UNIVERSITY OF CAPE COAST

FACTORS DETERMINING MATERNAL HEALTH CARE SERVICES IN THREE SELECTED DISTRICTS OF THE EASTERN REGION, GHANA

BY

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JANUARY 2014

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

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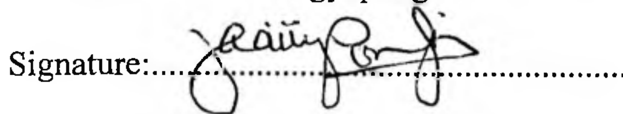
Signature:  Date: 10/01/2014

Supervisors' Declaration

We hereby declare that the preparation and presentation of this thesis were supervised in accordance with guidelines on supervision of thesis laid down by the University of Cape Coast.

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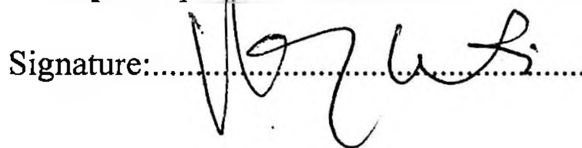
Signature:  Date: 10/01/14

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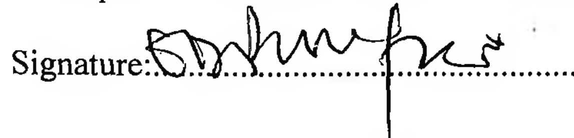
Signature:  Date: 10/01/14

ABSTRACT

Worldwide, it is estimated that 1600 women die every day as result of problems they encounter during pregnancy and or child birth. This thesis therefore sought to examine factors that determine the utilization of safe-motherhood services in three districts in the Eastern Region of Ghana. Specifically, it attempted to contribute to the policy debate to enhance public decision making in prioritizing the different components of safe motherhood programmes in resource-scarce locales. Using the survey research design, interview schedules and or questionnaires, the research solicited data from 598 respondents, comprising women in their reproductive age, married men and healthcare providers residing in the selected districts. The data was supplemented with nine (9) focus group discussions.

The study revealed that the proportion of women who had the recommended four or more care visits during pregnancy in the intervention areas had increased significantly, from 18 to 80 percent. However, rural-urban disparity in terms of access to healthcare facilities accounted for the low utilization of maternal healthcare services in both rural and urban areas.

It is recommended that central and local governments, non-governmental organisations and Ghana Health Service should partner with communities to empower women in their health-care decision making as this would enhance better maternal and child health outcomes. Additionally, there is the need to build the capacities of Traditional Birth Attendants and healthcare providers as a measure to address the oscillating maternal deaths in the Eastern Region.

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Lots of people helped me along the way but there are some that deserve special recognition because without them, this PhD thesis could not be accomplished. I would be ungrateful if I did not thank the individuals and organisations that offered me support by gently assisting me in communicating my thoughts more clearly and nudged me to insert my own opinion into the dissertation especially during my thinking with wonderfully stimulating discussions about the theoretical framework used in this work.

My deepest appreciation goes to both Professor P.W.K. Yankson and Dr. Kwabena Barima Antwi who were very patient and for their kind supervision, assistance and unparalleled encouragements which made it possible for the completion of this thesis. It is interesting to mention that, the research journey was quite challenging and I was hopelessly lost more than once, but their guidance upheld me throughout the period. I also appreciate the unfailing encouragement and advice offered me by Professor A.M. Abane. He provided a shoulder for me to cry on and words of wisdom while I struggled through this programme. I am forever grateful to him.

Finally, I also acknowledge the support and cooperation offered by the chiefs, opinion leaders and people in the various communities in the study area during the data gathering period. For any errors of facts, misinterpretations and omissions that may appear in this thesis, I am solely responsible.

DEDICATION

To my late parents, especially my mother who even on her sick bed encouraged me to pursue further studies to broaden my horizon.

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LIST OF ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Ante-Natal Care
ANM	-	Auxiliary Nurse and Midwives
ANOVA	-	Analysis of Variance
BCC	-	Behavioural Change Communication
CHPS	-	Community Health Planning Services
DFID	-	Development for International Development
EmOC	-	Emergency Obstetric Care
ERHD	-	Eastern Regional Health Directorate
FGDs	-	Focus Group Discussions
GDP	-	Gross Domestic Product
GHS	-	Ghana Health Service
GIS	-	Geographic Information System
IPPF	-	International Planned Parenthood Federation
JHS	-	Junior High School
JSS	-	Junior Secondary School
KABP	-	Knowledge, Attitudes, Beliefs and Practices
LHV	-	Lady Health Visitor
MCH	-	Maternal and Child Health
MDGs	-	Millennium Development Goals
NGOs	-	Non-Governmental Organisations
PHC	-	Primary Health Care

PNC	-	Post Natal Care
QA	-	Quality Assurance
RCHC	-	Rural Clinic and Health Centres
SHS	-	Senior High School
SPSS	-	Statistical Product for Service Solutions
SSA	-	Sub-Saharan Africa
SSS	-	Senior Secondary School
TBAs	-	Traditional Birth Attendants
THPS	-	Traditional Herbal Practitioners
UNICEF	-	United Nations Children's Fund
UNs	-	United Nations
WHO	-	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the study

Much empirical and theoretical information exists on the various causes of maternal death. However, despite the amount of published work on this problem, maternal mortality remains high in many parts of the world. The sad reality is that almost all cases of maternal death are avoidable (WHO, 2005); however, standard programmes to prevent deaths have not been effective in controlling the causes of maternal mortality. In 1998, the World Health Organisation's (WHO) Division of Reproductive Health stated that there had been little evidence of progress in the effort to reduce maternal deaths (AbouZahr, 2003). Some authors disagree with current safe-motherhood strategies and have been worried about poorly implemented interventions (Maine, 1997).

Strategies to reduce maternal mortality have also been criticized on the grounds that the associated programmes are based mostly on poorly gathered evidence derived from retrospective and observational studies, as well as empirical knowledge or conclusions reached via deductive reasoning. Furthermore, most of the current research is focused on providing evidence for clinical decision-making. This approach needs to be reconsidered in order to meet personal needs since maternal health strategies require complex and multidisciplinary public health policy approaches.

Pregnancy and childbirth are natural processes but they are no means risk free. Women in reproductive age die and suffer because they do not have access to the basic minimum of health care that is part of their basic human rights. Therefore, it is not for lack of knowledge that the majority of the world's women still face the prospect of death or disability as a consequence of childbearing. The burden of death and stigma of permanent injury are borne by women and their new born infants in large parts because, the holders of knowledge, the bearers of political authority and architects of health and social programs, have apparently failed to exercise their full creative capacity to commit energies and resources to the health and development needs of women. It is quite ironic that, in this era of scientific and technological advancement, many women, particularly in Africa, should lose their lives during pregnancy and childbirth.

According to Ransom and Yinger (2000), it appears the welfare of women has been undermined for a long period of time, and it was for this reason that compelled Sai, the former President of International Planned Parenthood Federation (IPPF) to argue that:

"No Country sends its Soldiers to war without seeing to it that they will return safely, and yet mankind for centuries has been sending women to battle to renew the human resource without protecting them" (Sai, 2000, p.5). Again, according to the former President of World Bank, "Maternal health is a human right, if the system has failed, our task and the task of many like us is to ensure that, in the next decade, Maternal health is not regarded as a fringe issue but as a central issue" (Wolfensohn, 1998 p.2).

Primary health care (PHC) is a strategy of public health, derived from the social model of health and sustained by the Alma Ata Declaration, which was jointly sponsored by the World Health Organisation and United Nations Children's Fund (UNICEF) (WHO, 1978, 1986).These Charters demonstrate the co- dependency of PHC and health promotion. The PHC sphere of activity extends much more broadly and with different intent, to primary care. Health care practitioners work from a social model of health which is partly based on the understanding that in order for health gain to occur, people's basic needs must first be met. These include for example, shelter, support, safety from violence and reliable, affordable food supplies. In addition to these basic provisions, the WHO regard essential primary health care services to include maternal and child health care, community based affordable medical care, the provision of essential medicines and immunisation against the six childhood killer diseases.

Primary health care and health promotion seek far-reaching solutions to problems that defy biological, genetic or biochemical solutions (Mittelmark, 2000); problems that demand new thinking, innovative approaches and values, one of which is universalism. In other words, primary health care and health promotion are integral to public health, therefore they should be provided universally in order to meet objectives of accessibility and affordability. Characteristically, PHC practitioners work to change the social, political, environmental and economic determinants of illness in order to create better health in communities. The range of social determinants of health as a result of poverty, wealth and income distribution, psycho-social deprivation, discrimination such as sexism and racism, powerlessness, factors related to

gender, age, race and ethnicity, socio-ecological environments, literacy and health service utilization, affect the lives of individuals. No one sector can deal with all the social determinants of health. Indeed, health requires the whole of government efforts not just those of the health sector (World Bank 1993; Podger & Hagan, 2000).

The term PHC is commonly interchanged with primary care as if their philosophies and practices were the same (Swerissen, 2000). Primary health care can be defined as a philosophy, as an approach, as a level of health care system, or even as a set of activities. Understanding what PHC means today, in light of the experience of trying to implement it, does not mean that new perspectives will not emerge over the next few years. We must be constantly reviewing the concept with new insights gained from experience. But it is understanding and acceptance of the underlying philosophical principles or values, outlined in this thesis, which will determine what PHC really means in countries. Political will and commitment to PHC on the part of governments first and foremost require acceptance of these values.

The PHC concept has been adopted as an ideology for health development in many developing countries, especially in Sub-Saharan Africa (SSA) since 1978 by emphasizing on people's participation and inter-sectoral collaboration.The significance of PHC is its values and strategic orientation towards the health of people whose need is greatest combined with the commitment of its practitioners to work in interdisciplinary ways to change social and structural barriers to health. Practitioners of PHC are closely connected with health promotion practitioners who seek 'to change social, economic and physical environments to improve health' (Moodie, 2000).

Primary health care and health promotion practitioners understand the necessity for effective, affordable and accessible primary care and good health education but their belief has a very different purpose to the belief of primary care. The task of PHC and health promotion is to ensure barriers to health care are dismantled. However, evidence emerging from the literature on the implementation of the Primary Health Care in developing countries, especially in SSA, and in particular Ghana, clearly indicated that, the relevance of the concept had not been experienced.

In discussing the contribution of the PHC in Ghana, the question that comes to mind is that, is there evidence about the extent to which PHC services contribute to any such improvements? In particular, if there is no strong evidence to support the contention that PHC improves 'mainstream' population health, it would be unwarranted to expect the evidence to show such a pattern in communities. In answering this question and throughout this thesis, we note the diversity of definitions of "primary health care" in the literature. The Alma Ata Declaration of 1978 describes a comprehensive model of primary health care that includes notions of participation and self-determination. This comprehensive model – upheld strongly in Africa by community-controlled health services – has strong claims as an ideal or best practice model of primary health care. The WHO (1984) defined PHC to mean the first level of contact of individuals, the family and community with the national health system with the intention and desire to bring health care as close as possible to where people live and work.

This is necessary to capture the available research literature to answer the question(s) asked. Of course, any positive results from studies using a

narrower definition of primary health care will understate the population health gain possible through a more comprehensive model. The literature indicates that there has been no comprehensive attempt in the field of primary health care policy in Ghana to stand back in this way and look into the broadest manner possible at the relationship between the provision of primary health care and the health of populations. However, answering these questions is necessary to set the theoretical and evidentiary foundations from which we can look at the more specific questions regarding health and primary health care in Ghana.

The PHC concept could not dismantle the barriers to health due to a lot of factors. Lack of political commitment has adversely affected the implementation of the programme. Governments are by no means homogenous in their shades of commitment and several different shades may exist in countries at the same time. Some countries in Africa already have policies, and are pursuing patterns of development in conformity with these principles. Some political systems are more favorable to PHC precisely because they emphasize these values and are concerned with a broad attack of poverty and inequality and on the socio-economic structures which maintain them. Even for the health sector, the pattern of existing health systems and opportunities for change reflect wider sociopolitical values. It will be easier to ensure the kinds of changes discussed above, in countries where the overall development policy gives priority to equity and social justice, than in countries where economic growth is being pursued regardless of human consequences. It has to be clearly understood at the outset that commitment to PHC is a commitment to a political goal which will have to be fought for against

opposition forces and progress is likely to be slow. This is why PHC is a political issue rather than health.

There is a linkage between PHC and some aspects of the Millennium Development Goals (MDGs), for example goals four and five focused on improving child and maternal health. The synthesis outlined in both approaches inevitably mask the range and variety of development experiences in individual countries since the goals were adopted. It is not only governments of developing countries that have adopted the MDGs as their framework for international development cooperation, but also the private sector and civil society in both developed and developing countries. Non – governmental organisations (NGOs) in developing countries are increasingly engaged in undertaking these activities, as well as in monitoring the outcomes. This global collective effort is yielding results.

One of the important MDGs is to improve maternal health, with the target of reducing maternal mortality by 75 percent between 1990 and 2015. While some developing countries have shown great progress in improving maternal health, progress remains slow and the level of maternal mortality are persistently high in much of the developing world. The United Nations' MDGs represent a concerted global pledge to significantly improve the human condition by 2015, with efforts aimed at reducing poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. By building on past declarations of the UN conferences, this goal reaffirms the international commitment to addressing the problems associated with maternal health and family planning. Furthermore, the MDGs initiative provides a unique opportunity to refocus and accelerate programme efforts by donors,

governments, and civil society, to improve maternal health for individual and societal well-being.

The health of mothers has long been acknowledged to be a cornerstone of public health and attention to unacceptably high level of maternal mortality has been a feature of global health and development discussions since the 1980s (AbouZahr, 2003). Poor nations and their development partners have failed to invest in the right proportions seriously in maternal health. Maternal health has tendered to be seen as a subset of other programs, such as child survival or reproductive health and is often perceived to be too complex or costly for under-resourced and overstretched health care systems that have limited capability.

According to a report in the Daily Graphic (September, 2007) unsafe abortion, which is on the ascendency, could be prevented even though, between 22 and 30 percent of women die through unsafe abortions in Ghana. This situation is unfortunate, because Ghana has the expertise and facilities to prevent deaths from unsafe abortions. It is therefore worrisome that with the provision of all these facilities and services in Ghana, women continue to die during pregnancy and childbirth and the maternal mortality rate, which is an international indicator for measuring quality of care, remains high.

The challenges that remain as far as maternal health is concerned are seen not to be technological, but perhaps attitudinal; poverty, ignorance and deep-rooted socio-cultural barriers that delay or prevent women from having access to proper medical interventions during pregnancy and childbirth. This observation seem to be supported by the WHO that, maternal deaths are partly caused by women's poor health and nutrition before pregnancy, inadequate,

inaccessible or unaffordable health care, poor hygiene, socio-economic and cultural practices, and their lack of decision making power in families, communities as well as societies (WHO, 1999).

Perception of the quality of maternal health interventions among women is very important for reproductive health care. Assessing quality of maternal health has been a low priority for policy makers in developing countries due, in part, to multiple meanings associated with the concept and apparent difficulty in its measurement. There is need for the recognition and understanding of the perceptions of the quality of maternal health from the perspective of clients who are users of the services. This emerging perspective on quality is, particularly important for reproductive health care services, where advances in the technical quality maternal health may be inconsistent with practices passed informally from generation to generation.

The urgent need to focus on health care users' perceptions of the quality of health services is based on the belief that this perception directly influences the search for and choice of treatment, which are based mainly on prior experience. This approach when effectively utilized would highlight the importance of factors such as waiting time, cost and form of payment, treatment received, and cleanliness of the facility. The level of communication between health care staff and patients, access to health services, understanding of personal problems, reliability of institutions, technical competence and continuity of treatment by the attending physician are equally important factors requiring urgent attention. Atkinson (1993) calls attention to the importance of including an analysis of quality of services within a broader

context that encompasses socioeconomic conditions, cultural differences, and models for interpretation of illness by the population.

Statement of the problem

The utilisation of a service is often dependent on the quality of services being provided. A number of complaints have been made by the public against the services they receive at public health institutions in Ghana. Cases of negligence on the part of some health workers that have aggravated the injuries or illness of some patients have been reported (Daily Graphic, 2002).With the introduction of the National Health Insurance Scheme (NHIS), a number of standards and guidelines have been produced with the view to improving technical procedures of service providers.

To the customer, the quality of care is judged only on the service aspect. Thus, a service of good quality has little to do with quality concerns as perceived by healthcare professionals. It is the consumer's definition of quality that should guide the decisions of service providers. According to Arnetz and Arnetz (1996) quality improvement strategy requires incorporation of consumer feedback, which is an integral part of quality assurance. Donabedian (1994) argued that, it is the responsibility of every health professional, individually and collectively to befriend and empower their actual and potential patients. The problem confronting health care delivery in Ghana is how to empower clients when providers do not know their expectations in terms of service delivery.

Implementation of quality maternal health interventions towards improving maternal health have been intensified, yet maternal deaths have

remained a major burden in Ghana. There have been public outcries through the media against the quality of maternal health interventions. Patients, many a time, complain of long waiting times, lack of privacy and confidentiality and unfriendly staff. Poor quality service could lead to loss of lives, loss of revenue, loss of trust, loss of respect and loss of recognition (Daily Graphic, 2007).

Anecdotal evidence and informal discussions tend to show that patient's perceptions, especially about service quality, might shape confidence and subsequent behaviours with regard to choice and usage of the available health care facilities. This is reflected in the fact that many patients avoid the system or use them only as a last resort. Those who can afford it seek help in other countries, while preventive care or early detection simply falls by the wayside. Patients' voice must begin to play a greater role in the design and delivery of health care in the developing countries.

The data presented in Figures 1, 2 and 3 explain the magnitude of maternal deaths in Ghana. Given the increasing maternal deaths in Ghana, and in particular in the Eastern Region, it is necessary to explore the factors determining the utilization of maternal health interventions and expectations of patients in order to understand its implications for service utilization with the view to reducing maternal deaths. Women constitute about 67.4 % of the total population in the Eastern Region (2000 Population Census), and to achieve better health condition, a focus on women is thus critical. What informs the decision to focus this study in the Eastern Region is that, first it is ranked second highest in terms of maternal deaths in Ghana (Figure 2).

Second, the number of maternal deaths keeps increasing every year even though; there have been a lot of interventions.

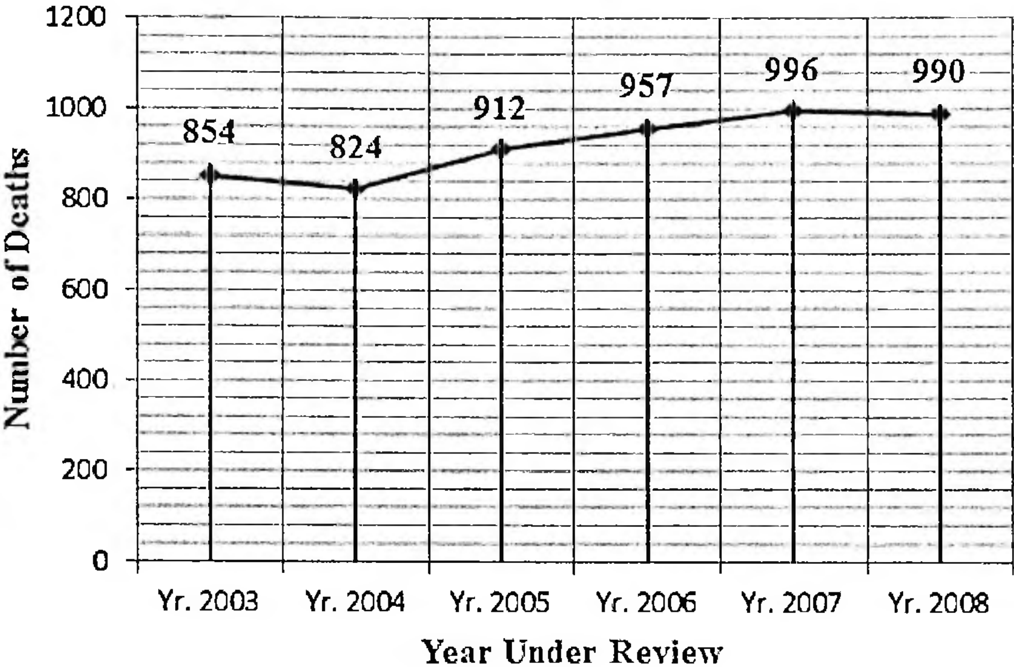

Figure 1: National institutional maternal deaths (2003-2008)

Source: Ghana Health Service Annual Reports (2003 – 2008)

Figure1 illustrates the national annual maternal deaths for the past six years. The annual maternal deaths fell from 854 in 2003 to 824 in 2004, and kept increasing till 2007 before it fell slightly in 2008.At the national level, the picture of maternal deaths falls, rises and sometimes attains an appreciable level of increase.

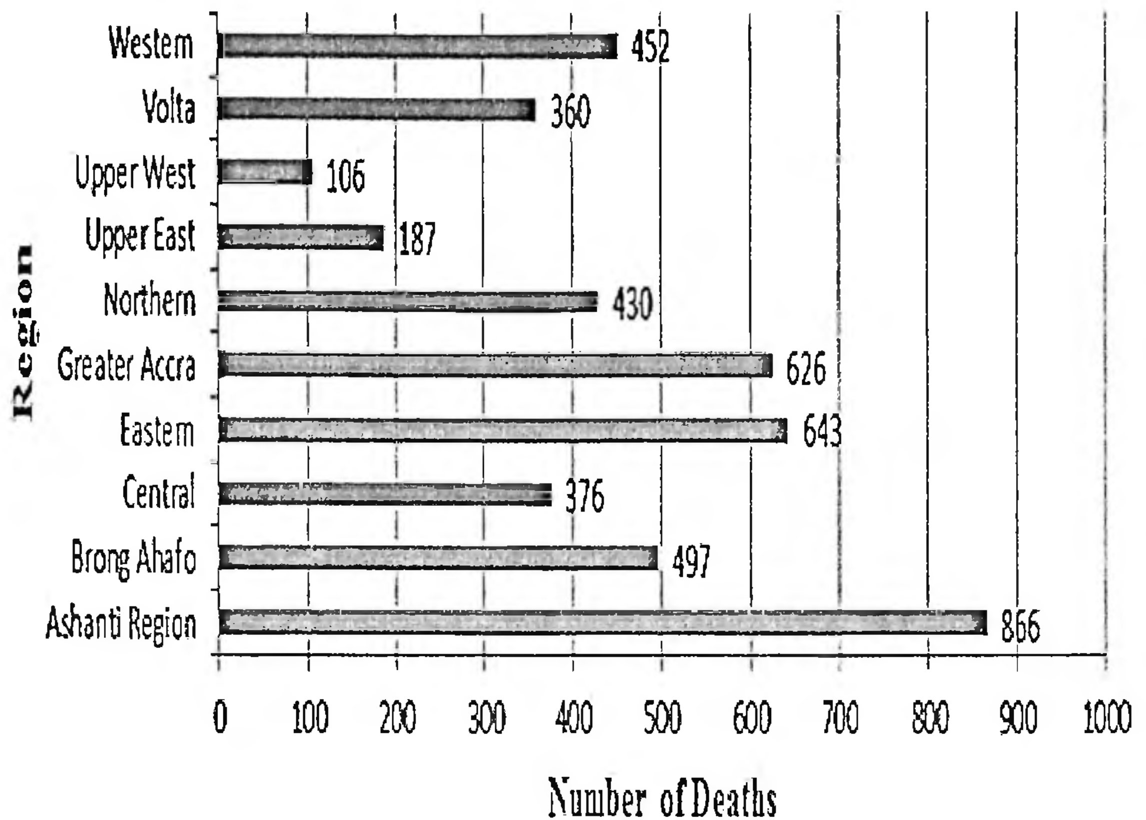

Figure 2: Regional institutional maternal deaths (2003-2008)

Source: Ghana Health Service Annual Reports (2003 – 2008)

Figure 2 shows regional contributions to the total maternal deaths (in absolute figures) for the past six years. Ashanti Region has remained the largest contributor to the maternal deaths in Ghana, accounting for about 20 per cent of all maternal deaths. Over the years, Eastern and Greater Accra Regions have ranked second highest contributors to the maternal deaths and together with Northern and Upper West regions increased their contribution to the total maternal deaths in the country. Western, Volta, Upper East and Brong-Ahafo regions reduced their contributions. It is observed that, leading regions are the regions with the highest populations, in relative terms; therefore, they may not be the regions worst off regarding maternal deaths.

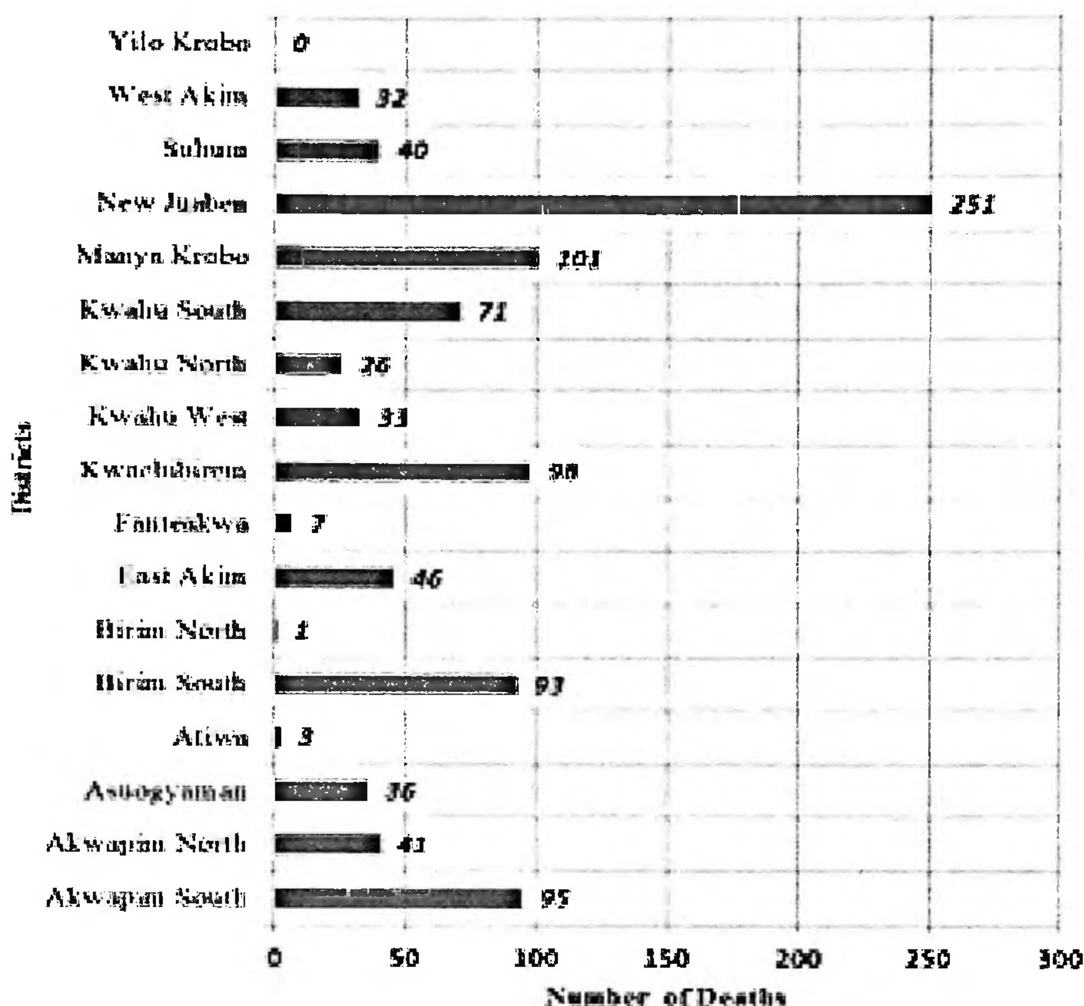

Figure 3: Total institutional maternal deaths by District

Source: Ghana Health Service Annual Reports (2003 – 2008)

Figure 3 shows the total institutional maternal deaths recorded in all the twenty-one (21) districts in the Eastern Region of Ghana. Apart from Yilo Krobo District, which has been recording zero maternal deaths, the report revealed an alarming rate of high maternal deaths in most of the districts throughout the period under review. The choice of Fanteakwa was influenced by the fact that, it recorded the forth lowest maternal deaths throughout the period. Yilo and Atiwa were not selected because of their closeness to Koforidua and most maternal health cases are referred to the Regional hospital.

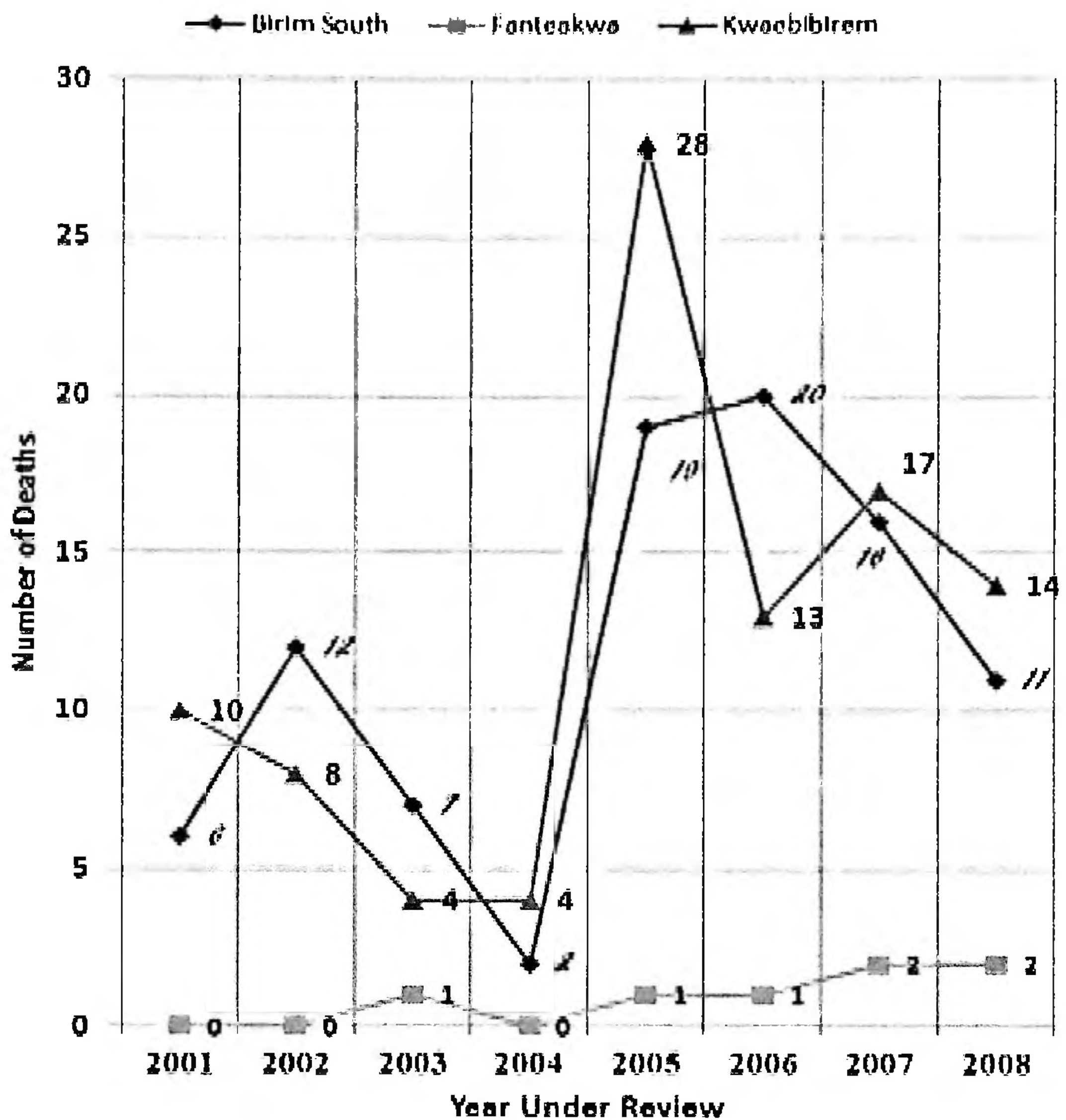

Figure 4: Institutional maternal deaths in the study area

Source: Ministry of Health (2009)

Inter District comparison shown by Figure 4 suggests an appreciable decline in maternal deaths between 2005 and 2006 and an appreciable increase in the number of cases between 2006 and 2007 in both Kweabibirem and Birim South districts (study areas with the highest maternal deaths) but the contribution from Fanteakwa District (selected for comparative purpose) over the years has remained almost zero percent. It is appropriate to investigate the

oscillating nature of this phenomenon. It is also useful to speculate that the medical perspective provides only a partial answer to the causes of maternal mortality because medical factors are usually only the last in a long chain of factors involved.

In most cases, and in some districts where maternal mortality levels are still alarming, many avoidable factors continue to be associated with the deaths. Lack of facilities for emergency transport, poor referral services with essential obstetric function, unavailability of blood transfusion services, deficient medical treatment of complications, inadequate essential supplies and trained personnel, inadequate access to maternity services, and poor prenatal and postnatal care are all crucial steps on the road to death of pregnant women (Daily Graphic, 2004).

In comparative terms, the Eastern Region seems to record many maternal deaths and also oscillating since 2003. While there was appreciable decline between 2005 and 2006 from 157 to 118 (33.1 %), it went up quite sharply between 2006 and 2007 from 118 to 146 (19.2 %). These emerging trends raise a number of questions which need to be investigated to understand the oscillating nature of this phenomenon.

The escalating nature of maternal deaths in the Eastern Region, especially in the study areas are only institutional reported cases and therefore the situation could be worse. In this regard, the perceptions about the quality of maternal health interventions and expectations of patients must be examined in order to understand whether the use of service could reduce maternal deaths. Against this background, the study sought answers to the following questions.

Research questions

- What proportions of pregnant women make use of maternal health services offered by available health facilities in the study areas?
- How do women perceive the quality of maternal health interventions?
- How significant are the behaviour, attitude, beliefs and cultural practices of women and men in explaining the patronage of maternal health services.
- What are the proximate and underlying factors influencing maternal health, especially during pregnancy?
- What measures have been put in place to improve the quality of maternal health interventions?

Objectives of the study

The general objective of this study was to explore the factors determining the utilization maternal health services in selected districts of the Eastern Region of Ghana.

Specifically, the research sought to:

- Assess the level of knowledge and perception of the quality of maternal health interventions;
- Establish the extent or level of usage of Maternal Health Care.
- Establish the proximate and underlying factors that prevent women from accessing and utilizing maternal health services.
- Examine the knowledge, attitudes, beliefs and cultural practices (KABP) that can potentially lead to maternal deaths;
- Explain the maternal mortality differences if any among the selected

districts,

- Establish the relevance of women's autonomy in enhancing maternal health decision-making, and
- Recommend appropriate policies and interventions that can improve the welfare and health seeking behaviour of women.

Scope of the study

Research Scope: - The map illustrated in Figure 5 shows that the spatial focus of the study is the Eastern Region of Ghana. However, due to financial, logistical, time and practical reasons, the survey was conducted in three local authority areas out of twenty one in the Region, namely Birim South, Kwaebibirem and Fanteakwa.

Content/Subject matter: - Conceptually, Gilbert (1993) has suggested that every research must be placed in an appropriate academic or subject matter. Within the context of the problem that was investigated, the subject matter of interest was on perception of respondents about quality of maternal health interventions, challenges facing health providers with the implementation of maternal health and the role communities play towards sustaining the various interventions.

Period: - On the question of period or time frame, the study explored the factors determining the utilisation of maternal health interventions in three selected districts of the Eastern Region from the implementation of PHC till the present study (eg. end of the field work).

Target Population: - The target population for the study with respect to data collection included, sampled health professionals in the study areas, women and married men.

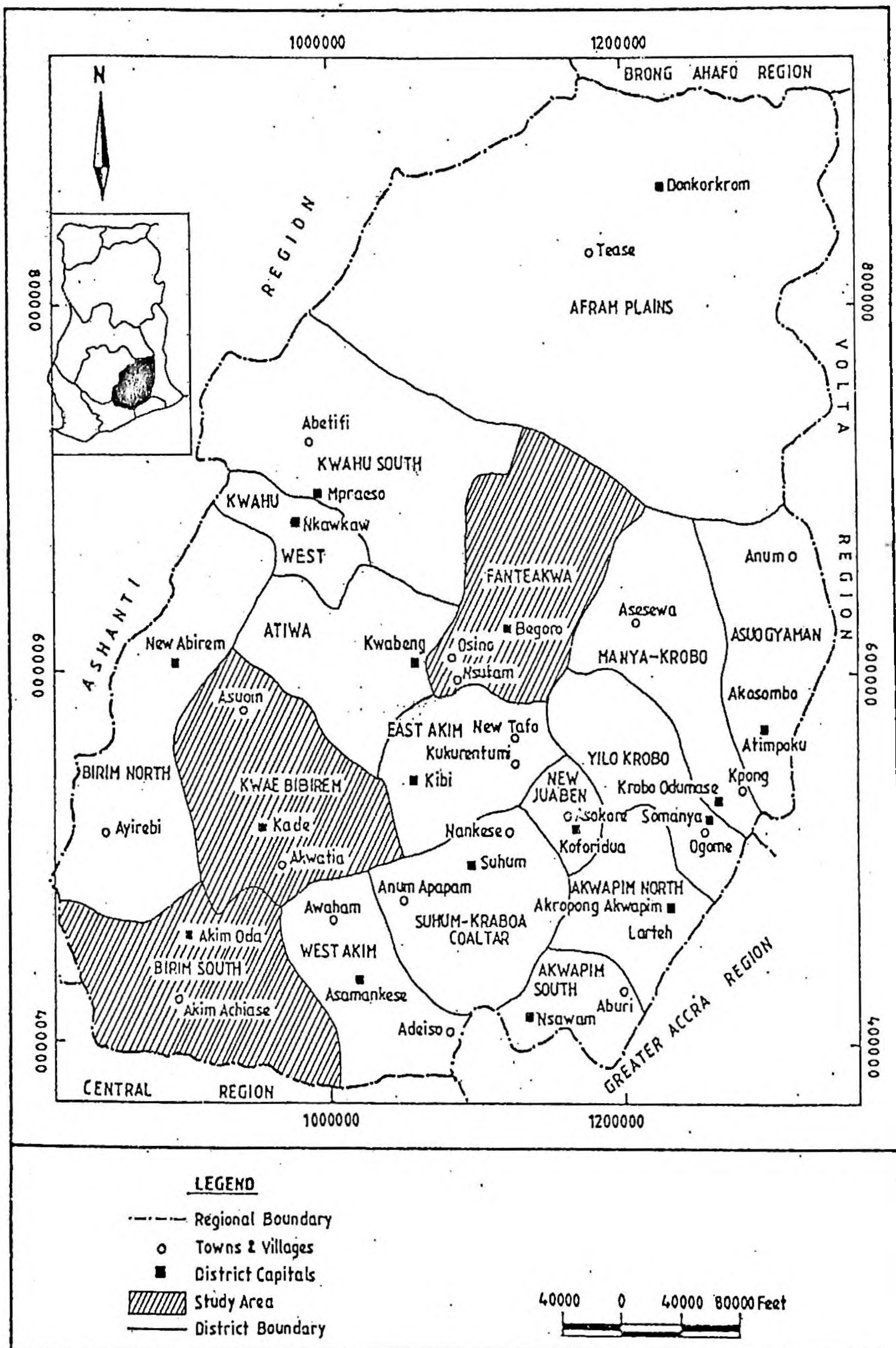

Figure 5: Study areas in Regional and National context

Source: Department of Geography and Regional Planning, UCC, (2011)

Significance of the study

The motivation for the researcher was to explore how quality of maternal health interventions is being pursued by the Ghana Health Service in the Eastern Region. Ghana has been implementing maternal health interventions aimed at reducing maternal deaths through PHC for more than five decades (since 1957).

Thus, the researcher sought to contribute to enrich our understanding on how far we have come since 1987 when an international conference brought global attention to an issue that previously had been ignored: the world's alarmingly high number of maternal deaths in childbirth. The conference ended with a declaration calling for a reduction in maternal mortality by at least half by the year 2000. The study results, especially from the point of view of participants, will inform us about how far Ghana has improved the quality of maternal health interventions.

Secondly, the study will contribute to the literature and knowledge of a crucial public health issue. Issues such as maternal health will serve as a useful source of reference for academics, researchers, students and policy makers interested in doing further studies in the area that was investigated. The study outcome could also be useful to practitioners in the health care sector, policy makers and NGO's interested in maternal health with the view to ensuring the realization of Millennium Development Goals (MDG's) four and five (reducing child mortality and improving maternal health).

Results of study, if shared with the community, might galvanize the people to action. On the other hand, if the findings are promising, the community can be shown that they are already doing a good job and should

keep it up. Alternatively, when the results are disappointing, this could also serve as a catalyst for discussions with the community on the most appropriate means of action. Similarly, the results of the study could be used to shape the communication strategy by assisting to further segment the priority interaction groups, sharpening communication objectives, and focusing content of health education. The health development plans of the Regional Health Directorate show a strong desire to develop and promote interventions to reduce maternal deaths in these areas. Furthermore, the study areas offer an appropriate opportunity to examine community reaction to maternal health interventions.

The research outcome and knowledge from the study will go a long way to help policy makers and planners as well as stakeholders interested in health planning and design of appropriate interventions to help improve upon maternal health practices. It is anticipated that the study will contribute to enhancing our understanding of the proximate and underlying causes that hinder or enhance maternal health interventions. The above reasons justify the choice of topic and study area.

Research logical process

Given that the entire research is a process that has to be accomplished, Figure 6 summarizes the systematic and the logical process the author went through to accomplish the research goals and objectives. It briefly chronicles all the important and relevant steps necessary to ensure the successful completion of the research project reported in this thesis. By and large, it was these logical steps that guided the entire research process. The details of each step are well articulated in the relevant chapters and their related subsections.

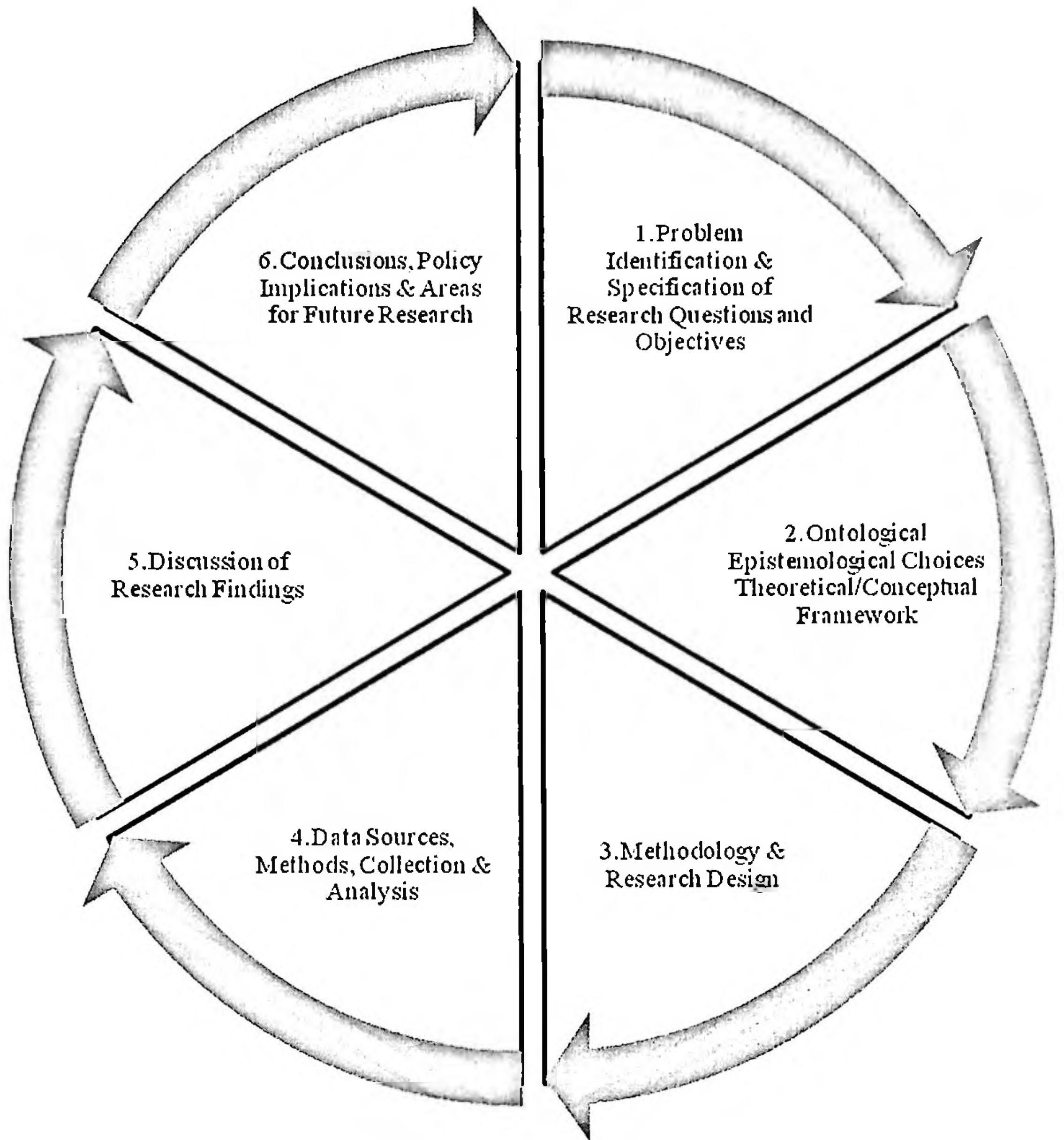

Figure 6: Research logical process

Source: Adapted from Antwi (2005)

Limitations of the study

Like many academic research enterprise this study has some limitations. First, despite a very large sample size, the statistical power remains modest for less common causes such as those leading to maternal deaths. However, for most of the major public health conditions of importance, sufficient events should occur to generate plausible absolute rates

and relative risks for risk factors. Second, careful attention in design means that most identified biases should be minimized and should ensure high internal consistency of fieldwork and coding. However, periodic revalidation of mortality outcomes against external standards as well as continuous improvement of exposure measurements, partially through careful pilots guided the study.

The study is only limited to three (3) districts out of twenty-one (21) in the Eastern Region of Ghana. Specifically, the Ghana Health Service (GHS) is used as a case study, there are other ministries which have significant roles or interventions to play in order to ensure the success of maternal health programmes; but were not considered in the study. Time and financial resource constraints did not permit the inclusion of other government ministries, departments and agencies (MMDAs) within the larger public sector.

Organisation of the study

The entire study is set out in nine chapters. Chapter one introduces the research agenda by outlining the general introduction, statement of the research problem, research objectives and questions, scope and significance of the study, research logical process limitations, and organisation of the of the study.

The second chapter examines the concept of health and the social determinants of health. The social theory of perception and the perception of quality of health care by both patients and health providers are the subject of the third chapter.

Chapter Four reviewed the literature on maternal health care and the factors which contribute to the escalating maternal death situation in Ghana. Accessibility difficulties which result in different forms including geographical distance, socio-economic distance, gender distance and spatial accessibility were considered. Furthermore, the effect on health outcome indicators due to economic inequality, private healthcare and economic inequality as well as the concept of quality in health care were discussed.

The three delay model and the proposed framework guiding the study and gaps identified in the literature are also discussed in chapter five. Chapter six brings on board the methodological issues and presents the adapted research design. It explains the philosophical basis of the study and the methods used to collect and analyse data as well as limitations and ethical considerations of the thesis.

The research analysis and results are captured in chapters seven and eight. Basically, these chapters present the empirical evidence generated from the secondary and primary data to answer the research questions raised, the objectives, as well as the conceptual and methodological framework of the study.

The final part of the thesis is focused on the discussions of the main research findings which summarizes and crystallizes the major findings and thereby drawing the appropriate conclusions, as well as discussion of the policy implications, recomendations and carved areas for future research.

CHAPTER TWO

DETERMINANTS OF HEALTH AND SOCIAL THEORY OF PERCEPTION

Introduction

This chapter of the literature review examines the social determinants of health, social theory of perception and factors influencing perception, as well as the link between perception and decision making.

The concept of social determinants of health

In his influential book 'The role of medicine – dream, mirage or nemesis', McKeown (1979), put forward a formidable and convincing argument to the effect that health care itself made only a minor contribution to the massive improvements in people's health between the mid-nineteenth and mid-twentieth century in the developed world. McKeown's argument was based on the fact that between roughly 1850 and 1970, the greatest reduction in mortality and advances in life expectancy for particular diseases occurred before the introduction of improved medical treatments for those conditions. He argued that these advances were actually the result of better nutrition associated with rising living standards. He even rejected any significant role for public health measures such as improved hygiene and sanitation, again because they only became effective after the decline in mortality was well underway (Mackenbach, 1996).

It is plausible to argue that, McKeown's theories flew in the face of accepted wisdom which saw scientific advancement and better medicine as the principal drivers of better health. His controversial hypothesis helped revolutionize how the health of populations was viewed. For nearly two decades or so, a whole new theory and field of research has grown up that, like McKeown's hypothesis, locates the major factors determining the health of populations outside the health care system, but which goes much further in exploring and documenting these factors.

According to the theory of the social determinants of health – a notion now supported by numerous studies and substantial evidence reviewed by the WHO (1984), explanations of illness could be discussed in terms of exposure to certain individual risk-factors (for example viruses, bacteria, smoking, alcohol misuse, or being overweight) are a powerful way of understanding disease and illness. Considerable evidence has now emerged that in addition to these individual causes lie other deeper causative factors, which can be described as the social determinants of health. According to a report by the WHO (1984), a person's social and economic position in society, early life experiences, exposure to stress, their educational attainment, employment status, exclusion from participation in society, and transport, all exert a powerful influence on their health throughout life (WHO, 1984).

In locating the major drivers of health and ill health outside of the health system – whether in living standards or the broader social determinants of health – these theories and research findings have presented a major challenge to health systems and the health professions. In other words, if poor health is largely driven by issues of poverty, poor nutrition, education, life

control, racism, housing, transport, addiction, employment etc, what role does the health system have in creating better health? Health service providers and policy makers have had to deal with two common reactions to this challenge. On the one hand, all too often the reaction is to acknowledge the importance of these 'upstream' factors that so powerfully influence health. On the other hand, we tend to consign them to the background, as issues that are too hard to address and outside the responsibility of the health system (Moodie, 2000).

The work of McKeown in the 1970s and more recently, substantial evidence of the importance of the social determinants of health, have critically challenged the 'common-sense' idea that improved population health is simply the result of better health care. His analysis was based on a particular social, epidemiological and historical context, and the time since then has been marked by significant advances in health care treatments, technology and organisation. This has included, in particular, the development of safe and effective treatments for chronic diseases, changes in the organisation of health care in developed countries (including, for example, the adoption of evidence-based medicine), the development of organised approaches to public health and the development of comprehensive primary health care.

Researchers have attempted to refine and elucidate the link between health systems and health status in a number of ways – for example, by relating national health status to health system spending or numbers of health professionals per capita. Making such comparisons across national borders is fraught with methodological problems. Most significantly, the diverse nature of how health systems are organised and the confounding effects of the

numerous health systems affect the determinants of health. It is not surprising, then, that the evidence is mixed.

Social determinants of health hypothesis by McKeown

The consensus among most historians about the McKeown thesis, a quarter of a century ago after it first stirred controversy is that one narrow aspect of it was correct - that curative medical measures played little role in mortality decline prior to the mid-20th century. However, most of its other claims, such as the assessment of the relative contributions of birth rates, public health and sanitation measures to population growth, were flawed. A new historical orthodoxy has, however, taken its place. The complex inter-relationships between economic changes, social trends, and professional medical and public health activities remain refractory to simple or sweeping explanations. Much of the problem in arriving at unified theory of change, as has been noted by Condran (1987, p.125) is that "competing explanatory variables were changing simultaneously".

Many public health and medicine historians in particular, have used McKeown's ideas as a starting point to re-examine and re-assert the value of various sanitary reforms, which he had discredited. For example, Condran (1987) acknowledging the McKeown thesis, examined the influence of public health and sanitary measures such as improvements in the milk and water supplies and in child care practices in Philadelphia and concluded that 'intervention as against economic growth was a major source of the decline in mortality in American cities' (Condran, 1987, p.125). The ongoing interest in McKeown's ideas, not only among historians but also among policymakers

addressing contemporary issues, is striking. What accounts for his work's remarkable durability? Why has the influence of the McKeown thesis persisted even after its conclusions were discredited?

In part, his writing continues to generate responses because many scholars believe that although McKeown's analysis was flawed, his underlying ideas regarding the effects of poverty and economic well-being on health were essentially correct. More broadly, McKeown's influence has continued to be felt because his research posed a fundamental question that has lost none of its relevance in the decades since he began writing in the post–World War II era: Are public health ends better served by narrow interventions focused at the level of the individual or the community, or by broad measures to redistribute the social, political, and economic resources that exert such a profound influence on health status at the population level?

Although McKeown's formulation of this question achieved unusually wide visibility, for the reasons discussed above, he was not the first to raise it. His work represented a reframing of a much older debate, dating to the latter part of the 19th century, between sanitary reformers devoted to improving social conditions in the broadest sense and germ theorists dedicated to controlling disease through the sophisticated tools of bacteriology. Far from fading in prominence, the questions he raised have assumed new salience at the beginning of the 21st century, especially in debates about how best to confront health threats such as AIDS, tuberculosis, and malaria in the developing world. For example, commenting on the recent initiative to provide AIDS drugs in poor nations, a health activist based in Nepal summed up the two sides of this debate and noted that, "There has been an overemphasis . . .

[on] drugs. The lack of drinking water is a much bigger priority in most countries than anti-retroviral treatments" (Steinhauer, 2001).

Marmot, Smith and Stansfield (1991) argued that most research findings suggest that broad social conditions must be addressed in order to effect meaningful and long-term improvements in the health of people.This research challenges public health professionals to view targeted interventions and social change, not as opposing choices, but rather as essential complement to each other, and to find ways to integrate technical preventive and curative measures with more broad-based efforts to improve all the conditions in which people live. These concepts, which lie at the heart of the McKeown thesis, account in large measure for its continuing resonance in the field of public health. McKeown's work, empirically flawed though, may have been placed before a wide audience a set of practical and ethical challenges with which policymakers in the United States and internationally will continue to grapple with in the coming decades.

Thirty years on, most workers in the field would agree in broad terms with McKeown's hypothesis. Nevertheless, his theory has been refined and most theories advanced in recent years see the provision of health care as at least part of the explanation for better health. For example, in his highly influential book, 'Regarding contribution of medical care to mortality decline', Mackenbach (1996) suggests that increases in life expectancy in 20th Century Britain were particularly strong in those periods marked by a strong emphasis on social sharing, and the public provision of health care and nutritional support.

Shortcomings of McKeown's hypothesis

The literature suggests that it was on empirical grounds that the McKeown thesis was challenged. The quantitative techniques used by historical demographers grew in sophistication from the 1950s to the 1980s (Preston, 1996). In England, the Cambridge Group for the History of Population and Social Structure began in the early 1960s to generate a considerable body of influential work on population trends in Britain (Saito, 1996). For instance, parish registers dating from 1538 recorded baptisms, burials, and marriages for the period before the first census in Britain.

The group's groundbreaking research gave rise to numerous articles that presented a more complete and nuanced view of population change than McKeown's work had offered (Hollingsworth, 1964). One of the criticisms of McKeown's later work was that it failed to acknowledge and incorporate these more recent findings. He countered that the parish data being used by the Cambridge Group were problematic because of their fragmentary and ambiguous nature. Answering his critics in a 1978 Population Studies article, he declared that "few would claim that they [parish records] provide a reliable picture of national fertility and mortality trends before the nineteenth Century" (McKeown, 1978).

The research of the Cambridge Group culminated in the publication in 1981 of the'Population History of England 1541–1871' by Wrigley and Schofield, which represented perhaps the most significant challenge yet to the credibility of the McKeown thesis (Wrigley et al., 1981). Applying a variety of sophisticated new statistical and analytical techniques to the parish registers to overcome problems of accuracy and interpretation, Wrigley and Schofield

(1981) produced a comprehensive and authoritative volume that conclusively demonstrated the invalidity of a central feature of McKeown's reasoning that the growth in population was due to a decline in mortality, not a rise in fertility. Indeed, the book dismissed the thesis of McKeown.

Probably the most detailed and thorough critique of McKeown's research came from an article by Szreter (1988). He claimed that the thesis suffered from conceptual inaccuracy, especially with respect to the catchall term 'rising standards of living', which conflated a heterogeneous group of phenomena, some of them related to economic changes and others to social reforms. What was more damning is that he conducted a new analysis of McKeown's own data on mortality trends in the 19th Century and found that McKeown had misinterpreted the death records, confusing the difference between tuberculosis, bronchitis, and pneumonia. This misreading led to, among other errors, an incorrect description of the timing of the decline in tuberculosis mortality and an underestimation of deaths from bronchitis and pneumonia, which he asserted played a more prominent role in overall mortality than McKeown had allowed. In his new interpretation of the data, public health measures such as clean water and milk supplies assumed greater importance, while changing social conditions, to which McKeown had attributed beneficial effects such as improvements in nutrition, were in fact a detrimental influence, resulting in, for example, overcrowded and poorly constructed housing resulting from rapid urbanization.

Finally, Szreter (1988) turned his attention to what he viewed as a crucial weakness that underlay McKeown's research. In other words the latter had allowed his prior assumptions about the limited value of medical

intervention and the need for social reform to predetermine his analytic categories, thus biasing his interpretation of evidence. Szreter (1988) concluded his critique examining the ideology that influenced the research with the following quotation below:

> "McKeown's professional and political battle was primarily directed against those who argued for ever greater diversion of the new National Health Service resources into curative technical medicine-invasive surgery and biochemical "treatments"—at the expense of preventive, humanistic medicine-efforts to understand and modify the health implications of the environment in its widest sense. . . . McKeown's exploration of the historical record was fantastically effective in these professional, political terms, thoroughly puncturing the inflated claims to importance, on the grounds of a supposed long history of life-saving achievements, of the medical "technocrats" (Szreter, 1988, p33).

Social theory of perception

According to Davies and Hougton (1991), the social theory of perception, is concerned with the interpretation of quality care of behaviour in social setting and generally refers to how people perceive others whether favourably or unfavourably. Of particular interest to psychologists are the processes by which individuals form opinions of other people or group of people and how these affect the quality of relationship with them. These factors include the means by which initial impressions are formed, the reasons

for prejudice and discrimination and also the development of linking and relationship with specific individuals through interpersonal attraction.

The theory in its contracted form argues that a person's first impression tends to influence people positively or negatively. In other words, a person's first impression may either draw people unto him/her or force people to withdraw. It stresses that often people tend to make sharp judgments about others and categorize them according to characteristics such as physical appearance, dress, accent, and so on. Initially these features are usually all we have to go through and as such can serve as a basis for future interactions (Davies & Hougton, 1991).

A person's character for example, hardworking, friendly, warm, cold, reserved or stubborn can positively or negatively influence peoples' perception whether to accept or reject that individual. The initial or later impression formed by an individual or presented to an individual may go a long way to influence peoples' perception. The theory implies that the initial or later impression formed by an individual or service provider may influence clients' perception positively or negatively to accept or not to accept the service received.

Pariani (1991) reports that the attitudes and skills exhibited by service providers can easily influence clients in a positive or negative way and may, thus, influence one's perception to accept service rendered. However, it is useful to note that even though impression formation has been found to be effective in influencing peoples' perception, it may not always be the case as impression may become distorted if assumptions are made from limited data.

One other related factor, which influences peoples' perception, is the prejudice and discrimination. Prejudice and discrimination in their restricted sense happen when clients begin to prejudge and have an unfavourable negative attitude towards a particular group of people. This normally takes place when people have negative attitudes or assumptions about people they are dealing with. This observation notwithstanding, prejudice and discrimination could also be from positive point of view. The focus of the client (whether positive or negative) may finally determine whether the client would cooperate with the service providers or discriminate against them. The issue is that both positive and negative inferences may be based on limited information but once an opinion is formed it would be difficult to erase. The advantage is that even though the initial information may be false or limited, the service provider can enjoy the support and the trust imposed in him/her by the clients based on the initial inferences, and generalization made about him/her (Davies & Houghton, 1991).

These stereotypes formed may be based on false assumptions, even though, in some cases, may be true. The problem of prejudice and discrimination, which form part of the social theory of perception, is that individuals may form a prejudiced viewpoint against others for many reasons and once formed, this prejudice may be highly resistant to change. At best, these unfavourable attitudes to others could only be reduced under certain circumstances, even though their perception may not have any basis for prejudice and discrimination against others. Consequently, these stereotypes may influence peoples' perceptions towards accepting or rejecting people and the kind of services that they provide.

Interpersonal attraction, one of the factors of social theory of perception which explains peoples' perception, posits that often people are attracted to others based on the quality of interaction. Several factors have been identified as major determinants for good interpersonal attraction. They include physical attractiveness, familiarity, mutual liking, similarity, complementarily and perceived competence (Davies & Houghton, 1991).

Physical attractiveness may be important for a number of reasons, one of which suggests that being in the presence of an attractive person gives prestige and status to the individual concerned. For example, attractive appearance by the use of clothing, cosmetics (good looks) may influence client perception towards the service provider. Familiarity, it is said, breeds contempt implying that the more contact you have with someone, the less you come to like them. In some cases, this may be true. However, in contrast to this view is the notion that familiarity and physical proximity lead to liking. Physical proximity to others permits regular contact, which in turn makes it generally likely that friendship will result (Bruce, 1990).

Mutual liking, which is one of the determinant factors, suggests that we like people who like us in return, and conversely those we dislike are people who appear to dislike us. This idea may be closely associated with self-esteem since it is comforting and satisfying to receive approval from others, whom we then respond to in similar ways. This seems particularly true when we are placed in a vulnerable position. Similarily, one of the determinant factors posits that it is often the case that our friends share similar beliefs and attitudes with us. Indeed, this may have been one reason for becoming friends in the first place; for example, people who share common beliefs may like

each other. For this reason, it has been indicated that there is a significant relationship between attraction and similar attitudes (Bruce, 1990).

The effects of similarity however, need not always lead to liking. It has been assumed that there is greater liking of others that had expressed liking of them, even though such people may not have the same attitudes. People usually like people who share similar values, others who find us attractive despite differences of opinion are sometimes liked more because we assume that they like us not just because of what we think (Aronson, 1988).The factors that account for interpersonal attraction, which suggests a link between similarity and attraction may include complementariness. Some people in relationship tend to have complementary attitudes, so that when combined, a harmonious relationship results. This notion, however, is not always the case. The length of relationship of individuals or groups of people could bring about harmonious relationship even though their qualities may not complement in any way (Stoner et al., 1995).

Perceived competence also has it that people tend to be attracted to those who appear capable, knowledgeable and intelligent as opposed to those who are not. In addition, we may gain some satisfaction from being with people who demonstrate competence in what they do. Thus, a competent person may become more endearing in our eyes if he or she occasionally shows signs of imperfection (Aronson, 1988). Bruce (1990) and Lewin and Wong (1990) are of the view that perceived competence of service providers attracts clients to them. It must be noted, however, that continued exhibition of competence does not always attract people.

Bruce-Jain model on perception

A framework developed by Judith Bruce in 1990, has been very influential in focusing attention on the clients' perspective of quality care (Bruce, 1990; Jain, Bruce, & Barbara, 1992).The Bruce-Jain framework includes six elements of quality care in any given services namely; (i) choice of methods, (ii) information given to clients, (iii) technical competence, (iv) interpersonal relations, (v) mechanism to encourage continuity, and (vi) appropriate constellation of services.With growing recognition of the clients' perspective, quality in any given service is being redefined as the way clients are treated by the system. When providers and those who work put clients first, they offer services that not only meet technical standards of quality but also satisfy clients' need for other aspect of quality, such as respect, relevant information, access and fairness (Bruce, 1990; Donabedian, 1980).

It is in the light of the above that the Bruce-Jain framework (Bruce, 1990; Jain et al., 1992) was introduced to deal with clients' perspective of quality care. It tends to examine the factors which influence clients' perception, (whether young, or old) towards quality service delivery of any given programme. The fundamental issue of the framework is that people everywhere continually assess the quality of the services that they receive. Given a choice, they use providers and facilities that offer the best available care, as they perceive them (Mens, Miller & Fisher, 1994).

One element of the Bruce-Jain framework explaining quality care is choice of methods. It is argued that successful programmes provide a range of methods, not just one or two. Offering a wide range of methods to clients afford them the opportunity to choose from the many options and alternatives

that meet the diverse needs of the clients. Riley (1994) argued that, choices of methods are the surest way that guarantee clients their rights to choose from varied options and alternatives that would best suit their interest, aspirations and needs. This is what would help the clients to make judicious decisions to effect changes in their behaviour.

Another element in the Bruce-Jain framework of quality care is information provided to clients. Thus, adequate and accurate information is essential for the provision of quality care for the client. It submits that clients value information and where it happens that programme organisers are not telling them all the facts, they become frustrated. Clients need useful and understandable information. It should explain to the clients various options and possible results. It should help clients make a specific decision. Information should help a client understand what the information means to him or her personally. Toole (1996) and Baltimore (1991) affirm this assertion by contending that providers should give clients accurate information about all available methods and more detailed information about the methods that they choose.

One other factor explaining the framework or clients' perception of quality care is the technical competences of the service provider. It opines that clients can and do judge the technical competence of the services they receive, although they may not use the same criteria as providers and they may not be technically accurate. Ultimately, clients judge technical competence by whether their needs are met or their problems are resolved. Bruce and Jain (1990) and WHO (1996) are of the view that technical competence and skills bring about good care and at the same time attracts, satisfies and keeps clients

by offering them the services, supplies, information and emotional support they need to meet their goals. It is further agreed that offering good quality care has always been a goal of any given programme and providers are always looking for ways to serve growing numbers of continuing clients and to serve them better, since the quality of services often affects whether people keep using any given programme or not.

Interpersonal relations also constitute one of the main elements of the Bruce-Jain framework of quality care. They affirm that good interpersonal relationships that exist between service providers and clients go a long way to promote fruitful co-operation and understanding in the course of their interactions. Clients want to be treated with respect and friendliness as they interpret courtesy, confidentiality and privacy as signs that providers are treating them as equals. Dealing with providers who treat them badly is more than some people are willing to endure. It argues that understanding a client is one way of promoting the programme. Clients value individualized service and prefer providers who make the effort to understand their particular situation and needs. They want providers to listen to them, to explain options in terms of what they understand and to assure them that problems can and will be taken care of. When providers are unresponsive and frustrated, clients may drop out.

Furthermore, proponents believe that clients want fairness in their dealings with the providers. Clients want providers to offer thorough explanations about issues to everyone alike. They abhor preferential treatment to friends, relatives, those from a higher social class or ethnic group, those with political connections or those who offer bribes. These viewpoints are

similar to that of Pariani (1991), who claimed that in dealig with clients; service providers are prepared to fairly deal with them.. They observe that clients continue to use methods or services when the providers are responsive and sensitive to their need for privacy. They also contend that clients may discontinue using services if providers are not friendly or if providers treat clients rudely. Mechanism to encourage continuity of programme and to whip up the interests and enthusiasm of clients also constitutes one of the factors that influence clients' perception of quality care towards accepting a programme or otherwise. It suggests that appropriate human and material resources must be put in place to attract the clients to the programme.

Both material and human resources are expected to meet the needs of the clients. That is to say that the service providers must find appropriate material resources available at the institution to work with and also to satisfy the needs of the clients. Where appropriate material resources are available for use by the clients but the human factor is lacking, clients may not get the needed satisfaction. Both human and material resources must be available and be put into maximum use to enable the target group (clients) achieve the desirable results. It is expected that with these services at the disposal of the clients, continuity of programme and active participation of clients would be achieved.

This point is reinforced by the fact that clients expect results in their dealings with service provides in any given programme. They are, therefore, dissatisfied when told to come back another day, to go to different facility or dismiss complains as unimportant. The idea here is that, they do not want anything that would frustrate them. Pro-active mechanism to encourage

continuity should therefore be put in place to satisfy the aspirations of the clients (Bruce, & Jain, 1990; Kumah, 1992).

Finally, the framework talks about appropriate constellation of services, which significantly influence clients' perceptions of quality care towards any given programme. Programmes succeed better when clients know where to go for information and services. The goal of every programme is to effect a definite change in the behaviour of the people. There is, therefore, the need for clients to get clinical services apart from the information that they receive from the service providers.

Young people may need contraceptives or any other health related services in order to survive. If for some reason this service is not available, the impact of the information one has received will not be well felt. According to the International Planned Parenthood Federation (IPPF, 1995) this viewpoint is re-emphasized by the reason that adolescents need a wide range of services to enable them respond to their reproductive health needs. In this direction, governments, non-governmental organisations (NGOs) and the private sector should increase the availability and accessibility of adolescent reproductive health services including, family planning, and management of sexually transmitted diseases, post-partum care and counseling at both public and private outlets.

Strengths and weaknesses of Bruce-Jain framework

Like any other framework, the Bruce-Jain (1990) model of perception of quality care has its own strengths and weaknesses. With respect to its advantages, it could be said that the issues raised are relevant to both youth

and adult. There is no doubt about how these factors could influence clients' perception of quality of care. The factors discussed in the framework are positive elements, which every human being needs to be accorded. For example, giving clients opportunity to choose from a wide range of methods accords them their dignity as individuals to decide what they want. Appropriate information to clients, technical competence of service providers, interpersonal relations that should exist between clients and service providers, and mechanism to encourage continuity and appropriate constellation of services all go to show how the needs, interest and overall welfare of the clients are taken into consideration.

The model addresses the clients' concerns about the quality of service that people are expected to receive from service providers. The model also cautions service providers to be respectful, careful and diligent in providing services to clients in order to win their support, confidence and cooperation. It attempts to find solutions to situations where both service providers and clients would be suspicious of each other. Thus, it is a client-centred model which supports modern technique of interaction (Whittaker, 1996; IPPF, 1995; Kumah, 1992).

Despite the strengths of the model, it fails to discuss issues relating to impression formation by clients, familiarity that exists between clients and service providers as well as physical attractiveness of the service provider which significantly influence clients, and for that matter, the youth's perception of quality care delivery. These weaknesses notwithstanding, the model has been quite influential in focusing attention on the youth perspective in terms of their social, psychological and emotional make up (Bruce, 1990).

Summary

This chapter has argued that there is not one comprehensive model or theory, which explains why people perceive the way they do. This suggests that, there is no one conclusive theory of perception but rather collections of theories which seek to provide explanation as to why people perceive the way, they do.

Improving quality of care for clients means understanding their cultural values, previous experiences, and perceptions of the role of the health system, and then bringing reproductive health service providers and the community together to map out a shared vision of quality. Culture stands for the mode of living, custom and beliefs, and therefore, it is socially constructed and learned. The cultural pattern of people has direct bearing on health activities. Similarly, enhancing quality of care for providers requires identifying their motivations, addressing their needs (including general administrative and logistical support from the health care system), and helping them to better understand and address clients' concepts of quality. Understanding of culture is important to bring about changes in habit, custom and belief of a community with respect to the health of the individual and community.

CHAPTER THREE

CLIENTS' PERCEPTION OF QUALITY OF CARE AND THE CONCERNS OF SERVICE PROVIDERS

Introduction

This chapter examines the perception of quality of care from both the provider and supplier of care and the recipient of delivery. The influence of society on maternal health and the knowledge, beliefs and attitudes of women during pregnancy are also discussed.

Clients' perception of quality of health care

According to Hulton, Matthews and Stone (2000, p.9), quality of care is: ''the degree to which maternal health services for individuals and populations increase the likelihood of timely and appropriate treatment for the purpose of achieving desired outcomes that are both consistent with the current professional knowledge and uphold basic reproductive rights''.Godlee (2009, p.10) argues that, one of the simplest definitions of quality of care in health is care that is ''clinically effective, safe and a good experience for the patient''.Patients are the judges of their own personal circumstances and expectations (Morgan, 1988). The judgment of quality is determined not solely by the objective output of care but by how the output filtered through the expectations, needs and knowledge and values of the stakeholders. This means that perception of service aspect is important for the evaluation of care

delivered as an essential factor to consider when analysing the quality of care of health facilities from the perspective of the client (Arnetz & Arnetz, 1996).

Patient satisfaction is one of the important goals of any health system, but it is difficult to measure the satisfaction and evaluate responsiveness of health systems as not only the clinical but also the non-clinical outcomes of care do influence the customer satisfaction. According to Agrawal (2006), patients' perceptions about health care systems seem to have been largely ignored by health care managers in developing countries. Patient satisfaction depends on many factors such as: quality of clinical services provided, availability of medicine, behavior of doctors and other health staff, cost of services, hospital infrastructure, physical comfort, emotional support, and respect for patient preferences (Jenkinson, Coulter, Bruster, Richards & Chandola, 2002). Mismatch between patient expectation and the service received is related to decreased satisfaction (McKinley & Roberts, 2001). Therefore, assessing patient perspectives gives them a voice, which can make public health services more responsive to people's needs and expectations (WHO, 2000).

In the recent past, studies on patient satisfaction gained popularity and usefulness as it provides the chance to health care providers and mangers to improve the services in the public health facilities. Patients' feedback is necessary to identify problems that need to be resolved in improving the health services. Even if they still do not use this information systematically to improve care delivery and services, this type of feedback triggers a real interest that can lead to a change in their culture and in their perception of patients (Boyer, Francois, Doutre, Weil & Labarere, 2006).

For clients and communities, quality of care is something that meets their perceived needs. Marr and Greengarten (1995) have stated that clients make judgments about quality based on variables they can appraise (courtesy, responsiveness, attentiveness and perceived competence of staff) and not what the provider of the service perceives it to be. The quality of the service then becomes a perspective whose precursor is customer satisfaction or the gap between client expectation and perception of factual service received (Donabedian, 1994). Interest in client satisfaction has developed mainly because it is an outcome variable that enables providers and managers to decide where to focus energy and resources (Harteloh & Verheggen, 1994). This observation is important if viewed from Donabedian's argument that, client can play some roles to improve the quality of care: - such as definers, evaluators, informants, co-producers, targets, controllers and reformers of health care (Donabedian, 1994).

To give high quality care, providers must understand and respect their clients' needs, attitudes and concerns. These clients' perceptions are in turn affected by personal, social and cultural factors. Research evidence highlights the benefits of addressing quality care concerns from client perspectives on quality of care, since it leads to improve client satisfaction, continued and sustained use of service and improved health outcomes (Kols & Sherman 1998; Bertrand, Hardee & Magnani, 1995; Vera, 1993). Client's perspective on the services they receive is considered an essential part of understanding and assessing quality of care. Client's perceptions are shaped by their cultural values, previous experiences, perceptions of the role of the health system, and interactions with providers. Their perceptions affect how clients view the risks

and benefits of care (Kelley & Boucar, 2000 cited in Creel, Justice & Nancy, 2002).

Thompson and Suñol (1995) found that patient satisfaction depends not only on service quality but also on patient expectation. Patient's satisfaction is an important indicator of service quality (Vouri, 1992). Client satisfaction may not necessarily mean that quality is good; it may only indicate that expectations are low. One woman in Bangladesh noted, "Even though the providers behave badly, I have to be content. We are lucky if we can get free medicine that they give out at the clinic.....We are poor people; how are we going to get better treatment than this''? (Schuler, Bates & Islaml, 2002, p. 279).

Clients may also argue that they are satisfied with care because they want to please the interviewer, worry that care may be withheld in the future, or have some cultural or other reason to fear complaining (Kols & Sherman, 1998). Further, educational and class differences between clients and providers often limit ability to access services. Thus, health providers should not assume that the quality of care provided is good because patients do not complain. According to Gilson, Alilio and Heggenhougen (1994), when patient's perception of quality of care is inaccurate, their expectations are likely to influence producer's behaviour and may be likely to lower the quality of care. In both cases, providers were afraid that patients would switch to other providers if they did not receive the care expected.

Variations in experiences and social environments mean that different clients define quality in different ways, but despite its changing face, no one can argue that client's satisfaction is unimportant. Patient satisfaction is a

strong influencing factor in determining whether a person seeks medical advice, complies with treatment and maintains a relationship with the provider or health facility. Ultimately, the dimensions of quality that relate to a client satisfaction affect the health and wellbeing of the community. According to Brawley (2000), the most important dimensions of quality for the client are interpersonal relations, technical competence, accessibility and amenities.

Interpersonal relations

Donabedian (1988) identified trust, respect, privacy, confidentiality, responsiveness, empathy, effective listening and communication between providers and clients as constituting interpersonal relations. The interpersonal relation between a client and a provider is reported by many authors to be one of the most important for client's perception of quality. Specifically, clients prefer a service provider who gives a warm welcome, acts friendly and politely, shows respect and treats clients as human beings, is sympathetic, acts fairly and does not discriminate (practice first come- first serve principle), is humble, communicates well in language the client understands, pay attention to the client, expresses or demonstrates commitment to their work and assures clients of confidentiality (Brawley, 2000).

Client-centred care requires providers to respect clients' point of view, encourage client and assist them in making decisions rather than telling them what to do (Kim, Putjuk, Basuki & Kols, 2000). According to Brawley (2000), the relationship between health worker and client is a tenuous one. The health worker has an opportunity to be extremely influential on a client simply by the way one interacts with that person. Many people view health workers in the

same light as a parent. Consequently, clients expect health providers to behave and act in a manner deserving such respect.Providing more complete and accurate counseling that is tailored to client's needs have been associated with higher levels of client satisfaction as well as client retention (Townsend, 1991). A study of 1,570 Norplant users in Indonesia found that women who had received counseling and information about Norplant were more satisfied than those who received less information (Tan, 1995). Numerous studies cite low client satisfaction of quality of care because of poor attitudes from health workers. For example, in Tanzania, it was discovered that some dispensaries were perceived as offering bad delivery care because of bad attitude of staff (Opare, 1996).

Clients feel more comfortable if providers respect their privacy during counseling sessions, examinations and procedures. One woman commented, "The examination and clean-up afterwards should not be done so publicly, because there are men moving around in the halls and you feel really embarrassed. There should be a curtain or a door. I do not want people to see my body" (Matamala, 1998). According to Whittaker (1996), the provision of services to people by most private health care providers report higher satisfaction due to the fact that, providers usually keep their needs and personal information confidential. Lack of privacy can violate women's sense of modesty and make it more difficult for them to participate actively in selecting family planning method. Clients are more likely to seek out and continue using family planning services if they receive respectful and friendly treatment (Nahlovu, 1995, Kenny 1995 & Vera, 1993), as cited in Williams (2002).

In many societies, courtesy is a sign that client is regarded as the providers equal. In Bolivia for example, when a medical doctor apologized to waiting women for delay and explained its cause the negative perceptions of the clinic may be reversed (Schuler & Hossain, 1998). Also clients value individualized service and peer providers who make the effort to understand their particular situations and needs. They want providers to listen to them, explain options in terms that they understand. The providers' tone, manner and mode of speech are important to client (Schuler & Hossain, 1998, Matamala, 1998 & Whittaker, 1996). In one study in Zaire, most patients who were asked about the two best qualities for a nurse mentioned qualities related to communication style such as respect and attentiveness (Hadded & Fournier, 1995).

Technical competence

Literature suggests that clients are particularly concerned about the qualifications and training of service providers. Clients would expect providers to conduct a proper examination, identify the problem and prescribe treatment. Many clients felt that the health facilities lacked qualified staff and resented being treated by midwives or nurses who were "training-on-the-job." Although facilities often had one trained provider, this person, albeit performing well, was often overburdened. Therefore, clients recommended that the facilities maintain an adequate number of staff to satisfy demand and to eliminate the policy of delegating responsibility to less qualified colleagues.

Many clients feel that the health facilities lacked qualified staff and it was for this reason that, Gilson et al. (1994) also referred to the issue of

unqualified health workers in Tanzania. Clients consider the provider consultation when judging quality of care. According to Brawley (2000), many studies have reported on client perspective on those who felt disappointed that the providers did not spend more time with them to discuss the problem and treatment. Clients thought provider should make the following improvements: spend more time listening to their problems; explain the examination procedure; explain the treatment, give clear instruction about medication; give clients the opportunity to ask questions and provide a referral if necessary. The quality of doctor-patient communication influences patient adherence to treatment, understanding of medical information, ability to cope with diseases and their quality of life (Ong, De-haes, Hoss, & Lames, 1995). According to Nshakire, Whyte, Jitta and Busuul (1996) sometimes, clients view referrals as a failure of the staff or health unit to correctly identify their problems. It treats financial problem for the user in terms of additional transport cost and unfamiliarity with a distant health facility (Creel et al., 2002).

Studies in Bangladesh found that providers of health care gave less information and most disrespectful treatment to the poorest and least educated patients (Schuler et al., 1994). Clients' definition of competence does not always coincide with technical definitions of quality. Ndulo (1995) argued that, clients based their judgment on how thoroughly they were examined. From the above, it could be argued with some degree of certainty that, clients judge technical competence by whether their needs are met or their problems are resolved.

Accessibility

The quality of care barrier does not only cover the quality of maternal healthcare per se, it can also be extended to the adequate staffing of the maternal and newborn health care institutions. Clients prefer to have increased access to health workers and are looking for the willingness to serve them at anytime of the day, even if the provider is not on duty. According to Nshakira, et al. (1996, page 52) the importance of staff living close to a health facility to provide service whenever needed was cited as one main reason that clients prefer private clinics. Many clients want health services to be provided free or that fees charged should be reasonable. Patient's desire affordable fees, not be denied services because they cannot pay charges for drugs, but not examination or consultation services and no unfair charges for beds, "drip water" or medical form (Brawley, 2000).

Clients are generally more likely to use low cost services. A study in Bangladesh indicated that families spent money on health care only in crisis situation. Clients may be willing to accept higher cost if they believe that services are of high quality. In Indonesia, an NGO found that clients were willing to pay reasonable fees for quality services in a range of women's health needs (Sadasivam, 1995). This agrees with findings reported by Opare (1996) in the Toronto District of Canada, where communities were willing to pay for improvement of quality of services.

One study found that people were uncertain about exact cost of health services because the charges varied depending on the services a client received. In addition, client complained of numerous informal charges that they had to pay over and above the formally established fees. Other users

mentioned the need to negotiate and bargain for reduced charges or service that is commensurate with the money they have – 'even if it means getting only one capsule and two aspirins' (Nshakira et al., 1996, page 52). Other clients complained that family and friends were flatly denied treatment because of their inability to pay.

Some of the main causes identified as the contributing factors towards excessive patient's waiting time are the registration time, insufficient number of counter service staff and insufficient number of doctors. Bachman and Barron (1997) argued that long waiting times have caused patient dissatisfaction elsewhere in Africa. Excessive waiting times for elective surgery are an important issue for many health systems in developed countries (Duckett, 2005). They continue to be of major political concern for the public and governments in each country we studied, with some governments investing much political capital in the issue by mandating maximum waiting times.

Traditionally, waiting times have been measured as the time between a surgeon's assessment that a patient needs surgery and when surgery is actually performed. Most of our countries have achieved or are close to achieving national mechanisms for measuring this aspect of waiting. Most systems also measure waiting beyond a defined time period, but this is not always the main focus of concern. Median waiting times are measured in most countries but are not always the basis for target setting. Several jurisdictions are now focusing on "hidden waiting times" by measuring times between referral and surgical assessment and times to access specialized diagnostic processes (Duckett,

2005). Long waiting times and inconvenient clinic hours can prevent clients from obtaining the services they need (Snow, 2000).

Amenities

Amenities refer to client's perception of the physical health care facility, as well as supplies and equipment within the facility. Amenities also include measures that improve cleanliness, privacy and waiting time towards ensuring the provision of quality services. According to Brawley (2000), the concerns expressed by clients for the quality of health care facility, include building in good repair, running water and electricity available all the time; cleanliness/sanitation (examination rooms, toilets/latrines) and having comfort at the health facility.

Perceived quality is one of the most important determinants of patient's choice of providers and willingness to pay. In Cameroon for example, a particular health centre was found to be very popular because management charged fees and used the revenue to improve drug supplies as compared with health centres that did not charge and did not improve drug supplies. This was seen as an evidence of user's willingness to pay for services as being of good quality. Patients equate availability of drugs with high quality services (Litvack & Bodart, 1993). Gilson, et al. (1994, p772) provide the following commentary by a participant in a focus group discussion (FGD): "To be frank, drugs are a big problem. It has reached the stage where we have to buy drugs and put them in our pockets, then we go to the dispensary to get them administered''.

Clients believe that a health facility with good quality service must be equipped with diagnostic, blood testing and laboratory equipment. Other suggestions included operational equipment, ambulance, furniture, beds, mattresses and gloves (DISH, 1996). Availability of equipment like microscope was found to be perceived by villagers in Zaire as very important for the quality of service. When asked what they would do if the microscopes were to disappear from the centre, they expressed their readiness to go to another centre (Opare, 1996). In Kenya, patients were asked what the Government should do to improve the quality of care; 42 percent said they wanted enough drugs, 7.9 percent renovation of building and 4.7 percent supervision of the medical staff. When respondents were asked for reasons for visiting a particular health facility, the reasons given by majority were because it was near to their home, followed by availability of drugs, good patient/staff relationships, referrals, good treatment and sanitation (Mwabu, Mwaozia & Liambila, 1995). Patients consider cleanliness of a facility as a sign of quality of the facility's services. Vouri (1992) indicated that majority of people using Government services judge the quality of care by the condition of the health facility and the surrounding environment.

Concerns of service providers on quality health care

Although the main focus of the literature review was to evaluate the client perspective of quality of care, it is also interesting to understand some concerns that service providers have regarding the subject under investigation. According to Bannerman, Tweneboah, Offei and Acquah (2002), health care managers are mostly concerned with judicious use of resources (efficiency)

and good results (effectiveness). Specific concerns identified by the health care managers include: cost recovery, utilization, accuracy of records; positive health outcomes and loyalty.

Brawley (2000) argued that, the concerns of service providers include the need for continuous training of staff to improve technical practice. Human resource development, availability and adherence to clear guidelines for management procedures, good image of the health facility and improving technical and management skills of a staff are considered important concerns. She further argued that, proper examination of patients is a must for quality care. She explained that, at times, patient demands inhibit proper medical practice (i.e. the desire for injections). Providers recognize the need for adequate communication about procedures and a positive interaction with the client (i.e. receiving patient politely, showing kindness, using language a client understands).

On availability of drugs, Brawley (2000) emphasized that, providers more often stressed supply problems rather than management or prescription habits as the reason for lack of a drug supply at the facility. Brawley (2000) further explained that poor pay, delayed salaries and lack of allowances are not conducive to the provision of quality of care. These things cause low morale and motivation for providers. Providers would also like to see proper appointment and confirmation of their positions, as well as occasional promotions.

Furthermore, putting in place incentive system and motivation strategies to sustain quality assurance (QA) initiatives, development of the culture of quality among staff; secure the support of health care professionals

to ensure ownership of the programme; lead in the improvement of internal and external customers relations and establishing effective communication system are equally relevant when considering quality of care (Brawley, 2000). Management's role will be incomplete with looking at the review processes. A constant provision of influx of new ideas through feedback and evaluative processes is very important. Feedback for corrective action and review of the function and activities with the view to providing the client with what will satisfy him/her for the utilization of facility is pertinent to the whole delivery process of quality assessment. Quality assessment system will not be completed without proper framework for review of quality process. This must be done on a timely basis, say once every month or by-monthly. The definition of review process and what it is supposed to achieve at the end of the day is the duty of management.

Finally, it is the moral duty of management to implement quality procedures after the fulfillment of the above in respect of the provision of tools, timely and adequate budgetary allocation, personnel and monetary resources, training for the staff (health professionals), a proper and functioning of quality system, structure, and provision of interface with customers. If these are met, then the implementation of quality procedures will hopefully lead to clients, staff and management satisfaction as proposed by Ovretveit (1992).

Summary

This chapter has reviewed literature on perception of quality of care by patients and providers of health care. The chapter initially highlighted that, patients are the judges of their own personal circumstances and expectations,

and that, the judgment of quality is determined not solely by the objective output of care but by the output filtered through the expectations, needs, knowledge and values of the stakeholders. Relevant issues which affect patient's perception of quality of care such as personal, social and cultural factors were considered most appropriate and important in the provision of high quality care. Consequently, providers must understand and respect their clients' needs, attitudes and concerns. Furthermore, attention was focused on the moral duty of service providers to put in place and implement procedures towards ensuring quality of care.The chapter ended by emphasizing the need to encourage and ensure effective doctor-patient communication since it influences quality of care and is one of the most acceptable ways of treating patients.

CHAPTER FOUR

UNDERSTANDING MATERNAL HEALTH CARE

Introduction

This chapter discusses literature and studies on maternal health care and the factors which contribute to the escalating maternal deaths in Ghana. The main causes of maternal death are due to medical, health service, reproductive and socio-economic factors, and are divided into two groups: direct and indirect obstetric deaths. Direct obstetric deaths are those resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, inadequate treatment, or from a chain of events resulting from any of the above. Indirect obstetric deaths are those resulting from a previously existing disease or a disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiological effects of the pregnancy (Ministry of Health, 2002). Apart from the above, other factors have been found in the literature to have contributed to the poor maternal health outcomes as briefly discussed in the subsequent sections.

Access difficulties to health care

Universal access to healthcare is a norm in most of the developed countries and some developing countries. The pre-existing inequality in the healthcare provisions is further enhanced by difficulties in accessing it.

Accessibility difficulties come in different forms including, and among them are geographic distance, socio-economic distance, gender distance and spatial accessibility.

Geographic distance: The issue of geographic or spatial distance is important in a large area with limited means of communication. The direct effect of distance of a given population from primary healthcare centre on childhood mortality is well documented. It has been shown that the effect of difficult access to health centres is more pronounced for mothers with less education (Caldwell, 1986). The same study found that distance from private hospitals does not affect the health parameters but the distance from public health centre does. Those who live in remote areas with poor transportation facilities are often removed from the reach of health systems.

Incentives for doctors and nurses to move to rural locations are generally insufficient and ineffective. Equipping and re-supplying health consumables such as drugs and related logistics to remote healthcare facilities is difficult and inadequate .This poor supply tends to deter people from using the existing facilities. Maternal mortality is clearly much higher in rural areas as trained medical or paramedical staff attends to fewer births and transport in case of pregnancy complications. Geographical difficulties in accessing healthcare facilities is an important factor, along with gender discrimination, that contributes to higher maternal mortality among women who live in remote areas (Caldwell,1986).

Socio-economic distance: A different aspect of healthcare access problem is noticed in cases of the 'urban poor'. Urban residents are extremely vulnerable to macroeconomic shocks that undermine their earning capacity

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Socio-economic distance: A different aspect of healthcare access problem is noticed in cases of the 'urban poor'. Urban residents are extremely vulnerable to macroeconomic shocks that undermine their earning capacity

and lead to substitution towards less nutritious, cheaper foods. People in urban slums are particularly affected due to lack of good housing, proper sanitation, and proper education. Economically, they do not have back-up savings, large food stocks that they can draw on over time. Urban slums are also home to a wide array of infectious diseases such as cholera, and malaria that easily spread in highly concentrated populations where water and sanitation services are non-existent (WHO, 1996).

Poor housing conditions, exposure to excessive heat or cold, diseases, air, soil and water pollution along with industrial and commercial occupational risks, exacerbate the already high environmental health risks for the urban poor. Lack of social safety nets and support systems, such as health insurance, as well as lack of property rights and tenure further contribute to the health vulnerability of the urban poor. Though the healthcare facilities are overwhelmingly concentrated in urban areas, 'socio-economic distance' prevents access for the urban poor. These socio-economic barriers include cost of healthcare, social factors, such as the lack of culturally appropriate services, language/ethnic barriers, and prejudices on the part of health service providers. There is also significant lack of health education in slums. All these factors lead to an inability to identify symptoms and seek appropriate care on the part of the poor (WHO, 1996). Morris and Easton (2008) argued that health inequalities are directly linked to housing conditions being one of the key social determinants of health, alongside child development, education, employment, and standard of living.

Gender distance and spatial accessibility: The third most important access difficulty is gender related distance. It is said that health of society is

reflected from the health of its female population. Gender discrimination makes women more vulnerable to various diseases and associated morbidity and mortality. From socio-cultural and economic perspectives women in Africa find themselves in subordinate positions to men. They are socially, culturally, and economically dependent on men (Narayan, 2000). Women are largely excluded from making decisions, have limited access to and control over resources, are restricted in their mobility, and are often under threat of violence from male relatives (Jejeebhoy, Shireen & Zeba, 2001).

Morris and Easton (2008) argued that sons are perceived to have economic, social, or religious utility; daughters are often felt to be an economic liability because of the dowry system. This gender discrimination in healthcare access becomes more obvious when the women are illiterate, unemployed, widowed or dependent on others. The combination of perceived ill-health and lack of support mechanisms contributes to a poor quality of life

Access to health care is an important component of an overall healthcare system which has a direct impact on the burden of disease that affects many countries in the developing world. Measuring accessibility to health care therefore contributes to a wider understanding of the performance of health systems within and between countries which facilitate the development of evidence based health policies. Accessibility to health care is concerned with the ability of a population to obtain a specified set of health care services. In this context, geographic accessibility often referred to as spatial or physical accessibility is concerned with the complex relationship which exists between the spatial separation of the population and the supply of health care facilities (Rubin, 1990).

According to Longley, Goodchild, Maguire and Rhind (2005), a number of techniques have been used within Geographic Information System (GIS) to analyse physical accessibility to healthcare. Black, Ebener, Najera Aguilar, Vidaurre and, El Morjani (2004), also argued that, access to health care has direct impact on the overall health system.

Relationship between income inequality and health outcome

Health standards of a country reflect the social, economic, political and moral well-being of its ordinary citizen. Economic and social growth of a society has direct bearing on the health of its constituents. Healthy living conditions and access to good quality healthcare for all citizens are not only basic human rights, but also essential prerequisites for social and economic development. Any inequality in social, economic or political context between various population groups in a given society will affect the health indicators of that particular society.

Research on the potential pathways and mechanisms linking income inequality to health is still in its infancy. Three specific pathways have been conceptualized. The first posits a "structural pathway" between income inequality and health. For instance, it is likely that the relation between income inequality and residential segregation is causal, such that income inequality leads to spatial concentrations of race and poverty, which in turn influence individual health (Kawachi, 2002; Lobmayer & Wilkinson, 2002). While American society is getting more, and not less, segregated (Massey, 1996) and getting more unequal (Kawachi & Kennedy, 2003), there is, however, little

systematic empirical research that has explored the connections between the two and their influence on health.

Second, the social cohesion and collective social pathway may mediate the multilevel relation between state income inequality and health (Kawachi & Berkman, 2000). In recent times, the collective attribute of social relations has been conceptualized through the idea of "social capital" (Lochner, Kawachi & Kennedy, 1999; Subramanian, Lochner & Kawachi, 2003). Again, a systematic multilevel investigation of how the state-level social capital may mediate the relation between state income inequality and health is currently lacking.

Third, there is the policy pathway, whereby the adverse influence of income inequality may operate through formulation and implementation of general social policies, as well as through health-related policies. A number of policy variables, such as primary health care indicators, welfare spending, child care, food assistance, vocational training, remedial training, health insurance, early childhood education, disability assistance, tax policy, and unemployment compensation, could mediate the relation between income inequality and health outcomes. The three pathways, moreover, need not be mutually exclusive. For example, social cohesion within a state may influence the pattern of state effort on social spending (Subramanian et al., 2003).

These health outcome indicators reflect a very disappointing state of public healthcare. The unfortunate fact is, these indicators have failed to improve in spite of various state run programs, mushrooming of private healthcare and a perceptible increase in the GDP. This underscores the importance of social and economic inequality as the stumbling block.

Private healthcare and economic inequality

The growth of private healthcare sector has been largely seen as a boon, however it adds to ever-increasing social dichotomy. The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban-biased, tertiary level health services with profitability overriding equality, and rationality of care often taking a back seat. The increasing cost of healthcare that is paid by 'out of pocket' payments is making healthcare unaffordable for a growing number of people. The services offered at a very high price are excellent but are unaffordable for a common man. This re-emphasizes the role socio-economic inequality plays in healthcare delivery. Effects of social and economic inequality on health of a society are profound. Unequal distribution of resources is a reflection of this inequality and adversely affects the health of under-privileged population. The socially under-privileged are unable to access the healthcare due to geographical, social, economic or gender related distances (Campbell & Graham, 1990).

Studies have shown that most of the maternal deaths occur in hospitals or on the way with or without receiving emergency care due to the three delays that is (a) delay in recognizing the problem, (b) delay in seeking care, (c) delay in receiving care (Thaddeus & Maine, 1994). The latter two delays explains the quality of health care facilities and studies have shown that delay in recognizing and treating life threatening complications contribute directly to maternal deaths (MacCaulay, 1995). It is for this reason that, Campbell and Graham (2006) stated that, every woman needs access to skilled attendance at

delivery and in post-partum period also timely referral in complications of pregnancy for emergency care.

In addition to health care and its availability there are other problems that live in the road to maternal death. These problems begin soon after a baby girl is born and continues throughout her childhood when gender preferential treatment (boys are favoured) in households makes her undernourished and more prone to ill health (Borooah, 2004; Walker, 1997). The road to death continues in her adolescence when she is married early and becomes pregnant before she has grown fully (Alam, 2000; Riley, 1994; Bhatia & Chandra, 1993).

In adulthood heavy workload, poor nutrition and repeated pregnancies make many women unable to cope with the physical demands of pregnancy, childbirth and lactation (Biernacka & Hanke, 2006; Romito, Sauret-Cubizolles & Cuttini, 1994). Moreover, lack of antenatal care from trained health personnel and skilled assistance during child birth and lactation makes matters worse both for mother and infant (Rosenfield, 1989). According to Maine & Rosenfield (1999), Kunst (2001) and DFID (2004), poverty further adds to the maternal mortality situation in developing nations apart from high fertility rate, poor nutritional status and lack of basic health services.

Similarly, in the case of children they are unable to cope with the harsh environment. The most important causes of neonatal deaths are (a) preterm births or low birth weight babies, (b) birth injuries & asphyxia and (c) infections of neonates. The possible solution could be interventions to improve birth weight which is generally not successful because, many of the determinants are beyond the scope of the healthcare System (Susser, 1981).

Birth injuries, asphyxia and infection can be prevented and managed by good screening and either institutional deliveries of the high – risk pregnancies or availability of emergency referral and obstetric care (Rosenfield, 1989). Although, infant mortality has fallen in many developing countries, the rate of change is very slow (UNICEF, 1999).

The reason behind the slow decline in neonatal mortality is due to unavailability of essential newborn care. WHO (1996) made it clear that, what's more important is the accessibility, availability and quality of essential Obstetric and Neonatal care for life threatening conditions, including complications after abortion.

It is a false belief that most life threatening obstetric complications can be predicted and prevented by intervention like antenatal care and traditional birth attendants in community (Maine 1991; Basu, 1997; Maine & Paxton, 2003). But for managing obstetric complications like bleeding, sepsis, hypertensive disorders, which is one of the largest killers, a functioning Essential obstetric Care unit is inevitable (Campbell & Graham, 2006). On the other hand, traditional birth attendants (TBAs) have limited skills and they may keep the women away from lifesaving interventions due to false assurance. The popularity of TBAs in the community can be used for spreading awareness of the danger signs of obstetric complications and information of availability of medical care. According to Rooney (1992) TBAs have limited role in reducing maternal mortality. They can however, provide opportunities for health promotion needed for planning for safe delivery and obstetric care. Rudoff, Lawn, Darmstadt, Begkoylan, Fogstad;

Walellgn and Paul (2005) established that, almost 53 million women in developing countries gave birth without professional help.

The effectiveness of maternal and child health (MCH) system is often hampered by organisations and institutional constrains (Narayan, Patel, Schafft, Rademacher & Koch-Schulte, 2000) and lack of facilities accessible to clients (Kwast, 1996). Moreover, improving access to good quality maternal health care is a challenge for many developing countries as it requires a functioning PHC System in the community and an influential referral system capable of providing emergency obstetric care (Rowe, Hamel, Flanders, Doutizanga, Ndoyo & Deming, 2000; WHO 1998). On the basis of this gap between the desired and the actual performance should be identified, a suitable intervention designed to bridge the gap responsible for high mortality, which when implemented and progress evaluated should lead to the desired outcome.

Health outcome in pregnancy and child birth are not strictly related with the number of staff or proportion attended to by skilled attendant but, relatively more influenced by the structure and operation of the healthcare system put in place (Parkhurst, Penne-kekana, Blaauw, Balabanova, Danishevski, Rahaman, Onama & Ssengooba, 2005). Also there are many factors such as local epidemiological profiles, health system capacity, community preferences and equity on which the coverage of services depends (Bowen, 2003).

In most societies where there is disparity in the socio-economic conditions of the tribes and other marginalised groups with the rest, to ensure that health is within the reach of everyone will require creatively integrating the new and culturally relevant technologies with a strong system and

subsequent behaviour change may bring equity (Elias, 2006). Thus, it is more important to know what will reduce maternal mortality in the population rather than knowing how to prevent maternal mortality. From the emerging evidence, the effectiveness of midwives and the positive outcomes of their services will be largely influenced by resource allocation, teamwork and accessibility to emergency care facilities.

Improving the quality of maternal health care

Quality of care is a remarkably difficult notion to define. According to Donabedian (2003), perhaps the best-known definition is that offered by Lee and Jones (1933) in the form of eight "articles of faith". These "articles" convey vividly the impression that the criteria of quality are nothing more than value judgments that are applied to several aspects, properties, ingredients or dimensions of a process called medical care. As such, the definition of quality may be almost anything anyone wishes it to be, although it is, ordinarily, a reflection of values and goals current in the medical care system and in the larger society of which it is a part. Patient care, like morale, cannot be considered as a unitary concept; consequently, it seems likely that there will never be a single comprehensive criterion by which to measure the quality of patient care.

Bruce (1990), pointed out that, at a clinical level, quality involves offering technically competent and effective safe care that contributes to the client's well-being, even though, quality of care is a multi-dimensional issue that may be defined and measured differently. Clients, whose perception of quality may be influenced by social and cultural concerns, place significant

emphasis on the human aspects of care. According to Donabedian (2003), service providers usually stress the need for technical competency, as well as infrastructure and logistical support from their institution in order to ensure quality of care. It is essential that while service providers focus on support systems, such as logistics and record keeping, policymakers and donors are concerned with cost, efficiency, and outcomes for health investment as a whole.

The complexity of defining quality of care makes it difficult to identify and measure improvements in service delivery. In health, quality of care means 'the excellence' in reference to improvement in health status (Gilson, 1995). Donabedian (2003) defined quality as the extent to which application of medical science and technology is expected to achieve the most favourable balance between risks and benefits. Roemer and Montoya (1988) agree that quality is a degree to which resources for health care services correspond to specified standards that are accepted to lead to desired results.

A high percentage of pregnant women in developing countries still receive inadequate antenatal care and deliver at home due to cultural practices (Campbell & Sham, 1995) and the perceived poor quality of services partly motivate them not to seek antenatal care and to deliver at home (Tamar, Campbell, Shediac-Rizkallah & Francoise, 2000). For example, among women of St. Petersberg in Russia, it was identified that poor care in a previous pregnancy, long waits, frequent examinations, fear and dislike of visiting doctors are the main reasons for delay in seeking prenatal care (Dennis, Flynn & Martin, 1995).

According Rawlins, Garrison Lynam and others, (2003) strengthening innovative decision making and problem solving capacity of mangers and providers, the quality and efficiency of healthcare delivery facility could be sustained. There is an international consensus that instead of wasting the scarce resources in predicting which women will have life threatening complications, it is better to consider all pregnant women at risk. To improve the quality of maternal care and reduce maternal mortality in the context of realizing the MDGs (4 and 5), all women must have access to high quality delivery care. Thus, all women should have access to a skilled attendant at delivery, access to Emergency Obstetric Care (EmOC) in case of complication and referral system to ensure that those who develop complications can reach the appropriate Emergency Obstetric Care (EmOC) in time.

In 1978, WHO identified PHC as the means of achieving 'health for all' by the year 2000. Studies have shown a favourable association of PHC systems to a variety of health outcomes (Mehrotra & Jarrett, 2002). However, in developing countries the correlation between increased PHC spending and improved health outcome is not strong due to the inherent difficulty of disaggregating socioeconomic and health system interventions (Elaine, 2005). Health care needs are examined within the context of local, cultural setting, political will and the choices of the people whose life is at stake before framing an intervention. If the public health system is unable to provide service to the poor in order to reduce the gap between rich and the poor, the poverty cycle cannot be overcome and so no reduction in maternal deaths (Mehrotra & Jarrett, 2002).

Although, PHC has been a major strategy for pursuing improvements in the health status of the population in developing countries over the past decades, few studies have been undertaken to assess how PHC services are actually implemented on the ground. The performance of the PHC services have usually been assessed in terms of coverage of services and very little emphasis on the quality of care provided (Reerink & Sauerborn, 1996), which is essential for reduction in maternal mortality.

Some studies have been undertaken by Kim, Rimon, Winnard, Corso, Mako, Lawal, Banaloa and Huntingdon (1992) on the quality of PHC services but, in countries such as India where maternal mortality is quite high and resources scarce to form appropriate strategies to reduce maternal mortality. In countries where maternal mortality are low it is inportant to find out the strategies adopted so that quality of maternal care can be accessed by all countries struggling to ensure that maternal mortality rate is reduced (Pathmanathan & Lilfestrand, 2003). The underlying philosophy for improving quality of care recognizes the need to ensure that health care providers have the knowledge, skills, resources (in terms of equipments and supplies) and attitudes that are responsive to the client's individual, social, cultural and medical needs (WHO, 1994). Making the health system purposeful and client friendly to improve its utilization and outcome, quality of health care is important for reducing mortality and morbidity.

Studies by Bryce, Toole, Waldman and Voigt (1992) and Kwast (1998) suggest that it is best to include elements of structure, process and outcome that help us to know why outcomes are different from expectations so that we can take steps to improve the situation. Inferences about quality are said to be

impossible unless there is a pre- determined relationship among the three approaches, so that structure influences process and process influences outcome, of course in a much more complex reality than a linear relation (Donabedian, 2003).

What is important for maternal health programme and for other components of reproductive health care is a process that identifies problems in all areas of structure, process and outcome in order to assist a programme manager to implement changes and improvements on both the supply and demand side (Kwast, 1998). A number of tools for quality assessment of primary-health care with respect to maternal and new born care are found in the literature, and the focus of the study assessed the current facility situation in government health care centres in relation to maternal and newborn care. However, the parameters of maternal health if ignored could worsen maternal mortality rate. Maternal health may be defined within the context of the "seven stages of woman." The implication is that there are seven periods in a woman's life when intervention is appropriate. These are:

- infancy;
- childhood;
- adolescence;
- pregnancy;
- lactation;
- recovery; and
- post-fertile period.

During infancy, breastfeeding provides excellent nutrition, immune system stimulus, and growth factors, as well as providing rapid involution of

the postpartum uterus and a period of time for maternal calcium storage. Breastfeeding also helps protect infants against chronic diseases such as diabetes and certain cancers. Murphy (2005) argued that pregnancy and child birth affects women's health. As a result it is imperative to improve maternal health by involving commitment from government, communities, non-governmental organisations, private sector and individuals to champion maternal health programmes that address the problems of pregnancy and childbirth.

Countries and Communities have adopted a number of maternal health programmes aimed at improving women's health and among them is family planning, which helps to reduce unintended pregnancies. For safer child bearing, women need ready transportation to a referral centre if serious complications develop. Tania, Vijay and Lori (2003) pointed out that, in Kolokani, Mali, transportation and referral system for women who need emergency care during labour and delivery is supported by contributions from District, the Community and individual patients. In these communities, transport for emergency case is a key factor to reducing maternal death resulting from pregnancy.

Peer influence plays significant role in maternal health, such that having sexually experienced friends was associated with a higher probability of ever having had sex and having more lifetime sexual partners. According to Magnani, Karim, Weiss, Bond, Lemba and Morgan (2000), peer influence and behaviours were strong predictors of sexual behaviour among Ghanaian women.

Karim, Magnani, Morgan and Bond (2003) in a study among unmarried youth in Ghana found out that communication with friends and family members was quite low and that communication with sexual partners was limited. Communication with family members about avoiding sex could be associated with a lower probability of ever having had sex among youth; however, the literature is silent about the influence of parents and other community members. The lack of family support can also limit access to resources needed for quality of maternal health interventions.

Society and community interventions in terms of the support of families and communities could play significant role in the promotion of quality of maternal health interventions. The long term commitment of politicians and decision-makers to maternal health programmes depends on popular support. Input from a wide range of groups and individuals is therefore essential including community and religious leaders, women's groups, youth groups, other local associations, and healthcare professionals. Health facility and community committees can be established to investigate maternal deaths and to help identify and implement strategies for improvements in such areas as referrals, emergency, transport, deployment and support of health care providers, and cost-sharing. Local committees also have a key role to play in monitoring and evaluating programs identifying weakness and taking appropriate action, by raising awareness of the need for women to reach emergency care without delay if complication arises during delivery.

The provision of health services in Ghana towards health care delivery may not be adequate to take care of the health problems of the population.

However, there is sufficient evidence from past studies that the level of utilization of such health facilities is rather low. Health agencies across the world have identified under-utilization of maternal and child health services as the major factor in the maternal mortality in developing countries (Raghupathy, 1996). When women do not utilize health facilities to prevent maternal deaths and other related complications, the purpose for the provision of such resources have not only been defeated, but the resources and the huge capital investment have been wasted. In a less developed country such as Ghana, poverty is often widespread among the rural population that rely on the land for their livelihood and income. Women in rural Ghana will stop dying in childbirth when they are able to plan their pregnancies, give birth under supervision of a skilled attendant, and have access to high-quality treatment with well-designed community support and interventions.

In the global, regional and national review of the process and progress of implementation of the maternal health interventions, several gaps and critical areas of concern have been identified. Others have been identified through technical workshops convened at national, sub regional and regional levels, with inputs from grass-roots communities and women's organisations, national and international NGOs, intergovernmental bodies and United Nations agencies. The intention is to reflect a broad-based consensus on the critical areas of concern for maternal health interventions such as women's vital role in culture, the family and socialization improvement of women's health, reproductive health including family planning; women's relationship and linkages to the environment, natural resource management and the girl child education.

Summary

To improve maternal health services, individuals within societies have collective responsibilities as members of families, communities, ethnic or religious groups, nations and increasingly, a global society to contribute their quota. The delicate balance between the rights of the individual and the society, and the groups within a society should be respected and encouraged for the social integration of the disadvantaged, particularly women, the vulnerable and the marginalized in society, through the enhancement of their potential and by making all institutions of societies more accessible to them, especially healthcare facilities.

CHAPTER FIVE

THEORETICAL PERSPECTIVES AND CONCEPTUAL FRAMEWORK

Introduction

This chapter examines some of the relevant theories, concepts and frameworks which have by and large been discussed during the literature review in chapters two, three and four respectively. It thus, attempts to re-examine some of the models that could inform the research problem, questions raised and the objectives it seeks to achieve. It does so by exploring the gaps identified in literature which served as the points of departure as well as the focus of the study; to enable the researcher make some meaningful contribution to knowledge.

Pathway to improving maternal health care

The core issues in the pathway to maternal health outcome framework are that, maternal health outcomes are influenced by a range of multi-sectoral factors, including household and community behaviours along with cultural norms, health systems, other sectors, and government policies and actions. All of these factors have the potential to impede or enhance maternal health. One way of contextualizing how these multi-sectoral factors affect maternal health outcomes is through the Pathways to Improved Maternal Health Outcomes Model (Figure 7).

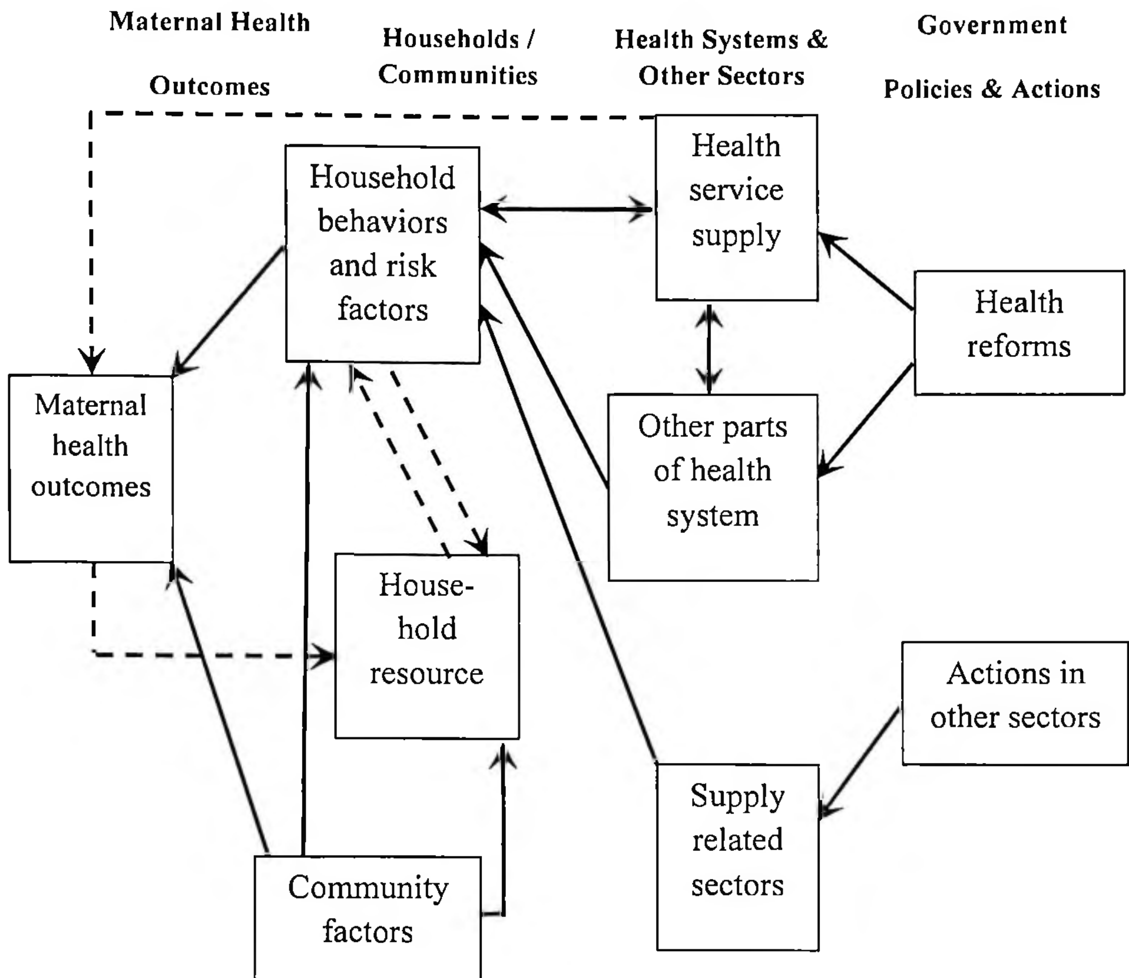

Figure 7: Pathway to improve maternal health outcomes

Source: Adopted from Cleason, et al., (2001)

This was adapted from the World Bank's Health, Nutrition and Population in the Poverty Reduction Strategy paper Sourcebook (Claeson, Griffin, Johnson, MacLachlan, Soucat, Wagstaff & Yazbeck, 2001). The pathways framework is used in the poverty reduction process because it responds to the results-based approach.

The framework allows one to conceptualize the inter-connectedness of variables that affect health outcomes and helps to identify risk factors and interventions at different levels of the system, all of which affect maternal health outcomes. It can also help us understand disparities in health status

between the rich and poor. As illustrated in the framework, the solid lines link the predominant pathways through which factors influence maternal health outcomes. The dashed lines represent some of the "secondary linkages" that also need to be considered.

As indicated in Figure 7, maternal health outcomes are directly affected by factors at different levels. Under government policies and actions, for example, health reforms and actions in other sectors such as transport directly affect the health service supply and the other parts of the health system, as well as influencing factors at the household and community level, which are immediate determinants of maternal health outcome. Traditionally, efforts to improve maternal health have tended to focus on issues within the health system. However, as indicated by the framework, improving maternal health outcomes requires strategic efforts that address forces inside and outside the health system. For appropriate interventions to comprehensively address maternal health, investments are needed at all levels of the pathways framework.

The pathways framework makes clear the steps between policies and improved maternal health outcomes. For the framework to help in identifying the desired outcomes, the actions needed to achieve the outcomes, the inputs required to produce the actions, and strategy for linking it all together to good maternal health must be present. Furthermore, the process requires achieving consensus on: key problems and how to address them; risks that need to be managed to achieve the outcome; and indicators that should be measured to monitor and evaluate performance. All of these are imperative in obtaining good health outcomes (Claeson, et al., 2001).

According to the framework, household and individual behaviours can be major determinants of maternal health outcomes. These behaviours include: use of household resources, nutrition behaviours, health-care demand (demand for contraception, antenatal care, etc.), and early marriage and pregnancy. To promote healthy behaviours adequately requires knowledge about how to promote health, and also requires the ability to use and act on this information. Household resources, to meet basic needs, can influence behavior and therefore affect health outcomes. Risks during pregnancy and early life are exacerbated by behaviours and by limited household resources.

Furthermore, poor maternal health outcomes can affect household resources. Research and interventions have tended to regard all members of a household as a single unit: whatever benefits one member of the household was assumed to benefit all members equally. Evidence now suggests that this is not, in fact, the case. For example, food distributions in a family and utilization and or access to health services are often not equal. It is commonly acknowledged that intra-household differences affect how decisions are made. Recognizing the importance of individuals and households in generating good or poor reproductive health outcomes should lead policy makers to focus on the constraints faced by vulnerable members within households (Merrick, 2004).

Community factors, such as gender norms and practices, fatalistic attitudes, social cohesion, access to community services and cultural practices can also have a direct impact on maternal health outcomes. This traditional and cultural practice could potentially have detrimental effects on the health of the expecting mother and fetus. Because the community factors that determine

the maternal health outcomes are not within the health sector, it is essential that initiatives that aim to achieve improved maternal health outcomes encompass a multi-sectoral approach.

The health sector and other sectors are also important areas for achieving improved maternal health. For example, an ample supply of blood and other medical supplies that are required for treating an emergency are also vital to ensuring safe delivery. This is often an overlooked area in the management of reproductive health services. Without a sustainable and ample supply of commodities, good maternal health will not be achieved. Sectors outside of health are also crucial, such as the education sector, water and sanitation as well as transport sectors. For example, in rural Tanzania, 84 percent of women who gave birth at home instead of delivering at a health facility is partly not due to distance, but lack of transportation (Bicego, Curtis, Raggers, Kapiga & Ngallaba, 1997). Other examples which are also important include human resources, a referral system, and health education and outreach services.

Finally, government policies and actions impact on health services and therefore health outcomes. These include health reforms, health financing mechanisms, factors that improve health sector performance, and public-private partnerships. Similarly, policies from other sectors can greatly affect health outcomes. It is important to note that, government policies for instance, that aim to improve girls' access to education will have a long lasting effect on maternal health outcomes. If all the arrows from the pathway boxes pointed directly to health outcomes, achieving improve maternal health would be significantly easier than it has proven to be so far. However, different factors

within the pathway framework affect one another, both positively and negatively, and influence the final desired outcome.

The three delay model

According to Thaddeus and Maine, (1994) the three delay model for seeking care could be used to explain maternal deaths. The model analyses maternal mortality as a function of delay in receiving appropriate quality treatment. It is further argued that, from the onset of obstetric complication to the outcome there are multiple factors that interfere with the chances of a woman getting rapid quality treatment which are called delay factors. The reasons for the delay are due to the different underlying issues which influence the decision making in seeking maternal care.The model has three phases as outlined in Figure 8.

Phase I: Delay in deciding to seek care

There are many factors that inhibit a woman from making timely decision to seek care. Decision making at this phase is facilitated by factors that can be either actual or perceived barriers. Prominent among these factors include; socio economic, cultural, political, geographical accessibility and perceived quality care at the point of delivery. This may occur for several reasons, including late recognition that there is a problem, fear of the hospital or of the costs that will be incurred there, or the lack of an available decision maker.

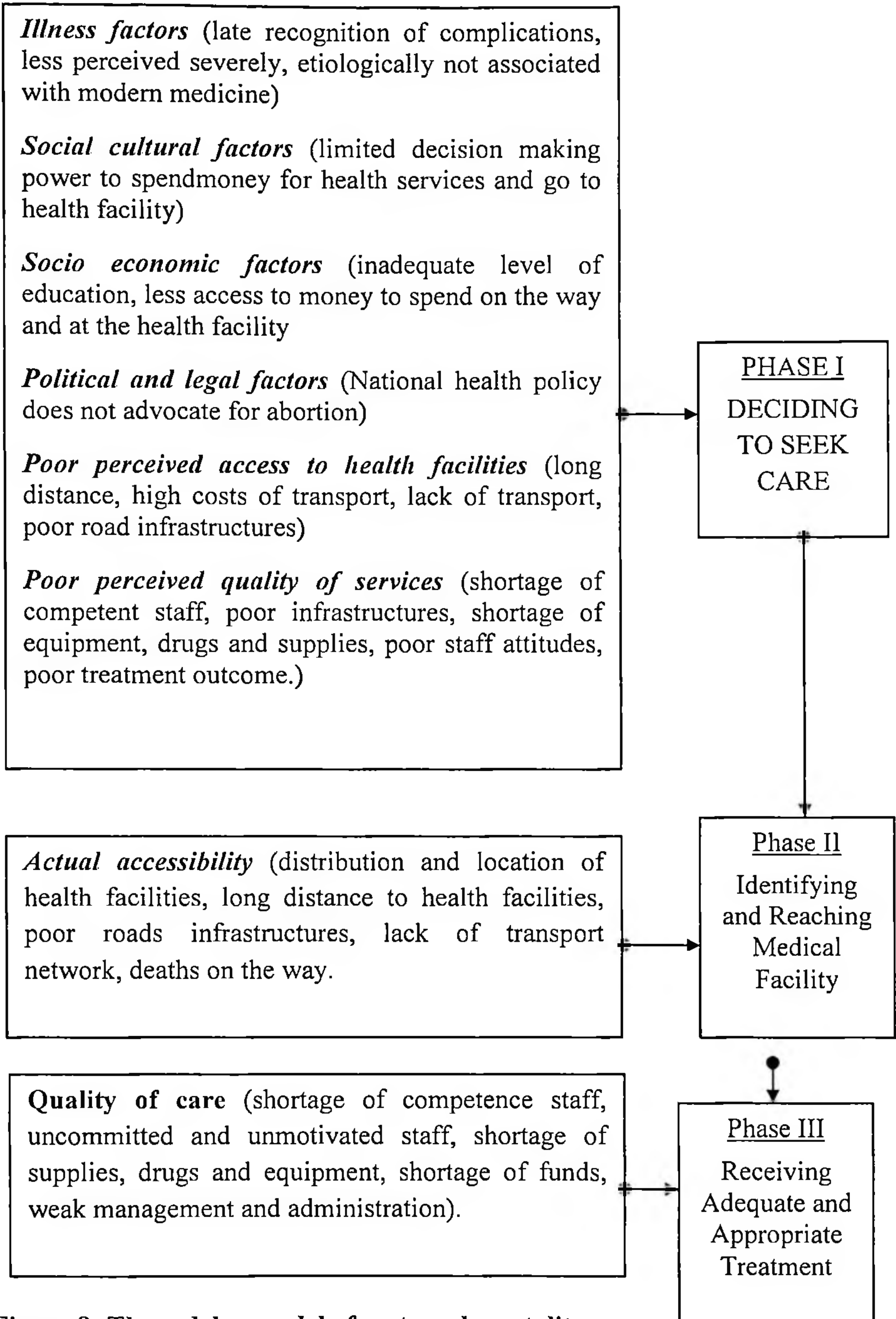

Figure 8: Three delay model of maternal mortality

Source: Maine & Thaddeus (1994)

Phase II: Delay in identifying and reaching medical care

The Second is a delay in actually reaching the care facility. This phase is mainly dominated by actual barriers that may hinder identification and reaching the health facility. Among these include geographical distribution of health facilities, distance from home to the facility, availability of transport and fare.

Phase III: Delay in receiving adequate and appropriate care

This phase entails health facility barriers that hinder the provision of timely quality care. These include adequacy of referral system, availability of equipment, drugs, supplies and adequate trained, competent and skilled manpower. This is one of the most tragic issues in maternal mortality, the reason being that, often women will wait for many hours at the referral centre because of poor staffing, prepayment policies, or difficulties in obtaining blood supplies, equipment or an operating theatre. Once a woman has actually reached the health facility, many economic and socio-cultural barriers have already been overcome. Focusing on improving services in the existing centres is a major component in promoting access to Emergency Obstetric Care (EmOC).

Having assessed and discussed the relevant frameworks considered for this study, and the elements of the frameworks which would constitute the theoretical framework on people's perception about the quality and utilization of maternal health interventions, it is interesting to observe that all the elements are useful and could be incorporated to guide the study. Attempts have therefore, been made to integrate the various determinants of quality and

utilization of maternal health interventions into a practical framework capable of helping to explain the realities on the ground.

Strengths and weaknesses of conceptual frameworks

The strength of Donabedian's model for assessment of quality of care recognises that performance must be measured against a defined set of objectives. It specifies that the primary objectives of the PHC system as a whole, and of the programmes and services within it, relate to consumers, rather than to policy makers, programs or providers. It is intended to be practical and useful tool. Indicators in the area of structure contain all tools and resources that are within reach for the players (personnel and management) in a health care institution. These indicators also reflect the organisational environment in which the core processes take place (e.g., personnel qualifications, formations and institutions). Process indicators contain all activities that take place between institutional players and patients (consumers). Within this area (just like the outcome area) there's a distinction between technical and interpersonal processes. The first identifies the clinical improvement of individual health, without increasing risk. The second identifies the social and psychological interaction between health care players and their consumers. Finally, indicators in the area of outcome contain the effects (outcomes) of the preliminary processes on the health and well-being of both employees and consumers (delivered service).

The weakness of Donabedian's model is that the partitioning makes it possible to specifically determine causal relationships between the several indicators to report malfunctioning in an early stage. For example, patients

who are incorrectly informed about treatment can result in bad client-satisfaction outcomes. These outcomes alone can hardly be sufficient to determine the real cause of the problem.

In respect of the strengths of the three delay model, it has been identified that in rural areas TBAs are the key people responsible for assistance during pregnancies and deliveries. Therefore, pregnant women and their family members are dependent on the knowledge and skills of these community providers. Secondly, the strength of the model is that it concentrates on the analysis of the factors that contribute to maternal deaths at the narrow interval between onsets of obstetric emergency outcome. Furthermore, the model focuses on the delays as a function of multiple determinants. Finally, it insists on birth preparedness as a key solution to avoid maternal deaths that occur to emergency obstertric conditions.

One of the weaknesses of the three delay model is its failure to recognize that, in communities where a substantial programme of community interventions takes place, the training of facilitators for support groups for women and men, transporters, TBAs and community health workers, tend to have had a strong positive impact. Though, it is difficult to separately evaluate the impact of the training of each of the cadres, it is apparent that particular components of the intervention are more likely to have a direct role in this decline.

Again, the model does not capture underlying risk factors for emergency obstetric events and therefore assumes all women have good health backgrounds, to withstand the emergency obstetric complications after treatment. Furthermore, it assumes that birth preparedness is central to

improving access and there will be available quality services. However, despite good birth preparedness there are other factors that may prevent timely access to Emoc such as transport break down, absence of health provider, unsatisfied treatment at health facility and change in climate. Finally, it assumes people will easily change their cultures and behavior to ensure timely access to care at health facility. However, in spite of the existence of behaviour change communication programmes cultural resistance to changes has been a threat to the strengthening of opportunities for behavioural change.

The strength of the pathway to improved maternal health outcomes could be identified in household practices and the use of services especially at the community level will increase newborn survival. In respect of care for or use of services by mothers and newborns, the issue of behaviour is central. The key emphasis of the model is behaviours, household and community practices which are now recognized components of good child survival programming for maternal health interventions. The framework has supported programme design, serving as a "menu" to aid in prioritizing interventions and monitoring indicators and to guide the development of health worker and caregiver training materials.

Based on the shortcomings of the frameworks reviewed, an integrated framework to assessing the utilisation of maternal health interventions has been proposed as illustrated in the Figure 9, showing how these variables interact leading to a desired maternal health outcome.

In the proposed conceptual framework (Figure 9), the study focused on behavioural change of women to ensure convincing change which can be demonstrated in knowledge, practice, or mortality.

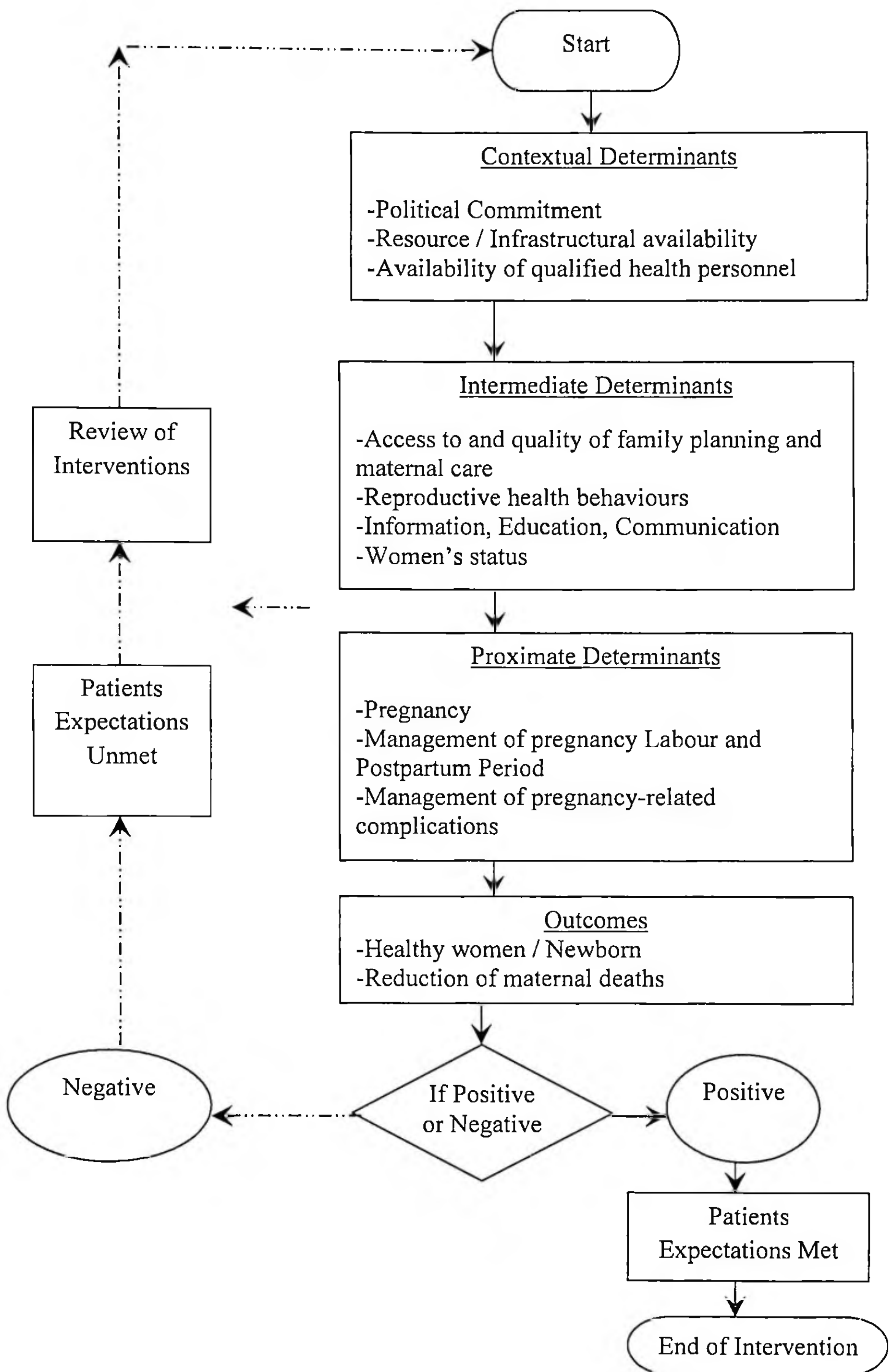

Figure 9: Factors determining utilization of maternal health services

Source: Adapted from Wouters (1992)

The important outcomes for a maternal health program are: prevention of maternal morbidity and mortality, recognition and treatment of complications as they arise, and the promotion of a healthy woman and healthy newborn. The proximate determinants of maternal morbidity and mortality include pregnancy; the development of pregnancy-related complications, including complications from abortion: and the management of pregnancy, delivery, and the postpartum period.

Utilization of health services is a complex behavioural phenomenon. For the purpose of the conceptual framework as well as the current study, utilization is defined as the use of health services which are related to the availability, quality and cost of services, and examines how people get access to health care, and what happens to patients as a result of this care (outcomes).

To illuminate the determinants of maternal deaths, the conceptual framework outlines the linkages between maternal mortality and morbidity and their contextual, proximate, intermediate, and distant factors. Family planning seeks to ensure that pregnancies are wanted and planned for, thereby reducing exposure to pregnancy-related risks. Maternal health care, which should start early in pregnancy and continue through the postpartum period, seeks to prevent the development of complications and ensure that they are managed appropriately if they do arise.

The proximate determinants are affected by intermediate determinants, including access to quality family planning and maternal health care, women's reproductive and health behavior, and women's health and nutritional status. Reproductive and health behavior involves, for example, the age at which a woman becomes pregnant, whether the pregnancy is wanted, and what kind of

health care the woman seeks. Although the focus of maternal health is on pregnancy and birth, many conditions that affect pregnancy outcomes are determined before pregnancy – for example, women's nutritional statuses – and some consequences, such as uterine prolapsed, extend beyond the postpartum period.

The intermediate determinants, in turn, are influenced by social factors such as women's status education, access to and control of income and resources, and level of isolation and political commitment, general resources availability, and infrastructure. Education, for example, has significant effects on women's health and reproductive behaviour through its influence on age at marriage, contraception and health care use, and awareness of risks and danger signs. Women's income, access to household resources, and power to make decisions influence their ability to seek health and family planning services. Male attitudes toward reproductive issues also influence women's willingness and ability to use family planning and health services. Political commitment determines whether resources are used to make good-quality care accessible to those most in need – for example, through the development of transport and communications infrastructure to link women with referral services.

Although all factors in the framework are likely to influence maternal morbidity and mortality as well as the health of newborns and all women, some have greater impact in the short term, particularly on the incidence of maternal death. Maternity care and family planning services, especially the management of emergency obstetric complications –have stronger effects on maternal mortality reduction than broad-based socioeconomic development.

With regards to the outcomes after delivery, if the results are positive implying that, the interventions have resulted in a reduction in maternal deaths, it is assumed that patient's expectations have been met or satisfied. On the other hand, if the results are negative then it is imperative to review the determinants as well as interventions. In sum, the adopted framework makes it clear that, for any intervention focusing on behavioural change of women to succeed, the government, family, community and healthcare providers have specific roles to play towards overcoming the seemingly insurmountable maternal deaths.

Gaps in literature

Issues related to maternal mortality have generated a lot of empirical and theoretical research. Despite the amount of work published on the subject, maternal mortality issues remain challenging and therefore solutions to the problem are still not clear. Scientific research on maternal mortality has focused mainly on clinical factors. However, this approach may not be the most useful if we are to understand the problem of maternal mortality as a whole and appreciate the importance of socio- economic, political, cultural, macro and micro structural factors.

To improve quality of maternal health interventions, a lot of strategies have been identified in the literature, which included raising awareness of and encouraging healthy behaviors of women before and during families and other community activities, beliefs and practices that may influence healthy self-care and care-seeking, specifically focusing on anemia, safe birth, and essential obstetric care. Again, strengthening the performance of front-line providers and their organisational networks to address anemia reduction,

provide a safe birth, and manage complications adequately through a women-centered approach was also identified in the literature.

Maternal and newborn care is an important factor in the PHC system, which needs to be given the first priority to reducing mortality. Much attention has been given in the literature to the introduction of maternal health interventions in 1987. However, no significant fall in maternal and infant mortality rate has been observed although the literature indicates high coverage of care. Making anti-natal care (ANC) and delivery care services available by way of providing health facilities, personnel and making of services free, is not a guarantee that women would access them. Out of a total number of 38,122 registered pregnancies in Upper East Region, only 74.8 percent deliveries were supervised, in spite of the fact that it is free (GHS; 2003). Overall, there is a lack of published information about the cultural and political determinants of maternal mortality.

Focus of the study

Having identified the relevant gaps in literature, it is important to indicate the point of departure and show which of the gaps in knowledge the study intends to fill. The current study intended to fill gaps regarding behavioural change and develop an understanding for the behavioural issues pertinent to maternal health and survival which are the research aims and objectives, as well as, the questions the research sought to answer.

Most of the interventions designed and implemented aimed at behaviour change which emphasized on health specialists deciding on what women and influential family members need to follow in order to improve

maternal health to yield the desired results perhaps due to the non-involvement of the community during the planning stage. The study would recommend a strategy which would promote maternal health programmes that encourage and facilitate a process of community education that stimulates actions determined and planned by the community.

In order to contribute to knowledge, the research anticipated how to promote 'social change' to maternal health interventions that support the idea of communities deciding what cultural beliefs, norms, knowledge and attitudes that affect maternal health. Again, the research examined major role for the community in ensuring that they consider maternal health as a priority concern. This approach ensured that, maternal health interventions could facilitate a process of community discovery and analysis toward the goal of improving maternal and newborn health.

The behaviour of a specific individual or groups could be defined based on four parameters: action, target, context, and time. For example, women must go or take (action) to the appropriate health care facility (target) when specific danger signs and symptoms appear during pregnancy, delivery, and the postpartum period (context) immediately (time).To ensure behavioural change, all the parameters need a careful consideration .

There are shades of opinions in literature regarding who should decide what strategy and actions should be implemented in order to improve on quality of maternal health interventions. Some emerging evidences from the literature suggest that:

- Health and behavioral specialists should determine the strategy and actions, albeit without substantial input from mothers, families and communities;
- Health professionals should take all of the actions to improve maternal survival and health because maternal survival in particular requires competent, accessible, and acceptable services that are appropriately utilized by the public, and;
- Some aspects of improving maternal health are not feasible without the direct participation of health services (e.g., improving maternal nutrition and micronutrient status; some methods of birth spacing), health services normally play an essential role in these and other actions to enhance maternal health.

None of these services are of any value without active participation of women (beneficiaries) on issues involving behavioural change. This was one of the gaps identified in the literature. It is therefore, plausible to advocate a stronger role of community mobilization and social change, which favours mothers and communities deciding on strategy and actions to adopt in order to improve on quality of maternal health interventions which would eventually reduce maternal deaths.

Additionally, the study outcome could be used to assist communities in the study areas in reviewing, analyzing, prioritizing, and developing strategies to improve specific maternal health indicators by involving pregnant women and influential family members. Experience has shown that behaviours are influenced by more than knowledge and other cognitive determinants. Many individual behaviour changes require actions that address the other levels of

behaviour change (family, community, institutional, political) that facilitate and interact with individual behavioural change.

Communication can provide women and influential decision-makers (e.g. husbands, mothers-in law) with information on danger signs of an illness, severity, logistics, and reasons to act, but just giving information are rarely enough to change key behaviours related to maternal health and survival. While information may influence some of the determinants of behaviour (e.g. self-efficacy, intention to act, skills), communication should normally work in tandem with such strategic components as training, policy change, service delivery improvements and collective community action.

Partnerships between communities and service providers are critical for stimulating utilization of services for maternal health and survival. In settings where health services and communities are separated by social class, ethnic and cultural traditions, improving the non-technical dimensions of quality of care may be as essential as improving the technical dimensions to stimulate use of services. Incorporating client and community or cultural perspectives in defining the quality of care in the early stages of projects and programmes will maximize the possibilities of ensuring that services are improved to be more responsive to the needs and customs of clients and communities. This may mean modifying service hours, reducing waiting times, increasing privacy, and allowing access of family members to patient.

It is possible that, some socio-cultural factors that may hinder women access to these services may significantly contribute to maternal deaths. Women are influenced in important ways by features of environment in which

they are raised, for example by their peers' behaviour and family "connections" (Magnani, Weiss, Bond, Lemba & Morgan, 2000).

Summary

This chapter has introduced and discussed relevant concepts that the researcher deemed appropriate to informing the study. It initially highlighted the core issues in the pathway to maternal health outcome framework which are influenced by a range of factors and have the potential to impede or enhance maternal health. Relevant concepts and theories such as the 3-Delay model for seeking care were also discussed.It then introduced and described the adopted conceptual framework which was influenced by the relevant aspects of the literature reviewed in the study. The chapter ended by pointing out the gaps that needed to be filled as the researcher's contribution to knowledge and the literature.

CHAPTER SIX

METHODOLOGY AND RESEARCH APPROACH

Introduction

This chapter describes the study methods and the rationale for selecting them. It thus focuses on the study design, sampling procedures, instruments for data collection, data analysis and the limitations to data collection.

Profile of study areas

Administratively, three districts in the Eastern Region, namely: Kwaebibirem, Birim South and Fanteakwa were selected for the study (Figure 1). The Kwaebibirem District is one of the 17 districts in the Eastern Region, with Kade as its administrative capital. The district, which has a land area of about 12.30 km2, was carved out of the then West Akyem District in 1988 as a result of the government's decentralization policy. Its total population stood at 179,209 in 2000 with an annual growth rate of 1.9 per cent. The current population is projected at 196,992 (2000 population cencus). Over two thirds of this population live in rural areas.

Crop farming is the predominant economic activity and thus serves as the source of livelihood for over 72 per cent of the population and contributes about 80 per cent of the Internally Generated Funds (IGF) of the district assembly. The main development problems facing the district include low agricultural output resulting from the use of rudimentary farming methods,

poor road network, and inadequate supply of basic social services such as education, health, water and sanitation. These factors have resulted in a high incidence of poverty, deprivation and generally low standards of living among the people. To address these problems, the Kwaebibirem District Assembly has since its creation carried out a number of development programmes and projects that seek to secure better livelihoods and alleviate poverty in the district. Prominent among these was the first medium- term District Development Plan (1996-2000), which was prepared and implemented in line with the Ghana Vision 2020 First Step (1996-2000).

The Birim South District is currently divided into Birim Central Municipal and Birim South District following the creation of new districts in 2007. As far as the study is concerned, Birim South refers to both Birim Central Municipal with Oda as the administrative capital and Birim South with its administrative capital at Akim Swedru. The Birim South is one of the 17 administrative districts in the Eastern Region of Ghana carved out of the former Birim Council in 1987 as part of the government's decentralization programme. It shares boundaries with Birim North and Kwaebibirem (to the north) Adansi South and Assin North (West), Asikuma-Odoben-Brakwa and Agona West Municipal (South) and West Akim Municipal (East). Thus the Municipality, especially the capital Oda, is linked up with many districts and this promotes commercial activities among the district capitals and other nearby communities.

The Fanteakwa District lies within longitudes 0° 32.5' West and 0° 10' East and latitudes 6° 15' North and 6°40' North. Begoro is the district capital of the Fanteakwa District with an estimated population of 23, 070 (18,200 in

1984) while the total district population stands at 103,711 (1997) and about 74,934 (1984). It is bounded to the North-East by the Volta Lake, to the North-West by Kwahu-South District, South-West by the East Akim District, Manya Krobo District to the East and the South East by the Yilo Krobo District. It is located exactly at the middle of the Eastern Region. Koforidua being the Regional capital of the Eastern Region is about 50km from Begoro and also lies to the south of the District capital. With a total land area of 1150 sq.km, Fanteakwa District occupies 7.68 per cent of the total land area within the Region (18,310 sq km).

The population of the district is estimated at 103,711 for 1997 with growth rates of 3.7 per cent between 1960 and 1970 censal period, 2.5 per cent between 1970 and 1984 and 1998. There has been steady increase in the population over the past censal years, with the highest growth rate of 3.7 per cent per annum recorded between the periods of 1960-1970. This growth rate fell to 2.5 per cent between 1970 and 1984, partly due to the fact that the country experienced drought during 1981 and 1983 which compelled the youth to move to the nearby urban areas for employment rather than farming, which was the pre-occupation in the district.

The age structure for the three districts shows a relatively large proportion of children (41.7%) and a small proportion of older people, 65 years and older (5.8%). The fact that a greater proportion of the people in the study area are surviving to old age implies that there is an increase in the life expectancy for the districts as a whole. This may be a reflection of improvement in the health status of the people in the region. The age structure for the districts follows the regional pattern with a broad base tapering

gradually at older ages and this may be due to mortality and migration as Ghana Statistical Service reported in the 2000 population and Housing Census.

Graphoically the population structure of the study area shows a typical pyramid, with a broad base and a narrow peak. The pyramid shows that a large new cohort is born every year as displayed at the bottom of the pyramid (ages 0-4 years). As cohorts age, they inevitably lose members either through death or migration or both. This is shown by the narrowing of the population pyramid as it peaks. The peaking of the population accelerates after age 45 years. Another feature of the population structure is that females in the oldest age groups form the substantial majority. The structure also shows that the population aged 5-9 years is slightly more than that of the 0-4 year age group. The reason is not clear but may be due to either age shifting or indications of a decline in fertility resulting in fewer births (2000 Population Census, 2002).

Traditionally, each community in the study areas has a chief and is regarded as agent and partner of change in nation building. The new dawn of Chieftaincy has produced a new generation of chiefs who have introduced a new sense of dynamism and vision into the Chieftaincy institution. These new generation of chiefs have been embarking upon many development initiatives such as Education Endowment Funds, Health Foundations, Environmental Protection and aforestation initiatives. On galvanising human and material resources chiefs usually use festivals as potential tools to facilitate the process of mobilising people for nation building. It is for this and other reasons that the Government treasured the institution of Chieftaincy as partners in development and had recognised the strategic role chiefs played as focal

points for mobilising communities for communal labour and developmental purposes. Generally, the chief is the custodian of the community lands and also custodian of the customary practices of the people. With regards to governance system, the chief is subordinate to the paramount chiefs.

Economic activities in the study areas are influenced by the availability of forest lands and its geography. Majority of the residents engage in small-scale farming, often involving the cultivation of food crops like cassava, maize, plantain and yam. However, there is limited commercial cultivation of cocoa and oil palm plantation.

Unemployment is a major problem in the study area. Majority of the jobs are found in the agriculture and fishing sectors which are experiencing decrease in output due to population increase. Although, there are no statistics regarding the number of people engaged in agriculture, it is likely to be greater than the regional average of 65 percent (Government of Ghana, 1996).

Health facilities situation in the study areas

Kwaebibirem District is made up of six (6) zones called sub-districts where various health staff and community health volunteers in conjunction with the communities work together to provide essential care. The health delivery system in the Kwaebibirem District is made up of 2 hospitals, 4 health centers, 3 community clinics, 1 maternity home, and 6 RCH centers and 4 CHPS centres. In addition to the above, outreach clinical activities are organised in most communities which lack established health facilities. The doctor-population ratio of the district is 1:118. The mission hospital, located at Akwatia, is the most well equipped health institution in the district, which

serves as a referral center for the other lower health institutions. The district has 10 medical doctors, 148 nurses, 5 medical assistants, 55 orderlies and 12 health aids and other paramedics like laboratory technicians.

The health facility situation even though is not different from that of Kweabibirem, but in terms of implementation of health intervention programmes in Fanteakwa District, the approach is quite different, hence the low maternal deaths. During the survey, it was realised that the contribution to good health needs of the people is constrained by problems such as inadequate health facilities and the prevalence of diseases.

Birim South District has 26 health facilities. These are made up of government institutions, private institutions, and a mission institution. The district hospital is situated in Akyem Oda the district capital while three (3) health centers are in Achiase, Akroso and Aperade. There are also 12 RCH centres and 7 community based health and planning services (CHPS) throughout the district. Others include maternity homes and 8 private clinics. In addition to these orthodox institutions, the district has trained about 63 traditional birth attendants (TBAs) who provide maternal service in various communities. There are also traditional herbal practitioners (THPs) who also contribute towards the health needs of the people in one way or the other. The details of health facilities used for the study are found in Appendix 1.

Rationale for selecting study areas

According to Mitra (1999) data collected from a survey provides the foundation and help to spur further research and public health action. Public

health planning could be effective when vital statistics on age, sex, and other socio-demographic characteristics of a population are known.

The pursuit of research on the quality and utilisation of maternal health intervention has recently become a big issue on the agenda of health care environment due mainly to the dimension of maternal deaths in the Eastern Region of Ghana. The increasing demand for maternal health care and the higher expectations by currently more enlightened population, the rising cost of services and the numerous complaints that have been coming forth about the quality of maternal health interventions by health care providers demand that people's expectations and perceptions be given a thorough examination.

There are many good reasons that inform the selection of the study setting. Among the reasons for considering the three (3) districts out of twenty-one (21) in the Region are: first it is due to the oscillating nature of the maternal deaths recorded in both Kweabibirem and Birim South from 2003 to 2008. The districts have maternal death trends which increase, fall and increase, thus clearly demonstrating an oscillating nature of maternal deaths; hence making it an interesting phenomenon for investigation.

Philosophy of social science research

The study of humans and social life is more complex than the study of physical and natural phenomena. This is partly because ethical and practical considerations often preclude the controlled conditions and the use of the experimental method of the physical and natural sciences. There is an overall commitment among investigators of humans to the basic elements of the scientific method, particularly in relation to the systematic collection of

information, the replication of research results and the norms that govern the rigorous conduct of social scientific research.

Despite this, there has been a long history of debate in social science about the appropriateness of the traditional scientific method for the study of human life, given its complexity and the nature of individual behavior, and about the interactions between scientific research and cultural beliefs which make a value-free science difficult to achieve. It is increasingly accepted that social science becomes scientific not by using the basic experimental method, but by adopting research methods that are appropriate to the subject under investigation, that are rigorous, critical and objective and that ensure the systematic collection, analysis and presentation of the data (Blaikie, 2001, 1993; Silverman, 1993).

According to Creswell (2003: p5), 'philosophically, researchers make claims about what is knowledge (ontology), how we know it (epistemology), what values go into it (axiology), how we write about it (rhetoric), and the processes for studying it (methodology'). This suggests that the nature of social reality has ontological, epistemological, methodological and methods dimensions. The opposing ends of these grounds of the philosophy of science are basically rooted in two major intellectual traditions: subjectivist and objectivist (Easterby-Smith, Thorpe & Lowe, 2001; Burrell & Morgan, 1979). Both Crotty (1998) and Sarantakos (1998) recommend the approaches indicated in Table 1 for selecting a research design. Crotty (1998) suggests a set of questions whose answers provide an appropriate research design while Sarantakos (1998) recommends three basic steps for selecting a research design.

Table 1: Suggestion for selecting a research design

Crotty questions	Steps by Sarantakos
1. What method do we propose to use? 2. What methodology governs our choice and use of method? 3. What theoretical perspective lies behind the methodology in questions? 4. What epistemology informs this theoretical perspective?	1. Select an appropriate paradigm; 2. Select a methodology; and 3. Select a set of method for collecting and analyzing data.

Source: Crotty (1998) and Sarantakos (1998)

There has been considerable interest in recent years in the role of philosophical assumptions and paradigms in doing research. During the 1970's and 1980's genuine concerns were raised about the limits of quantitative data and methods often associated with positivism, the prevailing paradigm. Positivism assumes an objective world which scientific methods can more or less readily represent and measure, and it seeks to predict and explain causal relations among key variables.

Critics argued that positivistic methods strip contexts from meanings in the process of developing quantified measures of phenomena (Guba and Lincoln, 1994). In particular, quantitative measures often exclude members' meanings and interpretations from data which are collected. These methods impose outsider's meanings and interpretations on data. And they require

statistical samples which often do not represent specific social groups and which do not allow generalization to or understanding of individual cases.

Table 2 seeks to examine the three paradigms or worldviews which are prominent in contemporary social science research: positivism, interpretivism and critical postmodernism. Interpretivism and critical postmodernism are increasingly common in management and organisational scholarship though they are not so well understood. Table 2 seeks to summarize the key features of each worldview, the nature of knowledge pursued, and the different means by which knowledge is produced and assessed within each worldview. It explains the philosophical assumptions with implications for practice. The assumptions reflect a particular stance that researchers make when they choose quantitative or qualitative research, and then further shape their research by bringing to the enquiry paradigms or world views (Creswell, 2007).

According to Guba, (1990, page 76), a paradigm or worldview is 'a basic set of beliefs that guide action'.These set of beliefs guide individual researchers and it is possible to use multiple paradigms when conducting a research. It is helpful to understand the major elements of each paradigm, and how they inform the practice of research differently as shown in Table 2.

Table 2: Paradigms and research methods

Issues of interst	Positivism	Interpretivism	Critical Theory/Postmodernism
Assumptions	Objective world which science can 'mirror' with privileged knowledge	Inter-subjective world which science can represent with concepts of actors; social construction of reality	Material world of structured contradictions and/or exploitation which can be objectively known only by removing tacit ideological biases
Key focus or ideas	Search for contextual and organisational variables which cause organisational actions	Search for patterns of meaning	Search for disguised contradictions hidden by ideology; open spaces for previously silenced voices
Key theories in paradigm	Contingency theory; systems theory; population ecology; transaction cost economics of organizing; dustbowl empiricism	Symbolic interaction; ethnomethodology; phenomenology; hermeneutics	Marxism; critical theory; 'radical' perspectives, poststructuralism; postmodernism; deconstructionism; semiotics

Table 2 continues

Goal of paradigm	Uncover truth and facts as quantitatively specified relations among variables	Describe meanings, understand members' definitions of the situation, examine how objective realities are produced	Uncover hidden interests; expose contractions; enable more informed consciousness; displace ideology with scientific insights; change
Nature of knowledge or form of theory	Verified hypotheses involving valid, reliable and precisely measured variables	Abstract descriptions of meanings and members, definitions of situations produced in natural contexts	Structural or historical insights revealing contradictions
Criteria for assessing research	Prediction Explanation Rigor; internal & external validity, reliability	Trustworthiness Authenticity	Theoretical consistencyHistorical insights, Transcendent interpretations, Basis for action, change potential and mobilization

Table 2 continues

Unit of analysis	The variable	Meaning; symbolic act	Contradictions, incidents of exploitation PM: the sign
Research methods and type(s) of analysis	Experiments, questionnaires; secondary data analysis; quantitatively coded documents Quantitative: regression; Likert scaling; structural equation modeling Qualitative: grounded theory testing	Ethnography; participantobservation; interviews; conversational analysis; grounded theory development Case studies; conversational and textual analysis; expansion analysis	Field research, historical analysis ,dialectical analysis PM: deconstruction, textual analysis

Source: Adopted from Robert Gephart (1995, p. 4)

Within academia it is a common practice to associate particular epistemologies with distinctive methodologies (Decrop, 1999; Neuman, 1994) For example, in the discipline of geography, positivism has traditionally been linked with quantitative methods, whilst more recent epistemological perspectives such as humanism and postmodernism have been linked with qualitative methods (Creswell, 1994). Faced with the quantitative-qualitative dichotomy, researchers have often been forced to choose one paradigm of the approaches in the social science. However, more recently, social science researchers have exhibited a growing recognition of the benefits of a multiple methods approach to research, especially as positivism has been discredited and new approaches such as postmodernism have emerged (Bowen, 2003; Blaikie, 1991). Also, while in the past policy makers have tended to display a preference for quantitative research, they have gradually begun to demonstrate a heightened awareness of the role of qualitative research in informing policy formulation (Decrop, 1999).

The method of investigation used depends on the investigator's assumptions about society. A considerable body of social science is directed by research methods drawn from the natural sciences. This approach is known as positivism. The principles of scientific enquiry used by bio-medicine, for example, are rooted in positivism. Positivism aims to discover laws using quantitative methods and emphasizes positive facts. Thus, positivism assumes that there is single objective reality which can be ascertained by the senses, and tested subject to the laws of the scientific method. The positivist conception of science was advocated in the late 18th and 19th Centuries and

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was developed in relation to the study of sociology by the 19th-Century philosopher Auguste Comte (Keat & Urry, 1982).

The natural scientist systematically observes and measures the behavior of matter and the results of these investigations are regarded as 'facts'; these are believed to be undistorted by the value judgment of the scientist. This is owing to the availability, in theory (although not always in practice), of objective systems of measurement (e.g. of temperature). Positivism in social science assumes that human behavior reaction to external stimuli is positive and that it is possible to observe and measure social phenomena, using the principles of the natural scientist, and the hypothetico-deductive method, and thereby to establish a reliable and valid body of knowledge about its operation based on empiricism (actual evidence gathered through use of the senses, i.e. observed). It is argued that social science should concern itself only with what is observable and the theories should be built in a rigid, linear and methodical way on a basis of verifiable fact. Positivists are not concerned with measuring the meaning of situations to people because they cannot be measured in a scientific and objective manner.

Most social science research has developed adhering to this positivist philosophy, alongside the physical sciences. The most popular tools that are used are surveys and experimental methods, and statistical technique of analysis. Similarly, positivist traditions shape many of the methods of research on health and health care, and the way the research instruments are administered. For example, interviews are standardized and structured in order to minimize the influence of the instrument and the interviewer on the respondent, and there has been an overemphasis on the experimental method,

with little attempt to combine it with qualitative methods better able to provide rich insights into human behavior and social processes(Keat and Urry, 1982).

The basic assumption of the current study is that a network of causal relationship exists between resident's perception about quality of maternal health interventions, knowledge, attitudes beliefs and cultural practices towards maternal health seeking behavior. Among the reasons for selecting this paradigm are that, using scientific method and language to investigate and write about human experience is supposed to keep the research free of the values, passions, politics and ideology of the researcher. This approach to research is called positivist, or positivist-empiricist and it is the dominant one among the general public. Positivist researchers believe that they can reach a full understanding based on experiment and observation. Concepts and knowledge are held to be the product of straightforward experience, interpreted through rational deduction.

Again, the idea that the only way to do social research is to follow a scientific model can lead to the dismissal of research as a valuable tool in understanding the rich complexity of social life. This scientific approach which positivism espouses is rightly thought to be inadequate when it comes to learning about how people live, how they view the world, how they cope with it, how they change it, and so on. The objective of the study was to identify factors that determine the utilization of maternal health services in order to help predict and control community attitude. Finally, the quantitative approach enabled the researcher to measure perceptions and attitudes of a number of people to a limited set of questions which facilitated comparison and statistical analysis of the data.

Opposition to positivist epistemologies has come from feminism, post structuralism, critical psychology, anthropology, ethnography and developments in qualitative research. Critiques of positivism are implicit in other movements for social change, as well as in the knowledge of Eastern, Asian and indigenous societies, who see all events and phenomena as inter-connected. This has come about because the movements and peoples concerned have:

- Emphasised that there is no neutral knowledge;
- Shown the inadequacies of dualistic, that is, either/or, or black/white thinking; and
- Emphasised the ethical aspects of research.

Positivism though challenged, it could be argued that, the positivist worldview or paradigm is still strong. It is still the dominant public model for research. Researchers can still find it difficult to get funding for post-positivist projects. The mechanistic view of the natural sciences continues to dominate the public perception of science, and in turn it affects views of what social research should be.

Despite the relative distinctions arising from the arguments discussed thus far, it can be submitted that in social science research, researchers hardly rely exclusively on a single method. In this respect, Silverman (2005) might be quite right when he argued that basic quantitative measures are a feature of good qualitative research. The implication of this observation is that the whole 'quantitative-qualitative' polarization polemics is probably without foundation, because even the self-confessed paradigmatic extremists do not consistently hold to one position or the other (Creswell, 2003; Esterby-Smith

et al., 2001; Burrell & Morgan, 1979). It can be said finally, that depending on the purpose of social enquiry as suggested by Blaikie (2001), whether it is exploratory, description, understanding, explanation, change or intervention, prediction or evaluation, one might employ a mixture of appropriate methods to achieve the research objectives. The present study opted for a mixture of methods because it has to explore the views of multiple actors.

Research design

The selection of the positivist paradigm had a number of implications for the study, ranging from research design, research method and the kind of variables to be collected, size of the sample to the validity of the measurement. The research questions, the objectives of the study and the research philosophy were considered as guiding principles, hence, the explanatory research design which is grounded on the hypothetico-deductive approach was adopted which had to be consistent with the chosen paradigm. Consequently, the structure and the sequence recommended by Crotty (1998) were followed.

One of the common methods for collecting data in most studies is direct, first-hand observation of daily participation. This can include participant observation. Another common method is interviewing, which may include conversation with participants and can involve small talk to long interviews. Questionnaires can be used to aid the discovery of local beliefs and perceptions and in the case of longitudinal research, where there is continuous long-term study of an area , they can act as valid instruments for measuring changes in the individuals or groups studied.

In addition to the existing literature which guided the research, it became obvious that it would be valuable to use the survey method, given that, it would provide an even platform to compare the research results with similar works. The evidence in the literature suggests that the positivist's assumption remains pervasive and continues to be a dominant rationale that underpins most theories and research works in the field of social science research.

Given the tenets of the positivists' tradition, it became necessary to focus mainly on the observables. As a result, most of the questions associated with the attitude of residents to maternal health interventions were tied to elements that were observable and measurable. This was critical in employing 'Likert scale' in the questionnaire as data were to be captured mostly on interval or ratio scale. Since the study assumes that residents' perceptions and attitudes could be measured objectively, there was the need for ensuring a high degree of reliability and accuracy. Crotty (1998) highlights the importance of reliability and valid measures in sound investigation. Validity of measurements relates to the extent to which the measurement provides an accurate reflection of the concepts with precision while reliability centres on the consistency of the instrument.

Finally, the chosen philosophy had implication for the sample size and the generalization of the study findings. Since, the approach assumes that there is an objective reality; there was the need for employing measures that provide an accurate reflection of the reality. As a result, the sample size was fairly large enough and the elements were selected through both probability and non-probability sampling techniques.

Data and sources

To achieve the study objectives, data relating to the economic conditions, societal needs, perceived impacts of health care programmes in the communities, socio-cultural values of the people and attitude towards maternal health interventions were needed. The study made use of both primary and secondary sources of data. The primary data were obtained from a field survey and observations in selected communities of the three districts. The primary data were collected through questionnaires and interviews, conversations and participatory observation as well as focus group discussions (FGDs). Secondary data were obtained from existing documents such as the 2000 Ghana Population and Housing Census Report, annual reports from hospitals, health centers, Ghana Health Service and the Ministry of Health. A library research was also conducted from which official statistics from central government were reviewed; journals, published books, topographical maps, journal, articles and the internet were all relied on (Figure 10).

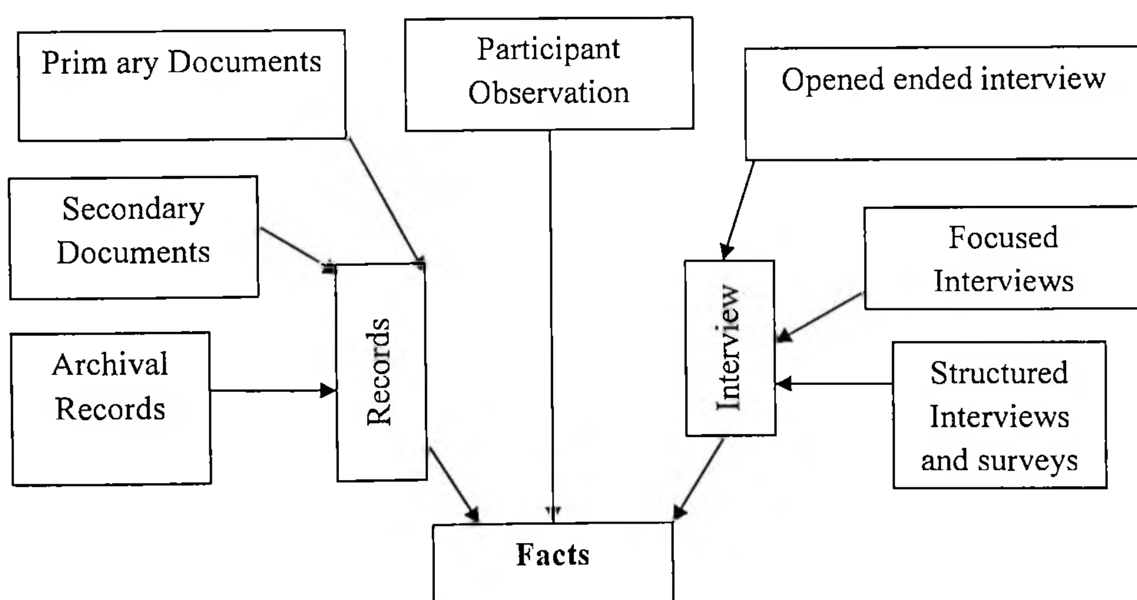

Figure 10: Convergence of multiple sources of evidence/mixed method approach

Source: Author's construct

Figure 10 demonstrates the use of triangulation or multiple sources of information gathered for the research. Notwithstanding the worldwide controversial debate amongst researchers on the quantitative-qualitative dichotomy, the demand for both qualitative and quantitative research has increased in the higher education field. Thus, the two research approaches should be regarded as complementary - one is not inferior to the other. By not relying on a single method, researchers can be more confident of their research results, due to increased reliability and validity. With the multi-method research approach (i.e. triangulation), therefore a more complete, holistic and contextual realities can be captured of the units under investigation.

Patton (2002, p.247) for instance, advocates the use of triangulation by arguing that, 'triangulation strengthens a study by combining methods. This can mean using several kinds of methods or data, including using both quantitative and qualitative approaches'.

Target population

A research population is generally a large collection of individuals or objects that is the main focus of a scientific inquiry. It is for the benefit of the population that researches are done. However, due to the large sizes of populations, researchers often cannot include every individual in the population because it would be too expensive and time-consuming. The target population is the entire group a researcher is interested in; the group about which the researcher wishes to draw conclusions. In the present study the target population consisted mainly of men and women residents in the study areas. Specifically it targeted women in their reproductive age group (15-49);

men in their reproductive age group (15-59) as specified by the Ghana Statistical Service (2008); and healthcare providers.

Sample size determination

If a researcher desires to obtain information about a population through questioning or testing, two basic options are available: every member of the population can be included which is a complete census; and or a sample can be drawn- ie, only selected members of the population are included. Contacting, questioning, and obtaining information from a large population is extremely expensive, difficult, and time consuming.

It is against this background that using a probability sampling technique to draw a sample tends to be more accurate than a complete census of the entire population. The smaller sampling operation lends itself to the application of more rigorous controls, thus ensuring better accuracy. These rigorous controls allow the researcher to reduce non-sampling errors such as interviewer bias and mistakes, non-response problems, questionnaire design flaws, and data processing and analysis errors.

To calculate the minimum sample size required for accuracy in estimating proportions, for populations that are large, Cochran (1963:75) developed an equation that can yield a representative sample for proportions; (i) where n is the sample size; (ii) X^2 is the abscissa of the normal curve that cuts off an area at the tails (1 - equals the desired confidence level, e.g., 95%)[1]; (iii) e is the desired level of precision; (iv) p is the estimated proportion of an attribute that is present in the population; and q is 1-p. The value for X is determined in the area under the normal curve.

Given the proportion in the target populations that are aware of efforts to promote maternal health interventions in the study areas as 0.60, the z statistic being 1.96 and desired accuracy at 0.04, the sample size is calculated as follows:

$$n = \frac{1.96(0.60)\ (0.40)}{0.04^2}$$

The calculated value of 'n' denotes that at least 576 respondents should be selected in the study areas to get a representative population. For the purpose of offsetting possible non-responses the figure was rounded up to 600. This was distributed among the three selected districts as presented in Table 3.

The reasons behind the allocation of equal sample size to all the districts irrespective of the differences in populations as per the 2000 Population Census was meant to eliminate bias, add quality and reliability to the data collected as well as validity to the conclusions drawn from the analysis.

Table 3: Sample size allocation by districts

District	Women	Men	Health Workers
Birim South	120	50	30
Fanteakwa	120	50	30
Kwaebibirem	120	50	30
Total	360	150	90

Source: Field survey (2009)

Ten (10) settlements were covered in each of the selected districts. These consisted of 5 communities with health facilities and 5 without in the

rural areas. All the districts hospitals were covered. The reason for the inclusion of district hospitals was that, they serve as referral centres for maternal healthcare and the most urbanized.

Sampling procedures

Closely related to sample size determination is the sampling procedure (Castillo, 2009 & Creswell, 2003). Given that there was no readily available sampling frame on the target population the convenient sampling method was employed by the researcher. First, with regards to the selection of the female and male target population, in each of the communities that was selected, individual houses were purposively visited to identify those who qualify to be included in the study (both males and females). In every house that was visited, qualified respondents who were ready and willing to participate in the study after the researcher and his assistants had explained the purpose for research were interviewed. Thus based on the sample size allocation, in each community visited, 12 females and 5 males were interviewed. At the health facility similar convenient sampling technique was used to select the healthcare providers.

Data collection instruments

Identifying the right research instruments is critical to ensure the validity of the design and the results. Bryman (2004) argued that, the aim of using research instrument is generally to collect systematically a body of quantifiable data in respect of a number of variables which can then be examined to discern patterns or associations. The main advantage of this

approach is that it can measure the reactions of a fairly good number of people which can facilitate comparison and statistical aggregation of the data (Robson, 1993; Veal 1993; Bell, 1992). In this particular study four main data collection instruments were used: (i) Interview schedule guide for females (Appendix 2); Interview schedule guide for males (Appendix 3); Questionnire for healthcare personnel (Appendix 4); and Focus group discussion guide for identifiable community members (Appendix 5).

The interview schedule was administered with the help of trained research assistants. It was basically used to obtain information about the thoughts, feelings, attitudes beliefs, values, perceptions, personality and behavioral intentions of research participants. As Maddox (1985) recommends, a 5-point Likert scale type can be utilized to measure issues relating to perceived impacts and support for maternal health interventions. For the purpose of this study, numbers 1 to 5 were assigned to each option, in order to allow participants being surveyed to quantify likes and preferences on a 5-point scale, with 1 being the least important and 5 being excellent or very important. Demographic data that was collected at the end of this instrument which included, sex, age, economic activity, marital status and level of education

The questionnaires for both female and male respondents consisted of four modules. The first module targeting the two groups (females and males) asked general information regarding maternal health interventions. It focused on the discussion of family planning and pregnancy related issues by spouses. Issues such as the length of stay in the community, the kind of decisions they take before, during and after pregnancy by couples, their understanding of

maternal issues, and individual intended contribution to sustaining maternal health interventions.

The second module dealt with questions relating to respondents' perception of accessibility of care and factors which influence their health seeking behaviour. Respondents were asked whether distance to the health facility remains for instance insurmountable, a very big problem, a normal problem, a small problem and not a problem, using the five-point likert scale suggested by Likert. It also included questions relating to the type of facilities available, the frequency of maternal care attendance and the level of satisfaction.

The third module covered issues bordering on perceptions about quality of maternal care. Questions were asked on factors influencing perception of quality of maternal care. Respondents were also asked to select from factors such as waiting time, cost of payment, treatment received, level of communication and reliability of health institutions regarding the provision of quality maternal health services and indicate which of them influence their perception of quality of maternal health services most.

The final module focused on respondents' attitude or reactions to quality of maternal health interventions. Respondents were asked to indicate how long they have to wait before seeing a doctor or nurse and in terms of the assessment on examination on maternal health services on a 1 to 5 scale; 1 representing 'satisfactorily examines', 2 'partially examines', 3 'does not examine';4 'not often' and 5 'never' were used to guide the respondents (see Appendices 2 & 3 for details). As can be seen from Appendix 4, the questionnaire for the health personnel was also structured into four sections

covering: profile of respondents; level of utilization of health facilities; quality of care; and perception of quality of maternal health interventions.

Focus group discussions (FGD) guide: - Since the study used the mixed method approach, there was the need to collect some qualitative data to complement the quantitative one. Accordingly, the researcher decided to conduct nine (9) FGDs. The communities selected for the FGDs were ***Kade, Asuom and Akwatia*** in the Kwaebibirem district. In respect of Fanteakwa district, ***Osino, Begoro and Amotare*** were covered, while ***Oda, Achiase and Akroso*** were chosen from Birim South District. The composition of the participants were women, married men, opinion leaders and health workers.They were put together in each selected communities. The rationale for putting them together was to reconcile the responses from the various groups. In the FGD sessions partipants were asked about their perceptions, opinions, beliefs and attitudes towards the factors determining the utilization of maternal health interventions. Details of the issues covered in the FGD sessions are presented as Appendix 5.

Community entry and integration

In a research like this, it is important to build relationships, trust and being considerate of community members' time and other obligations, being open about what one is doing, treating people with respect; and being seen to be impartial. It is now recognized that the research questions and subsequent research direction must come from the community. The focus of research then becomes the betterment of the community rather than the betterment of the investigator or other stakeholders outside the community. Researchers should

be instrumental in the research process rather than being in the centre of the process (Ryan, 1994). This shift highlights the importance of cultural sensitivity in the research process. Cultural sensitivity in research is defined by Henderson (1992) as research done with a raised consciousness concerning the impact of a culture on: 1) the persons and/or phenomena being studied; 2) on the research process itself and 3) perhaps most importantly, on the researcher.

Cultural sensitivity is required when conducting research so that entry into a community will result in an effective working relationship with community members. The stages of entry into any community have been identified by Johnson (1984) and Hutchinson (1985) as stopping, waiting, transition, and entry. Stopping occurs when one is impeded in entering a community through formal or informal means.

In our observation, gaining entry into a community can move through different stages with different individuals and groups even within the same community. This process is not necessarily unidirectional and may move backwards, as well as forwards, through the stages of entry. This issue has not been addressed in the literature. Another aspect which is not addressed in the literature is that the process of entry not only depends on the researcher gaining entry into the community but also on the community developing a relationship with the researcher.

Since it is unethical to collect information without the knowledge of participants in social research (Schinke & Gilchrist, 1993), access and confidence of the communities were gained, personally (researcher himself being a traditional ruler) sending drinks and official letters to the chiefs of the selected communities. Within the Akan tradition it is customary to provide

drinks when homage is paid to a chief's palace, hence the provision of drinks as part of the entry procedure. In each community the first contact was with the Unit Committee chairman who then introduced the researcher to the chief, Queen Mother, Elders and, Opinion leaders in the communities. The idea was to seek the consent and support of the key figures in the community.Community entry and integration in the study areas was led by the researcher. Community entry and integration helped establish the initial working relationship between the community and the research team involved with the research.

When reviewing research literature on community leaders and their efforts in ensuring co-operation for research development, it is necessary to understand the definition of community as used in research. Therefore, this section offers definitions of community and discusses the need for community integration by illustrating the nature of problems in local communities. Hillery (1955) presented the general definitions of community. According to the author, community consists of persons in social and cultural interaction within a geographic area and having one or more additional common ties. Mattessich and Monsey (2004, p.56), defined a community as "people who live within a geographically defined area and who have social and psychological ties with each other and with the place where they live". Table 4 explains the approach adapted by the team to ensure successful community entry and integration.

Due to the fact that, the research project and the initiator were coming from outside the communities, the key concern was the ability to build a strong relationship directly with the communities and local authorities. This

allowed for a certain level of legitimacy when the team was working at the village level that set the groundwork for a strong partnership.

Table 4: Community entry and integration

Stakeholder(s)	Role of Research Team
Communities and opinion Leaders as well as Health Workers.	• The introduction of research team, the programme and its objectives; and the concept of co-management were performed by the researcher.
Communities and opinion Leaders as well as Health Workers.	• Attended meetings and briefings, paid courtesy calls, participated in the identification of health facilities with communities and prepared work plans on the research with health worker and community leaders.

Source: Field survey (2009)

The research assistants who were selected from the communities facilitated the field work and made positive contributions which enhanced the overall project. A further spin-off is that by training and working directly with these people, their own capacity was strengthened. Thus, the approach facilitated open communication and dialogue; determined the level of support and encouraged participation and cooperation.

Training of field assistants and pre-testing of instruments

Strauss and Corbin (1990) pointed out that, the primary goal of research is to discover or generate meanings held by respondents through transcending facts and causal analyses in order to investigate how they are constructed. Harlos, Karen, Mallon, Mary, Stablein, Raplh, Jones and Campbell, (2003), argued that, research usually begins with observation or intuition, followed by searching for data that supports, contradicts, or leads other directions. Thus, it involves searching for data that support, contradict or lead other directions. By doing so, researchers will be better equipped to defend a position or further examine processes (Harlos et al., 2003).

From the above, it became important to organise training for all research assistants.The training aimed at ensuring that research assistants understand how to gather, measure and validate research, and then become familiar with research methodology and the focus of the research. The training was intended to guide research assistants to demonstrate commitment to personal and social improvement, analyse implications of decisions, and become conscious of the ethical course of action to be taken to avoid incurring the displeasure of respondents.

A total of fifteen (15) interviewers made up of graduates who had finished their National Service assignment participated in the 5-day survey training that took place from 12-16 July, 2009. All the participants were trained in interviewing techniques and the translation of the content of the questionnaire into the local language-Twi and Krobo for respondents in the Fanteakwa District where the majority of the population are predominantly Krobos. The 'forward- backward- forward' approach was adopted for the

translation. Thus, translation of the questionnaires was from English to Twi and Krobo; and then from Twi and Krobo to English. The procedures followed during the training session were class presentation, mock interviews using classmates, and tests using the questionnaire on selected residents in Nkawkaw and New Abirem, in the Kwahu West Municipality and Birim North District respectively.

Twelve (12) participants were finally selected to constitute a team for the data collection. The selection was based on their in-class participation, performance, in the field practices and fluency in Twi and Krobo. The fieldwork lasted for one month from 1st -30th September, 2009 with the researcher himself serving as the principal supervisor.

The study instrument was pre-tested during the last week of August, 2009 on 56 respondents who were purposively selected before the community entry and integration stage. Seven (7) respondents each were selected from eight communities in the two districts to form the sample. The pre-test helped the researcher to assess the viability of the survey instrument due to the fact that, the necessary modifications were made before the actual fieldwork.

Response rate

There is no magic figure on response rates. Higher is better: 60 percent would be marginal, 70 per cent is reasonable, 80 percent would be good, and 90 percent would be excellent (Archer, 2008). The reason that lower response rates are problematic is, of course, that people who do not respond may well be different from those who do. Low response rates therefore can create

sampling bias; the lower the rate, the greater the risk of such bias (Brick & Kalton, 1996).

The percentage of people who respond to a survey is called the response rate; which is very important in research. High survey response rates help to ensure that the results are representative of the target population. A survey must have a good response rate in order to produce accurate and useful results. While one can use formulas to determine the number of responses one must have before we can put faith in the results, one wants the largest number of people possible to respond. One can obtain the response rate by dividing the number of people who submitted a completed survey (80% or more of questions answered) by the number of people you attempted to contact.

Response rate

$$= \frac{\text{Total number of respondents}}{\text{Total number of questionnaires Administered}} = \frac{578}{600} \times 100$$

$$= 96.3\%$$

An important aspect of any survey is the response rate which suggests the level of participation of the respondents. Usually, high non-response rate has implications for the quality of the data. As has been mentioned earlier a total of 600 respondents were selected for the study, of which 578 of them (representing 96.3%) provided usable as well as reliable data for the study. The difference of 3.7 percent was due to either respondents refusing to participate or ending the interview process half-way.

The high response rate might be due to the fact that, the subject under investigation and questions were of interest, concern and value to the

participants. Survey response rate is often determined mostly by how relevant the survey is to one's participants. Again, the issue of communicating with participants was made clearly especially regarding how the survey will benefit them. The researcher met with all communities through their leaders; communicated ahead of time, alerted participants that the survey was coming and explained the value and importance of the survey and encouraged their participation. They were also made to understand that participation was voluntary, anonymous and confidential. Finally, the use of a cover letter signed by the highest ranking executive of the University of Cape Coast which explained the purpose of survey and the value to the participant as well as how the survey information will be used was also responsible for the high rate of response.

Data processing and analysis

It is pertinent to ensure and check for accuracy and completeness in surveys. After the data collection, the tree instruments were separately, serially numbered, edited, coded and fed into the computer. The Statistical Product and Service Solution (SPSS) software (version 16) was used for the analysis using both descriptive and inferential statistical techniques. With regard to descriptive analyses, percentages were used to describe the individual characteristics and the socio-economic conditions of the communities.

In statistics, logistic regression is used for prediction of the probability of occurrence of an event by fitting data to a logistic function. Logistic regression is a type of predictive model that can be used when the target variable is categorical. It is a linear model used for binomial regression. Like

other forms of regression analysis, it makes use of one or more predictor variables that may be either numerical or categorical. For example, the probability that a person has a heart attack within a specified time period might be predicted from knowledge of the person's age, sex and body mass index. Logistic regression is used extensively in the medical and social sciences fields, as well as marketing applications such as prediction of a customer's propensity to purchase a product or cease a subscription.

Logistic regression was employed to complement the results obtained. It helped to identify the relative importance of the variables that influence resident's perceptions and attitudes towards interventions in communities as well as the significance of the relationships. If two variables are correlated, then knowing the score on one variable will allow you to predict the score on the other variable. The stronger the correlation, the closer the scores will fall to the regression line and therefore the more accurate the prediction. Finally, the chi-square (X^2) statistic was employed to measure the degree of relationship between residents' socio-demographic and economic variables and their scale of maternal health preference.

The FGDs data were analysed by replaying the audio or videotape of the various groups and transcribed into English using the relevant themes. The transcription helped to pick up incomplete sentences, half-finished thoughts, parts of words, odd phrases, and other characteristics of the spoken word in a group discussion. Even though some editing was done to increase readability, the characters of respondents' comments were maintained, but nonverbal communication, gestures, and behavioural responses are not reflected in a transcript.

Challenges of data collection

It is important for a researcher to be aware of the potential challenges that are likely to emerge during data collection. The study was confronted with the following fieldwork challenges:

- Resistance of Respondents: The researcher was limited by the reluctance of some respondents to complete the questionnaires promptly and those who even failed to complete them at all. This thus, limited the number of respondents involved in the study despite the researcher's efforts and approaches to them explaining the potential benefits of the study to them.
- Funding also played a key challenge during the survey. Limited funds prevented the visit to key sites where pertinent information could be collected and offer the opportunity to the researcher to meet with key stakeholders that can provide more detailed information on the study. It is likely that there will be costs associated with efforts to collect data and training of field staff in what and how to collect data and report. Though, these initial investments can have great payoffs, financial constraint was a major challenge.
- There were occasions that interview sessions attracted quite a crowd that had a potential of influencing responses offered by respondents. In such instances, time was spent to educate them that their presence would prevent the interviewees from responding freely to the questions as well as voicing out their concerns. This proved to be valuable as the people tended to appreciate the wisdom behind this caution.

- Some husbands did not take kindly to the fact that interviews with their wives were granted in their absence. Women are normally relegated to the background when it comes to decision- making, especially on health seeking behaviour, and this was experienced during the fieldwork. In such situations, the researcher pleaded on behalf of the wife and also impressed upon the husband on the need to listen to their female counterparts as the study was focused on maternal issues; and such interventions positively paved way for the exercise to continue.
- There were some ethical issues which must always be considered when planning any type of data collection. Data collection always costs someone something. It may cost health workers' time and energy to complete surveillance forms. Data collection also costs the people in the population from which the data is collected a certain amount of time, discomfort, and potential harm. The current research focused on obtaining information on maternal health, and the situation in question normally elicits a particular moral response from respondents. In some instances, some of the participants lacked a response and were "cold" to situations which required revisiting the painful experiences especially when losses of lives were involved. To overcome such a challenge, as argued by Bandura, (1999) members of the team were cautioned to place themselves in the position of the participants likely to be harmed by the event and remind themselves of the golden rule- "Do unto others as you would have them do unto you".
- Issues on the privacy of the participants were overcome by the introduction of team members by Assembly members in all the

communities where the data were collected with the assurance that, the use of the data was specifically for academic exercise.

In spite of these challenges encountered during the survey, quality was not compromised. In sum, the whole data collected were reliable and therefore could be used.

Summary

This chapter was specifically devoted to describing profile of the study area; the philosophy adopted that served as the guiding principle for the research, procedures used to collect data, sources of evidence from the field and statistical tools employed for data analysis. The next chapter analysed the socio-demographic characteristics of the respondents.

CHAPTER SEVEN

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS AND VIEWS ON MATERNAL HEALTH SERVICES

Introduction

The purpose of this chapter is to explore the socio-economic and demographic characteristics of the respondents and assess how the demographic variables influence the health-seeking behaviour of women with regards to maternal health interventions. Among the social-demographic variables examined are age, level of education, occupation, income level, marital status and religious affiliation of respondents.

Age of respondents

The social determinants of health are the conditions in which people are born, grow, live, work and their age, including the health system. These circumstances are shaped by the distribution of income, power and resources at global, national and local levels, which are themselves influenced by policy choices.

From Table 5, it can be seen that, in both Fanteakwa and Birim South districts, respondents within the age bracket of 25-34 years constituted the highest representing 31.8 per cent and 42.9 per cent respectively. In contrast, 31 percent of the respondents in Kweabibirem District were in the age cohort

45-59. In respect of the age brackets which were in the minority, Kweabibirem was 15-24 (11.2 %); Fanteakwa was 15-24 (20.5%) and for Birim South it was 45-59 representing 14.3%.

Table 5: Age of respondents by district

Age in years	Districts (n = 578)			Total
	Kwaebibirem	Fanteakwa	Birim South	
15-24	11.2	20.5	16.3	15.8 (91)
25-34	30.0	31.8	42.9	34.9 (202)
35-44	27.8	26.2	27.5	27.1 (157)
45-59	31.0	21.5	14.3	22.2 (128)
Total	100.0	100.0	100.0	100.00
	(187)	(195)	(196)	(578)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

Respondents' level of education

The recognition of literacy as a major determinant of health status in developing countries was observed in the literature in the late 1970's. Education has been an essential component of action to promote health and prevent disease in both developed and developing countries. In developing countries, health educational programmes directed towards maternal health interventions remain a fundamental tool in the promotion of maternal and child health programmes.

As evident in Table 6 a,b and c, 18.2 percent in the Birim South District had never been to school for both female and male respondents, for Fanteakwa District it was 16.5 percent while Kwaebibirem District recorded almost 25 percent (24.7 %).

Table 6: Sex and level of education of respondents (in percentages)

District►	Kwaebibirem		Fanteakwa		Birim South		Totals
Level▼	Male	Female	Male	Female	Male	Female	
Never	1.6	7.5	5.6	5.1	3.1	7.7	10.2 (59)
Pre-School	2.7	5.3	3.6	7.7	4.1	1.0	8.1 (47)
Primary	1.1	4.3	2.1	11.8	4.1	3.1	8.5 (49)
Middle / JSS / JHS	6.7	20.9	5.6	23.6	2.0	15.8	24.7 (143)
Secondary / SSS / SHS	4.8	9.1	4.1	8.7	2.6	8.7	12.6 (73)
Voc / Tec / Com	3.2	6.4	2.6	2.1	1.5	9.2	8.3 (48)
Tertiary	13.4	13.4	7.2	10.3	17.3	20.9	27.5 (159)
Total	33.2 (62)	66.8 (125)	30.8 (60)	69.2 (135)	33.7 (66)	66.3 (130)	100 (578)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

As evident in Table 6, the level of educational attainment of the respondents, a little over 10 percent (10.2%) fairly well distributed across the various categories never been to school, primary (8.5 %), middle/JSS/JHS (24.7 %), secondary (12.6%), vocational (8.3%) and tertiary (27.5%). Even

though, close to a quarter (24.7%) indicated they had tertiary education, most of the respondents in this category were health workers. Thus, the educational level of respondents who were not health workers can be described as low, since only about 8 per cent of the respondents could be associated with both secondary and tertiary education.

The results in Table 6 tend to confirm that the higher the level of educational attainment of the mother, the lower the level of maternal mortality as shown in Table 7.

Table 7: Level of education of pregnant women who died in the Eastern Region (2001-2008)

Year	Never (%)	Primary (%)	Middle/JHS (%)	Secondary (%)	Tertiary (%)	Total (%)
2001	14.8	35.0	25.8	19.4	0.5	10.8(768)
2002	30.5	21.4	30.7	16.0	1.2	11.5(823)
2003	30.8	22.4	28.8	15.3	2.7	12.0(854)
2004	31.2	27.7	28.3	12.6	0.2	11.6 (824)
2005	27.3	33.9	29.1	8.8	0.9	12.8 (912)
2006	31.6	30.9	25.9	10.2	1.4	13.4(957)
2007	29.0	31.6	26.0	11.8	1.5	14.0 (996)
2008	29.7	30.2	27.0	12.2	0.8	13.9 (990)
						100 (7,124)

(Numbers in brackets are absolute figures)

Source: GHS, Eastern Region Annual Reports (2001-2008)

It is evident from Table 7 that, nearly 60 percent of pregnant women who died from 2001-2008 had low level of education. In communities where the level of education is high, the maternal death rate was low according to health care providers. This evidence tend to support Palloni and Tienda (1986) who reported that maternal deaths by level of education suggests that less educated mothers are almost 58 percent higher than that of educated ones. It is plausible therefore to conclude that educated women are more likely to engage in health-seeking behaviour than their counterparts.

Occupation of respondents

One of the foundations underlying occupational therapy and practice is the belief that there is a relationship between occupation and health and well-being (Wilcock, 1993).

Table 8a: Occupation of female respondents

	District (n=360)			
	Kwaebibirem	Fanteakwa	Birim South	Total
Occupation ▼	%	%	%	
Self employed (Farming/trading)	58.3	58.4	59.1	58.8(211)
Artisans	35.0	31.6	32.6	30.1 (119)
Salary workers	15.0	10.0	8.3	11.1 (40)
Total	100.0 (120)	100.0 (120)	100.0 (120)	100.0(360)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

For example, a framework developed by Wilcock (1993) emphasizes the relationship between several factors (personal, aspects of occupation, and environmental), and their effect on a person's occupational performance and their health and well-being. From Table 8a and b, it is obvious that farming and trading remain the common and popular occupation accounting for over half (51.2 %) of the respondents.

Table 8b: Occupation of male respondents

	District (n=360)			
	Kwaebibirem	Fanteakwa	Birim South	Total
Occupation ▼	%	%	%	
Farming/Trading	20.0	16.0	24.0	20.0 (30)
Artisans	26.0	24.0	16.0	22.0 (33)
Unemployed	14.0	26.0	32.0	24.0 (36)
Salary workers	40.0	34.0	28.0	34.0 (51)
Total	100.0 (120)	100.0 (120)	100.0 (120)	100.0 (360)

(Numbers is brackets are absolute figures)

Source: Field survey (2009)

In respect of those who were artisans, Fanteakwa district had the highest (45.9%), followed by Birim South (29%) while Kweabibirem District recorded 25.3 percent. Only 7.6 percent of therespondents were government employees in all the districts. Essentially, they were made up of the health workers who were included in the study. The artisans were those who either dress makers or seamstress.

The empirical evidences gathered from the FGDs support the fact that, there is relationship between occupation, health and well-being. This was alluded to by the following:

> 'The effect of occupation on health is dependent on the relationship between the person, environment and occupation, and the individualized balance in self-care, productivity and leisure' (A retired male banker at Oda).

Income level of respondents

One of the variables that may influence the utilization of maternal health interventions is income levels. Table 9 indicates that the people residing in the three districts have fairly low income. The annual household income distribution of the entire respondents is as follows: GH¢ 4,500 and over (13.2 %), from GH¢ 1,000 to 2,499.99 (30.5%), and those with less than GH¢ 1,000 Ghana Cedis (16.6 %). Income levels for residents' in the Birim South were satisfied with 15.5 percent earning almost GH¢4, 000 (GH 3,500-3,999).

The possible reasons for the difference in income levels might be due to the predominance of wage and self-employed in the urban areas. However, in rural areas, household incomes mostly come from farm products. Again, the differences in income levels are largely due to variation in individual education and employment status as against individuals without education and are unemployed.

Table 9: Income level of respondents

	District (n=578)			
Annual Income (GH)	Kwaebibirem %	Fanteakwa %	Birim South %	Totals
0.00 – 999	20.9	15.4	13.7	16.6 (96)
1,000.00 – 1499	11.2	12.3	9.2	10.8 (63)
1.500.00 - 1,999	8.6	9.7	10.2	9.5 (55)
2,000.00 - 1,499	13.9	11.3	5.6	10.2 (59)
2,500.99 - 2,999	4.3	9.7	9.2	7.8 (45)
3,000.00 - 3,499	5.3	10.3	13.3	9.7 (56)
3,500.00 - 3,999	4.8	7.7	15.3	9.4 (54)
4,000.00 - 4,499	15.0	10.3	13.3	12.8 (74)
4,500.00 - ∞	16.0	13.3	10.2	13.2 (76)
	100.0	100.0	100.0	100.0
Total	(187)	(195)	(196)	(578)

(Numbers is brackets are absolute figures)

Source: Field survey (2009)

Marital status of respondents

In the last few decades, Ghana has witnessed a number of demographic changes related to marital and other socio-economic behaviour of the population e.g. increase in age at first marriage; decline in marriages rates and increase in divorce rate. The 2000 population census classified “marital status” into married, living together, separated, divorced, widowed, never married, and consensual unions. The definition of marriage includes persons in any of

the following types of marriages: civil, traditional, and common law/consensual.

Table 10: Percentage distribution of respondents by marital status

Marital Status	District (n=578)						
	Kwaebibirem		Fanteakwa		Birim South		Total
	Male	Female	Male	Female	Male	Female	
Married	64.5	66.4	60.0	54.8	72.7	83.5	63.5(367)
Living Together	9.7	14.4	30.0	25.9	7.6	13.1	17.1(99)
Seperated	11.3	2.4	1.7	9.6	6.1	3.1	5.5(32)
Divorced	1.6	7.2	1.7	3.7	6.1	6.2	4.8(28)
Widowed	6.5	1.6	3.3	1.5	4.5	6.8	3.5(20)
Never Married	6.5	8.0	3.3	4.4	3.0	6.2	5.5 (32)
Total	100.0 (62)	100.0 (125)	100.0 (60)	100.0 (135)	100.0 (66)	100.0 (130)	100.0 (578)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

As has been indicated in Table 10, over 63 percent (63.5 %) of the respondents were married, whilst 5.5 percent were single. The remaining classes of marital status were divorcees (4.8 %), living together and married but had children (17.1 %) and widows (3.5 %). All the districts registered high numbers of married respondents: Kwaebibirem (33.5 %), Fanteakwa (30 %) and Birim South (36.5 %). However, respondents living together in Fanteakwa were much higher (53.5 %). In respect of divorcees, Birim South district recorded the highest number (42.9 %). All the districts exhibited similar

pattern of respondents who were separated; Kweabibirem (31.3 %), Fanteakwa (43.7 %) and Birim South (25 %) respectively.

Religious affiliation of respondents

Various studies have examined the relation between religiosity (religious beliefs and/or practices) and health. It also includes church attendance and its relation to drug use. The role of the church in health promotion is much discussed in the literature.

Table 11: Religious background of respondents

Type of Religion	Districts (n=578)						Totals
	Kwaebibirem		Fanteakwa		Birim South		
	Male %	Female %	Male %	Female %	Male %	Female %	
Christian	74.2	55.2	63.3	65.2	62.1	70.7	64.7(374)
Traditional	16.1	16.8	11.7	19.3	15.2	20.0	17.3(100)
Moslem	6.5	6.4	25.0	4.4	12.1	4.6	8.1 (47)
Athiest	0.0	0.0	0.0	0.0	0.0	1.5	0.3(2)
Others	3.2	21.6	0.0	11.1	10.6	3.1	9.5(55)
Total	100.0 (62)	100.0 (125)	100.0 (60)	100.0 (135)	100.0 (66)	100.0 (130)	100.0 (578)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

Table 11 suggests that respondents from different religious background participated in the survey. Among the respondents, Christians constituted the majority (64.7%), followed by Traditionalist/Spiritualist (17.3 %), Moslems (8.1 %) and only 2 people reported being atheist. This would appear to be a

good development as the various religious groups could be useful for disseminating maternal health information.

General living conditions of respondents

Respondents' general living conditions include lack of entertainment and cultural events and fewer opportunities for economic, political and educational development. However, this is somewhat expected that rural areas provide less opportunities for personal advancement and usually young ambitious people need to migrate in order to realize their ambitions. There is higher proportion of physical work, usually related to agricultural activities and the income levels of the respondents are generally low. About two thirds (68.2%) of respondents either agree or fully agree with the statement that income is lower in rural communities than in the city, but they also think that costs of living are significantly lower.

Privacy in rural communities is limited by smaller population, smaller living space, close family ties, tradition and other factors. As much as 69.2 percent of respondents consider privacy in a rural community to be lower than in the city, which consequently can have an impact on some individuals. Finally, the survey collected information on a variety of housing characteristics: the type of dwelling and the main materials used in house construction, occupancy status; waste disposal, utilities and household amenities. Most households in the selected districts (79%) live either in rooms in compound houses or other types of rooms. About 45 percent (26 percent in urban areas and 59 percent in rural areas) of the households own the houses

they live in. Only 14 percent of rural households have access to pipe-borne water.

Respondents views on maternal health services: The evidence

This section of the chapter seeks to explore the perceptions of the respondents, attitude and the level of knowledge on maternal health services or interventions as well as the maternal health seeking behaviour of women.

Women's views on quality of maternal health services

Reducing maternal mortality remains one of the most important social and developmental challenges currently facing SSA. Available evidence from the literature suggests that the MDG 4 which aimed at reducing maternal mortality rate by 75 percent by 2015 is most unlikely to be attained by many African countries (WHO, 2006).

One of the specific objectives of the present research was to assess the level of knowledge and perception of quality of maternal health interventions and to identify the areas of unmet needs with the view to drawing the attention of the health policy makers. As has been shown in Table 12, 92.5 percent of 360 women interviewed from the three districts (does not include health personnel; rather 120 women from each district) were satisfied with the availability of drugs at all the health facilities.

In respect of quality of time patients spent with health providers, 85.3 percent agreed that it was satisfactory; whilst 76.9 percent appreciated the level of cooperation between health care providers, which clearly demonstrates the level of team work existing among health workers. However,

delay at the service points (63.3 %), attitude of staff towards patients (69.2 %) and operations of National Health Insurance (59.2%) were unsatisfactory among the views expressed by the women studied.

Table 12: Perceptions of women about quality of health care

Patient's Perception	(n=360)	
	Satisfactory (%)	Unsatisfactory (%)
Availability of drugs in the pharmacy	92.5	7.5
Quality of time spent with the Doctor/ Nurse/Health Provider	85.3	14.7
Pharmacist explanation of drugs	79.1	29.1
Level of co-operation between healthcare providers	76.9	24.1
Period taken before admission and scheduling of operations	26.4	73.6
Delay at the service points	36.7	63.3
Attitude of staff towards patients	30.8	69.2
Uncleanliness of restrooms / washrooms	20.3	79.7
Health Insurance operations	41.8	59.2
Hospital food	28.3	71.7

Source: Field survey (2009)

Perceptions of quality of care at health facilities could influence client's adherence to advice on referral. It came out from the FGDs that quality of care was perceived as having several components, including the

mothers' chances of recovery, provision of free drugs and other services and respectful treatment by care providers. In the FGDs, the referral hospitals were cited as providing more satisfactory services compared to the health centres. This was alluded to by a participant with the following observation:

> "The prompt response by health workers towards emergency situations at the health facility may be perceived as good quality of care, apart from their kindness and willingness to listen and explain the health problem without verbal and physical harassment"[A Retired male Banker at Akim Swedru].

Men and women's perception of health care seeking option during pregnancy, delivery and postnatal periods

From Table 13, 78.5 percent of women and 67.3 percent of husbands said that they would advise a relative to seek prenatal care during pregnancy. On whether antenatal consultations were essential during pregnancy, over 80 percent of women and 75.2 percent of husbands responded in the affirmative. Again, the majority (72.5%) of men claimed they would prefer their partners to deliver in a health facility.

Table 13: Respondents' perception of health care seeking option during pregnancy, delivery and postnatal periods

Type of Service	Percent of Women (n=360)	Percent of Men (n=150)
Antenatal care		
Would advisepregnant women/relative/friend in household to seek prenatal care in a health facility.	78.5	67.3
Consider service essential for all women.	83.8	75.2
Delivery		
A pregnant women/relative to deliver in health facility.	88.5	95.3
Women who would deliver in a health facility if pregnant in future.	86.4	xx
Husbands who would like partners to deliver in health facility.	xxx	72.5
Postnatal care		
Would advise pregnant women/relative to seek postnatal care in a health facility.	89.6	85.3
Consider postnatal care essential for all women.	74.2	70.5

(xxx – Not applicable to males; xx – Not applicable to females)

Source: Field survey (2009)

Women's General Knowledge on marternal healthcare

The survey results indicate that, there was fairly good general knowledge about maternal health care, including the number and timing of antenatal and postnatal visits and danger signs before, during, and after delivery. Majority of women (more than 60%) indicated a good knowledge about maternal health care (see Table 14).

Table 14: Women general knowledge about maternal healthcare

District (n=360)			
	Kweabibirem	Fanteakwa	Birim South
Knowledge about	(%)	(%)	(%)
Number of antenatal visits	61.8	79.4	67.8
Number of postnatal visits	56.9	76.8	63.9
Danger signs of pregnancy	49.3	68.6	56.6
Premature births	63.2	70.2	69.1
Free maternal health policy	48.9	68.9	67.5

Source: Field survey (2009)

Tables 15 summarises the reasons provided by respondents (both women and husbands) for seeking maternal care. The main reasons cited were to protect the health of the mother and the newborn baby and to prevent/and or identify potential problems during childbirth. Most respondents were aware of the importance of seeking antenatal, delivery, and postnatal care at a health facility. Over 70 percent of women and men stated that they considered antenatal consultations to be essential for all pregnant women and that they would choose for a friend or household member to deliver in a health facility.

Table 15: Reasons cited by men and women for seeking antenatal, delivery and postnatal care

Reasons	Percent of Women (n=360)	Percent of Men (n=150)
Protect the health of mother	78.6	70.4
Protect health of infant	65.8	73.3
Avoid problems during pregnancy	58.2	43.6
Receive anti-tetanus vaccination	26.0	7.6
Identify potential problems during pregnancy	20.4	8.9
Receive anti-malaria tablets	19.4	5.1
Plan for childbirth	0.7	0.9
Receive iron tablets	5.8	4.3
Don'k know	4.7	2.1

Source: Field survey (2009)

Table 16 presents results on the risks or dangers women respondents experienced during pregnancy. Regarding long labour (ie more than 10 hours), on average about 70 percent of the respondents from the three districts had experienced this difficulty, and received treatment for it though they did not regard it as a serious disorder as indicated in Table 13. It was found that over 50 percent of these women regarded the issue of prolonged labour with levity.

Again, more than 50 percent (58.2%) of 360 women indicated that it is important to avoid problems during pregnancy. By implication, if most women are prepared to report any problem they are likely to encounter before, during and after pregnancy to health providers, the maternal deaths could be reduced.

Table 16: Proportion of women respondents who have experienced risk/danger during pregnancy

Risk/Danger Experienced	District (n=360)		
	Kwaebibirem (%)	Birim South (%)	Fanteakwa (%)
Massive bleeding	70.3	68.6	73.2
Long labour (more than 10 hours)	60.5	59.6	52.1
Baby in bad position	4.8	6.8	3.9
Retained placenta	10.7	15.8	6.9
Very high fever	20.1	20.9	20.6
Seeking treatment for massive bleeding	53.1	60.6	89.3
Seeking treatment for long labour	72.1	60.5	83.6
Seeking treatment for baby in bad position	60.6	59.6	74.3
Seeking treatment for retained placenta	58.1	63.1	65.0
Seeking treatment for fever/malaria	68.2	70.4	75.6
Arranging for caesarean operation	29.9	38.9	0.0

Source: Field survey (2009)

This apparently explains why most of the women discussants from all the districts claimed that long labour was normal, although there was a condition attached to this opinion as expressed by one of the women participants in FGD session who said:

> "A woman experiencing prolonged labour is not facing any extraordinary risks especially if it is her first delivery" [A TBA at Achiase].

In Fanteakwa district, a relatively high proportion (83.6%) sought help, and this was in spite of the fact that they usually regard the complication as a normal one. It came out that most of the respondents had initially planned to deliver their babies at home but changed their decisions when complications set in. According to the women when labour became prolonged they ultimately had to seek help in the hospitals because they believed their lives were endangered. Many cases of babies in bad or unsuitable positions went hand in hand with cases of prolonged labour. However, these were few for all the districts as Kwaebibirem had 4.8 percent, Birim South (6.8%) and for Fanteakwa (3.9%). The recognition of this disorder was encouraging because about 80 percent of all respondents agreed that there could be serious consequences for mother and child, if a baby remained in a bad position for a long time. The reported health-seeking behaviour was particularly encouraging, more especially, in Fanteakwa district.

There were very few cases of women with retained placenta in all areas. In spite of this, awareness about the reproductive condition could be regarded as very high because about four-fifths (80%) of all the women interviewed, agreed that this was a serious risk to face in pregnancy. This

probably explains why all the affected respondents went for help, and close to three out of every five women who experienced it were from the rural area. Some of the respondents who were Christians claimed to believe that `nothing was too serious or dangerous for God to put right'. This opinion was echoed by a woman discussant at Achiase in the Birim South district who said:

> "Although I agree that pregnancy complications may arise especially at delivery, I still believe in the supremacy of God over all problems and difficulties. There is no bad situation He cannot control".

It was observed that in both urban and rural areas, almost half (49.6%) of the respondents had their deliveries in hospitals. Of the other deliveries that did not take place in hospitals, more respondents in the rural area delivered at home. Given that quite a number of women experienced long labour and the unsuitable positioning of their babies before delivery, it was not surprising that caesarean operations were performed. In fact, there was none in Fanteakwa while almost 30 percent and about 39 percent (38.9%) of women respondents in Kwaebibirem and Birim South respectively had these operations.

A central element of maternal health is strengthening the knowledge and skills of healthcare providers at different levels of the health delivery system to ensure that they can provide high-quality care for normal pregnancies and deliveries, as well as identify and manage obstetric complications, as appropriate. During the FGDs, some participants made some interesting observations which are reported in Boxes 1 and 2:

"She just came quarrelling with me that put fear in me at the time I was delivering; I did deliver with a lot of fear. So in my opinion when I compared the behavior of some nurses with the TBA, the latter has some sympathy for pregnant women. The harassments we experience have discouraged us. Not all health workers are good. Some of them are 'extra rude'. Some just see you and make a conclusion immediately that this one is illiterate and uninformed. You will really wonder, and these even make you not to go back to that particular hospital." [Woman at Achiase-Birim South District]

Box 1: Focus group discussion session at Achiase, Birim South District

Source: Field survey (2009)

"Services are not the same. Some nurses feel unpleasant and distasteful to attend to patients from rural areas; because we are considered unclean At a time I was experiencing pains during labour, they were very harsh and did not want to help me, even though, they had been trained with the tax payers income and are knowledgeable. It's quite discouraging; it was the work of God that saved my life. God helped me not the nurses. If you fall into the hands of a good nurse, you are seen quickly, but if it is a bad provider, even if it is an emergency they delay to attend to you. Sometimes, you get to the health centre and the midwife cannot be found and your husband has to go looking for her" {Woman at Asuom, Kwaebibirem District].

Box 2: Focus group discussion session at Asuom, Kwaebibirem District

Source: Field survey (2009)

From the above observations by FGD discussants, it is clear that the quality of care issue plays a significant role in promoting maternal health and clients are aware of what constitutes quality care. It is critically important and clinically relevant to ensure that performance measures that have the potential to significantly improve the quality and efficiency of patient care are put in place by health care providers.

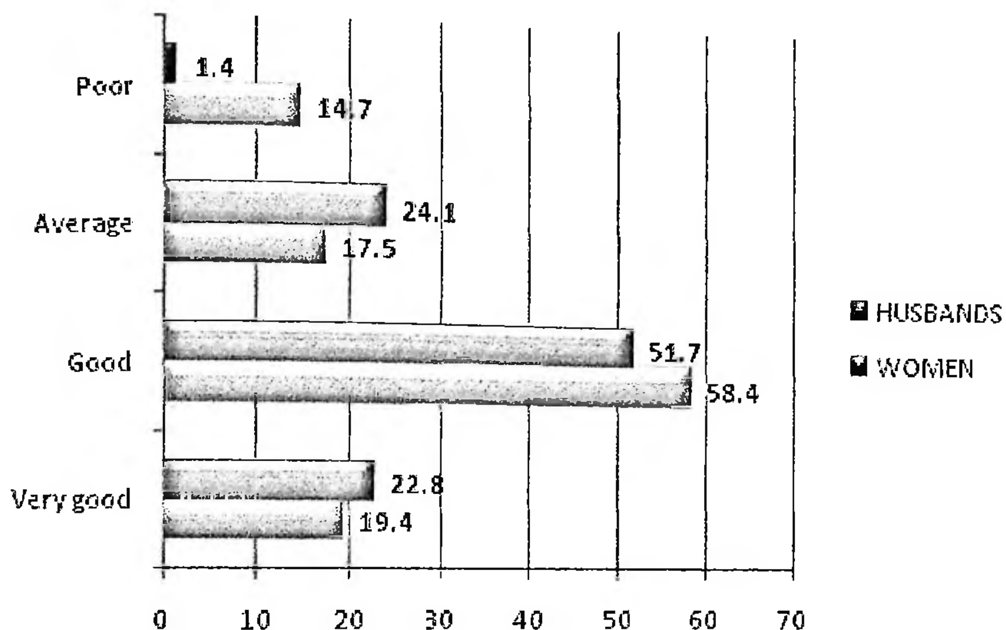

Figure 11: Level of quality care available to respondents

Source: Field survey (2009)

Figure 11 illustrates the assessment made by both women and men on the quality of care at health facilities in their communities. Over 70 percent of both males and females admitted that, quality care was at least good or very good, whilst 14.7 percent of women respondents claimed quality of care was poor. For patients, this aspect was much more important than the technical competence of the provider. Furthermore, a reduction in waiting time (on average to 30 minutes) was more important to clients. Waiting time, which

was about double at outreach services than that at fixed services, was the only element with which users of outreach services were dissatisfied.

Perceptions of quality of care by women

Generally, women reported "being grateful" for the care they received and confirmed the fact that they believed they would not have survived if it were not for the care they received at the facility. Moreover, based on their experiences, they would consider giving birth at the facility, should they get pregnant again. However, when different elements of care were explored in depth, women raised issues about the health care staff and facility, which could be utilized to improve to quality of obstetric care. The study explored women's experiences of potentially life-threatening events and maternal near miss as well as perceptions of the care they received during this period in the study areas. For many women in the study area, the loss of a baby negatively influenced how they viewed and coped with the traumatic delivery experience. These women were more fragile and more frequently reported negative emotions.

In the current study, women's perceptions of the quality of the care highlighted several key factors which influenced women's perceptions, such as the importance of information, good communication, attitude, and availability of human (i.e. more doctors) and physical resources (i.e. more beds) at the facility. Good quality care should include information provided to the women about their conditions and the treatment protocols. Women should have the opportunity to ask questions and receive clear answers. However for many women in our study, this was not possible since for some period of time

they were not conscious; yet, it is very important to highlight the fact that when it did occur, women reported it as calming their worries and making them feel safer in the situation. The negative attitude of the nurses and midwives were brought up by many women, which is in agreement with previous research from Africa both among general obstetric populations and among women with severe maternal morbidity (Gilson, Alilio & Heggenhougen, 1994).

It emerged that the impact of communication with health practitioners resonates positive interactions in terms of communication and attitude between patients and health care providers increase not only quality of care as perceived by these women; it also improve future health care seeking for these women and their families. Additionally, it empowers them by providing the essential information surrounding their delivery, which might be otherwise missed. This may make it easier to accept the consequences, cope with the trauma and the possible loss and move on with their lives. Some were pleased with the quality of information they received from the health care staff. This assertion is supported with a statement by a discussant at FGD session:

> "The doctor is very good, the one who took me to the theatre. Because he told me everything, and everything he did, he wanted you to know. He would tell you that I am doing this and that and that etc., so I always say that I am happy with that." (38 years old woman at Amotare, Fanteakwa District).

Unlike the factors directly related to the health care providers, some of the key issues raised by the women are not fully within the control of the health care providers. Issues related to the lack of human and physical

resources and the cost of services are such examples. Treatment at the facility was delayed in certain cases, mostly involving emergency surgeries, due to the high load of cases and unavailability of the operating rooms. Provision of mosquito nets, availability of water and beds for women influenced women's experiences especially after such a traumatic delivery. Cost was another issue commonly discussed in the interviews. The national health insurance scheme (NHIS) in Ghana, which started in 2003 and became fully functional in 2005, covers delivery services for women. But in the event of a severe maternal morbidity, the costs of hospital charges escalate rapidly and women need to pay certain expenses out of pocket, such as certain drugs not covered under the insurance or not available at the hospital pharmacy. This finding confirms the assertion by Witter and Garshong (2009) that the extra costs women incur while at the facility could be a deterrent for seeking care. This observation were expressed by two women at FGD session, which made it clear that, even though the national health insurance scheme covered the delivery, there were many 'hidden' costs for drugs and other services:

> "There is another problem. So when you come here, they've been taking some small small money from you, two cedis here, and four cedis there. Anything, a little thing that they do for you, even when they carry you from wherever you are to another place, they take money." (45 years old, Kade, Kweabibirem District).
>
> "Sometimes when you come, they will tell you there are no medicines so they will write medicine for you to go and buy

[outside the hospital], that one too is a financial problem." (26 years old, Oda, Birim South District).

Summary

This chapter has examined the socio-demographic characteristics of respondents. Poor social conditions are known to affect maternal health, which again has impact on maternal mortality. Social developments such as improved maternal education, household income and environmental conditions should or may, have effects on maternal mortality in the study areas. It examined how socio-demographic patterns are related to maternal mortality. Socio-demographic and economic characteristics provide the necessary context for understanding residents perceptions and attitudes towards maternal health interventions in the research area and also how they will contribute in explaining the major findings of the study, which is the subject of subsequent chapters of the thesis.

The latter section of this chapter explored the evidence from the field in respect of resident's views of maternal health services. It is interesting to observe that, in order to achieve optimal quality and safety, treatment decisions between health practitioners and women should integrate the knowledge, skills, and values of both parties. Developing an understanding of the capabilities and constraints that are unique to each woman is thus fundamental to achieve their participation in their treatment plans. Having specific details of the actual experiences of women with the health care system helps pinpoint areas for improvement in ways that standardized satisfaction measures.

CHAPTER EIGHT

UTILISATION OF MATERNAL HEALTH CARE SERVICES: THE EVIDENCE

Introduction

This chapter sought to identify factors that either enhances or constraint the utilisation of maternal healthcare services in the study area. Empirical studies of preventive and curative services have often found that use of health services is related to the availability, quality and cost of services, as well as the social structure, health beliefs and personal characteristics of the user (Fosu, 1994). Familly size, mother's education, income levels and husband's occupation are the components of personal characteristics.

Knowledge, attitudes and practices related to maternal health

Traditional cultural practices reflect values and beliefs held by members of a community for periods spanning generations. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. These harmful traditional practices include female genital mutilation (FGM), early marriage, various taboos or practices which prevent women from controlling their own fertility. There is also some preference and its implications for the status of the girl child, including female infanticide, early pregnancy and dowry. Despite their harmful nature and their

violation of individual human rights, such practices persist because they are not questioned.

It is against this background that the researcher sought to explore how traditional cultural practices might negatively affect maternal health interventions. To find out women's views on socio-cultural practices and maternal health care the women respondents (excluding health workers) were asked, if socio-cultural practices affect their maternal health seeking behaviour. From Figure 12, over 23 percent (23.1%) of the women's respondents claimed they were affected by certain socio-cultural factors which disturb them during pregnancy.

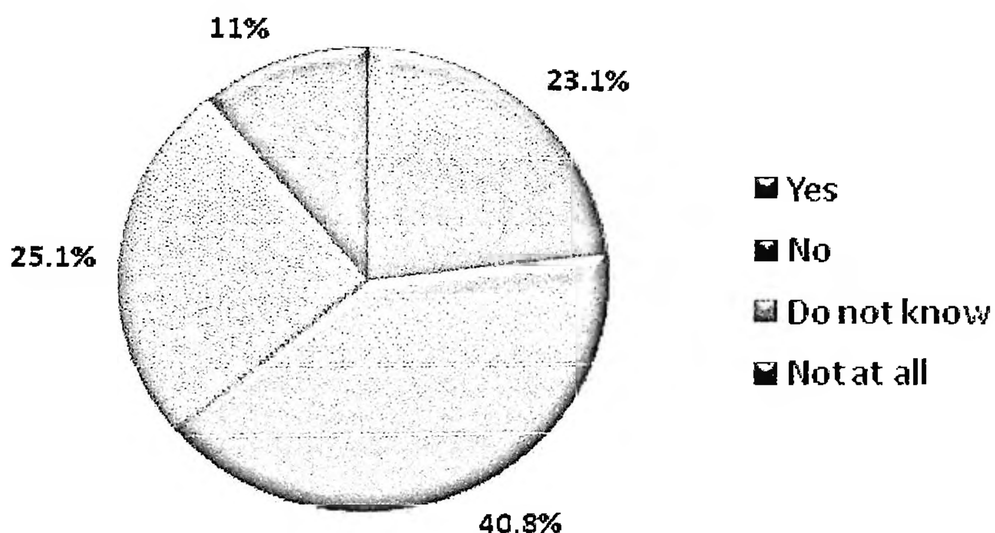

Figure 12: Women views on socio-cultural practices and maternal health care

Source: Field survey (2009)

Another socio-cultural factor discovered as affecting maternal health interventions in the study area was the attitude of women respondents towards delivery. As has been reported in Table 17, analyses of data from the three

study areas showed some improvement in the utilisation of skilled attendants with variations across the districts. For example, total institutional deliveries were almost 46 percent (45.4 %) with Fanteakwa District recording the highest (65.9 %). Deliveries with TBAs was 49.6 percent and 46.2 percent respectively in Kweabibirem and Birim South districts, however, it was significantly low (11.8 %) in Fanteakwa. A new development in Fanteakwa District where, volunteer health workers started to assist in health education drive of pregnant women to avoid home deliveries resulted in an increase in institutional deliveries.

Table 17: Women's reported place of delivery and type of attendant

Place of delivery	District (n=360)			Total
	Kweabibirem (%)	Birim South (%)	Fanteakwa (%)	
Institutional deliveries	38.4	30.8	65.9	45.4
Home deliveries with skilled attendant	8.0	11.5	11.8	10.5
Home deliveries with TBAs	49.6	46.2	11.8	35.5
Home deliveries with relatives	4	7.7	10.4	7.4
Delivery on the way to health facility	–	3.8	–	1.3
Total	100.0 (120)	100.0 (120)	100.0 (120)	100.0 (360)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

In addition to the recognition of the general health benefits of maternal health services, women and their families need sufficient amount of in-depth knowledge about maternal healthcare in order to make appropriate decisions about their health during and after pregnancy. These include awareness of when and how often they should seek care, services that should be received during antenatal visits, and signs of maternal health problems and obstetric emergencies. According to Bennett (2004) it is important for a pregnant woman to receive maternal healthcare from a trained health worker at least four times during her pregnancy and that the first prenatal visit occur by the end of the fourth month of pregnancy.

Table 18: Women's awareness of correct time of first antenatal visit by - level of education

Level of Education	District (n=360)			Total (%)
	Kweabibirem (%)	Birim South (%)	Fanteakwa (%)	
Never	7.0	7.2	5.5	6.2
Primary	10.0	11.2	8.6	10.1
JHS	14.6	13.9	16.7	15.3
Secondary/ Voc.	22.9	22.8	23.0	22.9
Tertiary	45.5	44.9	46.2	45.5
Total	100.0 (120)	100.0 (120)	100.0 (120)	100.0 (360)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

To assess level of awareness of these guidelines for care during pregnancy, the survey asked all women respondents at what point during pregnancy the first antenatal visit should occur. As shown in Table 18, more than 44 percent of women interviewed in the three districts [(45.5%) Kweabibirem (44.9%) Birim South and (46.2%) Fanteakwa] respctively stated that the first visit should occur in or before the fourth month, and they were women with tertiary level of education.

By implication more than half (50%) of the respondents with low level of education could decide to attend first antenatal visit after the fourth month of pregnancy. For the purpose of the current study, low level of education represents respondents who could not complete JSS/JHS. This is not good enough and there is the need for further education of women on this subject. When asked, how many times a woman should seek antenatal care during pregnancy, over 30 percent, (31.2%) and 25.4 percent of women interviewed in Kwaebibirem and Birim South respectively stated that a woman should have two antenatal visits as shown in Table 19.

Again, a little over 20 percent of women in both Kweabibirem and Fanteakwa districts indicated that more than 4 antenatal visits were preferred or is the best practice. It was only in Fanteakwa District where less than 15 percent of women interviewed responded that four visits was the best practice. The number of women who did not attend antenatal at all throughout pregnancy was quite insignificant apart from Kwaebibirem which was 7.2 percent, Birim South was 2.3 percent and Fanteakwa recorded zero percent.

The high awareness of the women from Fanteakwa district could be largely due to the vigorous public health education campaign which began in

1994 by the public health directorate coupled with the periodic training programme provided by Plan International for public health staff and queen mothers.

Table 19: Women's knowledge on number of antenatal visits during pregnancy

Frequency of visits	District (n=360)			Total (%)
	Kwaebibirem (%)	Birim South (%)	Fanteakwa (%)	
0	7.2	2.3	0.0	3.1
1-3	31.2	25.4	12.6	22.8
4-6	20.8	14.6	20.7	18.7
7-9	28.0	21.5	19.3	22.8
10-13	4.8	16.2	28.1	16.7
14-16	8.0	20.0	19.3	15.9
	100.0	100.0	100.0	100.0
Total	(120)	(120)	(120)	(360)

Source: Field survey (2009)

To enhance the maternal health intervention activities, the District Assembly in June, 1998 purchased 10 motor bicycles and donated them to the public health directorate. This perhaps may explain the low level of maternal deaths in the district. Over 28 percent (28.1%) of respondents in Fanteawa District agreed that throughout the period of pregnancy, it is pertinent and helpful to attend antenatal10-13 times before delivery.

Nutritional taboos and practices related to pregnancy and child delivery

Early pregnancy can have harmful consequences for both young mothers and their babies. According to UNICEF, no girl ought to become pregnant before the age of 18 because she may not yet be physically ready to bear children. The literature indicates that babies of mothers younger than 18 tend to be born prematurely and have low body weight; such babies are more likely to die in the first year of life. The risk to the young mother's own health is also paramount.

A woman is pressured to confess her misdeed so that labour may continue without complications. It was revealing that, this practice, which inflict great mental cruelty on a woman already in agony due to obstructed labour, was prevalent in a number of communities in both Kwaebibirem and Birim South districts. From Table 18, almost 59 percent of respondents in all the districts claimed they were aware of the existence of traditional practices. Again, on average over 58 percent (58.7%) of women respondents were aware of these practices in all the districts (Table 20).

Evidence from the FGDs indicated that nearly all the women participating in both Kweabibirem and Birim South districts agreed that such practices were harmful. An example of a statement from a woman at Asuom in the Kwaebibirem district alluded to the fact that:

> 'If you nowadays rely on fetish priests who have nothing apart from concortions you will die with your baby. As Christians we have to ignore all the taboos'.

Table 20: Women respondents' awareness and experience of traditional taboos and practices during labour

Variable	District (n=360)			Total (%)
	Kwaebibirem (%)	Birim South (%)	Fanteakwa (%)	
Level of awareness				
Women who were aware	58.4	58.7	58.9	58.7
Women who were not aware	41.6	41.3	41.1	41.3
Level of experience				
Women who have experienced this practice	45.2	39.9	25.6	46.8
Women who have not experienced this practice	29.8	28.5	47.2	28.7
Don't know	25.0	31.6	27.2	24.5
Total	100.0 (120)	100.0 (120)	100.0 (120)	100.0 (360)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

A good number of women in the study area appear not to be aware of their basic human rights. It is this state of ignorance which ensures their acceptance and, consequently, the perpetuation of harmful traditional practices affecting their well-being and that of their children. Even when women

acquire a degree of economic and political awareness, they often feel powerless to bring about the change necessary to eliminate gender inequality.

Decision making process in seeking maternal healthcare

Autonomy is defined from the literature as the control people, including women have over their own lives, the extent to which they have an equal voice with their husbands in matters affecting themselves and their families, control over material and other resources, access to knowledge and information, the authority to make independent decisions, freedom from constrains on physical mobility and the ability to forge equitable power relationships within families (Jejeebhoy et al., 2001).

Ethical issues that arise in the care of pregnant women are challenging to physicians, politicians, lawyers and the like. One of the fundamental goals in medicine and society is to optimize the outcome of pregnancy. If either of marriage couples play a domineering role or expect to make all the major decisions in the marriage, the marriage will suffer. Making decisions should be a shared responsibility. To solicit for the views of couples on autonomy and to make the illustrations more useful, the question of who has the final say in taking decisions on maternal health was posed.

Most women were subject to their husband's decision on the choice of treatment. In all the districts, it was found that relations had little contributions to make to the treatment choice. From Figure 13, more than 80 percent (82.2 %) of male respondents agreed that, issues on maternal care were discussed and mutually accepted course of action taken to avoid complications.

Results from the study suggest that, while 82.2 percent of male respondents claimed women were autonomous in maternal health decisions, 36.7 percent of female respondents also confirmed that they were autonomous. Women's autonomy on issues affecting their maternal health was surprisingly low (less than 37%). The situation becomes worse, especially when the woman is not working and had no regular source of income. Rural and poor women were less likely to be involved in decision making than urban or rich women. Most of women respondents claimed that the burden of seeking maternal care rests only on them when their husbands are not working. It was also established that 218 out of 360 constituting 60.5 percent of women in some communities experiencing such situations rely on their parents or relatives when their conditions become critical.

The indicators of the two dimensions of women autonomy along with questions that were posed to women in the survey were: women's involvement in decision making and economic security. In the present study, women's autonomy, as measured by the extent of women's sole final say in decision making and daily household purchases and of visiting families or relatives and their association with maternal health care utilisation were examined. The primary aim was to determine whether there is a link between the autonomy of women and utilization of maternal services. The outcome was that nearly 89 percent (88.7%) of women, who were educated (education above primary level) and earned regular incomes, were autonomous in taking decisions regarding maternal healthcare.

It may be argued that women with higher autonomy are more likely to use maternal and child health care services compared to women with lower

autonomy.The reason being that if a working woman has money to spend on bills there is no reason why the spouse has to take decision on when or how to seek maternal health.

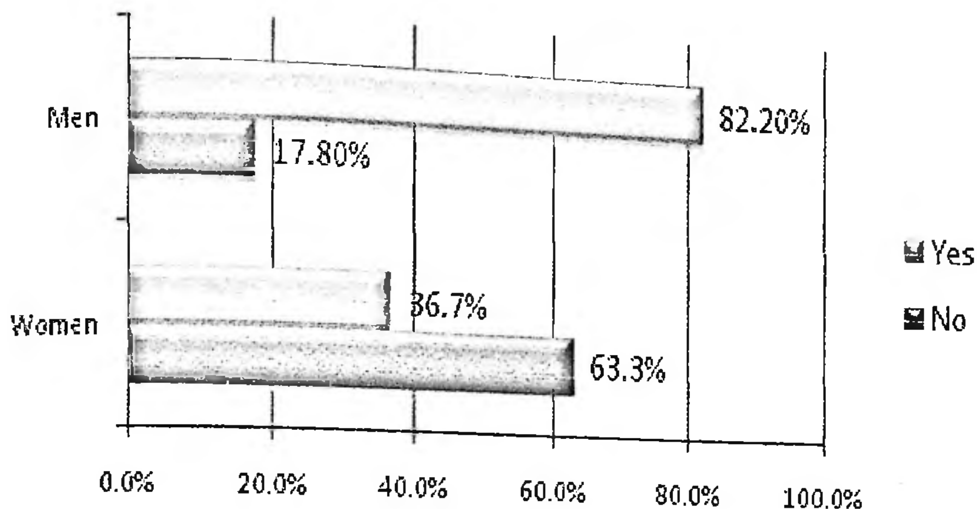

Figure 13: Discussion on maternal health services with partner

Source: Field survey (2009)

In respect of husbands' responsibility and participation in their wives' care, most husbands feel responsible for routine care and treatment of problems. Men indicated they want to participate in maternal care. Yet, high awareness and sense of responsibility do not translate into participation. In both routine care and treatment of problems, husbands participated more often by paying for care than accompanying their wives. The interview results suggest that husbands may be dissuaded by the belief that maternity is 'women affair' and by young women going to their antenatal home for delivery. Additionally, beliefs of health staff and poor conditions in health centers mean that even husbands who accompany their wives to clinics are often made to wait outside.

Views from discussants during FGD sessions, with regards to characteristics of knowledge and participating husbands, men who were better educated and had educated wives are more likely to participate in all three phases of care. Similarly, husbands who accompany their wives for routine care in one phase of maternity are more likely to accompany them for treatment of problems or for care in other phases.This was alluded to by a woman with the following statement:

> "My husband and I are uneducated. Both of us are blind and cannot sometimes administer drugs. Women with educated husbands are lucky; their husbands are likely to offer assistance during pregnancy" [A female trader from Osino].

Table 21 sought to examine women's autonomy in decision making on maternal health care. Women's participation either alone or jointly in household decisions on their own healthcare was considered as an indicator of women's autonomy in decision making.

The researcher sought to find out if discussions on maternal healthcare by husbands involved women. The results revealed that decisions of women's healthcare were made mostly by men without their participation. The reason being that, out of 510 respondents, 321 of them representing 62.9 percent agreed that, most of the maternal health decisions are taken by men even when the woman has to attend prenatal, antenatal, delivery and postnatal care.

Table 21: Decision making on maternal healthcare

Decision makers	District (n=510)						Total
	Kwaebibirem		Birim South		Fanteakwa		
	Male	Female	Male	Female	Male	Female	
Husbands	62.9	62.4	54.5	61.0	40.0	40.7	54.0
Women	12.9	24.0	22.7	15.4	20.0	51.1	26.6
Jointly	19.4	12.0	15.2	23.1	35.0	6.7	16.8
Parents/Relatives	4.8	1.6	7.6	0	5	1.5	2.6
	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total	(50)	(120)	(50)	(120)	(50)	(120)	(510)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

While majority of male respondents claimed they discussed maternal health issues with their wives, reactions from the women participants were surprisingly low. In most communities studied, decision making for contraceptive use was a collective responsibility. Results from table 21 suggest that women's participation in decision making with their partners for all the three districts was less than 20 percent (16.8%). In the absence of joint decision taking , the health seeking behavior of most women who were unemployed are likely not to have a stronger say in household decision making due to the over reliance on partners.

Evidence from the FGDs at Oda by a business woman tend to elucidate the autonomy of women in most communities with regards to decision making on maternal healthcare:

> "Most husbands especially mine, always feel that, no matter how rich or poor women are, if they are uneducated and are left alone to take decisions on their maternal healthcare seeking behaviour, it is likely that, complications in pregnancy and maternal deaths would always go high all the time".

Table 22: Respondents' views on spousal discussion of maternal healthcare

Sex Level of discussion	Male (%) (n=150)	Female (%) (n=360)	Total (%) (n=510)
Very much	16.0	17.7	22.3
Much	52.1	35.9	36.0
Sparingly	6.4	10.3	9.0
Not much	20.7	27.9	25.6
Not at all	4.8	8.2	7.1
Total	100.0 (150)	100.0 (360)	100.0 (510)

Source: Fieldwork, 2009

Spouses contribute to each other's health and survival by providing social support and companionship, encouraging a healthy lifestyle, expanding each other's social networks, and increasing access to financial resources (Elwert & Christakis, 2006).

From the results in Table 22, over 52 percent (52.1%) of male respondents claimed that spousal discussions on maternal health were regular

before, during and after pregnancy; only 35.9 percent of women agreed that, the discussions were regular. Regarding whether such discussions were very much done, it was less than 23 percent (22.3%) for both men and women while the total for not doing it much was 25.6 percent.

According to Chen (2005), it is very likely that individuals derive social support or receive demands from relatives living nearby, in addition to those in the same households. Therefore, our measurement of the presence of non-spouse household members probably underestimates the degree of interactions with relatives. This might explain why it was found that most married women in the rural areas co-residence with the parents of their spouse.

Women's lack of autonomy and mobility from the results of the study is illustrated by their need to receive permission from their partners in seeking care. Women working and living in rural communities or working outside of their own agricultural land or home reported having to receive permission from bosses or managers to seek antenatal care. Some women reported that their spouses express jealousy if their wives were examined by a health practitioner. Thus, some women were not permitted to seek care or chose not to in order to avoid potential violence or conflict. In respect of possible husband jealousy, one woman confessed during an FGD session of the difficulty she had to go through any time she wanted to go for maternal care at a time the husband may not have time to accompany her:

> "When the husband tells me that I cannot go . . . no, no, I cannot go. Then I have to stay and bear it". "Sometimes because he is jealous. Jealousy because of not wanting the

doctor to look at me or because he does not want [the doctor] to see my vagina" [25-year old woman at Begoro].

Community expectations of a mother to act as the caregiver were reinforced by the husband's demand for her to remain at home. As a result of society's acceptance of the husbands' dominant role within the family, many women attributed poor maternal outcomes to the husbands' control over women's healthcare utilization. Spousal discussion on maternal health significantly features in marriage. Most marriages all over the world have suffered and broken down as a result of the existence on relationships which are sometimes not cordial.

Finally, the study explored the amount of housework as a potential mediator of the marital effects on health. Although the burden of housework increase quite high for married women as compared to single women, controlling for the amount of housework does not significantly change the relationship between marriage and health. Table 23 which shows the logistic regression is also an extension of multiple linear regressions, where the dependent variable is binary in nature. It is being used to predict the discreet outcome from a set of variables that may be continuous, discrete, dichotomous, or of any other type.

Table 23: Respondents' views on issues influencing discussion of maternal healthcare

Discussion of family planning with partner	Odds Ratio	Wald	Significance
Background of respondents			
Age	0.349	5.669	0.017
Marital Status	0.744	2.022	0.155
Education	0.695	13.056	0.000
Employment	0.161	3.779	0.052
Status in Community	0.122	0.218	0.640
Consultation with TBAs			
Age	0.299	5.137	0.023
Marital Status	-0.142	0.074	0.785
Education	0.144	0.967	0.326
Employment	-0.129	2.392	0.122
Status in Community	-0.387	3.548	0.060

Source: Field survey (2009)

As can be seen from Table 23, the educational levels of women were positively associated with discussion with partners of maternal issues. The results revealed that the coefficient of women's education was positive and statistically significant at 1 percent level of significance. It showed that a unit increase in women's education will increase the odds of marital discussions by 0.695 times. It is important to note that, the views of health workers are excluded from this analysis. Again, education is being used as a continuous

variable. It is for this reason that a unit increase in education increases the likelihood of having marital discussions.

Figure 14 illustrates the frequency with which maternal healthcare decisions were made by partners. The results revealed that, decisions on the utilization of maternal health services were taken arbitrary. Both males and females respondents admitted that such decisions were taken depending on the availability of money.

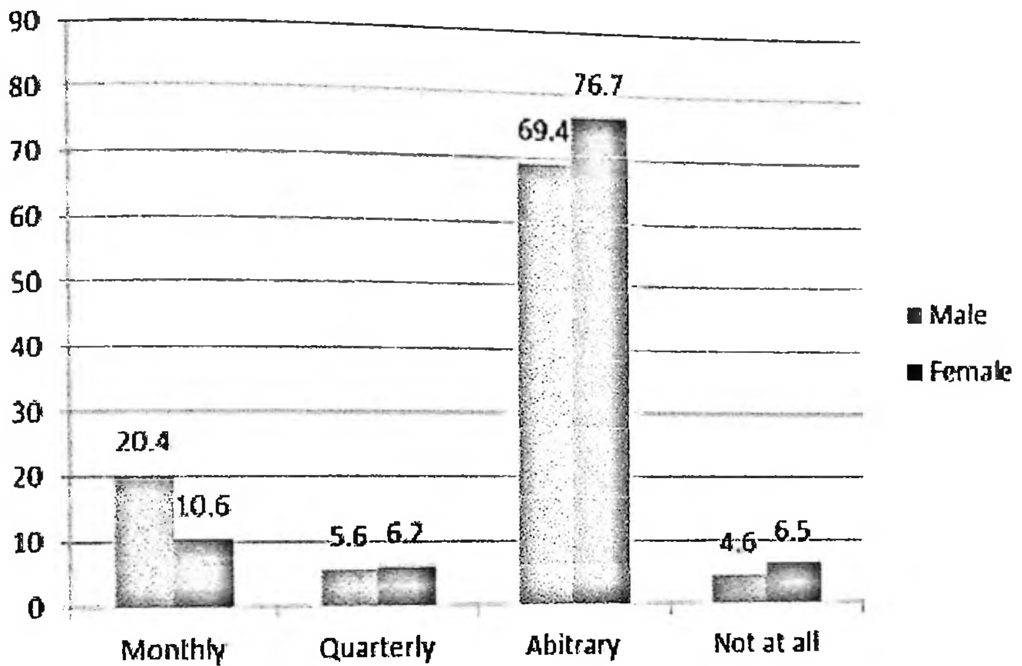

Figure 14: Respondents' views on frequency of decisions on maternal care utilisation

Source: Field survey (2009)

Over 76 percent (76.7%) of women and 69 percent (69.4%) of men agreed that it was taken arbitrary. Decisions on maternal healthcare are supposed to be taken monthly, but the empirical evidence revealed a different picture. Whilst 20.4 percent of male agreed that, decisions were taken monthly, as low as 10.6 percent of female admitted monthly decision making

on maternal healthcare. The ability of women to take frequent decisions on maternal health was constrained perhaps due to chronic poverty.

The husband's responsibility for making the decision on maternal health referral is a prominent issue that came out during the FGDs. Most of the women think that it is the onus of the husband, being the head of the household with the economic power and responsibility, to assist in arranging for blood transfusions. Some husbands who do not agree with the referral advice thus do not inform other relatives. It becomes the woman's responsibility to influence the decision-making as was described by a lady who was trying to persuade the husband to decide in accordance with her wish.

> "In most cases when the doctor tells you to go for referral, you have to inform your husband. The husband is now left with two options, either to accept or reject the advice.... The doctor will emphasize that he cannot handle such a problem at the health centre, and there is no equipment to help the woman, therefore, she must go to the hospital. Now the husband will understand that the problem is a big one" [Woman Respondent, Oda, Birim South].

Despite the husband being seen as the most important person in the decision making process, it appears that if the spouse neglects the need for maternal care or is unable to pay the costs of care, the parents of the pregnant woman may intervene. It was found out that if the pregnant woman's parents took their daughter for referral, the husband had no alternative but to accept and join them. The husband might also solicit help from the in-laws so that he

should not be blamed if death occurs. To support this assertion a woman made the following comment:

> 'Sometimes it becomes necessary for such external assistance to be in place to avoid being the one who contributed to the woman's death. This is because if she dies, her parents will say that you purposively contributed to the death because you can marry another woman' [Male Respondent Asuom, Kweabibirem Distric].

Problems experienced during pregnancy among married women

This section examines women respondents who had given birth to a living baby during the five years preceding the survey (2003-2008). The survey identified ten (10) problems during pregnancy: – i) night blindness, ii) blurred vision, iii) convulsions (not from fever), iv) swelling (of legs, body or face), v) excessive fatigue, vi) anaemia, vii) vaginal bleeding, viii) haemorrhage, ix) sepsis and x) eclampsia. These problems are based on women's self-reports and are not clinically recorded and therefore the results should be interpreted with caution.

Table 24 shows the number of women experiencing various health problems during pregnancy in the study area in the preceding five years before the survey. Excessive fatigue emerges as the most common problem reported by women. In most societies in Africa, women bear the burden of the household chores and it is not compensated for with balanced diet. Even during pregnancy the woman is not given any concession from the household work and there is hardly any improvement in her diet (Walker, 1997).

Thus, in most of the cases, she could be malnourished and overexerted, which worsens her condition during pregnancy. Anaemia is another major problem during pregnancy with 16.6 percent of the women reporting it. The recommended guide is that a woman should consume sufficient quantity of liver, green leafy vegetables, Vitamin B2 and folic acid to prevent anaemia. However, from the discussion we had with women discussants during the FGDs, their food basket often does not contain such items.

Table 24: Examination of common problems experienced during pregnancy among women

Districts	District (n=390)			Total
	Kwaebibirem	Birim South	Fanteakwa	
Condition	%	%	%	%
Excessive Fatigue	32.8	27.4	24.9	28.4
Anaemia	16.2	16.7	16.8	16.6
Convulsion	12.2	13.6	14.6	13.5
Haemorrhage	10.6	10.5	10.9	10.7
Blurred Vision	10.6	9.7	9.6	10.0
Night Blindness	6.6	8.3	8.6	7.8
Swelling	4.8	6.7	7.5	6.3
Eclampsia	3.6	3.6	4.4	3.9
Vaginal Bleeding	2.6	3.5	2.7	2.9
Total	100.0 (125)	100.0 (130)	100.0 (135)	100.0 (390)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

Women in many of the rural communities in the study area have so much internalized the patriarchal system that even in matters related to food they do not have their own preferences. Therefore, in the household not much attention is given to the food consumption pattern of women from their childhood. As a girl child, she is invariably discriminated against her male siblings in the sharing of food and often had to be satisfied with what she gets after the male members (fathers and brother (s) have had their share. After marriage her fate does not improve as she usually gives preference to her husband's choice. When she becomes a mother and is in-charge of the household, by tradition she prioritizes her husband and male children in matters of sharing and liking of food and hence the trend continues. As a result it leaves a woman malnourished and anaemic.The other problems that were significant among pregnant women in the study area are convulsion (13.5%), haemorrhage (10.7%), blurred vision (10.0%), swelling of legs, body or face (6.3%) and eclampsia (3.9%). However, vaginal bleeding does not seem to be a common problem among these women as it was reported by only 2.9 percent of women respondents.

Accessing maternal health services

Among the research objectives, was to identify the constraints that prevent women from accessing and utilizing maternal health services. Existence of maternal health services does not guarantee their use by women. Neither does the use of maternal health services guarantee optimal outcomes for women. An important aspect of care that has been highlighted and contributes to explain why women either do not access services at all, access

them late or suffer an avoidable adverse outcome, despite timely presentation, relates to the intangible concept of quality of care. Figures 15 and 16 indicate women's and men's explanation of factors affecting decisions by women on accessing maternal healthcare.

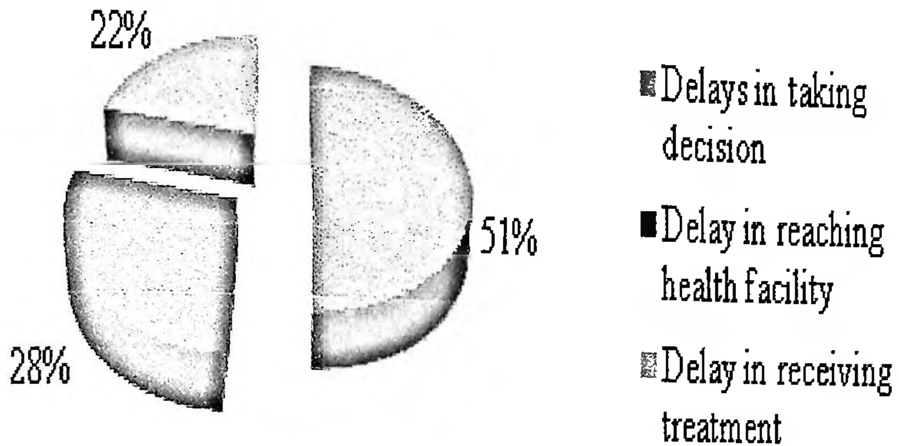

Figure 15: Factors affecting decision making by women on maternal health

Source: Field survey (2009)

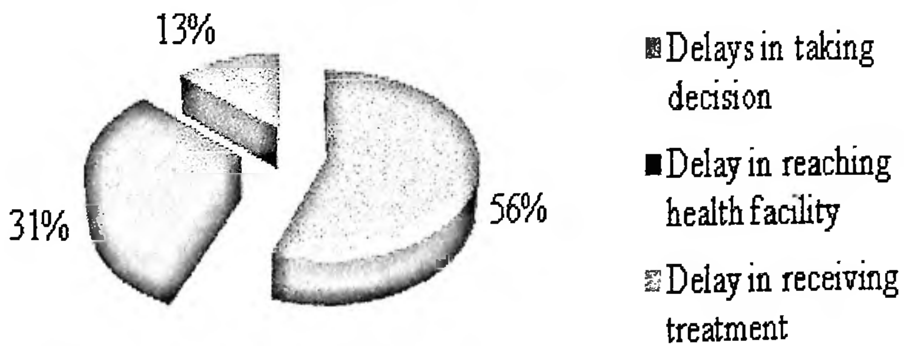

Figure 16: Men's view on factors affecting decision making by women to access maternal healthcare

Source: Field survey (2009)

From Figures 15 and 16, over 50 percent of both women (51%) and men (56%) agreed that, most of the maternal deaths were avoidable. They accepted the reality that, most of the deaths occurred as a result of delays by partners in deciding to take the women to the nearest hospital for care. Delay in reaching the health facilities as a result of poor roads and transportation difficulties was discovered as also a contributing factor which could make matters worse and the health providers are also constrained in providing immediate care.

Utilisation of maternal health services

In this research, utilization of maternal healthcare was of paramount importance. It also explored whether the correlates of use of maternal healthcare services vary across different social settings. Results from the study indicate that many women in the study area experience life threatening complications during pregnancy and childbirth and also after childbirth. However, maternal health services utilization was unacceptably low. The situation of pregnancy and childbirth related morbidity and mortality is worse in the study areas because of low utilization of maternal health services.

Based on the Anderson and Poole's (1994) health seeking behavior model, the study investigated individual's characteristics which influence health service utilization. In order to estimate the effects of individual's characteristics on maternal health services utilization, four dependent variables were considered: antenatal care, place of delivery, assistance during delivery and postnatal care.

The results presented in Table 25 revealed that education level is the most significant determinant for increasing utilization of antenatal care, place of delivery at health facilities, and assistance at delivery.

Table 25: Level of education of women and the utilisation of maternal services

	District (n=390)			
Level of education	Kwaabibirem	Birim South	Fanteakwa	Total
	%	%	%	%
Never	9.3	12.6	11.8	9.9
Primary	14.2	15.1	19.0	12.9
Middle/JHS/SHS	27.6	29.8	32.4	31.5
Tertiary	48.9	42.5	36.8	45.7
Total	100.0	100.0	100.0	100.0
	(125)	(130)	(135)	(390)

(Numbers in brackets are absolute figures)

Source: Field survey (2009)

To study the patterns and determinants of utilization of maternal health care services, it was necessary to consider the most recent births to women reported, which took place between2005-2008. In all, 1234 births were recorded in Kwaebibirem, 1251 in Birim South and 1237 in Fanteakwa. The analysis focused on the utilization of maternal health care services during pregnancy and these were antenatal check-ups, place of delivery and assistance during delivery.

The place of delivery and assistance during delivery are important determinants for reducing the risk of infant and maternal death.This is an important component in the reproductive health care services: given that it can reduce the risk of obstructed labour during delivery. Although assistance during delivery is highly associated with place of delivery, it has been treated as a separate variable because home deliveries can also be attended to by health personnel. It is expected that the determinants of assistance at delivery would be different from place of delivery. Information was collected on who assisted the mother during delivery whether health personnel ie (Doctor, Auxiliary Nurse, Midwife (ANM), nurse or midwife, trained TBA) or non-health personnel (untrained TBA, friends or relatives). It was discovered that, most women delivered with the assistance of a health professional.

Assistance during delivery

Women were more likely to have been assisted by health professionals at the time of delivery. Illiterate women were less likely to receive assistance from health professionals than literate women. This holds for all the districts as indicated in Table 26. Again, the results show that women who have ever given birth are less likely to have been assisted by health professionals in the Kwaebibirem and Birim South Districts.

The only result that is different is that, Muslim women in the Birim South district were significantly more likely to have been assisted by a TBA than their Christian counterparts.

Table 26: Determinants of delivery assistance by health personnel

Characteristics	District		
	Kwaebibirem	Birim South	Fanteakwa
Women ever given birth	*Odds ratios*		
No	1.00	1.00	1.00
Yes	0.69	0.84	1.19
Place of residence			
Rural	1.00	1.00	1.00
Urban	1.18	1.71***	1.88**
Level of education of women			
Illiterate	0.55 ***	0.54 ***	0.61 **
Primary	1.00	1.00	1.00
Middle	0.89	0.92	1.63
High school +	2.63 *	2.59*	2.68*
Religion			
Traditional	1.00	1.00	1.00
Muslim	1.34	1.41**	0.58
Christians	0.70	1.28	0.79
Work Status of Women			
Not working	1.28 *	1.07	1.28
Working but not earning	0.48 ***	1.12	0.75
Working and earning	1.00	1.00	1.00

Table 26 continued

Watch TV/listen radio			
Low	1.00	1.00	1.00
Medium	1.43 ***	1.04	1.31
High	1.75 ***	0.99	1.21
Log likelihood	-816.41	-990.70	-566.01
Chi square	389.47	527.08	297.13

Key

*** *-Significant at 1 per cent level*

***-Significant at 5 per cent level*

* *-Significant at 10 per cent level*

Source: Field survey (2009)

Fanteakwa was the leader in the use of all reproductive health services, followed by Birim South and then Kwaebibirem. The utilization of maternal healthcare services in Fanteakwa (receiving antenatal care, institutional delivery and delivery assisted by health professional) was higher than in the other districts after controlling for individual and household characteristics (see Table 26). Women in Fanteakwa were one and a half to three times more likely to use maternal health care services than their counterparts in Kwaebibirem. This could be due to differentials in the accessibility and availability of maternal health care services in these districts.

Moreover, around 89 percent of villages in Fanteakwa have at least one health facility followed by Birim South (54%). It emerged that the magnitude of work in respect of the foundation laid by previous public health officials

who focused on maternal health education in Fanteakwa district is not the same for all the maternal health care indicators among the two other districts. For instance, women in Fanteakwa and Birim South were 8 and 3 times respectively more likely to deliver babies at health care institutions than women in Kwaebibirem. The district level characteristics such as the availability and accessibility of health care facilities and programme factors could also enhance the utilization of maternal health care services even among the illiterate women.

Additionally, from the focus group discussion held in the research in the research area, there were considerable evidence that, the role of various socio-economic, cultural and programmatic factors in influencing the nature of utilization has varied effects depending on the state and the type of service. For example, while mothers with first order births were more likely to deliver their babies at health care institutions than mothers with second order births, there was no difference between first and second order births for receiving antenatal care. Similarly, women belonging to Moslem communities in all the districts were less likely than others to deliver their babies in a health institution. The main reason is the unpreparedness of Moslem women to expose the most sensitive parts of their body to healthcare providers.

The order of birth was an important determinant for the use of maternal health care services in the districts. It was found that for all indicators of maternal health care services, higher order births decreased the likelihood of using the services in all three districts. This is similar to findings elsewhere by Bhatia and Cleland, (1995) and Elo (1992). Lower parity women tend to give careful attention to seeking antenatal care and delivery assistance due to their

inexperience in pregnancy. Also, lower utilization of maternal health care services among higher parity women could be due to time and resource constraints faced by those with larger families (Bhatia & Cleland, 1995).

Women residing in urban areas are likely to use institutional delivery and assistance during delivery. The rural-urban differential in the use of maternal healthcare services is likely to be the differences in the availability of maternal healthcare facilities, including the distance to the healthcare centre. Similar findings have also been observed elsewhere (Bhatia & Cleland, 1995). It would be interesting to know why rural women are more likely to receive antenatal care even though availability and accessibility of health care services are usually low compared to urban areas.

In the rural area, the Nurse/Midwife, as a multipurpose health worker plays a pivotal role in providing information on services related to maternal and child health and family planning. In Fanteakwa District for instance, the female health workers are expected to visit every household at least once in two months. They enroll all the pregnant women in the area and provide antenatal care, supervise domiciliary services and also provide post-natal services for the mother and the child. The likelihood for rural women receiving antenatal check-up after controlling for education, economic status and communication variables could be due to the role of devoted health workers who visit and provide antenatal care at home.

In order to verify this claim, it was relevant to carry out a separate analysis of use of antenatal care by provider type (mothers visiting a provider vs provider visiting mothers). Results of the analysis showed that the likelihood of women receiving antenatal care by visiting a provider (outside

the home) was greater in urban areas due to the size of the population than in rural areas — a contrast to earlier analysis — in both Kwaebibirem (odds ratio=2.53, $p<.01$) and Birim South (odds ratio=2.46, $p<.01$). This implies that health workers are playing a crucial role in providing maternal health care services, particularly providing antenatal care, to pregnant women in the rural communoties of the study area. Studies which evaluated the quality of services provided by health workers with respect to frequency and regularity of outreach visits, time devoted by workers to outreach activities and duration of time spent with clients during outreach visits have shown significant shortcomings (Koenig, Gillian, & Joshi, 2000).

It was also found that women's literacy is an important predictor for the use of maternal health care services in all three districts. Illiterate women are less likely to use maternal health care services or seek delivery assistance and place of delivery compared to literate women in all the three districts. This result holds even after controlling for the residence of women. It is often claimed that the relationship between female education and health-seeking behaviour may not be due to education per se, but due to women childhood background for which education may serve as a proxy (Behrman & Wolfe, 1987). It is argued that analyses that do not control for childhood background may overstate the impact of education on health outcome. My analysis have controlled for childhood residence thereby removing the possible confounding of education effect by childhood residence.

The results also revealed that among the educated women, the decision making power within the household, awareness, knowledge and acceptance of modern medical treatment and health care institutions varies by their level of

education. Consequently, the number of years of schooling was positively associated with utilization of maternal health care services. However, it was discovered that utilization of maternal health care services does not differ significantly among the educated women by their level of education for most of the services. Moreover, the relationship is not uniform across districts. In contrast to the findings, women with primary schooling did not differ from women with no schooling in receiving delivery assistance in all the districts. Also, evidence from several countries shows that the impact of education on utilization of maternal and child health services depends on the type of service and the social setting (Dharmalingam, Hussain & Smith, 1999). Thus, a number of studies, including the current one clearly demonstrate that illiteracy among women leads to underutilization of maternal health care services.

Barriers to seeking maternal health care

Generally, in Ghana, following the introduction of the exemption policy and the subsequent introduction of free maternal healthcare services in 2007, women have received free maternal care during pregnancy. However, there are other indirect costs such as travel to and from the clinic, leaving work to seek care, and paying for prescribed medicines were reported as considerable barriers to accessing care and treatment. The respondents also cited the need to prioritize spending money on reproductive and sexual policy regimes. Food and school-related expenditures for children and other family members were identified as an economic barrier to service utilization. Women's perceptions of the cost of delivery services, including the cost of using a TBA and staying at the health facility, contributed to their decisions to

seek delivery care. Some young women commented on economic barriers as the following emerged from the FGDs at Akim Swedru, Begoro and Kade respectively:

> "Yes, it is the most difficult—the money—because I was alone. I did not have anyone to lend it to me" [26-year-old mother, Akim Swedru in the Birim South District];
>
> "It was difficult because . . . sometimes you save the [money] but with other older children in school you must borrow money for school fees, and after paying for the maternal services, you have to save to return this money" [32-year-old mother, Begoro].
>
> "They told me that I would have to pay but when I reminded them of free maternal care introduced by the President Kuffour administration, I was asked to pay for accommodation if I wanted to sleep at the hospital. Then I said, 'No, it is better if I go home' [28-year-old mother, Kade]

Women's intentions to utilize prenatal and delivery care were often impeded by their inability to cover the cost of transportation, especially in an emergency. Emergency transportation options cited by women included: paying a neighbour with a car; paying for fuel for the community ambulance; and calling on community members or the emergency transportation brigade (which often resulted in transport by hammock to the nearest health facility or to an available vehicle). The burden of accessing transportation was made difficult by the challenge of travelling long distances alone and/or in poor weather conditions. Some women in throwing light on the nature of the transportation difficulties commented that:

"If someone does not have money or means of transportation, she has to die in the home because here there is no one that will give it to you. We have to carry you or take you if there is a vehicle" [28-year-old mother, Kade].

"There is an ambulance here but there is no fuel, and if you do not have money for fuel you have to stay here and die . . . those who don't have 20 Ghana Cedis cannot be transported. Women must look for how to borrow money" [32-year-old mother, Oda].

"When it is rainy season the roads become bad . . . and so some women do not go. Also, the centres are often closed and sometimes women cannot find someone to accompany them on the roads Sometimes the taxis are dangerous especially at night" [25-year-old mother, Achiase].

Family support allowed women to overcome logistical barriers associated with seeking care. A woman's use of services was facilitated by her husband's financial contribution and recognition of the importance of maternal health care. Women frequently mentioned how husbands participated in securing monetary resources in preparation for the costs associated with transportation and care. Informed and engaged husbands indirectly supported women's utilization of services by bearing the burden of caring for their homes and children while women were seeking care. Financial preparation and support at the family level permitted women, especially those experiencing a first or second-order birth, to access delivery services,

including staying at the health facility to ensure the availability of emergency maternal services.

Value of maternal health care

A lot of factors directly or indirectly affect the accessibility to maternal services, and prominent among them is the value of health care. Women's knowledge and acceptance of the importance of maternal health care and healthy pregnancy practices are shaped by previous experiences as well as formal and informal communication within the households in particular and community in general. Out of the 360 women respondents, 279 of them representing 77.5 percent claimed that, the value they attached to maternal care depends on their experience with health care practitionersas has been shown in Figure 17.

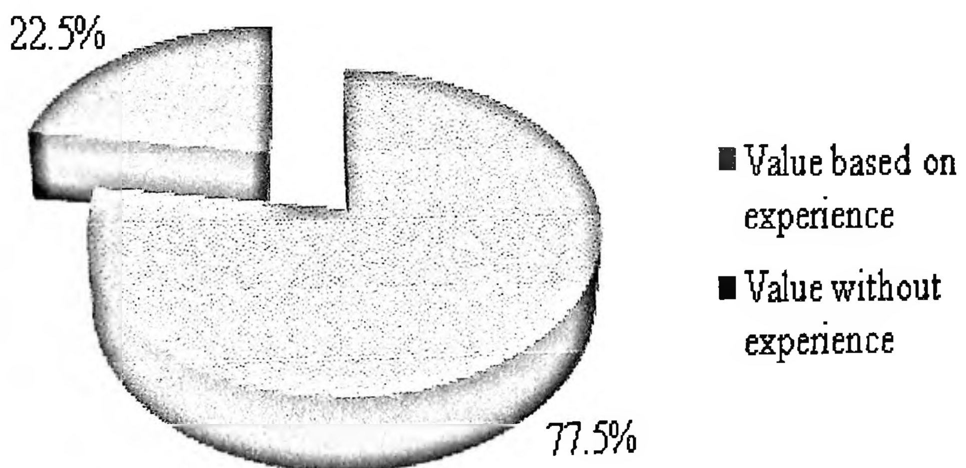

Figure 17: Respondents' perception about factors affecting accessibility of maternal health services

Source: Field survey (2009)

Many women who utilized maternal health services believed it was important as a means of reducing the risks of complications and ensuring the health of the unborn child. Women, often those who delivered healthy babies, praised the quality of care and attention they received during pregnancy and delivery. They invariably mention the importance of receiving vitamins, vaccinations, and examinations during pregnancy and the benefits of such care in regard to the healthy delivery of the new baby.

Women's past experiences with poor-quality care or unclear information in health facilities influenced future behaviours. Poor information and communication from health professionals also contributed to women's misperceptions and lack of understanding regarding healthy behaviours and potential complications, as were revealed in the interviews.

Negative past experiences in receiving care, including lack of attendance, excessive waiting times, lack of urgency regarding one's health, and embarrassing physical examinations discouraged women from seeking care at health facilities. A number of women who experienced complications and had to deliver via caesarean section believed returning to the health facility for a future delivery would result in the same outcome. Complications that resulted after having received care from some nurses appear to have deterred some women from seeking future care at facilities. A woman respondent recounting her experience during an FGD session had this to say:

> "Upon visiting the health centre you are given vitamins, after examination to determine the position and condition of the baby. For this reason, I visit the health centre for the sake of the child and myself, but the instructions are too complicated

> and what makes matters worse is the shouting and rude behaviour of some of the health workers. I am discouraged and unprepared to see these health professionals again, irrespective of the effects in future" [23-year-old mother, Oda]

Security of health facilities

Health facility based care increased women's sense of security and safety, which contributed to their perception of the value of institutional care and encouraged further utilization of services. Women's perception that facility based care provides a safe environment for receiving care evolved from the quality of care they received and their delivery outcomes with previous pregnancies. Many women who experienced complications with previous births or low parity had an increased fear and awareness of the risks involved in failing to seek care and thus sought care to avoid complications.

About 68 percent (67.8 %) of women respondents claimed that security of health facilities enhances their confidence as shown from Figure 18 before, during and after delivery. The statement below by a discussant further explains the importance women attach to their security:

> " If there is no guarantee that, maternal healthcare services are offered with the urgency deserved; and pregnant women are made to wait while standing at the premises of health facilities for a long period of time, then what security are provided for us" [A queen mother at Osino, Fanteakwa district].

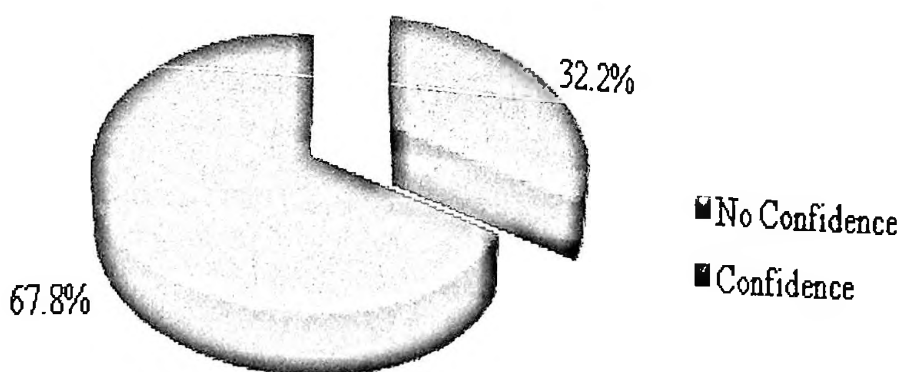

Figure 18: Level of confidence of women in health facilities

Source: Field survey (2009)

Communication

Many women stated that their knowledge of pregnancy and delivery practices came from health workers, prior experience, or other more experienced women in the community, especially their mothers and mothers-in-law. Open communication with one's husband about the importance of seeking care also facilitated a woman's utilization of services. It was evident that the women who used the maternal health services had received information from health workers or community members regarding the services offered and the purpose of the health facilities. Women who acknowledged their fears of complications and risks related to poor maternal and infant outcomes often communicated their feelings and received encouragement to seek care to avoid complications. Few women reported their desire to begin family planning to minimize the risk of complications due to notspacing birth and high parity.

Health communication encompasses the study and use of communication strategies to inform and influence individual and community

decisions that enhance health. It links the domains of communication and health and is increasingly recognized as a necessary element of efforts to improve personal and public health (Jackson and Duffy, 1998). The dissemination of health messages through public education campaigns that seek to change the social climate to encourage healthy behaviours, create awareness, change attitudes, and motivate individuals to adopt recommended behaviours were observed from the survey to have played significant roles.

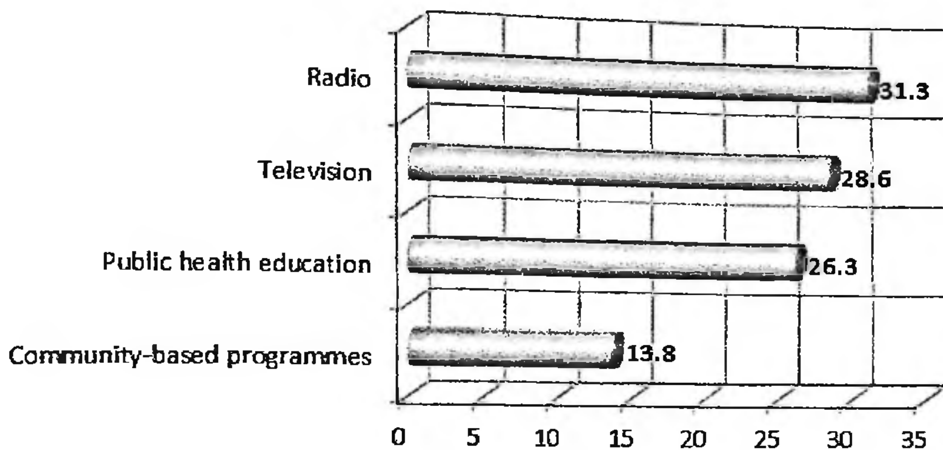

Figure 19: Respondents views about medium of communication on maternal health care issues

Source: Field survey (2009)

Results from the survey as shown in Figure 19 indicates that, over 30 percent (31.3%) campaigns traditionally have relied on radio announcements, television (28.6%), public health education (26.3%) and community-based programmes by Non-Governmental Organisation s (NGOs) (13.8%) to deliver health messages.

Women's decisions to seek care were affected by prevailing rumours of other women's adverse experiences, negative perceptions, and shared misconceptions that remained uncorrected by health workers or other formal

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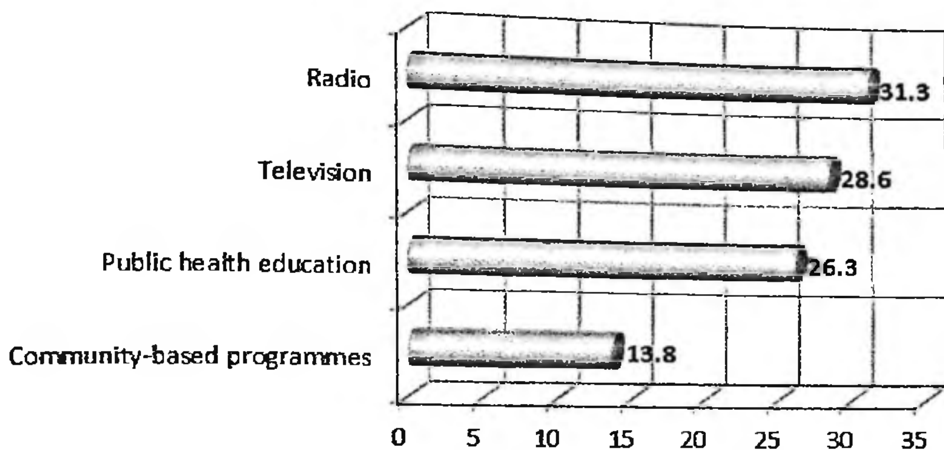

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Women's decisions to seek care were affected by prevailing rumours of other women's adverse experiences, negative perceptions, and shared misconceptions that remained uncorrected by health workers or other formal

sources of information. A woman's fear of receiving vaccinations, being touched or examined by health workers, and taking unsafe transportation to reach a health facility prevented some women from attending prenatal visits. Women reported that their fear of delivering in health facilities is related to the shared perceptions that delivering in a health facility causes illness or guarantees a caesarean section in the course of delivery.

Summary

This chapter has highlighted issues relating to our understanding of the perceptions, health seeking behaviour, attitudes and the level of knowledge of respondents on maternal health interventions. Although, it appears most of the respondents, especially women, were not satisfied with the behaviour and some practices of the service providers, majority of them were aware of the need to ensure and enjoy quality maternal health practices.

CHAPTER NINE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This concluding chapter of the study seeks to summarize the research process, briefly explore the relevance of the literature review of the study, discuss the results of the main findings; present the contribution to knowledge and practice, provide some recommendations and conclude by carving areas for further research.

Summary

Worldwide, it is estimated that 1600 women die every day as a result of problems they encounter during pregnancy and or child birth. This thesis therefore sought to examine factors that determine the utilization of safe-motherhood services in three districts in the Eastern Region of Ghana. Specifically, it attempted to contribute to the policy debate to enhance public decision making in prioritizing the different components of maternal health programmes in resource-scarce locales.

Using the survey research design, interview schedules and or questionnaires, the research solicited data from 600 respondents, comprising women in their reproductive age, married men and healthcare providers residing in the selected districts. The quantitative data was supplemented with information from nine focus group discussion sessions.

Relevance of literature review to the study

According to Anderson and Poole (1994), literature review serves as a hypothetical foundation for the research and helped in establishing the nature of the current research. Most building blocks upon which the research was established tend to show a clear tie between, the literature reviewed and shaped the focus of the current research and provided the necessary works of others that were cited.

The study reviewed literature on social determinants of health propounded by McKeown (1978), the social theory of perception from the point of view of Davies (1991), Bruce-Jain (1990) and Donabedian (2003) concept of quality of healthcare which were all very useful. The gaps in literature provided the point of departure for the thesis to suggest interventions aimed at behavioural change with emphasis on health professionals deciding on what women need to follow in order to improve maternal health.

The rest of the chapter will focus on five main issues. First, it will summarise and discuss the main findings of the thesis. Second, it will draw conclusions from the findings. Third, it will discuss some of the implications of the study for oscillating nature of maternal deaths in the study area. Fourth, it would indicate the thesis contributions to knowledge. Finally, a number of recommendations which are relevant for policy makers, health practitioners and residents are highlighted and ultimately suggests areas for further research.

Discussion of findings

The main findings of the study are discussed under the following: Socio-demographic characteristics of respondents and utilization of maternal health care intervention; Respondents' knowledge on quality of maternal health interventions and practices; Constraints preventing women from utilising maternal health services; Women's autonomy in maternal healthcare decision making; Oscillating nature of maternal deaths; and Utility of the conceptual framework.

Socio-demographic characteristics of respondents and utilisationn of maternal health interventions

From the results presented, it can be inferred that, marriage positively affects the health of both men and women. Several studies suggest gender differentials and their association with health (Lillard and Waite, 1995). Also it has been widely reported that even among females, a single woman enjoys better health status than a married woman (Addai, 2000; Celik and Hotchkiss, 2000; Carter et al., 1976). These findings however, differ from the results of the current survey. For example, out of 578 respondents covered, 367 were married, and 218 out of 390 (55.9%) women were unemployed but married and the study specifically found that women employed and married could afford the costs of maternal health care.According to these women, married women are supported by their husbands and most women claimed to have made some savings from the monthly remittance.

Furthermore, Hahn (1993) argued that unlike men, among women, much of the differential in marital status and health is explained by the

differences in economic well-being. This may be due to a range of factors associated with age, such as the change in marital status, propensity to engage in risky or otherwise negative health behaviours, social norms which prescribe marriage, social supports for or acceptance of the non-married status, and the quality of other relationships throughout the life course (Orbuch et al., 1996; Glenn 1989; Lawson, 1988). The study results support the fact that, women who were married, employed and receive some income have positive maternal health care seeking behaviour. For instance, it emerged that, 174 women were farmers and or traders, whilst 29 were salary workers. Thus, it was evident that, married women who were employed and their health seeking behaviour are inter-linked, and the degree of autonomy of these women in taking decisions on maternal health was high.

Again, it emerged that living with the parents of the husband does not bestow any reasonable benefits, but is associated with worse health condition in married women as a result of conflicts between women and their mothers-in-law which have been a perennial problem among families in the research area. Out of 360 women respondents, 147 of them (37.7%) were living in a house with relatives of both partners. This might explain why for married women, co-residence with the parents of the husband seemed to be detrimental to their health. It is very likely that individuals derive social support or receive demands from relatives living nearby, in addition to those in the same households. Therefore, measurement of the presence of non-spouse household members probably underestimates the degree of interactions with relatives.

According to Andaleeb (2001), higher educated people earn higher wages, and can better provide for their children, and healthier persons enjoy

higher quality of lives. Findings of the current research support this assertion. From Table 6, the educational attainment of the entire respondents was reported as; no formal education was between (18.2-24.7%) for all the districts, middle/JSS/JHS (16-24 %), secondary (10.6-12%) and tertiary was less than 5 percent for all the districts.

The finding shows the importance of the mother's education, age at birth and birth interval, all of which are strongly correlated with neonatal and infant mortality. There are obvious reasons why educated mothers would make better use of modern health facilities, both for preventive and curative purposes. In addition to the increased propensity of educated mothers to seek medical attention for themselves and their children, it is likely that they do so regularly. The results of the survey indicated that, out of 390 women interviewed, 73.6 percent had education from middle/ JHS/JSS to tertiary level. Among the educated women, 209 (72.8%) out of 287 responded that, they sought maternal health services regularly because of the fact that, they considered maternal care as paramount in the survival of pregnant women. This finding confirms studies by Palloni and Tienda (1986), which showed that high level of literacy, is associated with low maternal mortality rates.

Respondents' knowledge on quality of maternal health interventions and practices

One of the major factors that trigger maternal deaths is the near absence of affordable emergency obstetric services. In a country where 28.5 percent of the population lives below the poverty line, bringing emergency and mobile obstetric care to pregnant women is likely to reduce needless deaths. It

was against this backdrop that one of the study objectives was to assess the level of knowledge of respondents on quality of available maternal health services in the study area.

Results from the survey suggest that, the percentage of women respondents exposed to each communication channel in respect of knowledge of quality of maternal health intervention were as follows: Television (22.8%); Poster in a hospital/health center (26.2%); via a poster pasted on a wall at the Chief's palace or community centre (19.6%); On the radio (18.3%) and Health education programmes by public health officials (13.1%).

Monthly income was the only control variable found to be a statistically significant predictor of new knowledge acquisition. This might be due to the fact that, women who earned monthly income were mostly educated, and were likely to acquire new knowledge following the exposure to the various medium of communication. This finding suggests that when women were exposed to multi-media campaign messages about maternal mortality prevention and issues before, during and after pregnancy, women's knowledge increased and their action toward becoming interested in maternal health issues were enhanced.

The study found poor communication between spouses during pregnancy as crucial. While 63.3 percent of women respondents claimed that, there was 'no spousal communication', 82.2 percent of male respondents claimed there were spousal communications. The poor communication between some pregnant women and their spouses is likely to affect the attendance of maternal health care.

From the FGDs, it can be deduced with some degree of certainty that most men in rural communities do not want to discuss antenatal attendance with their spouses because the pregnant women nag a lot. Results from the survey indicated that 78.6 percent of male respondents complained that when their spouses became pregnant most of them nagged a lot. They wanted much attention and were always asking for money. This creates a communication gap that may lead to late attendance of antenatal care. Below are some comments made by both male and female respondents during FGDs:

> "My husband stopped talking to me the day I told him I was expecting our fifth born "Traditionally, he insists that, it is a taboo to talk about a child before it is born" [Old woman-Achiase].
>
> "It is difficult to discuss a sensible thing with a pregnant woman; they are too moody" [Male respondent from Kade].

It is clear from the above that there was little communication between couples during pregnancy in relation to antenatal care, especially on when to start and where to have the baby in respect of the place of delivery. Again, from the FGDs it was deduced that, most women respondents anticipated there were rumours and misconceptions on what is done at the health facility when a woman attended antenatal care or delivers her baby from there. Consequently, some women in the rural areas are scared of using these services during pregnancy, delivery and postnatal. This seemingly unfounded situation might have contributed to most preventable maternal deaths in the research area.

It emerged from the study that there are many traditional practices surrounding pregnancy and childbirth which prevent women from attending

antenatal care or delivering at health facilities in most rural communities, especially in both Kwaebibirem and Birim South districts. There are many myths attached to these practices that leave women no room to think positively about their health. In some instances, both men and women (couples) strongly believe in 'local herbs' which some women are encouraged to bathe with, drink or sit on after boiling. These herbs as recounted by them have been found useful, and as a result are used by women in addition to attending antenatal care in health facilities.

It is interesting to note that, the level of knowledge on dangers associated with pregnancy was very high among the respondents. When both females and males were recounting their experiences on such dangers, about 76.4 percent in both cases claimed they were fully aware of pregnancy complications which result in the death of a woman. Both men and women recognized that a woman can develop problems and die during labour or immediately after birth. They were also aware that every woman must be assisted during delivery. In this regard, these women attend antenatal care at least once so as to book the health facility in case problems arise.

Generally, there is mistrust between men and women in most of the rural communities. The marital relationships are sometimes constrained during pregnancy. Most of the traditional practices attached to pregnancy are geared towards preventing pregnant women from meeting other men and in the long run they also prevent women from early attendance of antenatal care. The result showed that almost 86 percent (85.7%) of women had good knowledge about signs of early pregnancy and on the onset of labour, yet about 65 percent

(64.8%) did not see the reason why women should go for antenatal care early before the baby was developed.

Constraints preventing women from accessing and utilising maternal health services

One of the specific objectives of the study was to identify the barriers preventing women from demanding, accessing and utilising maternal health services. This study examined the logistical and perceived barriers that confronted women when accessing maternal health services. It thus identified a range of logistical barriers to seeking care that had also been shown to be important in other countries and cultural contexts. Among the obstacles discovered were financial, especially in relation to transportation; time constraints, and availability of health care staff.

In terms of hierarchy of the barriers found were time constraints in respect of waiting time at the health facility (48.3 %), financial difficulties (28.6 %), transportation (19.9 %), and availability of health personnel (5.2 %). It came out that on average, waiting time was almost eight (8) hours and it discouraged most women from accessing health. About 65 percent of women respondents claimed that, the exemption policy introduced in 2007, which made it possible for pregnant women to avoid paying user fees had worsened their plight. The account by most women suggests that low grade drugs such as vitamins are normally given to them when they attend antenatal care due to the exemption from user fees.

Women who perceive antenatal and delivery care to be relevant overcome the barriers with the support of family members, most notably their

husbands and mothers or mothers-in-law. From the results of the study, it was discovered that various factors facilitate women's utilization of institutional-based maternal health services. Almost 33 percent (32.8%) of women agreed that the factors include savings, the support of their husbands (28.4%); timely preparation for delivery (16.2%); staying at the health facility (12%) and assistance from a family member or friend (10.6%). Furthermore, the results show that 62.8 percent and 56.9 percent of women respondents in Kwaebibirem and Birim South respectively reported that, the items required by midwives or nurses at the health facility which sometimes include milo, soap, any other powerful antiseptic (dettol) and others are discouraging and deter most women from delivering at the health facility. What is perhaps annoying according to some women is that, when you are being discharged after delivery, all these items are taken by the midwives.

Some women also cited their need to prioritize spending money on food and school-related expenditures for children and other family members as an economic barrier to service utilization. The results show that a range of socio-cultural factors may explain the situation between women's utilization of prenatal and delivery services. In respect of other considerable barriers to accessing care and treatment, 202 women out of 360 constituting 56.1 percent indicated that, cultural perception affects accessibility and utilisation, while 160 out of 360 (44.4%) agreed that geographical conditions greatly affect access to health services. For most women in the remote areas, especially during the raining season, hammocks become the only available system of transportation to the health facility in emergency situations.

The finding on cultural perspective on the use of maternal health services suggest that medical need is determined not only by the presence of physical disease but also by cultural perception of illness. This is supported by Addai (2000), who established that, in most African rural communities, maternal health services coexist with indigenous health care services; therefore, women must choose between the options. The use of modern health services in such a context is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of individual women.

Furthermore, the study revealed that, outmoded customs or traditions were practiced by some women before seeking health care hence the delay in health care seeking behaviour as well as possible complications for the patients. In both Kwaebibirem and Birim South districts, over 20 percent (21.2%) and nearly19 percent (18.9%) respectively, admitted that, sometimes they had to resort to the use of herbs and other cultural practices during pregnancy instead of attending antenatal care. The study also revealed that barriers, which are a product of the political, economic and environment, are easier to surmount than the inter-generational cultural influences in the study area. Many cultural, religious, or social factors may impede the demand for health care. In communities where women are not expected to mix freely, particularly with men, utilization of health services from static facilities may be impeded.

In the rural areas of Kwaebibirem District, for example, almost 80 percent (79.8%) of women who gave birth at home had the intention to deliver at a health facility but did not, due to distance and lack of transportation. Fees

reduce women's use of maternal health services and keep many women from having hospital-based deliveries or from seeking care even when complications arise. Even when formal fees are low or nonexistent, there may be informal fees or other costs that pose significant barriers to women's use of services. These may include costs of transportation, drugs, food, or lodging for the woman or for family members who help care for her in the hospital.

Women's utilization of services is affected by the varying degree to which they receive information about health care through formal and informal sources, including other women in the community, health workers, and partners. Furthermore, the level of encouragement and promotion of healthy maternal health care–seeking behaviours provided by those information resources influences a woman's ability to overcome the cultural barriers to seeking care. In most communities in Fanteakwa District, the foundation laid by public health nurses in the early 2000 had made it possible to ensure cohesive women's networks within families and communities, which link women and disseminate their knowledge and experiences. The public health education exercise which began almost ten years ago had yielded positive results, hence the low maternal deaths.This explains to some extent the maternal mortality differences in the three case studies or study areas.

The analysis revealed that women's disclosure of past experiences, traditional practices, and prevailing fears and misconceptions influence their attitudes toward prenatal and delivery care as well as their utilization of services. Some women often rely on the knowledge and advice of older, more experienced authority, personalities within their network to direct their health care seeking behaviours. Women's perceptions of prenatal and delivery care is

enhanced through positive personal experiences; an established sense of security in health facilities; shared positive experiences; and direct, comprehensive communication with health workers.

Regarding barriers caused by health providers, availability and quality of health services are important factors that influence use of healthcare services; this is supported by Govindasamy and Ramesh (1997). Available health care services ensure that people can access whatever and whenever they need. Results discovered from health providers indicated almost 64 percent (63.7%) agreed that quality of care depends mainly on the capacity and attitudes of health professionals, while over 36 percent (36.3%) claimed quality depends on the availability of drugs and equipment.

Results from the present study support the "three delays" model. Indeed, over half (53.8%) of women respondents claimed they delay in decisions to seek health care, 19.1 percent of them agreed that they were affected by the delay in reaching health facilities (distance and transportation) while 37.1 percent of them accepted the delay between arriving and receiving quality care at the health facility. Delay in decision to seek health care can be due to lack of information about the danger signs of pregnancy or cultural customs among minority of people or poor economic status. Delay in reaching health facilities can be due to several reasons, including distance, no transportation, and local traditions of self-care at home, lack of awareness of danger signs. Delay between arriving and receiving quality care at the health facility can be due to delay in treatment, wrong treatment, lack of equipment, lack of qualified health staff and lack of medicine. It means that the maternal

mortality rate is also strongly related to the organisation and management of the health system, and the quality of reproductive health services.

There was a lot of information collected about traditional beliefs and practices that surround pregnancy, child-birth and the immediate post natal period. The study only concentrated on those that influence the health seeking behavior of women and those that affect the woman's early attendance of antenatal care and her delivery at a health facility. The poor knowledge of what is done at the health facility, coupled with poor communication among spouses; lack of trust between spouses and the low status of women in the community greatly affect woman's utilization of health facilities. The low status of women in society and their marginalization puts them in a difficult and sometimes unpleasant situation and position in the household. These women cannot sometimes make decision on their maternal health without the prior approval of their husbands. In most rural communites, even when a woman has the money and can afford the cost of maternal healthcare, she cannot attend antenatal care without permission sometimes from the husband. It is therefore, a common practice that women do not go to the health facility if they have a problem that requires medical attention. There is poor knowledge about ANC in the communities and the benefits are not easily appreciated.

Forty-two percent of women who had at least one birth in the five years preceding the survey received antenatal care from a doctor, nurse, or midwife for their most recent birth. The use of professionally assisted delivery service is very low in the study area. Only 36 and 43 percent of women who delivered in the five years preceding the survey were assisted by a health professional for their most recent pregnancy in both Kwaebibirem and Birim

South. The situation in the Fanteakwa District was 74.8 percent and this may be a potential factor explaining the maternal deaths differences in the study area. Even more striking is the fact that less than 23 percent of women who delivered outside a health facility received postnatal care in both Kwaebibirem and Birim South districts. There is little difference in utilization of antenatal care by marital status; unmarried women are more than twice as likely as married women to receive delivery assistance from a health professional.

There was significant variation in the utilization of maternal health care by religion. Orthodox/Catholic and Protestant women exhibited greater use of maternal health care services than women who followed traditional beliefs. For example, between 55 and 58 percent of the former group received antenatal care from a health care professional, compared with 23 percent of women from the latter group. Due to small numbers, this pattern is not as visible for use of postnatal care. Mothers with one live birth are more likely to use maternal health services for first births than for second and higher order births. Utilisation of maternal health services is generally lower among mothers of birth order five and higher. Similarly, women who had only one birth in the past five years were also more likely to utilize maternal health care than women who had more than one birth in the same period.

One striking finding was that the use of antenatal care services has declined over the five years preceding the survey in the rural areas in Kwaebibirem. Even after controlling for a number of variables in the model, it appears that the use of antenatal care decreased on average by 23 percent per year between 2001 and 2008, assuming a linear trend. On the other hand, the study identified few, but interesting variables as independent predictors of use

of antenatal care in the area. Independent predictors for the rural sample included marital status, maternal education, and religion.

The effect of both marital status and education followed a similar direction as documented for the urban sample, although marital status has a weaker effect in the rural areas. Married women residing in rural areas are more likely to use antenatal care than their unmarried counterparts. Maternal education also has a positive effect on the utilization of antenatal care in rural settings, especially in both Kwaebibirem and Birim South districts. Unlike the results for the urban sample, religion stood out to be an independent predictor for the utilisation of antenatal care services in rural settings. Compared with Orthodox/Catholic females, women who followed a traditional belief system are less likely to use the service than any other religious group. Such women are 40 percent less likely to use the service than Orthodox/Catholic women.

Perception of quality of maternal health services

Although quality is one of the most important determinants of service-use, it is not surprising that there is no consensus on how to define or measure quality. What emerges from the literature is its multi-dimensional nature (Donabedian, 1980). To define quality, experts used structure-process-outcome dimensions from the perspectives of patients, service providers, and managers (Øvretveit, 1998). Understanding perceptions of populations about quality of care is critical to develop strategies to increase the use of health services.

In respect of quality care perceived by beneficiaries at different health facilities as was indicated in Figure 11, users of health services were mostly

positive about the behaviour and attitude of the service providers. Half (50%) of female users of health facilities and nearly 52 percent of male respondents respectively rated behaviour of care providers as good. Perception of users about attitude of the service providers was better when services were sought from private-sector facilities than from the government sector facilities.

With regard to privacy, 54.6 percent of the women respondents stated that they were examined privately. According to perception of patients, privacy was well-maintained in the organised private-sector and tertiary facilities (district level and above) than informal care providers, NGOs, and peripheral public facilities. The average reported time for history-taking and physical examinations was 10 minutes that varied significantly by type of health facility ($p<0.001$). More time was spent when the patient visited government sector facilities (25-30 minutes) or organised private facilities (15 minutes) than NGO facilities (17 minutes) and informal private-sector care providers (10 minutes).

With respect to the last reported morbidity, service-users reported prescription of four medicines on average. However, this reported number of medicines prescribed varied significantly by type of morbidity and type of facility visited as the highest health resource. The availability of prescribed drugs, as reported by service recipients, was poor in the government facilities. Only 23 percent of prescribed medicines were available from the government facilities while about 77 percent of prescribed medicines were available in the private and Christian health facilities, especially following the introduction of free medical care for pregnant women. Within the government facilities, there was a wide variation in the availability of prescribed medicines. The median

distance between home and facility availed of for the last serious morbidity was 8 km.

When asked about perception of the overall quality of services provided, a few of the users mentioned that it was excellent and a little over half of the respondents considered quality as good. Those who visited the Christian health services or private facilities rated quality higher than those visiting another type of facility whereas those visiting the peripheral public facilities gave the lowest ratings. The significant predictors for the reported perceived quality of care, by order of strength of association were: (a) behaviour of service providers ($p<0.001$), (b) attitude of service providers ($p=0.01$), and (c) availability of medicines ($p=0.05$). The quality elements that could not predict the overall perceived quality were consultation time, level of privacy maintained, and total expenditure incurred.

Some studies support the findings of the survey which has indicated that, measurement of patient perceptions also presents concrete advantages for evaluation due to the fact that patients constitute an essential and even exclusive source of information about accessibility or effectiveness of care (Donabedian, 1992). According to Ware and Hayes (1988), a patient's opinion directly influences his or her compliance with treatment and the continuity of the patient–physician relationship, and hence cares outcome. Furthermore, Pascoe (1983) and Rubin, (1990) pointed out that, the measurement of patient perceptions constitutes a positive approach to the evaluation of quality, in contrast to negative approaches that focus on the measurement of inadequate processes or undesired outcomes.

When a summary of quality indicator was computed combining all quality variables and compared by facilities available, the results showed that the perceived quality varied significantly from facility to facility and in a consistent way. Users of the organised private-sector facilities were 3.37 times more likely to be satisfied than users of informal care providers after controlling for the confounding effect of socio-demographic covariates and the severity/nature of the illness. Similarly, users of the tertiary facilities were three times more likely to be satisfied with quality of care than users of informal providers.

The results show that the perceived quality of services from informal care providers is comparable with services from the peripheral government facilities. Among the public facilities, the perceived quality was better for the referral facilities, such as regional hospital and district hospitals, than the peripheral health centres or posts. The overall perception about the quality of care provided did not vary by age, sex, religion, and socioeconomic status of the respondents but varied by nature of morbidity; those who suffered from acute minor maternal health complications were more likely to be satisfied with the quality of care than patients with acute grave or chronic type of morbidities.

The majority of women (63.5%) were satisfied with the quality of services provided. This finding might reflect a low level of expectation owing to their life-long experience of spending a short time with healthcare providers. Other explanations for this high level of satisfaction with the quality of care could be that, this was the highest level of care they sought for their last serious morbidity and was the preferred facility for seeking care. The

present study depicts that those perceptions of users about the quality of care vary significantly from facility to facility and by nature of disease but not by age, sex, religion, or socioeconomic status of patients.

Qualitatively, the perceived quality of care at the government health facilities was comparable with the services of informal care providers. The service recipients from the organised private sector rated services to be the best and next to that were the government health facilities. Since the private care providers are not subsidized and depend on income from patients, they would be more motivated than the public hospitals to provide quality services to patients to meet their needs more effectively and efficiently. Others have reported similar findings especially Andaleeb (2001). They have attributed the incentive structures under which they operate, as a key factor for this difference in the quality of care between public and private facilities.

Regarding the 'perceived quality of care', the problem is that it may not to a greater essence reflect the actual quality of care (technical) given that some of the women respondents in the study area are lay people. Obviously, it is difficult for them to judge all technical aspects of quality of care. It thus corroborates the findings of other studies that inter-personal communication, i.e. behaviour and attitude of service providers and the availability of medicines are significant predictors for better-perceived quality of care at the individual level but not consultation time or issue of maintaining privacy (Mendoza, et al., 2001).

From the perspective of nearly 90 percent (89.9 %) of respondents who are users, quality services are available at the tertiary facilities and private-sector facilities that are located in urban areas and far from rural communities.

Simultaneously, the reported costs of services from the organised private sector were higher than services from care providers at the public facilities. In respect of the costs of treatment, 83.5 percent of women respondents agreed that it was more in the higher-level public facilities (district and above) than in the organised private-sector facilities, although government services are officially free for maternal mothers. The possible explanation could be that the majority of maternal mothers visited the district hospitals or tertiary government facilities and pressure is always on the existing facilities and care providers.

Other explanations could relate to 'hidden costs' in public hospitals which include 'informal payments' to service providers and cost for buying medicines from outside markets. Higher cost of good-quality services and a longer distance between home and better-quality facilities certainly have a prohibiting effect upon their use, particularly by the poorest in the community. As a result, poorer households purchase poor-quality, ineffective and even dangerous services most frequently from small-scale, unregulated informal care providers. The results also suggest that 'perceptions of quality' and better 'ability to pay' drive wealthier patients to private facilities. The implication is that access cannot be equated simply with supply but is dependent on other demand-side factors (economic and social access) and, most importantly, upon the perceived quality of services. This finding confirms that the rapidly-growing private-sector facilities are playing a meaningful role in the provision of curative services in the Eastern Region of Ghana, justifying their existence, continuation, and growth even though, they are confronted with a lot of challenges which sometimes compel some to reduce quality by reducing

inputs, disregard social pricing considerations or, worse, try to increase their profits by providing services that are unnecessary.

The study found that, informal care providers are still dominant providers of curative care in rural areas where the survey was conducted. Members from the poorest quintile households are more likely to visit an informal care provider than those from the richest quintile. It is undeniable, as has been shown in the present study and others, that these informal care providers have been and will be the first point of call and choice for the great majority of the rural population, mostly the poor and other vulnerable groups.

Women's autonomy in maternal healthcare decision making

Autonomy is defined from the literature as the control women have over their own lives, the extent to which they have an equal voice with their husbands in matters affecting themselves and their families, control over material and other resources, access to knowledge and information, the authority to make independent decisions, freedom from constrains on physical mobility and the ability to forge equitable power relationships within families (Jejeebhoy, 2001).

One of the specific objectives of the present study was to establish the relevance of the autonomy of women in enhancing maternal healthcare in decision making. Results from the study suggest that, while 50.4 percent of male respondents claimed men were autonomous in maternal health decisions, 26.6 percent of female respondents also claimed they were autonomous. In respect of joint decision making, 16.8 percent of both males and females it was done together. Women's autonomy on issues affecting their maternal

health was surprisingly low. The situation becomes worse, especially when the woman is not working and had no regular source of income. Rural and poor women were less likely to be involved in decision making than urban or rich women. Nearly 85 percent (84.6 %) of women respondents claimed that the burden of seeking maternal care rests only on them when their husbands are not working. It was also established that 78 percent of women in some rural communities experiencing such situations rely on their parents or relatives when their conditions become critical.

The indicators of the two dimensions of women autonomy along with questions that were posed to women in the survey were: women's involvement in decision making and economic security. The relationship of women's social and demographic variables with women autonomy, antenatal care and institutional delivery and child immunization were examined using binary logistic regression model. This was used to identify the association between different social and demographic variables with maternal health care services.

In the present study, women's autonomy, as measured by the extent of women's sole final say in decision making and daily household purchases and of visiting families or relatives and their association with maternal health care utilisation were examined. The primary aim was to determine whether there is a link between the autonomy of women and utilization of maternal services. The outcome was that nearly 89 percent (88.7%) of women who were educated and earned regular incomes, were autonomous in taking decisions regarding maternal healthcare.

The study examined whether women's autonomy increases maternal care seeking behaviour. The results of this analysis show that most of the specified socio-economic factors and impact of women autonomy on antenatal care and institutional delivery have significant influence, which shows the impact of women autonomy on maternal and child healthcare in which the education, residence and religion of a woman were the most important predictors for autonomy. It may be argued that women with higher autonomy are more likely to use maternal and child health care services compared to women with lower autonomy.

Each of the four measures of womens' household position varied significantly according to social and demographic characteristics. The percentage of women involved in decision making on their own healthcare rose with increasing age, ranging from 16 percent for 15–19-year-olds to average of 34 percent for women aged 35 or older. The percentage of women who worked and had influence over how their earnings were spent also increased with age up to 30–34 years (rising from 11 to 17 %), but declined for the oldest age-group. The study revealed that women reporting having given birth to only one child were significantly less likely to be involved in decision making or to have influence over the use of their earnings than were women reporting two or more children.

Higher proportion of urban women (21%) than of rural women (10%) reported working and having influence over use of their earnings and having discussed family planning with their husbands, though there were no differences between the groups in the measures of decision making. Womens' education showed a positive association with all measures, though the patterns

varied. Compared with women who had no education or only primary schooling, those with a secondary or higher education were more likely to report involvement in decisions on their health care. In contrast, the proportion working and having influence over their earnings and the proportion reporting discussing of family planning rose with each level of education.

The proportion of women who worked and had influence over their earnings was slightly higher among those whose husbands were better educated, though the proportion of women who did not work at all was also higher in these sub-groups. The discussion of family planning was more common among women whose husbands had a secondary or higher education than among those whose spouses had no education or reached primary level. Husbands' occupation showed significant differences with all the indicators of women's household position. Nearly 24 percent (23.8%) of women whose husbands were unskilled were the least likely to report involvement in either type of decision making.

Furthermore, none of the decision-making indicators was associated with receipt of skilled delivery care after controlling for all confounders. Women respndents who were employed and had some control over their earnings were more likely to receive skilled delivery care than did women who worked but had no control over their earnings. Discussion of family planning was found to be consistently associated with delivery care. Thus women who had discussed it with their husbands have the greater chance of receiving such care than those who had not, once the effects of all potential confounders were accounted for.

These findings suggest that a woman's reception of skilled maternal healthcare may be related to her position within her household. However, the associations are not consistent across the indicators of household position, and therefore require careful interpretation. Several other variables, notably women's education, household socioeconomic status, the economic accessibility of healthcare and urban-rural residence, showed far stronger associations with reception of skilled care.

The varied result in decision making suggests that there are other factors which may explain the crude association between wealth and womens' autonomy in decision making. Women's economic status in the household emerged as an important factor associated with their autonomy in decision making. It seems that an important aspect of this difference lies in the perceptions of household members, particularly in older women, regarding the need of autonomy for women.

Oscillating nature of maternal deaths

A variety of reasons were given by the women respondents which explained the oscillating nature of maternal deaths in the study area. Prominent among them was the attitude of mothers, husbands and family members towards maternal health which is only important to them when conditions are critical. In their thinking, the health facility was considered the last resort. A midwife in FGD session recounted her experience as presented in Box 3.

'A very distraught woman came to the maternity ward of Oda Government hospital, appealing to us to assist her transport a woman who had given birth five days earlier who still had the placenta inside her. She was sure about the number of days, and quoted the day the woman had delivered which, indeed was five days earlier. She also told us that the woman may not be alive by the time we get there. We set out towards the home at the opposite end of the town from our hospital. On arrival few neighbours and others who had come to express their concern were found with TBAs offering assistance'.

Box 3: Focus group discusion session at Oda Government Hospital

Source: Field survey (2009)

This is just one example of what practicing midwifery in our part of the world entails. It can be argued that women in Africa die because of ignorance. Poverty is a strong factor that prevents women from seeking help because they apparently think that they cannot afford the cost of modern medicine and would rather consult traditional healers which leads to more complications. Women continue to die of causes that have been eliminated in countries where efficient, safe and adequate health care have been made available for their women. As far as African women are concerned, we seem to have very few rights, particularly in the area of safe reproductive health care. While little girls are the mothers of tomorrow, the issue of son preference being practiced in most communities had to a large extent diverted the attention of some parents towards their sons thereby neglecting their

daughters. The study discovered that, almost 89 percent (88.7%) of husbands claimed that, it is always good news to be told their wives had delivered and was a boy in the Fanteakwa District.. Currie and Moretti (2003) and Grönroos (1984) discovered that, man's happiest are demonstrated when the delivery of their wives is communicated to them and the child is a boy.

High fertility rate was identified as a factor contributing to the oscillating nature of maternal deaths in the study area. Once the girl is married, immediate and frequent fertility is expected of her without taking into consideration whether or not her body can take care of the baby she will conceive. Our women, therefore, produce as many children as they can to ensure their place in their new home. The finding from the field indicated that, about 66.8 percent of women respondents claimed they had between 6 and 9 children.

Furthermore, time of delivery was identified to have contributed to the oscillating maternal deaths.Pregnant women who are about to deliver and need skilled medical or midwifery assistance are often at the mercy of relatives or other individuals who have received no or insufficient training in the care of women during childbirth. The woman does not know nor seek proper medical care because she does not know that this is her right. Many women die of obstetric mismanagement with her relatives blaming her misfortune on "evil spirits" or "the evil eye of other women who were jealous of her baby." In effect, lack of autonomy by most women in taking decisions relevant to their health accounts for most of the avoidable deaths. This finding is supported by Govindasany et al. (1997), who pointed out that thousands of women bleed to death after giving birth. Most die in their homes. Some die on the way to

hospital; in taxis, on motorbikes or on foot. However, these deaths are preventable. This is not just a global health emergency; it is a human rights scandal. Majority of women who die are poor and come from developing countries. They are dying needlessly because of gender discrimination, social injustice and because politicians are dragging their feet in trying to tackle these problems. When maternal deaths are scaling up, interventions are strengthened towards reducing such avoidable deaths. After a period, the implementations of these interventions are relaxed and maternal deaths are worsened compelling stake holders to redouble efforts once again.

Utility of the conceptual framework

The conceptual framework that informed this study is a model of health-seeking behaviour. This behavioral model proposed that the use of health care services is a function of three sets of individual characteristics: (i) 'predisposing characteristics', e.g. age, household size, education, number of previous pregnancies, health-related attitude; (ii) 'enabling characteristics', i.e. income, characteristics of health care system and access, availability of health facilities; and (iii) 'need characteristics', i.e. characteristics of illness, perceived health status, and expected benefit from treatments. It emerged from the research that, operationalising the conceptual framework would enhance the identification of the predisposing factors which reflect the fact that families with different characteristics have different propensity to use healthcare services; while the enabling factors reflect the fact that some families, even if predisposed to use health services, must have some means to obtain them: i.e. income, access, and availability of health services.

To facilitate the strategic programming for maternal health, the conceptual framework which proposed levels of determinants of maternal health outcomes (socioeconomic determinants, proximate and biological determinants, and outcomes expressed in terms of growth and death), could be useful in reducing maternal deaths. The application of the model took into account household characteristics (behaviorual), intermediate variables (behavioural and biological), risk factors (biological), malnutrition-infection syndrome, and demographic outcome may be useful for incorporating government policies and actions, within or outside the health sector, that focused on health outcomes.These developments are relevant to maternal health and can be applied to generating a more comprehensive understanding of determinants and correlates of maternal health in the Ghana healt service.

Pregnancy outcomes and maternal deaths as indicated by the framework as household and community characteristics have strong correlations with household behaviour and decision making. The framework may be useful in the sense that enlightened communities value their mothers and seek prompt attention at the earliest indication of problems. Low status of women in the household and society as a whole, as exemplified by inequality in education, employment, property ownership, participation, and decision making, is another important correlate.

Implications of the key findings for policy and practice

In respect of the findings presented and discussed, it is imperative that, the research outcome should highlight the implications for policy and practice on factors determining the utilistion of maternal health services with the view

to identifying how to propose short, medium to long-term measures that can help in overcoming the seemingly insurmountable problems on the rising and falling nature of maternal deaths in the study areas in particular and Eastern Region in general.

According to a document on UN Millennium Development Goals (2004), eliminating disparities in maternal outcomes is an international priority. High-quality prenatal care can improve health care knowledge and satisfaction and increase social support, while giving women a sense of control over their lives. The findings reported in the present study have several implications in the organisation and delivery of health care to poor and underserved women during pregnancy.

First, structural barriers limited continuity of womens' relationships with medical providers (physicians, nurse, midwifes, etc.) and inhibited their trust. Women shared frustration with their limited ability to interact with prenatal care providers. Factors such as long appointment waits and inadequate staffing support the sentiments that poor women receive unequal treatment. Improvement in the structure of the context of the delivery of health care to poor women has been a persistent issue that requires more attention in the national discourse, if reducing disparities is to be achieved.

Following the first implication of this study is the need to better understand womens' willingness to follow provider recommendations. While the study did not focus on specific situations, most of the women (78.6%) responded that they did not spend enough time with a provider or have enough trust in a specific prenatal care provided to ensure compliance with his/her advice. Most women indicated that they would trust the opinion or and advice

given by TBAs, to the same extent that they would trust their antenatal care provider. Perceived mistakes, poor communication and limited time with their provider were expressed as reasons why women may not be willing to follow their physicians' advice. The use of TBAs to reinforce medical providers' advice may improve compliance. Given the unanimous expression of trust in TBAs, especially in the rural areas and the amount of time women spent with them, there is the need for more policy support to deepen the interaction between TBAs, health providers and recipients (mothers). The exchange of information between TBAs and physicians would provide valuable information to the physician, facilitate patient compliance with difficult regiments and improve aspects of patient care.

Furthermore, the policy implication for the proposed framework (Figure 9) is relevant when costing maternal health services. For example, when designing programmmes, it is essential to take into account, not only the effectiveness of interventions, but also their cost given that, we live in a world of limited resources. This is, particularly true of health sector budgets in developing countries, and within these health budgets, maternal health tends to receive limited priority. It is essential to advocate for greater resource allocation. This goal, however, will be assisted by efforts to prove that maternal health programmes are cost-effective and the substantial gains in maternal health can be achieved at limited cost.

Cost analysis of maternal health services would allow planners to forecast the impact of the expected changes: i.e. changes in goals, based on changing needs; changes in the services chosen to meet those goals and how best to deliver maternal healthcare services, based on improved knowledge of

effectiveness. Moving towards cost effectiveness analysis will require far better knowledge of the impact of services on health outcomes. This analysis would, assist with the generation of needed resources and provide guidance on how best to use the limited resources available to ensure maximum effect on maternal reduction. The proposed framework would make it possible to review the interventions especially, when the outcomes of all the Maternal health interventions are negative.

The revelation that some socio-demographic as well as economic variables have relevant influence on the attitude of women towards quality of maternal health interventions has implication for future research on community involvement towards the march on overcoming the seemingly insurmountable oscillating maternal deaths in the study area. Studies by Eyerusalrm (2010), Mekonnen (2003) and Gubhaji (2001) found significant relationship between socio-demographic characteristics and attitude of women towards maternal health care. Economic stability of households is also one of the well-recognized factors that can affect the utilization behaviour of a woman. According to Eyerusalem (2010), the poorest women in the poorest regions of the world have the lowest service coverage. Household economic status in particular was found to be an important factor associated with utilization of maternal health care services. This can be explained by the ability to pay for services by economically well off groups but the fact that there was a significant relationship after controlling for other factors like place of residence suggests that the richest groups differ from their poor counterparts by more than just disposable income (Gubhaji, 2001).

Womens' economic opportunity in providing for the family measured by their involvement in gainful or paid employment, type of occupation and status of work also affects their health and health seeking behaviour. This might empower women and they will have increased control over income and on decision making concerning their health. As a result they will have increased health seeking behaviour leading to improved maternal health. On the other hand employment may also pose physical exhaustion and in some cases working women may not have the time to attend to health services and this may have a negative effect on use of the services (Gubhaji, 2001).

Conclusions

- The concluding section was based on the main results of the study and the implications drawn from them. It became critical to define and measure the perceptions of women about healthcare quality and to understand precisely fully what drives those perceptions from the point of view of the patient. It seems there is confusion between patient perceptions and patient satisfaction and the difficulty of determining wether systematic variations in patient perceptions should be attributed to differences in expectations or actual experiences.
- In the health care field, technical quality focuses on the technical accuracy of the medical diagnosis and procedures, while functional quality is the manner in which the health care was provided. It emerged from the study that, when expectations are greater than perceptions a service quality gap exists. Patient satisfaction should therefore be

interpreted carefully, due to the lack of theoretical foundations on which the concept of satisfaction and measurement are based.

- There was sufficient evidence found in this study to conclude that significant relationships exist between husbands and relatives in the role they play in deciding and ensuring that women receive quality care. Women were only involved in decision making in acceptance of maternal health advice to a limited extent. This was especially true in emergencies where the husband, together with his mother and other relatives, had the responsibility of deciding and later informing the pregnant woman on the final decision. Women deliberately abstain from participating in the decision making process and this passive role of the pregnant women may be hidden in the cultural context and economic status of women in the society. Involving husbands in antenatal health education increases post-partum care utilization and likelihood to be highly prepared for birth among women compared with women who received antenatal health education alone and with women who received no education.
- It was discovered that lack of transport and financial constraints play a crucial role in the failure of referral for obstetric emergencies in most communities in the study area. Rural areas have few roads which are difficult to use, especially during the rainy season. This observation was confirmed in a study by Ram and Singh (2006). The FGDs in the present study identified the same factors as obstacles in adhering to referral advices. TBAs in the study area mentioned transport difficulties and cost as the main factors for women not accepting

maternal and referral advice, especially when the signs of pregnancy complications are quite clear.

- Beyond transport costs, the cost of care, accommodation for accompanying people, food, and sometimes drugs were major concerns expressed in the FGDs. This confirmed the findings from other studies in Africa (Coverston et al, 2004; Shen and Williamson, 1999; and Okafor and Rizzuto, 1994). These costs may deter women with complications from accepting referral advice given at health facilities because rural women mostly feel insecure (Sai & Measham, 1992). This may play a role in delaying the community members to reach a decision when a health worker gives a referral advice, thus contributing to the first phase of delay.
- Awareness aims at involving local traditional leaders, administrative and religious leaders, assembly members, local associations and NGOs in maternal health education was identified to be lacking in the study areas. In a context of low literacy, and where there is a value for community self-identification and where communities are responsive to recommendations of religious and traditional leaders, it is critical that any intervention in a community meets the needs of local stakeholders and wins their support. Communities are not 'empty vessels' and understanding and building upon cultural beliefs of care and means of communication is more likely to be effective. The implementation of community-driven interventions increase institutional births and reduce maternal deaths as it is the situation in Fanteakwa District.

Contribution to knowledge and practice

It has been argued by Philips and Pugh (1994:34) that, with special reference to doctoral research 'an original contribution to knowledge' is a very shaded term: it does not mean an enormous breakthrough which has the subject rocking on its foundation; rather it demonstrates that one has a good grasp of how research is normally done in your area. According to Silverman (2005:70-71), contribution to knowledge could be demonstrated in four areas. These are developing a concept or methodology; thinking critically about your approach; building on an existing study; and being prepared to change direction. In the context of the present study therefore, contributions to knowledge include:

- The expansion of the knowledge base of respondents' attitude towards the contribution of couples in decision making on maternal health. It has also filled current gap in research on womens' autonomy with respect to fertility issues in the study area. It provides fairly useful insights on the main factors that determine womens' autonomy in poor settlements and inform decision makers with some guidelines to intervene and reduce fertility through increased utilization of family planning contraception;
- In general, the current study has focused on how specific communication practices influence the social construction of human identities, shared knowledge and decision making in human organisations, especially on health seeking behaviour. It has contributed to a theoretical understanding of complexities of governance and decision making within the families. The intention is

promoting a more in-depth understanding of various organisational forms and encouraging the exploration of alternative communication practices that allow greater democracy, and more productive collaboration among couples and family members, especially on maternal health care issues. As such the thesis has added to the understanding of communication processes and the identification of individual and community characteristics as factors determining health as captured in the conceptual framework;

- Furthermore, the research was able to build on existing study such as Thaddeus, et al. (1994) and Cleason, et al. (2001). The Pathways frameworks of Cleason et al. (2001) made clear the steps between policies and improved maternal health outcomes which can help in identifying the desired outcomes; the actions needed to achieve the outcomes; the inputs required to produce the actions; and strategy for linking it all together to good maternal health. The adapted exploratory framework that informed this study (Figure 9) focused on facility-based training to ensure convincing change, which can be demonstrated in knowledge, practice, or mortality. The framework identified some important outcomes for a maternal health programme such as : prevention of maternal morbidity and mortality, recognition and treatment of complications as they arise, and the promotion of a healthy woman and healthy newborn;
- The study has equally identified three factors that adversely affected the health seeking behaviour of women in the research area, namely: limited autonomy of women in deciding on pertinent issues which

affect their lives; inadequate maternal health information which denied rural women especially access to health education; and the fact that, potential interventions do not sometimes reach the intended beneficiaries. This has made it difficult to expand the existing knowledge relating to perceived impacts of these interventions;

- In respect of the study's contribution towards practice, the provision of baseline data for the three districts could be a useful stepping stone towards future longitudinal research to enhance comparative analyses. In most cases, the perception and attitude vary with time and growth. Therefore, in order to trace the changing nature of the attitudes and perceptions of residents some further studies would be needed in order to make comparative analyses; and
- Finally, the scientific data generated from the study can form the foundation for decision making and implementation on any intervention on maternal health. According to Maddox (1985), planners and entrepreneurs take due cognizance of the views of members in communities where survey is being conducted. To successfully embark on a research journey with the intention of yielding dividends, the views of host communities are paramount.

The current research consolidated and or expanded the existing knowledge by the identification of the role of men and their involvement as a central issue towards the provision of support to women to enhance positive health outcomes. Few maternal health care interventions have targeted men. The important role male partners are supposed to play in women's reproductive health is increasingly becoming recognized. It was for this reason

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that, the study identified the need to incorporate men into health education interventions.

Recommendations

Despite the multiciplicity of challenges, there is a ray of hope for improvement as evidenced by the windows of opportunities that exist. The current thesis therefore, concludes the research journey with the following recommendations, based on the findings and conclusions:

Enhancing women's autonomy and involving men as partners in reproductive healthcare services:

- Womens' autonomy in health-care decision-making is extremely important for better maternal and child health outcome, and as an indicator of women's empowerment. The third millennium development goal (MDG) aims to promote gender equality and empower women. In the household, husband-wife relations are central to women's autonomy in decision making. To enhance the autonomy of women in maternal health decision making, healthcare providers as well as policy makers and pracitioners should not exclude men from family planning information, counseling and maternal healthcare services. To ignore the important role men's behaviour and attitude may play in thewomen's reproductive health choices are likely to contribute to scaling up maternal deaths. Therefore, health policy makers and practitioners should encourage men's participation in the

promotion of reproductive health to strengthen their roles as promoters at the family, community and national levels.

- Employment and education has always empowered women and brought a positive impact on decision making, including reducing the inequalities among men and women. One effective method to get more girls to school first, brings the numbers of girls at par with males and then empower women. A curriculum for such programmes should be developed with a clear policy guideline to reduce diffrences in education and employment between men and women. The government should intensify and encourage the girl child education policy.
- Local government should partner NGO's to assist women especially those in the remote and rural areas to be involved in income generation activities by supporting them in entrepreneurship training to improve access to property and economic resources to enhance their ability to establish and realise their rights as a means to empower them to be more autonomous in decision making.

Sharing the burden of pregnancy

Among the gaps identified in the literature which the study intended to fill included the absence of partnership between communities and service providers. Partnerships between communities and services are critical for stimulating use of services for maternal health and survival.

- It is therefore recommended that, to ensure behaviour change interventions, the principle of care, share and prepare to offer assistance should be instituted in various communities in the research

area. The programme should be designed with the strategy which should focus on the principle that, all family members, the entire community and health service providers share the burden of pregnancy to ensure maternal health thereby promoting positive partnership. The active involvement of pregnant women, family members, community members and community-based health workers are likely to ensure behavioural change.

- Again, health policy makers in designing interventions should encompass household members, community and religious leaders, politicians, transport unions, employers, and other interested parties. The encouragement of men to share the burden of pregnancy while the communites register all pregnant women progammes on reproductive healthcare services with midwives or nurses considering themselves as the link between government and the community could reduce or prevent maternal deaths.

Effective communication towards promoting maternal health services

- Lack of effective communication between service providers and women on maternal health services was identified as one of the constraints preventing women from utilizing maternal healthcare services. Information may influence some of the determinants of behavior (e.g. self-efficacy, intention to act, skills), communications must normally work in tandem with such strategic components as training, policy change, service delivery improvements and collective community action.

- The central government, GHS, NGO's, religious bodies and the media both electronic and print should through television, conferences, and health education increase awareness among women on the magnitude of maternal health problem. Communications can support the overall maternity care programme not only by incorporating local perceptions and preferences into service design, but also by letting the community know where and when services are available. It is paramount to notice that, the study has no option than to recommend the use of effective communication as reliable tool to support the suggestion by Anon (1997) that home visits by health workers could reduce the monetary and opportunity cost of pregnant women in the rural areas and thereby increasing the utilization of reproductive health services.

Building the capacity of TBAs

- The capacity and skills for delivering better services to the rural population where qualified practitioners are difficult to deploy depends to a large extent on bridging the gap in the provision of social amenities. The activities of the informal group of healthcare providers should be monitored and brought under some regulatory mechanisms by healthcare poviders.
- A coherent approach geared towards building the capacities of TBAs and caregivers that abound in rural parts of the country in this regard is feasible. The GHS should be committed to improving the quality of services as a means of increasing the use of government facilities in the rural areas thereby reducing the rural-urban drift and its concomitant

effects. It is in this context of seeking a way to attract more people that the client focus is likely to emerge with singular force. Basu (1997) and Maudlin (1994) argued that building the capacity of TBAs is likely to increase efforts towards 'clients' satisfaction' or 'perceived quality of care'.

Provision of emergency transport facilities by Government

- Problems with transport between institutions were reported in 28.4% of cases requiring transfer and that subsequently died. Delay in seeking medical help was reported in 36.7 percent of cases. The most common reason for the delay was the lack of transport between the woman's home and a health care institution. Delay in referring cases occurred in 25.6 percent and managing them at an inappropriate level occurred in 23.7 percent of women managed at some point at the district hospitals. As each category is mutually exclusive almost 30 percent of maternal deaths managed at some point at most of the health centres had problems with referral. Criteria for referral and referral routes must be established and utilized appropriately in all district hospitals. Emergency transport facilities must be available for all pregnant women in need (at any site).
- It is revealing to know that unfortunately one woman dies every minute around the world through childbirth.Thus, going by the statistics, therefore, in any given day, 1,440 are dying from childbirth. To achieve the MDGs set for 2015, we need to focus our efforts. African

countries can definitely focus on bringing down the unfortunate high statistics on maternal deaths.

- A lot of interventions including improving and upgrading of emergency obstetric services, providing in-service training for better diagnosis and treatment within referral facilities, improving management to reduce delays and instituting mechanisms for audit/review of all maternal deaths, to support better practice have been implemented. There still is an unfinished agenda because of the fact that, every maternal death counts. Working to prevent maternal deaths is not an act of benevolence towards women because they are mothers, but the duty of all who respect human rights, which includes the right of women to life.

Areas for future research

The present study may be used as a stepping stone for other researchers to contribute to enriching the research on maternal health interventions. Areas requiring further research, some linked to interventions suggested above, include:

- The relevance of cultural beliefs related to practices associated with birth which are likely to endanger the lives of women;
- The impact of the introduction of exemption of user fees on maternal health services; and
- Violence and abuse of women by medical personnel and their consequences.

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APPENDICES

APPENDIX 1

HEALTH FACILITIES SITUATION IN THE STUDY AREAS

No	District	Name	Type of Facility	Ownership
1	Birim South	Achiase Health Centre	Health Centre	Government (public) facility
2	Birim South	Akim Oda Govt Hospital	District Level Hospital	Government (public) facility
3	Birim South	Akroso Health Centre	Health Centre	Government (public) facility
4	Birim South	Anamase RCH	Clinics	Government (public) facility
5	Birim South	Aprade health Centre	Clinics	Government (public) facility
6	Birim South	Apoli CHP's	CHPS	Government (public) facility
7	Birim South	Asene RCH	Clinics	Government (public)

				facility
8	Birim South	Assam CHP's	CHPS	Government (public) facility
9	Birim South	Atiakama Nkanta RCH	Clinics	Government (public) facility
10	Birim South	Catholic Clinic/Maternity	Clinics	Others
11	Birim South	Ehyiam CHP's	CHPS	Government (public) facility
12	Birim South	Emmanuel Mat Home	Maternity Home	Private, for profit facility
13	Birim South	God Lives Clinic	Clinics	Private, for profit facility
14	Birim South	Kyeremase RCH	Clinics	Government (public) facility
15	Birim South	Manso CHPS	CHPS	Government (public) facility
16	Birim South	Manso RCH	Clinics	Government (public) facility

17	Birim South	Mawuli Mat Home	Maternity Home	Private, for profit facility
18	Birim South	Ntoboase Maternity Home	Maternity Home	Private, for profit facility
19	Birim South	Oda Nkwanta CHP's	CHPS	Government (public) facility
20	Birim South	Oda RCH	Clinics	Government (public) facility
21	Birim South	Oldtown RCH	Clinics	Government (public) facility
22	Birim South	Owusu Maternity Home	Clinics	Private, for profit facility
23	Birim South	Paulina Maternity Home	Maternity Home	Private, for profit facility
24	Birim South	Psychiatric Unit	Clinics	Government (public) facility
25	Birim South	St Theresa's Clinic	Clinics	Private, for profit facility
26	Birim South	STI CLINIC	Clinics	Government (public) facility

27	Fanteakwa	Abroso RCH	RCH	Government (public) facility
28	Fanteakwa	Ahomahomaso RCH	RCH	Government (public) facility
29	Fanteakwa	Begoro RCH	RCH	Government (public) facility
30	Fanteakwa	Bosuso Health Centre	Health Centre	Government (public) facility
31	Fanteakwa	CPHS	CHPS	Government (public) facility
32	Fanteakwa	Dedeso RCH	RCH	Government (public) facility
33	Fanteakwa	District Hospital	District Level Hospital	Government (public) facility
34	Fanteakwa	Hemang	CHPS	Government (public) facility
35	Fanteakwa	Nkankama	CHPS	Government

		CHPS		(public) facility
36	Fanteakwa	Osino Health Centre	Health Centre	Government (public) facility
37	Fanteakwa	Reharb Begoro	CHPS	Government (public) facility
38	Fanteakwa	Salvation Army Clinic	Clinics	Government (public) facility
39	Kwaebibirem	Asuom health centre	Health Centre	Government (public) facility
40	Kwaebibirem	Boadua chps	CHPS	Government (public) facility
41	Kwaebibirem	Dwenase	RCH	None
42	Kwaebibirem	Gcd hospital	Other Hospitals	Private
43	Kwaebibirem	Gopds clinic	None	Quasi – Govt
44	Kwaebibirem	Health centre	Health Centre	Government (public) facility
45	Kwaebibirem	Health centre	None	Government

				(public) facility
46	Kwaebibirem	Kade Government Hospital	Hospital	Government (public) facility
47	Kwaebibirem	Larbikrom chps	CHPS	Government (public) facility
48	Kwaebibirem	Okumaning chps	CHPS	Government (public) facility
49	Kwaebibirem	Okyenso chps	CHPS	Government (public) facility
50	Kwaebibirem	Otumi	RCH/FP	Government (public) facility
51	Kwaebibirem	Pramkese health centre	Health Centre	Government (public) facility
52	Kwaebibirem	Takorase	Rch/fp	Government (public) facility
53	Kwaebibirem	Salvation army	Clinics	Chag
54	Kwaebibirem	St. Dominics	District	Public

		Hospital	Level Hospital	
55	Kwaebibirem	Subimaan Clinic	Clinics	Government (public) facility
56	Kwaebibirem	Takyiman Clinic	Clinics	Private, for profit facility
57	Kwaebibirem	Takyiman RCH/FP	RCH/FP	Government (public) facility
58	Kwaebibirem	Topremang Chps	CHPS	Government (public) facility
59	Kwaebibirem	University Clinic Arc	Clinics	Government (public) facility
60	Kwaebibirem	Yehowabewhe Mat Home	Clinic	Private, for profit facility

Source: Regional Health Administration, Koforidua

APPENDIX 2

INTERVIEW SCHEDULE FOR FEMALE RESPONDENTS

Female Respondents

Household decision-making

1. Women's participation in decision-making regarding maternal health.

a. Do you discuss family planning and maternal health care with your husband/partner?

Yes ☐

No ☐

Why?

b. Does your husband/partner show interest?

Yes ☐ No ☐

2. Are your spousal discussions of maternal health regular **before** pregnancy?

Yes ☐ No ☐

What is the rate or How often? .... per month.

3. Are your spousal discussions of maternal health regular **during** pregnancy?

Yes ☐ No ☐

What is the rate or How often? .... per month.

4. Are your spousal discussions of maternal health regular **after** pregnancy?

Yes ☐ No ☐

What is the rate or How often?............................... per month.

5. Focus on two decision making variables for which the researcher could create the dichotomous categories involved.

a. Women involved in final decision (has the final say or jointly)

b. Not involved in final decision.

Who makes the final decisions or has the final say?

Man ☐ Woman ☐ Jointly ☐

6. The decision to utilise health care and the further decision of how frequently to utilise it are made:

a. Jointly (With Husband / Partner) ☐

b. Arbitrary (Randomly) ☐

c. Sequentially (one after the other, schematically). ☐

d. Alone ☐

e. Not at all ☐

7. **CAUSATION**

Perception of the accessibility of care

When you require medical advice or treatment

a) Distance to the health facility is...

I. an insurmountable problem ☐

II. a very big problem ☐

III. a normal problem ☐

IV. a small problem ☐

V. not a problem ☐

b) Getting the money needed for transport and others other than direct medical expenditure is...

I. an insurmountable problem ☐

II. a very big problem ☐

III. a normal problem ☐

IV. a small problem ☐

V. not a problem ☐

8 (a). Are the decisions you make regarding the management of pregnancy within the sphere of influence of older female relations?

Yes ☐

No ☐

Why?

8 (b).If yes, how often?

☐	☐	☐	☐	☐
Every time	Often	a few times	once a while	never

9.(a)What type ofhealth facility is available to you and which do you use most often?

None ☐

Trained Traditional Birth Attendant ☐

Untrained Traditional Birth Attendant ☐

Mid wife ☐

Community health centre ☐

Poly Clinic ☐

Private Clinic ☐

Referral Hospital ☐

Other

9.(b)Which health facility do you use most often?

None ☐

Trained Traditional Birth Attendant ☐

Untrained Traditional Birth Attendant ☐

Mid wife ☐

Community health centre ☐

Poly Clinic ☐

Private Clinic ☐

Referral Hospital ☐

Other

10.How will you grade quality care at the Health facilities available to you?

Very Good ☐ Good ☐ Average ☐ Poor ☐ Very Poor ☐

11. Will you patronise the facility when you have any obstetric complication?

Yes ☐ No ☐

12(a.) Have you ever used the services of skilled Traditional Birth Attendant's (TBA's)? Yes ☐ No ☐

12(b). If yes, how often?

Every time ☐ Often ☐ A few times ☐ Once a while ☐ Never ☐

13. Do you prefer their services even in complicated obstetric cases to that of conventional Health care Institutions?

Yes ☐

No ☐

Why?

14. What is the highest number of your visit to the health facility during pregnancy?

....

Perception of quality of care

15(a). What factors influence your perception of quality of care? (You may tick more than one response)

a. Waiting time ☐

b. Cost of payment ☐

c. Form of payment ☐

d. Treatment received ☐

e. Level of communication ☐

f. Access to care ☐

g. Reliability of institution ☐

h. Other (State) ....

15(b). Which of them is the most important consideration? ....

15 (c). Which is the least important consideration? ....

Cultural belief

16(a). Do you consult older women who are usually in their menopause (TBA's) when there are complications?

	Why?
Yes ☐	
No ☐	

16(b). Do other women in your community do likewise?

Yes ☐ No ☐

16(c). How widespread is this in your community or area of abode?

☐ Every time ☐ Often ☐ A few times ☐ Once a while ☐ Never

17. Would the distance you must travel to health facilities and the availability of transport options have a significant impact on the accessibility of safe motherhood interventions?

☐ Yes ☐ No ☐ Don't Know

18. Would your accessibility of care be affected by socio-cultural factors?

☐ Yes ☐ No ☐ Don't Know

19. If yes, what are the main factors that can affect your accessibility of care?-
----
----

20. What are effects of women's education on receipt of skilled care during pregnancy?--
----

21. The introduction of free maternal care has helped women to have better health outcomes. Do you still have problem on the use of available financial resources to access health services?

		Why?
Yes	☐	
No	☐	
Don't Know	☐	

Quality of safe motherhood intervention

22. Did you have to wait for a long time before seeing the doctor?

☐ Yes ☐ No

23. How long did you wait before you saw the doctor?

.... Mins/hrs

24. Did the doctor tell you what was wrong with you?

☐ Yes ☐ No

25. Did the Doctor explain your condition to you?

☐ Yes ☐ No

26. Is that done every time you see a Doctor?

☐ Yes ☐ No

27. Did the Doctor give you instructions about your illness?

☐ Yes ☐ No

28. If yes/no, has always been like that? ☐ Yes ☐ No

29. How was the attitude of the doctor towards you?

☐ Very Good ☐ Good ☐ Poor

30. What were your expectations before you visited the hospital?

Brief profile of respondent

a) Sex ☐ Male ☐ Female

b) Marital status ☐ Married ☐ Single ☐ Divorced

c) Age ☐ (0-18) ☐ (19-40) ☐ (40-60)

(60+) ☐

d) Employment status ☐ Employed ☐ Self-Employed ☐ Unemployed

Retired ☐

e) Status in community ☐

Opinion Leader ☐ Counsellor ☐ Ordinary ☐

f) Literacy level ☐ Graduate A-Level/SSS O-Level/JSS 1st ☐

Cycle ☐ Illiterate ☐

APPENDIX 3

INTERVIEW GUIDE FOR PARTNERS

Brief profile of respondent--husbands

a) Sex ☐ Male ☐ Female

b) Marital status ☐ Married ☐ Single ☐ Divorced

c) Age ☐ (0-18) ☐ (19-40) ☐ (40-60) ☐ (60+)

d) Employment status

☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired

e) Status in community

☐ Opinion Leader ☐ Counsellor ☐ Ordinary

f) Literacy level

☐ Graduate ☐ A-Level/SSS ☐ O-Level/JSS ☐ 1st Cycle ☐ Illiterate

Respondents-husbands

Household decision-making

1. Women's participation in decision-making regarding maternal health.

   a. Do you discuss family planning and maternal health care with your wife/wives?

Yes ☐

No ☐

Why?

b. Does your wife show interest?

Yes ☐ ☐

2. Are your spousal discussions of maternal health regular **before** pregnancy?

Yes ☐ No ☐

What is the rate or How often? .... per month

3. Are your spousal discussions of maternal health regular **during** pregnancy?

Yes ☐ No ☐

What is the rate or How often? .... per month

4. Are your spousal discussions of maternal health regular **after** pregnancy?

Yes ☐ No ☐

What is the rate or How often? .... per month

5. Focus on two decision making variables for which the researcher could create the dichotomous categories involved.

   a. Women involved in final decision (has the final say or jointly)

   b. Not involved in final decision.

Who makes the final decisions or has the final say?

Man ☐ Woman ☐ Jointly ☐

6. The decision to utilise health care and the further decision of how frequently to utilise it are made:

a. Separately and Sequentially ☐

b. Jointly (with husband) ☐

c. Not at all. ☐

d. Alone ☐

e. Not at all ☐

☐

7. What would you do when you get to know that your wife has obstetric complications?--
----

8. Causation

Perception of the accessibility of care

When you require medical advice or treatment

a) Distance to the health facility is…

☐ VI. a big problem

☐ VII. a small problem

☐ VIII. not a problem for you

☐ IX. normal problem

☐ X. Very big problem

b) Getting the money needed for transport and others other than direct medical expenditure is…

☐ XI. a big problem

☐ XII. a small problem

☐ XIII. not a problem for you

☐ XIV. normal problem

☐

XV. *very big problem*

8 (a). Are the decisions you make regarding the management of pregnancy within the sphere of influence of older female relations?

Yes ☐

No ☐

Why?

8(b). If yes, how

9.What type ofhealth facility availability you and which does your wife use most often? ---

----

10. Howwill you grade quality care at the Health facilities available to you and your wife?

Very Good ☐ Good ☐ Average ☐ Poor ☐ Very Poor ☐

11. Will your wife patronise the facility when she has have any obstetric complication?

Yes ☐ No ☐

12(a.) Have your wife ever used the services of skilled Traditional Birth Attendant's (TBA's)?

Yes ☐ No ☐

12(b). If yes, how often? ---------------------------------

13. Do you prefer their services even when your wife has complicated obstetric cases to tha

Why?

Yes ☐

No ☐

14. What is the highest number of your visit to the health facility during pregnancy? ---

Perception of quality of care

15(a). What factors influence your perception of quality of care? (You may tick more than one response)

- ☐ a. Waiting time
- ☐ b. Cost and form of payment
- ☐ c. Treatment received
- ☐ d. Level of communication
- ☐ e. Access to care
- ☐ f. Reliability of institution
- ☐ g. Other (State)

15(b). Which of them is the most important consideration?-----------------------

15(c). Which is the least important consideration?-----------------------------

Cultural belief

16(a).Does your wife consults older women who are usually in their menopause (TBA's) when she is pregnant?

Why?

Yes ☐

No ☐

16(b).Whether other women do likewise? Yes ☐ No ☐

16(c).How widespread this is in your area of abode?

APPENDIX 4

QUESTIONNAIRE FOR HEALTH PERSONNEL

Brief profile of respondent

g) Date ……………………………………………2009

h) Sex ☐ Male ☐ Female ☐

i) Marital status ☐ Married ☐ Single ☐ Divorced

j) Age ☐ (0-18) ☐ (19-40) ☐ (40-60) ☐ (60+)

k) Name

(Optional)…………………………………………………………………

l) Department………………………………………………………………

m) Rank of officer ……………………………………………………

n) Name of Institution……………………………………………………

o) Location…………………………………………………………………

Level of utilizations of health facilities

1. What factors influence the utilisation of health facilities that provide maternal healthcare?

a) ……………………………………………………………

b) ……………………………………………………………

c) ……………………………………………………………

d) ……………………………………………………………

2. What effect does manpower availability have on the utilisation of maternal care?

----

3. Under what conditions do relatives of women-Traditional Birth Attendant's (TBA's) perform deliveries in the communities?

----

4. The high incidence of maternal and infant mortality could be reduced if childbirth were to occur in health centres or under the supervision of trained TBA's.

Yes ☐

☐ No

What are your reasons? ……………………………………

5. Having a better understanding of the processes related to pregnancy increases the likelihood of utilising maternal health care services.

Yes ☐

☐ No

What are your reasons? ……………………………

6a. What are the major sources of knowledge about safe Motherhood?

☐ *a)* Family members

☐ *b)* Relatives

☐ *c)* Friends

☐ *d)* Co-workers

☐ *e)* Health Care Personnel

☐ *f)* Mass media

☐ *g)* Other (State)

....

6b.Which of the above is most effective and why?--------------------------------

----

6c.Which of the above is least effective and why?--------------------------------

----

7. What are the barriers to accessing maternal health care in the nearest health facility?

a) ....

b) ....

c) ....

d) ....

Quality of care/accessibility of utilisation

8. What factors are related to patient / client satisfaction

(ii) ....

(iii) ....

(iv) ....

(v) ....

(vi) ....

9. What is the highest number of maternal visit to health facility during pregnancy?-------------------------

10. The utilisation of maternal health care lies beyond the direct domain of health care providers Do you agree? If **yes/no,** what are the reasons?--
----

11. Theabsence of health care facilities at a population point negatively affects the likelihood of using maternal health services

☐ Yes ☐ No ☐ Have no idea

Perception of quality of safe motherhood interventions

12. What is the status of safe motherhood activities currently?

....

....

13. What was the state of it 5 years ago?----------------------------------
----

14. What measures have been instituted in the last 5 years to ensure quality of safe motherhood by your outfit

....

....

15. What factors affect accessibility to maternal care in your of operation?

....

....

16. In spite of the various interventions, maternal deaths continue to increase, what factors account for that?

....

....

17. How do people perceive quality of safe motherhood interventions in the community?

....

....

....

18. What measures have been put in place by management to improve quality of safe motherhood interventions?

....

....

....

19. What role does the following play to influence the level of utilisation of maternal health services?

(A) Traditional belief.--

(B)Cultural practices.---

(C) Behaviour play.---

APPENDIX 5

FOCUS GROUP DISCUSSION GUIDE

1. Household decision-making

A. How do you plan giving birth in the family?

B. What role does couple play in decision-making regarding maternal health?

i. Are your spousal discussions of maternal health regular before, during and after Pregnancy?

2. Accessibility of care

A. How often do you encourage your wives to attend health care during and after pregnancy? (men)

B. How often do you access health during and after pregnancy (women).

C. What main factors that can affect accessibility of care?

3. Perception of quality of it care

A. What are your views on perception of quality of health care in your community?

B. What has been the attitude of personnel towards you at the health facility?

4. Cultural practices

1. What role does the following play to influence the level of utilization of maternal health Service:

(i) Culture practices

(ii) Traditional belief

(iii) Behaviour