

WHY ARE THERE LOW INSTITUTIONAL DELIVERY RATES IN THE GAMBIA? WOMEN'S OPINION

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Community Health

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ABSTRACT

Rationale for the Study: The Gambia, a small and poor Country in West Africa. Health is one of the key pillars in the agenda of the Gambia government. Spending has been increased from 13.6% in 2001 to 4.95% in 2003. Public health expenditure also increases steadily to 3.2% in 2003. Expenditure on health per capita US\$8 is only spent by the Government.

Access to health facilities is good, with over 85% of the population living within 3 kilometres of a primary health care or outreach health post and 97% of the population within 5 kilometres. Despite the high Antenatal Care coverage of 96%, only few deliveries take place in the health facilities. Skilled attendant at deliveries is estimated at 44%. The majority of the deliveries take place at home attended by TBAs or a relative. Cost of Antenatal services is extremely low and it's paid once during registration for the entire visit. Women with normal deliveries pay D12.50 (US\$0.45) and D25.00 (US\$ 0.90) respectively. Those with Caesarean Section (CS) pay D50.00 (US\$1.79). After delivery, they attend infant welfare clinic immediately after the naming ceremony. It is the same distance and they know the facilities well.

However, the women do not use the institutions for delivery. Institutional delivery is very low, estimated at 30.4%.

Objectives of the study:

1. To identify and describe the socio- demographic factors associated with not utilising health facility for delivery.
2. To identify and describe the economic factors associated with the low institutional deliveries.
3. To describe health services related factors contributing to the low utilization of health facility for deliveries.
4. To identify and describe cultural factors (if any) that act as a barrier to health facility deliveries.

5. To put forward recommendation for improved care and increased utilization of health institutions for delivery care and improved maternal health outcomes.

Materials and Methods: A cross sectional design was used. Individual in-depth interview using a semi structured interview guide and a focus group discussion were used to collect information on women who have just delivered and have come to the clinic for registration of their infants for infant welfare clinic; immunization and growth monitoring in 2 of the health divisions WD (urban) and NBW (rural) in the Gambia. The women with live births were randomly selected from the MCH clinics, interviewed and followed back in the community for a focus group discussion.

Results: A total of 391 women were interviewed in the quantitative study and 36 women participated in the focus group discussions. Four focus groups was performed; 2 in each division. The study revealed that cultural factors, attitude of health care providers, previous experiences with the health system, long waiting time, negligence of health care workers, alternative delivery services, transport and cost of receiving services and expectations are factors that influenced their utilization of health facilities for delivery.

The individual in-depth interview revealed that place of delivery for first pregnancy in NBW was health facility 60% and home 40.6% and WD place of delivery for first pregnancy was health facility 88% and home 13%. Those who delivered in health facility during their first pregnancy, (N296) in both divisions, only 24% delivered at home during their index pregnancy and 40% delivered in health facility. In NBW 80% did not receive any information on place of delivery. Of those who received information, 45% delivered at home and 55% delivered in HF. In WD, 42% received information and 60% did not receive information. Of those who received information, 18% delivered at home and 82% delivered in HF. The prominent danger signs that are the major causes of maternal death are not known. Bleeding before and after delivery which are

very severe and are major causes of maternal death is only known by 14(4.4%) and 3(1.0%) respectively in both divisions.

Conclusions: Cultural factors and health services factors which include staff attitude and lack of maternal education during ANC attendance were the most frequently identified contributing factors to the low Uterlisation of health institutions for delivery in this study.

Keywords: Maternal mortality, Institutional Deliveries, Home Deliveries, Skilled Attendant, TBA, Gambia.

DEDICATION

This study is Dedicated to my entire family; My husband (Winston Able-Thomas) and children. I could not have made it without you been there at home taking care of the children. I appreciate your understanding and patience for my absence during these challenging years. Your encouragement and support during the time I needed it most were well appreciated. I express my gratefulness.

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Last but not the least, I thank and praise God the Almighty for guiding me and giving me the strenght throughout the entire process.

ACRONYMS

ANC:	Antenatal Care/ Clinic
CHW:	Community Health Worker
DOSH:	Department of State for Health
DHT:	Divisional Health Team
EOC:	Emergency Obstetric Care
EMOC:	Emergency Obstetric Care
FGD:	Focus Group Discussion
GDP:	Gross Domestic Product
GNP:	Gross National Product
GFPA:	Gambia Family Planning Association
JFP:	Jammeh Foundation for Peace
KMC:	Kanifing Municipal Council
MCH:	Maternal and Child Health
MRC:	Medical Research Council
MDGs:	Millennium Development Goals
NBDW:	North Bank Division-West
NGO:	Non- Governmental Organisation
PHC:	Primary Health Care
PI:	Principal Investigator
RH:	Reproductive Health
RVTH:	Royal Victoria Teaching Hospital
SPSS:	Software Package for Social Sciences
TBA:	Traditional Birth Attendant
TFR:	Total Fertility Rate
UNFPA:	United Nations Fund for Population Affairs
VHS:	Village Health Service
VHW:	Village Health Worker
WHO:	World Health Organisation
WD:	Western Division

DEFINITION OF TERMS

Antenatal Care: Care given to women during pregnancy that provides an important opportunity for discussion between a pregnant woman and a health care provider about health behaviour during pregnancy, recognising complications that may arise during pregnancy, and delivery plans that will meet the needs of the individual woman [1].

Antenatal Care Coverage: Percentage of women attended at least once during pregnancy by skilled health personnel for reasons related to pregnancy [1].

Deliveries attended by skilled health personnel: Percentage of deliveries attended by skilled health personnel irrespective of outcome (live birth or fetal death) [1].

Deliveries in health facilities: Percentage of deliveries in public and private hospitals, clinics and health centres, irrespective of who attended the delivery at these facilities [1].

Maternal Death: Death of a woman whiles pregnant or within 42 days of termination of pregnancy, irrespective of what but not from accidental or incidental causes [2].

Person with Midwifery Skills: A person who has successfully completed the practical course in midwifery and is able to give necessary supervision, care and advice to women during pregnancy, labour and the post partum period, to conduct deliveries alone, to provide lifesaving obstetric care, and to care for the newborn and the infant [1].

Skilled Care: Care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at her/ his disposal the necessary equipment and the support of a functioning health system, including transport and referral facilities for emergency obstetric care [3].

Skilled Attendant: Doctors(specialst or non- specialst), and/ or persons with midwifery skills who can diagnose and manage obstetrical complications as well as normal deliveries [1].

Skilled Attendance: The process by which a woman is provided with adequate care during labour, delivery and the early post- partum period [4].

Traditional Birth Attendant (TBA): A TBA who initially acquired her ability by delivering babies herself or through apprenticeship to other TBAs and who has undergone subsequent extensive training and is now integrated in the formal health care system [1].

CHAPTER ONE: INTRODUCTION

1.1. BACKGROUND

Every year over 500,000 women die of pregnancy and childbirth related complications globally. Of these, 99% occur in developing countries and mostly in sub-Saharan Africa [5]. Thus maternal mortality is the indicator with the widest disparity between developed and developing countries.

In realization of this unacceptable level of maternal mortality around the globe, in 2000 world leaders committed themselves and set goals commonly known as Millennium Development Goals (MDGs) [6]. "Improving Maternal Health" is MDG 5 with set target of maternal mortality ratio reduction by three-quarters of the 1990 levels by the year 2015 [6]. Critical in the attainment of the above goal is to ensure availability, utilization and quality of maternity care services - antenatal, delivery and postpartum care. Intrapartum and peripartum death accounted for over 70% of the global maternal death. Thus, making skilled attendance during pregnancy is critical and an essential intervention in reducing maternal mortality and morbidity [6]. In the developed world where less than 1% of maternal deaths occur, it is estimated that 97%, 99% and 90% of women receive antenatal care, deliver in health institution and receive postpartum care respectively [1].

In developing countries, 65% receive antenatal care services, 53% deliver in health institutions and 30% receive some form of postpartum care [1]. This discrepancy in maternity care coverage between developed and developing countries offer some explanation to the maternal mortality situation around the world.

In The Gambia, maternal mortality is unacceptably high and its reduction is a priority area for the government and indeed the Department of State for Health (DOSH). However, whilst antenatal care is nearly universal, 96% of pregnant women make at least one antenatal care visit, and delivery and postpartum care are generally low [7]. It is documented that only 30.4% of deliveries around the country takes place in health facilities [8]. The majority

deliver at home attended to by a traditional birth attendant or a relative. This situation is worrying and poses a tough challenge to the attainment of the MDG focusing on maternal health.

1.2. LITERATURE REVIEW

Of all the indicators monitored by the United Nation, maternal mortality is the one with the widest discrepancies between the developed and developing countries. However, monitoring progress towards maternal mortality reduction is difficult, therefore indicators set to monitor progress is proportion of deliveries by skill birth attendant. A skilled Attendant can be a medical doctor or a person with midwefery skills who is trained to diagnose and manage obstetric complications as well as normal deliveries, give necessary supervision, care and advise to women during pregnancy, labour and the postpartum period [9]. Skilled attendant is often available at health facility level, although there is historical evidence of well developed home visiting midwives at community level as in Norway, Sweden, and also in Holland.

“For a mother and her newborn, a skilled birth attendant can make a difference between life and death. Not only can they recognize and prevent medical crises, but can identify obstetric complications early and effect immediate referral is a life saving care” says Joy Phumaphi [10]. Trained traditional birth attendants cannot, in most cases, save women’s lives because they are unable to manage most of the obstetric complications arising during pregnancy, delivery and postpartum period. Referral in the community is constrained by transport difficulties.

Maternal deaths are very rare in developed countries but an every day event in developing countries. Most life threatening obstetric complications require hospital treatment to avert maternal mortality. In Africa maternal mortality is estimated at 251,000 women who die annually from pregnancy and child birth related conditions [2]. For every maternal death there are at least thirty women who suffer short or long term disabilities. Most maternal deaths occur during child birth and in the immediate post partum period. To avert this

situation, all women should have access to basic maternity care during pregnancy and delivery, which includes quality antenatal care, clean and safe delivery and post partum care for mother and child and unlimited access to EmOC.

In many developing countries large proportion of deliveries (47%) take place outside the formal health care system often assisted by a relative or Traditional Birth Attendant.

In Sri Lanka, maternal mortality has followed a down ward trend from 2100 per 100 000 live births in 1981 to 240 per 100 000 live births in 1995 [11]. This decline is attributed mainly to high rate of institutional delivery (90%) attended by midwives. Similar situation also obtains in Sweden. The low maternal mortality registered is attained through the training of community midwives to conduct delivery assistance to poor women and offering them the option of having a safe and inexpensive home delivery [12]. Reduction in maternal and infant morbidity rates in England and united States have been attributed to good antenatal care [13].

Reduction by three- quarters, between 1990 and 2015, the maternal mortality ratio; goal 5(MDG) is the proportion of births attended by a person who is trained on midwifery skills (skilled health personnel). A vast majority of women will need only basic care during labor and delivery. Cleanliness and the presence of skilled personnel will help to ensure that normal births are clean and safe and that obstetric complications are dealt with promptly. During child birth, every woman should be helped by health personnel who can manage a normal delivery, be able to detect and manage complications such as hemorrhage, convulsions, shock and infection [14]. Doctors, midwives and nurses who attend deliveries must have midwifery skills needed to recognize the onset of complications, perform essential interventions, start treatment and supervise the referral of mother and baby for management of interventions which are beyond their competence [9]. Skill attendant play a pivotal role in reducing maternal and newborn mortality and morbidity says the joint statement of World Health Organization(WHO), ICM and FIGO [10]. This

statement calls for better monitoring and reporting on progress in achieving the MDG target of increasing the proportion of births attended by a skilled attendant to 90% by 2015 [10].

Series of studies conducted in developing countries shows a large proportion of deliveries without skilled attendant and how it contributes to high maternal mortality and morbidity. A study in South Eastern Nigeria shows a total of 52% deliveries outside health institutions while 47.1% delivered with health institutions. Twenty seven percent (27%) of the women had no formal education, 37.4% had primary education, 13.5% secondary and 21.5% post secondary. Choice of place of delivery may be influenced by educational level, and place of residence [15]. Another study in a rural Nigerian community reveals the same. Among the 225 randomly selected mothers, private maternity centre was the most preferred place of delivery (37.3%), then traditional birth attendant (25.5%), and government facility (15.7%). Education level was also found to be significantly associated with the choice of place of delivery [16].

Many studies conducted in Nigeria, revealed similar situations. A cross sectional survey of 100 randomly sampled women in Oyo state in Nigeria to study the pattern of utilization of antenatal, delivery and postnatal services in the community, revealed that utilization of antenatal care services was relatively high, however, most of the respondents delivered at home without the supervision of trained personnel. This poor utilization of institutional delivery services was attributed to advanced labor and or perceived poor quality of the health facilities. Educational attainment also significantly influence the respondents choice of place of delivery [17]. Most of these home deliveries are attended by Traditional Birth Attendant (TBA), relatives or women themselves. Similar studies revealed high home deliveries with trained TBAs or untrained. In the Gambia a study on maternal mortality levels, causes and contributing factors, revealed that out of the 18 deaths studied, 5 were home deliveries attended by relatives and trained TBAs. Of these none had live births. Causes of death for 2 women were hemorrhage from retain placenta which cannot be

managed effectively by such attendants. Times of death are mostly during the post partum period [18]. In the Gambia a study on Emergency Obstetric Care (EmOC) revealed 30.4% institutional deliveries despite the high Antenatal Care (ANC) coverage of 96% [8] .

In Malawi, another study also revealed a 95% ANC coverage but low institutional delivery (41%) [19]. Some women prefer to deliver at home because of adherence to traditional birthing practices and they believe that pregnancy is a test of endurance and maternal death is sad but normal event [20]. Another study in India revealed that out of 2861 deliveries, 85% were at home, and 14.4% of the deliveries were complicated. Of the complicated deliveries, 78.9% were in a hospital but case fatality among these complicated deliveries was only 0.3% [21]. This indicates the importance of institutional deliveries in maternal mortality reduction.

In Kenya, to determine the utilization of antenatal and maternity services by mothers revealed that utilization of health facility for maternity services depends on number of children and distance to health facility. As the number of children increases, utilization decreases [22]. This also shows that distance hinders the use of health facilities.

Referred and actual place of delivery often differ as revealed in a cross sectional study in Zambia which revealed that of the 332 women interviewed, 94% prefer to deliver in health facility but only 54% did so. Lack of transport, long distance, user fees and lack of adequate health education given during ANC attendance were cited as reasons for non- use [23].

In Papua New Guinea were most women deliver at home, maternal deaths were explored to assess circumstances surrounding to their deaths. Post partum hemorrhage from retained placenta and puerperal sepsis were common causes of death. Follow up of a group of pregnant women shows that abnormal labour was frequent. Twenty four percent (24%) of multigravida reported a labour that lasted longer than 24 hours. In 9% of all births, the third stage lasted longer than one hour, or products were retained. Twenty seven percent (27%) of village deliveries were attended by female relatives, while 12% by their

husbands. Delay with delivery of the placenta was relatively common; 1-2 hours after delivery in 5 women and after 2 hours in another 5 women [24].

Most studies revealed how women resulted to delivering at home or even loss their lives on the way to health facilities due to lack of transport or long waiting hours to get one. Women's account of maternity services during labour and delivery in Ghana, shows that choice of place of delivery depends on poor outcomes of previous pregnancies, staff attitude, cost of services, geographical access, recommendation from friends and family members and proximity of a facility to family members for support and care, confidentiality and privacy [25]. Perception and poor quality of care deterred women from choosing certain facilities for delivery.

The majority of these births are carried out in ordinary homes under relatively unhygienic conditions by relatives and TBAs. This leads to high incidence of maternal and newborn mortality that could be reduced if childbirth were to take place in health facilities or under the supervision of trained health personnel who has the knowledge, equipment and supplies. The immediate causes of pregnancy related complications, ill health and deaths are due to inadequate care of mother during pregnancy and delivery.

1.3 CAUSES OF MATERNAL DEATH

Maternal death is death of a woman whilst pregnant or within 42 days of termination of pregnancy, irrespective of what but not from accidental or incidental causes [2].

Maternal Death is as a result of direct and indirect causes. The single most common causes accounting for a quarter of all maternal death is severe bleeding. The other direct causes are obstructed labour sepsis, Eclampsia, and complications of unsafe abortions. Globally, up to 80% of all maternal deaths are the direct results of complications arising during pregnancy, delivery or the puerperium. The indirect causes of death, such as anaemia, malaria, cardiovascular diseases, diabetes and HIV/AIDS, accounts for at least 20% [2].

Nearly all direct causes of maternal deaths are avoidable with prompt and high quality of obstetric care. The outcomes of direct causes are determined by the quality of obstetric care services. Literature has also indicated that 15% of all pregnancy will develop life threatening obstetric complications but no risk approach can predict which individual woman will develop complication [26]. Thus there is need for availability and accessibility of Emergency Obstetric Care (EmOC). EmOC is a set of medical interventions available in medical facilities, thus the utilisation of these facilities particularly during delivery is essential.

1.4 PROBLEM STATEMENT

In the Gambia, health facilities are relatively accessible, costs of health services are generally low, with ANC coverage high but maternal mortality is unacceptably high. Delivery rate in health care facilities is very low. In the Gambia antenatal care coverage is 96%, implying that women are aware of the importance of attending clinic. But only few deliveries take place in the health facilities. After delivery they attend Infant welfare clinic immediately after the naming ceremony. Skilled attendant at deliveries is estimated at 30.4% [7]. This statistic may include the TBAs. Comprehensive EmOC is provided only by the hospitals. The majority of the deliveries take place at home attended by TBAs or a relative. Cost of services for ANC is relatively low and paid once at registration for the entire duration of pregnancy. Furthermore, access to health facility in the country is good with over 85% of the population living within 3 kilometres of a primary health care or outreach health post and over 97% of the population within 5 kilometres [27].

Sadly, very low proportion of the women uses the health facilities for delivery. Thus, institutional delivery is very low, estimated at 30.4% nationally, and lower in rural areas [8].

In addition, maternal mortality is unacceptably high (730 per 100, 000 live births) ranked among the highest in the world. Reasons for women not

uterlising health facilities for delivery in the Gambia is not known as no research on the topic has been conducted. Many factors have been advanced to be contributed to low institutional delivery.

Cultural practices, traditional beliefs and valued customs are often barriers to accessing health services which are extremely adhered to by many ethnic groups particularly delivery practices.

The Health human resource situation especially trained staff is unsatisfactory. The rapid expansion of health care facilities coupled with the high attrition rate complicate matters. The poor staffing affects accessibility and quality of care particularly maternity care at public facilities. Worst is the rural areas where health staff especially nurse and midwives are confronted with serious deficiencies in health service support resulting in negative attitudes of staff towards work and on patients. The general research question is why very low proportion of Gambian women gives birth in health care facilities around the country?

The deficiency in information on the low proportion of institutional deliveries in the Gambia warranted this study.

The findings of this study will help:

1. The health institutions to understand the factors that motivate women to deliver at home and thus devise ways to improve the situation;
2. The findings of the study are important in our drive to reduce maternal mortality and attainment of MDG 5;
3. The findings of the study will add new knowledge in understanding contributing factors to the low delivery in developing countries.

1.5 RATIONALE, PURPOSE AND OBJECTIVES OF THE STUDY

1.5.1 RATIONALE FOR THE STUDY

Improving maternal health and most importantly reducing maternal mortality and morbidity are top agenda for the Government of the Gambia. However, for

these to be attained, maternal health programs should be based on evidence or on the right type and quality of information. Improving delivery care is an essential element of attaining improved maternal health. To that end, this study is conducted to generate information on factors contributing to the low rate of institutional delivery in the Gambia. This information is necessary to form policy, programming and delivery interventions for improvement in maternal health care.

1.5.2 PURPOSE OF THE STUDY

The purpose of this study was to explore and describe factors hindering utilization of health care institutions for delivery in the Gambia.

1.5.3 OBJECTIVES OF THE STUDY

1. To identify and describe the socio- demographic factors associated with not utilising health facility for delivery.
2. To identify and describe the economic factors associated with the low institutional deliveries.
3. To describe health services related factors contributing to the low utilization of health facility for deliveries.
4. To identify and describe cultural factors (if any) that act as a barrier to health facility deliveries.
5. To put forward recommendation for improved care and increased utilization of health institutions for delivery care and improved maternal health outcomes.

CHAPTER TWO: PROFILE OF THE GAMBIA

2.1 GEOGRAPHY

The Gambia is a small Country that shares borders with Senegal on the north, south and east, and on the west with the Atlantic Ocean. It has a land area of about 10,680 square kilometres. There is a river that runs through the country. The Gambia is divided into 6 administrative divisions and Municipalities. They are Western Division, Lower River Division, Upper River Division, Central River Division and North Bank Division, Kanifing municipality and Banjul City Council. (See attached map in figure 1)

The Gambia has two climates: Dry season and the rainy hot season. The dry season last for seven months; (May to December) and the rainy season are between June to September.

2.2 POPULATION AND DEMOGRAPHIC CHARACTERISTICS

The Gambia has a population of 1.3 million, with an annual growth rate of 4.2%. The population density is 97 persons per square kilometre [28]. The projected population for 2015 is estimated at 1.7 million. The population of women aged 15-45 years is 46.7% and probability at birth of surviving to age 65 years for male and female is 48.7 years and 54.3 years respectively [29]. Adult female literacy is only 24% [28].

Fertility rate is high estimated at 5.35(2003) nationally and NBD and WD its 5.83 and 5.01 respectively [30]. Contraceptive prevalence rate is 17%. Age at first birth is estimated at 16.5 years nationally but lowers among rural women those not schooled. Marriage is a social norm and polygamy is widely practiced as 34.3% of males and 50.2 % of females married are in polygamous marriage [27]. The Crude birth and death rates is estimated at 46.2 and 19.2 per 1,000 populations respectively. It has no natural minerals but depends on agricultural farming, fishing and tourism which have a limited base. The Country has experienced increased in refugees from the West African region due to its

relative peace in the sub-region. The population of the Gambia is characterised by its youths and famine nature as 44% are below the age of 15 years and females comprises of 51% of the total population [28].

In the Gambia, 95% of the population are Muslims. There are seven different ethnic groups. The major ones are namely Wolof, Mandingo, Fula, Jola and sarahulay which accounts for 14.6%, 39.5%, 18.8%, 10.6% and 8.9% of the Country's inhabitants.

2.3 SOCIO-ECONOMIC

The Gambia is regarded as one of the least developed Countries in the world with a population growth rate of 4.2% and the GDP per capita US\$ 1,991 one of the least in the sub- region [29]. It has no mineral or natural resources, but depends mainly on agriculture. It has been estimated that about 75% of the population depends on crops and livestock for its livelihood. Agriculture, trade and tourism account for 23%, 16% and 6% of its Gross Domestic Product (GDP) respectively. Despite the annual increases in GDP, per capita GDP has been reducing largely because of its high population growth rate. The Gambia is a heavily indebted Country; debt servicing alone accounts for 31.6% of its recurrent budget for the year 2003.

In the Gambia, 69% of the total population were classified as poor and of these 51% are extremely poor. Only 31% of the population are classified as not poor. This is according to the National Poverty Household Survey (NHPS) report on the poverty situation in the Gambia [28] .

Population living below the national poverty line is 57.6% [29].

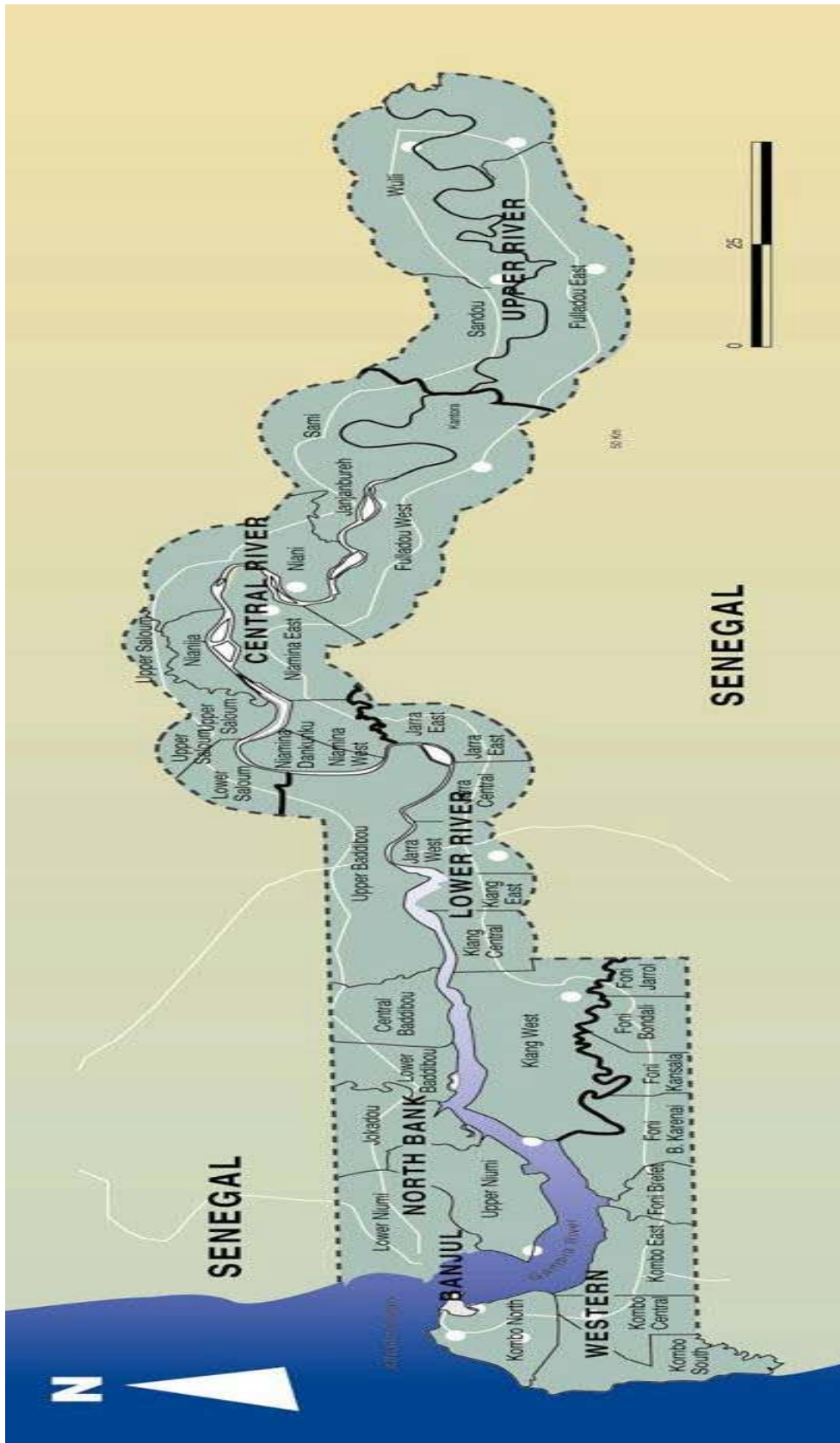
Health is one of the key pillars in the agenda of the Gambia Government. Spending has been increased from 13.6% in 2001 to 4.95 in 2003 [29]. Public health expenditure also increases steadily to 3.2% (2003) [29]. Over the years, a substantial proportion of annual development budget was spent on the health sector. Expenditure on health per capita US\$ 8 is only spend by the Government [31]. However, despite this substantial spending on the health

sector, maternal and child health has never been allocated a budget. The main activities of this unit are mainly funded by donor funds mostly from UNFPA.

Table 1: National Indicators

INDICATOR	FIGURE
Population(2003)	1.3 million [28]
Annual population Growth Rate(2004)	4.2% [29]
Population Density	128 per square km [28]
Adult female Literacy	24% [28]
Population women aged 15-49 years	46.7% [28]
Probability of surviving to 65 yrs Male	48.7 Years
Female	54.3 Years [29]
GDP per capita	US\$1,991 [29]
Contraceptive prevalence	17% [7]
Skill birth attendant	44% [8]
Institutional deliveries	30.4% [8]
Maternal Mortality rate(2001)	730 per 100,000

Figure 1: Map of the Gambia



2.4 HEALTH SERVICES ORGANISATION AND ADMINISTRATION

This was initiated after the Gambia adopted the Primary Health Care (PHC) strategy in the delivery of health services since its inception in 1979. Health services are organized into primary, secondary and tertiary levels. The primary level or village health services (VHS) is the first contact with the health system. The primary level mainly provides continues health education, essential drugs, preventive care and treatment of minor ailments and injuries and act as a link between village level PHC services and referral health services available at dispensaries and health facilities. Community Health Workers (CHW) is trained which includes Traditional Birth Attendants (TBAs) and Village Health (VHW). They are supervised by trained Community Health Nurses (CHN) who are usually mobile and meet them in circuits. Maternal and child health and family planning services with a vaccination programme are accessible to both PHC and none PHC villages.

The secondary level comprises of the basic health facilities, clinics, dispensaries, minor and major health centres. These facilities provides preventive, curative and at times have patient services. They are staffed by trained personnel including Doctors, Nurses, Midwives, laboratory assistance and other health professionals. The Major health centres serves as referral facility to other clinics within. They provide more advance care and services particularly to manage obstetric emergencies or complications.

The tertiary level comprises the Hospitals teaching and district or rural. They provide the specialist care. They are referral for major health centres.

There are total of 11 hospitals (4 public), 7 major health centres (6 public), 22 minor health centres (18 public), 41 dispensaries (13 public) and 18 other special health institutions all of which are privately or Non Governmental(NGO) run in the Gambia. There are four hundred and ninety two (492) village health

posts in the country. With the coming of the Cuban Doctors as technical assistance, 29 village clinics were established in the country to increase access to basic health services. Distribution wise 29.7% of public facilities and 72.9% of private or NGO run facilities are located within the greater Banjul area while 3 of the public hospitals are in the rural Gambia [32]. The up grading of 6 major health centres with equipments and personnel to be able to cater for Emergency Obstetric Care (EmOC) within the division, building of four more hospitals one in North Bank Division and the rest in Western Division to increase accessibility and reduce long distance referral, new ambulances, both river and road, to facilitate evacuation of patients to higher level for care, the training of nurse midwives in advanced midwifery to be able to provide adequate and appropriate care to obstetric emergencies. In addition, Cuban doctors were recruited from Cuba and most of them deployed to the primary health care level where village clinics are established to increase access.

The human resource for health is far from being satisfactory. The ratio of service providers to the population continues to be unacceptably high. The rapid expansion of the health care delivery services coupled with the high attrition rate of trained health staff particularly nurses and midwives contributed to this undesirable scenario [32]. The ratio of Doctors per population was 1:5679; and that of nurses and midwives per population was 1:1964 and 1:5614 respectively [32].

To ensure effective and efficient management and functioning of the health system, The Government through the Department of State for Health (DOSH) established Divisional Health Teams (DHT). These DHTs are responsible for the supervision, management, administration and day to day running of the health facilities and primary health care level in their respective health divisions. All the public hospitals are also provided with management board and are semi-autonomous in managing the affairs of the hospital.

2.5 STUDY AREA

2.5.1 *North Bank Division (NBW)*

This is one of the six health divisions in the Gambia. The division is under Kerewan Administrative Local Government with a total population of 172 806 and a population density of 77 persons per square kilo meter. The number of households is 18 458 [7]. The division is further divided into north and west. This particular study was done in North Bank West (NBW) with a population of 87 281 and 9 040 households [7].

NBW has the lowest institutional deliveries 24.3% and a met need of obstetric emergency care of 3.5% [8]. NBW has a total of 5 health facilities. One is a major health centre, 3 minor health centre and 2 dispensaries. Two of the facilities are run by Non Governmental Organizations (NGO). All 5 facilities provide maternity health services. The division is further divided into 3 districts; Lower Nuimi, Upper Nuimi and Jokadu District. The study was conducted in all districts in the division.

NBW is 14km which is 7 sea miles from capital city Banjul to which you have to cross the river. All referrals from the division are sent to the main hospital in Banjul; Royal Victoria Teaching Hospital (RVTH) through a ferry or sea ambulance.

2.5.2 *Western Division (WD)*

WD is one of the biggest health divisions with a population of 965 491 and a population density of 8 139 persons per square kilo meter. It has 101 704 households [7]. WD is further divided into 3; Banjul with a population of 34 828, Kanifing 322 410 and Brikama 392 987 [7]. This study was concentrated in Kanifing which is an urban setting. The cities within the study were Serekunda, Bakau, Fajikunda, Sukuta, Bundung (Jammeh Foundation for Peace) and Kanifing (Gambia Family Planning Association). It is relatively developed and characterized by urban and semi urban settings. WD has a total of 16 facilities

that provides maternal health services and two referral hospitals. The division receives referrals from all over the country especially to the RVTH which is situated in the capital city.

2.6 MATERNAL HEALTH CARE SERVICES

Promoting health behaviours and increasing knowledge on pregnancy and pregnancy related complications among women, families and communities are essential to the health and well being of women in general.

Reduction of maternal and neonatal morbidity and mortality is a priority for the Government of the Gambia. Since the launch of the global Safe Motherhood Initiative in 1987, the Department of State for Health and its developing partners, have put in place certain interventions implemented. In 1983 a primary health care (PHC) programme, which incorporated a strong mother and child health (MCH) component, was introduced. Because of the adoption of PHC in the Gambia, maternal and health services have introduced a well organised programme. This programme included antenatal care (ANC), screening of high-risk pregnancies, a referral system for high-risk pregnancies and labour complications, family planning services and the identification and training of TBAs in each primary health care village (with at least 400 inhabitants). National coverage of the programme is close to 100%, with over 96% of women having had one or more antenatal care visits, and 87% and 88% respectively of infants having been immunised against the childhood preventable diseases [7]. The goal of the programme is to reduce maternal and prenatal morbidity and mortality.

Maternal and child health programme is provided by both Government and NGO/Private clinics. Antenatal care services are available both through fixed clinics (base) and mobile trekking clinics or outreach services. These clinics provide preventive and minor curative services to both women (ANC) and children under five. Services benefit both primary health care villages and none primary health care villages. Examinations performed includes: taking personal

and obstetric history, health education, weight measurement, height measurement, blood pressure measurement, abdominal palpation, checking for oedema, auscultation of the foetus, tetanus toxoid immunisation haemoglobin testing, urine testing, referral for delivery and now referral for voluntary counselling and testing.

The services are provided by trained midwives, trained state registered nurses, trained enrolled nurses, trained public health officers and trained community health care nurses. In addition, maternity waiting homes were built in all the major health centres for at risk mothers to have easy access of care. Though, they were later used for staff accommodation and admission wards because the mothers were not willing to leave other siblings at home. In addition, horse cart ambulances were introduced in 1992 in the communities for transportation of patients to health facilities. Postpartum care services are meant to be provided by these clinics, but mainly provided by the TBAs.

2.6.1 User-Fees for Maternity Care Services

Pregnant women (Gambians) pay a mandatory registration fee of five Dalasi (equivalent to US \$0.18) for the antenatal care. An antenatal card is issued and obtaining this card will allow the pregnant woman free consultation, examination and medication throughout pregnancy at public health institutions. Delivery fee vary between D12.50 (US\$0.45) in health centres to D25.00 (US\$0.90) in hospitals. Operations (such as caesarean section- CS) cost D50.00 (US\$1.79) with an additional bed fee weekly of D25.00 for those admitted. Non- Gambian women pay higher; normal delivery D600.00 (US\$22) and CS D1600.00(US\$57.1) [33].

2.6.2 Institutional Deliveries

These are deliveries that take place in health facilities; public and private hospitals/clinics with maternal care services, irrespective of who attended the delivery at these facilities [9]. Health institutions should be well equipped with

well trained and motivated staff, with adequate drug supply and equipments and be able to provide effective emergency obstetric care within an enabling environment. While any woman can develop complications at any stage of pregnancy; most if not all such complications can be managed effectively. Interventions that are benefits to mothers help babies too [9]. Thus utilizing health facilities for delivery is critical for the live of the pregnant woman and that of her unborn child.

Sixty-eight percent (68%) of women globally attend antenatal care, but only 46% deliver in health facilities and 57% had skilled attendant at delivery [9]. In Africa 63% of the women attend antenatal care and only 30% of delivery takes place in health facilities. Skilled attendant at delivery is only 42% [9].

Countries with low institutional deliveries have high maternal deaths, compared to those with high institutional deliveries. For example in Botswana, 66% of deliveries take place in health facilities and 77% are delivered by skill attendant [9]. Maternal mortality is registered at 100 per 100, 000 live births [34]. South Africa and Mauritius also registered 79% and 95% health facility delivery and 82% and 97% respectively of deliveries attended by skilled attendant [9]. Ghana also registered 42% health facility delivery and 44% of deliveries are attended by skilled attendant [9]. Whilst in the Gambia, 18% deliver in health facilities and 44% are delivered by skilled attendant. (This figure includes births by TBAs who are not term as skilled attendants) [9]. Maternal mortality is estimated at 730 per 100,000 live births. Skill attendance is now widely advocated as the single most crucial intervention to reduce mortality owing to pregnancy and child birth [3].

2.7 REFERRAL SYSTEM

In the Gambia, patients are referred from lower to upper level; that is from the primary to secondary level or from secondary to tertiary. However most of the patients by pass this arrangement. Each facility is provided with an ambulance for referral, outreach activities and other health related services.

Ambulance services are free. Sadly, there are no referral policy, protocol or guidelines and not even a standard referral register. This makes the referral system some what chaotic and ineffective.

CHAPTER THREE: METHODOLOGY

3.1 DESIGN

The study was a cross-sectional design. Cross sectional studies measure exposure and outcomes at the same time; as such they are relatively easy to carry out. Considering previous studies and current knowledge in this area, it was deemed necessary to combine both qualitative and quantitative methods. Thus, method triangulation was adopted. Using this approach makes for more rigorous and rich data collection which will improve the quality of the data findings. Triangulation of methods also facilitates in depth analysis and validity checks [35].

Grounded theory was used to explore why the women in the Gambia do not use the health facilities for delivery. Since there was no study conducted before in the Gambia, and no data exist about the topic, grounded theory was appropriate for the qualitative part of this study. As it aims at discovery and it's good for investigating topics with relatively little prior research [36].

3.1.1 The Quantitative methods

The quantitative part reviewed the demographic characteristics of the women who had just delivered and had come to attend clinic for registration of their infants. Data was collected using a semi structured questionnaire. The demographic characteristic was collected to determine past pregnancies, use of health services and educational level, marital status, tribe/ ethnicity, age, parity, number of antenatal visits from the ANC card, risk factors, and haemoglobin level. Then their antenatal cards were reviewed to confirm information.

3.1.2 The Qualitative methods

This part of the study was done to explore in depth the contributing factors from the women's experiences and knowledge. The cultural factors that

contributed to choice of place of delivery were also easily identified since the focus group were conducted with people who share the same experiences. The main aim was to engage women themselves in small groups to tell their own stories on why they do not use the health institutions for delivery.

3.2 STUDY POPULATION

The study population were women who have just delivered and reported to the clinic for registration. Participants were women living within the Gambia both in rural and urban setting within the two divisions. They were recruited from the MCH clinic, interviewed and followed back in the community for a focus group discussion. As most women with babies do attend infant welfare clinics, the main group of women that this study did not capture are actually those that have died or are seriously ill. If the baby survived, some of these cases were captured when the relatives cared for the baby.

3.3 SAMPLE SIZE AND SELECTION

For the quantitative part, sample size was determined by the number of home deliveries (70%) and in the institutions (30%) in the two study areas. To assess the background variables (socio demographic) that may be of importance here as explanatory factor, the number (N) was calculated using proportion of institutional deliveries. This study was exploring and assessing the reasons why women do not go to health institutions for delivery with a confidence interval of 25% to 30%. The standard error was therefore 2.5%. The required sample size was:-

$$n = \frac{p(100-p)}{e^2} = \frac{30 \times 70}{2.5^2} = 336 \text{ women}$$

A total of 336 women was planned to be interviewed after calculating the sample size, but more women were recruited due to the number of deliveries at the time and to assure enough power for analysis. Therefore a total of 391 women were interviewed. The sampling technique was random selection of

eligible women who have just delivered a live baby. The study was conducted in a total of twenty five (25) health facilities. Nine (9) of them are in the urban setting and sixteen (16) in the rural.

A convenient sampling method was basically used in selecting study areas and sites, (health division and facilities) as well as study subjects or participants. Study areas were selected to ensure the best possible contrast of society and the level of health care between rural and urban health division. Western Health Division (WD) was the only urban health division so was automatically included. The rural health division selected, North Bank West (NBW), was a factor of its proximity and the available financial resources for the project. Secondly, health centres and dispensaries providing delivery services within the two health divisions were selected. For NBW, all the five centres were included while for WD those within the capital and in Kanifing Municipal Council were included. These included public and private health institutions. In selecting the 336 individual women as the sample size for the quantitative study, the 2005 antenatal care registration statistics was used as weight to determine the proportion of women selected in each individual health facility. After determining the number to be selected by facility, women were then recruited during routine child welfare clinics (base and outreach) using a convenient sampling method.

3.4 Quantitative Data

For the quantitative data, the number of women who registered for ANC attendant for the year 2005 was first checked for each of the selected health facilities. North bank west (NBW) registered 4 297 women whilst Western division (WD) registered 19 796 women. This was used as a weight to determine the proportion of women to be selected in each individual facility. Since WD is bigger and it's in the urban setting with more registered women, the sample size of 400 was rated 3:2. Therefore, in NBW which is a rural setting 160 women were interviewed and in WD 240 women. The health facilities in the

study were conveniently selected and the sample size distributed among the facilities. All women who delivered and reported to the clinic at the time of data collection were successfully and automatically interviewed until the required number is obtained for that particular health facility.

3.5 Qualitative Data

In the qualitative approach, as many different types of clients as possible were recruited to get a variety of good representation (primigravida and multigravida, old and young, polygamous and monogamous, educated and no-schooled). A total of 38 women participated in the focus group discussions.

Women were followed into the communities where the health facilities are located and the focus group discussions were held. In most communities, the women who were interviewed in the quantitative study were not captured in the qualitative part. Another set of women were in this group, which was really good as the two results will compliment each other and helps to generate more information. Permission to participate in the focus group was sought prior to the meeting. Four focus group discussions were held. Two in each study area. The intention was to include women, who have just delivered, but some of the participants who had babies; their babies were a bit older like a month or two old.

3.6 DATA COLLECTION METHODS

Experiences with different methods have shown that to obtain attitudes of people, their experiences towards certain issues especially with health care services, it is easier with triangulation of methods. The two main approaches used for this study were:

- **Individual In-depth Interviews**

This was done to identify the factors that contribute to low utilization of health institutions for delivery. What determines the choice of place of delivery? This was done by asking women past experiences about their

deliveries and their interactions with health institutions. The women were interviewed one by one in a quiet corner within the clinic after the registration of their babies or before depending on the organisation of the clinic. Data was collected using a semi structured interview guide. First the demographic characteristics were noted to determine past pregnancies, use of health services and educational level, marital status, tribe/ ethnicity, age, parity, number of antenatal visits from the ANC card, risk factors, and haemoglobin level. Their antenatal cards were reviewed to confirm information.

- **Focus Group Discussions**

This was conducted to get a broader picture from people's experiences and knowledge. The rationale for using focus groups is that attitudes and perceptions are not developed in isolation but through interaction with other people. The data obtained, although reflecting the views of the individual members, are thus very different from participants own narratives obtained through one-to-one interviews [36]. The focus group produced believable results at a reasonable price and it is possible to include a larger number of informants in the study than when one-to-one interviews are used alone [36]. Focus group discussions allow the moderator to probe. This flexibility to explore unanticipated issues is not possible within the more structured questioning sequences [37]. Another reason for using focus group is that it has high face validity, the technique is easily understood and the results seem believable to those using the information [37]. FGD are relatively low in cost and it can provide results within a short time span. FGD also is an instrument to be used to explore shared values /opinions/experience in a specific cultural context, or controversies that exist between opinions.

A total of four (4) focus Group Discussions (FGDs) were conducted with 38 recently delivered women who have reported for child welfare clinic registration. Two discussions were held in each division; NBW and WD. Each group consisted of between 8-10 women within the ages of 14 - 43 years. The

women were selected in the clinic. Because all the women who were interviewed could not be part of the FGD; the nurses helped in recruiting other women. Each session lasted for 30-45 minutes. The discussions were centred on different themes relating to factors inhibiting utilisation of health facilities for delivery care. These included; a) the women's previous experience with health facilities for labour and delivery care; b) attitude of health workers; c) perceived quality of care; d) negligence by the health care workers; e) preference for alternative services; f) expectations of women; and g) their satisfaction or dissatisfaction to services.

The combination of these two methods was to compliment each other and helps to generate information on the contributing factors to the low institutional deliveries. The assumption with the FGDs was that individual's attitudes, beliefs and actions do not form in a vacuum. People often need to listen to others opinions and understandings in order to form their own. People open up in FGD and share insights that may not be available from individual interviews, questionnaire, or other data source [37]. In addition, the discussions would allow a collective impression of the topic under study which in turn would produce results that have high face validity [37]. Typically, FGD have high face validity, which is due in large part to the believability of comments from participants [37].

Data was collected by the PI and two (2) research assistants that were recruited and trained.

Data collection for both methods of the study proceeded simultaneously and data was analysed separately. The results were both merged to answer the research questions.

3.7 INCLUSION AND EXCLUSION CRITERIA

All women who had delivered a live baby and are reporting at a clinic with the baby; for child welfare, registrations were included. This includes Gambians and non- Gambians. As most women with babies do attend infant welfare

clinics, the main group of women that this study did not capture are babies that have died or are seriously ill, and then the women will not report to the clinic.

3.8 STUDY INSTRUMENTS

3.8.1 Quantitative study

For the quantitative part, a questionnaire which intends to collect the demographic characteristics, past pregnancies and deliveries, index pregnancy and delivery, knowledge on danger signs of pregnancy, labour, delivery and postpartum and health seeking behaviour was developed. The interview was done in Wollof and Mandinka (local languages).

3.8.2 Qualitative study

The qualitative part, a guide with important themes was prepared and used. The themes were:

- The women's awareness on the importance of health facility deliveries.
- What are the women's views on access to the health facilities?
- Are they satisfied with the services offered?
- What are their expectations with the services offered?

Both instruments were pilot tested in clinics that did not take part in the actual study and; clients with similar characteristics as those in the actual study participated.

3.9 DATA COLLECTION, MANAGEMENT AND ANALYSIS

The quantitative part, the raw data from the questionnaire was entered by the researcher into the computer using SPSS software package version 14.0. At the end of each day, (with the help of a statistician) that was helping to ensure

that questions were correctly filled and entered, all data was cross checked before entry.

Two (2) research assistants were initially recruited during the first 2 weeks. Later we added a third one, because one of the first two had to leave the division. All of them were nurse midwives with maternal health experience. Both were trained prior to data collection and each conducted one interview as a pilot testing before the actual process of data collection. They all had experience with data collection as they were involved in series of data collection before. They were sensitised on the purpose and objectives of the study and relevant parts of the protocol were shared. Their roles, duties and expectations were explained.

All interviews were conducted by the researcher (PI) and her assistants at the clinics following the women's consent. Each interview lasted between 30- 45 minutes. All interviews went as scheduled. In some cases, a facility had to be visited twice or even three times when the number of women needed for that particular facility was not available during that clinic day.

Qualitative data analysis was done after the interviews. All data were transcribed verbatim, typed and stored safely. All data was stored in a lockable cupboard and was only accessible to the researcher. The transcripts were categorised into themes and analysed. Instead of using NUDIST 6 computer software package as originally planned; manual data analysis was done. At the end of the study, all tapes used for the focus groups were planned to be destroyed in accordance with the research ethics requirements.

In summary, validity and reliability was increased in the study through the use of triangulation of methods, the training of the research assistants, pilot testing, and review of antenatal cards with continuous checking of collected data at each point.

3.10 ETHICAL ISSUES

Participation was completely voluntary. Consent was sought from each individual participant before the commencement of each interview as well as each focus group session. Since the majority of women in the Gambia are illiterate, verbal consent was used. No names were attached to the questionnaire. The women were only identified by codes during the process. Their antenatal registration numbers was referenced in case of a follow up. The study was cleared by the ethical review committee in Norway and also from the Gambia Government/ Medical Research Council Laboratories Ethical Committee. Permission was sought from the Directorate of Health Services.

3.11 LIMITATIONS, VALIDITY AND RELIABILITY OF THE STUDY

To improve the reliability of the data, two approaches (qualitative and quantitative methods) were utilized. The inclusion of a rural and urban health division (which are socio-economically different) as study areas complimented each other to enriched the findings thus provided a broader understanding of the issues under exploration. Furthermore, the pre-testing of the questionnaire was to purposely done among other things to assess how reliable it was in collecting information on the variables intended to be investigated. It was this process that modifications in the questionnaire were performed to improve its accuracy. The recall period was good as the women were interviewed between 1- 2 weeks after delivery. All these measures combined, increased the accuracy or reliability and validity of the study and the data generated.

The convenience sampling method employed in generating the quantitative data; recruitment of study subjects from health care facilities and the subsequent interviews with those women conducted at health facilities are limitations. Women may have not been comfortable enough within the health facility environment to talk freely and openly. Fear may cause courtesy bias. This study systematically excluded women without a live birth and those with miscarriages. These women may have different perception on the health

system and also on services. Thus the findings cannot be generalized to the entire population.

CHAPTER FOUR: RESULTS

4.1 PART A: QUALITATIVE

PREVIOUS EXPERIENCES

People's past experiences with the health system tend to influence future use of health care services. Women in particular openly talked and gossiped about their past experience with the health care system. These include their interaction with care providers, examinations subjected to, waiting time and other issues. They also get information from relatives and friends about their perceived quality of health services.

Examinations

Vaginal examinations women are subjected to during labour and delivery is often viewed and expressed as painful, frequent and often cited as a factor inhibiting the use of health facility for delivery.

"I do not like health facility delivery..... The vaginal examinations are frequent and painful. In my last pregnancy I delivered in a health facility.....they (nurses) kept on inserting their hands in my private part(vagina).....different persons examined me was very painful and embarrassing. I wonder if they knew what they are looking for" (FGD 3, Para 3 woman)

"In my last delivery I was subjected to series of vaginal examination..... If it was my first delivery with the health facility, then I would never go their again" (FGD 3, Para 2 woman)

Not being physically examined after reporting your ailment to a health care provider may also not go down well with some women. Women in labour generally expects to be examined at least e.g. blood pressure measurement, vaginal examination and etc. Not been examined is viewed as a departure from the norms. A woman who just had her fourth child narrated:

“I reported to the health facility with abdominal pains..... I was asked to go home and wait..... I was never examined. Immediately I arrived I delivered”.

Waiting time

Long waiting time in clinics or health care facilities before being attended to has been consistently mentioned as a disincentive to use such facilities even for delivery. A woman who had just given birth to her sixth child narrated her frustration on long waiting time she was subjected to during her routine antenatal clinic attendance:

“We (pregnant women) go to the clinic as early as 8am..... We spend the whole day waiting to be attended to.....the nurses will not start work early” (focus group 3, para6)

ATTITUDE OF HEALTH WORKERS

Users of health care services often consider attitude of health workers when deciding where to seek care. Women, often mentioned poor attitude of health workers as a major deterrent for the utilisation of health services particularly institutional delivery. The women reported varied testimonies. Poor reception, poor provider attitude, poor interpersonal relationship and not being attended to were highlighted. A Para 3 lady explained:

“My sister in law was in labour. We took her to the clinic where they asked her a few questions and gave prescription to collect medication the following day without examination. The moment we arrived home, she delivered whilst getting out of the vehicle” (focus group 1, para3 narrated)

Women in labour expect support and good care during that painful process. They also expect the care provider be it the nurse, midwife even the doctor to frequently check and monitor their progress.

"This is all because of lack of checking and help. If someone comes to you with pain and you asked her to go back home without checking her, you know that is not good" (FGD 1, Para 2 narrated)

"I have experienced myself in the hospital in Banjul (referring to Royal Victoria Teaching Hospital)... The nurses do not stand by your side till you deliver. You always have to call them when your baby is about to come. Some times they come when the baby have already delivered. So home and hospital delivery is the same.....infact delivering at home may be safer as there you will always have someone by your side." (FGD 4, Para 4 woman)

Not been checked during labour may be viewed as poor provider attitude. A Para 4 woman explained:

"I have seen a woman who was in severe abdominal pain..... reported to the hospital... she was not examined but asked to go home because they (care providers) felt she was not in labour. As soon as she arrived home, she delivered." (Focus group 1, para3)

Poor provider attitude acted as an obstacle to the uptake delivery services in a health care institution. Shouting at patients or patients' escorts and exercise of impatience by the care providers was consistently echoed during the discussions.

"In my last pregnancy.....I delivered at home due to quick labour.....I refused to report to the health centre immediately after to avoid embracing myself. If I go to the health facility the nurses will shout at me for delivering at home.....if you deliver at home and go and report to a health facility they (care providers) are angry.....if you opted to deliver in a health facility they (care providers) don't treat you well" (FGD 1, Para 3 woman)

Women believe that health workers, particularly nurses and midwives should have more patience and understanding because they are trained on the work they do. Lack of patience and understanding among health care workers is an inhibiting factor to utilising health facility for delivery.

“Nurse should have patience and understanding. We (patients) can be very ignorant sometimes. I escorted a woman to the labour ward one night. The nurse on duty asked me to stay out. They (care providers) did not examine her..... and was left to lie down until the baby camethey (care providers) started shouting at her that she should not have pushed. Just imagine that” (FGD1, Para 5 woman)

Poor reception at a health care facility was another issue raised. A Para 3 woman narrated:

“One day I escorted my sister in law. The nurse we found on duty asked my sister in law to choose any bed she could lie in the labour ward. She(nurse) ordered me out in a way as if am not a human being.....she (nurse) shouted at me and pointed at the door for me to follow suit” (FGD 1, Para 3 woman)

NEGLIGENCE OF HEALTH CARE WORKERS

Negligence on the side of the nurses particularly those at the antenatal clinic, labour or delivery wards in performing their duties with diligence was also highlighted. Nurses’ sleeping throughout the night whiles on duty or relying on the patient’s call for help in determining that labour is eminent. Negligence of care providers was in one case blamed for a woman to undergo a caesarean section because to them (women) the nurse they met on duty at the labour ward send her to the theatre even without examining her. A Para 2 woman said:

“I was operated due to the negligence of the nurses. I was not even examined... the moment I entered the labour ward ...she (nurse) said you

(referring to me) move over there you are going to be operated. All they (nurses) kept on saying was that you cannot deliver because your last delivery was CS. They take me to theatre by force. Having a operation (caesarean section) in your previous delivery does not mean you must be operated again"
The woman concluded (FGD 4)

Lateness on the side of the care providers in reporting to work resulting in long waiting hours; engaging in personal duties for survival were issues raised by women.

A woman said:

"The nurses do not have any regard for their patients..... We (patients) come to the health centre very early in the morning but we spent long hours waiting. Nurses spend a lot of time doing other things - eating, chatting and going up and down rather than attending to the patients"(FGD 3, Para 6)

Use of mobile phones while attending patients particularly when conducting a delivery was strongly criticised. A woman asserted that during her last delivery her baby nearly fell off the bed.

"I nearly lost my baby the nurse placed her at the edge of the bed which she (the nurse) was rushing to answer to a call in the mobile cell phone"
(focus group 3, para1)

ALTERNATIVE DELIVERY SERVICES

Women have alternative places to seek health care including delivery for varied reasons. The options mentioned were delivery at home, public health facility (health centre or hospital) or a private health facility (for-profit or otherwise). Home or private maternity clinics are alternative places women resort to. The choice of place of delivery is dictated by many factors ranging from personal, socio-cultural to health service related factors.

Positioning during Labour

Some women prefer to deliver at home mainly because of the unrestricted positioning or the presence of a familiar face.

"I delivered at homemy mother in law is a Traditional Birth Attendant. She gives me all the care I need during labour and delivery.....I am allowed to deliver in the position that favours me" (FGD 4, Para 5)

Services of a Doctor

The availability and accessibility of a doctor in a health facility also influence women's choice of place of delivery. In instances of emergency they (women) believe the doctor can be of help. Though private for profit health institutions charge exorbitant user-fees women still opt for them because of perceived quality.

"The private hospitals are better..... patients receive more attention from the nurses..... You can even get a Doctor to attend to you" (FGD 1, para2)

Male Midwives

The type of care-provider and most particularly the sex matters to some women. Male midwives are regarded as more caring, sympathetic, polite and receptive as oppose to their female counterparts.

"In all my 3 deliveries, I was lucky to be attended to and examined by a male nurse..... he was very sympathetic, polite and helpful.....female nurses should behave in that way since they are women like us". (FGD 1, Para 3)

Cultural and Spiritual Sensitive Care

Cultural and spiritually sensitive care is valued by women in the Gambia. Care such as massaging of the waist and rubbing of the abdomen soothes pain and are believe to quicken labour. Herbs and holy water (preparation from the Holy

Quaran) are concoctions administered during labour to drink. These as well are believed to fasten and make the labour process safe and without event.

A testimony of Para 3 woman was:

"I have never delivered in a hospital..... my mother in law is a TBA..... She gives herbs to help me deliver early..... rub my stomach and in the process praying when my baby is not well positioned.....this is very helpful.....such care you know I will not get it in facilities" (FGD 4, Para 3)

"I have not delivered in the health facilities before, I do not know why but know that I have a woman at home who helps me a lot during labour and delivery" (FGD 4, Para 5)

Traditional and Cultural Practices

Inability to use traditional things (herbs or concoctions) during labour and restrictive policies in health care facilities and not being culturally sensitive or competent were viewed by women as deterrent to using medical facilities for delivery.

A woman with 4 children narrated:

"I always used my traditional things during labour.....these are very helpful to me. Whenever I use them I have an event free labour.....but these are not allowed in the health facility..... because of that reason I prefer to deliver at home" (FGD 4, Para 4)

Support and Care

Support, care and companionship during labour and delivery are highly cherished and valued. Unfortunately these were not always obtained in health facilities. As these were always assured for home deliveries women opt to deliver at home as oppose to a medical facility.

A testimony of a woman:

"In the health facility, the nurses do not stand by your side; they only come when the baby comes if you are lucky." (FGD 4, Para 3)

Transport and Cost

Utilisation of health services has generally been influenced by many factors including distance to a facility, availability of transport and cost of receiving care. Lack of readily availability of a means of transport bars some women from visiting health facilities even during delivery.

“I planned to deliver in the health facility, but when labour started and I look for a taxi, I delivered before it came or you will not get at all” (FGD 3, Para 5)

Some women because of lack of transport facility resort to alternative ways of reaching a medical facility.

“I have to walk for long distance when I was in labour.....there was no transport” (FGD3, Para 2)

In some settlements or rural villages transport is available but only at certain period's example in the mornings or evenings.

“We live in a place where transport is hard to come by. When you are in labour and need it, you find it difficult to get one. The available transport ply the road only twice in a day. So it is not possible to get one after they have left” (FGD 3, Para 3)

User-fees prevent use of health facilities not only for delivery but for other services. In The Gambia though user-fees levied are relatively low, non-Gambians pay higher. For example normal delivery or operative delivery (such as caesarean section) will cost a non-Gambian D600.00 (equivalent to US\$ 21) and D1500.00 (US\$ 54) respectively. Such fees are identified as stumbling blocks even to Gambian women.

A woman who had 6 deliveries explained:

“Most women in Barra town (a growth centre within North Bank West) do not use the health facilities for delivery.....the cost of delivery services is high.....”

we instead deliver at home rather than pay D600.00. Even Gambian women who are not presenting national identification documents are asked to pay the same amount as non-Gambians” (FGD 3, Para 6)

SATISFACTION WITH SERVICES

Women also have positive experiences with the health system and viewed as encouraging factors to use health facilities for delivery. Furthermore, the perceived associated benefits of giving birth in a health facility were also highlighted and were mentioned as motivating factors too. Some of the issues raised included:

“Hospital or health centre (meaning any medical facility) delivery is the best..... You can be helped to deliver quickly” (FGD2, Para 1)

Perceived availability of life-saving interventions or facilities (blood transfusion, caesarean section, infusion) in a medical facility was mentioned as a reason to deliver in a health facility.

“In health facilities, there are people with expertise who can help you to deliver safely even when you have a difficult labour.....at times you are taken to theatre” (FGD 2, Para 2)

“Blood and water (infusion) can be given when you need them. All these can save live..... these cannot be done if you deliver at homeIn my last delivery in the hospital as I was going to the toilet, feeling dizzy, I fell down. They (nurses) immediately saved my life by putting up water (infusion) for me. If that occurred at home, then by now am dead” (FGD 2, Para 2)

“It’s important to deliver in hospital in case there are problems..... Small and short women like me who may need operation should delivery in a hospital” (FGD3, Para 2)

"I met a nurse at the hospital who was very polite, helpful and patient..... She assisted me throughout labour and delivery..... She comes to see me at my bed whenever I need her" (FGD 4, Para 1)

EXPECTATIONS

Expectations were generally governed by experience of the women which influenced their future expectations. All women expressed a desire to have staff with a positive attitude. Some women expressed positive staff attitude they would expect. These included encouragement, politeness, giving reassurance, available by the bedside and exercising patience and tolerance.

A woman with 2 children narrated:

"In all my previous deliveries in the hospital I always met good nurses..... they helped me a lot during my last delivery. One of them was with me until I delivered that's was the time she left for home" (FGD 4, Para 2)

"I do not think that all nurses are bad..... Some will leave you to lie down on the bed unattended when you are in pain or need their help... but some will do all they can to help and make you comfortable before they go home" (FGD 1, Para 3)

Women expected the nurses attending to them to be knowledgeable and competent and apply their skills when providing care, guidance and talk to them during labour and delivery.

"Hospital delivery is very important and the best..... but we have lots of problems..... Sometimes we do not get what we expected..... We are not given chance to ask questions" (FGD 4, Para 4).

Women also expressed that everybody including the nurses has social problems but further asserted that such problems should not be transport to the workplace.

They should leave their problems at home when coming to work. They displace their personal problems on us (patients)” (FGD 4, Para 4)

“The nurses should know that they were employed because of us..... They should have patience and understanding. If it was not us (patients) then they (nurses) will not have jobs to be paid salary” (FGD 4, Para 5)

Availability of drugs and supplies in health facilities is a high expectation among the women. Lack of drugs and being given empty prescriptions only to buy the drugs in a private drug store is an issue that concerns them too.

“We are receiving good care at the health centre..... but drugs should be made available. Not everyone can afford to buy drugs at the pharmacies.....they are expensive.....those who can afford it do not visit the health facility (public health facilities) but rather go to the private health facility” (FGD 2, Para 3)

What women hear about the health system also raised or lowers their expectations. Thus if their expectations are not met future use of health care facilities may be affected.

“We always hear that drugs are available, but when we visit the health facilities we are given prescriptions to buy from the pharmacies” (FGD 2, Para 2)

4.2 PART B: QUANTITATIVE STUDY

A total of 391 women were interviewed: 226(57.8%) women in Western division and 165(42.2%) in North Bank west. In Western Division (WD), data was collected in 7 health facilities and in North Bank West (NBW) in 4 health facilities and 13 outreach or mobile clinics. Tables 2 show the number of participants in the health facilities where the study was conducted and demographic characteristics of participants.

Three hundred and twenty three (323) of the women (83%) were recruited from the public facilities whilst 68(18%) were from NGO/Private clinics.

Table 2: Sociodemographic characteristics

Characteristic	Freq	%
Health Division		
North Bank West	165	42.2
Essau Health Centre	25	6.4
Kuntair Health Centre	19	4.9
Kerr Chernoh Health Centre	6	1.5
Ndugu Kebbeh Health Centre	27	6.9
Western Division	226	57.8
Serekunda Health Centre	39	10
Bakau Health Centre	39	10
Fajikunda Health Centre	31	7.9
Jammeh foundation for peace	30	7.7
Gambia family planning	41	10.5
Poly clinic	29	7.4
Sukuta Health Centre	17	4.3
Marital status		
Married	367	93.9
Not married	24	6.1
Ethnicity		
Wolof	121	30.9
Mandinka	97	24.8
Fula	73	18.7
Jola	40	10.2
Others	60	15.3
Education Attainment		
No Education	245	62.7
Primary	69	17.6
Secondary/High	65	16.6
College	3	0.8
University	2	0.5
Others(Arabic)	7	1.8
Parity		
1 pregnancy	83	21.2
2-5 pregnancy	235	60.1
6-10 pregnancy	73	19
Age (Years)		
14-19	43	11.8
20-24	107	29.4
25-29	118	32.4
30-34	57	15.7
35-39	28	7.7
40-44	11	3

DEMOGRAPHIC CHARACTERISTICS

a) Age distribution of the women

The majority of the women interviewed (60%) were between the ages of 20-29 years. The mean age was 26 and median was 25. 95% Confidence Interval was 25.3- 26.6. Minimum age of the attendees in both divisions was 14 years and maximum was 43 years.

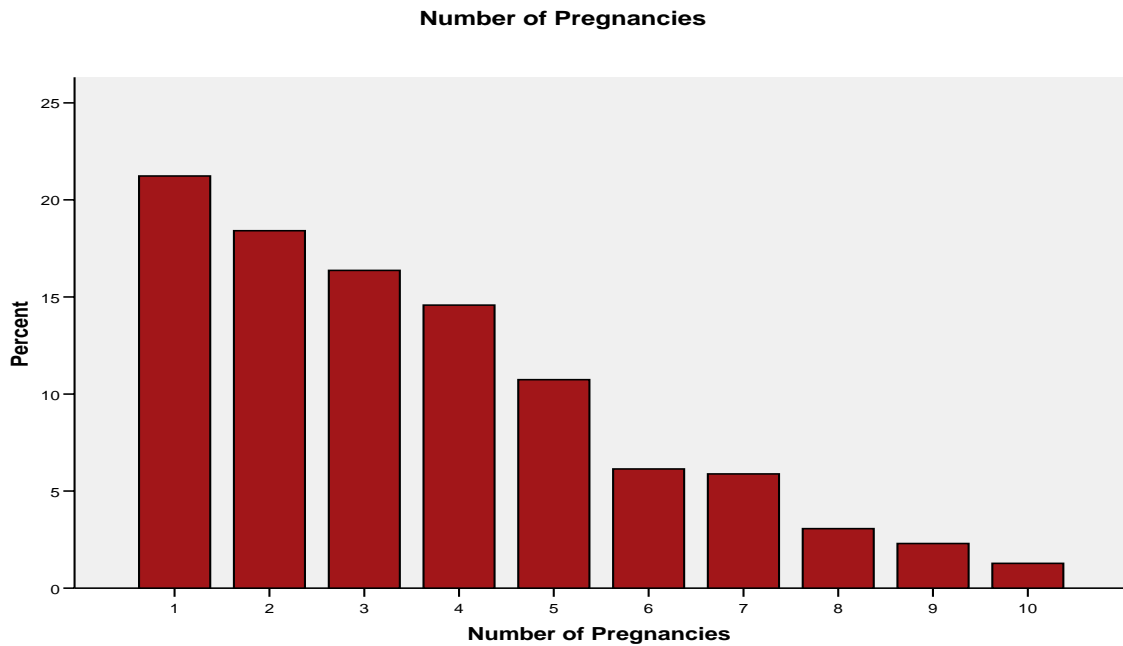
b) Marital Status of the women

The majority of the women living in WD, 209(93%) were married and 17(8%) were single. The same goes to NBW, 158(96%) were married and 7(4.2%) were single. Over all, very few women in the study were single 24(6%) and more were married 367(94%).

c) Highest Education Attainment

The majority of the women 245 (63%) had no formal education. Of those with education, 69 (18%) had at least 6 years of primary education, 65 (17%) secondary/high school, 3(0.8%) college and 2(0.5%) attained university education. The illiteracy level of the women in the two divisions is even higher than the national illiteracy rate which is 24%.

Figure 2 NUMBER OF PREGNANCIES OF THE WOMEN IN BOTH DIVISIONS



The above figure shows that the women in the study for both divisions had a minimum of 5 births and maximum 10 births. Mean is 3.6, median 3.00. The lowest age of given birth for the first time for both divisions was 14 years.

Place of delivery first pregnancy

The Place of delivery for the women in WD was home 28 (12%) and health facility 198 (88%). In NBW, 67 (40.6%) delivered at home and 98(60%) delivered at health facility.

Of the 296 who delivered in health facility during their first pregnancy, (both divisions), 71(24.0%) delivered at home, whilst 225(76%) at health facility in their index pregnancy.

Place of delivery Index pregnancy

The place of delivery during the index pregnancy in WD was home 37(16%) and health facility 189(84%) compared to 97(59%) and 68(41%) for NBW respectively.

Reasons for delivering at home

Reasons for delivering at home were explored and NBW, 47(50%) said labour advanced progressed quickly and they could not reach a health facility and never had any problems during labour. Six (6.3%) said that the health facility was closed and there was no transport to reach the other facility. In WD, 9(26%) said labour progressed very quickly at night and there was no transport, 9(26%) says that labour progressed quickly and could not reach the hospital and 3 (9%) says that whenever they are in labour and report to health facility they are told to go home and when they go home they deliver.

Place of delivery first pregnancy compare to place of delivery Index pregnancy

The study reveals that 95(N391) women deliver at home during their first pregnancy. Out of this number, during their index pregnancy, only 32(34%) deliver at health facility, whilst the rest 63(66.0%) delivered at home.

Reasons for delivering at home in first pregnancy

For those who deliver at home, 30 (50.0%) stated that they do not have problems during labour and labour being quick without events, were the main reasons.

Benefits of hospital delivery for those who delivered at home

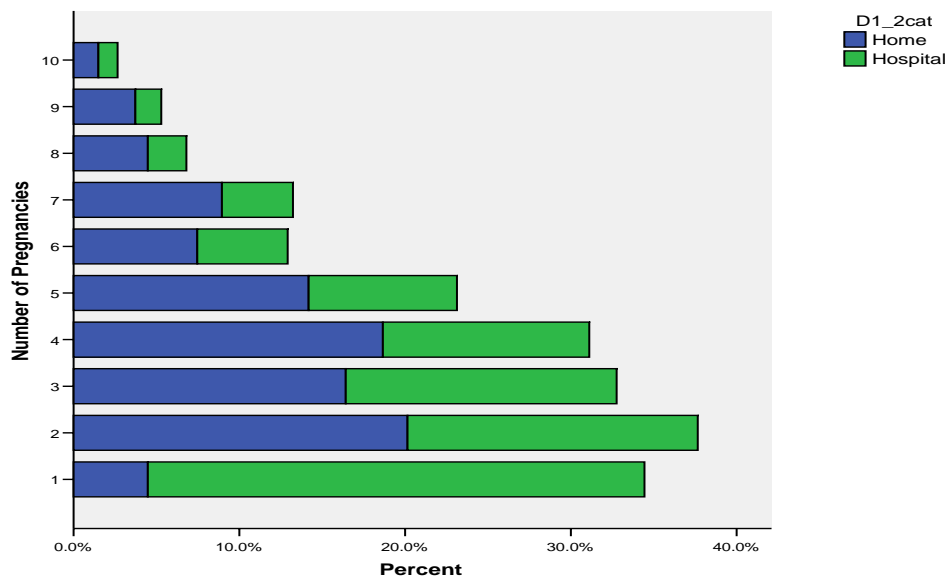
When asked about benefits of hospital delivery, 92(97%) thinks that hospital deliveries had some benefits whilst 3(3%) thinks there are no benefits. Regarding the benefits of hospital delivery for those who delivered at home during their index pregnancy, in both divisions, 294(99.3%) thinks that there are benefits in hospital delivery whilst 2(0.7%) thinks there are no benefits.

Highest educational attainment with place of delivery index pregnancy

With regard to highest educational attainment and place of delivery in NBW, the results shows that 77 of those who had no formal education deliver at home and 50 deliver at health facility. Nine (9) of those with only 6 years of primary education deliver at home and 11 delivered at health facility. For the one with secondary/high school education, she delivered at home and women who only studied the Koran, 5 delivered at home and 2 in health facility. When Mann Whitney Test was used, it shows P Value 0.51 which is not significant. The number of cases is less than 5.

Whilst in WD, those with no formal education, 20 delivered at home and 99 in health facility. Those with 6 years of primary education 11 delivered at home and 38 delivered at health facility. It further shows that those with secondary/high school 6 delivered at home and 48 delivered in health facility. While those who attained college and University, no deliveries takes place at home but 4 delivered in health facility. Statistical analysis also shows P value 0.46 which is also not significant.

Figure 3: Number of Pregnancy with Place of Delivery Index pregnancy



The above figure shows the results of women in both divisions on number of pregnancy and place of delivery of their index pregnancy.

Receive any information on place of delivery during ANC visit: Index pregnancy

In NBW, 31(20%) said they received information on place of delivery during ANC whilst a significant number 128(80%) received no information. Among those who did not receive information 79(62%) delivered at home and 49(39%) delivered in Hospital. Whilst those who received information on place of delivery, 14(45%) delivered at home and 17(55%) delivered in hospital. In WD, 95(40%) received information and 130(60%) did not receive information on place of delivery. Seventeen (17.9%) of those who received information on place of delivery, delivered at home and 78(82%) delivered in hospital. While those who did not receive any information 20(16%) delivered at home and 110(85%) delivered in hospital. Statistical analysis shows P values that are not significant.

Table 3 shows danger signs during pregnancy, labour and the postpartum as dictated by the women without being prompted in the two divisions. It is

showing that the most dangerous signs are not known by the women in the study. The sign that was highly mentioned by the women in both divisions was dizziness. The signs were listed and the women were mentioning the signs that they know.

Table 3: Checklist for Danger Signs among the 391 women

Danger signs	Frequency	Percentage
Swollen/puffy face	61	19.4
Swollen legs	18	6.0
Raised BP	20	6.3
Dizziness	113	35.9
Seeing water before delivery	25	8.0
Bleeding before delivery	14	5.0
Bleeding after delivery	3	1.0
Labour more than 12hrs	1	0.3
Paleness	7	2.2
Severe headache	10	3.2
Severe vomiting	7	2.2
Severe abdominal pain	24	8.0
Foul smelling discharge	1	0.3
High fever	11	4.0

Table 4: Number of pregnancies with age group of women in NBW

Age	14-19	20-24	25-29years	30-34	35-39	40-44
Category	years	years		years	years	years
Pregnancy <=6	18	37	45	18	6	0
Pregnancy >6	0	0	1	11	9	4
Total	18	37	46	29	15	4

Table 5: Number of Pregnancy and age group of women in WD

		Age group						Total
		14-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	
No. pregn ancy	1 - 6 deliveries	25	70	68	22	6	6	197
	6 and > deliveries	0	0	4	6	7	1	18
Total		25	70	72	28	13	7	215

The above tables show the number of pregnancies in both divisions. Women between the ages of 20-29 years had more deliveries in all the divisions. It is self evident that as age increases, number of pregnancies do.

DEILIVERY IN HEALTH CARE FACILITY

Decision maker on place of delivery index pregnancy

In NBW, 96(58%) of the women themselves decides on were to deliver; husbands 26(16%) and Doctors/nurses 13(8%). TBAs and mother in- law accounted for 10(6%) respectively. In WD 122(54%) of the women decided where to deliver; followed by husband 63(28%) and mother 11(5%) of the cases.

Family factors that encourage women to deliver in a health facility

Recommendation from family members accounted for 62(49%), previous experience 36(29%) and availability of a family member near facility were cited by 27(22%) of the cases in NBW. In WD, recommendation by family members was mentioned by 85(76%) women, previous experience 19(17%) and availability of family members near facility for assistance 7(7%).

Environmental factors that encourage women to deliver in a health facility

In NBW, distance to a health facility was mentioned by 36(68%), readily availability of transport 11(21%) and cost of transportation 5(10%). In WD the reasons that would make the women deliver in health facilities include if the distance to health facility was not far 32(70%) and availability of transportation was 12(26%).

Health service factors that encourage women to deliver in a health facility

Perceived quality of care was mentioned by 90(65%), attitude of staff 41(30%) and availability of equipment/drugs/supplies in a health facility by only 5(4%) in NBW. In WD, perceived quality of care was more prominent and up to 43(73%), attitude of staff 38(20%) and availability of equipment/drugs/supplies in a health facility by only 11(6%).

Women's opinion on men attending them during labour and delivery

The study revealed that in NBW, 28(17.0%) had no problem with that, 25(15.2%) have no idea, 14(9%) said the men are more sympathetic and 24(14.5%) said that men have more sympathy, more willing and quicker. In WD too, the results shows that 68(30.1%) says that men are more sympathetic, 48(21.2%) says they are good, 43(19.0%) thinks that they are doing their job and 15(7%) says they have no idea.

Who would you prefer to take care of you during labour and delivery?

Despite the fact that the women have positive opinion on men attending them during labour and delivery, when asked who they will prefer to deliver them during labour, the results shows that in NBW 78(47.3%) would prefer female nurses, 45(27.3%) said anyone who can safe their lives followed by male nurses 36(21.2%).

Whilst in WD 93(41.2%) would prefer female nurses, anyone who can safe their lives 68(30.1%) followed by male nurses 62(27.4%).

CHAPTER FIVE: DISCUSSION

The combination of both quantitative and qualitative methods complemented each other, and this enhanced validity and reliability of the findings. The low proportion of institutional deliveries that obtains in the Gambia can be associated with poor attitude of health care providers and strong cultural adherence. Women in the Gambia perceived pregnancy, labour and delivery as a secret and prefer to deliver quietly without the knowledge of many for fear of being bewitched. Witch craft is associated with pregnancy, labour and delivery.

Health workers attitude, which was consistently mentioned, is associated to low health institutional delivery. The acute shortage of trained health personnel may be a factor contributing to poor staff attitude; the available ones are over worked and demotivated.

Previous Experience

Interplaying health systems, social and economic factors are thus responsible for the low utilisation of health facilities for delivery despite the high awareness of its importance. Past experiences of the women with health facilities (interaction with care providers, examinations subjected to, long waiting hours and other issues) were health services factors raised.

These factors have considerable influence on acceptability and utilization of services.

Similar studies done in Malawi to look into factors influencing choice of place of delivery, also expressed similar issues. The women reported varied experiences at different health facilities when they reported for delivery ranging from not been examined during labour and after delivery, poor reception at the labour ward, left alone not assisted and sometimes no midwife to deliver [19].

Expectations

The expectation of the women on the health systems was not to their satisfaction. They expected a great deal of interpersonal relationship; on the contrary they viewed health care providers as rude, unsympathetic and uncaring, and thus prefer to use the services of traditional birth attendants and healers. Women who are in labour needs constant support and motivation until the delivery of the baby which they think they cannot get from the health facilities. It is well to mention that in the health facilities; more than one woman in most cases is in labour, so it will be difficult to concentrate on all at the same time especially with the shortage of staff. Unlike in the community where only one person will be in labour and all the attention is given to her. In the study, negative attitude of the health care providers was explicitly mentioned, a situation which health workers can and should try to change. Attitudes towards patients are a critical element of care offered to the patients. The clients should be governed by policy to help them in this regard. This was also found in studies conducted in Ghana and in Bangladesh [25, 38].

Alternative Delivery Services

Preference for alternative services was influenced by quality of care from the perspective of the service provider's behaviour. Women prefer to seek services from the private clinics (despite the high cost). TBAs (in the community) and male midwives (in public health facilities) were preferred as they are considered to be more empathetic and caring. TBAs allowing women more liberty on birthing positions was also cited as a preference for home deliveries. Longer waiting time reported from public facilities discourage women from delivering in health facilities. Confined to bed the whole labour and delivery period were issues that send women away from delivering in health facilities. Health facilities in the Gambia, the women are only delivered in the lithotomy position. Therefore if other alternative is been offered, then those who do not prefer the lithotomy position will not visit the health facilities. More birthing positions should be employed, but through the midwifery training schools so

that midwives are used to it before graduation. Facilities to cater for other positions also should be provided.

A similar study conducted in a rural Nigeria to assess maternal health seeking behaviour indicated that pregnant women prefer TBAs and the private clinics were considered to be more affectionate and caring compared to public facilities. Waiting time was also considered to be longer in the government facility compared to other alternative source of care [16].

Another study done in Zambia to describe the routine care of women during normal labour and delivery, and the immediate care of newborn babies also shows that women were confined to bed during the whole labour and delivery period. All women were delivered in lithotomy positions and primiparae were fixed in stirrups during the second and third stages of labour [23]. A study done in Bangladesh also shows how women's active participation in their own birthing experience can be taken away from them. Most women greatly preferred the squatting or kneeling position when giving birth, which has been used for generations and which was more comfortable [16, 38].

Cultural and Spiritual Sensitive Care

The values of cultural and traditional preference were important to Gambian women. The present study reveals how women resort to delivering at home just to be able to practice and use their cultural believes (herbs or concoctions). The health facilities are only resort to when complications arises which in most cases is late because it's always the last option. Gambians are known to their cultural believes and stick to it at all times. There are so many cultural believes that are done for women who are in labour and most women adhered to it. Even when women are facing difficulties, these believes are practiced first, and if failed they resort to the health facilities which in most cases is late. The culture of preference for women attending to women in labour as reflected in the quantitative study, also affects the utilisation of health facility especially if the only midwife is a male. Formal health services can conflict

with ideas about what is normal and acceptable including preferences for privacy, modesty and female attendants.

A study that was conducted in Uganda to look into why women when faced with complications of pregnancy or delivery, still continue to choose high risk options leading to severe morbidity and even their own death. The finding demonstrates that adherence to traditional birthing practices and believes that pregnancy is a test of endurance and maternal death sad but normal event are important factors [20].

Skilled attendant can only be available in the health institutions. To reduce maternal mortality and morbidity, and to attain the millennium development goal that Improving Maternal Health is outlined as one of them which set a target of maternal mortality ratio reduction by three-quarters of the 1990 levels by the year 2015 [6].

Critical in the attainment of the above goal is availability, utilization and quality of maternity care services - antenatal, delivery and postpartum care. Of the global maternal deaths over 70% occur during delivery or shortly after thus making skilled attendance during pregnancy but most importantly during delivery and the postpartum period key intervention in reducing maternal mortality and morbidity [1].

Home births remain a strong preference, and often the only option, for many women in the developing world. A large proportion of these home deliveries take place without skilled attendants.

The women should therefore be encouraged to use the health institutions and delivered by a skilled attendant.

Why focus on skilled attendant now?

Well intended efforts to reduce maternal and new born mortality and morbidity have been underway for more than a decade. These efforts have resulted in success in a few Countries, but regrettably, progress in most countries has been unacceptably slow. Experience from past projects and ongoing research, point to the importance of access to a functioning health care system as a key factor in reducing maternal mortality. Currently, as part of economic development

support linked to MDG targets, health systems are being reformed and strengthened in many developing countries. WHO, ICM and FIGO believes that this is an opportunity moment to push the case for skilled attendant with view to ensuring that this vital function is institutionalized in the newly reformed/developing health systems [3].

Over the last decade many traditional birth attendants have been given midwifery training as part of the Safe motherhood strategy. Their training appears, however, to have had little impact on maternal mortality.

Provision of a health worker with midwifery skills at every birth place, plus access to emergency hospital obstetric care, is considered the most crucial intervention for safe motherhood.

The required skills and ability of a midwife includes being able to communicate effectively. Will need to cultivate effective interpersonal communication skills and an attitude of respect for the women's right to be a full partner in the management of their pregnancy, child birth and the post natal period [3]. The midwife should be able to perform vaginal examination; ensuring the woman's and her/his own safety. Identify the onset of labour and monitor maternal and fetal well-being during labour and provide supportive care [3].

The majority of maternal and perinatal deaths could be avoided by access to basic maternity care; which is supported by adequate medical and surgical care. The medical staff should realised and recognised that their health services are in competition with alternative health systems which are wildly used and often perceived to be better. The people we serve do not think in terms of what is medically sound, but what is culturally appropriate. Their medical decisions are often based on non-medical rationales.

Maternity care can be disrespectful and inhuman or even exploitative [39]. Offensive and demeaning language by health personnel, and ridiculing of women's poverty, clothing, parity, smell, hygiene, cries of pain, or desire to remain clothed is not only disrespectful, but abusive [40].

The maternity services need to be made more culturally and socially relevant to be able to save lives. Procedures during labour can be undertaken with little

discussion, but might be considered shameful or disgusting to women, and unnecessary by international standards, including episiotomies, perineal shaving, and enemas [41].

A poor reputation of staff attitude means that the women will less likely use health services for delivery. They will only come when it is too late. Providers need to improve the acceptability of care provided, and communities should be encouraged to help with transportation for their women to go to a health facility when they are in labour. Referral is another important aspect of quality maternal care as it improves the efficiency of services facing resource constraints.

In summary, the qualitative data has described and give an insight of the contributing factors that influence the women not using the health institutions for delivery. There was a high preference for delivering by TBAs who lack skills to respond to emergency obstetrical conditions.

Sociodemographic Characteristics

The studies has shown that age of the women do not influence their choice of place of delivery.

Number of pregnancy with place of delivery Index Pregnancy

The study reveals that in NBW women with 1-6 pregnancy deliver more often at home than those with high parity 6 or more pregnancies. In WD, the scenario is different; women with 1-6 pregnancies deliver in health facility and those with 6 or more pregnancies deliver at home. The findings are showing that in the rural area, the use of health facility for deliveries is very low. This may be due to the fact that the educational level of these women is very low. The study shows us that the literacy rate among women in the Gambia is very low. Sixty three percent (63%) of the women had no formal education and also the maternal education for the women is very low especially in the rural area. It is well recognised that mother's education has a positive impact on health care utilisation. Having more children may cause resource constraints, which may

have a negative effect on health care utilisation. Women with more children will prefer to deliver nearby so that they can still care for the other children. Because of this fact, the maternity homes that were built in major health facilities around the country was not effective as women were not willing to leave other siblings at home. Women in the urban area, because of their socio-economic status and their influence of the western style, thus might be the factors that enable them to seek proper medical care. Women with a large number of children underutilize available health services because of too many demands on their time force them to forgo health care [42].

Marital Status

This does not actually influence the place of delivery. Although in the Gambia, single women who got pregnant before married hide their pregnancy and visit the clinics mostly at the 3rd trimester. Thirteen percent (13%) of the women in the study were single in both divisions.

Highest Educational Attainment

The study has shown that the educational level of the women determined their place of choice of delivery. Women who are educated tend more often to deliver in health institutions than those who had non formal education. Comparing the two divisions where the study was held, NBW which is rural, 77 of those who had no formal education deliver at home. In WD (urban) 20 delivered at home. Home deliveries were more in the rural than in the urban. In the urban setting with more health facilities with the influence of the western world, one should not expect home deliveries. Although the number is not significant. Efforts at reducing maternal mortality and increase deliveries in health institutions in the Gambia must increase the literacy rate among women. Now with the strategy in place which is free education for girls should increase the level of women who are educated in the Gambia. It is well recognised that mother's education has a positive impact on health care utilization. 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. It has reflected in WD where more women are educated, the use of health facilities is higher. Several other studies also found a strong positive impact of mother's education on the utilization of health care services.

A study that was conducted in Nigeria to determine the current influence of formal maternal education and other factors on the choice of place of delivery, shows that formal education is still a significant predictor of whether women deliver within or outside health institutions [15, 23]. In Bangladesh, the utilization of a hospital or clinic for delivery instead of birth at home is higher among women with secondary or higher education, who desired the pregnancy, and who made regular visits for antenatal care [43].

Reasons for delivering at home

Reasons for delivering at home as said by the women includes labour that progressed very quickly and could not reach health facility and labour progressed smoothly with no problems encountered. So the need for reporting to the health facility was not necessary. One of the health facilities in the rural area was closed, so the women reported that it was far to reach other health facilities and there was no transport available, so they decided to deliver at home. NGO facilities that close occasionally for staff vacations should liaise with DHTs for the continuous availability of the services for the women in the area, since the distance to other health facilities is far and it's hard to get a transport.

In the urban area, reason for delivering at home as stated by the women includes quick labour which was at night; lack of transport and the staffs always sends them away when they report with labour and when they go home they deliver. The culture of staying at home and hiding the onset of labour is natural among the Gambian women. Women do not discuss the onset of labour or reveal it to even immediate family members until the contractions are

stronger; which in most cases it's late especially when they have to look for transport.

The attitude of the health care providers also contributed as the women were sent home when they report in labour. This is done mostly when there is lack of space to accommodate everyone who report with labour and the cervix is not yet dilated. Some maternity rooms are very small to include everyone. It is also done when health workers are about to close and do not want to attend to new clients. It is bad though as it contributes to the usage of health facilities for delivery.

A study that was done in Nigeria to study the pattern of utilization of antenatal, delivery and postnatal care services in the community shows that utilization of ANC to be relatively high but most of the respondent delivered at home without the supervision of trained personnel. This was attributed to advanced labour and perceived poor quality of care of the health facilities and the believe that the women can deliver safely at home [17].

Place of delivery first pregnancy

The study shows that place of delivery for women in their first pregnancy was health facility for both divisions. This shows that the message that first pregnancy should be delivered in a health facility is understood. They may also be scared of the dangers and the risk involved. It may also due to the fact that they have no experience as yet on labour and delivery, so they do not hesitate to result to the hospitals.

The study further shows us that, among those who deliver their first pregnancy in hospital in their index pregnancy, only 24% delivered at home and 40% delivered at health facility. Because of perceived risk associated with first pregnancy, the women in most cases seek maternal health care services than in subsequent pregnancies.

Information on place of delivery

Information on place of delivery during ANC is very important and helps the women in deciding where to deliver. The ANC is the first contact between the women and the health care providers. Since 95% of the women attend ANC, it is a good place to capitalize on giving them meaningful information that will help them in their care. The study shows us that information on place of delivery is not adequately given to women or not given at all. In the focus group discussion, the women told us how the nurses do not communicate with them at all. This habit starts from the ANC clinic. The study shows us that in the urban area, the scenario is different; those who receive information 18% delivered at home and 82% delivered in hospital. Whilst those who did not receive information 16% delivered at home and 85% delivered in hospital. This shows that more effort should be made to increase information given to women during ANC clinics. In the urban area more women are educated and influenced by the western world, used the health facilities for delivery more than the rural areas. This could be also that TBAs are not available in the urban area, so they have no other alternative than the health facilities. Through my experience with women, information that is given to them on their health and that of their children are always valued. Studies have shown us how information given to women and their immediate families helps them in utilizing the health institutions for delivery. The benefits of delivering in a hospital were mentioned by all most all the women in this present study (99.3%), yet still the utilization was low. Since the awareness on benefits of hospital delivery is high, more knowledge should also be given on place of delivery and the importance of delivering in health facilities.

In Zambia to determine the level of use of maternal health services and to assess factors that influence women's choices of where to deliver, shows that 96% wanted to deliver in hospital, but only 54% did so because of lack adequate health education given during ANC clinic [23].

Family factors that will encourage them to deliver in a health facility

The study reveals that the women will use the health facilities more when it is recommended by other members of their families who have perceived the facilities as good. Their previous experiences also play an important part in the utilization of health facilities for deliveries. The experience of their families and friends also encourages them to use the health facilities. The extended family system in the Gambia is very strong and they listen to each other often. Therefore, if a family member views the services better and recommends it, it will be honored. Places that are viewed as good, even if it means paying more and get better service are visited. In Ghana to investigate women's account of interactions with health care providers during Labour and delivery; and to access the acceptability and utilization of services shows that factors that influence choice of services were cost of services, access and recommendation by family and friends. The availability of family members near facility or known person, who could assist in caring for mother and child also influence choice of place of delivery. Previous experience with staffs either positive or negative also influence their choice [25].

Health services factors that will encourage them to use health facilities

Perceived quality of care was mentioned in both divisions as the most prominent issues. It is important to encourage them to use the health facilities for delivery where they perceived quality of care, followed by the attitude of staff towards them and the availability of equipment, drugs and supplies in the facilities. The perceived quality of care is very important in making sure that women utilize the health institutions for delivery. Therefore, the services should be made friendly for users and optimum care given at all times. In the qualitative study, the women talked of how their expectations with the health care providers generally influence their utilization of the health facilities. The attitude of staff towards the women comes out throughout the studies. It is true that the nurses are over worked coupled with poor working conditions, but

that should not reflect on their relationship of care seekers. The services offered should be accessible in terms of quality offered and time required to receive the services. The women should be treated with respect. They should be treated as women that leave with us. Bolivian women who selected home birth spoke about being on display at hospital: "One doctor comes along, then another and another. Its like we are a video for them to watch"[44]. Maternity care can be disrespectful and inhuman. In Uganda, a study shows that most women go to the health facility as a last resort that is in case of emergency. They were aware of the shortcomings of unskilled and TBA assisted births, but they preferred them. They are known and seen as fellow community members; their services are familiar and acceptable in the community [20].

Environmental Factors that will encourage them to use health facilities for delivery

The unprompted answers of the women includes that they will use health facilities for delivery if the facility is near to where they live, easily availability of transportation and the cost of transport affordable. We have heard of women who wanted to use a health facility, but because it was close and other facilities are not within reach, resorted to delivering at home. The focus group revealed how the women resorted to delivering at home because of lack of transport. In the Gambia, transport is basically a problem especially in the rural area. Most places are hard to reach because of bad roads. The situation is worst during the rainy season. Therefore, vehicles ply the roads twice a day; in the morning and in the evening. If they are needed after that, you can't get one or you are charge a high amount that one cannot afford. The qualitative studies revealed how women had to walk whilst in labour due to lack of transport. Because of this, it affects the usage of the facilities for delivery. Women may plan to use health facilities for delivery, but because of transport difficulties, end up delivering at home or even on the way.

Similar studies mentioned how women will not use health facilities due to lack of transport and long distance to health facilities [22, 23, 38]. Vehicle shortages and poor road conditions mean that walking is often the main mode of transportation, even for women in labour. In Rural Tanzania, 84% of women who gave birth at home intended to deliver at a health facility, but could not because of distance and the lack of transport [45].

Opinion on men attending women during Labour and delivery

The women's opinion on men attending them was very positive. They have no problem with men attending them during Labour and delivery since they see them as sympathetic, more caring and that they are doing their work. Since the introduction of male midwives in the Gambia, there were so many controversies towards them delivering women because of the Muslim religion that preaches that a woman's private part should only be seen by her husband. It was later not adhered to and accepted because of the fact that Doctors were male and they examine women when they are sick. The male nurses come out to be more sympathetic and caring.

In contrast, the study reveals that the women would prefer women to take care of them whilst in labour and delivery. They are still shy to be cared for during labour and delivery by the male midwives. Most of the facilities in the Gambia are headed by male midwives especially in the rural areas, because most of the female nurses prefer to work in the urban area. This shows that the women have no choice when they meet up with male midwives, but to accept them to take care of them. This may not be accepted in all places in the country, thus women may not visit health facilities where more male nurses are seen. It also contributes to the usage of the health facilities. Twenty seven and three percent (27.3%) and 21.2% of women in NBW and WD respectively says that they do not mind who deliver them, but the person should be able to save their lives and that of their babies. Women who want to have babies want to do so safely, with assurance and care throughout their pregnancies, during birth and beyond, for themselves and their babies. If professional care is provided

(midwifery care and the support that can be provided by a comprehensive essential obstetric hospital) then chances of survival for mothers and infants improve [46].

Checklist for Danger signs

The study reveals that maternal education is very poor in the Gambia. In both divisions, the prominent danger signs that are the major causes of maternal death are not known. Bleeding before and after delivery which are very severe and are major causes of maternal death is only known by 14(4.4%) and 3(1.0%) respectively. Only 1(0.3%) knows foul smelling discharge and labour more than 12 hours 1(0.3%). Dizziness 113(36%) was the highest sign that was mentioned by the women. This is because in the Gambia, dizziness is a sign that is scary and it is therefore well known.

Maternal education is poor in both divisions. Labour more than 12 hours was only mentioned by 1 person whilst in NBW it was not mentioned by any of the women. Women in the Gambia stay in labour for longer hours and still yet consider it normal. They resort to the health facilities when it is too late. Therefore, they should be educated well on the danger signs and the importance of reporting early to the clinic.

If danger signs are not known, especially haemorrhages which are the leading cause of maternal death, then it will be difficult for women to recognise them as signs that need urgent attention to seek medical attention. Most women believe that bleeding during pregnancy is normal and always refer to it as menstruating whilst pregnant. Therefore, more time should be taken during ANC and in community activities to educate women on danger signs especially the haemorrhages. The contributing factors to lack of health education during clinics are the fact that our clinics are over crowded with only few nurses on the ground. A study that was conducted in the Gambia on women's experiences with antenatal, Delivery and post partum care shows that women received almost no health education at ANC clinics especially with regard to pregnancy

and delivery danger signs, where to seek help for problems, or postpartum care [47]. This shows why maternal mortality is high in the Gambia.

CHAPTER SIX: CONCLUSION AND RECOMMENDATION

6.1 CONCLUSION

This study has revealed that the low rate of deliveries taking place in health care facilities in The Gambia is as a result of interplay of both health service and socio-cultural factors. The prominent health services identified are: attitude of health staff, previous experience of the women, lack of information given on place of delivery during ANC, the leading causes of maternal mortality (haemorrhages) not known by the women, negligence of the health care workers, lack of care and support during labour, alternative delivery services, low expectations of the women when they visit the health facilities and cost of receiving services especially for non Gambians. And the socio-cultural factors are adherent to cultural and spiritual care which will not be allowed in the health facilities, distance to the health facilities, and lack of transport especially during labour and low educational level of the women. These are generally the factors identified in the study that deterred women from using health facilities for delivery. The popularity, which is also reflecting in the study, shows that women believe that health facility delivery is beneficial.

However, the study has shown that ANC attendants influence the decision on where to deliver and most women did not receive health education during their ANC clinics on place of delivery. Education of the women and their households, improving the quality of services, improving the human resources situation for health service delivery, as well as ensuring that the policies of healthcare institutions and practices within them are sufficiently friendly to the women.

The recommendations emerging from the study reinforce the importance of provider awareness regarding attitude, and the need for development of interpersonal communication skills into education and training.

The means to address the factors relating to good delivery care practices are therefore to ensure a high level of awareness amongst practitioners. Sitzia and Woods describe several mechanisms by which patient views might be communicated to the health system from patient- provider discussions, patient advocates, patient comment boxes in hospitals, patient committees, focus groups, public meetings and surveys [48].

6.2 RECOMMENDATIONS

Policy

There should be a system in place for rewarding service providers with good incentives, better working conditions and satisfactory accommodation facilities especially for those working in the rural areas to motivate them to stay and work. Staff should be increased to meet the staff patient ratio and strategies put in place for retention. Quality assurance system should be introduced within the health system to protect the rights of the women. There should be a clear cut advise on what documents the women should produce when they are registering (passport, birth certificate, voter's card or identification card) because most of the time it is inconsistent, and this is confusing to clients.

Management

The managers of health facilities should make sure that services are friendly for the users. Adequate staff should be available in health facilities to meet the demand of patients especially in the rural area. NGO facilities that operate within divisions who occasionally close, DHTs should make sure that alternative arrangements are put in place for maternity services to continue for the needy. Divisional health teams should continue to support health care providers through continuous supervision, monitoring and evaluation. If they know that they are continuously monitored, then it will influence their attitude towards work. Thus, the services will be improved and user friendly.

Health education in Antenatal Care Clinics (ANC) and in the communities

Since the ANC clinic is the first contact with the women, it is necessary for the midwives to seize the opportunity and spend more time than is currently done on each patient to give appropriate counseling, health education and discussion of plans for delivery. This will not only provide knowledge, but also trust. Community mobilization and sensitization targeting women and men who provide finance for seeking care and are involved in decision making in the community.

Raised awareness on danger signs of pregnancy, labour and delivery

Both the community and ANC clinics should be targeted for health education on dangers signs of pregnancy, labour and after delivery to reach as many people as possible. If the women know the danger signs that are leading causes of maternal mortality and morbidity, then they will report early to health facilities. It should target both men and women especially those who are involve in making decision. The information should provide where care is available. Community needs to understand that women can survive pregnancy and that the thorns and other hazards on their paths can and should be removed as a community obligation. Active community participation in such education, including that of men as leaders and as partners, is required.

Relationship of health care providers and the women

To assure the continuation of the health facilities for delivery by the women, action is needed to improve providers' attitudes towards the women and their relatives. The women should be treated with respect, understanding and dignity. Midwives should reorient their caring practices to more culturally, appropriate and evidenced- based maternity care. Traditional views on pregnancy and motherhood are important cultural factors influencing health care- seeking behaviour that must be kept in mind and made a subject for further research. Allowing a family member or husband to accompany a woman during labour might be a possible intervention, to overcome the cultural need

of family to be around and witness the delivery. It may also reduce the barrier of unfamiliar environment.

Others

The Department of State for Health (DOSH) should post midwives in every health facility and strategies to maintain midwives in the field especially in rural areas should be improved.

Improving the road conditions and putting in place a sustainable public transport system in particular in the rural areas. Communities with transport should help in the evacuation of their women to the nearest health facility.

Reference:

1. Health, W.H.O.M.a.N., *Coverage of Maternity Care. 4th edition:* p. 11.
2. Organisation, W.H., *Revised 1990 Estimates of Maternal Mortality.* WHO: Geneva, 1996.
3. Organisation, W.H., *Making Pregnancy Safer: the critical role of the skilled attendant.* A joint statement by WHO, ICM and FIGO, Geneva, 2004.
4. Group., S.M.I.-A., *Skilled Attendant at delivery: A review of the evidence.* New York: Family Care International, 2000.
5. Mortality, W.H.O.M., *Estimates developed by World Health Organisation, UNICEF and UNFPA.* 2001(Geneva).
6. Nations, U., *The millennium Declaration, Resolutions.* United Nations: New York, 2000.
7. Health, D.o.S.f., *Evaluation of the Maternal, Child Health and Family Planning Services.* 1990-2000, Department of State for Health: Banjul the Gambia.
8. Njai Ismaila, K.M., *Availability, Uterlisation and Quality of Emergency obstetric care services in the Gambia* 2004, Department of State for Health: Banjul.
9. Organisation, W.H., *Coverage of Maternity Care.* Maternal and newborn care, ed. f. Edition. Vol. 96.28. 1997, Geneva, Switzerland: WHO. 71.
10. Organisation, W.H., *Skilled Attendant vital to saving lives of mothers and newborn.* 2004.
11. H.R. Senviratne, L.C.R., *Safe Motherhood in Sri Lanka: 100- year march.* International Journal of Gynaecology and Obstetrics 70(2000)113-124, 2000: p. 113-124.
12. Ulf Hogberg, M., PhD, *the Decline of Maternal Mortality in Sweden: The Role of Community Midwifery.* American Journal of Public Health, 2004. **94**(8): p. 1312-1320.
13. I, L., *Maternal and Infant Mortality; Society for the social history of medicine.* American Journal of Public Health, 1991. **72:** p. 2415-2465.
14. AFRO, D.o.F.H.W.H.O.-. *Road Map: African Union resolves to tackle Maternal Mortality.* 2004. **No 2:** p. 2.
15. Ikeako L.C, O.H., Iloabachie GC, *Influence of formal maternal education on the use of maternity services in Enugu, Nigeria.* Obstet Gynaecology, 2006: p. 1.
16. Osuber KM, F.A., Chiwuzie JC. *Maternal Health- Seeking Behaviour and Associated Factors in a Rural Nigerian Community.* Maternal and child health, 2005: p. 1-11.
17. Bawa SB, U.U., Onadeko M, *Uterlisation of Obstetric care services in a rural community in south-western Nigeria.* Africa Journal Med. Medical Sciences, 2004. **3:** p. 239-44.
18. walraven G. M. Telfer, J.R.a.C.R., *Maternal mortality in rural Gambia: levels, causes and contributing factors.* Bulletine of World Health Organisation, 2000: p. 603-613.
19. L, S., S. J, and C. J, *Factors influencing women's choice of place of delivery in rural Malawi - An explorative study.* 2005.

20. Kyomuhendo, G.B., *Low use of Rural Maternity Services in Uganda: Impact of Women's status, Traditional Beliefs and Limited Resources*. Reproductive Health Matters, 2003. **11(21):16-26**.
21. C. McCord, R.P., S. Arole, R. Arole, *Efficient and effective emergency obstetric care in a rural Indian community where most deliveries are at home*. International Journal of Gynaecology and Obstetrics 75(2001)297-307, 2001: p. 298-307.
22. P.K.Mwaniki, E.W.K.a.G.G.M., *Uterlisation of Antenatal and Maternity Services by mothers seeking child welfare services in Mbeere District, Eastern Province, Kenya*. East African Medical Journal, 2002. **79(4 April 2004):** p. 184-187.
23. Stekelenburg J, K.S., Mukelabai M, Wolffers I, van Roosmalen J, *Waiting too long: low use of maternal health services in Kalabo, Zambia* Tropical Medicine and International Health, 2004. **3(9 march 2004):** p. 390-398.
24. Garner Paul, L.D.a.B.M., *Child Birth in Rural areas: maternal deaths, village deliveries and obstetric service use*. Papua New Guinea Medical Journal, 1994. **37(09 1994):** p. 166-172.
25. Lucia D'Ambruso, M.A.a.j.H., *Please understand when I cry out in pain: Women's accounts of maternity services during labour and delivery in Ghana*. BMC Public Health, 2005. **5(140):** p. 1-23.
26. Organisation, W.H., *Reduction of maternal mortality UNFPA, UNICEF, WORLD BANK STATEMENT*. WHO: Geneva, 1999.
27. Cham, M., *Maternal Mortality in the Gambia: Contributing factors and what can be done to reduce them*, in *Department of General Practice and Community Medicine*. 2003, University of Oslo Norway: Oslo. p. 141.
28. M.S., J., *Banjul, the Gambia: National Population Commission Secretariat; in Population Data Bank 1995*. April 1996: Banjul.
29. UNDP, *Human Development Report, Statistics*. UNDP, 2006.
30. Department, C.S., *Preliminary 2003 Census Data*. Government of the Gambia, 2005.
31. Region, W.A., *the African Regional Health Report*. WHO, 2003.
32. Health, D.o.S.f., *Public Expenditure Review 2001*. 2001, Department of State for Health: Banjul.
33. AM., N., *Changes in the Schedule of fees charged by Health Facilities*. Department of State for Health, 2002. **Ref: NH/C/5:** p. 39.
34. WHO, U., UNFPA, *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, UNFPA*. WHO: Geneva, 2000(2000): p. 1-29.
35. Catherine Marshall, G.B.R., *Designing Qualitative Research*. Fourth Edition Ed, ed. I. Sage Publications. 2006: SAGE Publications. 1-261.
36. Field, J.M.M.a.P.A., ed. *Qualitative Health Research Methods for Health Professionals*. Nursing Research, ed. n. Edition. 1995, SAGE Publications, Inc: London, UK. 253.
37. Sage Publications, I., ed. *Focus Groups. A Practical Guide for Applied Research*. 1988, Sage publications: London, New Delhi. 197.
38. Kaosar Afsana, S.F.R., *the Challenges of meeting Rural Bangaldeshi Women's Needs in Delivery Care*. Reproductive Health Matters, 2001. **9(No 18)**.
39. D' Oliveira A, D.S., Schraiber LB., *and Violence against women in health- care institutions: an emerging problem*. Lancet, 2002. **359:** p. 1681-85.

40. Harvey S, A.G., Bermeo PH., *Reframing authoritative knowledge about childbirth in Ecuador*. 104 annual meeting of the American Anthropological Association. 2005.
41. Kabakian-Khasholian T, C.O., Shediak-Rizkallah M., *Women's experience of maternity care: satisfaction or passivity?* Social Sciences Medical, 2000. **51**: p. 103-13.
42. Mckinlay, J.B., *Some approaches and problems in the study and use of services: an overview*. Journal of Health and social Behaviour, 1972. **13**: p. 115-152.
43. M Ataharul Islam, R.I.C., Halida.Akhter, *Complications during Pregnancy, Delivery, and Postnatal Stages and Place of delivery*. Health Care Women International, 2006. **27**(9): p. 807-821.
44. B., B., *like a video: the sexualization of childbirth in Bolivia*. Reproductive Health Matters, 1998. **6**: p. 50-56.
45. Al, G.B.e., *Survey on Adult and Childhood Mortality, Tanzania*. Macro International, Calverton, MD, 1995.
46. etal, M.K., *Maternal survival 3 Going to scale with professional skilled care*. The Lancet, 2006. **368**.
47. Michelle L Telfer, J.T.R.a.G.E.W., *Experiences of Mothers with Antenatal, Delivery and Postpartum Care in Rural Gambia*. African Journal of Reproductive Health, 2002. **6**(1): p. 74-83.
48. N., S.J.W., *Patient Satisfaction: A review of issues and concepts*. Social Science and Medicine, 1997. **45**: p. 1829-43.

APPENDICES: 1

**INSTITUTIONAL DELIVERY IN THE GAMBIA:
WOMEN'S OPINION**

QUESTIONS NUMBER	QUESTIONS & FILTERS	RESPONSE CATEGORIES	SKIP TO
SECTION A CASE IDENTIFICATION			
A1	Health Division	NBW(1) WD(2)	
A2	Health Facility (Name):		
A3	Type of facility	Private(1) NGO(2) Government(3)	
A4	ANC Clinic (Name):		
A5	ANC Registration Number:		
SECTION B: DEMOGRAPHIC DATA			
B1	Age (yrs.): Dont Know	
B2	Ethnic Group:	Wollof (1) Mandinka (2) Fula (3) Jola (4) -----Others (state) (5)	
B3	Marital Status:	Single (1) Married (2) Divorced (3) Widowed (4) Cohabiting (5) -----Others (6)	
B4	Highest Educational Attainment:	None (1) Primary (2) Secondary/high (3) College (4) University (5) -----Other (6)	
B5	Occupation:	Housewife only (1) Petty Trader/business (2) Farming (3) Civil Servant (4) -----Other (5)	
B6	Number of pregnancies:		
B7	Number of deliveries:		
SECTION C: PAST PREGNANCY INFORMATION			

QUESTIONS NUMBER	QUESTIONS & FILTERS	RESPONSE CATEGORIES	SKIP TO
PREGNANCY RANK	ANC Attendant Yes(1) No(2)	Place of Delivery (Home(1), H/F(2), Others(3)Not Applicable (4)	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

SECTION D: INDEX (LAST) PREGNANCY INFORMATION

D1	Place of Delivery:	Home (1) Hospital (2) H/C, Clinic, Dispensary (3) -----Other (4)	
D2	ANC Attendance:	Yes (1) No (2)	→ D8
D3	Fundal Height on 1 st ANC Attendance		
D4	Number of Routine ANC Visits None (2)	
D5	Can you please state what motivated you to attend antenatal care		
D6	During your routine ANC, did you receive any information on place of delivery?	Yes (1) No (2)	→ D8
D7	If yes, what information was given?		
D8	What factors determine your preferred place of delivery?		
D9	Can you please tell me the benefits (if any) to deliver in a health facility (Health centre/Clinic/Hospital)		

QUESTIONS NUMBER	QUESTIONS & FILTERS	RESPONSE CATEGORIES	SKIP TO
D10	Can you please tell me the barriers (if any)to deliver in a health facility (Health centre/Clinic/Hospital)		
SECTION E: KNOWLEDGE ON DANGER SIGNS OF PREGNANCY, LABOUR AND POST PARTUM			
E1	What signs/symptoms do you perceive as dangerous during pregnancy?		
E2	What signs/symptoms do you perceive as dangerous during Labour/delivery?		
E3	What signs/symptoms do you perceive as dangerous after delivery?		
E4	Checklist for danger signs during pregnancy, delivery and the postpartum period	Swollen/puffy face (1) Swollen legs (2) Raised B/P (3) Dizziness(4) Seeing water before delivery (5) Bleeding before delivery (6) Bleeding after delivery (7) Fitting (8) Labour > 12 hours(9) Anaemia (10) Dizziness(11)	
SECTION F: HEALTH SEEKING BEHAVIOUR			
F1	Who makes decision on your place of delivery? (relationship)		

QUESTIONS NUMBER	QUESTIONS & FILTERS	RESPONSE CATEGORIES	SKIP TO	
F2	Who provides the fund to seek delivery care? (relationship)			
F3	What factors do you consider important in deciding which place to deliver?		Unprompted	
		FAMILY		
		Recommendation by family members and friends		
		Availability of family members near facility for assistance		
		Previous experiences		
		Others		
		ENVIRONMENT		
		Distance to health facility		
		Availability of transportation		
		Cost of transportation		
		Others		
		HEALTH SERVICES		
		Cost of health services		
		Type of facility		
		Attitude of staff		
		Perceived Quality of care		
		Availability of equipment/drugs/supplies		
		Type of staff		
Availability of ambulance etc.				
Time spent in health facility				
		Others		
SECTION G: G1	INDEPT/QUALITATIVE DATA Can you please tell me your opinion on men attending women during delivery?			

QUESTIONS NUMBER	QUESTIONS & FILTERS	RESPONSE CATEGORIES	SKIP TO
G2	Who would you prefer to care for you during Labour/delivery?		

Appendix 2

Why low institutional delivery rates in The Gambia: Women's opinion SCC/EC 1052/2006

Information Sheet

23rd August 2006

We invite you to take part in a study to assess the factors associated with women's choice of place of delivery. Should you agree to participate in this study you will be asked questions concerning your last pregnancy - antenatal and delivery care.

The information you provide during the interview will be kept confidential and only me [interviewer] and the researchers involved in this study will have access to the questionnaires. Your names will also not appear in any of our records.

By participating in this study and answering the questions asked, you will help us broaden our understanding on factors responsible for women's choice of place of delivery. Such understanding is vital for planning and provision of maternity care services in The Gambia.

Your participation is voluntary and you have the right to withdraw at any stage should you wish. The decision to withdraw will not in anyway affect the medical care you should require.

If there is anything that is not clear we should be delighted to clarify it.

Appendix 3

Why low rate of institutional delivery rates in The Gambia: Women's opinion SCC/EC 1052/2006

Consent Form

23rd August 2006

The information sheet has been read to me and I understand it / I have read and understood the information sheet.

I understand what participation in the study means for me.

I understand that the information regarding me that is collected in the course of this study will remain confidential.

I understand that laboratory tests will be done on the blood sample(s) that I provide, and that part of the blood will be stored for possible future tests.

I understand that if I get sick during the study period, I can go to the clinic where study staffs are providing care, and be examined and treated for free.

I understand that I am free to take part in the study or refuse, and that I can withdraw from the study at any time, and without giving any reason. Deciding not to take part or to withdraw from the study will not affect the care that I am normally entitled to.

I have had a chance to ask questions and have them answered.

Signature or thumb-print of volunteer:

#####

This form has been read by / I have read the above to _____
(Write name of volunteer)

In a language that he/she understands. I believe that he/she has understood what I explained and that he/she has freely agreed to take part in the study.

Signature of field worker:

Name of field worker:

Date: / /