Author's response to reviews

Title: Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana

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Version: 3 Date: 13 October 2005

Author's response to reviews: see over
13th October 2005

BMC Public Health (ISSN 1471-2458)
BioMed Central Ltd,
Middlesex House,
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London W1T 4LB, UK

Dear Editor,

Re: Please understand when I cry out in pain: women’s accounts of maternity services during labour and delivery in Ghana

I am pleased to re-submit the manuscript entitled " Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana" for consideration in BMC Public Health. This manuscript has been revised in response to three peer reviews. In accordance with your procedures, please find attached a point-by-point response to each review. We have re-iterated, verbatim, the reviewers’ comments with our responses and an indication of how and where the point has been addressed in the manuscript in the following pages.

The manuscript has been prepared in the format required of your journal and submitted using your web-based system. No conflict of interest is anticipated by any of the three authors. Sources of funding for the work done are acknowledged in the manuscript. The article has not already been published and is not being considered for publication elsewhere.

I have sent the article to you in Word format. I hope you will find the article suitable for consideration.

Yours sincerely

Lucia D’Ambruoso

Attached: Response to Reviewers Reports #1-3
Response to Reviewer’s report #1
Reviewer: Ana Langer

Major Compulsory Revisions

1. Background
• The introductory discussion does not include a clear reference to the importance of skilled attendance for the reduction of maternal complications. Such a reference is essential, especially considering that the study focuses on the quality of institutional care.

The introduction of the revised manuscript (paragraph 3, page 3) includes a reference to skilled attendance and the results are discussed within a standard conceptual framework for skilled attendance.

• In the last sentence of the second paragraph, the authors highlight an apparent contradiction in international agencies’ discourse: if maternal deaths are preventable, how come maternal mortality has not decreased in most places? It is important to clarify that there is no contradiction: most maternal deaths could be prevented if all women had access to current knowledge and technologies that, when correctly used, would allow to successfully manage most serious obstetric complications or to prevent them, as in the case of abortion and post-partum infection. In practice, though, women don’t have access to these resources or services and providers are not prepared to use them. In other words, maternal mortality is “avoidable” or “preventable” only in theory.

The reference to a contradiction has been removed and paragraphs 2 and 3 on page 3 now suggest that the lack of reductions in maternal mortality (despite the clinical means to prevent these deaths being well known) is due to the barriers women face in access and quality of services. “Maternal deaths could be prevented if women were able to access and utilise good quality services, especially when complications arise. However, in reality, most women experience serious barriers to accessing services or even if they do reach them, the services themselves are often not of sufficient quality or effectiveness”.

• In the 4th paragraph, authors say that the interpersonal dimension of quality of care has only recently been acknowledged. However, the article they cite was published 15 years ago. Therefore, I would change the word “recently” for a more appropriate one.

Paragraph 1 on page 4 has been changed to state that “considering the perspective of the service-user has been seen to increase the acceptability of services”.

• In the second sentence of that same paragraph, the authors say that “patient satisfaction….has been recently seen to be an effective way of improving services”. I don’t think satisfaction per se is a way to improve services, but a dimension of quality of care that strongly influences acceptability, utilization and compliance and, therefore, affects health outcomes.

Paragraph 2, page 4 now states that “service planning which does recognise and address the influence of the patient-provider interaction has been seen to be an effective means by which to improve the quality of services”. The paragraph continues to state that “in the longer term, this translates into better quality of care and ultimately, improvements in health outcomes”.

2. Methodology
The methodology used by the authors (i.e. qualitative) is appropriate to explore the sensitive issues the study focused on, particularly in a setting where women are extremely vulnerable
and socially disadvantaged. There are some problems in this section however, that I included in the following list:

- Researchers first conducted focus groups, but soon decided individual interviews would work better, both in terms of the amount and the quality of the information collected from women. While this may have been a right decision, authors should reflect on the implications of this change in methodology findings on their findings, and describe how results were analyzed. Did they merge the data? What are the potential problems associated with that? If they did not, do findings described in the following section come only from the interviews? If information was collected and analyzed separately, they should specify the source of information more clearly.

Paragraph 2, page 5 in the methods section now considers the change in methodology. “Changing the methodology during the course of the study from FGDs to in-depth interviews was a reactive way to respond to the unsatisfactory results of the FGDs and maximise upon the opportunity to collect meaningful data. The results of the FGDs were used to develop the in-depth interview guide and were analysed with the results of the interviews. There were some potential problems with this approach. Analysing the FGD and interview data together ran the risk of ‘diluting’ the importance of factors identified in the interviews that may not have been as pertinent in the FGDs. However this risk was deemed to be favourable to the alternative of loss of key issues that arose during the FGDs. In addition, since women were asked in both the interviews and FGDs to consider the same issues, the data was sufficiently consistent. However, during the course of the analysis, we took care to maintain this consideration in terms of the conclusions we arrived at.”

- “Sample size” in qualitative studies is not based on any statistical calculation, but on clearly defined criteria. In the case of this study it would be useful to know the based on which researchers established the number of encounters (either focus groups or individual interviews) and the selection of the participants. Why 21 interviews? Did they recruit women that somehow “represented” the population that attended those health facilities, in terms of age, parity, schooling, and marital status? Not having this kind of rationale undermines the validity of the findings and substantially limits their interpretation. Please provide more detail.

Paragraph 4 page 5 describes how women were recruited to the study. “Women attending antenatal and child welfare clinics and who had delivered with a health professional were included in the study. The opportunity to conduct our study arose during the course of another piece of research that recruited women who had delivered with a health professional in the last five years. The sample of women included in the study we report here was thus opportunistic.”

Paragraph 4, page 6 describes how the number of encounters were determined “transcripts were translated into English, reviewed and coded to identify pertinent themes…The analysis was thematic to draw out the main themes and contradictions. A theme needed to recur in a (non-statistically) significant proportion of the women, to indicate that it was an important issue. When emergent themes had recurred sufficiently, it was appropriate to conclude the interviews as no new themes were likely to emerge (“thematic saturation” had occurred).”

We did not attempt to make the sample representative of the population and the implications of this are acknowledged in the discussion, paragraph 2, pg 14 “despite the internal consistency of the results, the external validity of the findings is low. Although the women involved in the study were broadly comparable with those of the wider population in Ghana, in terms of education and employment, the findings have relevance only to those groups of women involved in the study.”
• The authors recruited women who had delivered within the past five years. This is an extended period of time! I wonder why the authors decided to do that, considering that they could have recruited women who had delivered within a shorter period. As the authors state, women usually remember reproductive events well, but this assertion usually applies to very tangible outcomes such as number of deliveries, live births or abortions. But women do not remember well subjective feelings such as satisfaction with care received. Furthermore, views and perspectives change over time, and are modified by more recent events (for instance, women may have been unhappy with their delivery experience, but if the baby survives a difficult delivery, their perception will change and most probably, when asked, they will not complain about the personal care they received.) I suggest authors provide the rationale for their decision about recruitment, and expand on the strengths and weaknesses of the approach they chose.

Paragraph 4, pg 5 considers the strengths and weaknesses of the choice of recall period “the opportunity to conduct our study arose during the course of another piece of research that recruited women who had delivered with a health professional in the last five years … the five year recall period was originally chosen as women’s recollection of obstetric events even over long periods of time is thought to be accurate and experiences are recalled in great detail. However, this may apply to more tangible events (e.g. number of births or deliveries) and subjective elements (such as feelings and satisfaction) may change over time. While acknowledging the potential for recall bias, we were able to draw upon the combined perceptions of women’s birth experiences over the five year period.” The potential for recall bias is also mentioned in the discussion, page 14, paragraph 3 “there may have been bias in the way respondents recalled subjective events around pregnancy and childbirth, particularly since the recall period was up to five years."

• The authors don’t mention the location where the interviews were conducted. This is important because previous studies have shown that women usually do not feel comfortable enough to express their views in a straightforward way when they are interviewed in the health facility, where they receive clinical care. For instance, more than 90% of women would say they were satisfied with the care received, when asked about it in a hospital. This effect is similar to what epidemiologists call “courtesy bias.” I suggest authors describe where the interviews were conducted, and analyze the strengths and weaknesses derived from those circumstances.

Paragraph 3, page 6 describes where the interviews were conducted and the implications of the place of interview “interviews and FGDs were conducted in various locations – health facilities and women’s homes, the place of the interview being chosen by the respondent. When it did not inconvenience the woman to be interviewed immediately, the interview was conducted in a quiet area in or near the facility. In other cases, women requested that the interviewer visit her at home, and so the interview was conducted there at a later date. Conducting an interview or FGD in a health facility location might have biased some respondents to give accounts of care that may have been more positive, and less reflective, of their true perception. However, it was felt that it was more appropriate, and that this courtesy bias could be minimised, by offering women a choice of interview setting." The potential for courtesy bias is also mentioned in the discussion, page 14, paragraph 3 “There also may have been courtesy bias, women may have felt that expressing negative feelings about their care may have implications for future care. There was an attempt to minimise this bias by allowing the women to choose the location of the interview, but again, the results should be interpreted with this consideration in mind.”

• The authors state that the analysis was “intuitive.” Could they please clarify? Did they use a technique (such as grounded theory), which would justify such an approach? What were the hypotheses they had before starting the study. Please, clarify and expand on this.
The reference to an intuitive analysis has been removed, and the exploratory nature of the study has been expanded and clarified upon. Page 4 paragraph 4 explains how the opportunity for the study arose and how this affected our approach to the investigation. “The accounts of labour and delivery discussed in this paper arose out of a wider study, published elsewhere … During the course of the wider survey, women spontaneously shared their views on delivery experiences and factors were identified that warranted further investigation, prompting us to conduct this exploratory study”. To re-iterate that the study was not undertaken with a specific hypothesis, page 6, paragraph 4 states “The approach to both the data collection and analysis was exploratory and did not pre-suppose any relationship or significance of the factors which were identified. The analysis was thematic to draw out the main themes and contradictions. A theme needed to recur in a (non-statistically) significant proportion of the women, to indicate that it was an important issue.” Finally, the objective of the study is defined in Paragraph 2, page 4 “This study was undertaken with the objective of investigating women’s accounts of interactions in delivery care and to assess their implications for acceptability and utilisation of maternity health care services in Ghana”.

3. Presentation of results

- Researchers mention the age difference between participants in focus group discussions (FGD) participants and individual interviewees, but do not provide any explanation about the reasons that explain this difference, and do not get into the possible implications of this in terms of perceptions.

We do not feel that the age ranges were sufficiently different between participants of the FGDs and interviewees, and in the description of study participants have stated a combined age-range, page 7, paragraph 1 now states “The women included in the study were aged between 18 and 38 years”. However, in the discussion, we do consider how the ages of participants may have affected perceptions. Page 13, paragraph 2 now states “the age range of respondents was 18-38 years. Women of reproductive age (15-49 years) will have been accessing the antenatal and child welfare services where recruitment to the study took place. In addition, women who had had a facility delivery were likely to be younger, low parity women. This may be why the age-range of the respondents fell short of the women of reproductive age-range. The different ages of women may have given rise to differences in perceptions, recollection of care etc, i.e. younger, less experienced patients are likely to have fewer expectations and so be more satisfied with services. By contrast, older patients have been seen to be more satisfied and compliant with care than their younger counterparts … other factors such as wealth and education can also be influential on perceptions. However, despite the socio-economic and demographic differences between respondents, there was a considerable level of consistency in the factors that were identified as determinants of satisfaction, and consequently access to, utilisation of and compliance with care.”

- Furthermore, there must have been other differences between participants in FGD and interviews. Authors should describe and discuss this point.

Since only two FGDs were conducted and women were recruited to the FGDs and interviews by the same method, we do not feel that there are differences between the two sets of participants that warrant discussion.

- Authors should standardize the presentation of their findings and add information on some of the topics. For instance, they provide quite detailed information about perceptions’ about place of delivery, illustrated with quotes. But they only have one summary sentence for “expectations”, which is a key issue in this kind of study.
The results section (pg 7-12) has been re-structured so that the accounts of women are arranged into the four topics of the interviews and FGDs to balance the section. The ‘Expectations’ section (pg10-11) now includes a narrative and supporting quotes.

• In some cases, authors may consider changing some of the quotes. For instance, two of the three quotes used to illustrate the second part of the “Place of delivery” section refer to physical distance. It would be more interesting if authors would add or substitute one of those quotes with another on a different issue that also influences the utilization of health facilities, such as perception of quality, cost, etc.

The quotes originally included in the ‘Place of Delivery’ section have been supplemented to reflect a number of factors which may influence women’s choice of delivery facility – these include presence/distance to facility, cost and community norms.

• The section on “staff attitude” is illustrated by quotes that show relatively minor problems of attitude. Authors must have much stronger quotes they could use that would better illustrate the unacceptable situations some of these women faced. Please consider substituting some of these quotes with others that address different considerations (in fact, some of those provided to illustrate the “satisfaction” section would better illustrate this one.)

The ‘staff attitudes’ sub-section has been removed from the ‘Place of Delivery’ section. Quotes to illustrate the theme of ‘staff attitudes’ are now included in each of the results sections to emphasise the pervasive nature of this factor.

• The section on “Recommendations of women” does not include real recommendations but comments on staff attitudes. Authors should consider including actual recommendations: this would be a key input for discussions with providers and, potentially, to induce positive changes as a result of this study.

This section has been changed to include actual recommendations.

4. Discussion
• This section is not clearly structured and a bit repetitive (e.g. the last paragraph on page 13 about findings).

This section is now structured around 1/ study limitations, 2/ theoretical frameworks and 3/ recommendations. The paragraph on page 13 referred to in the point above has been removed, as have the re-iterations of the findings to reduce the repetitiveness.

• The section is not well written and there is no analytical framework to help the reader clearly understand the implications of the findings. Table 1 just provides different lists of issues, with no further explanation. Authors may want to elaborate more on it and/ or describe the S.A.F.E. study framework either in the background or the discussion sections.

The components of skilled attendance are introduced in the Background section (page 3, paragraph 3). The results are interpreted in terms of these components in the discussion section. A section on theoretical frameworks (section 4.2, page 14) has been added to the discussion that draws on standard frameworks of skilled care and patient satisfaction in the interpretation of the results. The table has been converted into a figure and paragraphs 1 and 2 on page 15 contain an explanation of the figure.
• It would be interesting to learn more about the dissemination activities the researchers undertook to convey their findings to the primary target group of this study, i.e. health service providers.

We have expanded upon the description of how the results of the study were fed back to health care providers in paragraph 3, page 15. “How to feed back the results of the research was discussed with district health officers and a meeting of health professionals in the study area was agreed upon. Although it was not feasible to have all health professionals attend the meeting, it was recognised that the implications for practice from the study were important and further feedback was organised via the meeting attendees to their colleagues. This approach was favourable as it may have been threatening for health professionals to receive this information from researchers and district health officers, and was more conducive to change if it was fed back from colleagues.”

• One important problem of this study, which I have highlighted above, is the fact that researchers asked women on subjective issues (i.e. views, perception, satisfaction, etc) around an event that happened long time before the interview. In the discussion they justify that decision by saying that “women’s recollection of obstetric events is thought to be accurate, even over long periods of time and experiences are recalled in great detail.” Please see my comments on this above.

As in the methods section, this is considered in the discussion under study limitations/potential biases on page 14 “there may have been bias in the way respondents recalled subjective events around pregnancy and childbirth, particularly since the recall period was up to five years…the results should be interpreted with this consideration in mind”.

• The importance of exploring providers’ views is briefly mentioned in the last paragraph of this section. When the aim of a study is to change providers’ attitudes and, consequently, improve quality of care, considering that side of the equation is essential. The authors may want to review an article that presents the findings of a study that is referred to in their paper (16), which includes some discussion about this (Nigenda G, Langer A, Kuchaisit C, Romero M, Rojas G, Al-Osimy M, Villar J, Garcia J, Al-Mazrou Y, Ba’aqeel H, Carroli G, Farnot U, Lumbiganon P, Belizan J, Bergsjo P, Bakketeig L and Lindmark G. Womens' opinions on antenatal care in developing countries: results of a study in Cuba, Thailand, Saudi Arabia and Argentina. BMC Public Health 2003, 3-17 (20 May 2003))

The exploration of provider views has been emphasised in the discussion (paragraph 4, pg 16) “A broader sense of the issues could be obtained by observing interactions, and including perspectives of women who choose to deliver outside facilities and without a health professional. Provider’s accounts of care are an even less examined area…We would therefore recommend that providers’ perspectives and motivations are investigated in conjunction with descriptions of user-views, as two parts of a whole, in order to identify effective mechanisms by which needs of the users can be responded to, to ultimately increase quality of care.” and in the conclusion on page 18 “provider perceptions are also an important area to investigate to facilitate change in clinical practices.”

5. Conclusion
• From my perspective, this section should summarize the key conclusions of this study, and avoid repeating what was already said in other sections and the corresponding references.

This section has been refined to conclude on the findings and summarise the recommendations, as advised.
Response to Reviewer’s report #2  
Reviewer: Christine McCourt

Discretionary Revisions

• Intro: Perhaps the authors should describe this as a study of women’s perceptions/views of interactions rather than of the interactions per se, as it was reliant on interviews, without observation, and gives the woman’s view rather women’s and professionals’ perceptions. There is a good discussion towards the end of the limitations of the study, however.

The title of the paper has been changed from “...women’s experiences of maternity services” to “…women’s accounts of maternity services”. In addition, the introduction has been adapted to clarify women’s perceptions of provider-client interactions are investigated, rather than the interactions themselves. Paragraph 2 on page 4 now states “This study was undertaken with the objective of investigating women’s accounts of interactions in delivery care and to assess their implications for acceptability and utilisation of maternity facilities in Ghana.” This point is also amplified in the discussion. Paragraph 4 on page 16 now states “The study was dependant on interviews, women’s subjective accounts of the care they received. A broader sense of the issues could be obtained by observing interactions, and including perspectives of women who choose to deliver outside facilities and without a health professional. Provider’s accounts of care are an even less examined area…we would therefore recommend that providers’ perspectives and motivations are investigated in conjunction with descriptions of user-views, as two parts of a whole, in order to identify effective mechanisms by which needs of the users can be responded to, to ultimately increase quality of care”.

• Background: There is no reference in background to the roles of TBAs/traditional midwives. Although this study is set in a semi-urban context, including only women who have used formal health services, it would be useful to sketch in the situation in Ghana as such roles and level of experience and skill do vary across different countries. No health professional present is not necessarily no care, depending on the situation. This will set the study more realistically in its context.

Paragraph 3 on page 4 of the background section has been adapted to emphasise the role of the TBA. “…this study was concerned with deliveries attended by health professionals, it should be noted that within the Ghanaian context, and particularly in rural Ghana, utilisation of informal health care services such as traditional birth attendants (TBAs) is common, and TBAs attend up to half of all births”. This point is also raised in the Context section of the discussion on page 13 “institutional deliveries are not common in Ghana, only two in five births taking place in a health facility and less than half of all births are attended by a qualified health professional. Furthermore, the study was confined to a semi-urban area where facility deliveries with health professionals are more common. The results of the study therefore, have implications primarily for care related to deliveries that occur in health facilities, attended by health professionals.”

• Findings and discussion: References from other ‘developing’ countries are available on similar issues, which would provide useful points of comparison – e.g. Egypt, India. Such work has not been drawn on particularly here. I think it would be useful to do so, particularly to show that such issues are widespread in formal health services, especially in post-colonial contexts.

Evidence from other developing countries (South Africa and Brazil) has been incorporated into the discussion section in paragraph 3 on page 15. “In studies from …nations such as South Africa…and Brazil, reasons for such prominent negativity from staff towards patients have been suggested to be used to exert control and obedience, command and respect.”
• There is also work from both ‘developed’ and ‘developing’ countries looking at issues of professional behaviour, abuse, and the organisation of health care etc., which discuss possible theoretical approaches to help understand and explain such patterns. This literature has not been drawn on at all. As a result the work lacks theoretical contextualisation and there is no discussion of what the underlying issues may be, that need to be understood in order to change practice.

A section on theoretical frameworks has been included (page 14) drawing on standard frameworks of skilled care and patient satisfaction. Evidence which supports the findings is also referred to on pages 15 and 16 from Brazil, Chile, South Africa, Zimbabwe, the US and Finland.

• I wasn’t entirely convinced by the point made on women not recommending services of abusive staff – one quote showed this is not necessarily the case – they might recommend facilities despite this because of fears of unsafe birth – feeling they have to put up with such treatment for sake of this. Again, there is theoretical and substantive work which could help make sense of this. People may accept and tolerate abusive behaviour for a range of reasons, including institutional factors. Lack of access to good information may also mean that women feel they have little choice if they want a ‘safe’ birth.

This point is articulated in the findings section (paragraph 1, page 12) “some accounts suggested that women would recommend services despite abusive behaviour in order to have a ‘safe’ (facility) birth, underlining the importance of a successful birth outcome.”

• Issues of information and women’s knowledge which were brought out in the findings were not picked up strongly in the discussion – I would like to hear more about how women in Ghana get information about childbirth? or about formal health facilities?

The discussion has been changed (paragraph 2, page 16) to consider how women receive this information and construct their health seeking behaviour. “It should … be acknowledged that it is likely that women not only construct their expectations on the basis of their experience, but also the basis of the experience of other women. The willingness of women to travel long distances to be close to family and friends also indicates that the importance of social, community and familial factors”.

• Do the authors have any recommendations for ways to tackle such issues, within the constraints of the context?

The recommendations suggest that since women’s expectations of care are governed to a significant degree by their (and others’) experiences of staff attitudes in the form of recommendations made by friends and family, that staff should be made aware of women’s perceptions of acceptable care. Paragraph 3 on page 16 states “the means to address the factors relating to good delivery care practices by are therefore to ensure a high level of awareness amongst the practitioners. This paragraph continues to recommend that “…training and supervisory interventions that encourage acquisition of interpersonal skills are currently recommended… These include general care and counselling of women, cultural sensitivity, appropriate communication skills, provision of psychological support and involving women, parents and families in provision of care”.

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Response to Reviewer’s report #3
Reviewer: Pirkko Kouri

General

• In the abstract I would change the results; first the ’positive’ results, then ’negative’ - > conclusion -> developmental challenges.

The negative result “Some of the accounts of care provided by women depict disturbing abuse and neglect” has been moved from the abstract to the last paragraph of the discussion. The results section of the abstract (paragraph 3, page 2) now focuses only on the results, with no interpretation.

• The extracts from conversations made the text vivid. The table where factors related to important aspects was a little bit narrow, and what was the path to categorising this particular way?

The table has been converted into a figure which draws on a standard framework of skilled care. Paragraph 1 on page 15 now states “Figure 1 illustrates the original [standard skilled attendance] framework with the key components referred to by women as important in delivery care, categorised by and super-imposed on the framework ... Our findings reinforce the critical links between the professional, the enabling environment and the wider community...The findings bring an additional perspective to the framework in terms of the interpersonal aspects of care, and their influence”.

Major Compulsory Revisions

• The authors should read carefully the whole manuscript and check the theoretical part that is logical with the findings.

A section on theoretical frameworks has been included which draws upon on standard frameworks of skilled care and patient satisfaction. Paragraph 2 on page 15 now states “From this diagram [Figure 1 referred to above] and the Sitza and Wood discourse on satisfaction, we can infer that health professionals have the potential to influence all of the elements of skilled care and a major determinant of satisfaction – women's expectations, which in turn affects utilisation”.

• In the text there a some writing mistakes, e.g. use of space bar varies near brackets

This has been addressed throughout the manuscript.

• In references the removal of hyperlinks should be done.

Hyperlinks are given in the citations of websites, in accordance with BMC Public Health’s referencing guidelines.

• I would consider the key words and the order of words once more e.g. reject the word Ghana from key word list. To me terms 'labour' and 'delivery' have the same meaning = birthgiving. Key words and the title of manuscript do not support each other.

The key words have been re-ordered to reflect the title of the manuscript. However, I would prefer to keep Ghana as key word as it is a MeSH term which will help categorise the article
according to content. I would also prefer to retain the key words labour and delivery as they refer to specific events and again are MeSH terms.

• The explanatory notes to Table 1 were missing (?)text. In what part of the manuscript the Table 1 is inserted.

The table has been converted into a figure and paragraphs 1 and 2 on page 15 now contain an explanation of the figure.

• The discussion part begins with information which should be in background, I would start with women's experiences.

This information is a re-iteration of the information contained in the Background section. Paragraph 1 on page 13 has been changed to reflect this “as stated in the introduction, institutional deliveries are not common in Ghana; only two in five births taking place in a health facility”. The women's experiences are discussed at a later stage, in line with the theoretical frameworks.