care before, during and after delivery. This study sought to explore barriers to accessing maternity care among expectant mothers at a Teaching Hospital. A facility-based cross-sectional study was conducted. The systematic random sampling technique was used to sample 345 pregnant women for the study. Structured questionnaires were used to collect data from women regarding barriers to accessing maternity care. Data were analyzed using Statistical Package for Social Sciences (SPSS). Demographics (age, ethnicity, education, marital status, occupation) were summarized using frequency tables while the χ^2 test used to determine associations between respective variables. Variables that displayed significant associations were entered into a multiple logistic regression model to ascertain the strength of association (Odds Ratios) between respective variables. At the 95% confidence interval, a p-value less than 0.05 was deemed statistically significant. The results showed that 89.6% agreed maternal health services were available at the Tamale Teaching Hospital but, over 66.4% could not access these services due to the judgmental attitude of health staff at the facility. About 72.1% could not access lifesaving care due to lack of means of transport especially ambulance service. Another barrier mentioned in this study was the deplorable road network which hindered 68.7% of participants from accessing maternal health care. The χ^2 analysis revealed that age ($p<0.05$), religion ($p<0.05$), educational status ($p<0.01$), level of knowledge on obstetric risks ($p<0.01$), number of ANC visits ($p<0.01$), marital status ($p<0.05$), income level of participants ($p<0.01$) and cost of services ($p<0.01$) determined access to healthcare services and the choice of facility delivery among the study women. Generally, logistics, and refurbishment, building of more hospital at least two in each district and the training of more health workers with positive attitude toward clients are necessities in order to adequately address access barriers. Until road networks in the country are properly constructed and accessible to all parts of Ghana, the effort to reduce maternal mortality will be unattainable.

Keywords: Barriers, Expectant Mothers, Maternity Care.

1. INTRODUCTION

Access to health services has been variously defined. Byford-Richardson et al. (2013) defined access as the timely use of services according to need. Utilization of health care is viewed as an operational proxy for access to health care. Access has four dimensions: availability, geographic accessibility, affordability and acceptability. Barriers to accessing health services can stem from the demand side and/or the supply side (2). Demand-side determinants are factors influencing the

ability to use health services at individual, household or community level, while supply-side determinants are aspects inherent to the health system that hinder service uptake by individuals, households or the community. The need to differentiate demand-side from supply-side barriers is related to the formulation of appropriate interventions to address both sides concurrently, because access barriers may not always be mutually exclusive, and may interact and influence each other. Most researchers provided a framework for assessing barriers along the four dimensions of access (each of them having supply-side and demand-side aspects) while few presented a framework of supply-side and/or demand-side barriers(1,2). Waiting time and direct payment for services are considered mixed supply-side and demand-side barriers(2). This is because long waiting times indicate a distribution of staff and equipment not in accordance with need, and the pricing of services is determined by the health facilities (supply side), meaning that both factors are outside the control of the public as users of health services (demand side). It is well documented that the unwelcoming staff attitude or poor interpersonal communication skills as well as complex billing systems at hospitals impede access to maternal health care (3). This attitude of health workers creates lack of assertiveness and low self-esteem among the poor, which increases the difficulty of accessing services. Restrictions put on some obstetric tasks that can be performed by general nursing staff also limited provision of timely maternal care services. For instance, general nurses on certain grounds are restricted from performing certain lifesaving activities for the mere fact that they are not midwives. As a result, a client with an urgent health care need may have to wait until a midwife or a doctor arrives. This problem is critical in facilities where there are no clear protocols regarding service delivery (4). The late referral or non-referral to specialist care of patients who may report with a condition at lower-level health facilities also serves as a barrier to maternal health care.

Teenagers who are pregnant but are not married face a dehumanizing stigma (5). This makes them stay away from essential maternal health service risking themselves with pregnancy related complications. A lack of trust in health care providers by users or the intermediates that link the population with these providers makes people reluctant to use the respective services (1). Another barrier to maternal health services is failure to deliver integrated health services together with complementary programmes provided to a target group, such as overlooking the opportunity to check and update vaccination status or to administer Vitamin A when a child is brought to the health facility for other services. The effect of non-financial barriers, such as lack of health awareness, apparent unmet need or lack of opportunity (defined as exclusion from social and health providers) also play a major role in accessing maternal care. Other non-financial barriers, such as means of transport, private-public dual practice through which patients are siphoned off from public health facilities to health workers' private practices, where they may be subjected to more expensive often irrational treatments are evident (6). Staff absenteeism, limited opening hours that do not allow for dealing with emergencies or working times that are not convenient for patients, especially working people are notable demand side barriers affecting effective provision of maternal health services.

Ethnicity and religion are often considered markers of cultural background and are thought to influence beliefs, norms, and values in relation to childbirth, service use, and women's status. Ethnic identity may also be associated with health beliefs that influence whether care is sought and whether that care is traditional or biomedical (7). However, a study conducted in Nigeria, it was shown that ethnicity made no significant difference in the use of antenatal care (7) although it made a significant difference in the use of skilled assistance and post-natal care. Moreover, the level of service utilization was significantly higher among the Igbo (in the Southeast) compared to the Hausa (in the North) (7). These findings reflect the influence of cultural and religious beliefs on access to maternal health services. The employment status of women has also been shown to predict the usage of maternal healthcare(3). However, little is known regarding barriers to accessing maternity care in the northern part of Ghana which is economically less developed and culturally diverse. Women who work and earn money have the opportunity to save and hence make an easy decision to spend on a facility delivery of their choice (8). The central aim of this study was to investigate barriers to accessing maternity care among expectant mothers at the Tamale Teaching Hospital, one of four Teaching Hospitals in Ghana located in the Northern Region. While physical barriers were investigated, this study also drew attention to emerging social determinants that influence access and utilization of maternal health care services.

2. METHODS

This study used a descriptive, cross-sectional study design to assess barriers to maternal healthcare among expectant mothers in Tamale Teaching Hospital in the Northern Region of Ghana. The cross-sectional design involves the collection of data at one point in time or multiple times in a short period and was therefore suitable for this study. The main advantage of cross-sectional designs is that they are economical and easy to manage.

Setting:

The study was conducted at the Tamale Teaching Hospital, the only Tertiary referral hospital in the whole of the Savanna Ecological Zone of Ghana. This zone includes Northern Region, Upper East, Upper West and some parts of Northern Volta and Brong Ahafo regions of Ghana. The hospital also received cases from neighbouring countries like Burkina Faso, Mali and Northern part of Togo. The Teaching and Regional Hospitals have higher maternal mortality figures than the national average because most of the very ill patients are usually referred to these tertiary centres for management. Maternal mortality has previously not been studied at the Tamale Teaching Hospital, but being the main referral hospital in Northern Ghana, its institutional figures from internal audits over the past few years have been unacceptably high. According to (9) Gummaga et al, the main causes of 139 audited maternal deaths in The Tamale Teaching Hospital from 2008 to 2010 were sepsis (19.8%), hypertensive disorders (18.6%), haemorrhage (15.8%), unsafe abortion (11.5%), obstructed labour (5.7%), anaemia (8.7%), sickle cell disease (5.7%) and malaria (5.0%). The ages of the 139 audited maternal deaths ranged from 14–48 years; with mean age of 26.5 ± 4.6 years. Nearly 50% of the maternal deaths were aged 20–29 years and about 10% were 14–19 years. Eighteen percent (18%) of the maternal deaths were from towns over 150km from Tamale. It was for these reasons that the Tamale Teaching Hospital was chosen as the setting for this study as findings will contribute to solving maternal morbidity and mortality issues in the catchment area.

Population:

All pregnant women and mothers who were in the period of exclusive breast feeding (within 6 months after delivery) qualified to take part in the study. In contrast, pregnant women who migrated into the metropolis during the period of data collection and those who did not give their consent to partake in the study were excluded from the study.

Sampling procedure:

The sample was obtained from expectant mothers attending antenatal clinic at the Tamale Teaching Hospital. The population of expectant mothers who attended antenatal clinic at the Tamale Teaching Hospital during 2013/2014-year review was 2489 (Annual review report, 2014). Adopting a simplified formula from Yamane (1967), the sample size for the above population was calculated as follows: A 95% confidence level and $p=.05$ were assumed for the equation: $n = \frac{N}{1 + N(e)^2}$ where n is the sample size, N is the population and e is the level of precision. Substituting the values in the equation $n = \frac{2489}{1 + 2489(0.05)^2} = 345$

To select participants, a systematic random sampling method was used to calculate the intervals from population of the previous year's ANC attendance which was found to be 2489. The interval was determined ($2489/345$ where the denominator represents the sample size) and found to be approximately 7. Hence, every seventh mother on the queue who met the inclusion criteria was selected and included in the study. An average of 125 women reported at the ANC per day and a period of two months was used for the entire data collection process by self-administering at least 40 questionnaires per week until the required sample size of 345 was obtained.

Ethics:

An ethical clearance certificate with reference number UCC/IRB/3/40 was obtained from the University of Cape Coast's Institutional Review Board. Approval was also obtained from the Committee on Human Research, Publication and Ethics (CHRPE) of the Tamale Teaching Hospital Tamale, Ghana. Participants' safety was guaranteed as the data collection process followed their normal pattern of daily activities and information obtained from them was kept strictly confidential. The participants were informed that the research did not guarantee any direct or short term benefit. It was expected, however, that the information elicited would inform policies and programmes in the region to prevent maternal mortality and improve maternal health.

Data collection instrument and procedure:

The main research instrument for the study was a structured questionnaire personally developed and self-administered to participants who met the eligibility criteria of the study within the period of data collection. Although the original questionnaires were in English language, questions were translated into the local languages participants during the data collection for those who could not speak English

Pre-test/pilot study:

A pre-test was conducted at the Kings' Medical Centre (KMC) in the Kumbungu District of the Northern Region to validate the instrument for the actual study. Permission was granted and questionnaires were self-administered to 35 volunteer clients at the antenatal clinic after obtaining their consent for the trial. Technical words in the questionnaires were explained to the respondents in their mother tongue with the help of research assistants. Internal consistency was measured statistically and cronbach's co efficiency alpha was .8. This was done to ensure reliability of the instrument for the actual study.

Data processing and Analysis:

Data were collected using a self-administered pre-tested structured questionnaire which was double entered into Excel, validated for data entry errors and then exported onto the Statistical Package for Social Sciences (SPSS) software version 20.01 for windows and analyzed. Demographic characteristics such as age, ethnicity, education, marital status, occupation, etc were summarized using frequency distribution tables and displayed as frequencies and percentages. The Pearson's chi-squared (χ^2) test was then used to determine associations between maternal demographics (age, ethnicity, education, marital status, occupation, religion, etc) and mother's access to maternal health services. Where there were significant associations, the multiple logistic regression model was employed to determine the strength of association and hence the Odds Ratio between respective variables. At the 95% confidence interval, a p-value less than 0.05 was considered to be statistically significant.

3. RESULTS

Table 1: Demographic and background information of women receiving antenatal and prenatal care at the Tamale Teaching Hospital

Variable	N (%)
Age	
11-20	68 (19.7)
21-30	188 (54.5)
31-40	77 (22.3)
41-50	12 (3.5)
Ethnicity	
Dagomba	180 (52.2)
Gonja	45 (13.0)
Ewe	16 (4.6)
Akan	19 (5.5)
Konkomba	11 (3.2)
Bimoba	10 (2.9)
Gruni	14 (4.1)
Dagaaba	22 (6.4)
Others	28 (8.1)
Religion	
Muslim	235 (68.1)
Christian	100 (29.0)
Traditionalist	10 (2.9)
<i>Table 1 continued</i>	
Marital Status	
Single	73 (21.2)
Married	250 (72.5)
Widowed	8 (2.3)
Divorced	14 (4.1)
Educational Status	

No formal education	110 (31.9)
JHS	75 (21.7)
SHS	56 (16.2)
Tertiary	104 (30.)
Occupation	
Unemployed/housewife	62 (18.0)
Trader	86 (24.9)
Student	22 (6.4)
Skilled worker	70 (20.3)
Farmer	20 (5.8)
Public/civil service	85 (24.6)
Income level	
Low Income (<C 400)	243 (70.4)
Middle Income (C 500-1500)	90 (26.1)
High Income (C > 1500)	12 (3.5)
Level of knowledge	
Inadequate knowledge	62 (18.0)
Adequate knowledge	283 (82.0)

The findings from table 1 revealed 54.5% of the study participants were within the category of 21-30 years, 72.5% were married, 30.1% were without education, 68.1% belonged to Islam, 52.2% were Dagbamba and Gonjas were 13.0%. With respect to occupation, the findings showed 24% worked in the civil/public sector, 20.3% were skilled workers, 24.9% traders and only 5.8% were farmers. However, 18% were unemployed and over 60% of respondents were not salaried workers and were engaged in businesses with irregular sources of income. Hence, overwhelmingly 70.4% of the participants were low income earners, 26.1% represented middle income earners with only 3.5% belonging to the high income category.

Table 2: Maternal health services available to participants at the Tamale Teaching Hospital

	Strongly disagreed n(%)	Disagreed n (%)	Agreed n (%)	Strongly Agree n (%)
Services available at health facility				
Laboratory, blood bank, HIV/AIDS/Hep B, counseling, theatre services and ANC	3 (0.8)	33 (9.6)	206 (60.6)	100 (29.0)
Barriers to maternal health services				
Judgmental attitude of health workers	7 (2.0)	109 (31.6)	196 (56.8)	33 (9.6)
Lack of ambulance service	14 (4.1)	82 (23.8)	184 (53.3)	65 (18.8)
Deplorable road network	11 (3.2)	97 (28.1)	76 (51.0)	61 (17.7)
Reasons for home birth				
Home birthing tradition	34 (9.9)	210 (60.9)	81 (23.5)	20 (5.8)
Poor hospital Infrastructure	31 (9.0)	130 (37.7)	126 (36.5)	58 (16.8)

Table 2 above showed that 89.6% agreed maternal health services were available at the Tamale Teaching Hospital but, over 66.4% of the participants agreed the judgmental attitude of health staff impeded access to maternal health services. The study also revealed lack of means of transport especially ambulance service as a great challenge to accessing emergency health care as 72.1% agreed they could not access lifesaving care due to this challenge. Another barrier mentioned in this study was deplorable road network which 68.7% agreed prevented access to maternal health care. These among others were the reasons why some pregnant women chose to deliver at home instead of the Teaching Hospital, even though 23.5% and 36.5% of some pregnant women give birth at home due to home birth tradition and poor hospital infrastructure, respectively.

Table 3: Obstetric Beliefs as barriers to seeking healthcare among antenatal clients

	Strongly disagreed n (%)	Disagreed n (%)	Agreed n (%)	Strongly agreed n (%)
Obstetric belief				
Talisman protects against witchcraft	40 (11.6)	91 (26.4)	107 (31.0)	107 (31.0)
A man who sees a woman naked in labour causes obstructed labour	40 (11.6)	116 (33.6)	125 (36.2)	64 (18.6)
Early announcement of pregnancy causes miscarriage	38 (11.0)	74 (21.4)	123 (35.7)	110 (31.9)
Unassisted birth is a mark of fidelity and bravery on the part of the woman	34 (9.9)	111 (32.2)	125 (36.2)	74 (21.4)
Rituals for safe delivery	14 (4.1)	39 (11.3)	127 (36.8)	165 (47.8)

In table 3 above, 62% of the respondents believed a talisman offers protection to the pregnant woman and her unborn child against diseases and evil spiritual attacks; however, 38% of the respondents disagreed with this belief. Similarly, 54.8% of the pregnant women in the study agreed that no man other than the husband or a doctor should see a woman naked in the process of giving birth as this could lead to obstructed labour. About 67.6% of the participants held the belief that early announcement of pregnancy could cause miscarriages whilst 32.4% disagreed. Furthermore, 57.6% of the study populace was of the view that unassisted birth is a mark of fidelity and bravery on the part of the woman as opposed to 42.4%. On the other hand, 84.6% of participants as opposed to 15.4% believed that for a safe delivery, a pastor or imam or traditionalist must be called in to perform rituals for the woman in labour based on her faith.

Table 4: Determinants of Facility Delivery (Multiple logistic regression Analysis)

Variable	S.E.	Df	Sig.	AOR	95% C.I.for AOR	
					Lower	Upper
Age	0.232	1	0.811	1.057	0.671	1.666
Education2	0.247	1	0.011	1.877	1.157	3.044
Religion		2	0.735			
Religion(1)	0.943	1	0.673	1.489	0.234	9.461
Religion(2)	0.985	1	0.926	1.096	0.159	7.561
Knowledge2	0.466	1	0.278	1.658	0.666	4.13
ANC2	0.38	1	0.00	5.359	2.544	11.289
Income		2	0.551			
Income(1)	1.264	1	0.733	0.649	0.054	7.74
Income(2)	1.265	1	0.938	1.104	0.093	13.17
Means of transportation 1	0.561	1	0.382	0.612	0.204	1.84
Items Delivery	0.495	1	0.695	0.824	0.312	2.174
Tradition	0.36	1	0.015	2.393	1.181	4.849
Marriage2	0.29	1	0.915	1.032	0.584	1.822
Birth Plan	0.714	1	0.544	1.542	0.38	6.252
Birth Preparedness	0.896	1	0.769	1.301	0.225	7.536
Attitude of health staff	0.411	1	0.343	0.677	0.302	1.516
Deplorable Road network	0.477	1	0.986	1.008	0.396	2.57
Cost of services	0.496	1	0.931	0.958	0.362	2.533
Constant	2.499	1	0.043	0.006		

Compared to those without any formal education, lower level of education, those with higher education were about 1.9 times more likely to deliver in a health facility (AOR=1.9, 95% C.I. 1.16-3.04, p=0.01). Compared to those with the number of ANC visits less than four (4), those with four plus (4+) visits were about 5.4 times more likely to deliver in a health facility (AOR=5.4, 95% C.I. 2.54-11.29, p<0.01). More so, compared to those who agree with the “home birthing tradition”, those who disagree with it were about 2.4 times more likely to deliver in a health facility (AOR=2.4, 95% C.I. 1.18-4.85, p=0.02) (See table 10).

4. DISCUSSION

The findings showed majority of the respondents were within 21-30 years of age. This was predictable because most women marry at this age and would like to have babies during this period in life to continue their generation. This notwithstanding the study also revealed 19.7% were below the age of 20. Girls in this age category were reported to be in forced marriages and often prevented from accessing sexual and reproductive health services. Despite the fact that risk of maternal death for mothers within 11-20 years in low-and middle-income countries doubles that of older females 21-40, nevertheless, this group of very young adolescents lack access to national health, education and maternal health services. Similarly, in Nigeria, women in the middle child bearing ages were more likely to use maternal health services than women in early and late child bearing. So, being of older age at marriage is positively associated with the use of healthcare services (10). One study in rural India also reported that access to maternal care was higher among women married at 19 or older compared to those married at less than 19 years (11). Early marriage or child marriage is practiced more often in Africa and Southern Asia and the western world is no exception where teenagers marry and/or just live together against the parents' wishes (12). In circumstances like this, these girls may be restricted from seeking healthcare services because of fear or need for permission from a spouse or in-laws (13). A girl in such a situation may also flee to her maternal/paternal home place to seek redress and care.

Women who had at least primary education were more likely to have access to maternal health care compared to those who did not. These findings have also been observed in the study conducted in Mpwapwa district Tanzania, rural Uganda, North Ethiopia and Indore City India (14). This might be due to the fact that educated women know the issues related to their health. Hence, the findings indicated, as educational level of these expectant mothers increased there was a corresponding increase in the likelihood of facility delivery. The study further revealed that respondents who could not patronize health care services were those with no formal education. Education was found in this study to be integral and directly proportional to health care access among mothers. Studies showed that women with formal primary education and above were two times more likely to have access to maternal care services compared to those who lacked formal education(15). Another reason why better educated women had more access to maternal health services is their ability to better understand health messages and search for more information regarding health issues. Similar studies conducted in Tanzania and in Ethiopia have shown separately clear relationship between high education and awareness of danger signs of pregnancy(16). Hence, better educated women are more aware of health problems, know more about the availability of health care services and use this information more effectively to maintain or achieve good health status. According to literature, women's education has been found to be one of the key determinants of maternal healthcare utilization. In India for example, women with high school education and above were 11 times more likely to use antenatal care compared to illiterate women (14). Education of women is therefore likely to enhanced autonomy so that women could develop confidence and capabilities to make decisions regarding their own health.

In terms of religion, the study revealed that more Christian women were likely to deliver in a health facility than traditional and Islamic women. This could be as a result of certain practices by Muslims and Traditionalists that encourage home delivery regardless of the dangers thereof. For example, many communities in the northern part of Ghana, it is customary for a woman with her first pregnancy to deliver at home and undergo some rituals deemed necessary for survival of both mother and her new born (personal observation). Religion therefore played a key role in this study concerning maternal health care access. Findings in this study are in consonance to a study conducted in Nigeria, where the level of access to health care services was significantly higher among the Igbo (in the south) and the minority tribe compared to the Hausas (in the north) (7). The Islamic religion may have had a strong influence on the cultural beliefs and traditions on child birth in the north. Also, some women in this study chose to turn to their deities for a normal birth. For example, the new brand of Pentecostalism interferes with timely health care utilization as women see pastors, prophets and general overseers for special anointing. For Catholics, turning to the Virgin Mary and making novenas cannot be over emphasized (17).

Women who had a salaried job were more likely to access maternal health care services compared to women who were not employed. This finding was comparable with the studies conducted in Southern Ethiopia and Uganda (18). This might be due to the fact that paid employment meant a greater likelihood of having cash that can enhance access to maternal health care services. Early and frequent antenatal care attendances are important to identifying and alleviating risk factors in pregnancy and to encourage women to seek maternal health care services (19).

Access to maternal health services was crucial in this study to ensuring safe motherhood care before, during and after delivery. According to literature, access has four dimensions: availability, geographic accessibility, affordability and acceptability (8)). Barriers to accessing health services in this study arose from both the demand side and the supply side. Demand-side determinants are factors influencing the ability to use health services at individual, household or community level, while supply-side determinants are aspects inherent to the health system that hinder service uptake by individuals, households or the community (2). From the study, 89.6% of the participants in the Tamale Metropolis agreed that maternal health services such as laboratory services, blood bank services, HIV/AIDS/Hep B counseling services, theatre services and ANC etcetera were available at the facility they went to access care. On the other hand, respondents said there were also concurrent challenges accessing these services due to some intractable barriers. For instance, in the study, over 66.4% of the participants felt the judgmental attitude of health staff impeded access to maternal health services. This confirmed the assertion that unwelcoming staff attitude or poor interpersonal skills as well as complex billing systems at hospitals, increased the difficulty of accessing services especially in developing countries(18). This could breed lack of trust by users in health care providers or the intermediates that link the population with these providers, making people reluctant to use the respective services. The study also revealed lack of means of transport especially ambulance service as a major challenge to accessing emergency health care as 72.1% was prevented from accessing lifesaving care. Another barrier mentioned in this study was deplorable road network which 68.7% agreed had prevented them from accessing timely maternal health care services. These among others were the reasons why some pregnant women in this study could not access maternal care and were likely to deliver at home.

In Ghana, as in many developing countries, deaths during pregnancy and childbirth are often linked to the three delays: Delays in the home, delays in accessing the health facility and delays at the health facility (20). The first delay is deciding whether to seek care or not. Lack of information and inadequate knowledge are responsible for the delay in responding to initial warning signs of complications of pregnancy and danger signals during labour. Certain traditions and cultures in the country maintain that women must wait for approvals from male relatives before seeking help (21). The second delay is linked to the constraints that women face in accessing health facilities. Weak referral linkages as pointed out in this study exist between communities, health centres and district hospitals making it difficult for women in emergency situations to get the care they need. The situation as mentioned is made worse by poor road and communication networks, distant health facilities, and a lack of transportation and inadequate community support (22). The third delay identified occurs between the time the woman arrives at the health facility and the facilities response in providing appropriate care. Facility preparedness to respond to obstetric emergencies is generally inadequate in terms of skilled attendants, equipment, supplies and drugs and motivated staff (20).

Traditional culture played a major role in the way a woman perceived and prepared for child birth experience; this may positively or negatively affect the use of health care in general and maternal health in particular (23). In this study 62% of the respondents believed talismans offer protection to the pregnant woman and her unborn child against diseases and evil attacks. The implication of this belief is modern ways of providing protection for pregnant women and their unborn babies such vaccination, taking vitamin supplements etcetera could be substituted with wearing mere talismans. Similarly, 54.8% of the pregnant women in this study agreed that no man other than the husband should see a woman naked in the process of giving birth as this could lead to obstructed labour. This perception of the mothers affects access to maternal healthcare services. A similar study was done among Ethiopian Afar, where women stated during a focus group that only God and their husband could see them naked (8). Pregnant women therefore, preferred consultation with local religious leaders, traditional healers, and traditional birth attendants (TBAs) where expectant mothers assumed autonomy to seeking care from qualified health providers. The danger here is that when there are obstructed labour issues these traditionally skilful birth attendants introduce local medicine (concoctions) to stimulate contractions. These concoctions, despite their long tested medicinal effects may also result in repeated and strong contractions leading to rupture of the uterus, a probable cause of maternal and new-born death (24). With respect to early announcement of pregnancy 67.6% of participants held the belief the practice could cause miscarriages. Respondents who believed in this normally start ANC visit late in order to protect their pregnancy against miscarriages (25). Furthermore, 57.6% of the study populace was of the view that unassisted birth is a mark of fidelity and bravery on the part of the woman as opposed to 42.4%. This is in line with a study conducted in Uganda that stated women felt embarrassed to give birth in a health facility because other members of the community would think they were not brave enough to give birth on their own (16). Child Birth therefore, represented a rare opportunity for a woman to demonstrate pride, courage, and bring honour to her and her husband's families by her stoic demeanor. The woman who managed to deliver without indication that she was in labour and without calling for assistance until the child was born was especially esteemed.

On the other hand, 84.6% of participants as opposed to 15.4% believed that for a safe delivery, a pastor or imam or traditionalist must be called in to recite special prayers for the woman in labour based on her faith for safe delivery. During obstructed labour, the pregnant woman was made by these unskilled birth attendants to mention the name(s) of the man or men she might have slept with during pregnancy in order to deliver normally. If she could not still deliver then she was made to go to the hospital by which time she might be near death. According to Fischer women have used prayer and other spiritual practices for their own and others' health concerns for thousands of years(21). This they believe is a prerequisite for safe delivery however; it is a medium for deadly delays.

5. CONCLUSION

The finding of this study revealed relatively serious challenges accessing maternal health services in the Tamale Teaching Hospital emanating from both demand side (barriers outside health facility) and supplied sides (barriers embedded in service delivery at the facility). However, in pregnancy related complications, time for survival decreases while risk for death increases and facility delays as cited above in rendering timely interventions to mothers in obstetric danger could have contribute to the soaring maternal morbidity and mortality in the Tamale Metropolis rendering the frantic efforts in combating maternal death by the Ghana Health Services, Ministry of Health and International safe motherhood organizations impotent. Maternal deaths in the Northern part of Ghana could be reduced if qualified and dedicated Nurses, Midwives and Doctors were ready to serve humanity in a professional manner. Furthermore, logistics, and refurbishment, building of more hospitals in each district-one district one modern referral hospital, are necessities in order to adequately attend to patients timely. The Government indeed has a huge responsibility but individuals and cooperate entities equally have a role to play in this direction to improving knowledge, practice and nursing research geared at attaining zero tolerant to maternal death.

ACKNOWLEDGMENT

I acknowledge Professor Juventus Ziem of University for Development Studies and Prof. Dannabang University of Puerto Rico, Department of Humanities, Puerto Rico for their editorial suggestions; Mrs. Esther Doe, the CNO and staff of the Obstetric and Gynaecology Department of the Tamale Teaching Hospital; Evelyn Dannikuu, CNO of neurosurgery department and all my research team members for their selfless support.

REFERENCES

- [1] Byford-Richardson L, Walker M, Muckle W, Sprague A, Fergus S, Rennicks White R, et al. Barriers to access of maternity care in kenya: a social perspective. J Obstet Gynaecol Can [Internet]. 2013;35(2):125–30. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23470061>
- [2] Ensor T, Cooper S. Overcoming Barriers to Health Service Access and Influencing the Demand Side Through Purchasing. Heal Nutr Popul Discuss Pap. 2004;1–78.
- [3] Debelew GT, Afework MF, Yalew AW. Factors affecting birth preparedness and complication readiness in Jimma Zone, Southwest Ethiopia: a multilevel analysis. Pan Afr Med J [Internet]. 2014;19:272. Available from: <http://www.scopus.com/inward/record.url?eid=2-s2.0-84913602137&partnerID=tZOtx3y1>
- [4] Solnes Miltenburg A, Roggeveen Y, van Elteren M, Shields L, Bunders J, van Roosmalen J, et al. A protocol for a systematic review of birth preparedness and complication readiness programs. Syst Rev [Internet]. 2013;2(1):11. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3599634&tool=pmcentrez&rendertype=abstract>
- [5] Kaso M, Addisse M. Birth preparedness and complication readiness in Robe Woreda, Arsi Zone, Oromia Region, Central Ethiopia: a cross-sectional study. Reprod Health [Internet]. 2014;11(1):55. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=4118259&tool=pmcentrez&rendertype=abstract>

International Journal of Novel Research in Healthcare and NursingVol. 4, Issue 2, pp: (185-195), Month: May - August 2017, Available at: www.noveltyjournals.com

- [6] Jacobs B, Ir P, Bigdeli M, Annear PL, Damme W Van. Addressing access barriers to health services : an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy Plan.* 2011;10(3):1–13.
- [7] Iliyasu Z, Abubakar IS, Galadanci HS, Aliyu MH. Birth preparedness, complication readiness and fathers' participation in maternity care in a northern Nigerian community. *Afr J Reprod Health.* 2010;14(1):21–32.
- [8] Tura G, Afework MF, Yalew AW. The effect of birth preparedness and complication readiness on skilled care use: a prospective follow-up study in Southwest Ethiopia. *Reprod Health [Internet].* 2014;11:60. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=4127036&tool=pmcentrez&rendertype=abstract>
- [9] Gummaga. Trends in Maternal Mortality in Tamale Teaching Hospital, Ghana. 2011.
- [10] Cooke JG, Tahir F. Maternal Health in Nigeria with leadership, progress is possible. 2013.
- [11] Nawal D, Goli S. Birth preparedness and its effect on place of delivery and post-natal check-ups in Nepal. *PLoS One [Internet].* 2013;8(5):e60957. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3655026&tool=pmcentrez&rendertype=abstract>
- [12] Union A, Africaine U. Campaign to End Child Marriage in Africa The Effects of Traditional and Religious Practices of Child Marriage on Africa ' s Socio-Economic Development.
- [13] Campbell B, Martinelli-heckadon S, Wong S. Motherhood in Childhood, Facing the challenges of adolescent pregnancy. 2013.
- [14] Agarwal S, Sethi V, Srivastava K, Jha PK, Baqui AH. Birth preparedness and complication readiness among slum women in Indore city, India. *J Heal Popul Nutr.* 2010;28(4):383–91.
- [15] Urassa DP, Pembe AB, Mganga F. Birth preparedness and complication readiness among women in Mpwapwa district, Tanzania. *Tanzan J Health Res.* 2012;14(1):1–7.
- [16] Kabakyenga JK, Östergren P-O, Turyakira E, Pettersson KO. Influence of birth preparedness, decision-making on location of birth and assistance by skilled birth attendants among women in south-western Uganda. *PLoS One [Internet].* 2012;7(4):e35747. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3338788&tool=pmcentrez&rendertype=abstract>
- [17] Crowther S, Hall J. Spirituality and spiritual care in and around childbirth. *Women and Birth [Internet]. Australian College of Midwives;* 2015;28(2):1–6. Available from: <http://linkinghub.elsevier.com/retrieve/pii/S1871519215000037>
- [18] Asp G, Odberg Pettersson K, Sandberg J, Kabakyenga J, Agardh A. Associations between mass media exposure and birth preparedness among women in southwestern Uganda: a community-based survey. *Glob Health Action [Internet].* 2014;7:22904. Available from: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3888909&tool=pmcentrez&rendertype=abstract>
- [19] Karkee R, Lee AH, Binns CW. Birth preparedness and skilled attendance at birth in nepal: Implications for achieving millennium development goal 5. *Midwifery [Internet].* 2013;29(10):1206–10. Available from: <http://dx.doi.org/10.1016/j.midw.2013.05.002>
- [20] Asante AE. An assessment of the effect of the free maternal care policy on the utilisation of maternal care services in the New Juaben Municipality. Kwame Nkrumah University of Science and Technology, Ghana; 2011.
- [21] Fischer M. Childbearing in Ghana : How beliefs affect care Childbearing in Ghana : How beliefs affect care. *African Diaspora Collect.* 2002;10(1).

International Journal of Novel Research in Healthcare and Nursing

Vol. 4, Issue 2, pp: (185-195), Month: May - August 2017, Available at: www.noveltyjournals.com

- [22] Ekabua JE, Ekabua KJ, Odusolu P, Agan TU, Iklaki CU, Etokidem AJ. Awareness of birth preparedness and complication readiness in southeastern Nigeria. *ISRN Obstet Gynecol.* 2011;2011:560641.
- [23] Berrin Okka, Yasemin Durduran NDK. Traditional practices of Konya women during pregnancy, birth, the postpartum period, and newborn care. *Turkish J Med Sci.* 2016;501–11.
- [24] Iliyasu Z, Sabubakar I. Women ' s Health and Action Research Centre (WHARC) Complication Maternity Care in a Northern Nigerian Participation in Community. *African J Reprod Heal / La Rev Africaine la Santé Reprod.* 2015;14(1):21–32.
- [25] Craig sienna R. childbirth Across Culture Ideas and Practices of Pregnancy, Childbirth and the Pospartum. In: *sSCIENCE ACROSS CULTURES: THE HISTORY OF NON-WESTERN SCIENCE.* USA; 2009.