WOMEN’S PERCEPTION ON THE UNDER UTILIZATION OF INTRAPARTUM CARE SERVICES IN OKAKARARA DISTRICT, NAMIBIA

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A Mini-Thesis Submitted In Partial Fulfillment of the Requirements for the Degree of Masters of Public Health in the Department Of Community and Health Science

University of the Western Cape

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April 2005
Women’s perception on the under utilization of Intrapartum Care Services in Okakarara district, Namibia.

KEY WORDS

Namibia
Maternal mortality
Perinatal mortality rate
Qualitative research
Thematic analysis
Socio - economic/cultural and service related factors
Quality of care
Maternity ward
Traditional Birth Attendants
Further research
ABSTRACT

Women’s perception on the under utilization of Intrapartum Care Services in Okakarara district, Namibia.

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Background

Maternal health care services (MHCS) are one of the health interventions to reduce maternal and infant morbidity and mortality. The health of mothers of childbearing age and of the unborn babies is influenced by many factors some of which include the availability and accessibility of health services for pregnant women. Low quality of the health services being provided, and limited access to health facilities is correlated with increased maternal morbidity and mortality. This situation is caused by long distances between facilities as well as the people’s own beliefs in traditional practices (MOHSS, 1991).

This study was about the assessment of the women’s knowledge on benefits of delivery in a hospital, the barriers to delivery services, and the perception of the delivery services rendered in the maternity ward of Okakarara hospital. The study was qualitative in nature and the study design was a descriptive and comparative study that focuses on describing and comparing women who did and did not deliver in Okakarara hospital. Data were analyzed by thematic content analysis.
Methods

The study was conducted in Okakarara district at 2 rural clinics; Goblenze and Okondjatu during the last 3 weeks of November 2004. The participants consisted of 40 women who were identified and purposively sampled when they brought their babies for immunization. The inclusion criteria were women who delivered during August 2003 – July 2004, irrespective of place of delivery, aged 15 – 49 years, speak Otjiherero language, multiparity and at least one child was delivered in Okakarara hospital. They were divided in two groups; Group one - Women with all children delivered at Okakarara hospital and Group two - Women with a last child not delivered in Okakarara hospital.

Results

It is evident from the findings that the pregnant women know and appreciate the benefits of delivering in a health facility though sometimes they find it difficult to access delivery services due to the socio economic, cultural and service related factors. The socio economic and cultural factors include long distances, lack of transport and availability of traditional birth attendants (TBAs). The service related factors included negative attitude of nurses, lack of communication, inadequate health education and shortage of medicine. However, there was recognition that poor behavior of the nurses was an individual not a systemic issue, and the women agreed that the majority of nurses have an acceptable and positive attitude.

Participants appreciated some aspect of delivery care rendered but suggested improvements in those areas they felt lacking in quality. Areas of concern included lack
of routine delivery care at clinics, lack of maternity waiting home at the hospital and inadequate supplies in the maternity ward.

**Recommendations**

Due to various issues that arose from this study and in light of the results; recommendations are proposed, including: community education should be strengthened and health workers should provide comprehensive, respectful and non-judgmental care that is responsive to women’s needs. In order to verify and contextualize the study results, additional research on a wider scale is recommended.

**April 2005.**
DECLARATION

I declare that under utilization of delivery health care services in Okakarara hospital: women's perspective in Okakarara district, Otjozondjupa Region, Namibia, is my own work, that it has been not submitted before for any degree or examination in any other university, and that all the sources I have used or quote have been indicated and acknowledge as complete references.

Asser Kondjashili Ngula

April 2005

Signed …………………….
DEDICATION

This mini thesis is dedicated to my wife, Elizabeth Nyanyukweni Aluhe, for her love, continuous support and encouragement.

It is also dedicated to my father, Titus Kasindani and my mother, Maria for their love, emotional support and encouragement.
ACKNOWLEDGEMENT

Firstly I wish to thank my Father in Heaven and the Lord Jesus Christ for being with me and granting me grace, guidance and strength throughout my studies.

I am greatly indebted to Dr. Debra Jackson, my supervisor for her open and intelligent guidance at all stages of this study. I salute her.

I wish to thank the Ministry of Health and Social Services and Gesellschaft fur Technische Zusammenarbeit (GTZ) for financial support.

Last but not least, my colleague, Aini-Karin Toivo. I wish to appreciate and acknowledge her assistance throughout this study.
<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence Interval</td>
</tr>
<tr>
<td>DCC</td>
<td>District Coordinating Committee</td>
</tr>
<tr>
<td>EDD</td>
<td>Estimated Date of Delivery</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussions</td>
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<td>HRD</td>
<td>Human Resource Development</td>
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<td>MHCS</td>
<td>Maternal Health Care Services</td>
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<td>MCHC</td>
<td>Maternal and Child Health Care</td>
</tr>
<tr>
<td>MOHSS</td>
<td>Ministry of Health and Social Services</td>
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<tr>
<td>MOU</td>
<td>Midwifery Obstetric Unit</td>
</tr>
<tr>
<td>NDHS</td>
<td>Namibia Demographic and Health Survey</td>
</tr>
<tr>
<td>PI</td>
<td>Principal Investigator</td>
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<tr>
<td>PNC</td>
<td>Postnatal care</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER 1. INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This chapter is concerned with an orientation to the study in which formulation of research problem, the purpose and significance of the study, definitions of terms and an outline of the study is given.

1.2 FORMULATION OF THE PROBLEM

1.2.1 Background to the problem

The health of mothers of childbearing age and of the unborn babies is influenced by many factors some of which include the availability and accessibility of health services for pregnant women. Low quality of the health services being provided, and limited access to health facilities are related to increases in maternal morbidity and mortality. This situation can be caused by long distances between facilities as well as the people’s own beliefs in traditional practices (National Motherhood Conference 1991).

In developing countries, 65% of women make at least one antenatal visit and 53% give birth with a skilled attendant. At the end, only 30% make at least one post partum care visit with rates as low as 5% is some regions. In developed countries, 97% of women make least one antenatal care visit; 99% deliver with a skilled attendant and 90% make at least one postpartum care visit (Safe Motherhood 1998).

In surveyed countries of Eastern Europe and Central Asia, nearly all women deliver with the assistance from skilled attendants. In developing countries surveyed, however, skilled
attendants are present at an average of only about half of births. Women are most likely to have skilled delivery assistance in Latin America and the Caribbean, at an average of 69% of births. In Costa Rica, the Dominican Republic, and Jamaica, skilled assistance at delivery is nearly universal. The only countries in the region where fewer than half of women deliver with the help of skilled attendants are Guatemala (41%) and Haiti (24%). Among the 30 countries surveyed in sub-Saharan Africa, about half of women deliver with skilled assistance. This average conceals wide variation, however. Sub-Saharan countries report some of the highest and lowest levels of skilled delivery assistance, from more than 9 women in every 10 in Cape Verde and Mauritius to less than 1 in every 10 in Ethiopia. In most rural areas, one in three women live more than five kilometers from the nearest health facility and 80% of the rural women live more than 5 kilometers from the nearest hospital. The scarcity of vehicles, especially in remote areas and poor road conditions can make it extremely difficult for women to reach even relatively nearby facilities. Walking is the primary mode of transportation even for women in labour (Safe Motherhood 1998).

In rural Tanzania, 84% of women who gave birth at home intended to deliver at a health facility, but did not due to distance and the lack of transportation. In Malawi, a study found that 90% of women wanted to deliver in a health care facility, but only 25% of them did. The most important reason given by 53% of the women was that by the time they realized they were in labour, they did not have enough time to get to a health facility (Safe Motherhood 1998).
Around 515,000 women worldwide die each year from maternal causes. Out of these deaths, 273,000 occurred in Africa (Safe Motherhood 1996). At least 40% of women in developing countries receive antenatal care (ANC) during pregnancy and only about 31% deliver with the assistance of a skilled attendant (Safe Motherhood 1996). The complications of pregnancy and childbirth are the leading causes of death and disability among women of reproductive health in developing countries. A number of socio-economic, cultural and service-related factors act as barriers to the utilization of maternal health services. Ideally, all stages of maternal assessment should be completed for all pregnant women (National Motherhood Conference 1991). National data hide gross inequities, with maternal ill health and deaths disproportionately clustered in the poorest population. Poor women face financial and other barriers that prevent women from using health services where they are available. The cost of hospital care, particularly for severe obstetric complications, can have a catastrophic impact on household resources. In many communities, the health system is unable to ensure access to effective care even for those women willing to incur debt to obtain life-saving treatment (Koblinski 2003).

When women develop obstetric emergencies or medical complications during or immediately after delivery, skilled attendants are crucial to managing the problem quickly and effectively. Surveys measure skilled delivery care in two ways: by the percentage of women giving birth in a health facility rather than at home and by the proportion of all births that are attended by skilled personnel, whether at home or in a health facility. Usually, the higher the level of home deliveries, the lower the level of the skilled assistance. In countries where many women deliver in health facilities, skilled assistance at delivery is also high (De-Brouwere 1998). Skilled attendants are trained to
manage uncomplicated deliveries safely, recognize complications, treat those they can and refer women to health centers or hospitals if more advanced care is needed. In 1996, only 53% of deliveries in developing countries took place with skilled attendants present. Many countries and most rural areas have a serious shortage of skilled birth attendants, particularly midwives. Studies suggest that having skilled attendants present at delivery is one of the key interventions for the reducing maternal and perinatal mortality (Coverage of Maternity Care 1997). In order to provide skilled attendants at all births, targeted programmes of training, supervision and deployment are needed.

Three countries have successfully reduced the maternal mortality ratio to about 100 in less than a decade from initial levels of 174 (Egypt), 182 (Honduras) and 149 (Yunnan, China). Honduras reduced their maternal mortality ratio by 47% over seven years. A 1990 mortality study gave the Honduran Ministry of Health a ‘rude awakening’ and a programme was initiated to increase access to skilled attendants, comprehensive referral facilities and community birthing centers. Efforts were initially targeted at regions with the highest mortality rates. In Yunnan China mortality was reduced through reliance on skilled attendants but with rapid and free access to emergency care (Koblinski 2003).

Maternal health services are potentially one of the most effective health interventions for the prevention of maternal mortality and morbidity. A woman is expected to maintain good health throughout the pregnancy, delivery and postnatal period. A woman can have her condition checked and monitored during pregnancy by ANC clinic, deliver her baby with the assistance of a trained health worker and attend the PNC clinic for the treatment of any complications that arise from pregnancies or deliveries.
1.2.2 Study setting

Namibia is located in the south western part of Africa and ranks as Africa’s fifteenth largest country. It became independent in 1990. The Republic of Namibia covers a total area of 824,295 square kilometers. It forms boundaries with Angola and Botswana to the East, South Africa to the South and the Atlantic Ocean to the West. Namibia is a culturally diverse and multi-ethnic society. Namibia is divided into 13 regions. Otjozondjupa is the largest region covering an area of 154,555 square kilometers but is sparsely populated. It is consisting of 4 districts Otjiwarongo, Okahandja, Okakarara and Grootfontein (MOHSS, 2003). The study was conducted in Okakarara district. In addition to the main town of Okakarara, there are 3 other sub districts with a clinic each; Okamatapati, Okondjatu and Goblenze and are at a distance of 100km from each other and roughly 120km from Okakarara hospital. Okakarara is the most affected district in the region with the lowest maternal health care services coverage. Okakarara is the third largest and least populated district in the region with a population of 23,249 and a growth rate of 2.6%. It covers the total area of 14,604 sq. km. It is mainly a communal area. 90% of the inhabitants are mainly Otjiherero speaking whose traditional system of leadership of headmen is very much in existence and women have limited say in running family and community health. There are 30 untrained traditional birth attendants in the area. There are 3 clinics. Each clinic has a registered nurse and an enrolled nurse. (Okakarara Annual Report 2003) Goblenze clinic and Okondjatu clinic were selected as study areas, using a random sampling selection method. Both clinics are conducting ANC, but due to the lack of an ambulance, pregnant mothers are advised to ‘hike’ (take a taxi or other public transport) to Okakarara hospital for routine blood investigations. The
clinics are conducting emergency deliveries only because all deliveries should be conducted at Okakarara hospital. All pregnant mothers with at least 38 weeks gestation are advised to go to Okakarara to stay with their relatives or friends, due the absence of ‘maternity waiting homes’ at the hospital and to deliver at the hospital when the contractions start.

The Namibian Ministry of Health and Social Services (MOHSS) has adopted a Primary Health Care (PHC) strategy in the delivery of health services to the Namibian population. Hence, maternal and child care has been elaborated as one of the PHC programmes. A variety of measures are available to prevent and reduce the risk that expectant mothers and their children face. The measures are collectively known as Maternal and Child Health Care (MCHC). The MCHC Programme was launched in 1991. The Programme was initiated to support the main health policy objective i.e. the reduction of infant and maternal morbidity and mortality. The programme tries to promote, protect and improve the survival and development of women and children of Namibia, who constitute 60% of the population. These services have been decentralized to the district hospitals, health centers, clinics and outreach services to make them accessible to the communities. Ideally, all stages of maternal assessment should be completed for all pregnant women with exemption of no one. To encourage this, ANC and Postnatal care (PNC) are some of the services provided by the Ministry of Health and Social Services free of charge (National Motherhood Conference 1991).
1.2.3 Statement of the problem

In 1992, the Namibia National Demographic and Health Survey (NDHS) revealed that 32% of women nation wide do not deliver in a health facility. Also, 87% and 19% received ANC and PNC respectively, from a doctor or trained midwife. It is clear that there is a disproportionate higher number of women receiving ANC than women delivering in a health facility. In 2000, the NDHS result shows that the proportion of births in health facilities has increased from 68% (1992) to 75%, ANC coverage increased from 87% (1992) to 93% and the PNC coverage has increased from 19% (1992) to 50%. The increase was a result of intensive training of midwifes country wide and the provision of transport to most of the rural health facilities (Namibia Demographic and Health Survey 2001).

As from 1993 - 1999, the coverage of ANC and delivery care services countrywide was above the national target of 80% while PNC was below the national target. However, during 2000 there was a sudden decline in utilization of all maternal health services in the region in general and Okakarara district in particular. It is the purpose of this study to identify, describe and analyze the contributory factors to low utilization of delivery services in Okakarara district.

The maternal health services coverage in the Otjozondjupa region has dropped dramatically since the year 2000. Okakarara is the most affected district in the region.
During the course of pregnancy to delivery, utilization of maternal health services declines dramatically. Women attended the antenatal care services in large proportions yet small percentage of women deliver in a health facility and even a smaller percentage attended PNC. Many women deliver at home assisted by untrained Traditional Birth Attendants (TBAs) who may still practice primitive methods under unhygienic conditions, posing health risks to women and their babies. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause death or serious illness to the mother or the baby.

It is not known what causes women to seek health in such declining proportions. Further more, there is no information regarding at what point women utilize maternal health care services and at what point women decline to use these services. Are some women attending ANC, deliver at home and not receiving PNC? Do some women seek health services only when they are delivering and do not attend ANC and PNC? Why is the PNC utilization so low compared to other maternal health care services?

Table 1 ANC, Delivery and PNC utilization: Otjozondjupa Region, 2000-2003.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ANC</th>
<th>DELIVERIES</th>
<th>PNC</th>
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<tr>
<td>2000</td>
<td>78%</td>
<td>56%</td>
<td>31%</td>
</tr>
<tr>
<td>2001</td>
<td>73%</td>
<td>52%</td>
<td>30%</td>
</tr>
<tr>
<td>2002</td>
<td>69%</td>
<td>51%</td>
<td>25%</td>
</tr>
<tr>
<td>2003</td>
<td>70%</td>
<td>48%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: Otjozondjupa Region Health Information System 2000-2003
Table 2 ANC, Delivery and PNC utilization: Okakarara district, 1999 – 2003.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>ANC</th>
<th>DELIVERIES</th>
<th>PNC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>68%</td>
<td>42%</td>
<td>59%</td>
</tr>
<tr>
<td>2000</td>
<td>53%</td>
<td>32%</td>
<td>49%</td>
</tr>
<tr>
<td>2001</td>
<td>65%</td>
<td>33%</td>
<td>55%</td>
</tr>
<tr>
<td>2002</td>
<td>65%</td>
<td>35%</td>
<td>44%</td>
</tr>
<tr>
<td>2003</td>
<td>51%</td>
<td>28%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Source: Okakarara District Health Information System: 1999 - 2003

Although there might be error associated with data collection and coverage rate or poor population estimates, there is a clear indication that delivery health services in Okakarara are low. Several key factors may contribute to the poor and inconsistent utilization of the maternal health care services. Lack of transport, low income, unemployment, low educational level and inaccessibility to health facilities may play a major role in the decision making process of health seeking behavior. Other factors may be related to the availability of traditional birth attendants. A study on the availability of TBAs was done in Okakarara during 1995 (TBA Survey 1995). The result reveals that 86.8% and 88.2% of mothers attended ANC and were delivered respectively by the TBAs. Service related factors such as previous childbearing experience and the experience with the health care system could have an impact on the health seeking behavior of women, who can decide to deliver at home or go to other hospitals. If a woman has suffered complications during pregnancy or delivery she might be more likely to seek care from a health facility. On the other hand the quality of care (good or poor) received from a health facility during
previous pregnancy or delivery can have an associated effect on her future utilization of maternal health care services at the facility. Affordability may also affect utilization rates of maternal health care services.

1.2.4 Purpose of the study

The purpose of the study was to explore women’s perceptions and experiences of delivery services at Okakarara Hospital, Namibia, in order to gain insight into the contributing factors for women’s poor utilization of delivery services.

1.2.5 Significance of the study

This study is relevant and significant as insight into clients’ views of delivery services and descriptions of problems in accessing care could assist in finding a solution to the current under – utilization of delivery services and may support the provision of a service that considers client’s needs and preferences.

1.3 AIM AND OBJECTIVES

1.3.1 Aim

To examine the factors contributing to the under-utilization of delivery services in Okakarara district.

1.3.2 Specific objectives

A) To determine women’s perception of the importance of delivering in a hospital.
B) To describe the reasons for under utilization of hospital delivery services in Okakarara district

C) To compare the perception of women on the quality of care received in Okakarara hospital maternity ward among women with differing histories of delivery service utilization.

1.4 DEFINITIONS USED IN THE STUDY

**Antenatal care** is a service that is provided to pregnant women before delivery.

**Delivery service** is a service provided to pregnant women when true labour pains begin all the way until the baby and placenta are born.

**Postnatal care** is care immediately after delivery of the baby up to six weeks post delivery

**Traditional Birth Attendants**: Women or men, in the community, who assist pregnant women during delivery

**Maternal Health Care Programme** is a programme that designated to minimize the health risk of pregnancy and childbirth to the mother. These programs include antenatal, delivery and postnatal care services.

**Maternal mortality** is a death of a woman while pregnant or within 42 days of termination of pregnancy, due to complications from the pregnancy, delivery or management of either or due to existing medial conditions that were aggravated by the pregnancy or delivery, but not from accidental or incidental causes.
1.5 OUTLINE OF THIS REPORT

CHAPTER 1. Introduction to the study, formulation of the problem, purpose and significance of the study, objectives of the study and definitions of terms.

CHAPTER 2. A review of the relevant literature (Socio-economic, cultural and service related factors)

CHAPTER 3: Research design and methodology (study design, study setting, sampling, data collection and data analysis procedures, ethical considerations and limitations of the study).

CHAPTER 4: Results and discussion on findings

CHAPTER 5: Summary of the findings, conclusion and recommendations.
CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter (1) provided an orientation to this study by discussing the statement of the problem, purpose and the significance of the study, aim and objective of the study, research methodology and the outline of the research study. This chapter is concerned with review of literature related to this study. The review of the relevant literature contained in this chapter is centered on:

- Benefits of hospital delivery
- Barriers to hospital delivery
  - Socio-economic and cultural factors
  - Service related factors

A search was conducted through published and unpublished journals, books etc, which were relevant to the causes of the low utilization of delivery services in health facilities.

Maternal health care is potentially one of the most effective health interventions for the prevention of maternal and neonatal morbidity and mortality, in areas where the general health status of women is very poor (National Motherhood Conference 1991). Although we expect pregnant women to maintain good health through their pregnancy, delivery and post natal period, studies revealed that there are a lot of discrepancies in the quality and utilization of maternal health care services.

A qualitative study done in Bangladesh of women’s perceptions determining use of maternal health services (MHC) identified the following typical reasons for non-use:

- MHC services are seen as places to which one goes only if one has problems
- Long distances and lack of company for visiting the clinic.

- Long waiting time for service

- Unconcerned attitude and rude behavior of clinic personnel (Armstrong & Royston 1989).

Essential obstetric care will undoubtedly save a woman’s life and certain antenatal measures will contribute to the reduction of maternal deaths, provided that high-quality essential obstetric care is available (Ronsmans et al 1998).

Lack of access to antenatal care services or a skilled attendant at delivery is associated strongly with high mortality indices (De-Brouwere et al 1998). A number of socio economic and cultural factors act as barriers to utilization of health services (Khan 2000).

The World Health Organization (WHO) estimates that 60% of births in low income countries occur outside a health facility, with 47% assisted only by traditional birth attendance, family members or without any assistance at all (Coverage of Maternity Care 1997).

### 2.2 BENEFITS OF HOSPITAL DELIVERY

Each year, over half million women die from complications of pregnancy and child birth. Almost all of them would live if they had access to a skilled midwife or doctor during child birth and effective emergency obstetric care when complications arise. Countries that have successfully reduced maternal mortality have had a high level of access to a skilled attendant at birth (a nurse or doctor with midwifery skills) and basic emergency obstetric care (BEOC) (Reducing maternal deaths: Evidence and Action 2004)
2.2.1 Reduction of maternal and newborn morbidity and mortality
Recognizing the pivotal role of the skilled attendant in reducing maternal and newborn mortality and morbidity, WHO undertook to increase access to skilled attendants for all women and newborns in pregnancy, childbirth and immediate post natal care period. By focusing on skilled attendants, WHO hopes to highlight the significance of this crucial function within the health care system for saving the lives of mothers and newborns. Experience from the past projects and ongoing research point to the importance of a functioning health care system in reducing maternal mortality. (Reducing maternal deaths: Evidence and Action 2004)

2.2.2 Skilled attendants
Skilled attendants are communicating effectively cross culturally in order to provide holistic “women centered” care and assist pregnant women and their families in making a plan for birth (i.e. where delivery will take place, who will be present and, in case of a complication, how timely referral will be arranged). Skilled attendants perform the following functions:

- Educate women in self-care during pregnancy, childbirth and postnatal care period.
- Monitor maternal and fetal wellbeing during labour and provide supportive care.
- Identify delayed progress in labour and take appropriate action including referral where appropriate.
- Assess the newborn and give immediate care.
- Identify any life threatening condition in the newborn and take essential life saving measures including active resuscitation (Making Pregnancy Safer 2004).
2.3 BARRIERS TO HOSPITAL DELIVERY

2.3.1 SOCIO ECONOMIC AND CULTURAL FACTORS

2.3.1.1 International studies

Barriers to improving women’s health are often rooted in social, economic, cultural, legal and related conditions that transcend health considerations. Social factors such as lack of literacy and of educational or employment opportunities, deny young women alternatives to early marriage, early childbearing, and economic and other means of access to contraception. Women’s vulnerability to sexual and other abuses, in and out of marriage, increases risks of unsafe pregnancy and motherhood. Social religious and economic customs become embedded in the law, and historically have been claimed to provide a justification for discrimination against women (Cook 2001).

Health system intervention such as provision of essential and emergency obstetric care is crucial to the reduction of maternal mortality and morbidity. These interventions cannot however be implemented without taking into account the host of social factors affecting pregnancy related illness and death. Health services maybe very far away with no transport available, or may simply not exist. If they are reachable, a pregnant woman may not be able to decide to go there without her husband’s permission; she may not be allowed to travel on her own. She may not know that swollen ankles, vaginal bleeding or feeling giddy are signs for which she could seek professional advice. She may simply not be able to pay for professional health care. These factors often result from women’s poor status in society and from laws, policies and practices that hinder rather than promote their rights.
Health care providers who are aware of their patients and their own human rights can undertake their clinical and administrative responsibility in ways that protect and promote these rights, and employ human right claims in negotiating with their institutions, communities and governments on behalf of women’s right to safe motherhood. A human rights approach allows health care providers and administrators to determine which human right might be more effectively implemented in order to advance safe motherhood (Cook 2001).

Barriers to delivery in health facilities include traditional customs, beliefs, practices, poor image of health facilities and lack of maternity waiting homes. Women need to be taught about the importance of maternal and child health care in health facilities (Gotpagar 1997).

Different models of maternity waiting homes exist in counties like Bangladesh, Cuba, Indonesia, Malawi and Mozambique. The purpose of a maternity waiting home is to provide a setting near the skilled care where a woman can stay in the final weeks of pregnancy. Some maternity waiting homes conduct education and counseling activities to improve self care for the woman and the newborn. Although there has been no formal evaluation of their effectiveness, their continuing existence indicates some local sustainability (Fortney 1997).

Traditional births attendants (TBAs) have a role in supporting women during labour, but generally are not trained to deal with complications. Because most “trained” TBAs have had one month or less of training, they are not defined as skilled attendants (WHO, 1998). Studies in Africa and Asia have found that training of TBAs in the absence of skilled back-up support did not decrease women’s risks of dying in childbirth. However,
TBAs can contribute to reducing newborn deaths and disabilities, and play an important role in providing assistance during delivery. TBAs can offer pregnant women much-needed moral and emotional support. Many women return to TBAs because the doctors and nurses are not available or cost too much, or because TBAs are neighbors or friends who know local customs and respect women’s needs (Fortney 1997).

It is generally agreed that where the use of TBAs is strongly rooted in local customs, it is beneficial to:

- Train TBAs to avoid harmful practices during delivery, recognize danger signals and refer complicated cases to higher-level care
- Establish or strengthen linkages between TBAs and the formal maternal health care system; and
- To ensure that health centers and hospitals will accept referrals from the TBAs.

Still, TBAs are not substitutes for skilled attendants. Long-term investments must be made to develop enough skilled birth attendants, primarily midwives, to meet women’s needs (Safe Motherhood 1998).

Speculation about the cost and effectiveness of programmes to train TBAs has led to their widespread abandonment, despite an absence of trial evidence. Absence of evidence of effect is not evidence of absence of effect. A recent meta-analysis of 60 studies showed that training TBAs was associated with significant improvement in performance and mortality. Bang and colleagues showed a 62% reduction in neonatal mortality in Rural India through a community based approach that include training of TBAs and local women to treat sick newborn infants at home. This supports the idea that primary care
strategies can reduce neonatal mortality substantially in areas with high rates, even if institutional approaches are necessary to reduce them further (Safe Motherhood 1998). A study to identify socio cultural and economic factors associated with low utilization of ANC and hospital deliveries was conducted in Kano, Nigeria during October 2000 (WHO, 1996). 107 women were interviewed using questionnaires. The results of the study reveal that 88% (CI= 81.8% - 94.2%) in the study area did not attend ANC. 96.3% (CI= 93.0% - 99.6%) had delivered or plan to deliver at home without a skilled attendant. It was gathered that their relatives would usually assist during the labour phase until delivery. It was only at that point that the traditional birth attendant (TBA) would be invited to section the umbilical cord and provide postpartum care. It is, however, pertinent, to note here that there exists at the study site a traditional surgeon (a woman) who would be called upon in cases of prolonged/obstructed labour to facilitate delivery. The surgeon would usually perform a minor incision on the vaginal wall of the parturient, known as ‘Kakanda-cut’ as treatment. Kakanda was described by a TBA in the area as ‘something like membranes that protrude and cover the birth canal of a woman in labour during labour. Financial constraint (46%) was the main reason for not attending ANC and delivery in the hospital. Other major barriers identified were economic, cultural and those related to the women’s perception of their condition. The study recommended that poverty reduction and economic empowerment of rural women are prerequisites for any tangible improvements in the utilization of antenatal and delivery services.

In a study about obstetrics services utilization by the community in Lebowa, Northern Transvaal (Uyiworth 1997), it was found that ANC coverage was high (93.5% overall range 80 – 98%) with 74.6% of deliveries occurring in health facilities, while 26.3% were
home births (range 0 – 44%). The health wards with a higher proportion of home deliveries tended to be rural. TBA’s were present at 34.8% of home births. Reasons for home delivery included lack of access to health services (19%) and lack of money to pay for the services (15.2%). Mothers who delivered at home were more likely than their counterparts who gave births in a health facility to be of higher parity.

A cross-sectional descriptive study to determine the level of use of maternal health services and to identify and assess factors that influence women’s choice where to deliver in Kalabo District, Zambia, using a semi structured questionnaire and focus group discussions between 1998 and 2000 for 332 women. The study reveals that although 96% of respondents prefer to deliver in a health facility, only 54% actually did. Reasons given were long distances, lack of transport and user fees (Stekelenburg 2004).

In another study done in India where heads of 3000 households from various castes and socio-economic classes were interviewed, it was found that the heads did not think that women need to deliver in hospital or need a postnatal care, and if they become ill, 56% and 62% would allow witchcraft, or an indigenous method, respectively, to treat them. These findings revealed misconceptions about maternal health, warranting a more in-depth, multi-disciplinary study to learn why this rural population does not accept maternal health family welfare services and, perhaps to use the data to develop a mass education policy (Devi 1993).

A study conducted with clients attending the Mulago Hospital STI clinic in Kampala, in-depths interview revealed that Ugandans, especially women, do not know all dangers signs during the antenatal, delivery and the postnatal periods. It also seems that husbands make decisions on maternal health services use at modern facilities, traditional postnatal
care, resumption of sexual intercourse and family planning use during breastfeeding (Riley 1996, p.10).

2.3.1.2 Namibian Studies

The 1992 NDHS revealed that rural women are at a disadvantage compared to urban women. 39% of women in Namibia are more than 30km from delivery care. 35% are one hour from delivery care and 28% have to travel more than 2 hours or more (Namibia Demographic and Health Survey 1992).

A cross sectional analytical study on Health Seeking Behavior Related to Poor Utilization of Maternal Health Care Services (MHCS) was done in Nankudu district, Namibia during 2000. 409 women were interviewed using semi structured questionnaires and a checklist for staff establishment. The study revealed that a total number of women reporting at least one ANC visit was 359, giving a prevalence of ANC utilization of 88.2% (95% CI: 85.0% - 91.4%). 196 women delivered in a health facility, giving a health facility delivery prevalence of 48.2% (95% CI: 45.72% - 50.68%). Finally, only 18.3%, 73 women (95% CI: 16.36% – 20.24%) received PNC. A large proportion of women commented that their culture does not oppose the use of ANC (395, 96.8%), delivery in a health facility (393, 96.3%) or PNC (372, 91.2%). Furthermore, 222 (56.1%) women did not know if it was necessary for every woman to attend PNC. The study further revealed that the majority of women, 210 (53.2%) experienced home deliveries assisted by mainly TBAs (85.4%) or relatives (97.4%). The study also revealed that a majority of women 336, (83.8%) reported the need for every woman to deliver at the health facility. Of these women reporting the need for every women to deliver at a health facility, 171 (50.1%)
actually delivered in a health facility. In fact, women who deliver in a health facility are 2.81 more times likely to believe that every woman should deliver in a health facility than women who deliver at home. Reasons given for delivering in a healthy facility were to be assisted and given medication, 233 (61%) (Research on Health Seeking Behavior Related to poor Utilization of Maternal Health Care Services 1998).

2.4 SERVICE RELATED FACTORS

2.4.1 International studies

Most maternal and neonatal deaths take place at home, beyond the reach of health facilities. Current international policy emphasizes the provision of skilled birth attendants and improved obstetric services in health facilities as key intervention to reduce neonatal and maternal mortality (Costello 2004, p.3).

Service related factors such as availability, accessibility and quality of care could affect a woman’s decision to utilize maternal health care services. An innovative safe motherhood pilot project was conducted in the city of Zhezkazgan, Kazakhstan. The aim was to modernize and improve quality of care for women and newborns and to increase satisfaction among women and their families. An evaluation was completed using qualitative methods. As an example of results during the in-depth interview with Gulshyan, aged 32, on the birth of her second baby, she said that during labour she walked about and sat on a big rubber ball, which was very comfortable and relaxing. She was asked what position she wanted for delivery; she ended up semi-reclining and everything went very smoothly. The midwife helped her throughout, put her baby on her
stomach right after he was born and showed her how to breastfed him. She concluded that the quality of service was up to standard (Making Pregnancy Safer 2003).

Quality is determined not only by technical capacity, but also by cultural appropriateness and the dynamic interaction between clients and providers. WHO and other key partners support improving provider interactions, with women, men and community as a key element of quality. Further, different studies have shown that improving provider’s interpersonal and intercultural interactions with women can influence compliance on women’s knowledge, perceptions of quality of care and use of service. All health workers should be aware of the importance of good communications, that good counseling is also a lifesaving skill, which intercultural and interpersonal competencies increase the use of care, that communication and health education functions are not separate or less important than their more clinical functions. Increased awareness and change in provider’s practices can result in providing “care” to women and newborns rather than just “curing” (Making Pregnancy Safer 2003).

A pilot study was done in Zambia. The objective was to describe the routine care of women during normal labor and delivery and the immediate care of newborn babies in Zambia at different levels of health care. A descriptive survey was conducted between 1994 and 1995 on 84 women from 11 urban and rural maternity facilities. Based on the findings, the researchers suggested that many present maternity wards routines should be carefully studied. It was also suggested that the midwives reorient their caring practices to more culturally-sensitive and evidence-based maternity care ( Estimates of maternal mortality 1995).
A survey was conducted in Leeds, on women’s views of care they received from a maternity unit, to ascertain whether the local maternity service was meeting the main objective of ‘Changing Childbirth’ a woman centered approach to care based on women’s individual needs. Results obtained from the 160 conveniently sampled subjects showed overall high satisfaction levels. Important common themes were quality of information and friendliness. Women also reported high levels of satisfaction about labour and delivery but there was least satisfaction with postnatal care received in the hospital (Stekelenburg 2004).

Sri Lanka and Malaysia reduced mortality by ensuring that all deliveries, whether at home or in a health facility, were attended by a trained midwife. Removal of financial barriers ensured free access for all. In Sri Lanka expanded access to services including maternity homes in rural areas. Both countries established quality assurance programmes that held staff accountable. (Pathmanath 2003, p.12).

In response to considerable dissatisfaction expressed by women with all aspects of their birth experiences and perinatal care, a survey study utilizing questionnaires was done. The aim was to determine the characteristics of a sample of women giving birth in one hospital in South Australia, and these women’s perception of the usefulness of the service and care that they were given during postnatal period. The study was conducted on a convenience sample of 235 women. The study results revealed women’s view of midwives’ attitudes being insensitive (8%) and judgmental (9%), midwives being unhelpful (40%) and gave conflicting advice (10%). Positive perceptions were in relation to midwives giving emotional support (57%), answered questions (32%) and gave health education (30%) (Coverage of maternity care 1997).
A study was conducted in Zambia during 1994 to ascertain women’s perceptions of factors which affect their health and well being during the postnatal period and to establish the influence of partners, relatives, friends or health professionals. Findings from this study suggest that women receive inadequate information, advice and support from health professionals during antenatal and postnatal period to facilitate their transition to motherhood (Making pregnancy safer 2003).

An exploratory, descriptive study was undertaken in a South African Metropolitan area to determine utilization of a Midwifery Obstetric Unit (MOU). The objective of the study was threefold:

- to describe the opinion of members of the community about reasons for the underutilization of the MOU,
- to describe suggestions of the community for improvement in utilization of the MOU,
- to describe intervention strategies for the community nurses to improve the utilization of the MOU (Jewkes1997, p.21).

Data were collected by mean of focus group interviews. The investigation revealed that the community was not utilizing the MOU because of negative attitude of nurses, lack of material and human resources, poor safety and security measures and lack of community involvement and participation. The study clearly showed that community involvement and participation in planning services to be offered is important. Clients may offer suggestions that may prove to be useful and if they are involved may be more inclined to utilize a service.
In a study about obstetrics services utilization by the community in Lebowa, Northern Transvaal, it was found that reasons for home delivery include negative staff attitude (12%) and precipitate labour (7.2%) (Uyiworth 1997).

A cross-sectional descriptive study to determine the level of use of maternal health services and to identify and assess factors influencing women’s choice where to deliver was conducted in Kalabo, Zambia and revealed that the quality of delivery service was perceived as good or satisfactory by 96% of respondents. 87% of the respondents perceived the quality of ANC as good. However, no significant association was found between the perceived quality and the use of the services. Women who visited ANC were asked about their estimated date of delivery (EDD). Only 45% knew their EDD and of this group 78% deliver in a health facility (OR=3.7; 95% CI 2.1 - 6.6). During focus group discussion it emerged that health workers usually do not inform the expecting mothers about their EDD. A statistical association between the mother’s attitude towards male attendants and the use of services that are exclusively manned by male health workers was found during the study. Women who do not mind delivery by a male health worker more often delivered in a health facility (OR=3.5; 95% CI 2.2 – 5.6) (Stekelenburg 2004)

It is interesting to note that sometimes pregnant women do not completely understand the importance of seeking maternal health service at modern health facilities. According to a study done with clients attending the Mulago hospital STI’s clinic in Kampala, in-depth interviews revealed that Ugandans do not know when or how often pregnant women should attend ANC or deliver in a health facility or that they should have a postnatal check up (Riley 1996).
A study to identify factors associated with low utilization of ANC and hospital deliveries was conducted in Kano, Nigeria during October 2000. 107 women were interviewed using questionnaires. Most women in the district delivered at home with the assistance of family members. The most frequent reason given was ‘it is easier at home’, an explanation that accounted for 26.2% of the responses. But what does this imply? Almost all the women interviewed expressed their desire to deliver safely at home within the privacy of their rooms and in the company of their relatives who could understand their situation. Hospital delivery was seen as the unavoidable alternative; that is, unless it was absolutely necessary, women in the study area would not want to deliver elsewhere but at home. On further questioning, it was evident that the pregnant women in the study disliked certain practices associated with hospital delivery. These includes the lithotomic position imposed on them instead of the squatting posture they were used to, the lack of privacy, presence of a male staff attendant and episiotomies conducted without plausible explanations. To avoid these inconveniences, in addition to the transportation difficulties, the pregnant women in study area felt strongly ‘it is easier at home’ (Making pregnancy safer 2003).

Women sometimes refuse to seek health services that are available, because they believe that their medical confidentiality will not be sufficiently respected. This may be particularly so in a smaller communities where personal relationships among patients and clinic personnel exist in social life outside the clinic setting. Women’s perceptions that their confidentiality may be breached might be usefully addressed by ensuring that the clinic policies and legal duties of confidentiality are carefully explained to all those seeking health care (Cook 2001).
2.4.2. Namibia studies

The 2000 Namibia Demographic and Health Survey revealed that the proportion of births delivered in health facilities has increased from 67% in 1992 to 75% in 2000. More than 3 in 4 women who gave birth in the five years preceding the survey were assisted by trained medical personnel (doctors and nurses), while 6% were assisted by traditional birth attendants. 17% were assisted by relatives and less than 1% had no assistance during delivery. There are large differences in type of delivery assistance by background characteristics. Urban women are more than twice as likely to receive assistance at delivery from a doctor as rural women (Namibia Demographic and Health Survey 2001).

Concerning the attitude of health workers, a cross sectional analytical study on Health Seeking Behavior Related to Poor Utilization of Maternal Health Care Services was done in Nankudu district, Namibia during 2000. 409 women were interviewed using a semi structured questionnaires and a checklist for staff establishment. The study revealed that a large number of women, 290 (72%) reported health worker’s attitudes to be good. Reasons given to support their response included that the health workers explained procedures well and that they were given medicine. Furthermore, an association exists between health worker’s attitudes and attending antenatal care. Women who attend ANC are 3.33 times more likely to report health worker’s attitude as good than women who do not attend antenatal care. There was no relationship between health worker’s attitude and delivery in a health facility. Concerning the operating time, respondents were asked whether the operating time at the nearest health facility suited them. No association between operating hours and maternal health care services was found. Only a small number 49 (12%) reported that the operating time did not suit them, and suggest that
nurses should start at 08h00 (Health Seeking Behavior Related to poor Utilization of Maternal Health Care Services 1998).

Effective interventions are available to reduce the burden of ill health in pregnancy. Essential obstetric care will undoubtedly save a woman’s life, and certain antenatal measures will contribute to the reduction of maternal deaths, provided that high-quality essential obstetric care is available and women utilize the services (National Motherhood Conference 1991).

### 2.5 CONCLUSION

This chapter has covered a review of previous research studies related to delivery services, experiences of women, perceptions, satisfaction and dissatisfaction with delivery services. It has clearly come out that developing countries have a problem of low utilization of maternal health services, compared to the developed countries. The literature has also suggested that long distances, lack of trained skilled attendants and negative attitude of nurses are some of the barriers to the utilization of delivery care.

There was limited information from Namibian literature. The available literature was mainly from African countries and developed countries.

The next chapter focuses on the qualitative research methodology that was adopted to conduct the study: study design, study setting, sampling, data collection and data analysis procedures, ethical considerations, validity and reliability and limitations of the study.
CHAPTER 3. RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter was a presentation of prior research studies related to antenatal and delivery care services, consumer utilization and satisfaction/dissatisfaction with services as well as preferences for type of care.

This chapter presents the methodology. According to Burns and Grove (1995:225), Research methodology “refers to the strategy of the study, from identification to final data collection.” It focuses on the following; study type and design, study setting, sampling strategy, data collection and analysis, validity and reliability of the designed instruments, ethical consideration and limitations of the study.

3.2 RESEARCH DESIGN

The study was qualitative in nature and the study design was a descriptive and comparative study that focused on describing and comparing two groups of women.

A qualitative approach was selected for this study because the phenomenon can be understood in its complexity and within a particular situation and environment (Marshall & Rossman 1995). In this approach the relationship between the researcher and the participants and the phenomenon under study is acknowledged and emphasized (Lincon & Guba 1985). Qualitative research designs “focus on qualitative aspects (meaning, experience and understanding) from the view point of the research subjects and in the context in which the action takes place” (Brink 1999, p.119).
A descriptive and comparative study involves the systematic collection and presentation of data to give a clear picture of a particular situation and is attempting to establish causes or risk factors for certain problems. This is done by comparing two or more groups some of which have or develop the problem and some of which have not (Varkevisser et al 1991). The study allowed the researcher to compare the perceptions of different groups of women on quality care and key factors related to under utilization of deliveries in a health facility. The design was relevant to the study as the main objective was to describe the women’s views on the delivery services.

3.3 STUDY POPULATION AND SAMPLE

The study population included all women who brought their babies for immunization at the 2 clinics during the last 2 weeks of October 2004. The nurse in charge of each clinic assisted the researcher to identify the participants. The inclusion criteria were as follows:

- Delivered during August 2003 – July 2004, irrespective of place of birth
- Women aged 15 – 49 years
- Speak local Otjiherero language
- Has 2 or more children (Multiparity)
- At least one child was delivered in Okakarara hospital

There is no justification for a very large sample as data from large samples might lack the depth and richness of a smaller sample (Patton 1990). A purposive sample was used as it allows one to select participants who will provide the required information. This is a type of non-probability sampling in which respondents are selected because they are identified
as knowledgeable regarding the subject under investigation (Burns & Groove 1995; Bailey 1997).

Two focus group discussions (FGD) were identified at each clinic. Inclusion criteria were:

- Group 1 – women with all children delivered at Okakarara hospital
- Group 2 – women with last child not delivered in Okakarara hospital

10 women were selected for each focus group discussion held at the selected clinics in the office of the nurse in charge. During the last 2 weeks of October 2004, I, the Principal Researcher (PI), went to Goblenze clinic and Okondjatu clinic to select the 2 groups for the focus group discussions. The sister-in-charge of each clinic identified all the women who brought their children for immunization and had delivered between August 2003 and July 2004. They were referred to me in the office of the sister-in-charge. I used the selection criteria to select the potential women. 40 of them were purposely sampled and divided according to the criteria of the 2 groups. They were given an appointment date and time to attend the focus group discussions session to be held at each clinic. This study excludes women who have never delivered a baby at the Okakarara Hospital, which represents a limitation as the views of those women would not be represented. However, this research wanted to include investigation of service factors which impacted on utilization. Therefore, women who had “experienced” the phenomenon under study, that is maternity health services, were purposively selected so that they could provide information on the study question. Purposive sampling of this type is consistent with a qualitative methodology.
3.4 DATA COLLECTION METHOD

Data were collected during November 2004, at Goblenze and Okondjatu clinics, Okakarara district, Namibia. Focus group discussion method was used to collect information. Participants were served with refreshments to compensate for their time. Group discussions are more interactive and stimulating than individual interviews, and so they can more efficiently identify new ideas, allow open exploration of conflicting ideas and can be a more cost effective approach (Murphy 1993). However, transcription and coding are time consuming, costly and require access to skilled personnel (Coreil 1995).

I, assisted by a research assistant, conducted the FGD. My experience both as the maternal health provider, and my academic role as maternal health educator, influenced the research. Training of a research assistant included writing skills, listening skills and handling of audiovisual equipments. An interview guide consisting of open-ended questions with enough flexibility to allow new issues to be raised was used. It also contained a section on demographic data of the participants such as age, marital status, standard of education, religion, employment status and obstetric history (Gravida). These were included to obtain a general view of the participants’ social characteristics. The major section contained open ended questions that dwelt on the issues of interest for the study such as knowledge about the importance of delivering in the hospital and previous experience of delivery care services. The discussions were tape-recorded and the non-verbal cues were noted by the research assistant.
3.5 DATA ANALYSIS

Data analysis is the process of bringing order, structure and meaning to the mass of collected data (Marshall & Rossman 1995). The analyzing of the data should start while collecting the data, in order to address the unclear issues before the data collection is over (Varkevisser et al 1991). Qualitative data analysis is the process of systematically organizing the field notes, interview transcripts and other accumulated materials until they are understood in such way as to address the research questions and can present that understanding to the others (Patton 1990; Bailey 1997).

For quality control of the information, the information was checked for completeness and consistency before and during data processing. The data was sorted in two groups right after collection for comparison. A Priori method of coding was used for forming different overall categories of themes from the data based on the study questions. A Priori refers to having named categories before data collection (Bailey 1997). The researcher used the thematic and content analysis method to obtain the information, which answered the research questions and addressed the objectives. Content analysis is a more specific type of analytic approach that can be used once the more general themes in a set of data have been identified. (Gifford undated). Data were analyzed and managed by adopting Burnard’s model of thematic content analysis, which is an adaptation from various works on content analysis. The aim of the qualitative analysis is to produce the detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews under a reasonably exhaustive category system’. Burnard’s method allows for data to stay as close to the original material and yet allowing for categories to be generated which allow the researcher report to ‘make sense ‘of the data.
By following the stages outlined by Burnard (1991) the researcher listen to the audio taped interviews immediately after the daily interview sessions and noted emerging topics from the interviews. This allowed the researcher to get acquainted with the data and ascertain the quality of audiotapes (Marshall 1995; Bailey 1997). The transcribing process involved repeated listening to the tapes. The tape recordings were transcribed verbatim and the transcribed tape recordings were then read through noting down emerging general themes within the transcripts. The identified categories were than grouped together under main and sub-headings to reduce the list to a reasonable number. The available data from transcripts were grouped into units of information that served as the basis for the categories. These included phrases of sentences that had a meaning to the researcher. The transcripts were than coded according to the list of category headings. During analysis, the researcher referred to these themes to form categorization of client responses and attempt to link the data examples and commentary to the literature. In addition, emergent themes from the data were also incorporated and the result was a blend of predetermined and emergent themes or categories (deductive and inductive). The codes were collapsed and combined. Relationships between the themes were examined. Themes were grouped with other themes of related meaning and organized into aggregates. Once all the sections were compiled, a list of categories and emerged themes was then compiled and the data were described under the identified categories and sub-categories of themes.
3.6 VALIDITY

Four constructs that more accurately reflect the assumptions of the qualitative paradigm are: credibility, transferability, dependability and confirmability (Lincoln & Guba 1985)

3.6.1 Credibility

Credibility refers to the confidence in the truth of the data. In ensuring credibility, “the goal is to demonstrate that the enquiry was conducted in such manner as to endure that the subject was accurately identified and described.” This is one way by which the credibility of this study was enhanced. The researcher identified the ideal participants based on study objectives and gave a comprehensive description of them. (Marshall and Rossman 1995, p.143)

The researcher created rapport with the participants by explaining the background and the aim of the study insured that strict confidentiality and privacy will be ensured and maintained throughout the study. Prior to the interview sessions, the researcher ensured that the tape recorder was in working condition. After the interviews, the tape recorder was played back to listen to the recorded interviews. This was to ensure that the focus group was recorded in full and effectively.

3.6.2 Transferability

Transferability allows the researcher to generalize the findings about a particular sample to the population from which the sample was drawn (Marshall & Rossman 1995, p.144). Retrievable data base (field notes and audio tapes) was kept for other interested researchers and participants to examine the evidence to formulate the generalization of
the findings. Comprehensive descriptions of the setting, participants and research process assisted with assessment of transferability. “The researcher needs to provide sufficient descriptive data so that other can consider the applicability of the data to other settings”. (Potter 1996, p.6)

### 3.6.3 Dependability

Dependability can be strengthened by carrying out the research in a team and by ensuring that methods of data collection and analysis are clearly articulated. (Marshall & Rossman 1995). Detailed notes and records were maintained throughout the research process. Dependability of qualitative data refers to the “stability of data over time and over conditions for example through inquiry audit that involves scrutiny of data and relevant supporting document by an external reviewer.” (Potter 1996, p.7)

### 3.6.4 Confirmability

Confirmability captures the traditional concept of objectivity (Marshall & Rossman, 1995). Confirmability suggests that data are factual and reliable. There would be agreement between two or more independent people about relevance of the data. An audit trail was developed to keep an account of the whole process from data collection and analysis. (Baumgartner, Strong & Hensley 2002). This was achieved in the present study through the use of the interviews in which the evidence was obtained from the participants about the phenomenon under study.
3.7 ETHICAL CONSIDERATION

Written permission to conduct the study was sought from the Permanent Secretary of the Ministry of Health and Social Services through the Directorate: Policy, Planning and Human Resource Development (HRD); Subdivision: Management Information and Research. Permission was granted accordingly. The research protocol and consent form were also approved by the University of the Western Cape Higher Degrees Committee.

The aim of the study was explained to the potential participants. Permission to include them in the study was sought and written consent was obtained. The respondents were informed that they are free to withdraw at any time without giving reasons. A decision not to participate was strictly respected and women assured that non-participation would not affect their health care. Strict confidentiality and privacy was ensured and maintained throughout the study. In addition, interviewers were trained on community approach about local culture and beliefs. The procedure was conducted in the way that no harm was caused to the participants. Should any harm be caused as a result of this procedure the extent would be measured and action would be taken whether to withdraw or to carry on with the study.

3.8 LIMITATIONS OF THE STUDY

- This is a small qualitative study focusing primarily on quality of care and potential improvements for local health services. Broader application outside the study setting may not apply and would have to be judged independently.
- Many babies were brought to the immunization sessions by the “aunts’ due to the fact that the mothers are working in towns e.g. Otjiwarongo. So it was difficult to get the study population.

- Possibly due to the fact that I was known to the study participants as a health worker, they may have not expressed themselves freely at the beginning of the discussions. However as the discussions progressed, they appeared to relax and were talking freely.

- A reflexive journal was not kept during the interview process by the researcher.
CHAPTER 4: RESULTS: PRESENTATION AND DISCUSSIONS

The previous chapter dealt with research design and methods. This chapter endeavors to give meaning to the data by presenting the data as comprehensively and clearly as possible using narrative report writing style. The data is presented by content analysis method.

4.1 INTRODUCTION

The interviews were conducted during the first 3 weeks of November 2004. All the participants in both groups met the inclusion criteria:

- Speak local Otjiherero language
- Women aged 15 – 49 years
- Delivered during August 2003 – July 2004, irrespective of place of birth
- Has 2 or more children
- At least one child was delivered in Okakarara hospital

The two focus group discussions at each clinic also met the following criteria:

- Group 1 – all children delivered in Okakarara hospital
- Group 2 – last child not delivered in Okakarara hospital

The participants consisted of 40 women who were identified and purposively sampled when they brought their babies for immunization at Goblenze and Okondjatu clinic.
Table 3 Demographic Profile of study participants

<table>
<thead>
<tr>
<th>Characteristic variable</th>
<th>Number of participants</th>
<th>Percentage of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
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<tr>
<td>15 – 19</td>
<td>5</td>
<td>12.5%</td>
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The majority of the participants 19 (47.5%) were in the age group of 30 - 39 years. In relation to marital status 30 (75%) of the participants were single. In relation to education, the majority of the participants 18 (45%) had some form of primary level
education. With regard to employment status, a total of 30 (75%) were not employed. Regarding the parity, the majority 15 (37.5%) had 3 children.

The information proved useful in the presentation of the qualitative data but was not used for quantitative analysis as the study was of a qualitative in nature.

The results of the interviews have been reported using the following 2 main themes:

1. Knowledge about the importance of delivery in a hospital

2. Factors/Reasons contributing to underutilization of delivery service

Each theme is discussed under the 2 main groups of participants, that is, those who delivered all their babies in Okakarara hospital and those who had delivered babies in Okakarara hospital, but the last one was delivered outside Okakarara hospital.
4.2 RESULTS

4.2.1 Knowledge about the importance of delivering in the hospital

Both study participants who delivered all their children in Okakarara hospital and those who did not deliver the last child in Okakarara hospital were asked about the importance of delivering in a hospital. Generally the participants who delivered all their children in the hospital had a more positive perception about the importance of delivering in the hospital than those who did not deliver the last child in Okakarara hospital.

4.2.1.1 Treatment of diseases and other conditions

Maternal health care services are potentially one of the most effective health interventions for the prevention of maternal mortality and morbidity. A woman is expected to maintain good health throughout the pregnancy, delivery and postnatal period. A woman can have her condition checked and monitored during pregnancy by ANC clinic, deliver her baby with the assistance of a trained health worker and attend the PNC clinic for the treatment of any complications that arise from pregnancies or deliveries (Namibia Demographic and Health Survey 2001).

Participants who delivered all their children in Okakarara hospital reported that during pregnancy, some women developed diseases like blood sugar, high blood pressure and dizziness. They appreciated the treatment they received during the delivery and postnatal period. “It is very important to deliver a baby in the hospital, because sometimes a woman has a higher blood pressure and she is not aware, the nurses and doctors will find out and treat her accordingly.” Another one adds: “Hey, when I was pregnant with my last born, my hands, my legs, my abdomen and my face was swollen. I was admitted
for 5 days before the doctors decided to do an operation to remove the baby. I was informed by the nurses at maternity ward that I and the baby could have died if I delivered at home or came late at the hospital.

The participants who delivered all their children in Okakarara hospital praised the nurses for the treatment received during the delivery period. “Aaa, in Okakarara hospital, let me tell you, the nurses, the doctors, they are wonderful people. When my blood sugar went up during the delivery of my second baby, they put me on a drip, and there was a nurse sitting next to me counting my pulse and other things….mhhh, I forget now. I think if I did not come on time I could have not be with you here today heeee…. (laughing).”

The same participants valued the importance of delivering in a hospital. They feel they are secured and safe in the hands of the trained nurses and doctors. One said: “I always advice my friends who like to deliver at home that at the hospital, it is very safe because if a woman has a disease and she did not know about it, the nurses will detect it very quickly, and treat her very quick.”

For participants who delivered the last child outside Okakarara hospital, the majority of them felt that a woman should deliver in a hospital, due to the fact that a woman would get medicines for any conditions; but they reported some negative aspect of the situation. Concerning the treatment of certain diseases or conditions some of the participants felt that the hospital does not have the necessary of medicine or lotions sometimes. A participant retorted: “My sister is an epileptic sufferer. When she went to deliver at the hospital, she starts fainting. They asked me if we brought with us her epileptic tablets from home because the hospital runs out of stock, 3 days ago. Do you know what
happened, she was transferred to Otjiwarongo hospital that is 100 km away, and I am telling you she nearly died…….. (screaming).”

The majority of both groups of participants feels strongly that every woman should deliver in the hospital, although some women who deliver the last child outside Okakarara hospital feels that unless ‘gaps’ are filled at the hospital e.g. out of stock medicines, it is not comfortable to deliver in a hospital.

4.2.1.2 Handling/management of complications

The complications of pregnancy and childbirth are the leading cause of death and disability among women of reproductive health in developing countries. (WHO, 1998).

The majority in both groups of participants responded that the hospital is the only place where all the complications of the pregnancies can be managed effectively and efficiently. There was a mixture feeling among all study participants; some feel that the nurses are capable to handle complications and some feels that the nurses are not capable and committed in their work.

Participants who delivered all their children in Okakarara hospital mentioned that the nurses in the maternity ward are competent in their work and should be praised.” Hmmm, there is no a hospital in our region with well trained nurses like Okakarara hospital. What complications of delivery services is concerned, they are number one. My dear, I am telling you! (clapping hands). Do you know what they do not waste time with you, what they cannot manage; the doctors refer you to Otjiwarongo or Windhoek hospital as quick as possible. Aaa, these days I noticed, they just send you to Windhoek, to the specialist maybe….. (laughing).”
They continued: “During the delivery of my last baby, I nearly bled myself to death. I inform the nurse who was on duty that time. She examined me and informed me that a small section of the ‘after birth’ retained in the womb. She inform the doctor and within one hour, they remove it at the theater and the bleeding stops”

The study participants who delivered all their babies in Okakarara hospital have confidence and trust on the nurses and doctors. They felt safe and secure in their care. They praise the staff on good management of complications. However the majority of the participants who delivered the last child outside Okakarara hospital expressed their dismay that some nurses could not handle some complication cases. The participants felt that one day a woman will die in the hospital before, during or after delivery, due to the mismanagement of complication of delivery cases. The study participants who delivered the last child outside Okakarara hospital: “When I was admitted for delivery of my second child, I told the nurses that with my first pregnancy, I was put on ‘drip’ because apparently my blood pressure dropped during the delivery process. The nurse ignored me and I just kept quiet. Immediately after delivery, I felt very weak and dizzy and start to vomit. The nurse I informed earlier on my history of blood pressure tried to put drip on but in vain. She was told by others nurses to call the doctor, but refuse and said ‘what will the doctor do if the veins are collapsed?’ By the grace of God I regain my strength and the vomiting stop. How on earth a trained nurse could do that to me?” One participant: “Before delivery of my first child, I felt something hanging between my legs. I realized that it was a cord that hanging outside. I informed the nurse about the hanging cord. She tried to insert it back, but in vain. The other nurse told her that what she was doing was wrong; she should have only call the doctor. Anyhow, the other nurses call the
doctor and the operation was conducted on me to take the child out. I nearly lost my baby, my first one ..... Mhhh, later I was informed by the nurses that it was a cord prolapse!”

Not all participants who delivered outside Okakarara hospital have problems with the handling of complications. ‘It was on the third day in the hospital after delivery of my third child. I smell a bad odour of my vaginal discharge. I informed the nurse who informed the doctor. I was put on a drip and given a lot of antibiotics. After two days I was well and was told it was something …mhhh infection or septic something.”

All participants who delivered all their children in Okakarara hospital had a positive perception on how the complications are handled. Out of the experience they were satisfied with the procedures performed on them as well as the hospital’s strategy to refer patients to other institutions for further management.

On the other hand, the majority of the study participants who delivered the last child outside Okakarara hospital understand well that every woman should deliver in the hospital. However some complications were not handled to the satisfaction of participants due to the misunderstanding between the mothers and nurses or due to the incompetence of nurses. However, some participants who delivered outside Okakarara hospital expressed appreciation of the work the nurses are doing.

4.2.1.3 Clean and conducive environment

Many women deliver at home assisted by untrained Traditional Birth Attendants (TBAs) who may still practice primitive methods under unhygienic conditions, posing health risks to women and their babies. Proper medical attention and hygienic conditions during
delivery can reduce the risk of complications and infections that can cause death or serious illness to the mother or the baby.

The participants who delivered all their children in Okakarara hospital indicated that it is important for a woman to deliver in a clean environment. They indicated that the maternity ward, including the delivery room of Okakarara hospital, was spotless clean. This is very important for the health of the mother and baby. The environment outside was also clean with a lawn, flowers and trees. ‘I did not even felt pain when I delivered my last child due to the fact that my heart was full of joy. Do you now why? First of all I bath myself with ‘lekker’ hot water, you know, at home I wash myself in the basin, then when the pain start, I was taken to the delivery room that was very clean. There ...... (smiling) I did not concentrate on the delivery procedure, but looking only to the shining delivery equipments....Aaa, till the nurse said: ‘this is your baby boy’. Really, the maternity ward was very clean; no one will get infected by the bacteria and viruses in Okakarara hospital, no way!” One participant: “I was so ashamed to enter the maternity ward with my dirty and broken shoes. My clothes was also not that much clean because I did not have a washing powder for the last 2 days at home... The floor was polished and I could see my face on it. My heart was so happy, the beddings was very clean although not enough. In the maternity ward, there are no diseases, it so clean, clean .... Don’t even talk about the delivery room, clean!”

The participants who delivered all their children in Okakarara hospital were very satisfied with the cleanliness of the maternity ward and the majority of them mentioned that they will never deliver at other hospitals or at home, because they do not want to contract diseases due to the dirty environments. ‘I, to deliver in the dirty hospitals, like I hear
Otjiwarongo hospital is dirty, never, never ever…. I don’t want infections and diseases. I like the cleanliness of Okakarara hospital. Even the nurses are clean and wear the clean uniforms, when you look outside the windows, don’t talk just the flowers, flowers.”

The participants who delivered their last child outside Okakarara hospital also mentioned that it is very important for a woman to deliver in hospital because of the hygienic conditions. Although some of the study participants have delivered their last child at home or at other hospitals, they were happy with hygienic conditions of Okakarara hospital.” I delivered my last child at Otjiwarongo hospital. The hospital was so dirty; I could not even eat the hospital food there. I regret why I did not deliver in our clean hospital of Okakarara. I thought I will contract diseases there. O, clean environment is very important especially for the new born babies. O, Okakarara hospital, you will feel healthy because of the healthy environment.” One participant: “I respect a clean place like Okakarara hospital, maternity ward section. Let me tell you, I deliver my last child at my sister’s house. That day it was raining, the pain started and I could not reach my neighbor to take me at the hospital nor could I reach my house. I deliver my baby on her bed. Aaa... Dirty linen, no water to wash her hands, the towel! Anyway, everything went well. We did not contract any disease.”

Both groups of participants recognize the importance of delivery in clean environment, the hospital. As can be noticed Okakarara hospital was praised by all participants as a clean hospital and the majority of the participants wish to deliver there again if they happen to get pregnant again.
4.2.1.4 Proper care of the mother and detection of anomalies

The participants who delivered all their children in Okakarara hospital express the fact that if a mother delivers in a hospital she will be given a hygienic care and proper investigations; physical, radiological and serological if need be. Anomalies that were not detected during the ANC can be detected during delivery.” When a mother delivers in a hospital, she delivers on a comfortable delivery bed, assisted by well trained nurses and doctors. She receives an injection immediately after delivery. The nurses clean her birth canal area and put the baby immediately on the breast. They measure her temperature, blood pressure, pulse and check her hemoglobin to assess the blood loss.”

The participants who delivered their last child outside Okakarara hospital also expressed their feelings that it is true that at the hospital, a woman can get the hygienic care and the nurses and doctors may detect some anomalies and treat them;” In comparison with home deliveries, it is better to deliver in a hospital where a woman can be given an injection and get some painkillers for the pain and also some infusion if the nurses feel that the woman needs it especially when she loose a lot of blood during the delivery. When you deliver at home although you loose a lot of blood, you are only told to drink lots of water and if you develop some other complications, you are given lots of traditional medicine that sometimes make you very sick.” One participant: “It was not my wish to deliver at home. I know the hospital is a safe place and I wish to deliver there but due to long distances, I fail to deliver there.”

In Namibia most women who delivered at homes in rural areas use traditional medicine because sometimes they cannot afford to pay for transport to take them to the hospital.
All in all, both group’s participants have the knowledge on the importance that a woman should deliver in a hospital to be cared by competent nurses and doctors.

4.2.1.5 Proper care of a baby

It was very interesting to note that study participants who delivered all their babies in Okakarara hospital and who delivered the last child out of Okakarara hospital have the same view that a woman should deliver in a hospital so that the baby can get proper care. Babies can be born healthy, premature or sick.

The participants who delivered all their children in Okakarara hospital mentioned that all children should be born in a hospital without any exceptions. “In delivery room, when a child is born, the nurses give the child an injection, clean the eyes with clean water and put eye drops in both eyes of the newborn immediately after birth.” One participant: “In addition, the nurses wash the baby and give to the mother to breastfed immediately after birth. Before I forget, they also clean the airway of the baby and care for the umbilical cord. Uuu… the nurses are wonderful people.” One participant: “If a baby was born very small, they put the baby in a … What is the name? Yes, ‘broeikas’ for some days or weeks to grow.”

The participants who delivered the last child outside Okakarara hospital have also a positive input on the same issue: “The nurses inject a baby after birth and give some other medicines for the baby to drink. My first born was so yellow in colour when he was born. The nurses put him under the blue light, first they closed his eyes. Ooo… Within 3 days he was well and fresh. What should happen with my boy if it was a home delivery like the one for my last baby?”
One participant: “The nurses are good people, because when they see something wrong with a baby, they will tell you. If you deliver at home the birth attendant will never tell you anything, because of this witchcraft ... you now, she fear and don’t want to be blamed. My sister born a baby with six fingers at one hand... left ... right, I forget anyway. The nurses told her just there, right away! It was removed later I think after some days.”

The assumption that can be drawn from the discussions is that both participants appreciated the good work done by the nurses and doctors on caring of a newborn in hospital. Both study participants appreciated the fact that the nurses weigh the babies and inform them about the weight and before discharge, a baby is given an immunization injection and a mother is told when to bring back the baby for the second injection.

To verify this, study participants who delivered all their children in Okakarara hospital: “The nurse inject my baby and give her some drops in the mouth then she write on the baby’s passport and show me the next date I should bring the baby back for another injection”

4.2.2 Reasons for under utilization of delivery services in Okakarara hospital

The complications of pregnancy and childbirth are the leading causes of death and disability among women of reproductive health in developing countries. A number of socio-economic, cultural and service related factors act as barriers to the utilization of maternal health services. Ideally, all stages of maternal assessment should be completed for all pregnant women (National Motherhood Conference 1991).
4.2.2.1 Socio economic and cultural factors

A number of socio economic and cultural factors act as barriers to utilization of health services (Khan 2000). The participants were asked to give their opinion regarding factors that contribute to the under utilization of the delivery services in Okakarara hospital. It was very interesting to listen to various reasons given by both sets of study participants.

4.2.2.1.1 Accessibility of delivery services

The study participants who delivered all their children in Okakarara hospital did not experience any problems to access the hospital, however on the accessibility of delivery services: “Any how, my father has got a car; he is the one who transported me to Okakarara hospital. However I observed that the reason why some pregnant women do not deliver at the hospital is because like at Goblenze clinic, there is no ambulance to transport patients to the hospital. Nurses are telling pregnant women to hike to Okakarara to deliver there. Most of the people here are poor and cannot afford to pay for a hike.” The hike fee between Goblenze and Okakarara is N$30.00 (R30.00). The same fee applied for the transport between Okondjatu and Okakarara. The majority of the people in Goblenze and Okondjatu are not employed. Most of them survive on the few domestic animals they are having. For them N$ 30.00 for hike plus N$ 24.00 for the hospital user fee = N$54.00 is too much. They feel that they cannot afford to pay that amount of money, because most of them are not working and do not have any kind of income.

The Goblenze clinic has not had an ambulance since 1996, after the ambulance was involved in an accident and was written off and was never replaced. The ambulance of
Okondjatu clinic was transferred to Okakarara hospital at the beginning of 2002, due to the shortage of transport at the hospital.

The study participants who deliver all children in Okakarara hospital mentioned also that one of the contributing factors is long distances from the village to the main road. They also mention the lack of communication. In order to communicate with someone who owns a means of transport, one has to send a person on foot or bicycle. By the time the transport arrives, a woman has already delivered.

The study participants who delivered their last child outside Okakarara hospital responded that they are not allowed to deliver at the clinics. Although when they arrived there on time the nurses at the clinics tell them to proceed to Okakarara hospital or somewhere else, due to the fact that they are not allowed to conduct a normal delivery, only the emergency deliveries. Some women who do not have enough money then go back home and deliver there or some opt for Grootfontein hospital (60km) from Goblenze. ‘We know that Grootfontein is not our district, but some of us make use of Grootfontein hospital because the transport fee is minimal, N$ 15.00 and there is a regular transport. You see, sometimes it happen that you deliver in Okakarara hospital, but the transport back home is a problem, you will stay there for weeks looking for transport and the nurses some times use rude words against you like: ‘Some people are afraid of going back to their homes because there is no food to eat’.

Goblenze and Okondjatu clinics are situated approximately 100km from Okakarara hospital. Most of the villages around these clinics are some 30 – 40 km away. Some pregnant women are forced by the situation to walk on foot to the nearby clinic/hospital.
The participants who delivered the last child outside Okakarara hospital also proceeded to say that the other contributing factor is lack of relatives and friends in Okakarara town. “When you are told to go to Okakarara, where are you going to stay if you do not have relatives or friends there? The Okakarara hospital does not make provision of waiting homes like at Onandjokwe and Engela hospital. Even the pre-natal care room is only for those who have problems like, swollen legs!”

Pregnant mothers who do not have relatives in Okakarara are forced to deliver at other towns where they have relatives or friends.

Another issue seen in the literature as a barrier to care is user fees (Stekelenburg 2004; Uyiworth 1997). Both group’s participants were asked if they have a problem with the payment of user fee for delivery services. No one was having a problem in both group’s participants. The reasons given were that they are aware that the medicines they receive in hospital as well as the food are very expensive and the user fee was minimal. They feel that it is their obligation to pay the service fee, although sometimes some women do not have the money to pay.

Participants who did not deliver the last child in Okakarara hospital concluded: “Even if you do not have the money to pay, the nurses do not chase you away; they will help you and tell you to pay when you get the money”

4.2.2.1.2 Availability of TBAs

The study participants who delivered all their children in Okakarara hospital mentioned that they are aware of some TBAs in their areas and some other relatives who can assist during home deliveries. However when they were asked what services they were
providing, one participant responded: “I heard that they deliver babies and treat women after deliveries. That’s all I can say.” According to the participants who deliver all the babies in Okakarara hospital it seems that they do not possess knowledge on services provided by the TBAs, apart from delivering babies.

Some of the participants who delivered the last child outside Okakarara hospital responded on the availability of TBAs that they know many of them as well as family members who assist pregnant women during home delivery. They mentioned that it was not really their wish to deliver at home but they do, due to the unavoidable circumstances. They mention the services provided by the TBAs as provision of ANC and delivery services.

The TBAs or relatives in Namibia, who know how to conduct a home delivery, are working in isolation. A relative may conduct alone the delivery of her daughter or her sister’s daughter and a TBA mostly conduct delivery services for any one in the community against a minimal fee or being paid in kind.

Some of the study participants who delivered the last child outside Okakarara hospital seem not to support the services of the TBAs although they are delivered by them. They feel strongly that every woman should deliver in a hospital. “I deliver at home, assisted by a TBA just because there was no transport available to take me to the hospital.”

All participants who delivered all their babies in Okakarara hospital seem not have interest in TBAs. They do not know what services they are providing, apart from delivery services. They feel strongly that every woman should deliver in hospital without any exception.
4.2.2.2 Service related factors

Service related factors such as availability, quality care of services and attitude of the staff could affect a woman’s decision to utilize MCH services.

4.2.2.2.1 Availability of delivery services

The participants who delivered all their children in Okakarara hospital mentioned that the availability of delivery services is a matter of concern: “I deliver in the hospital just because I was given money by my aunt for the first delivery. For the last delivery I came to Okakarara before time and stay with my relatives till the day I was taken in for delivery. I was told by the nurse at Okondjatu clinic that they are not conducting delivery services, only emergency deliveries. Why?”

It seems that, although all the participants who deliver all their children in Okakarara hospital, did deliver there, but not without difficulties. They struggle to get a transport from the rural areas to Okakarara hospital, some struggle to acquire money, etc. They suggested that delivery services should be expanded to all outlying clinics: “What is the problem to expand the services to the clinics if all the clinics are manned by registered nurses who are qualified in midwifery?”

For those who delivered their last child outside Okakarara hospital, their future seems bleak. “For the first pregnancy, my brother gave me some money to go to Okakarara for delivery. My sister was staying there. There was no problem, I deliver in the hospital. My dear, the last pregnancy, I was given some money by my boyfriend but there was no accommodation for me in Okakarara because my sister who was there is now staying in Windhoek. Heeee … and the clinic is only one kilometer from my house. I get a transport
to Grootfontein and delivered there!” One participant: “This clinic without delivery services is just a wasting of time. Is it greatly difficult for the nurses to conduct delivery services here? I deliver my last born at home because when I came to the clinic the nurse told me that I will deliver only the next day and I should look for transport to go to Okakarara. I was having money for transport but I know that it was too late to go to Okakarara, so I went back home and my mother assisted me to deliver my baby.”

The Policy on Maternal Health Services in the Ministry of Health and Social Services stipulated the services that should be executed by various levels in the Ministry. The policy stipulated that all delivery cases should be conducted at the hospitals where there are doctors as well as all life saving equipment. The clinic should conduct only emergency deliveries when a woman came to the clinic ‘head on perineum.’ Therefore each remote clinic was provided with a maximum of two delivery packs for emergencies deliveries only (Policy: Maternal Health Care Services 1993)

Concerning the transport, the Okakarara hospital is experiencing a shortage of transport due to the regular break down of the old fleet of ambulances. Pregnant mothers are advised at the ANC to go to Okakarara to the relatives and wait for the time, in order to deliver in the hospital. However, pregnant women with complication who need hospitalization are being collected at clinics by the ambulance and admitted in the pre-natal care ward.

4.2.2.2.2. Previous experience

The participants were asked to recall their experience in the maternity ward and whether they will deliver again in Okakarara hospital if they happen to get pregnant again. The
participants who deliver all their children in Okakarara hospital mentioned that the reception they get from the nurses was good; the atmosphere in the delivery room was conducive, the food was of a good quality the place was very clean and they get medicine as prescribed by the doctors and all of them wish to deliver again in Okakarara hospital:

“When my mother brought me in, the nurses was so friendly and assure her that her daughter is in good hands. They show me the bath rooms and toilets and give me a bed. When the pain gets stronger I was transferred to the delivery room that was very clean. They assisted me well till I give birth to my baby. They put her on my breast, yaaa… this happen for both of my children. I will deliver again in Okakarara hospital if I become pregnant again.”

The information indicates that the nurses behaved professionally and gave support and assistance to the patients. One participant: “After delivery, I was bleeding profusely. I call the nurses, they come quickly, and they call a doctor ... Ooo, I was so happy. However I overheard a nurse screamed to a woman ... who looks poor and dirty I think they respect some women only.”

After a long deliberation it comes clearly out that some nurses are good and some are bad. The nurses also treat well those who they know or know their relatives,” When I was admitted, I ask a nurse to show me the bath room. She shouted at me ‘Is it for the first time you came here or you are just ignorant?’ Later when she was giving us medicines she looks on my file and sees my father’s name. My father is a principal, then she start to greet me in a friendly way and she suggested that when the contractions gets stronger I should call her and she gave me her name.”
The information gives an impression that the nurses discriminate against those who are known and those who are not known or between the poor and ‘well to do’s.’ When the participants who delivered all their children in Okakarara hospital were asked whether they or their relatives were known to the nurses, they answered “yes” On the question whether they will deliver again in Okakarara hospital all them indicated the willingness to deliver there, because they did not encounter any problem, in this regard, with the nurses.

The participants who delivered the last child outside Okakarara hospital have another story to tell. They said they experienced lot of problems in the hospital. Most of them were not known by the nurses, neither their relatives. They indicated that nurses sit most of the time at the nurses’ post and do not give attention to the mothers. When the pain starts and mothers are looking for nurses, they are nowhere to found, that is why some mothers deliver alone due to the absence of the nurses in the maternity ward. “I was admitted at 15H00… I forget the date. By 17H00 the pain gets stronger and I call the nurse. She does investigations and tells me that I will deliver maybe after 3 hours. The pains get stronger and stronger and I call her again. She was alone in the ward. She ignored me and I saw her leaving the ward. There was no way; I just deliver there… assisted by two mothers. When she comes back she was very angry, shouted at me and calls me a fool. That is the reason why I deliver my last born at home where I were assisted professionally by my mother” One participant: “I was treated badly by the nurses. It was my first pregnancy. I was still young. In the delivery room … I was told to push. I push… and push……and push. The nurses were shouting at me. One of the nurses beat me between the thighs and another nurse claps me in the face…. At the end I deliver
my baby. Those nurses... They are not human beings. I deliver my last born in Otjiwarongo hospital. The nurses were very friendly and assisted me very well. I was happy with their services.” During the discussions it came clearly out that the study participants who delivered their last child outside Okakarara hospital were not known to the nurses, nor their relatives. This emphasizes the fact that discrimination may be an issue in this regard. It also has come out that the nurses do not have time to listen to the concerns of the mothers; apparently they are always very busy. However the mothers noticed that most of the time they are just discussing private issues or listening to the radio.

The majority of the study participants who did not deliver the last child in Okakarara hospital indicated that they will never deliver in Okakarara hospital again. They express the dissatisfaction of the services they received compared to the other hospitals or by TBA’s.

4.2.2.2.3 Attitude of health workers

The participants were asked to describe the attitude of staff at the maternity hospital. Some of the participants who deliver all their children in Okakarara hospital express their satisfaction with the attitudes of the staff, “The nurses are friendly and rendered satisfactory services. They answered all questions.... They are good, they are wonderful people.” Some study participants did not encounter any negative behavior of the nurses, nor the doctors. They indicated the willingness to utilize the delivery services in Okakarara hospital in future. However some said, “Myself, I did not encounter any negative of strange behavior of the nurse and doctors. They were very helpful and fulfill
their work with pride, but I see and listen to some of them who were shouting other mothers for nothing. I think I will conclude that some nurses are good and some are bad.”

The participants who delivered the last child outside Okakarara hospital were having negative perceptions on the attitude of nurses according to the behaviors of the nurses while in maternity ward: ‘They treat people like animals, they don’t have respect, and I think that is the reason why most of the women deliver at home or go to other hospitals like Otjiwarongo or Windhoek.” Another one said: “Some nurses do not have respect and some have. Some of them will greet you, some not. I think this is the case at all hospitals.”

During the discussion it came out clearly that in general, at all hospitals there are good nurses and bad nurses, however the majority are always the good ones as in the case of Okakarara nurses.

It was evident from both the study participants that nurses are not behaving the same way. There are those who has respect and treat the patient with respect and there are those who are rude and do not show any respect to the patients. They are seen as unsupportive and unresponsive to patient needs.

4.2.2.2.4 Quality of care

The participants who delivered all their children in Okakarara hospital seems to be happy with the treatment received in the maternity ward: “I was happy with the treatment I received in maternity ward. My baby was cleaned and was put on my breasts... I was shown how to breast fed because the baby was my first born. The baby was immunized
and I receive the Vitamin A, after birth”. One said: “The nurses are very competent when they execute their duties. When they inject you, they take you to the injection room, privately and inject you. You won’t even feel the pain of the injection. If they give medicine they explain to you the purpose of the medicine and again before they discharge you the call a meeting with other women and give some lectures on Aids and personal hygiene. When you ask questions, they answered you very professional.” However, some of the participants were not very happy with some issues like shortage of nappies and some antiseptics like Savlon lotion. “Well... the care we got from the nurses, with available resources, is excellent... but there are some issues that needs improvement; like the shortage or some times lack of nappies and antiseptic liquids like Savlon.”

The participants who did not deliver the last child in Okakarara hospital describe the quality of care in the maternity ward as not satisfactory: “Point number one... I do not understand Afrikaans or other languages... like English, but the nurse talk to us the languages we do not understand. Look, not all of them, but some. Point number two, myself I came to hospital to be assisted with the delivery, but because the nurses are full of nonsense, I deliver alone, alone... in the hospital! Again there were no nappies for my baby. The nurses asked me if I brought with me the Savlon and Spirits. What is that? Hmmm, tell me!” One participant: The nurses lecturing us in English. Who understand the language? They talk only about Aids...Aids all the day! What about family planning or maybe the immunization of our children... they think we have Aids... What about their husbands... we know them.... Anyway, the hospital... no soap... no toilet paper, and the food? How can they give us meat? We need more soup and more milk and tea... we pay for that?”
Participants who delivered all their children in Okakarara hospital brought along the necessary commodities e.g. Savlon because they are not complaining while those who delivered their last child outside Okakarara hospital did not bring because of possible poverty and lack of information.

Both groups’ participants do not like the idea of being examined by the students: ‘*Three students came in the delivery room. Every one of them put her fingers in... it was so painful. I hear them telling the sister, the registered nurse, I get 5... I get... 3 etc. They went out. In about 5 minutes the pain was so unbearable ... The baby’s head was out ... a student nurse catch the baby without any gloves....*”

It seems that the sister in charge of the students trust the results she got from the students nurses. She did not verify the measurement given to her by the students to make sure how far the cervix dilated. It is not possible for a woman to deliver if the cervix was dilated 5cm – 3cm 5minutes ago.

### 4.3 Suggestions for improvement

Participants were requested to point out areas that need improvement. Participants who delivered all their children in Okakarara hospital mentioned only few suggestions due to the fact that they were satisfied with the services they received. However, participants who delivered their last child outside Okakarara hospital gave more input on the topic due to the fact that they are more affected by the situation.
4.3.1 Ambulance services

Both group’s participants suggested that there is a need for an ambulance to be available, at least at one of the clinics.”  We know that there is a shortage of ambulances at the hospital. I was told that there are 3 ambulances or… I forget, but I think 4 of them… yes! Please is it not possible for the chiefs of the hospital to send only one ambulance to serve all 3 clinics? The ambulance can station at Okamatapati clinic, the clinic in the centre. Please, please… will you tell them? Another participant: “Other option is to send an ambulance from Okakarara hospital to any clinic each time a woman reported here and she is in labor. Other district hospitals are sending ambulances to collect women in labor at clinics… why not Okakarara! (shouting)"

A consensus was reached by both group’s participants that they propose that the ambulance should be sent from Okakarara hospital to collect any woman who is in labor and who cannot afford to pay a public transport.

4.3.2 Delivery services at clinics

The participants who delivered their last child outside Okakarara hospital suggested that due to the fact that each clinic is headed by a registered nurse any normal delivery should be conducted there: “We are suffering. We know the importance of delivering in a hospital, but what should we do if we do not have the means to travel to the hospital? Is it really difficult for the nurses to conduct all deliveries at the clinic? Hmm… what is the problem… They are qualified… so what. This government also… a… let me not politic! Any how, please tell them, we want to deliver at the clinic, near to our people, not at the hospital were the nurses do not have the respect… (angrily) One retorted: “By the way,
why did the hospital managers allocate each clinic with a midwife? Is she there only for emergency deliveries? If so, all women will from now on go at the last minute so that they will deliver as emergency cases...(laughing). The fact is; we want all normal deliveries to be conducted at the clinic, please...please...please!” (the whole group laughs)

The feeling of the group was that midwives at clinics should start with delivery services at clinics, because the hospital is very far and they are trained to do the job.

Participants who delivered all their children in Okakarara hospital did not comment on the issue of deliveries at clinics. “That’s not our problem. We are happy”

4.3.3 Maternity waiting home at Okakarara hospital

Participants who delivered their last child outside Okakarara hospital supported strongly the idea of the maternity waiting home at Okakarara hospital: ‘Some of us do not have relatives in Okakarara and is very difficult to stay at somebody’s house that you are not very familiar with. The idea of the maternity waiting home at the hospital is very good. I have seen one at Onandjokwe hospital” Another participant: “I am supporting the idea. Let us hope our dream will become true so that women who are staying far can come at least some days before the onset of the labor, and I am telling you, no one will deliver at home…! (excited).

Participants who delivered all their children in Okakarara hospital also indicates that it is necessary to have a maternity waiting home. One said: “Who knows? Maybe one day one of us will need it…life is like a wheel… (laughing).
Both group’s participants feel that a maternity waiting home is very important and will alleviate the accommodation problem of women who do not have relatives or friends in Okakarara.

### 4.3.4 Negative attitude of health workers

The majority of the participants who delivered all their children in Okakarara hospital have no problem with the attitude of health workers. One participant: “Their attitude is acceptable because they respect the mothers, what more do you expect from them?” Another one: “Not all of them are good. For the good ones, fine…… but those who have bad attitude they have to change!”

The participants who delivered the last child outside Okakarara hospital said that the attitude of the majority of the health workers is not acceptable and they should change or they should be disciplined. One participant: “Those nurses are bad…bad, I’m telling you. They suppose to be maybe at…at another planet, not this one! They are there only for money. They should change their attitude, they should respect us…! We are also human being like them… go and tell the matron or who ever, they must respect us and treat us with dignity!... (shouting). Another one: “It is true what you are talking, I hope the matron can dismiss some of this bad things……ah……I am sorry, some of the bad nurses to be an example of the others. They do not have respect and shout at us…….nooooo…they have to change…please inform their chief please!

Both group’s participants have the feeling that human beings can change and if the matron can give them a feedback of their discussions, maybe they will change their attitude and respect the dignity of their patients.
4.3.5 Shortage of certain medications and inadequate supplies.

The participants who delivered the last child outside Okakarara hospital said that there is always a shortage of some medicines and supplies and this problem need to be solved once and for all. *Since I start to deliver my children 6 years ago in Okakarara hospital, each time I was told: there is no Panado for pain, did you bring your toilet paper? And your soap and this and that...nooooo...nooooo, please! We are paying the required fees...so what is this? Please, something should be done. The in-charge of the maternity ward should make sure that medicine and other supplies should be available always!*”

Another one:” *About the food, my dear, the food is not tasty... and is always meat and porridge... no... please, let them give the lactating mothers at least milky porridge and more juice and tea and coffee as many times as they can, because the lactating mothers need more of this than meat……(laughing)*”

The participants who delivered all their children in Okakarara hospital mentioned that they are satisfied with the services. One said: “*When I go for delivery, I take with me the Savlon, Spirits and other things and my family brought food... no problem so far*”. The group agrees.

4.3.6 Collaboration with TBAs

The participants who delivered the last child outside Okakarara hospital expressed their feelings that TBAs are very important people in the community and should be recognized and supported by the health sector. One participant: ‘*Without them we could have not been survived. Our life is in their hands. The hospital is too far, that’s why we shall continue to use their services. The only thing I want to stress is that the health workers*
should visit them, train them and give them things like scissors and cords so that they can work very hygienic” Another participant: “Health workers should give them recognition like batches or at least a certificate so that they can feel proud for what they are doing for us. I want to add on what the previous speaker had said that things like Savlon and spirits should be given to them …please!”

The participants who delivered all their children in Okakarara hospital also mentioned that TBAs should be supported by the health workers. “They can give them training on hygiene and supply them with blades etc.”

It comes clearly out that those participants who delivered the last child outside Okakarara hospital experience more problems with the health system than those who delivered all their children in Okakarara hospital. This was proved by the suggestions for improvement by both groups. Judging from the recommendations made by both groups the conclusion could be made that they would like to see the improvements in maternal health care services in the district.
CHAPTER 5. SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

The previous chapter dealt with the results of the study and the interpretation of the study results. This chapter gives a summary of the major research findings and relates them to relevant literature. Conclusion and recommendations are drawn from the main issues arises through out the study.

5.1 SUMMARY OF FINDINGS

The summary of the findings as based on two of the main themes that were identified according to the research objectives and research questions;

- knowledge on the importance of delivery in a hospital and
- discussions on the contributing factors to the low utilization of delivery services in Okakarara hospital.

The third theme: recommendations for improvements in maternal health services will be reviewed later in this chapter.

5.1.1 Knowledge about the importance of delivering in a hospital

It has come out very clearly that the majority of participants; those who deliver all their children in Okakarara hospital and those who deliver the last baby outside Okakarara hospital feel strongly that every woman should deliver in a hospital in order to reduce maternal and perinatal deaths.
In developing countries, 53% give birth with a skilled attendant compare to 99% in developed countries (Safe Motherhood 1998). In surveyed countries of Eastern Europe and Central Asia, nearly all women deliver with the assistance from the skilled attendants. In developing countries surveyed, however, skilled attendants are present at an average of only about half of births.

Studies suggested that having skilled attendants present at delivery is one key intervention for reducing maternal and perinatal mortality. Three countries (Egypt, Honduras and Yunna, China) have successfully reduced the maternal mortality ratio from around 100 in less than a decade by introducing comprehensive referral facilities, increased access to skilled attendants and community birthing centers to augment health facilities (Koblinski 2003).

Similarly different models of maternity waiting homes exist in countries like Bangladesh, Cuba, Indonesia, Malawi and Mozambique. The purpose of maternity waiting home is to provide a setting near the skilled care where a woman can stay in the final weeks of pregnancy in order to deliver in a health facility (Fortney 1997).

A study done in Nankudu, Namibia on Health Seeking Behavior revealed that women who deliver in a health facility are 2.81 more likely to believe that that every woman should deliver in a health facility than women who deliver at home. The study also shows that a majority of women, 83.8%, reported the need for every woman to deliver at the health facility, but also sometimes hospitals runs out of stock of some medicine which makes the situation the same as to deliver at home.
Concerning the treatment of other diseases all participants who delivered all their children in Okakarara hospital express their appreciation of delivering their babies in hospital, due to the fact that they were satisfied with the treatment and they did not encounter problems with the delivery services.

This is in line with an innovative safe motherhood project conducted in Zhezkazgan, Kazakhstan (*Making Pregnancy safer* 2003). The aim was to modernize and to improve quality of care for women and newborns and to increase satisfaction among women and their families. As an example of results during the in-depth interview with Gulshyan, aged 32, on the birth of her second baby, she concluded that the quality of service was up to standard.

On the issue of the handling of complications, the participants who delivered all children in Okakarara hospital view the hospital as the only place where all the complications can be managed effectively and efficiently. Out of their experience the nurses and doctors are competent in the execution of their work.

However, participants who delivered the last child outside Okakarara hospital differ in their opinions. The majority feel that the nurses are not capable to handle some complication such as cord prolapse. They suggested that a doctor must be called in such a case. The minority of this latter group felt similar to the participants who deliver all children in Okakarara hospital that nurses are capable of handling the complications.

According to the view of both groups of participants, the doctors are very competent in their work and they should just keep up with the good work.
Concerning the cleanliness of maternity ward and the hospital environment, both groups of participants are satisfied and know the benefits of delivering in a clean hospital. They have also indicated that the maternity ward seems to be bacterial free.

Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can course death or serious illness to the mother or baby (National Safe Motherhood 1991)

About proper care of mothers and detection of anomalies, both groups of participants appreciated the proper care rendered to the mothers in maternity ward. Some of those who did not delivered the last child in Okakarara hospital and delivered at home regretted the home delivery, but said that due to the circumstances beyond their control, deliveries were done at home.

Concerning the proper care of the baby, the assumption can be drawn from the discussions of both group participants that the nurses and doctors do their utmost best to render proper care to the newborn babies.

Essential obstetric care will undoubtedly save a woman’s life and certain antenatal measures will contribute to the reduction of maternal deaths, provided that high-quality essential obstetric care is available (Ronsmans et.al 1998).

5.1.2 Reasons for under utilization of delivery services in Okakarara hospital

De-Brouwere’s (1998) study indicates that lack of access to antenatal care services or a skilled attendant at delivery is associated strongly with high mortality indices. The World Health Organization (1997) estimates that 60% of births in low income countries occur outside a health facility, with 47% assisted only by traditional birth attendants, family
members or without any assistance at all. A number of socio economic, cultural factors and service related factors act as barriers to utilization of health services. This was verified by the results of this study. It was evident from both groups of participants that there are factors contributing to the under utilization of delivery services in Okakarara hospital. Participants who delivered all the children in Okakarara hospital agree that long distances, lack of transport and money are the main contributory factors for under utilization of delivery services. Though they delivered in the hospital, they also experienced the problems of lack of transport and money. However they managed by all means to reach the hospital and deliver there.

Participants who did not deliver the last child in Okakarara hospital feel very strongly that long distance, lack of regular transport to and from Okakarara and the absence of relatives or friends in Okakarara are contributing factors to the under utilization of delivery services in Okakarara hospital. They delivered some of their children in Okakarara hospital except the last ones; some deliver at home and some at other hospitals, based on available resources and circumstances around each delivery that acted as facilitators or barriers to reaching the hospital.

In most Sub-Saharan rural areas, one in three women live more than five kilometers from the nearest health facility and 80% of the rural women live more than 5 kilometers from the nearest hospital. The scarcity of vehicles, especially in remote areas and poor road conditions can make it extremely difficult for women to reach even relatively nearby facilities. Walking is the primary mode of transportation even for women in labour (Safe Motherhood 1998).
This is the same situation in rural Tanzania where 84% of women who gave birth at home intended to deliver at a health facility, but did not due to distance and the lack of transportation (Safe Motherhood 1998).

This is also in line with the Namibia Demographic and Health Survey, that revealed that rural women are at a disadvantage compared to urban women. 39% of women in Namibia are more than 30km from delivery care. 35% are one hour from care and 28% have to travel 2 hours or more. (Namibia Demographic and Health Survey 1992)

This is also supported by a cross-sectional descriptive study to determine the level of use of maternal health services and to identify and assess factors which influence women’s choice where to deliver in Kalabo, Zambia; Stekelenburg (2004) reveals that although 96% of respondents prefer to deliver in a health facility, only 54% actually did. Reasons given were long distances, lack of transport and user fees.

In the study about obstetrics services utilization by the community in Lebowa, Northern Transvaal, the ANC coverage was high, 93.5%, with 74.6% of deliveries occurring in health facilities, while 26.3% were home births. TBA’s were present at 34.8% of home births. Reasons for home delivery included lack of access to health service (19%) and lack of money to pay for the services (Uyiworth 1997)

Hospital user fees are another potential barrier to health services. Although this did not seem to be the case in this study, as participants felt an obligation to pay and also stated that the nurses would not “chase you away” if they did not have the money. This was also supported by the Circular No 9 of 1996, from the Office of the Permanent secretary in the MOHSS that no patient should be refer back home on the ground of lack of user fee. However, combined with the high transport costs, it may be prohibitive for some women.
With regard to the availability of TBAs, participants who deliver all their children in Okakarara hospital seem not to have an interest in them. The majority indicated that they did not know of their existence, or of the services they are providing, besides the delivery services.

This is contrary to a study that was done in Kano, Nigeria during October 2000 to identify socio cultural and economic factors associated with low utilization of ANC and hospital deliveries. Most women in the district delivered at home with the assistance of family members. The most frequent reason given was ‘it is easier at home’, an explanation that accounted for 26.2% of the responses. Almost all the women interviewed expressed their desire to deliver safely at home within the privacy of their rooms and in the company of their relatives who could understand their situation. Hospital delivery was seen as the unavoidable alternative; that is, unless it was absolutely necessary, women in the study area would not want to deliver elsewhere but at home.

Different from those who delivered all their children in Okakarara Hospital, the majority of the participants who did not deliver the last child in Okakarara hospital are aware of the existence of the TBAs in their area. They also know exactly the service package they are offering e.g. to provide assistance during deliver and post partum care.

Regarding the knowledge of the availability of the TBAs, a cross sectional analytical study on Health Seeking Behavior Related to Poor Utilization of Maternal Health Care Services (MHCS) that was done in Nankudu district, Namibia during 2000, Namibia Demographic and Health Survey, 1998, revealed that knowing if a TBA is in the area is
associated with place of delivery. Women who deliver at a health facility are 1.52 times more likely not to know of a TBA in the area. The study also revealed that services provided by TBAs, other than delivery, were reported to be the provision traditional medicines, ANC and palpations. Another study on the availability of TBAs was done in Okakarara during 1991. The result reveals that 86.8% and 88.2% of mothers attended ANC and delivered respectively by the TBAs. (TBA Survey 1995).

This is in line with a study done in Kano, Nigeria WHO (1996) to identify socio cultural and economic factors that associated with low utilization of ANC and hospital deliveries. The results of the study reveal that 88% (CI= 81.8% - 94.2%) in the study area did attend ANC and that 96.3% (CI= 93.0% - 99.6%) had delivered or plan to deliver at home without a skilled attendant.

Traditional births attendants have a role in supporting women during labour, but generally are not trained to deal with complications. Because most “trained” TBAs have had one month or less of training, they are not defined as skilled attendants. Studies in Africa and Asia have found that training of TBAs in the absence of skilled back-up support did not decrease women’s risks of dying in childbirth. However, TBAs can contribute to reducing newborn deaths and disabilities, and play an important role in providing assistance during antenatal care and delivery. TBAs can offer pregnant women much-needed moral and emotional support. (Safe Motherhood 1998)

Similarly, this is in line with the results of the study conducted in Nankudu, Namibia that revealed that services provided by TBAs, other than delivery, were reported to be the provision of traditional medicine, ANC and palpations.
The participants who delivered their last child outside Okakarara hospital express their feeling that TBAs are very important due to the fact that their absence means their death and the death of their babies and they want them to be trained to conduct their services hygienically.

This is in line with De-Brouwere (1998) that speculation about the cost and effectiveness of programmes to train TBAs has led to their widespread abandonment, despite an absence of trial evidence. Absence of evidence of effect is not evidence of absence of effect. A recent meta-analysis of 60 studies showed that training TBAs was associated with significant improvement in performance and mortality. Bang and colleagues showed a 62% reduction in neonatal mortality in Rural India through a community based approach that include training of TBAs and local women to treat sick newborn infants at home.

This supports the idea that primary care strategies can reduce neonatal mortality substantially in areas with high rates, even if institutional approaches are necessary to reduce them further.

Although the majority in both groups of participants indicated knowledge of the existence of the TBAs in their areas, one can conclude that they were seen as alternative health care givers. This is proved by the statement made by all participants that they agree that every woman should deliver in a health facility.

With regard to the service related factors, the participants have various opinions. Concerning the availability of delivery services, all participants in both groups indicated the availability as a matter of concern because the hospital is very far. Nurses at the clinics are not allowed to conduct delivery services, apart from the emergency delivery.
Unfortunately, this is in line with the Policy on Maternal Health Care Services that no delivery services are allowed to be conducted at clinics, only emergency delivery. All deliveries should be conducted at the hospital. However participants are not happy with the content of that specific policy and suggested the revision of the policy if possible. However, policies are formulated by a “task force” at national level, not at district level. Regarding the previous experience on delivery services in Okakarara hospital or elsewhere, participants had different opinions.

Participants who delivered all their babies in Okakarara hospital indicated that their experience in the hospital was good because they were treated as human beings; their dignity was respected. Participants who did not deliver the last child in a hospital mentioned that they were treated like animals. They were shouted at and did not get support from the nurses. It emerged in discussions that the nurses were practicing discrimination. Those who are known to them or seem to be from higher class levels are treated well and the unknowns and those from the lower classes are treated badly. This resulted in some of them to taking a decision not to deliver again in Okakarara hospital.

This is supported by the findings of the study in Nankudu, Namibia, 1998 that previous child-bearing and experience with health care system can have an impact on the health seeking behavior of a woman. It can have an associated effect on her future utilization of maternal health care services at the facility.

Concerning the attitude of health workers, the majorities of participants who delivered all their children in Okakarara hospital expressed their satisfaction with the attitude of the staff; nurses and doctors and indicate the willingness to utilize the services again if they happen to become pregnant. However some of them, although they were treated well,
witness how some nurses were rude towards some of the patients, particularly those from the lower class.

Participants who delivered the last child outside Okakarara hospital strongly agreed that most of the nurses are very rude with bad behaviors. They do not show respect to their patients. They discriminate against those who are not known or seem to be not from the upper class. Some of the participants mentioned that the reason why some women deliver at home or at other hospitals is because of the rudeness and bad behavior of the nurses.

This was found similarly in a study conducted in one hospital in South Australia to determine the characteristics of a sample of women giving birth and these women’s perceptions of usefulness of the service and care that they were given during postnatal period. The study results revealed women’s view of midwives’ attitudes being insensitive (8%) and judgmental (9%). Midwives were unhelpful (40%) and gave conflicting advice (10%). Positive perceptions were in relation to midwives giving emotional support (57%), answered questions (32%) and gave health education (30%) (WHO, 1997). The implication of the results on midwifery practice was that contact with midwives in the early postnatal period is ideal for support and advice, though midwives were not always perceived as fulfilling this part of their role. This is also justified by the findings of the study conducted in Bangladesh that reveals that one of the reasons why the mothers are not using the maternal health services is the unconcerned attitude and rude behaviors of the nurses (Fortney 1997).

This was similar to a study about obstetrics services utilization by the community in Lebowa, Northern Transvaal (Uyiworth 1997). It was found that reasons for home delivery includes negative staff attitude (12%) and precipitate labour (7.2%)
However, there was recognition that poor behavior was an individual and not a systemic issue. It was agreed that the majority of nurses have acceptable and positive attitudes.

Concerning the quality of care in the hospital, the majority of the participants who delivered all their children in Okakarara hospital were impressed by the quality of care in the maternity ward. The nurses gave attention to the mothers and support them wherever they need support. However, some participants indicated that although they are satisfied with the services, there were not satisfied with the shortage of some crucial items like Savlon and nappies for the babies.

Participants who delivered the last child outside Okakarara hospital were not satisfied with quality of service at all. They complain about the language used during health education sessions; English. Most of the mothers do not understand it and there was not someone to interpret. They complain also about the low quality of food, lack of toilet papers and soap in the maternity ward. The main complaint was the incompetent nurses who cannot perform their duties to the required standard.

In my opinion, there was a lack of communication between the nurses and the mothers. If the nurses could have explain about the reasons why there are no toilet papers or soap, in a language which the mothers understand, in a good manner and with respect, for sure, women could have understand and take it easy.

Women should be provided with appropriate and specific information on relevant issues. This should be in a language that the client can understand (Safe Motherhood 1998)

The quality of care is determined not only by technical capacity, but also by cultural appropriateness, and the dynamic interaction between clients and providers. WHO and other key partner support improving provider interactions, with women, men and
community as a key element of quality. Further, different studies have shown that improving provider’s interpersonal and intercultural competencies can influence compliance with care, women’s knowledge, perceptions of quality of care and use of service. All health workers should be aware of the importance of good communications, that good counseling is also a lifesaving skill, that intercultural and interpersonal competencies increases the use of services, that communication and health education functions are not separate or less important than their more clinical functions. Increased awareness and change in provider’s practices can result in providing “care” to women and newborns rather than just “curing”. (Making pregnancy safer 2003)

Similarly, an exploratory, descriptive study, which was undertaken to determine utilization of a Midwifery Obstetric Unit (MOU) in a South African Metropolitan area, verified this. The investigation revealed that the community was not utilizing the MOU because of negative attitude of nurses, lack of material and human resources, poor safety and security measures and lack of community involvement and participation. The study clearly showed that community involvement and participation in planning services to be offered is important. Clients may offer suggestions that may prove to be useful and if they are involved may be more inclined to utilize a service. (Jewkes 1997)
5.1.3 Suggestions from participants

It has come out very clear that the participants who deliver all their children in Okakarara hospital did not give much input on the suggestions for improvement. It can be assumed that most of them are from the high class. They have no problems with transport or money and they are known to the nurses.

Participants who delivered their last child outside Okakarara hospital gave valuable suggestions. One gets a feeling that these women feel that they are left out and want to see the improvements in the health service in general and in maternal care in particular. Some of their suggestions are included in the recommendations of this study.

5.2 CONCLUSION

This study was about the assessment of the women’s knowledge on benefits of delivering in a hospital, the barriers to delivery services and the perception of the delivery services rendered in the maternity ward, Okakarara hospital. It is evident from the findings that the pregnant women know and appreciate the benefits of delivering in a health facility though sometimes they find it difficult to access delivery services due to the socio-economic and service related factors.

According to the literature review, major barriers to the under-utilization of delivery services includes long distance, lack of transport, poverty, poor quality of care and negative attitudes of the nurses. This was also verified by the findings of this study as major barriers in Okakarara district.
The majority of the participants were satisfied with the services although there are some issues that need the district manager’s attention. It is therefore hoped that through the participant’s suggestions and study recommendations, tangible solutions can be found and implemented in order to remedy the situation before it gets too late!

5.3 RECOMMENDATIONS

Various issues arose from this study and in light of the results, the following are the recommendation:

1. The District Co-coordinating Committee should recommend to the national level to consider revision or amendment of the Policy on Maternal Health Care Services, particularly on the section that forbid nurses to conduct normal deliveries at clinics.

2. Increase the re-distribution of ambulances, and assess and revise the transport policies. (Improved ambulance availability may increase feasibility of the first recommendation)

3. In order to assure high quality care, maternal health services should be evaluated on a monthly basis, from both service provider and women’s perspectives, and improved as needed.

4. Health workers should provide comprehensive, respectful and non-judgmental care that is responsive to women’s needs. The supervisors should give quarterly in service training to all health workers on patient charter, interpersonal and communication skills as well as ethics of nursing. They should also develop an exit assessment form to be filled by the mothers on discharge.

5. Women should be seen as partners in health care and active participants in protecting their own health.
6. For the women who do not know the hospital/maternity ward structure, they should be physically oriented to the place of delivery before they go into labour.

7. Student midwives should work under close supervision when dealing with a woman in labour.

8. The maternity waiting home should be considered as a matter of urgency. Due to the financial implications involved, a room in a hospital or at nurses home can be allocated for this purpose for the time being.

9. Community Education and Mobilization should be strengthened so that women and their families should learn about the need for special care during pregnancy and childbirth. Such education must include how to recognize obstetric complications and when and were to seek help and should be in a language that the women and their families can understand.

10. The linkages between health workers and traditional birth attendants should be improved by establishing partnership and clear roles through training, monitoring and supervision of TBAs.

**5.3.1 Future Research**

It will be important to verify and contextualize these results. Additional research is recommended:

1. A follow up study of this nature as the current study, on a wider scale using individual interviews covering more maternity units within Otjozondjupa Region.

2. A study similar to the current one, to obtain views from the key informants for example; traditional birth attendants and community members.
3. To conduct a study to identify the constraints faced by the midwives in delivery of antenatal care, delivery and postnatal care and to obtain their suggestions for improvement.
6. REFERENCES


Fortney, J 1997 *Ensuring Skilled Attendant at Delivery: Research Triangle*, Family Health International, NC.


Potter, JW 1996, *An Analysis of Thinking and Research about Qualitative Methods* Lauren Erlbam, New Jersey, pp. 6-7


ANNEXURE I: INTERVIEW GUIDES.

A) INTERVIEW GUIDE FOR GROUP I. (All children delivered in Okakarara Hospital)

KNOWLEDGE ABOUT THE IMPORTANCE OF DELIVER IN A HOSPITAL
1. Is it important that a woman should deliver in a hospital? Why or why not?
2. Are there some situations where it is ok or better to delivery outside the hospital? If yes, what are they?

FACTORS/REASONS CONTRIBUTING TO UNDER UTILIZATION OF DELIVERY SERVICES
3. In your opinion what makes women not to deliver in health facilities? Probe regarding issues such as distance, transport, expense, cultural factors etc.

PREVIOUS EXPERINCE AND QUALITY CARE OF DELIVERY SERVICES
4. Why did you deliver all your children in the hospital?
5. Briefly, explain the treatment you received in the maternity ward.
6. Will you deliver in Okakarara hospital if you get pregnant again? Why or why not?
7. Do you think the treatment you receive will have an impact on your decision where to deliver if you become pregnant again?

HEALTH EDUCATION
8. Describe health education you received while you were in the maternity ward for your deliveries. Where you satisfied with the education you received?

SUGGESTIONS FOR IMPROVEMENT
10. How would you like to be treated by the health staff?
11. How would you improve services in maternity ward?
B) INTERVIEW GUIDE FOR GROUP II. (Last child not delivered in Okakarara hospital).

KNOWLEDGE ABOUT THE IMPORTANCE OF DELIVER IN A HOSPITAL
1. Is it important that a woman should deliver in a hospital? Why or Why not?
2. Are there some situations where it is ok or better to delivery outside the hospital? If yes, what are they?

FACTORS/REASONS CONTRIBUTING TO UNDER UTILIZATION OF DELIVERY SERVICES
4. In your opinion which factors makes women not to deliver in health facilities? Probe regarding issues such as distance, transport, expense, cultural factors etc.
5. Where did you deliver your last born?
6. Why do you deliver some children/child in the hospital and the last one outside Okakarara hospital?

PREVIOUS EXPERINCE AND QUALITY CARE OF DELIVERY SERVICES
7. Briefly, explain the treatment you received in the maternity ward.
8. Briefly, explain the treatment you received where you deliver your last born.
9. Do you think the treatment you received at Okakarara hospital in previous births had an impact on your decision where to deliver?
10. If you become pregnant again where will you plan to delivery?

HEALTH EDUCATION
11. Describe health education you receive while you were in the maternity ward. Where you satisfied?

SUGGESTIONS FOR IMPROVEMENT
12. How would you like to be treated by health staff?
13. How would you improve services in maternity ward?