

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

MSc. HEALTH SERVICES PLANNING AND MANAGEMENT

UTILIZATION OF MATERNAL HEALTH SERVICES IN THE BOSOMTWE

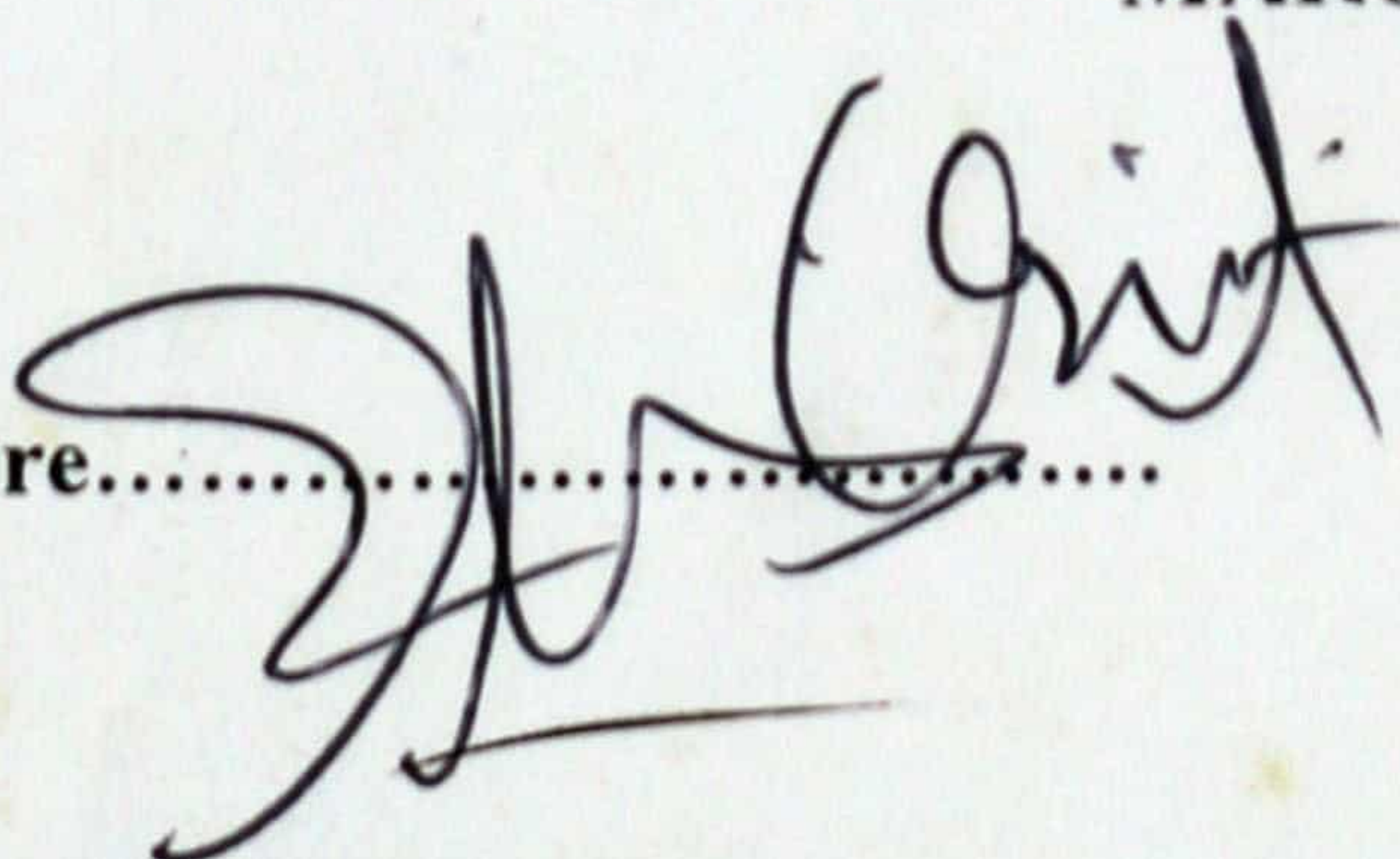
ATWIMA KWANWOMA DISTRICT, ASHANTI REGION, GHANA

A THESIS SUBMITTED TO THE BOARD OF POSTGRADUATE STUDIES,
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KUMASI IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
AWARD OF MSc DEGREE IN HEALTH SERVICES PLANNING AND
MANAGEMENT

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MARCH, 2004

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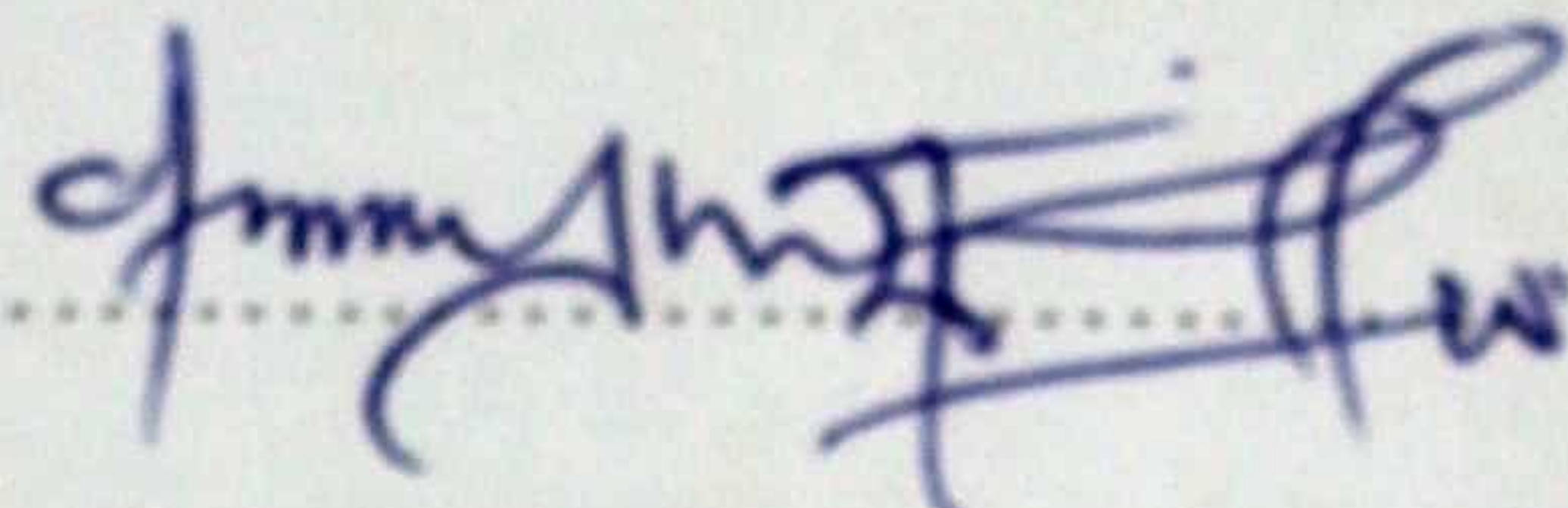
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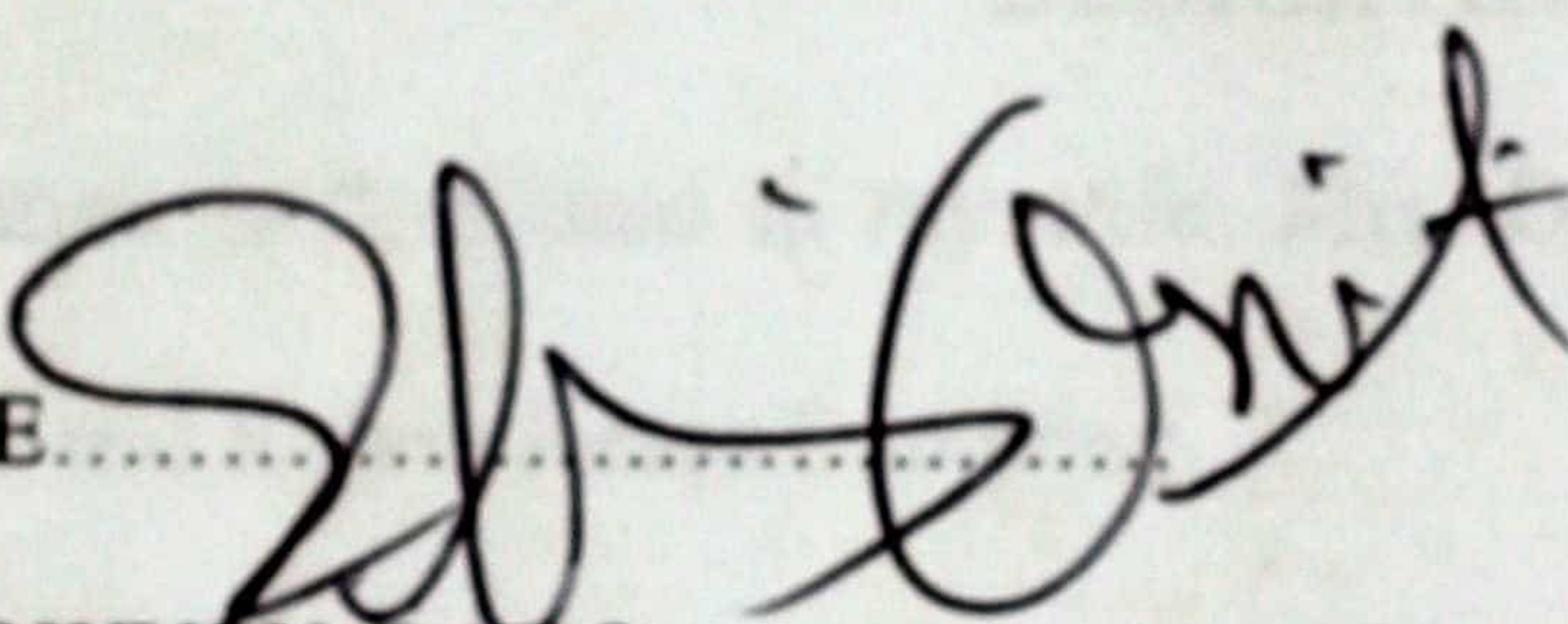
DECLARATION

I hereby declare that, except for references to other people's work which have been duly acknowledged, this work is the result of my own original research and it has neither in whole nor in part been presented for any degree elsewhere.

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DEDICATION

This dissertation is dedicated to my wife, Mrs. Dorcas Frimpong and our children Bright Kwasi and Kelvin Kesse Frimpong.

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Lastly, I would like to acknowledge that with God all things are possible.

ACRONYMS/ABBREVIATIONS

A N C:	Antenatal Care
B A K:	Bosomtwe Atwima Kwanwoma
C B S V:	Community Based Surveillance Volunteers
DHA:	District Health Administration
DHMT:	District Health Management Team
EOC:	Essential Obstetric Care
E M O C:	Emergency Obstetric Care
F G D:	Focus Group Discussion
G D H S:	Ghana Demographic and Health Survey
H C C:	Health Care Centre
I U D:	Intrauterine Device
M C H:	Maternal and Child Health
M H S:	Maternal Health Services
N G O:	Non Governmental Organization
O O U T H:	Olabisi Onabanjo University Teaching Hospital
OPD:	Out Patient Department
S M I:	Safe motherhood Initiative
T B A:	Traditional Birth Attendant
U F C:	Under-Fives' Clinic
U N F P A:	United Nation Population Fund
U N I C E F:	United Nation Children's Fund
W H O:	World Health Organization
W I F A:	Women In Fertility Age

GLOSSARY/DEFINITION OF TERMS

ACCESSIBILITY: How close a health facility is to the people, and the means of getting to the facility.

ALTERNATE SOURCE OF HEALTH SERVICES: Other means of health services apart from the orthodox medical service

BASIC (PRIMARY) EDUCATION: Comprising Primary, Middle and Junior Secondary School levels

HEALTH SEEKING BEHAVIOUR: Respondents' attitude towards cure for their sickness

MONTHLY INCOME LEVEL: Estimated amount of money that is received by the woman within the month

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ABSTRACT

Pregnancy related complications are the leading cause of death among women in the reproductive ages 15-49 years in developing countries. Despite the interventions instituted globally to reduce this menace, maternal mortality is still high in the developing countries. Research has shown that adequate use of antenatal and delivery services can reduce maternal deaths between 10% to 45%, especially in the developing countries.

The objective of this study is to assess factors responsible for the decreasing trend in ANC attendance and delivery services as well as low utilization of family planning services in the Bosomtwe Atwima Kwanwoma (BAK) district in order to come out with recommendations to improve the maternal health services utilization.

A descriptive cross-sectional study was carried out in 3 out of the 5 sub-districts in BAK namely Kuntanase, Amakom and Trede. They were selected by simple random sampling. A multistage cluster sampling was employed to identify the respondents' household. In all 18 clusters of communities were selected and a total of 180 women within the age group of 15-45 years who had delivered at least once within the five years preceding the study were interviewed through interview guide and focus group discussions.

The modal age class was 30-34 years (26.7%) with 19.4% uneducated, 80.6% of respondents earned monthly income of less than two hundred thousand cedis with unemployed being 6.7%. 53.3% claimed their husbands decided on the place of delivery. 92 (51.1%) lived less than 5km away from health facilities and 50% walked to health care facilities. 7.2% preferred to deliver at home and 56.1% preferred to deliver at public health care facilities. 11.7% were using some modern family

planning method. 57.2% attended ANC more than 4 times. About 80% of respondents were satisfied with service delivery. The study also revealed other factors which accounted for the downward trend in utilization, such as the influence on women by the family members and delay in reporting to health facility when in labour.

It is recommended to the Ministry of Health that, health education on the benefits of ANC and delivery at public health care facilities should be intensified. Also there is a need to disabuse the minds of both men and women about the erroneous impression and the false beliefs on family planning services.

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Maternal mortality is defined as the death of a woman during pregnancy or within 42 days of termination of pregnancy (WHO, 2001). The maternal mortality ratio in the African Region, estimated at an average of 940 per 100000 live births, is the highest in the world. The 50th session of the WHO Regional committee had as subject for technical discussion "Reducing maternal mortality: a challenge for the twenty-first century". This was in recognition of the magnitude of the problem and the need for prevention (WHO, 2001).

Of all the health statistics monitored by the WHO, maternal mortality is the one with the largest discrepancy between the developed and the developing world. It is on the average 18 times higher in developing countries than in the developed world (WHO and UNICEF, 1996). Everyday, at least 1600 women die of complications of pregnancy and childbirth. In addition to the number of deaths each year, over 50 million more women suffer from maternal morbidity and acute complications of pregnancy. For at least 18 million of these women, these morbidities are long term and often debilitating (UNICEF, 1996).

In his overview of the historic development of maternal and newborn care, Prof Otolorin, Reproductive Health Advisor, Regional Centre for Quality of Health, Uganda, traced the international response to the unnecessarily high risk of death

during pregnancy for women in poor countries. Realising that measures to prevent direct obstetric deaths, which account for nearly 80% of maternal deaths worldwide, can be affordable and effective, international organizations became involved in the problem (WHO, 2002).

In 1987, the World Bank, the WHO, the UNFPA, UNICEF and international non-governmental organizations organized the first International Conference on Maternal Mortality Reduction, in Nairobi, Kenya, where the Safe Motherhood Initiative (SMI) was launched. The objective of the SMI was to reduce the 1990 maternal mortality levels by 50% by 2000. The international consultation on maternal mortality reduction held in Colombo, Sri Lanka, to mark the 10th anniversary of the Safe Motherhood Initiative, noted that maternal mortality rates, despite the efforts made, remained unacceptably high and in some countries were increasing. The Safe Motherhood comprises of Antenatal Care, Delivery, Postnatal Care, Family Planning Services and Post Abortal Care (WHO, 2002).

Pregnancy related complications are the leading cause of death among women in the reproductive ages (15-49) years in developing countries. The highest maternal mortality figures are found in Eastern and Western Africa where in some countries, more than 1000 women die for every 100000 live births (WHO and UNICEF, 1996). The estimates for maternal mortality ratio for the Africa Regional blocs are: 1060 for East Africa, 1020 for West Africa, 950 for Central Africa, 340 for Northern Africa and 260 for Southern Africa, compared to ratios of less than 30 in developed countries. In some countries in the Region, one woman in 12 dies of pregnancy related complications compared to one in 4000 or even one in 10000 in developed

countries (WHO, 2001). In Kenya, the incidence of maternal mortality is estimated to be 365 deaths per 100,000 live births; Mali 1750 per 100,000; Somalia 1100 per 100,000 and Ghana 214 per 100,000 live births (WHO, 2001).

Studies indicate that greater number of maternal deaths could be avoided with widespread accessibility and utilization of maternal health care services. For half a million women each year, the complications of pregnancy are fatal. The causes of these deaths are essentially the same around the world. It is estimated that 127,000 women (25%) die due to haemorrhage, 76,000 (15%) due to sepsis, 65 000 (12%) due to hypertensive disorders in pregnancy, 38 000 (8%) due to obstructed labour, and almost 70 000 (13%) due to abortion (WHO, 1996). Inadequate medical facilities, treatment of complications and inadequate medical personnel contribute between 10% and 45% of all maternal deaths (Benter, 1999).

Although the services may be available and accessible, they may not always be used due to lack of information on the available health facilities or other constraints, which may be social, cultural and economic. Complications arising from maternal obstetrics conditions need not lead to death; they occur because of severe socio-economic deprivations that are prevalent in developing countries. However, the socio-economic factors do not operate in isolation, but in conjunction with access to health services and ease of transportation (Benter, 1999).

Maternal health care depends on the socio-economic and cultural milieu in which a woman lives. The WHO Expert Committee on maternal and child health (MCH) stated that if MCH care programmes are to be effective, they must concern

themselves not only with immediate causes of morbidity and mortality, but with the social organization and values that characterize the populations (WHO, 1997).

This is because pregnancy and childbirth are entrenched in beliefs and customs that affect health and health seeking behavior. The resources available both to the family and the community determine the access that women have to maternal health services. The cultural set up also influences health care behaviour and use of health services. Modern maternal health services may be available but if culture prohibits some practices, women may not make use of them. (WHO, 1997). Most maternal deaths result not from lack of understanding of the nature of the medical and obstetric causes but because their treatment are inappropriate, delayed or non-existent.

The delay is in deciding to seek help or in getting to the appropriate health care facility or in receiving the right treatment at the health care facility. Ideally, treatment ought to start early when maternal illness is mild, but because of the delay, treatment often starts when maternal illness is well advanced. Consequently, more mothers and their babies die, the survivors take longer to recover fully, while treatment costs increase, contributing further to the vicious cycle of poverty and ill-health (WHO, 2001).

1.2 PROBLEM STATEMENT

Childbearing is quite unsafe in sub-Saharan Africa. The high mortality and morbidity in this part of the region is the direct result of the serious defects in the social, cultural and economic backgrounds as well as in the inadequacies in existing health facilities (WHO, 2001). Research has shown that adequate use of antenatal and delivery services can reduce maternal deaths between 10% to 45%, especially in the developing countries where maternal mortality is highest (WHO, 1997).

Maternal health programme effort in developing countries is seriously deficient, particularly in the rural areas. Rural women are disadvantaged in many respects, but especially regarding treatment of emergency obstetric cases. Both rural and urban women receive inadequate HIV counselling and testing and have quite limited access to safe abortion (Bulatao and Ross, 2002). There is inadequate information at present regarding the level of utilization of maternal health services in the district. Similarly the factors that affect utilization of the services have not been fully identified and are poorly understood.

Family planning prevalence and usage is inadequate in the Bosomtwe Atwima Kwanwoma (BAK) District (BAK-DHA, 2002). The trend of reproductive health services utilization in BAK District shows a gradual decline from year 2000 through to year 2002. For Antenatal Care (ANC), there was gradual decline from 97% in 2000 and 92% in 2001 to 90% in 2002. Supervised delivery declined from 96% in 2000 to 93.6% in 2001 and declined further to 88% in year 2002. Family planning services utilization has been on the lower side. From a low of 5% in 2000 to about 6% in 2001 and 9% in year 2002 (BAK-DHA, 2002). Though utilization of family

planning seems to be picking up, it is rather slow and there appears to be peculiar problems or factors that may influence the low patronage. The reason for this failure of utilization is unclear. Although the availability of maternal health services is very important, its effectiveness can only be achieved through utilization of existing facilities (Benter, 1999). The study seeks to identify factors that influence the use of various maternal health services in Bosomtwe-Atwima-Kwanwoma District (BAK). The study is useful for BAK District because if the factors influencing the maternal health care service use are established, especially family planning, then appropriate strategies can be devised to enhance the use of maternal health care services in the district. That way, maternal morbidity and mortality could hopefully be reduced.

1.3 RATIONALE FOR THE STUDY

In an effort to decrease maternal and under-5 mortality rates, Ghana's Ministry of Health has established standards for maternal and child health services with limited results. Poor birth outcomes are a major concern in Ghana. The Ministry has cited several instances where traditional and cultural beliefs appear to influence health seeking behaviour and maternal and child health practices and outcomes within the country.

Traditional cultural beliefs have been identified in government health reports as an important factor that impact on the health status of women and children and the Bosomtwe Atwima Kwanwoma District is not an exception. The study is supposed to come out with facts to support this assertion and to identify solutions that would help modify mothers' behaviour towards the use of health services. These beliefs may influence such health-seeking behaviours as the type of health care system to use, the

place of delivery (home or hospital), and the type of health care practitioner chosen. Benter (1999), points out that "pregnancy is one of the areas of female life in sub-Saharan Africa in which cultural expectations and responses still influence and at times dominate health status either for good or for bad".

Therefore in order to improve birth outcomes, and for that matter maternal health in the (BAK) District, it is essential to understand, among other factors, the socio-cultural health beliefs, the impact they have on pregnant women's health behaviour and to determine the effects of these beliefs on birth outcomes. The study seeks to come out with findings that would be useful to the health decision makers to bring about improvement in maternal health services utilization, and also positive changes in the health delivery system of the district.

1.4 RESEARCH QUESTIONS

1. Are there any geographical factors affecting the level of utilization of maternal health services?
2. Are there any socio-cultural and demographic factors affecting the level of maternal health services utilization, including family planning?
3. Are the expectations of mothers being met with respect to facility utilization?
4. What are the health seeking behaviours of the mothers?
5. What is the perception of mothers on the cost of care of maternal health services?

1.5 MAIN OBJECTIVE

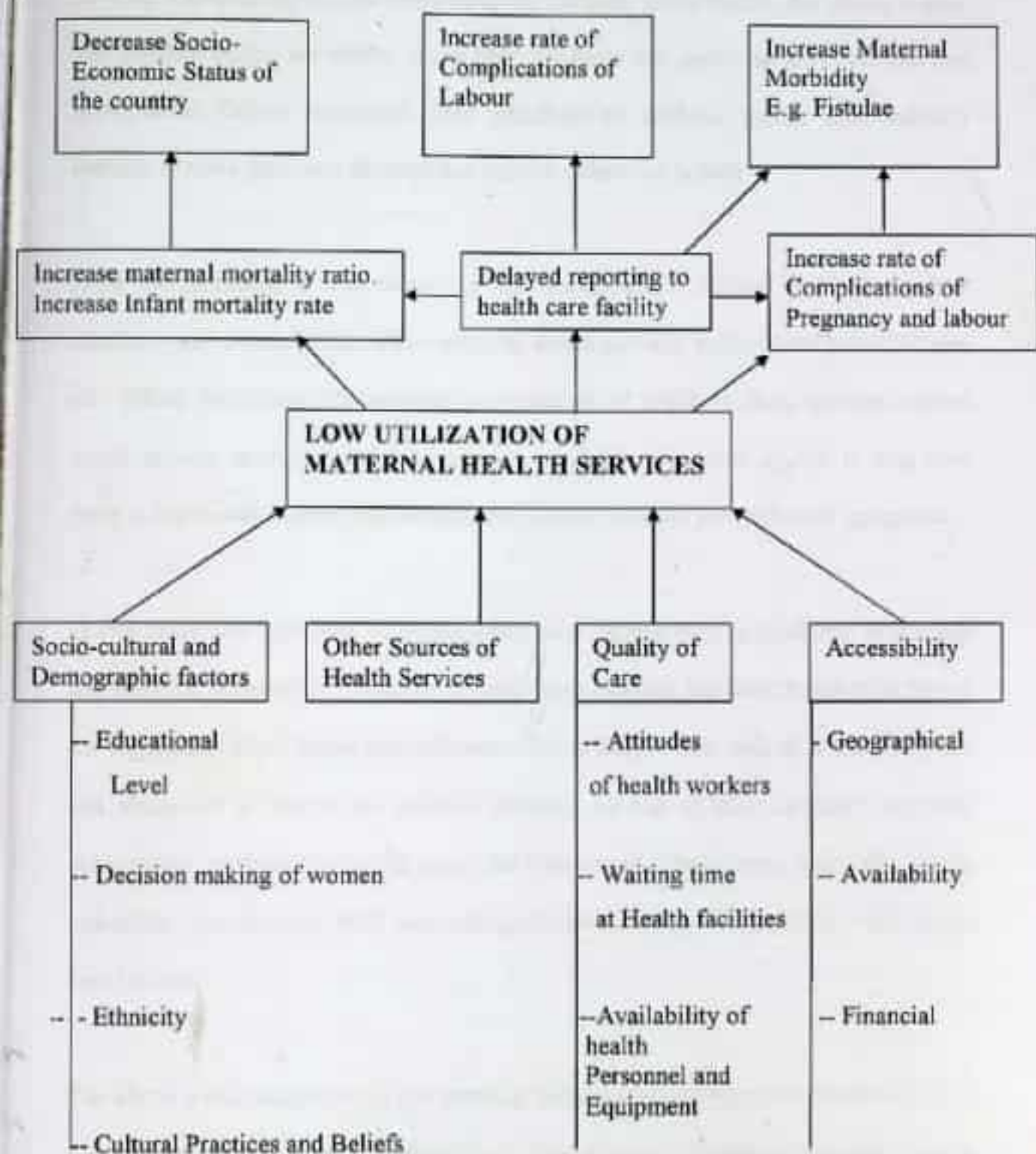
To assess factors influencing utilization of maternal health services in Bosomtwe-Atwima- Kwanwoma District.

1.5.1 SPECIFIC OBJECTIVES

1. To determine the influence of distance in relation to maternal health service utilization.
2. To identify the socio-cultural factors, beliefs and demographic factors that influence the use of maternal health services.
3. To determine the expectations of mothers at the maternal health facilities
4. To identify the health seeking behaviour of mothers in the district.
5. To determine the perception of mothers about the cost of care in accessing maternal health services.
6. To make the necessary recommendations on improving utilization of maternal health services.

1.6 CONCEPTUAL FRAMEWORK

FIGURE 1: Interrelation between the causes and effects of low MHS utilization



Source: Author, 2004

Figure 1 above shows the conceptual framework of the utilization of maternal health services. The possible factors influencing the problem in the middle are shown below. The possible effects are shown above (Fig. 1). From the study, the socio-cultural and demographic factors considered were education of mothers, parity, age, women's inability to make their own decision and cultural values and beliefs.

From the literature, it was found out that socio-cultural factors like low maternal education and illiteracy can affect maternal health services utilization. Quality of care also affects utilization. For example poor attitude of health workers towards women would prevent mothers from using services available. The same applies to long time spent at health care facility and also non-availability of health personnel and equipment.

In this study, the indicators for accessibility were geographical, availability of services and financial accessibility. Distance to health care facilities has been found to be one of the factors that affect health care utilization if it is longer. Also lack of health personnel and equipment at health care facilities prevents the use of these facilities. Financial accessibility, according to the literature, has been found to be a strong factor that affects utilization. Low-income levels and unemployment prevents women from using health care facilities.

The above would contribute to low maternal health services utilization. Mention should also be made of the fact that availability of other sources of health services may lead to low maternal health services utilization. If the services at these areas are considered

convenient and cheap by the mothers, they would be patronized. One should not lose sight of the fact that these other services are also closer to the mothers, e.g. spiritual churches, fetish priests, herbalists etc. The low utilization of maternal health services may lead to delay in reporting to a health care facility which may in turn lead to increased rate of complications of pregnancy and thence to increased maternal morbidity and mortality.

Low maternal health services utilization may also have direct effect on maternal mortality and morbidity. High maternal mortality ratio and high infant mortality rate are also poor indicators of the socio-economic status of a country.

1.7 STUDY METHODS AND DESIGN

1.7.1 Study Type

A descriptive cross sectional study was employed to carry out the study in the district.

1.7.2 Study Site

The study took place in the Bosomtwe Atwima Kwanwoma District. They included the following sub-districts Kuntanase, Amakom and Trede.

1.7.3 Study Participants

The study population consisted of 180 women in the fertile age (15-49) who had lived in the district for at least 5 years and who had delivered at least once within the 5 years preceding the study.

1.7.4 Sampling

Simple random sampling was used to select three out of the five sub-districts (Kuntanase, Amakom and Trede) in BAK. A Multistage Cluster Sampling method was used to come

up with the households within which the respondents belonged. In all, 18 clusters of communities were selected and a total of 180 women who had labored at least once within the five years preceding the study were interviewed. After multistage cluster sampling, a systematic sampling was used to select the actual households within which respondents lived in the communities.

1.7.5 TABLE OF VARIABLES

VARIABLES	INDICATORS	DEFINITION	OBJECTIVE
Accessibility to health care facility			
1. Geographical	1. Distance from nearest health care facility	How far a health facility is from mothers (km).	One
	2. Means of transport to health facility	By what means do mothers get to the health facility	
	3. Time taken to get to the nearest health care facility	How long it takes to get to the nearest health facility	
2. Availability	1. Availability of health personnel e.g. Doctors, Nurses	Number and type of health professionals in a health facility	
	2. Availability of essential obstetric care (EOC) services in the facility	Types of EOC services provided at the facility	
3. Financial	Cost of maternity care	Ability of mothers	

	services	to pay for services	
Socio-demographic and cultural factors	1. Maternal age 2. Mother's Education 3. Mother's Occupation 4. Income Level of mothers	Age at last birth date Level of education of mothers What mothers do for a living Estimated amount of money earned at the end of the month	Two
	5. Number of children born 6. Marital status 7. Religion of mothers 8. Paternal education 9. Paternal occupation	Number of children ever born (not necessarily those alive) E.g. Single, married, divorced etc. Religious affiliation of mother Husband's educational level What the husband does for a living	Two
Socio-cultural Beliefs and Values	1. Decision maker on choice of place of delivery 2. Belief in gods and	Person responsible for final decision on choice of place of delivery Effect of idol	Two

	fetish	worship on maternity services utilization	
Utilization of MHS			
1. Family Planning (FP)	1. Attitude and beliefs	Perception of mothers on the use of FP and Barriers to the use of FP	
	2. Practice	Level of FP utilization	
2. Antenatal care	Attitude towards ANC attendance	1. Time of starting ANC. 2. Frequency of ANC visits	
3. Availability of Health workers	Presence of health workers at (MCH) facilities	Number of Doctors and midwives at health facilities	
Expectation of Mothers on Service Utilization	1. Waiting time of mothers at the facility	Number of hours mothers expect to spend at the facility	Three
	2. Privacy given to mothers	Presence of the doctor, nurse and the client, with or without a relative	Three
	3. Attitude of health workers to mothers	The way mothers are talked to in the	

		clinic. Assistance offered to mothers as and when needed. Timely assessment of progress of labour. Paying attention to patients' complaints	
Health seeking Behaviour of mothers	1. Other areas of seeking health care 2. Choice of place of delivery	Availability of other sources of health care Deciding on where to deliver (home, TBA or health facility)	Four
Perception of mothers on cost of care	Views of mothers on fees charged at health facilities (high, low or moderate)	Affordability of services provided	Five

Source: Author, 2004

1.8 DATA COLLECTION TECHNIQUES AND TOOLS

1.8.1 Source of Primary data

To obtain primary data, respondents were interviewed by means of structured interview guide. The questionnaires were administered in such a manner that, respondents understood the questions first, before answering them. Some Community-Based

Surveillance Volunteers (CBSV) and health care providers were trained on basic skills in data collection, which helped in the collection of primary data.

Focus Group Discussions (FGD) were organized to obtain qualitative primary data and to get an in-depth understanding on their perceptions of maternal health services utilization, by way of focus group discussion guide.

1.8.2 Sources of Secondary Data:

Sources of secondary data were the District Hospital and the District Health Administration, basically from the BAK, Annual Report, 2002; and from other departments within the Administration and the Hospital, which were of relevance to the study.

1.8.3 Data Handling

The data collected on the variables identified was analyzed using EPI-INFO 6.

1.8.4 Pretest

This was carried out in the Ejisu-Juaben District, in two separate communities namely, Onwe and Akyenakrom. This district shares boundary with the BAK district, in the North.

1.9 LIMITATIONS

The tools used in all cases of data collection required the presence of the data collector (interviewer). This increased the cost, effort and time needed to collect the data. Hence there were limitations of time, financial resources and transport.

The data was dependent on the client's availability at home, at the time of its collection, since most of them leave their homes early for their farms.

1.10 SCOPE OF THE STUDY:

The study is about the utilization of maternal health services, which is concerned with Women In their Fertility Age (WIFA) in the study area. The total population of the WIFA, according to the BAK District's Annual Report 2002, is 37453. This is about 23.2% of the total population in the district, which is 156,127. 180 respondents who are indigenous or had lived in the district for at least 5 years were interviewed.

The study was limited to the usage of maternal health services and was also concerned with the reason why the women were not using the services provided by the health care facilities in the district. Other variables of much importance were the age, educational level, marital status, distance to health care facilities, influence of relatives on the women when it comes to decision-making in choosing the type of health care, cultural and traditional beliefs and their influence on maternal health services utilization.

1.11 PROFILE OF THE STUDY AREA

Bosomtwe-Atwima-Kwanwoma (BAK) is one of the eighteen (18) districts in the Ashanti Region of Ghana. Kuntanase, the district capital is about 28km from Kumasi. The district shares common borders with Atwima, Ejisu-Juaben and Kumasi Metropolis to the North, Asante-Akyem North on the East, and Amansie-East and West on the South.

The district covers an area of approximately 681.799sq km, which represents about 2.8% of the total area of Ashanti Region. Extrapolation from 2000-year census figures has BAK as having a population of 156,127 with a growth rate of 3.4%. Women in their Fertility Age (WIFA) form 23.2% of the total population, adolescents form 21.8% and children below 5 years form 15.3% of the total population.

The main economic activity of the populace is farming. Cassava and Maize are the major crops grown. Plantain and shallots are also grown in the Bosomtwe area while Sugarcane is grown in the Atwima area. People around the lake do fishing in the Lake Bosomtwe. The people in Atwima are also engaged in craft making mainly carving.

The district has four (4) secondary schools namely; Jachie-Pramso, Atwimanman, Cardinal Tonko and Beposo Secondary Schools. There are also three vocational schools. These are St Michael, St George and Osei-Tutu vocational/Commercial Schools at Pramso, Kuntanase and Esreso respectively.

The road network from Kumasi, the regional capital to Kuntanase and to Abono is a second-class road. Most roads around the Lake and in Atwima area are not motorable. All the five sub-district centres have telecommunication systems. There are 120 communities in the district, most of which are connected to the National electricity grid and 94 out of the number had a wholesome water supply.

The total number of health care facilities is twenty (20), comprising 2 Hospitals (one of which is a mission hospital), 6 Health Centres and 12 clinics. Of the 12 clinics, 5 are mission clinics, another 5 are private maternity clinics and the rest are community clinics. The doctor/patient ratio is 1: 19,516. The number of outreach points, trained Traditional Birth Attendants (TBAs) and trained Community-Based Surveillance Volunteers (CBSVs) are respectively 59, 54 and 122; thus at least there is one CBSV in each community.

On Out Patient Department (OPD) attendance, there was consistency in the increase of female attendance to health institutions over their male counterparts from year 2000 to 2002. Jachie-Pramso sub-district attended to 70% of total OPD cases in the district. This is because a lot of patients from the Kumasi metropolis, Amansie-East district and other parts of the region use St. Michael Hospital at Jachie.

In the year under review, 88% of all expected deliveries were supervised and 75% of all supervised deliveries had postnatal care. Only 65% ANC registrants had Tetanus Toxoid-2 vaccination. Family planning acceptor and modern contraceptive prevalence rates are still low. The district's acceptor rate was 6.8%. Teenage pregnancy was minimally reduced from 13.6% to 13.0%.

The Top-10 Diseases in the district for years 2001 and 2002 is shown in the table below.

Table 1.11

CLINICAL TOP-10 DISEASES

2001- DISEASE	NUMBER	2002 – DISEASE	NUMBER
Malaria	26980	Malaria	35043
Diarrhoea	3471	A. R. I.	6872
Skin Diseases	1581	Diarrhoea	3779
Intestinal Worms	1529	Pregnancy Related	2673
Rheumatic Pains	1471	Skin Disease	2361
Pregnancy Related	1220	Intestinal Worms	2243
Hypertension	1167	Hypertension	1691
Anaemia	1083	Rheumatic Pains	1624
Pneumonia	536	Acute Eye Infection	1456
Gynaecological Dis.	515	H/ Occup. Accident	1276

Source: DHA-BAK, Annual Report 2002

From Table 1.11, Malaria continues to take a firm lead amongst the top 10 OPD cases. Hypertension is emerging as a serious health problem in the district. Of interest in the table is pregnancy related diseases. From a sixth position on the top 10 list of diseases in year 2001, it moved to fourth position in year 2002.

1.12 ETHICAL CONSIDERATION

Permission to carry out the study was first obtained from the Department of Community Health, School of Medical Sciences, KNUST. In the district, permission was sought from the District Chief Executive, the District Health Administration, District Health Management Team (DHMT), and the Medical Superintendent of the BAK District of Ashanti Region, Ghana.

Verbal consents were given by the three selected sub districts' health management teams to participate in the study. The various communities selected under the cluster sampling were entered either through their unit committees, or through their chiefs and elders; and they were duly briefed on the importance of the study and how the results, and the recommendations thereafter, would be used to improve the health delivery system in the district and how they were going to benefit in the long run from the study.

Care was taken to ensure that, there were no interruptions of respondents' work during data collection and that respondents were made to understand the study from the beginning. The responses from the respondents were recorded verbatim to ensure consistency in data collection.

1.13 ORGANIZATION OF REPORT

The first chapter deals with the background information of the study, problem statement of the study, rationale, research questions and objectives of the study. The problem analysis has been presented schematically as a conceptual framework. The study methods and design as well as data collection tools and techniques were described briefly.

Chapter two is also a write up of review of related literature. In chapter three, the results of the analyzed data were presented both graphically and in a tabular form with a brief description of the results. In chapter four, the study results were interpreted and discussed comprehensively by comparing the analyzed results with previous works.

Conclusions were drawn from the discussions in the previous chapter to form part of chapter five. The other part consisted of the recommendations made to DHMT, GHS and MOH based on the conclusions.

The report was adequately referenced and the author(s) of cited publications duly acknowledged. Individuals, group of individuals and organizations that assisted in diverse ways in this study were also acknowledged.

1.14 DELIMITATION

Maternal health service is very broad. Hence for the above limitations, the study was confined to antenatal, delivery and family planning services.

CHAPTER TWO

2.0 LITERATURE REVIEW

Maternal mortality must be considered a violation of women's human rights necessitating changes in legal, political, health and educational systems to provide more equitable women-centered health services through strong partnerships between governments and communities (UNICEF, 1999). Greater investments in basic social services (health, education, nutrition, water and sanitation) are essential to achieving safe motherhood. Men, parents, in-laws, families and neighbours need to join efforts to support women in improving their lives and health. They must also help break down barriers to health care by mitigating distance, cost and socio-cultural obstacles by providing education, integrating customs and traditions, and enhancing women's status and decision making powers (UNICEF, 1999).

2.1 Actions to Reduce Maternal Mortality

Reducing maternal mortality requires coordinated, long-term efforts at the household and community levels as well as at the level of national legislation and policy formulation, especially in the health sector (UNICEF, 1999). Making high quality obstetric services available to all women during pregnancy and childbirth is critical to supporting the above actions. Health services for women should focus on the prevention of unwanted pregnancies, the prevention of complications during pregnancies and the appropriate management of any complications that do occur.

This implies

- Client-centered family planning services and information that offer women, men and adolescents the choices that meet their needs
- Basic prenatal and postnatal care to detect and manage nutritional deficiencies, and to treat endemic diseases such as malaria, helminthic infestations and sexually transmitted diseases. Prophylactic care should include tetanus toxoid immunization, anti-malarial tablets, iron/folate supplementation and voluntary counseling/testing for HIV.
- A skilled attendance with midwifery skills present at every birth, with the capacity to provide first aid for obstetric complications and emergencies, including life saving measures when needed. At least four basic Essential Obstetric Care (EOC) for every 500,000 population.
- Good quality obstetric measures at referral centres to treat complications including facilities for blood transfusion and caesarean section, at least one comprehensive Essential Obstetric Care to perform this, for every 500,000 population.
- Contraceptive counseling for women after childbirth and for those who have experienced obstetric complications (UNICEF, WHO, UNFPA, 1997).

2.2 ACCESSIBILITY OF HEALTH SERVICES

Women-friendly health services must be available, geographically accessible, affordable and culturally acceptable in order to reduce maternal morbidity and mortality. Services should include essential obstetric care (EOC) at the primary and referral levels, in order

to minimize delays in deciding to seek care, reach a treatment facility and receive adequate treatment at the facility (UNICEF, WHO, UNFPA, 1997).

2.2.1 Geographical Accessibility

The geographical accessibility of the health facility and the availability and efficiencies of transportation affect women's ability to access health services. Speedy and easy access to health services is particularly critical when it comes to the treatment of life threatening complications.

In a study to determine the utilization of antenatal and maternity services in Mbeere District, Eastern Province, Kenya, it was found out that the proportion of mothers who utilized health facilities for antenatal and maternity services was 97.5% and 52% respectively. Utilization of health facilities for maternity services was significantly influenced by the distance to health facility in that, mothers living less than 5 km to a health facility utilized the services better than those living 5km and beyond.

The major constraint experienced by mothers included lack of transport, lack of money for transport and hospital fees (Mwaniki, 2002). This can be compared to the work done by Fourn and Ducic (2002) in Benin, which proposed to describe the trend of unfavourable pregnancy outcomes and antenatal care utilization. The research observed an increase of antenatal care utilization and one of the major factors that contributed to this was closeness to health care facility. In most rural settings, the trend appears to be similar, talking about effect of distance on utilization of maternity services.

This is not to say that the situation in the urban centres is always good. This is because Lamina and colleagues (2002), at the Olabisi Onabanjo University Teaching Hospital (OOUTH) in Sagamu, Lagos, observed in their study that while 52.7% gave miscellaneous reasons for not delivering in OOUTH, 23.1% complained about distance and 11% about the time wasting attitude of the teaching hospital set up.

In Lebowa, northern Transvaal, in East Africa, the obstetric services utilization by the community was also assessed. It was found out that antenatal coverage was high at 93.5%; the proportion of health facility deliveries was 74.6% while 25.3% of all births occurred at home. Inaccessibility of maternity services like distance, among other factors, was the common reason given for preference of home delivery (Uyirworth *et al.*, 1996).

Still considering distance, the attitudes of pregnant women attending ANC clinic in Al-Baha region of Saudi Arabia were assessed to determine their views on maternity services. 49.9% of the women desired prenatal care services in primary health care centres, and the reason they gave was closeness to home (Al-Nasser, 1996). Distance cannot be overemphasized talking about the utilization of maternity services worldwide.

The study to be carried out in BAK district will assess this variable, and see how it influences mothers. For example in rural Haryana, India, the impact of health centre availability on utilization of maternity services was carried out in four villages. 600 married women with a delivery in the two years prior to the study were interviewed. One village had a primary health care center (PHCC), one had a sub center, and two did not

have an HCC, but were within 5km of such facility. Overall, 98.2% of the respondents had contacted health staff for antenatal care. 49.8% of deliveries in the PHCC village, 76.1% in the sub center village, and 75.6% in those without an HCC, were performed by a traditional birth attendant (Kumar *et. al.*, 1997). Sometimes the availability of health services does not guarantee their use by mothers, as it can be seen from above study.

Finally, some researchers used data from the 1993 Kenya Demographic and Health Survey to study the variations in the use of antenatal services in Kenya. The result showed that the availability and accessibility of health services, among other socioeconomic factors were found to be responsible for variations in the use of antenatal care in Kenya (Magadi *et. al.*, 2000).

2.2.2 Availability

The most important criterion for women-friendly health services, and especially maternal health services, is to be as close as possible to the community. Some levels of health infrastructure exist in most developing countries, however, even where health services are available, they may be under-utilized, reflecting a dearth of trained personnel, non-availability of drugs and supplies or poor quality of care provided (UNICEF, WHO, UNFPA, 1997). All women should have access to a skilled attendant during pregnancy, childbirth and post-partum period. This attendant should be able to provide basic EOC and refer women for comprehensive EOC, in case of complications. No woman should be denied access to life-saving EOC when complications occur during pregnancy or childbirth.

One indicator for measuring the availability of maternal health services could be the proportion of women who receive EOC. Another indicator could be the proportion of births attended by a skilled birth attendant.

In seeking health care, one of the factors considered generally by health seekers is the availability of a provider at post and the reputation of the provider. Asenso-Okyere and colleagues (1996) observed that availability of doctors or medical and laboratory services are the major attractions to hospitals.

In most of the private clinics in Winneba, in one of the districts studied (Efutu-Awutu-Senya), both men and women prefer attending private clinics because they perceive the quality of service to be higher at these facilities than at the government hospitals. Specifically, it was mentioned that availability of drugs at the private clinics and the prompt service provided are the main attractions. Asenso-Okyere *et. al.*, (1996)

2.2.3 Financial Accessibility

Access to health services is influenced by direct costs, example services, drugs and supplies, food during hospitalization and indirect cost like transport. When complication occurs, the woman needs to access specialized care at additional cost to her and her family. A poorly equipped facility requires the woman to purchase the necessary drugs herself which imposes unexpected and untenable financial burden on the woman and her family. This often results in the woman going to the facility at a stage when it is too late to treat her (UNICEF, WHO, UNFPA, 1997).

Brieger and colleagues (1994), in their work on the utilization of maternity services by pregnant women in a small Nigerian community, followed 60 Yoruba women through pregnancy to childbirth. They found that although there was a functioning government facility which offered full range of maternity and antenatal services, most of the women did not register for antenatal care until their sixth month of pregnancy or later, and 65% delivered at home.

This behaviour is explained in terms of: fees for delivery services, level of income, cultural beliefs and education. It can be observed that provision of relatively accessible services does not guarantee their use and that other social and cultural considerations must be taken into account.

Similar work was done in Rajshahi District, Bangladesh. The research examined the extent of utilization and factors influencing antenatal care. Of the 810 respondents, 30.1% had antenatal checkups. 69.5% of the women did not have any antenatal checkups for reasons such as absence of complications and the feeling that it was not mandatory to have such checkups, but the most important factor influencing utilization of ANC was low income (Hafez, 1999).

The behaviour of the women in Bangladesh can be compared to those in Ghana. In Ghana, although user charges, especially the cash and carry system for drugs has precluded access for some categories of people to health care, the reactions of both health care seekers and providers to the policy have been mixed (Asenso-Okyere *et al.*, 1996).

The general consensus among health seekers was that the introduction of the charges has led to a reduction in hospital attendance. Asenso-Okyere and colleagues (1996) further observed that, there was a feeling that most people tend to treat themselves when they become ill, or delay going to the hospital for few days under a "wait-and see" strategy. This is usually the case when the sickness is considered to be mild, and therefore not in a state to incapacitate the sick individual.

The women in Bangladesh also behaved in a similar manner. The common denominator for these two groups of women can be attributed to cost of services. Another finding from the above study was that, the negative impact of the user charges was exacerbated by the diminishing role of the extended family as the nucleus family bond gets strengthened. Health care expenses that used to be the responsibility of the whole extended family have now been virtually left with individuals with little or no help from outside the household.

The situation does not only apply to rural communities but some urban centres as well. In a major Teaching Hospital in Benin City in Nigeria, 378 pregnant women initiating antenatal care were interviewed. The results had it that the sixth month was the peak period for the initiation of antenatal care. Late booking due to financial constraints was observed in 25% of the respondents (Gharoro and Igbafe, 2000).

AbouZahr (1997), in a presentation at the Safe motherhood Technical Consultation in Sri Lanka, noted that low utilization rates for maternal health services are caused by a range of factors: costs, including the direct fees as well as the cost of transportation, drugs and

supplies, multiple demands on women's time and women's lack of decision-making power within the family. The poor quality of services, including poor treatment by health providers, also makes some women reluctant to use services. Financial constraint does not only limit women from utilizing maternity services but also sometimes causes delay in seeking health services in agreement with Asenso-Okyere and colleagues (1996).

It was generally made known that people rush to hospitals and clinics when they have an emergency like convulsions, accidents and when a pregnant woman starts bleeding. The responses from participants of focus group discussion indicated that patients now delay more in reporting cases to hospitals and clinics than earlier times when drugs and services were free.

Even though barriers to maternity services are common in developing countries, sometimes however, the socio-economic status does not have effect on maternity services utilization. Griffiths and colleagues (2001) in Maharashtra, India, noted that socio-economic status was not found to be a barrier to service use when women perceived the benefits of the service to outweigh the cost, and when the service was within reasonable distance of the respondent's place of residence.

A large number of women perceived private services to be superior to those provided by the government, although cost often meant they were unable to use them. The provision of services did not ensure that women used them, they had to first perceive them to be beneficial to their health and that of their unborn child. Respondents identified the poor

quality of services offered at government institutions to be a motivating factor for delivering at home.

2.3 SOCIOCULTURAL AND DEMOGRAPHIC FACTORS AFFECTING UTILIZATION OF MATERNITY SERVICES.

International indicators for poor pregnancy outcome are: maternal education, maternal age, number of previous births (parity), first trimester of prenatal care visit and income level. These factors may be associated with traditional cultural beliefs. The traditional cultural belief has been identified in government health reports as an important factor that impacts the health status of women and children (Forbes, 1997).

Ethnic culture and ethnic membership may have more impact on behaviors than perceived barriers or benefits. Results in a study of under-fives in Ghana, supported the placement of ethnicity at the forefront of theories and analysis of child mortality in Africa which incorporate social, as distinguished from entirely epidemiological considerations (Brockerhoff and Hewitt, 2000).

Recently, traditional cultural norms have started to be analyzed in relation to birth outcomes. Advocates for the inclusion of the components of ethnicity have supported the contention that traditional cultural norms are powerful influences on health beliefs, which may also influence health-seeking behaviors (Abotchie, 1997).

The components of ethnicity: group membership, ethnic culture and ethnic membership have been identified in some studies as psychosocial and structural variables which may serve as moderating factors associated with health behaviors. Group membership requires individual conformity to behavioral values of the membership group. The endorsement of services by family members and others significant to the individual has been found to affect the willingness of the individual to use services (Bond, 1965; Lambert, 1962).

Some studies have found that ethnic culture, representing patterns of behavior and beliefs, was previously identified as the most significant component of ethnicity (Keefe, 1992). Severity and susceptibility are components of health beliefs that have been identified in several health belief model studies as important factors in predicting health-seeking behaviors and birth outcomes.

Cultural barriers to health care, relating to the lack of autonomy and decision-making power, often affects women's access to health care. In some areas for example, women are not allowed to leave home unaccompanied, while in others, women are not permitted to be attended by male health care providers. Sometimes the fear of not having her cultural values respected inhibits a woman from accessing the needed healthcare. To eliminate these barriers, health services should be organized in a way that respects women, their culture, religion and beliefs (UNICEF, WHO, UNFPA, 1997).

Men often hold the strings to financial as well as other assets. They decide on what women can do and cannot do, and consequently how they will be treated in many

societies. In order to improve women's health therefore, men must be targeted with Information, Education and Communication (IEC) messages on pregnancy and childbirth to make them aware of their responsibilities (UNICEF, 1999).

Among traditional healers (spiritualists, juju men and herbalists) and midwives in Ghana, several cultural factors have been associated with birth outcomes including: dietary taboos, religious beliefs, superstitions and the use of various indigenous treatments (Marshall, 1989).

Paternal occupation has been used as proxy for income in several studies, as income can be difficult to measure across cultures in developing countries (Caldwell, 1986; Fosu, 1994). This proxy was originally identified as professional, government and military positions. These occupations were believed to contribute to affording the family a higher standard of living and increased access to care by "western" style medical practitioners.

Although foods differ depending upon the particular ethnic group, specific foods are believed by each ethnic group to contain special elements that are needed during the pre and postnatal period. These beliefs are reinforced as desirable behaviors. Different herbs are used in Ghana to make special soups to start the production of breast milk; special types of greens are eaten to stop cramping or unusual blood flow, and other foods are eaten to increase the mother's haemoglobin level (Forbes, 1997).

These beliefs may influence such health-seeking behaviors as the type of health care system to use, the place of delivery (home or hospital), and the type of health care practitioner chosen. Therefore, in order to improve birth outcomes, it is essential to understand socio-cultural health beliefs, the impact they have on pregnant women's health behavior and to determine the effect of these beliefs on birth outcomes (Forbes, 1997).

Demographic characteristics affect utilization of maternal health services worldwide. In Botswana a study to assess the factors associated with non-use of maternal health services was conducted by Letamo and Rakgoasi (2003). They observed that teenagers were less likely to seek prenatal care, to have their babies delivered by qualified persons, and to seek post-natal check-up. From logistic regression analysis, it can be observed that low parity women were less likely to use maternal services. Another finding was that, women with low educational level, those residing in rural areas, and those with low socioeconomic status were less likely to use maternal services.

The story is similar in Ghana where the relative importance of selected characteristics on the use of maternal and child health (MCH) services in rural Ghana was examined. The analyses demonstrated that the use of MCH services tends to be shaped mostly by the level of education, religious background, and region of residence, and partially by ethnicity and occupation (Addai, 1998). Talking of religious affiliation and occupation, Van den Heuvel and colleagues (1999) observed in a rural area in Zimbabwe, in their work on the use of maternity services that; ninety-seven percent of the pregnant women

attended the antenatal care facilities at least once. Seventy-three percent came at least five times or more. Belonging to certain religious groups proved to be the strongest explanatory factor for not attending antenatal care facilities, whereas unemployment and being without a husband were associated with deliveries outside the hospital.

Barbhuiya and colleagues (2001) noted in a study carried out in fourteen selected villages of Gazipur Thana, in Bangladesh that 83% of the respondents received antenatal check-up throughout their last pregnancy. Most of this group (88.5%) received this care from health assistants or family welfare visitors, while only 3.1% received care from graduate doctors. Out of 505 respondents 91.3% was found to have delivered at home while only 8.7% occurred at institutions. Study findings also suggested that there was an association of place of delivery with level of education and family income of the respondents. Also there was association of utilization of antenatal care with level of education and family income of the respondents.

According to the Ghana Statistical Service (1998), data collected on the effect of education on utilization of maternity services showed that; as woman's education increases, the likelihood that she would not receive any antenatal care decreases sharply from 19 percent of births to women with no education to only 3 percent of births to women who have some secondary education. Use of a doctor for antenatal care increases from 17 percent among births to uneducated women to 59 percent of births among women who have some secondary education. Younger women are more likely to use antenatal services than older women. This is especially true with regards to care of

doctors and nurses or midwives. Similarly, lower birth order is associated with greater use of services provided by medically trained health workers. Young women and low parity women are more likely than older, high parity women to deliver at a health care facility. A child born in an urban area is twice as likely to have been delivered at a health facility as a child born in a rural area in Ghana (Ghana Statistical Service, 1998).

Education and other demographic factors continue to influence maternity services in developing countries. Rajna and colleagues (1998) observed in a study carried out in Uttar Pradesh, India that education had direct as well as indirect effects through antenatal care and family formation patterns on neonatal mortality. Maternal education also has a substantial effect on later childhood mortality. The study in the BAK District would come out with findings to either support the assertion or otherwise.

In a related study carried out in rural Bangladesh, findings revealed that the socio-demographic factors such as the age of the woman and occupation of husband had no association with the prevalence of maternal knowledge. The knowledge was much greater among credit forum participants than non-participants, although exposure to the media and the education of women had also played a significant role in raising the level of knowledge. Multivariate analysis suggested that the duration of credit programme participation and exposure to the media were significantly more likely to raise the health knowledge among women when the influence of demographic and socio-economic factors was controlled (Hadi, 2001).

Also, the pattern and determinants of maternity services utilization were studied in a rural community in Nigeria. Of the 488 randomly selected women, 93% registered for prenatal care in a health care institution, only 51% delivered in a health care institution while 49% delivered at home mainly under the care of TBAs. Factors found to be most associated with the use of health institutions for delivery were maternal education and occupation, religion, and occupation of the husband. Maternal age, parity and marital status and place of residence were not significantly associated with the choice between home and institutional delivery (Nwakoby, 1996).

Still on demographic factors, Swenson and colleagues (1996) observed in Vietnam that most pregnant women received prenatal care services from midwives or medical assistants (34.8-51.2%). Less than 5% received prenatal care from a physician. Level of education and utilization of prenatal care were positively associated. Higher parity women were less likely to use prenatal care (47.1% vs. 68.8%), perhaps reflecting that they were more confident about pregnancy and felt less need for prenatal care.

The Ghana Statistical Service (1998) had a similar result with regards to parity. Maternal age did not affect utilization of prenatal care, regardless of parity. Urban women were more likely to use prenatal care than rural women and those living in the provinces where infant mortality was higher than 40/ 1000 live births.

Similar studies in Nigeria and Tunisia on socio-cultural and demographic characteristics can be compared to the ones above. Some characteristics of the booking visit were

studied in a major teaching hospital in Benin City, Nigeria involving 378 pregnant women initiating antenatal care. The results had it that majority of the patients were middle class (52.1%), while 87.5% have a secondary or tertiary education. The mean age of the mothers was 29.7 years, and a mean parity of 1.3. Primigravidae constituted 32% of the patients; the number of mothers booking declined with increasing parity.

The sixth month was the peak period for the initiation of antenatal care. The decision to attend University of Benin Teaching Hospital for antenatal care was taken by the husband alone in 52% of the cases. Late booking because of ignorance was observed in 41.5% of the patients respectively (Gharoro and Igbafe, 2000).

In Tunisia for instance, a survey was conducted on 1190 women who delivered at the maternity ward of the Fattouma Bourguiba University Hospital center in Monastir, to evaluate the coverage rate of prenatal care and to identify the determinants of the correct prenatal follow-up among users of the central maternity ward. 45.8% of the women received adequate prenatal care (i.e., 4 prenatal visits). 14.4% received no prenatal care.

The frequency of adequate prenatal care decreased with age (51.78% for 15-24 years, 45.29% for 25-34 years, and 35.51% for 35 and over; relative risk = 1.34). Based on occupation, mothers who did not work received the least number of prenatal care (40.47% vs. 55.63% for moderate profession and 51.76% for superior profession; RR= 1.36). Women who received the least amount of prenatal care were illiterates (39.89% vs. 53.18% for secondary education and 67.69% for higher education; RR =1.86). Women

whose last pregnancy resulted in poor outcome (foetal death or miscarriage) were more likely to receive adequate antenatal care than those whose last pregnancy had a good outcome (54.7% vs. 33.6%; RR = 1.47). Women who experienced a medical condition during pregnancy were more likely to receive adequate prenatal care than those who had no such problem (53.7% vs. 45.2%). Primiparous women were more likely to receive adequate ANC than multiparous women (55.7% vs. 38.7% for parity 2-4 and 21.7% for parity 5; RR = 1.77). The influence of parity continued even when the researchers controlled for age (Soltani *et al.*, 1993).

In a related work that determined the utilization of ANC and the association between quality of ANC and maternal literacy, occupation, age and parity, in South Kanara district of Karnataka State, the findings indicated that socio-economic status, religion and matriarchal system were significantly associated. Characteristically, those who do not receive any ANC were illiterate, poor, multiparous unskilled mothers over 30 years of age and who lived far away from a medical facility (Chandrashekar, 1998).

Demographic characteristics usually do not operate alone. They occur together with other socio-cultural and socioeconomic factors. Adamu and Salifu (2002), in a rural community in Kano state, in Northern Nigeria, observed in their study that the majority of the women (88%; CI= 81.8-94.2%) in the study area did not attend for antenatal care, and 96.3% had planned to deliver or had delivered at home without a skilled attendant. Major barriers identified were economic, cultural and those related to the women's perception of their condition. Another study carried out by Fatmi and Avan (2002), in

rural Pakistan revealed that, out of the 222 married women selected, 29.3% (65) utilized antenatal care during their last (most recent) pregnancy, and out of them 72.3% (47) received it from the government health care provider. Women whose husbands were in white-collar jobs were utilizing antenatal care services significantly more (AOR = 2.4; 95% CI 1.2-4.6) compared to women whose husbands were in blue-collar occupations. The study found that social status and economic condition of a woman are an important determinant of utilization of antenatal care.

Similar findings were observed in rural Rajasthan, India, where Gupta and Gupta (2000), studied the reasons for the poor uptake of referrals to specialist medical units in a group of 276 women. Of the 276 cases that were referred, 242 (88%) of the women failed to attend for specialist consultation. A range of geographic, cultural and socio-economic factors was identified as influencing decisions to attend referral units.

In much the same way, Magadi and colleagues (2000) showed that delivery care in Kenya is determined by a wide range of factors: socioeconomic and cultural factors associated with the individual woman or her household, her demographic status or reproductive behavior relating to a specific birth, as well as availability and accessibility of health services within her community.

In addition, a significant variation in delivery care behavior is observed between women and between communities, implying that there are unobserved factors within families and communities that have a significant effect on delivery care. The woman or family effect

on delivery care is particularly strong, but varies by distance to the nearest delivery care facility. There are reports indicating a worsening of women's health in transitional rural societies in sub-Saharan Africa. A study was done in Ethiopia, to reflect the health situation of women in a rural area and to address the socio-demographic and cultural factors that have potential influence on the health of women in the context of a low-income setting.

The result had it that: poverty, traditional practices, poor social status and decision-making power, and lack of access to education were among the highly prevalent socio-cultural factors that potentially affect the health of women in Butajira. Though the majority of the women use traditional healers younger women show more tendencies to use health services (Berhane, 2001).

Also Jido and colleagues (2002) carried out a study in a rural area in Kano State. A total of 152 women were interviewed. Women that deliver at the health care facilities were the controls while those that deliver elsewhere were the cases. The results were as follows: 33 (21.7%) delivered at health care facilities, 117 (76.9%) delivered at home, while 2 (1.4%) delivered in TBA houses. The cases were of higher parity ($p=0.007$) and the controls had a higher level of formal education ($p=0.005$). The mother in 47.1% of cases and 6.6% of controls took the decision about the place of delivery. In all other instances, the husband decided. Of the 63 cases that the husband decided, 10 (15.9%) would have decided differently.

2.4 FAMILY PLANNING UTILIZATION

Attitude and Practice of Family Planning

A study to describe the utilization of reproductive health services (family planning, antenatal care, and delivery services) and the socioeconomic determinants for utilization of health services was conducted in rural Vietnam. Altogether 1132 mothers with children under 5 years of age were interviewed about antenatal, delivery, and family planning services utilization during a five-year period. The results had it that: Seventy per cent of the women used contraceptive methods, with the intrauterine device being the most common. The use of the intrauterine device was positively associated with the number of children alive but not with other sociodemographic factors in the mothers. Thirty per cent of the women had attended an antenatal clinic for check (Toan *et al.*, 1996).

Similarly, Younis and colleagues (1995) assessed the patterns of contraceptive use by rural women in Egypt. 1,781 married, sexually active women were involved. They were classified according to the type of contraceptive method used. There were statistically significant differences of method users according to the level of education, occupation, history of pregnancy wastage, time lag between last labour and administration, breast feeding, menstrual characters and the type of last method used.

In a related study however carried out by Ferrinho and colleagues (1991) in Bophuthatswana, South Africa, the results for family planning showed that, 97% of the mothers knew of modern methods of fertility control but only a minority (37%) was using

them. It was also found that maternal education is positively related to utilization of modern methods of fertility control.

Still considering the practice of family planning, Ordonez (1991) analyzed the sociodemographic changes affecting rural Colombian families. The most important determinant of rural fertility decline has been family planning. Between 1969-90, the proportion of rural women using contraception has increased from 10 to 60%. 47% of women in union do not desire more children, with poorly educated mothers of 3 or more children least likely to want more children.

In a similar study by the same author, 7412 household interviews and 8647 individual interviews with women aged 15-49 years were completed. Among all respondents and respondents currently in union respectively, 57.6% and 86.0% had ever used a method, and 39.9% and 66.1% were currently using a method. Among all respondents and respondents currently in union respectively, 52.2% and 78.9% had ever used a modern method and 33.0% and 54.6% were currently using a modern method.

Among women in union, 14.1% currently used pills, 12.4% IUDs, 2.2% injectables, 1.7% vaginal methods, 2.9% condoms, 20.9% female sterilization, .5% vasectomy, 11.5% some traditional method, 6.1% periodic abstinence, 4.8% withdrawal, and .5% others. Equal proportions of rural and urban women were sterilized. The prevalence of female sterilization declined with education and increased with family size. 57.5% of

urban and 47.7% of rural women, 44.0% of illiterate women, 51.8% of women with primary and 57.8% with secondary educations used modern methods (Ordonez, 1991).

According to the GDHS (1998), one in two currently married women reported ever using a contraceptive method, with 38% having ever used a modern method and 31% having ever used a traditional method. The most popular modern method ever used was the pill, followed by the condom. The percentage of currently married Ghanaian women using a FP method as at the time of the survey is 22%. Current use of a modern method is higher (13%) than current use of a traditional method (9%). The most widely used modern method is the pill (4%), followed by injectable and the condom (3 percent each)

2.5 EXPECTATION OF MOTHERS IN THE USE OF MATERNITY SERVICES

In a study to determine the utilization of antenatal and maternity services by 200 mothers of Mbeere District, Kenya, it was found out that the proportion of mothers who utilized health facilities for antenatal and maternity services was 97.5% and 52% respectively (Mwaniki *et al.*, 2002).

The major constraint experienced by mothers included delay in admission to health facility once mothers report in labour, shortage of drugs and essential supplies, lack of commitment by staff, poor quality of food and lack of cleanliness in the health care facilities. Most health facilities in developing countries are faced with similar problems as above, which serve as a barrier to the use of maternity services. The study in BAK district would determine whether this fact holds for the district.

A household survey of Solenzo district of Burkina Faso was carried out in order to study the utilization of trained birth attendants (TBA) versus professional health workers as providers of under fives' clinic (UFC), antenatal (ANC), and maternity care (MC). Overall utilization by the target groups varied between 13 per cent (UFC), 31 per cent (ANC), and 32 per cent (MC). The presence of a village health post did not increase utilization of MCH care. Furthermore, those who did utilize preferred to choose another source of care: the professional midwife for ANC, the traditional 'old woman' for delivery.

The determinants of utilization were assessed. Wrong attitudes of health staff towards patients were one of the major reasons that hampered the use of health facilities. A strong case is made for improvement of quality of care before extension of geographical coverage (Nougara et al., 1994). In the study by Jido and colleagues (2002) already mentioned above, it was also found out that safe and supervised delivery was the reason for health facility delivery in 28 (84.8%). 75.6% were satisfied with the care they had, while only 2 (1.7%) of the cases will have their next baby in hospital. On improvement of attendance 73 (48.0%) wanted hospital staff to be friendlier, 43 (28.6%) wanted improvement in the number and quality of staff and 44 (25.9%) wanted services to be free.

The perception of the quality of the services of a provider is very important in the choice of health care provider. Asenso-Okyere and colleagues (1996) observed that many residents of Kade (one area covered by the study) and its environs prefer to go to a

nearby mission clinic where charges are relatively higher instead of the government-owned Kade Health Centre (which also had a doctor at post) because of the perception that they would receive better quality services at the mission facility than the government facility. Many discussants in the Kwaebibirem district were also not satisfied with the operations of the health centre at Kade.

Their contention was that, apart from being asked to buy some of the drugs from outside, there are no laboratories to help in disease diagnosis. The attitude of health workers has been one of the factors considered by patients in the choice of a health care provider. Many health care seekers have resorted to traditional medicine because both the herbalist and the fetish priest devote a lot of time to the patients and so there is a personal touch to the treatment that is offered. The attitude of health workers in the orthodox system has been an issue that has bothered many health care managers for some time now.

One thing that was clear during the focus group discussions was that, health care seekers in the rural areas have a more positive impression about the prescribers at the health posts and health centres, as opposed to the negative impression from urban health seekers about the health care professionals in the hospitals. Many nice things were said about the medical assistants in the rural communities. Specifically, mention was made of the patience they have in the consulting room, their willingness to respond to emergency calls and their follow up visits to patients who have been detained or admitted (Asenso-Okyere *et al.*, 1996).

2.6 ALTERNATE SOURCE OF HEALTH CARE

Most communities in Ghana have fetish priests and herbalists who provide health care for a number of illnesses. Some of these providers are contacted after the patient had tried in vain to obtain a cure from orthodox medicine providers. However, there are many instances of first visits to fetish priests and herbalists, especially when the cause of the illness is perceived in the beginning to be supernatural.

Some key informants in the Awutu-Efutu-Senya district, during the study by Asenso-Okyere and colleagues (1996), disclosed that because of their belief that every disease is caused by some mishap in the family, many people consult fetish priests when they, or members of their family are sick before they would attempt any other form of treatment. In much the same way, these socio-cultural beliefs affect the utilization of maternity services by pregnant women.

There are also spiritual churches that try to heal diseases through prayers. Some sicknesses are considered by some people to be spiritual in nature, and as such healing is sought through faith, prayers and fasting. It was also revealed through Focus Group Discussions (FGD) that most of these churches were patronized by women and children and so the healing powers of their leaders were stressed more by the women in the discussion groups than the men who seemed to be sceptical about their efficacy.

In many rural communities, the only contact of the inhabitants with modern medicine is through drug peddlers who move from one village to the other to sell drugs. The drug

peddlers also give injections. Either the patient asks for a particular medication, or the drug peddler prescribes the medication based on symptoms that are described to him. Thus the drug peddlers tend to fill a vacuum that exists in the rural areas and provide a convenient service to the inhabitants. Due to several reasons including convenience and quick service, patronage of drug stores and pharmacy shops for consultation on treatment is increasing in many places. Disease symptoms are described to the pharmacist or drug store attendants, who would then suggest the medication to be purchased for treatment.

Some drug stores even provide dressing services for cuts and abrasions and some give injections to patients at the shops. Drug peddlers and drug store operators provide services that are closer to the people and also cheaper than regular health care providers because they do not pay for consultations. In Asuom, nurses were of the view that patients attempt some treatment by buying drugs from the drug stores and come to the health centre only when the condition becomes worse. In other areas like Kade, covered by the study, the nurses thought that people patronized the drug stores in order to avoid the payment of hospital fees (Asenso-Okyere *et al.*, 1996).

In a study done to analyze reasons for use and non-use of antenatal care services and malaria treatment among pregnant women living in rural areas in Uganda, findings are as follows: Parity and distance significantly influenced ANC attendance, but level of education, religion and marital status did not. Malaria as perceived by the pregnant women is common and multiple health service providers are used for its treatment. About 66% of the mothers reported having suffered from malaria during the current pregnancy,

of these, more than half had received treatment outside the formal health delivery system. Self-treatment with drugs bought from ordinary shops was commonly reported. Nearly all women knew about the antimalarial drug chloroquine and 83% thought that it was used for the treatment of malaria (Ndyomugenyi *et al.*, 1998).

Self-medication or self-prescription is widespread among all classes of people. People accumulate knowledge on diseases treatment from previous illnesses or through neighbours and when they or other members of their households get sick of the same disease or show similar symptoms, similar treatment is offered. The treatment may be pharmaceutical or herbal preparations. Sometimes drugs left over from the treatment of a previous disease are used to treat diseases with similar symptoms (Asenso-Okyere *et al.*, 1996).

2.7 PERCEPTION ON THE COST OF CARE

Studies have shown that when fees are increased at government health care facilities, use by the poor decreases (Waddington and Enyimayew, 1989) and that the poor are proportionately less likely to use more expensive medical facilities, such as those provided by missions (Ndeso-Atanga, 2000 and Fosu, 1994). Others have shown that travel is a large portion of the cost of accessing health care in Africa, and that the poor are less likely to use more distant facilities (Gertler and Vander Gaag, 1990).

Economic or financial access refers to factors related to cost of seeking care, obtaining care and following through with treatment. Economic access includes transportation cost,

direct fees paid for care at the health facility and medication and other consumables. It is important to note that, for the poor people in many developing countries, the cost of medicines and transportation often accounts for the majority of the total cost for health care compared to direct fees for service (Katherine and Shaw, 2000).

Economic cost of health care that people face can lead to inappropriate and sometimes dangerous health practices, particularly for the poor. There are many examples of countries where it is common practice for the poor when they are ill, to bypass treatment from a medical provider to avoid paying direct fees and transport cost and go directly to drug stores or traditional health care providers (Katherine and Shaw, 2000).

These observations have led most policy analysts to conclude that the interest of Africa's rural poor are best served by giving priority to the lowest-cost-possible facility close to their homes. The standard view of health seeking behaviour, especially in the developing countries, contributes to a restrictive view of the results of the empirical studies mentioned above (Leonard and Leonard, 2000).

In this view, health centers provide a series of curative interventions to patients who live within their catchment area. When patients suffer from an illness, they evaluate the costs they can expect to incur against their budget constraints (that is the amount they are able or prepared to pay for health care) and if they can afford service, they seek care. Centers of higher quality care are seen as augmenting the utility that patients gain from visiting a center but cannot affect the budget constraint. Thus if a low quality inexpensive center is

not affordable, a high quality more expensive facility is even less affordable. Governments are responsible for providing basic health care at a price that the poor can afford. If price increases lead people to no longer consume this basic good, they are not receiving necessary level of health care (Leonard and Leonard, 2000).

According to the paper by Leonard and Leonard (2000), they held a slightly different view from the existing empirical findings from other people's work already mentioned above. First they reviewed health care as an investment good, and not a normal economic good (Grossman, 1975). When a person falls ill, the purchase of health care can make a substantial difference in their ability to earn, consume and enjoy the fruits of their labour.

The cost of obtaining health care is compared not to the budget constraint, but to the net difference in utility (that is personal benefit) that the consumption of health care can make. Health care improves utility by increasing the chance that a person will recover from an illness. Higher quality health care has a greater impact on the probability of recovery than lower quality health care does.

According to Leonard and Leonard (2000), with perfect capital markets, budget constraints are less likely to be a binding constraint on the health seeking activities of the poor (that is people should borrow to purchase good health care that has a high probability of making them well). Of course capital markets are not perfect, but there is increasing evidence that, health seeking decisions often involved loans or grants from extended families or saving societies activities that improve capital markets (Haile

Mariam, 2000). The view of Leonard and Leonard is somewhat consistent with the empirical evidence mentioned above, but is further supported by the following observations. Although the rural poor of Africa are more likely to go to the less expensive and nearer health care facilities, substantial number of them is also traveling to distant, NGO providers (Ndeso-Atanga, 2000; Haile Mariam, 2000).

CHAPTER THREE

3.0 RESULTS

3.1 ACCESSIBILITY TO HEALTH CARE FACILITY

3.1.1 Distance to Health Care Facility

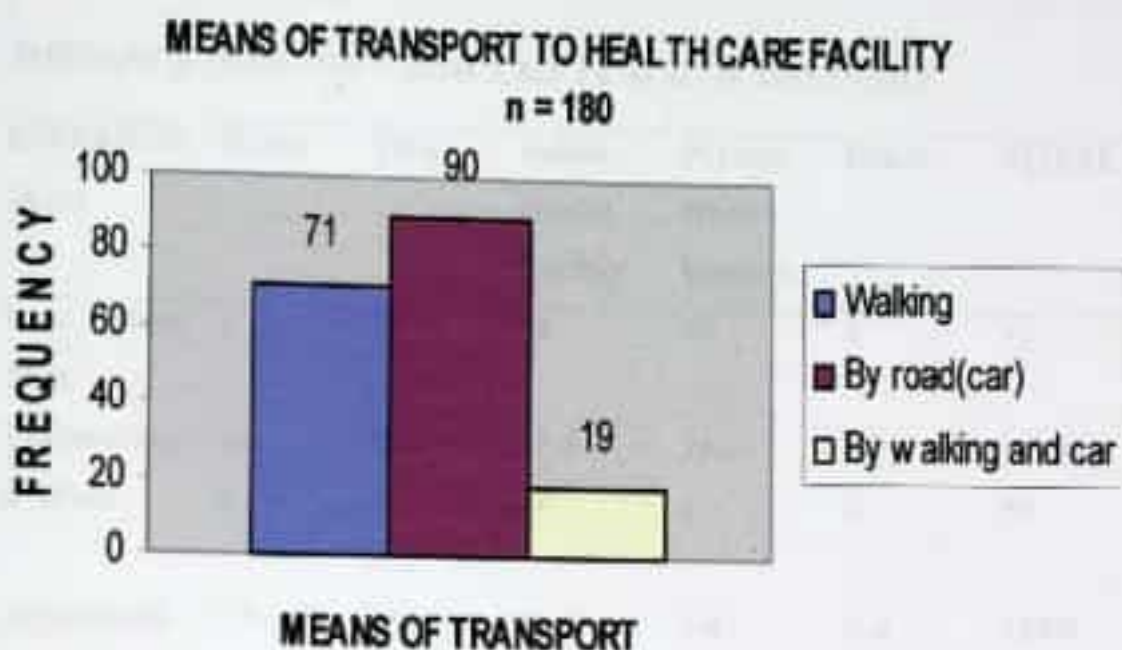
TABLE 3.1a

Distance	Frequency (n=180)	Percentage
Less than 5km	92	51.1
5 – 10km	53	29.4
More than 10km	21	11.7
Don't know	14	7.8
Total	180	100.0

Source: Author, 2004.

Table 3.1a shows the distances from respondents' residences to the nearest healthcare facility. 92 (51.1%) lived at distances less than 5 km from health facility, 21 (11.7%) lived more than 10 km away from healthcare facilities.

Fig. 2



Source: Author, 2004

From Fig 2, majority of the respondents, 90 (50%) accessed health care facilities by making use of vehicle, (71) 34.9% walk to health care facilities.

Whilst 131 (72.8%) said they got to the health care facilities within an hour, 24 (13.3%) said it takes them more than 2 hours to get to health care facilities.

3.1.3 DISTANCE (Km) AND CHOICE OF PLACE OF DELIVERY

TABLE 3.1b

DISTANCE (Km) AND CHOICE OF PLACE OF DELIVERY

DISTANCE (Km)	Home	TBA	Public Health Facility	Private Health Facility	Other	TOTAL
Less than 5km.	7	21	44	12	8	92
Percentage.	7.6	22.8	47.8	13.0	8.7	100.0
5-10km	4	21	24	2	2	53
Percentage.	7.5	39.6	45.3	3.8	3.8	100.0
More than 10km.	0	4	13	0	4	21
Percentage.	0.0	19.0	61.9	0.0	19.0	100.0
Don't Know.	1	5	8	0	0	14
Percentage.	7.1	35.7	57.2	0.0	0.0	100.0
TOTAL	12	51	89	14	14	180
Percentage.	6.6	28.4	49.5	7.7	7.7	100.0

Source: Author, 2004.

From Table 3.1b, it was revealed that 47.8% of respondents living less than 5km away from facilities delivered at public health facilities. 45.3% of respondents living between 5-10km and 61.9% of those who stayed more than 10km away from facilities also delivered at the public health facilities. 14 out of 180 respondents did not know the distance from their residences to the nearest health care facilities.

3.2 SOCIO- CULTURAL AND DEMOGRAPHIC CHARACTERISTICS

TABLE 3.2a Socio-Demographic Characteristics of Respondents (N = 180).

Age of Women		
Age	Frequency	Percentage
15-19	13	7.2
20-24	41	22.8
25-29	37	20.6
30-34	48	26.7
35+	41	22.8
Educational level of Respondents		
Education	Frequency	Percentage
No education	35	19.4
Primary	138	76.6
SSS	2	1.1
Tertiary	5	2.8
Occupation		
Occupation	Frequency	Percentage
Farming	89	49.4
Self Employment	76	42.2
Paid Employment	3	1.7
Unemployed	12	6.7
Number of children born		
Children	Frequency	Percentage
1-3	90	50.0
4-6	63	35.0
7+	27	15.0
Income earned per month		
Monthly income (Cedis)	Frequency	Percentage
Below 200,000	145	80.6
Between 200,000 - 500,000	29	16.1
500,000 and beyond	6	3.3
Marital Status		
Status	Frequency	Percentage
Single	33	18.3
Married	61	33.9
Living-in	72	40.0
Separation	3	1.7
Divorced	11	6.1

Source: Author, 2004.

3.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS:

Table 3.2a shows socio-demographic characteristics of respondents.

On age distribution, the modal class was 30-34 years, with a frequency of 48, this formed 26.7% of the total sample size. The least frequency was 13, found in the age group of 15-19 years, making up 7.2% of the total sample.

On educational level of mothers interviewed, 35 (19.4%) had no education, 138 (76.6%) had had at least primary (basic) level education.

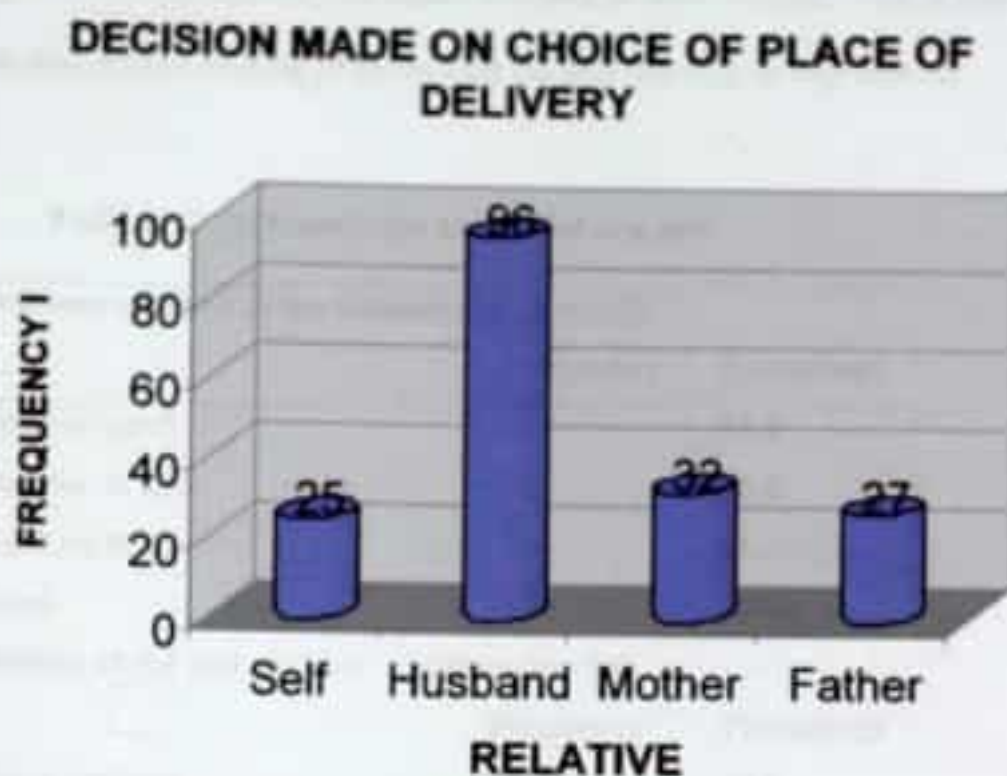
For the occupation of mothers, those into farming were 89, forming the largest percentage of 49.4%, with unemployed respondents being 12 (6.7%) as shown in Table 3.2a above. 50% of respondents had less than four (4) children, whilst those with more than six (6) children were 27 (15%).

Income level of the mothers interviewed showed that 145 (80.6%) earned below £200,000 whilst only 6 (3.3%) earned monthly income of more than £500,000.

For marital status, 133 (73.9%) were in union, 14 (7.8%) were divorced and 33 (18.3%) were single.

On religion, majority, (80%) were Christians. On spouses' education, 34 (18.9%) were uneducated, 17 (9.4%) had secondary education and 22 (12.2%) had tertiary education. Concerning Spouses' occupation, 20 (11.1%) were unemployed, 48 (26.7%) were self-employed, and 69 (38.3%) were farmers.

Fig. 3 Cultural Values and Beliefs.



Source: Author, 2004

Of the 180 respondents, 25 (13.9%) claimed they made their own decisions about choice of place of delivery. 96 (53.3%) said their husbands took the final decision. This is shown in Fig 3 above.

The study also determined respondents' knowledge and belief of a god. Out of 180 respondents, 86 (47.8%) knew or had heard of a god in their villages. This is shown in Table 3.2b below. 33 (38.4%) out of the 86 said the god was held in high esteem.

TABLE 3.2b Knowledge and Belief of a god

Presence of a god in the Community (n = 180)		
	Frequency	Percentage
There is a god	86	47.8
There is no god	73	40.6
Don't know	21	11.6
Total	180	100.0
Ability of the god to "give" children (n = 86)		
	Frequency	Percentage
Gives children	34	39.6
Does not give children	36	41.8
Don't know	16	18.6
Total	86	100.0
Effect of the protection on maternal health services usage (n = 36)		
	Frequency	Percentage
Protection affect utilization	30	83.3
Protection does not affect utilization	6	16.7
Total	36	100.0

Source: Author, 2004.

Out of the 86 who knew of some god, 34 (39.6%) believed the gods were able to "provide" babies for barren women. Of the total number of respondents, 36 (20%) were under some form of "spiritual protection" (e.g. from spiritual church leaders, fetish

priests, native doctors etc.). Out of this number, 30 (83.3%) said it prevented them from using maternity health services and 6 (16.7%) said the protection acquired did not prevent them from using maternity health services (Table 3.2b above).

**TABLE 3.2c EDUCATIONAL LEVEL OF MOTHERS AND CHOICE OF
PLACE OF DELIVERY**

MOTHERS EDUCATIONAL LEVEL	Home	TBA	Public Health Facility	Private Health Facility	Other	TOTAL
None	5	12	9	3	6	35
Percentage	14.3	34.3	25.7	8.6	17.1	100.0
Primary	2	8	12	4	0	26
Percentage.	7.7	30.8	46.2	15.4	0.0	100.0
JSS	4	11	33	6	4	58
Percentage.	6.9	19.0	56.9	10.3	6.9	100.0
SSS	0	0	2	0	0	2
Percentage.	0.0	0.0	100.0	0.0	0.0	100.0
MSLC	2	17	27	2	6	54
Percentage.	3.7	31.5	50.0	3.7	11.1	100.0
Other	0	3	2	0	0	5
Percentage.	0.0	60.0	40.0	0.0	0.0	100.0
TOTAL	13	51	85	15	16	180
Percentage	7.2	28.3	47.2	8.3	8.9	100.0

Source: Author, 2004.

Education of mothers as a socio-demographic characteristic was analyzed with respect to facility utilization. It was observed that, as the level of education increases, the tendency of mothers to use health facilities for delivery also increases.

3.3 UTILIZATION OF MATERNAL HEALTH SERVICES.

3.3.1 Family Planning (FP) Utilization

TABLE 3.3.1a

Type of method Practiced	Frequency (n= 21)	Percentage
Norplant Implant	3	14.3
Depo provera (Injectable)	10	47.6
Pills	8	38.1
Total	21	100.0

Source: Author, 2004.

Current FP practices by respondents showed that: 21 (11.7%) were currently using some form of modern FP method. 159 (88.3%) were not using any FP method. Of the current users of modern FP methods during the survey, 3 (14.3%) used Norplant implant, 10 (47.6%) used injectable, 8 (38.1%) used the pill (Table3.3.1a).

TABLE 3.3.1b Reasons for Stopping FP Use

Reasons	Frequency (n=30)	Percentage
Failure of the method used	5	16.7
Due to complication/side effect	9	30.1
Husband did not agree	3	9.9
Financial reasons	7	23.3
Other	6	20.0
Total	30	100.0

Source: Author, 2004.

Respondents who had ever used some form of modern family planning methods, out of the sample were 30 (16.7%). Reasons for stopping modern FP use were as follows: 5

(16.7%) because of failure of method used; 9 (30.1%) stopped because of perceived side effects and 3 (9.9%), because of spousal disagreement, as shown in Table 3.3.1b above.

Fig.4



Source: Author, 2004.

The findings on reasons for not using current FP methods, as seen in Fig. 4 above were as follows: out of 150 respondents who had never used current FP methods, 48 (32%) attributed it to complications or fear of side effects of the methods; 6 (4.0%) were constrained financially, and a significant number of 70, forming 46.6% had no specific reasons to give

Perception of respondents about the importance of FP revealed the following: out of the total number interviewed, 96 (53.3%) believed it is a good idea; 38 (21.1%) did not believe FP is a good idea and 46 (25.6%) could not made their perception known.

3.3.2 Antenatal Care Utilization

TABLE 3.3.2 Timing and Frequency of Antenatal Visits

First visit to the clinic during pregnancy (N = 180)		
	Frequency	Percentage
1st trimester	109	60.6
2nd trimester	63	35.0
3rd trimester	8	4.4
Frequency of visits to Anti-Natal Clinic (N = 180)		
	Frequency	Percentage
No visit	5	2.8
1-4 times	62	34.4
More than 4 times	103	57.2
As and when necessary	10	5.6

Source: Author, 2004.

Table 3.3.2 above shows that 109 (60.6%) attend ANC within the first trimester and 8 (4.4%) attend within the third trimester.

On the frequency of respondents' visit to ANC clinic, 5 (2.8%) did not attend ANC at all; 62 (34.4%) attended ANC 1-4 times before delivery and 103 (57.2%) had more than 4 ANC visits before delivery.

During ANC, 165 (91.6%) of mothers claimed services were provided by midwives and 15 (8.4%) of respondents claimed they were attended to by doctors.

3.3.3 Health Professionals Present at Delivery

TABLE 3.3.3 Health Professionals who provide care at delivery

Professionals who provides assistance during delivery in the health facility		
	Frequency (n = 180)	Percentage
Doctor	26	14.4
Nurses/Midwife	154	85.6

Source: Author, 2004.

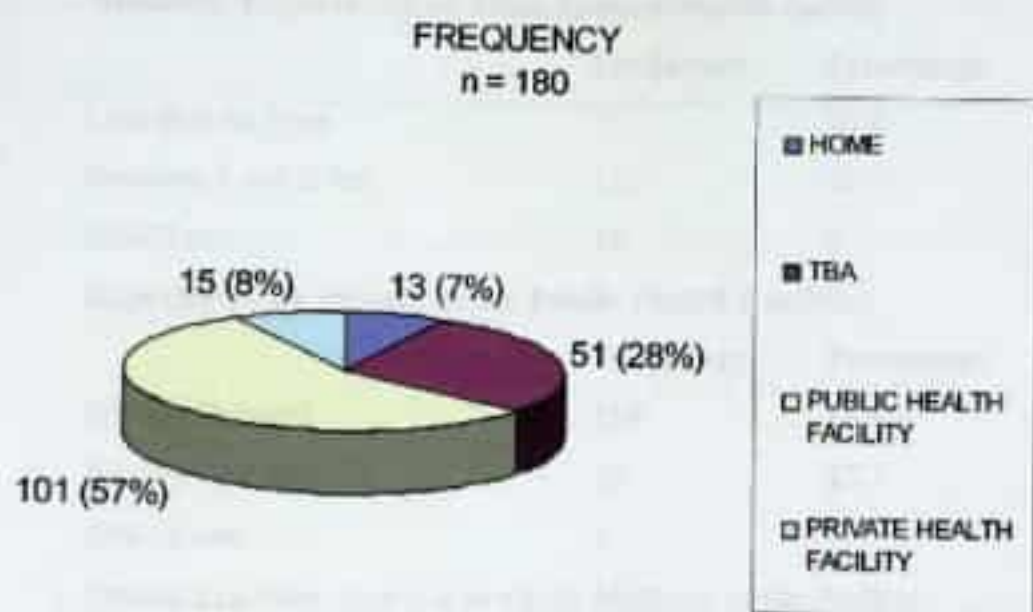
At delivery, 154 (85.6%) of respondents said midwives attended them and 26 (14.4%) claimed they were attended to by doctors.

On importance of ANC to respondents, 166 (92.2%) believed it is beneficial to both mother and baby and 14 (7.9%) did not believe ANC was important.

On the reasons why ANC is important, out of the 166, more than half, that is 90 (54.3%) said the fetus position (lie) is checked and 40 (24.1%) said it is good because drugs are given.

3.3.4 Preferred Place of Delivery

Fig. 5



Source: Author, 2004.

On respondents preferred place of delivery, from Fig. 5 above, 13 (7.0%) preferred to deliver at home; 51 (28.0%) with traditional birth attendants; 101 (57.0%) preferred to deliver at public health facilities and 15 (8.0%) preferred to deliver at private health facilities.

3.4 EXPECTATION OF MOTHERS.

TABLE 3.4.1 Quality of Maternity Care (N = 180).

Mothers' Expectation on Time Spent at health facility		
	Frequency	Percentage
Less than an hour	55	30.6
Between 1 and 2 hrs	113	62.7
Don't know	12	6.7
Expectation on Privacy at the Public Health Facilities		
	Frequency	Percentage
Privacy Ensured	154	85.6
Privacy Not Ensured	23	12.7
Don't know	3	1.7
Health Provider Attitude towards Mothers at the facility		
	Frequency	Percentage
Attitude Cordial, with Respect	153	85.0
Attitude not the Best	17	9.4
Can't tell	10	5.6
Satisfaction with Delivery at Health Care Facility.		
	Frequency	Percentage
Satisfied	142	78.9
Not Satisfied	38	21.1
Total	180	100.0

Source: Author, 2004.

From Table 3.4.1 above, 55 (30.6%) expected to spend less than 1 hour, 113 (62.7%) expects to spend between 1 and 2 hours before leaving the health facility.

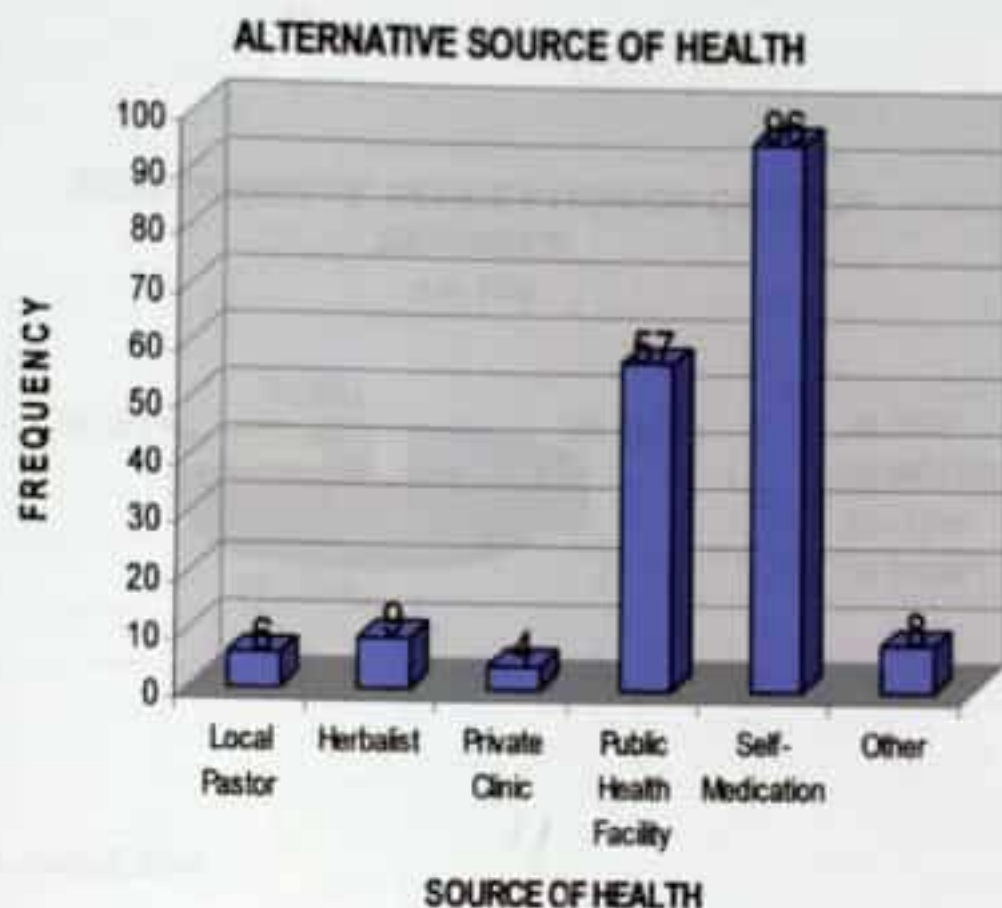
154 (85.6%) were satisfied with privacy at the health facility, 23 (12.8%) were not satisfied with privacy at the health care facility.

Of the 180 respondents interviewed, 153 (85.0%) were satisfied with the attitude of health workers at the health care facilities during ante-natal and delivery services. 17 (9.4%) were not satisfied with health care providers and 10 (5.6%) could not tell or come out boldly to say whether they were satisfied or not.

142 (78.9%) were satisfied with delivery services rendered by health workers. 38 (21.1%) were not satisfied with services rendered, as shown in Table 4.4.1 above.

3.5 HEALTH SEEKING BEHAVIOUR OF MOTHERS

Fig. 6



Source: Author, 2004.

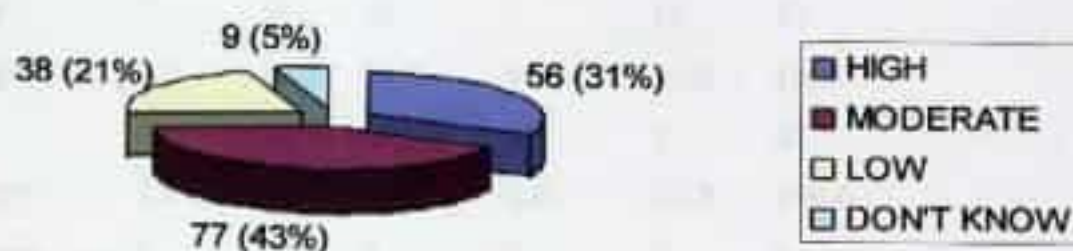
From Figure 6 above, information on the alternative source of health showed that 6 (3.3%) consulted local pastors, 9 (5.0%) consulted herbalist, 96 (53.3%) self-medicated, and 8 (4.4%) consulted fetish shrine.

3.6 PERCEPTION OF RESPONDENTS ON THE COST OF SERVICES

Fig 7

RESPONDENTS' PERCEPTION ON COST OF SERVICES

n = 180



Source: Author, 2004.

Perception of respondents on the cost of services at health care facilities showed the following: 56 (31.0%) believed cost of services was high; 77 (43.0%) believed it was moderate; 38 (21.0%) believed it was low.

TABLE 3.6.1 Table showing Perception on Cost of Services and Choice of Place of Delivery

PERCEPTION ON COST OF SERVICES	PLACE OF DELIVERY					TOTAL
	Home	TBA	Public Health Facility	Private Health Facility	Other	
High	5	15	26	8	2	56
Percentage	8.9	26.8	46.4	14.3	3.6	100.0
Moderate	4	14	42	7	10	77
Percentage	5.2	18.2	54.5	9.1	13.0	100.0
Low	3	18	13	0	4	38
Percentage	7.9	47.4	34.2	0.0	10.5	100.0
Don't Know	1	4	4	0	0	9
Percentage	11.1	44.4	44.4	0.0	0.0	100.0
TOTAL	13	51	85	15	16	180
Percentage	7.2	28.3	47.2	8.3	8.9	100.0

Source: Author, 2004.

From Table 3.6.1 above, 26 (46.4%) out of 56 respondents who claimed fees charged for services was high delivered at public health care facility as against 5 (8.9%) who delivered at home. Also, as many as 18 (47.4%) out of 38 respondents who claimed fees charged for services was low delivered with TBAs as against 13 (34.2%) who delivered at the public health care facility.

CHAPTER FOUR

4.0 DISCUSSION

4.1 Accessibility to Health Care Facilities

The research showed that about 41.1% of respondents lived more than 5km from health care facilities. 51.1% however lived within 5km from health care facilities (Table 3.1a). 92 out of the sample population of 180 lived within 5km of health facilities. Of these, 7 (7.6%) had home deliveries which were supervised by relatives, 21 (22.8%) delivered with TBAs; 44 (47.8%) delivered at the public health facilities; 12 (13.0%) delivered at the private midwives facilities and 8 (8.7%) were respondents who were mainly booked for elective caesarean section and hence had to deliver at other hospitals (Table 3.1b).

Distance from facilities did not have any significant effect on the use of maternal health services. This is because the percentage (7.6%) of respondents living within 5km of facilities who had home deliveries is similar to those living between 5-10 km who also delivered at home (7.5%). Also none of those who lived more than 10km from facilities even had home delivery.

Whilst 21 (22.8%) of those who lived within 5km of facilities delivered with TBAs, 21 (39.6%) of those who lived between 5-10km of facilities and 4 (19.0%) of those living more than 10km away from facilities also delivered with TBAs. From Table 3.1b, there may be a slight increase in percentage that delivered with TBAs, probably due to distance but this was nullified by those living more than 10km from facilities, because it could be

expected that with distance more home deliveries and deliveries with TBAs should have been demonstrated. Reasons usually given for preference in home delivery and/or delivery with TBAs was the support given to women in labour by their relatives and also perceived high cost of care at the health institutions. Many also attributed the reasons for home delivery to unpreparedness as labour sets in, transportation problems and the fact that their progress of labour were short-lived (some claimed they delivered whilst effort were being made to arrange for transport).

The use of Public Health Care Facilities (PHCF) for delivery was encouraging. Whilst 44 (47.8%) of respondents living within 5km used the PHCF especially the District Hospital for delivery, a similar percentage 45.3% of those living 5-10km also used the PHCF for delivery. It is interesting to note that 13 (61.9%) of those who lived more than 10km used the PHCF. This goes to buttress the above point that, irrespective of distance, mothers were doing well in accessing the health care facilities (Table 3.1b). At the National level, 43% of births are delivered in health care facilities (Ghana Statistical service, 1998).

The study done by Mwaniki and colleagues (2002) showed that the utilization of maternity services was significantly influenced by distance to health facility. Mothers living within 5km reached to a health facility more than those living 5km and beyond. This study done in Mbeere District in Kenya, contrasted with the one done at the BAK District in the Ashanti Region of Ghana. Uyirworth and colleagues (1996) assessed the obstetric services utilization in Lebowa, East Africa and found that one of the reasons respondents gave for preference to home delivery was inaccessibility of maternity

services in terms of distance. In BAK, distance did not significantly affect maternity services utilization. Also Brieger and colleagues (1994) followed 60 Yoruba women through pregnancy to childbirth. They found that although there was a functioning government facility sited within reach in a small Nigerian community that provided full range of maternity and antenatal services, most women did not register for antenatal care until the sixth month of pregnancy, and 65% of deliveries occurred at home.

It was concluded in the Yoruba study that provision of relatively accessible services does not guarantee their use and that other socio-cultural considerations must be taken into account. In BAK, it appeared from the study that provision of accessible services relatively ensured their use.

A study that can be compared to the one conducted in BAK District is the one carried out in a rural community in Nigeria by Nwakoby (1996). Of the 488 randomly selected women who had childbirth within 2 years prior to the study, although 93% registered for prenatal care in health care institution, only 51% delivered in a health care institution while 49% delivered at home. It was found out that, place of residence were not significantly associated with the choice between home and institutional delivery.

4.2 Socio-cultural and Demographic Factors

4.2.1 Educational Level of Mothers:

The study took into account the educational level of mothers as a demographic characteristic and choice of place of delivery. From Table 3.2c, mothers who had no education tend to use the home rather for deliveries than the health institutions. Out of the 35 mothers with no education, 5 (14.3%) were assisted at birth by their relatives, 12 (34.3%) were assisted at birth by TBAs, 9 (25.7%) had their deliveries at PHCF and 3 (8.6%) preferred to deliver at private health institutions. 6 (17.1%) had had to deliver outside the district in Kumasi, through referrals, due to various complications in their previous pregnancies.

The trend that is observed is that, as the level of education increases, respondents tend to use health institutions for delivery rather than the home delivery or delivery with TBAs (Table 3.2c). This shows some relationship between level of education of mothers and choice of place of delivery. This is further strengthened by the fact that all the women with secondary education had their deliveries at the PHCF.

The educational level of mothers and utilization of maternity services in the BAK can be compared with the work done in Ghana by Addai (1998). One of the factors considered in the study was choice of place of delivery within the 3 years preceding the 1993 GDHS. The analyses demonstrated that the use of MCH services tend to be shaped mostly by the level of education of the mothers.

The current GDHS (1998) also has it that, women with no education who delivered at health facilities were 24.3% (similar to BAK district study which is 25.7%) and 75.0% delivered at home. For those with secondary education and above, 85.7% delivered at health facilities and 13.7% delivered at home. Ghana Statistical Service (1998) revealed that as woman's education increases, the likelihood that she will not receive any antenatal care decreases sharply from 19% of births to women with no education to only 3% of births to women who have some secondary education. Other related works on maternity services utilization which had educational level as an important factor affecting it includes the ones conducted by Rajna and colleagues (1998) and Barbhuiya and colleagues (2001), as documented in the literature review.

In Peru, Elo (1992) in his study on the hypothesis that maternal education influences the use of maternity services found maternal education had a profound effect on seeking medical care. The lack of access to education was identified, among other socio-cultural and demographic factors that potentially affect the health of women and the utilization of maternal health services in a study conducted by Berhane and colleagues (2001) in Ethiopia.

These works can be compared with the results on level of education and choice of place of delivery in the study done at the BAK District, which showed that the higher the level of education, the more likely the woman would deliver at a health care facility. Celik and Hotchkiss (2000) in their study on the socioeconomic determinants of maternal health

care utilization in Turkey also had educational attainment as one of the significant factors that affect the use of health care services thought essential to reduce infant and child mortality rates.

4.2.2 Cultural Values and Beliefs:

From Table 3.2a, under marital status, it could be seen that 133 respondents were in marital union, though 72 women out of this number were cohabiting. In Fig 3, out of 133 in such marital relationship, 96 (53.3%) claimed their husbands decided the choice of place of delivery for them. In most societies in Ghana, the husband is the head of the household and the breadwinner and as such has a lot of influence on the woman. Traditional cultural beliefs have been identified in government health reports as an important factor that impact on the health status of women and children (Forbes, 1997).

These beliefs may influence such health seeking behaviours as the type of health care system to use, the place of delivery (home or hospital) and the type of health care practitioner to choose (Benter, 1999). From the Focus Group Discussion (FGD), it was realized that those who were single were more likely to be influenced by their relatives (mothers, fathers and other family members).

In a study conducted by Jido and colleagues (2002), involving 152 respondents, in a rural area of Kano State in Nigeria, 33 (21.7%) delivered at health facilities, 117 (76.9%) delivered at home while 2 (1.4%) delivered with TBAs. The mothers in 47.1% out of the

76.9% and 6.6% out of the 21.7% took the decision about the place of delivery themselves. In all other instances, the husband decided. Of the 63 cases that the husband decided, 10 (15.9%) of the wives would have decided differently.

A teenage mother of one, and a JSS graduate had this to say during the FGD;

“When I went into labour, I told my grand mum several times that they should take me to the hospital for safe delivery but she refused and called in the TBA. After several attempts at “pushing” had failed, I started bleeding and I didn’t see anything again. I woke up in a hospital having been operated with blood hanging on me”.

This is a case where the discussant, probably due to her educational level, knew the benefits of the delivery at the health facility but because she was a child, and the fact that she was dependant and also the fact that she had to respect the elders’ decision, in a typical Ghanaian society, she nearly lost her life. In other instances too the endorsement of services by the family members and others significant to the individual has been found to affect the willingness of the individual to use services (Bond, 1965). In the BAK study, 13.9% of the married women however, were able to make their own decision on the choice of place of delivery (Fig.3).

About 86 (47.8%) claimed there was a god in their communities but 33 (38.4%) believed that the said gods were held in high esteem by the communities, and similar number 34

(39.6%) believed the gods can "give" children to infertile women. Of the 180 respondents interviewed, 36 (20%) were actually under some form of "protection" by some supernatural forces through a fetish, a god, deity, native doctors or spiritual church leaders. As gathered from the FGD, the said protection was to provide security for their lives, health, and prosperity and also against perceived evil forces that may attack them with sickness and barrenness. Of these respondents, 30(83.3%) out of the 36 consult their spiritual protectors for medication and rituals when they are pregnant and they are more likely to deliver at home than at health institutions as revealed during the FGD. It can be observed that, a fifth of the total sample size of 180 were under some form of protection by supernatural forces which may influence their decision to seek maternity services.

4.2.3 Family Planning Attitude and Practice:

Mention should also be made of some respondents who believed FP was brought so as to reduce the number of children a woman was destined to bring forth. It was revealed in the FGD that this belief had been one of the reasons for non-use of FP and some had to stop the FP methods they were using when they got to know about this erroneous idea.

21 (11.7%) out of 180 interviewed practised modern family planning methods. With an awareness percentage of 95.6%, the user percentage of 11.7% is inadequate, confirming the district's 2002 Annual Report information. According to the 1998 GDHS, the percentage of currently married Ghanaian women using a FP method at the time of the survey is 22 percent, almost twice the value for the study at BAK District.

In BAK, the most widely used method is Injectable, which is 10 out of the 21 current users (47.6%). This was followed by the Pill (38.1%) and then Norplant (14.3%). According to the 1998 GDHS, the most widely used modern method is the Pill, followed by Injectable and condom. A study conducted by Toan and colleagues (1996) in Vietnam on FP utilization had the following findings, 70% of the total number of 1132 respondents used contraceptive methods, with the intrauterine device being the most common.

A contraceptive prevalence survey was carried out by Ordonez (1991) in Colombia. In all, 8647 individual interviews with women aged 15-49 years were completed. It was found out that among all respondents, and respondents currently in union respectively, 98.2% and 99.7% knew some contraceptive methods, 94.1% and 97.9% knew some source of FP, 57.6% and 86.0% had ever used a method, and 39.9% and 66.1% were currently using a method. These figures compared to the BAK district study shows clearly that FP utilization in BAK is on the lower side and we need to do a lot, as health managers to increase the acceptance rate.

All women interviewed in the study who said they have heard of a method of contraception were further asked if they had ever used a method to avoid or delay pregnancy. 30 out of the 180 respondents (16.7%) had ever used a modern contraceptive method. In the 1998 GDHS, 50% of currently married women reported ever using a contraceptive method with 38% having ever used a modern method. In the study done at

the BAK district, the reasons given for stopping the use of modern FP method was mainly the perceived side effects of the methods used.

Some were also influenced by friends as they (friends) narrated their experiences with methods they had practised previously, sometimes on their own initiatives without consulting the appropriate authorities or through misinformation. These were made known during the FGD. The wide gap between knowledge and ever use of FP could in part be due to the fact that, having heard of a method (defined as knowledge in the GDHS) does not necessarily imply the detailed familiarity with a method that may actually lead to its use.

Moreover, women who are either pregnant or trying to get pregnant may not yet have the need for FP even though they may have the knowledge of it. Some also contended that they had just started bringing forth children and would wish to have their desired number of children before practicing FP. Of the 150 who had never used any FP methods, 70 (46.6%) attributed their non-use to no specific reasons. 32.0% said they were afraid of complications and 8.0% attributed their non-use to fear of premature menopause (Fig. 4). 78.9% of the respondents believed FP is good yet this is not reflected in the practice. There may be some socio-cultural factors within the communities that prevent women from making a free choice of FP.

4.3 Expectation of Care

There seemed to be some satisfaction on the part of respondents with respect to time spent at the health care facility. From Table 3.4.1, 55 (30.6%) expected to spend less than an hour and 113 (62.7%) out of 180 expected to spend less than 2 hours in the public health facilities during ANC visits. One observation noted at the public health facility was that, usually most of the women attending ANC were seen within 2 hours, as the clinic starts at 9 o'clock and closes between 12 noon and 1pm.

Also 154 (85.6%) believed privacy was ensured in the health care facilities during ANC visits and delivery. A similar percentage, 85%, believed that health care providers attitude towards clients was cordial and with respect (Table 3.4.1). An interesting observation during the study was that, most of the respondents praised the resident midwife mainly, and a few of other nurses in BAK district Hospital for their dedication to service and their caring nature and attitudes towards patients. This was also realized during FGD.

From the analysis above, it can be observed that, women's expectations were somewhat met or they were satisfied for that matter. In the study by Mwaniki and colleagues (2002), some of the findings observed were that: lack of commitment by health staff, delay in hospital admission and wrong attitude of health staff towards pregnant mothers among others were the major constraints experienced by mothers and which affected their maternity services utilization.

"Pattern of Hospital deliveries" was a study conducted at OOUTH by Lamina and colleagues (2002) in Nigeria. 72 of the deliveries were booked but percentage of patients who had ANC at the Teaching Hospital and subsequently delivered in OOUTH was 47.6%. Apart from 23.1% that complained about distance, 11% complained about the time wasting attitude of the Teaching Hospital set up.

4.4 Health Seeking Behaviour of Respondents

It was realized that more than half of the respondents 96 (53.3%) practised self-medication, as the first step in seeking health when they get sick (Fig. 6). It is after self-medication has failed that they seek services from health care institutions. During the FGD, it was realized that most respondents believed a lot of their ailments was malaria and body pains from farming activities and therefore if drugs like chloroquine and analgesics like paracetamol and brufen are easily assessible from the community chemical shops, they see no reason why they should waste time and money to journey to health facilities. Most of these drugs were however abused.

From Fig. 6, it is observed that 57(31.7%) of respondents would want to report straight to the health care facility when they fall sick to seek treatment. During the FGD, some mothers saw no reason why they should attend ANC. To them, pregnancy is a natural occurrence and not a disease. In one of the two FGDs carried out, two out of eight discussants had an entrenched position on this.

Similar work was done in Rajshahi District, Bangladesh. The research examined the extent of utilization and factors influencing antenatal care. Of the 810 respondents, 30.1% had antenatal checkups. 69.5% of the women did not have any antenatal checkups for reasons such as absence of complications and the feeling that it was not mandatory to have such checkups (Hafez, 1999).

Asenso-Okyere and colleagues (1996) mentioned in their study that, herbs have been used to treat diseases in Ghana long before the advent of orthodox medicine. Each community visited during his study had fetish priests and herbalists who provide health care for a number of illnesses. There are many instances of first visit to herbalists and fetish priests if the cause of the illness is perceived to be supernatural in the beginning. In BAK, there are quite a number of communities with gods that are worshipped by fetish priests (47.8%), as shown in Table 3.2b. The study showed that 5% and 4.4% of respondents consulted herbalists and fetish priests respectively (Fig. 6).

Some of the reasons given by respondents were that the herbalists takes time to explain things to them and they also sympathized with their conditions and ailments. Asenso-Okyere revealed that, in many rural communities, the only contact of the inhabitants with modern medicine is through drug peddlers who move from one village to the other to sell drugs. Sometimes they give injections. From the FGD of the BAK study, it was realized that the few respondents who claimed the attitude of health workers wasn't the best were more likely to self-medicate and report at health facilities when their sickness are advanced and they happened to be those more likely to deliver at home.

4.5 Perception of Mothers on the Cost of Services

Respondents' perception on cost of services and choice of place of delivery revealed the following: Out of 56 respondents who perceived services to be high, 5(8.9%) delivered at home, 15 (26.8%) delivered with TBAs, 26 (46.4%) delivered in public health care facilities and 8 (14.3%) delivered in private health institutions. It means that, 34 (60.7%) out of 56 respondents who claimed services were high used health care facilities for delivery, as against 8.9% who delivered at home.

Also, out of 38 respondents who perceived fees for services to be low, it should have been expected that most would use the health facilities instead of home or TBAs for delivery but it wasn't so because, 18 (47.4%) delivered with the TBAs whilst 13 (34.2%) delivered at public health care facilities. It can be observed from this study that the perception on cost of services does not affect maternal health services utilization.

Brieger and colleagues (1994), in their work on the utilization of maternity services by pregnant women in a small Nigerian community, followed 60 Yoruba women through pregnancy to childbirth. They found that although there was a functioning government facility which offered full range of maternity and antenatal services, most of the women did not register for antenatal care until their sixth month of pregnancy or later, and 65% delivered at home.

This behaviour is explained in terms of: fees for delivery services, level of income, cultural beliefs and education. This work contrasts the one done in BAK district as cost of

health care did not affect utilization, in terms of choice of place of delivery and ANC attendance.

In agreement with Leonard and Leonard (2000), probably the rural poor in developing countries, and BAK district for that matter, are gradually becoming aware about health as an investment rather than a normal economic good. This is because majority of the discussants were prepared to sell their last property to mobilize funds to treat themselves when they fall sick and it doesn't matter where such cure is sought.

They held in their view, an adage in Akan, translated to mean *"If you have life, you have property"* and hence would go every length within their capacity to source funds to seek health with the help of their relatives.

Asenso-Okyere and colleagues (1996) revealed that, because of the extended family system, formerly monies were mobilized from family members to cater for the sick person. Unfortunately, of late, this is gradually loosing its socio-cultural touch, as the nucleus family bond gets stronger.

Having said this, Ndeso-Atanga (2000) and Haile Mariam (2000) still believe that even though the rural poor of Africa are more likely to go to the less expensive and nearer health facilities, substantial number of them are also traveling to distant health care facilities to seek cure irrespective of cost of services.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATION

5.1 CONCLUSIONS

From the results of the study, the following conclusions were drawn based on the research questions and study objectives.

As far as accessibility to health care facilities was concerned, geographical barriers did not affect maternity services utilization in the study population, as more than half of the respondents (51.1%) lived less than 5km from health care facilities. With respect to means of transport, 39.4% had to walk due to proximity.

On financial accessibility, even though 80.6% of respondents earned monthly income of less than two hundred thousand cedis, their perception on cost of services did not significantly affect ANC attendance and choice of place of delivery.

There seems to be some relationship between the level of mothers' education as a socio-demographic characteristics, and choice of place of delivery, because as level of mothers' education increases, the tendency to utilize health institutions for delivery also increases.

Family planning utilization was found to be low, with only 11.7% of the total sample size currently practicing a modern family planning method.

It was revealed from the study that over 80% of the mothers were satisfied with maternity services provision in terms of privacy ensured and time spent at the facility, attitude of health workers towards pregnant mothers and satisfaction during delivery at the health care facilities.

Health seeking behaviour of mothers was varied. Self-medication was high (53.3%), as most of this category of women believed pregnancy is a natural process and they saw no reason why they should waste time and money at health facilities. Another 33.9% report to health institutions as a first step in seeking health care. The rest consulted herbalists, local pastors or fetish priests.

5.2 RECOMMENDATION

From the conclusions drawn from the results and discussion of the study, the following recommendations were made:

1. The District Health Management Team (DHMT) should intensify health education programmes especially on family planning utilization. The focus should be on disabusing mothers' perception on family planning as the reasons usually given for non-use and discontinuation of use of FP methods mostly centered on wrong perceptions about side effects.
2. The DHMT should device strategies to carry the message of FP to the doorsteps of mothers through frequent outreach visits and possible house-to-house education of mothers to increase coverage.
3. The Ghana Health Service should intensify education on benefits of ANC attendance to the expectant mother and her baby, and the importance of seeking care from trained health professionals at recognized health care facilities. This would go a long way to improve maternal health services utilization.
4. The Ministry of Health should come up with policies to set up maternity waiting shelters in the district for pregnant mothers who are at term to reside. This would decrease the number of home deliveries and especially so for those who would have wished to deliver at health care facilities but due to distance and or the fact that, as some claimed, their labor process was precipitated (short-lived).

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APPENDIX 1

INTERVIEW GUIDE ON UTILIZATION OF MATERNAL HEALTH SERVICES

BOSOMTWE ATWIMA KWANWOMA DISTRICT (BAK-D).

NAME INTERVIEWER:

INTERVIEW NUMBER:

DATE: UNIT AREA:

I) PERSONAL DATA

(Thick as appropriate)

a. How old are you?

- (1). 15 - 19 yrs ☐ (2) 20 - 24 yrs ☐ (3). 25 - 29 yrs ☐
(4). 30 - 34 yrs ☐ (5) 35 +

b. What is your educational level?

- (1) No education [] (2) Primary [] (3) J.S.S []
(4) S.S.S [] (5) MSLC [] (6) Other specify

c. What is your present Occupation?

- (1) Farming [] (2) Trading [] (3) Paid employment []
(4) Not working (unemployed) [] (5) Fish monger []
(6) Seamstress [] (7) Hairdresser []
Other Specify.....

d. Number of children ever born (How many children do you have?)

- (1) 1 - 3 [] (2) 4 - 6 [] (3). 7+ []

e. How much do you earn in a month (estimate)?

- i) Below 200,000 cedis [] (2) Between 200,000 - 500,000 cedis []
(3) 500,000 cedis and beyond. []

f. What is your Marital Status?

(1) Single []

(2) married []

(3) living - in []

(4) Separation []

(5) Divorced []

g) What is your Religion?

(1) Christian []

(2) Moslem []

(3) Pagan []

(4) Other (specify)

IF MARRIED ANSWER (h) and (i)

h) What is your husband's education Level?

(1) No education []

(2) Primary []

(3) JSS []

(4) SSS []

(5) MSLC []

(6) Other specify []

i) What is your husband's Occupation?

(1) Unemployed []

(2) Carpenter []

(3) Tailor []

(4) Farmer []

(5) Mason []

(6) Paid employment []

(7) Artisan []

(8) Apprentices []

(9) Other Specify.....

SOCIO-CULTURAL VALUES AND BELIEFS

a). Who in your family, takes the final decision as far as choice of place of delivery is concerned?

1. Self []

2. Husband []

3. Mother []

4. Father []

5. In-law []

6. Other [] Specify

b) Is there a god in your village? (1) YES [] (2) NO [] (3) DON'T KNOW []

c) Is it held in high esteem? (1) YES [] (2) NO [] (3) DON'T KNOW []

d) Can the god make women pregnant? (Does it give children?)

(1) YES [] (2) NO [] (3) DON'T KNOW []

f) Are there any forms of "protection" given you by any body?

(1) YES [] (2) NO [] (3) DON'T KNOW []

h) If yes, who gives the protection?

g) Does the protection, so acquired, prevent you from using health services?

(1) YES [] (2) NO [] (3) DON'T KNOW []

(II) ACCESSIBILITY TO HEALTH CARE FACILITY

a) How far is it from your resident to the nearest health facility?

1) Less than 5km [] (2) 5 - 10 km [] (3) 10 km +

b) What is your means of transport to the health facility?

(1) Walking [] (2) By road (car only) []

(3) Walking and Use of Vehicle []

c) How much time does it take you to get to the public health facility?

(1) Less than an hour [] (2) Between 1 and 2 hours []

(3) 2 hours and above [] (4) Don't Know []

(III) UTILISATION OF MATERNAL HEALTH SERVICES.

a) When, during pregnancies do you first visit the clinic?

(1) 1st trimester [] (2) 2nd trimester [] (3) 3rd trimester []

b) How many times do you visit Anti-Natal Clinic?

(1) No visit [] (2) 1 - 4 times [] (3) More than 4 times []

(4) As and when necessary []

c) Who takes care of women when they are pregnant in the health facility?

(1) Doctor / Medical Assistant [] (2) Nurses / Midwife []

(3) Other [] Specify.....

d) During delivery, who provides assistance in the health facility?

(1) Doctor [] (2) Nurses / Midwife []

(3) Other specify

e) Do you think antenatal care (ANC) is important?

1) YES [] (2) NO [] Give reasons for your choice

.....
.....
.....
.....

f) Where do you prefer to deliver? Give reason(s).

(1) Home [] (2) TBA [] (3) Public health institution []

(4) Private health institution [] (5) Other specify

REASON(S)

(IV) FAMILY PLANNING UTILISATION.

(a) Have you heard about family planning? (1) YES [] (2) NO []

(b) If yes, what do you know about it?

.....
.....
.....

(c) Do you practice family planning currently? (1) YES [] (2) NO []

(ii) If yes, which method?

.....

(d) Have you practice family planning before? (1) YES [] (2) NO []

(e) Why did you stop practicing family planning? (Answer, if you are past user)

(1) Failure of the method used [] (2) Due to complication / side effects

of the method [] (3) Husband did not agree to it []

(4) Financial reasons [] (5) Other specify

Answer (f) if answer to (e) is NO

(f) Why haven't you practice family planning before?

- (1) Religious reasons [] (2) Due to complications / side effects []
(3) Financial reasons [] (4) Spousal disapproval []
(5) No reason [] (6) other specify

(g) Do you think family planning is good? (1) YES [] (2) NO []

If No why?

(V) EXPECTATION OF MOTHERS / QUALITY OF CARE.

(a) How much time do you want to spend at the health care facilities? (During ANC)

- (1) Less than an hour [] (2) Between 1 and 2 hrs []
(3) More than 2 hrs [] (4) Do not know []

(b) Do you get privacy at the public health facilities?

- (1) YES [] (2) NO [] (3) Do not know []

(c) Do the health workers relate to you nicely at the facility?

- (1) YES [] (2) NO [] (3) Cannot tell []

(d) When in labour, do the health workers regularly assess your progress and give you the necessary support? (1) YES [] (2) NO []

VI ALTERNATE SOURCE (S) OF HEALTH

(TICK AS APPROPRIATE)

a) Where do you go first you when fall sick?

1. See the local pastor for prayers []
2. See the herbalist for herbal treatment []
3. Midwife + Private clinic []
4. Public health care facility []
5. Self-medication []
6. Other, specify

b). Why do you prefer to take that step and not others?

Give reasons for your choice

(VII) PERCEPTION ON COST OF CARE

(a) What do you think about the amount charged for services rendered at the health facility, taking your monthly income into consideration?

(1) High [] (2) Moderate [] (3) Low [] (4) Do not know []

b) Does the amount charged hinder you in anyway from using maternal health services? Give reasons

c) How much do you expect to pay?

(1) Low (< 15000 cedis)

(2) High (> 20000 cedis)

(3) Moderate (15000- 20000 cedis)

APPENDIX II

FOCUS GROUP DISCUSSION GUIDE ON THE UTILIZATION OF MATERNAL HEALTH SERVICES IN THE BOSOMTWE ATWIMA KWANWOMA DISTRICT

INTRODUCTION

The discussants were welcomed as they came in. In all 8 discussants reported for the first FGD and 9 reported for the second FGD.

They were made to feel relaxed. Introduction then followed.

I introduced myself and then my secretary. The importance of the secretary was made known to the discussants. They were assured of the confidentiality of the information that they would give and that we as investigators were there to learn from them and not the other way round. The presence of the Tape Recorder, camera and other tools used in the discussion were also explained.

They were also made to introduce themselves one after the other and their background information, relevant to the topic under discussion, were collected. Rapport was then established and the process began.

1. ACCESSIBILITY TO HEALTH CARE

1.1 Geographical Accessibility

1. In your own estimation how far is the distance from this community to the nearest health care facility?
2. Do you think it is far? What is your means of transport?
3. How much time does it take you to get to the health facility?
4. Is there any difficulty in reaching the facility in times of labour? If so, does the difficulty faced prevent you from using the facility?

1.2 Financial Accessibility

1. What do you think about the fees charged at the maternal health facility?
2. Does the amount charged prevent you from using the services?
3. Is it appropriate for someone to sell all his/her properties to cater for his health?
(Explain).

2.0 Socio-cultural values and Beliefs

1. What are your views about orthodox medical practice?
2. Who is the final decision maker when it comes to choice of place of delivery and why?
3. Is ANC important? Give reasons for your answer.
4. Should a woman with many children still deliver at a health facility or home?
(Discussants should explain their views).
5. Is there a god in this community? If so do infertile women consult it in order to get pregnant?

What is the influence of such a consultation on the woman's health seeking behaviour?

3.0 Family Planning Utilization

1. Is the idea of family planning good or bad? (Explain your answer)
2. If it is good, when is the appropriate time to use the services?
3. Where can the information about family planning be sought?
4. Is it really true that there are a lot of side effects of FP as we've been hearing?
5. Why are people not using modern FP methods?

4.0 Expectation of Mothers

1. What are your expectations as mothers with respect to FP and ANC utilization?
2. What would you say about the attitude of health workers towards their clients?

5.0 Health seeking Behaviour of Mothers

1. What are the other places people go and seek for health services apart from the health care facilities?
2. How do people compare the services at these places to the existing health care facilities?

APPENDIX IIB: FGD SCENES



MAP OF GHANA SHOWING ASHANTI REGION

GHANA



BOSOMTWI ATWIMA KWANWOMA DISTRICT

SCALE 1: 250,000

