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DEPARTMENT OF COMMUNITY HEALTH**



**FACTORS CONTRIBUTING TO LOW UTILIZATION  
OF MATERNAL HEALTH SERVICES IN KUMASI**

**A DISCERTATION SUBMITTED TO THE SCHOOL OF GRADUATE  
STUDIES, (KNUST), IN PARTIAL FULFILMENT  
OF THE REQUIREMENTS FOR THE AWARD  
OF THE MPH DEGREE IN POPULATION AND  
REPRODUCTIVE HEALTH**

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**SEPTEMBER 2007**

**DECLARATION**

**This thesis has been the result of my own field research except where specific references have been made. It has not been submitted towards any degree or being submitted concurrently in candidature for any other degree.**

**I hold the responsibility for the views expressed and the factual accuracy of the contents**

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**DEDICATED**

**TO**

**MY HUSBAND**

**AND CHILDREN**

## ACKNOWLEDGEMENT

I am grateful to the Almighty God for seeing me through this course successfully.

I owe much gratitude to several individuals who have helped me to bring this work to completion.

I am most grateful to my academic supervisor, Professor (Mrs.) Ernestina A. Addy for the encouragement, comments, suggestions and corrections. I owe much gratitude to all my lecturers; Dr Edmond Nii Laryea Browne (Head of Department), Dr E. Otupiri, Dr A.K

Edusei, Mr P. Agyei – Baffour, Mr Addai-Donkor, Dr P.E Karikari, Dr Ellis Owusu

Dabo Mr L.O. Agyare, Dr Tagbor and Dr Mrs Eva Tagoe all of department of community health.

Also Mr D. Asamoah and Dr Osei Kuffour (Computer Sciences).

I also thank my field supervisor Dr Oduro and all staff of Kumasi Metropolitan Assembly (KMA) for their support as well as Dr Opoku Adusei (medical director, Suntreso) and all the staff of Suntreso, Manhyia and Tafo Government Hospital for their unflinching support

Last but not the least are the field assistants who provided data towards the production of this important document.

## DEFINITION OF TERMS

**Access:** The extent to which users can reach and obtain service.

**Maternal Death:** The death of woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of pregnancy from any cause related to or aggravated by the pregnancy or its management, but not from accidental cause.

**Maternal Mortality Rate:** The number of maternal deaths per 100,000 women aged 15 – 49 per year.

**Multi gravida:** A pregnant woman who has had two or more pregnancies.

**Obstetric Complication:** Obstetric complications are defined as haemorrhage, prolonged or obstructed labour, ruptured uterus, post partum, sepsis, pre eclampsia, complications of induced abortion and ectopic pregnancy.

**Quality:** The degree to which a product or service meets the expectations of an individual or group.

**Safe motherhood:** This is the process of achieving conception, going through pregnancy and childbirth and resulting in the birth of a healthy infant while the woman is in the best health.

**Supervised Delivery:** Monitoring and supervision during labour and delivery by a skilled birth attendant.

## ABBREVIATIONS/ACRONYMS

ANC                      Antenatal Clinic.

FGD	Focus Group discussion.
GDHS	Ghana Demographic Health Survey.
GHS	Ghana health Service.
GPRS	Ghana Poverty Reduction Strategy
GSS	Ghana Statistical Survey
JSS	Junior Secondary School
KMA	Kumasi Metropokitan Assembly.
KNUST	Kwame Nkrumah University of Science and Technology.
MOH	Ministry of Health (Ghana).
NHIS	National Health Insurance Scheme.
OPD	Out Patient Department.
PMM	Prevention of Maternal Mortality.
SSS	Senior Secondary School.
TBA	Traditional Birth Attendants.
UNICEF	United Nations Children’s Emergency Fund.
WHO	World Health Organization.
HIV/AIDS	Acquired Immune Deficiency Syndrome
PMTCT	Prevention of Mother to Child Transmission
KATH	Komfo Anokye Teaching Hospital
VCT	Voluntary Counseling and Testing

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## **ABSTRACT**

The primary means of preventing maternal deaths is to provide and increase access to supervised delivery. A greater portion of women attend antenatal clinic yet only a few get quality of care.

Previous research in many developed countries showed that underlying causes of high maternal mortality was related to women not utilizing the existing health facilities.

This research was conducted to determine the factors contributing to the utilization of maternal health services in Kumasi.

The study was descriptive cross- sectional which was qualitative and quantitative in approach.

The data were collected from pregnant women and women with children under one year.

Tools for data collection include structured interview guide and questionnaires. Information was collected on knowledge of danger signs in pregnancy among community members. Categorical variables were analyzed using EPI INFO

The findings of the study revealed that health services are available and that pregnant women are attended to satisfactorily as soon as they get to the hospital. Though cost of service is expensive, few people have registered with the national health insurance scheme. Mothers in the community have a fair idea about complications of pregnancy and labour. Also mothers with education are more likely to be convinced through health education on the need to utilize maternal health care facilities.

Majority of the mothers do not believe in the existence of any traditional beliefs about place of delivery but few said beliefs exist.

Education on national health insurance should be intensified to reach all women in their reproductive ages wherever they are. Ministry of health and Ghana health services (MOH/GIS) should organize workshops on periodic bases to educate nurses and midwives on the need for attitudinal change towards pregnant women.

## **CHAPTER ONE**

### **1.0 Introduction**

#### **1.1 Background**

Millions of women in developing countries face life threatening and other serious health problems related to pregnancy or childbirth. Complications of pregnancy cause more deaths and disability than any other reproductive health problems (EN/UNFPA, 2000).

The number of deaths due to treatable complications of childbirth is tragic. Even though Asia and Africa had an almost equal number of deaths, the risk of maternal deaths is highest by far in Africa, where countries struggle to provide health services for large, dispersed mainly rural populations and the average number of children per woman

is close to six (6). A woman has a 1 in 16 risk of dying in pregnancy or childbirth over her life time, compared to 1 in 94 risk in Asia.

The situation is worse in developing countries like Bangladesh due to inadequate access to modern health services and poor utilization. Despite government serious commitment to deliver health facilities to the doorsteps of common people through innovative approaches, such as Essential Service Package (ESP) the utilization of health services is still far below any acceptable standard.

In Europe where the average number of children per woman is less than two (2) and medical care is readily available, a woman has a 1 in 2,400 risk of maternity related causes (Collymore, 2003).

In Ghana, the high maternal mortality rate remains an indictment on the health status of

women and the general quality of health care service delivery. The recent data available indicated a maternal mortality ratio of 214 per 100,000 live births (GSS, 2003). Most

maternal deaths result from excessive bleeding, infections, hypertensive disorders, obstructed labour or complications from unsafe abortions. Sadly, these complications are

difficult to predict. Nearly half of all maternal deaths in developing countries occur during labour or the post partum period (Majorie, 2003). In many poor countries, getting

to the appropriate health facility is not a problem but receiving prompt treatment (Collymore, 1996). Agencies and governments have to provide Emergency Obstetric Care (EMOC) supported by functioning referral system.

About 99% of deaths today occur in Africa, Asia and Latin America. The question therefore is why do pregnant women die, and what do they die of? They die of obstetric complications that need not be fatal. Most of these complications can be managed successfully in our facilities, but problems like inadequate health facilities, cost of health care, quality of care as well as socio-cultural beliefs more often than not prevent the women from making use of the existing maternal health services, thereby leading to high maternal mortality.

## **1.2 Problem Statement**

Maternal mortality is a worldwide problem. Every minute, a woman dies from complications of pregnancy and childbirth .Somewhere in the world **at least 530,000 people die per year and those who survive about 30% to 50% suffer injury, infection or** disability. Maternal mortality shows the huge disparity between rich and poor countries demonstrating that they could be avoided if resources and services were available (WHO,1996). The number of deaths due to treatable complications of pregnancy and child birth is tragic.

Even though Asia and Africa had an almost equal number of deaths, the risk of maternal death is highest by far in Africa. In Europe, where, the average number of children per woman is less than 2 and medical care is readily available, a woman has a 1 in 2400 risk of dying of maternity related causes ( Collymore, 2003).

The Kumasi Metropolitan Health report of 2006 indicated that 109 maternal deaths were

recorded and out of the 107 audited deaths 51 were residents in the metro, 42 referred from other districts and 14 were of unknown residential addresses.

The percentages of Antenatal Care coverage from year 2000 to 2006 were 90,86.9, 83.6, 79, 63 and 74. The percentage of supervised deliveries from year 2000 to 2006 were 56.6,

54.1, 55.7, 56.2 ,56.2, 44.and 40.8.indicating a downward movement. The exact factors for the cause of these deaths are not clearly defined in some instances, contrary to expectations by the Health directorate of Kumasi, the use of maternal health services is on the decline against a backlog of increasing expenditure in terms of infrastructure etc.

The report also indicated that out of the 29,112 deliveries, 637 were stillbirth, 3,858 were

emergency deliveries and 109 women died (3.8%) (KMA report 2006).

### **1.3 Justification of Study**

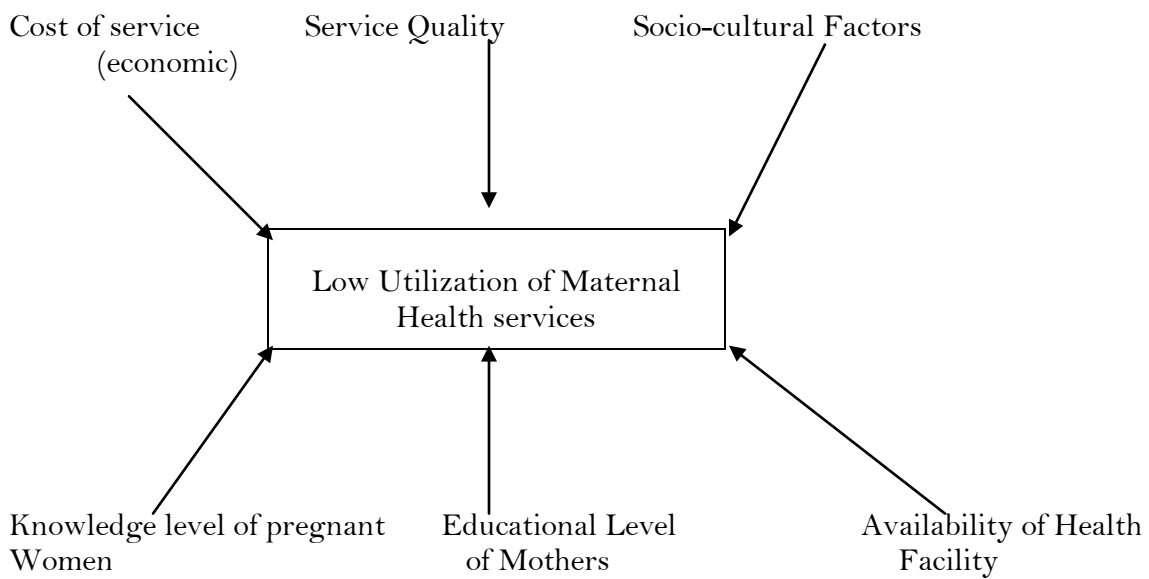
A number of factors contribute to the high maternal mortality rate. The study seeks to examine the factors that influence the use of maternal health care services in the urban communities in Kumasi. It is hoped that the findings of the study will be useful in solving

the problem of low utilization of ANC and supervised delivery services in Kumasi which

in turn will reduce maternal mortality thereby allowing women to stay alive for

themselves and bring up their children in an acceptable way to produce responsible citizens for the nation. Women who are by far more than men in Ghana today contribute immensely towards the development of this nation and so the deaths of these women has a negative repercussions on the nation in terms of nation building and development (GSS, 2006).

#### 1.4.0 CONCEPTUAL FRAMEWORK OF UTILIZATION OF MATERNAL HEALTH SERVICE



#### 1.4.1 Explanation of Conceptual Frame work

Accessibility to health facility, quality of health services, cost of health care, socio-cultural practices, knowledge level of mothers on complications of pregnancy and labour as well as educational level of mothers are some of the factors that bring about low utilization of maternal health services. Nevertheless there are other factors which also bring about low utilization of maternal health services such as delays, ineffective referral

system, geographical access etc.

Improvement in the quality of health care, addressing cost of service by encouraging residents especially women to register with the national health insurance scheme, addressing beliefs and practices that have a negative impact on the health of women, upgrading mothers' level of knowledge on complications of pregnancy and labour as well as encouraging formal education for girls will all lead to patronage of maternal health services in the metropolis. This in turn will result in an increase in the coverage of ANC and supervised delivery in the metropolis.

#### **1.5.0. Research Questions.**

- ◆ Are ANC and delivery services available in the community?
- ◆ What is the quality of services rendered to clients in the health facilities?
- ◆ What are the economic factors contributing to the use of maternal health services (ANC and Delivery) in the community?
- ◆ What are the socio-cultural factors contributing to the use of ANC and Delivery services in the Urban Communities in Kumasi?
- ◆ What is the knowledge level of pregnant women on complications of pregnancy and labour?
- ◆ What is the effect of mothers education on utilization of maternal health services?



### **1.6.0 General Objectives**

To determine factors contributing to the low utilization of maternal health services (ANC,

Delivery) in Kumasi

### **1.6.1 Specific Objectives**

- ◆ To determine the availability of health facilities in the communities
- ◆ To assess the quality of maternal health services. (ANC, Delivery) in Kumasi.
- ◆ To determine the economic factors contributing to the utilization of maternal health services (ANC and Delivery).
- ◆ To determine the socio-cultural factors contributing to the utilization of maternal health services (ANC, Delivery) in the urban communities in Kumasi.
- ◆ To assess the knowledge level of pregnant women on complications of pregnancy and Delivery in the Kumasi Metro
- ◆ To determine the effect of mothers education on the utilization of maternal health services.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

Like any problem in human life, a great deal of research has been done on the area of maternal health.

Maternal mortality is high in Africa with an estimated lifetime risk of maternal death of 1 to 16 and a maternal mortality ratio of about 100 deaths per 100,000 live births (WHO, 2001). Within Africa, Ghana ranks relatively favourably with a maternal mortality ratio of 590 (World Bank, 2002).

According to national estimates, the maternal mortality ratio in Ghana was more than 50% in the past decade, ie. from 500 in 1990 to 214 in 1999 (MOH, 2000). Still even such a level is rather high when compared to the 21 deaths per 100,000 live births for the developed countries. In the developed countries, majority of women obtain good antenatal care and are delivered by skilled personnel, that is midwives, medical doctors and this facilitate early detection of complications that occur during pregnancy and delivery. Prompt and appropriate measures are then put in place to avert maternal and perinatal mortality and morbidity. Only 53% of women in the developing countries give birth with the assistance of a trained midwife or doctor (WHO, 1997).

In Ghana supervised delivery is one of the strategies that the safe motherhood programme intended to reduce maternal mortality and morbidity uses. Even though much effort is

being made to realize this objective, most deliveries still take place in homes by untrained TBAs, relatives and other unskilled people and this sometimes results either in the mother ending up with serious morbidity or death.

The areas of interest in the literature review are:

- ◆ Availability of transport to the service centre
- ◆ Service quality
- ◆ Cost of service
- ◆ Socio-cultural beliefs
- ◆ Knowledge on complications
- ◆ Educational background of mothers

## **2.2 Availability of Health Facilities**

It is well known that the utilization of maternal health services is undoubtedly influenced by the characteristics of the health delivery system such as the availability of the services. However, this does not necessarily mean that, where there is a good supply of services, demand is created in and of itself, which will then lead to increased utilization. Thus there has been a considerable debate in the literature recently as to whether the mere provision of health services will lead to increased utilization (Magadi and others, 2000; Obermeyer, 1993; Basu, 1990). It may be true that, even under the same condition of availability, some women are more likely to use maternal health services than others. If so, characteristics of health delivery system may not be the only explanatory factors for the utilization of maternal health services.

Other factors such as the social structure and characteristics of individuals should also be

considered in promoting the utilization of maternal health services.

Studies on health seeking behaviours have identified the importance of the characteristics

of health services such as the availability of services to the general population in

determining increased utilization (Develay et al, 1996; Becker et al, 1993;

Magadi et al., 2000) The focus of such studies is mainly on the supply side of

services; increasing the availability and accessibility of the health services is sufficient to

increase utilization (e.g. Rosenwein and Shultz, 1982; Elo, 1992, Kumar and others,

1997). However other studies argue that the mere existence of health services is not

enough to lead to better utilization (e.g. Basu, 1990). Since health care is a consistent

choice of individuals, the factors that change women's perception of the available

alternatives and their motivation to seek care need to be understood properly. In the case

of preventive health care such as maternal health services women must realize the

potential benefit of utilizing the services available.

Nepal has one of the highest maternal mortality rates in south Asia. Of the estimated

92700 pregnancies that take place in Nepal every year, 40 percent of the pregnancies are

considered to be highly risky for both the mother and the child (UNICEF, 1996).

Frequent pregnancies and inadequate nourishment of women during pregnancy place

women at high risk during delivery. Furthermore the low availability of maternal health

services during pregnancy increases the risk of expectant mothers. Thus maternal health

services, such as prenatal care, skilled assistance during delivery and post-natal care,

along with adequately equipped health institutions, play a major role in the reduction of

maternal mortality.

### **2.3 Quality of Maternal Health Services.**

Some health care providers do not treat women with respect or spend enough time and attention on them during labour and delivery. Some of the perceptions women have about

health personnel attitude are the following:

- ◆ Health personnel shout at and scold pregnant women
- ◆ They seem to have no time for the expectant mothers when in labour
- ◆ Health personnel look down upon expectant mothers.

A study found that 21% of women delivered at home because of the rudeness of health staff even though delivery in a health facility was safer (Cashin et al, 2002). Many

women describe providers in the formal health care system as rude,

unsympathetic and uncaring. When health workers are perceived to be hostile and unfriendly, many women would rely instead on traditional birth attendants for antenatal,

delivery and post partum care. This can lead to fatal delays in seeking adequate care for pregnancy related complications.

### **2.4 Economic Factors**

In Ghana, a study of women who died of pregnancy – related complications found that 64% of the women had sought help from a herbalist, soothsayer or other traditional provider before going to a health facility. Families cited costs and believed that the woman's condition would improve or that the woman was not ill enough to justify the costs involved as the main reasons for not taking a woman to a hospital (Odoi-Agyarko et

al, 1993).

Women in the rural areas earn little or no income because most rural areas are typically farming communities. Some also engage in selling food stuffs in the market . User fees reduce women's use of maternal health services and keep millions of women from having hospital- based deliveries or from seeking care even when complications arise. Even when formal fees are low or non existent, there may be informal or under the table fees, or other cost that pose significant barriers to women's use of services. These may include cost of transportation, drugs and food or lodging for the women or the family members who help care for her in the hospital. The high cost of seeking help for pregnancy or delivery related complication can deter women from seeking care and have a devastating effect on household budgets when they occur (Borghini et al, 2003).

In a study intended to find out the reasons for women not utilizing delivery services at health facilities in the Nashik District, Maharashtra, India it was observed that the higher incidence of home deliveries in the rural areas was because the women felt it was expensive to deliver at the local health facilities (Griffiths et al, 2001).

A study done in the Asante Akim District of Ghana found that cost of health services is one factor which influence the utilization of health services (Waddington et al, 1989).

With the advent of the national health insurance scheme, many women are now making use of the available health facilities. Maternal health care is virtually free now.

The poorer women are the more likely fees would affect them in the use of health facilities for quality health care. Fees reduce women's use of maternal health services and

keep millions of women from hospital - based deliveries, or from seeking care even when complications arise.

In 2003, Government introduced a policy exempting delivery from user fees. This indicates how financial access or cost of health services constitutes a big problem for most women to access obstetric services. This policy however was implemented in only the four most deprived regions – Central, Northern, Upper East and Upper West Regions

in line with Ghana Poverty Reduction Strategy (GPRS) and Health Sector Five Year Programme of Work (5YPOW) objective to bridge inequalities in health between the regions. However in 2005 government extended the exemption policy to cover all parts of the country.

A study in China showed the importance of financing schemes and their effect on maternal health care. Insurance coverage appears to contribute to a higher utilization of hospital delivery and skilled attendants (Bogg et al, 2002).

In September 2003, the Government of Ghana introduced the policy of exempting users of maternity services from delivery fees in the four most deprived region of the country, which are Central, Northern, Upper West and Upper East Regions. The Policy was later

extended to the remaining six regions of Ghana in April 2005 with the aim of reducing financial barriers to using delivery services. The prospect was that it will lead to an increase in rate of skilled attendance at delivery and consequently to a reduction in maternal and perinatal mortality rate, and also contribute to poverty reduction.

Financial barriers are one of the most important factors or constraints to seeking skilled care during deliveries. In general delivery cost tends to be lumpy and may go up as much

as eight times a household monthly income. The fee exemption policy by reducing these cost, may play a very important role in increasing the rates of skilled attendance and protecting households from making catastrophic payments for maternal delivery and consequently from falling into poverty.

## **2.5 Socio-Cultural Factors**

This deals with social or cultural characteristics, values, beliefs and attitudes that may serve as a catalyst or barrier to services. In some communities in Ghana, vaginal delivery

is recognized as the normal delivery and any other form of delivery is considered as abnormal. A woman who has obstructed labour for instance is accused of being an unfaithful woman in the marital home. It would therefore, not be surprising if family members or community members refuse to help her to the hospital.

A study in Arug District, Uganda revealed that most women (multi gravida) who had successful home delivery believed that health facility delivery was a waste of time. It was also reported that young girls who got pregnant accidentally “shunned” health facilities for fear of being labeled bad mannered girls by doctors and nurses (Amandu, 2004).

Nepal has one of the highest maternal mortality rates in South Asia partly owing to the low utilization of maternal health services (UNICEF, 1996).

It has been argued that changes in women’s status have been the key to differentiate the behaviour of those seeking modern health care from those following traditional practices

(Flores and Hogan, 1990). In general women with low status are less likely to use

modern facilities whereas women with higher status take the initiative in seeking care for

themselves and their children (Caldwell, 1996). It has also been pointed out that



differences in household characteristics influence the utilization of maternal health services (Wickrama and Keith, 1990). This is partly because, in developing countries, the decision to use any kind of health care for women is made at the household level. A woman cannot visit a clinic or hospital without the permission of husband, mother-in-law or the head of the household (WHO, 1989).

Again several studies have found association between women from large families and the use of health care services because of too many demands on their time. Large families also cause resource constraints, which have a negative effect on health care utilization (Wong et al, 1987).

## **2.6 Knowledge of Complications**

There are major medical causes of direct obstetrical death: heamorrhage (25%); complications of unsafe abortion (13%); eclampsia (12%); infection (15%) and obstructed labour (8%). Direct and indirect obstetric deaths account for about 75% and 25% respectively of all maternal deaths in developing countries (WHO, 1997)

At least 40% of women experience complications during pregnancy, childbirth and the period after delivery. An estimated 15 percent of these women develop potentially life-threatening problems (Graham et al, 1997). Long term complications can include chronic pain, impaired mobility, damage to the reproductive system and infertility. Each year almost 8 million stillbirths and early neonatal deaths (deaths within one week of birth) occur. These deaths are caused largely by the same factors that lead to maternal death and

disability – poor health of women during pregnancy, inadequate care during delivery and

lack of new born care (WHO,1997).

In some developed countries, almost all births take place in a hospital and physicians manage normal deliveries as well as complications. In the developing countries the situation differs in that many deliveries occur at home and when complications arise, they

may or may not be recognized and as such women may or may not be taken to a facility where the needed care is available. Home deliveries may be attended by various health workers, by untrained family members, and some women deliver completely alone.

(WHO, 1997).

Women and community members often do not know how to recognize, prevent or treat complications, or when and where to seek medical care. In many parts of the world women's power to make decision ,is limited, even over matters directly related to their own health. Study conducted in Bangladesh revealed that it is usually the mother-in law and the husband who make the decision to seek (or not seek) care for a sick woman.

These people are often the least likely to know about pregnancy – related complications and their possible fatal consequences (MOH, 1997). A study conducted in certain

parts of Accra found that in certain communities where women are considered to be subordinate to men in decision making, women who need care will have to wait for the husband or relation to decide whether or not to take the women to health care facility.

(The PMM network).

In a study conducted in Zambia on (the) cultural childbirth practices and beliefs, the TBAs advised women in labour on the use of traditional medicines. They (TBAs) relied

on traditional beliefs and witchcraft to explain complications of deliveries when (the complications) occurred because of lack of the understanding of causes of obstetric complications and appropriate management of labour and delivery (Maimbolwa et al, 2003).

Many studies have shown the value of medically trained midwives in providing adequate

and accessible care to women in developing countries (de Bernis et al, 2000). Most life-threatening obstetric complications cannot be predicted or prevented, but they can be treated (Maine et al, 2001).

It is important that women of reproductive age, traditional birth attendants and the general population have a good knowledge of the danger signs of in pregnancy. Some of the danger signs in pregnancy are shown in the table below.

**Table 11**

Danger Sign	Complications
Sudden gush of fluid from the vagina two weeks before due date	Premature rupture of the membranes.
Vaginal bleeding	Abruption placenta, placenta previa, lesions of the cervix or the vagina
Temperature above 38oC and chills	Infection
Dizziness, blurring vision, double vision, spots before eyes.	High blood Pressure preeclampsia /eclampsia
Swelling of hands, face, leg and feet	Preeclampsia/eclampsia
Convulsions	Preeclampsia/eclampsia
Absence of foetal heart movement	Maternal medication, obesity, foetal death

Bleeding rate in pregnancy (after six weeks) is a danger sign in pregnancy which may mean the placenta is blocking the birth opening, without expert's help the woman will bleed to death (Werner, 1995). Unsafe abortion and obstructed labour are other serious pregnancy complications that need prompt quality care. Studies in two countries in Cross Rivers State in Nigeria revealed that only very large amounts of blood (e.g. enough to fill a bucket) were said to signal a problem. Witchcraft, internal heat and

the woman's adultery or insolence were believed to be among the causes of haemorrhage.

Other causes cited were retained placenta, frequent childbirth and effect of contraception.

Herbalists and traditional birth attendants (TBAs) were the first choice for help when bleeding occurred (Colanmiran et al, 1997)

## **2.7 Educational level of mothers**

Many would have thought that majority of the women in the Kumasi metro might have formal education thereby influencing positively the utilization of health services in the metro, but it was noted that many could not read or write English especially those who ended their education at primary six. This could affect the utilization of health facility for

delivery. Since they have low education most of them ended up peasant farmers and petty

traders. Education was found to be a strong determinant of female utilization of health services in a related study (Obour, 2004).

It is well recognized that mother's educational background has a positive impact on health care utilization. In a study in Peru using DHS data Elo (1992) found qualitative important and statistically significant effect of mother's education on the use of prenatal care and delivery assistance. In another study, Becker and colleagues (Becker et al, 1993)

found mothers' education to be the most consistent and important determinant of the use

of child and maternal health services. Several other studies also found a strong positive

impact of mothers' education on utilization of health care services (Fosu, 1994; Constello et al, 1996). It is argued that better educated women are more aware of health problems, know more about the availability of health care services, and use this information more effectively to maintain good health status. Mother's education may also serve as a proxy variable of a number of background variables representing higher socio-economic medical status, thus enabling her to seek proper medical care whenever she perceives it necessary.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1 STUDY METHOD AND DESIGN**

Descriptive study type and cross sectional study design (type) were used with both qualitative and quantitative components. The study focused on extracting information directly from subjects with regard to utilization of maternal health services.

##### **3.1.1 Cluster Survey**

The study adopted the WHO EPI cluster survey method because of its usefulness in

measuring other health indicators collected at the district level (WHO 1991). The district

was divided into 213 clusters, with a cluster containing an average of 100 compounds.

Average of 500 people live in a cluster. Using the EPI cluster system, the 213 clusters were organized into 24 new clusters. Twelve (12) women who were either pregnant or nursing a child less than one year were interviewed in each cluster on the day of visit.

The most critical issue for the cluster survey was how to select the first compound (household) when the interview commenced. With the assistance of geographic maps and

people who are knowledgeable about the locality, a bottle was spanned in a central location of each cluster to identify the direction for selection of households (WHO 1991).

After the selection of the first household, snowball method, which use one respondent to identify the next respondent to be included in the study was also employed to speed up the data collection process.

### **3.2 Profile of Study Area.**

Kumasi, Ghana's second biggest city is 300km from the national capital, Accra. It is 150sqkm in size and divided into five sub-metropolitan areas namely Manhyia North, Manhyia South, Asokwa, Bantama and Subin. It has an estimated 2006 population of 1,430, 212 with an annual growth rate of 3.4%. There are 213 communities known in the

metropolis. The main occupation of the citizens are trading and farming. There are 180 private health services 8 public or government health services and 4 quasi- government health services.

Kumasi is bounded by four districts; to the north, Kwabre, on the south Bosomtwe-Atwima Kwanwoma; on the east, Ejisu-Juaben; on the west, Atwima.

Politically Kumasi is divided into ten(10) sub-metropolitan areas namely; Manhyia, Tafo,

Suame, Asokwa, Oforikrom, Asawase, Kwadaso, Nhyiaeso and Subin, but for health service activities, it is sub divided into five(5) sub metros namely; Asokwa, Bantama, Subin, Manhyia North and Manhyia South.

### **3.3 Population/Ethnic Group**

In terms of population, it is the largest of the 21 political districts in the Ashanti region. It

has an estimated 2006 population of 1,430,241 with an annual growth rate of 3.4%.

This figure is however probably applicable during the night since daytime population is above two million. There are 76 communities known in the metropolis.

Since Kumasi is a Cosmopolitan city, it contains members of most major ethnic groups from West Africa, although the indigenous Asante people dominate life in general, especially in commerce and industry. Although these migrant communities maintain their language and cultural identity, Asante Twi is universally spoken and understood.

*Table 1: Population Distribution per Sub-Metro Health Area – 2006*

<b>Sub-Metropolitan Area</b>	<b>% of the Total</b>	<b>Estimated Population</b>
<b>Asokwa</b>	30.3	433,365
<b>Bantama</b>	24.2	346,118
<b>Manhyia South</b>	18.6	266,025
<b>Manhyia North</b>	16.0	228,839
<b>Subin</b>	10.9	155,896
<b>Kumasi</b>	100	1,430,241

### **3.4 Occupation**

The main occupation of the citizens are trading and farming. Adum, central market, kejetia and racecourse are the main trading centres. There are other satellite trading centres located in the various sub metros. The communities at the outskirts of Kumasi do some farming.

### **3.5 Health Services**

The Metropolitan Health Services are organized around 5 sub-metro health teams, namely Asokwa, Bantama, Manhyia North and South and Subin.

There are several health facilities in both the public and private sectors. These include Komfo Anokye Teaching Hospital (KATH), which is one of the two national autonomous hospitals, four quasi health institutions, (4MRS, KNUST Hospitals, Police and Historic Advent Herbal Hospital), two MCH Clinics (Dote and Ayeduase), one Community Clinic (Apatrapa in the Bantama sub-metro) and five government/public hospitals with one designated as a Regional Hospital (Kumasi South Hospital) Awaso clinic started functioning in December 2006. Mesowam, Bobai, Moshie Zongo and Ayeduase clinics are yet to function.

In addition there are 180 known private health institutions in the metropolis. This figure includes 13 industrial clinics.

The breakdown is as below.



**Table 2: Registered Private Institutions per Sub-Metro Health Areas**

Sub-Metro	Gov't Hospital	Quasi Gov't Hops/Clinic	Mission Hospital/Clinic	Private Hospitals	Private Clinics	Mat. Hones	Homeopathic Clinics	Private
Asokwa	1	1	1	14	22	18	3	1
Bantama	1	0	1	15	16	12	0	7
M. North	1	0	1	5	10	16	13	2
M. South	1	0	0	7	8	6	4	2
Subin	1	3	0	3	11	3	0	3
Metro	5	4	3	43	67	55	20	15

### 3.6 Education

#### *Educational Attainment of population 6 years and older – 2000 population census*

◆ Pre-school	-	1.4%
◆ Primary	-	26.5%
◆ Middle/JSS	-	44.4%
◆ Secondary/JSS	-	13.9%
◆ Vocational/Technical/Commercial	-	5.7%
◆ Post Secondary	-	3.5%
◆ Tertiary	-	4.5%

*Table 3 :Distribution of educational Institutions*

Institutions		Manhyia South	Asokwa	Bantama	Manhyia North	Subin
<b>Public Schools</b>	Pre-school	39	35	39	22	20
	Primary	46	54	53	28	30
	J.S.S	33	44	37	22	24
	S.S.S	1	4	8	2	3
<b>Private Schools</b>	Pre-school	71	172	134	94	25
	Primary	64	158	115	91	20
	J.S.S	35	60	67	43	7
	S.S.S	6	5	6	2	2

### **3.7 Safe Motherhood Project**

A series of durbars are held in several communities in Kumasi with the aim of improving access to maternal health services and preventing avoidable maternal deaths.

As part of measures to improve women's health, the Metro Health Directorate organize a

series of activities in a programme called "Saving Women's Lives".

Midwives especially and some other staff are drawn from both public and private institutions sensitize and provided with the message to help with the dissemination.

#### Target Groups

- \* Women's Groups
- \* Policy Makers (Assembly Men/Women And Unit Committee Members)
- \* Traditional Rulers/TBAs
- \* Professional Bodies (GRMA, Teachers)
- \* Religious Leaders
- \* Health Workers
- \* Youth Clubs/School Children etc.

#### Key Messages

1. "The Delays" – Prompt Recognition of Danger Signs/Reporting/Referrals.
2. Birth Preparedness.
3. Abortion and Its Complications
4. Premarital Sex (STIS/Teenage Pregnancy).
5. Family Planning.
6. HIV/AIDS (PMTCT)
7. Importance of National Insurance Schemes

HIV/AIDS and S.T.I.HIV/AIDS continue to be a challenge to health professionals in the metropolis. Prevention of Mother-to-Child-Transmission (PMTCT) and Voluntary Counseling and testing (VCT) activities were carried out at Kumasi South, Suntreso, Tafo, Manhyia, and Maternal and Child Health Hospitals, Bomso Clinic, Aninwaa Medical centre, KNUST Hospitals, Kwadaso SDA Hospital and KATH, Counseling services were given to pregnant women who attended ANC and the general public to know their HIV status.

The main problem is lack of funds to do more sensitization activities, because people refuse to do VCT/PMTCT.

**Table 4. Coverage for PMTCT & VCT**

	<b>INDICATOR</b>	<b>PMTCT</b>	<b>VCT</b>
<b>YEAR 2005</b>	Number Tested	2,500	596
	Number Positive	72	270
<b>YEAR 2006</b>	Number Tested	4,861	1,394
	Number Positive	146	453

**Top Ten (10) Causes of OPD Attendance**

**Table 5**

<b>Diseases</b>	<b>Annual 2005</b>	<b>Diseases</b>	<b>Annual 2006</b>
<b>Uncomplicated Malaria</b>	333,307	Uncomplicated Malaria	242,773
<b>Uncomplicated Malaria Lab Confirmed</b>	66,066	Cough Or COLD (IMCI)	59,442
<b>Cough or Cold (IMCI)</b>	55,583	Skin Disease & Ulcers	31,434

<b>Severe Malaria</b>	47,268	Diarrhoea With No Dehydration	29,340
<b>Skin Diseases &amp; Ulcers</b>	39,746	Home/Occupational Injuries	22,286
<b>Diarrhoea With No Dehydration</b>	30,432	Uncomplicated Malaria Lab. Confirmed	22,145
<b>Hypertension</b>	27,394	Hypertension	17,698
<b>Home/Occupational Injuries</b>	24,202	Acute Urinary Tract Infection	10,125
<b>Rheumatic &amp; Other Joint Conditions</b>	11,735	Severe Malaria	7,666
<b>Diarrhoea With Some Dehydration</b>	9,339	Rheumatic & Other Joint Conditions	6,653
<b>All Other Diseases</b>	122,038	All Other Diseases	74,484

### Top Ten (10) Causes of Admissions

Table 6

<b>Disease</b>	<b>Annual 2005</b>	<b>Disease</b>	<b>Annual 2006</b>
<b>Uncomplicated Malaria</b>	2,373	Uncomplicated Malaria	6,175
<b>Cholera</b>	650	Diarrhoea With No Dehydration	1,758
<b>Severe Malaria</b>	540	Severe Malaria	715
<b>Diarrhoea With No Dehydration</b>	453	Hypertension	607
<b>Uncomplicated Malaria Lab. Confirmed</b>	272	Anaemia	400
<b>Diarrhoea With Some Dehydration</b>	267	Diarrhoea With Some Dehydration	333
<b>Malnutrition</b>	202	Uncomplicated Malaria Lab. Confirmed	328
<b>Hypertension</b>	179	Typhoid fever	324
<b>Typhoid fever</b>	168	Pneumonia	304
<b>Pneumonia</b>	165	Acute Urinary Tract Infections	281

<b>Diseases</b>	<b>Annual 2005</b>	<b>Disease</b>	<b>Annual 2006</b>
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<b>Malnutrition</b>	31	Malnutrition	29
<b>Cholera</b>	21	Uncomplicated Malaria	10
<b>Uncomplicated Malaria</b>	7	Pneumonia	9
<b>Anaemia</b>	4	HIV/AIDS related condition	6
<b>Hypertension</b>	4	Diarrhoea With Some Dehydration	5
<b>Septicaemia</b>	3	Uncomplicated Malaria Lab. Confirmed	4
<b>Uncomplicated Malaria Lab. Confirmed</b>	2	Severe Malaria	4
<b>Severe Malaria</b>	2	Diarrhoea With Severe Dehydration	3
<b>Diarrhoea With Severe Dehydration</b>	2	Hypertension	3
<b>Diabetes Mellitus</b>	2	Malaria with severe Anaemia	2

**TOP TEN CAUSES OF DEATH**

**Table 7.**

National Health Insurance was implemented in all the public facilities in Kumasi metropolis. Revenue accruing from the insurance is around 30% of the total income generated by the public facilities, most of the health insurance schemes therefore still had outstanding claims to be settled to the facilities. The delay in the settlement was seen to be causing financial problems for the facilities. Find outstanding indebtedness, scheme by scheme to facilities in the tables below.

***Table 8: National Health Insurance Indebtedness to some Health Facilities in Kumasi Metro***

Manhyia Hospital	Services Rendered	Amount	Balance
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		<b>Reimbursed</b>	
<b>Manhya Scheme</b>	544,349,968	370,731,430	173,618,538
<b>Bantama Scheme</b>	30757140	9,409,510	21,347,630
<b>Subin Scheme</b>	169,051,710	72,518,730	96,532,980
<b>Asokwa Scheme</b>	212,632,710	129,632,980	83,000,000
<b>Grand Total</b>	956,791,798	582,292,650	374,499,148

<b>Suntreso Hospital</b>	<b>Services Rendered</b>	<b>Amount Reimbursed</b>	<b>Balance</b>
<b>Manhya Scheme</b>	205,042,976	84,314,469	120,728,507
<b>Bantama Scheme</b>	724,473,393	338,269,413	386,203,980
<b>Subin Scheme</b>	74,358,332	19,761,947	54,596,385
<b>Asokwa Scheme</b>	23695,431	3,521,237	20,174,194
<b>Grand Total</b>	1,027,570,132	445,867,066	581,703,066

<b>Tafo Hospital</b>	<b>Services Rendered</b>	<b>Amount Reimbursed</b>	<b>Balance</b>
<b>Manhya Scheme</b>	857,520,452	784,650,139	72,870,313
<b>Bantama Scheme</b>	32,700,694	21,852,801	10,847,893
<b>Subin Scheme</b>	39,434,342	22,930,302	16,504,040
<b>Asokwa Scheme</b>	13,416,239	8,592,259	4,823,980
<b>Grand Total</b>	943,071,727	838,025,501	105,046,226

<b>M.C.H.H</b>	<b>Services Rendered</b>	<b>Amount Reimbursed</b>	<b>Balance</b>
<b>Manhya Scheme</b>	59,235,697	29,995,157	29,240,540
<b>Bantama Scheme</b>	60,344,905	24,080,750	36,264,155
<b>Subin Scheme</b>			0
<b>Asokwa Scheme</b>	36,449,650	21,323,615	15,126,035
<b>Grand Total</b>	156,030,252	75,399,522	80,630,730

<b>KSH</b>	<b>Services Rendered</b>	<b>Amount Reimbursed</b>	<b>Balance</b>
<b>Manhya Scheme</b>			0
<b>Bantama Scheme</b>			0

<b>Subin Scheme</b>			0
<b>Asokwa Scheme</b>			0
<b>Grand Total</b>	476,444,724	209,470,514	266,974,210

<b>S.D.A</b>	<b>Services Rendered</b>	<b>Amount Reimbursed</b>	<b>Balance</b>
<b>Manhya Scheme</b>	463,372,425	367,561,900	95,810,525
<b>Bantama Scheme</b>	1,235,760,149	1,125,343,000	110,417,149
<b>Subin Scheme</b>	185,572,215	119,212,508	66,359,707
<b>Asokwa Scheme</b>	53,796,884	31,461,834	22,335,050
<b>Grand Total</b>	1,938,501,673	1,643,579,242	294,922,431

*Exemptions* – Exemptions in relation to Aged, ANC and paupers were not offered.

However, reimbursement of claims is still outstanding for most of the facilities in the Metropolis (both Public and Private). Find below statement of affairs in respect to the five (5) public facilities.

*Table 9: Exemptions (Maternal and ANC, Aged, Paupers)*

<b>Facility</b>	<b>Mat. Delivery</b>			<b>Exemptions (ANC, Under 5yrs, Aged)</b>		
	Service rendered	Receipt	Outstanding	Service rendered	Receipt	Outstanding
<b>M. North (TH)</b>	85,430,400	81,740,400	3,690,000	0	0	287,964,500
<b>Asokwa (KSH)</b>	406,550,000	378,280,000	28,270,000	0	0	90,978,500
<b>Bantama (SH)</b>	609,172,000	582,682,000	26,490,000	0	0	707,647,560
<b>Manhya South (MH)</b>	533,970,700	533,970,700	0	0	0	319,052,000
<b>Subin (MCHH)</b>	85,540,000	85,540,000	0	0	0	233,992,100

### **3.9 Data collection Techniques and Design**

Quantitative and qualitative study design were employed to collect the primary data.

Face to face interview guide was used.

Five field assistants were engaged in the study.

Secondary information was obtained from the Kumasi metropolitan assembly annual report 2005 and half year report, 2006, and from the various District Health Administration (DHA) in the metropolis.

### **3.10. Study Population**

The study population was made up of pregnant women and women with children under one year who are citizens of Ghana. Tourist and visitors were not included.

### **Study Variables**

Variables for this study are categorized into dependent and independent variables.

**Dependent Variables:** Low utilization of maternal health services.

Independent Variables:

- ◆ Availability of health facilities
- ◆ Quality of health care
- ◆ Cost of health care
- ◆ Socio-cultural factors
- ◆ Knowledge level of mothers on complications of pregnancy and labour
- ◆ Educational level of mothers.

### **3.11. Sampling Techniques and Sample size**

A multi-stage cluster sampling technique comprising cluster sampling, simple random sampling, systematic and convenient sampling were used.

### **3.12 Pre-testing**

A pre-test of the techniques and tools designed to be used to collect the data was done,



this was to identify possible challenges associated with the design, techniques and tools intended to be used. The pre-test communities had similar characteristics as those that was actually part in the study.

All data collection instruments developed were pre-tested at the Komfo Anokye Teaching

Hospital which was not part of the selected hospitals. This was done to determine respondents understanding of the question and the appropriate corrections made before the survey began.

### **3.13 Data Handling and Storage**

The daily administered questionnaires was checked by the coordinator to ensure the completeness and quality of the data collected. The data was entered using EPI-INFO 3.4

and STATA 9.1 software versions. Data entry started after the first week of collection and continued to the end of the survey and was entered twice to improve the quality.

### **3.14 Data Analysis**

Data cleaning preceded the analysis; this was done using SPSS (version 11).

Statistics/data analysis software. Frequencies were generated for all the variables to check

the consistency of the data and outliers. Tables, figures and graphs were generated using

SPSS (version 11) statistical software.

### **3.15 Ethical Considerations**

All subjects were at liberty to participate in the study, however the survey team was minimized to reduce discomfort and inconvenience of the participants . This was

applied to community entry techniques and undertook the activities of the comfort of the

women creating rapport and a suitable atmosphere for the interaction between the field enumerators and respondents

### **3.16 Limitation / Assumptions of Study**

Pregnant women and mothers of children under one year were in their work places such as the farm or market.

## **CHAPTER FOUR**

### **RESULTS**

#### **4.0 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS**

Table 4.0 shows the background of respondents used for the study. About a third (33.8%)

of the women who participated in the study were between 25 – 29 years old while 5% of the mothers were teenagers. About 60% were traders, 19% were unemployed while 2.1% were farmers. For education, about 41.3% were middle or JSS graduates while 9.2% had

no formal education. Majority, (55%) of the respondents were Christians.

**Table 4.0 Background of respondents**

Variables	Frequency (N=240)	Percentage
<b><u>Age</u></b>		
< 20	12	5.0
20 – 24	55	22.9
25 – 29	81	33.8
30 – 34	58	24.2
35 and above	34	14.2
Mean = 28.11; median = 27.5; mode = 27.0, SD = 5.87		
<b><u>Education</u></b>		
No formal education	22	9.2
Primary education	35	14.6
Middle or JSS	99	41.3
Secondary/Vocational	47	19.6
Post secondary	3	1.3
Tertiary	34	14.2
<b><u>Occupation</u></b>		
Farming	5	2.1
Trading	145	60.4
Teaching	16	6.7
Clerical	6	2.5
Artisan	22	9.2
Unemployed	46	19.2
<b><u>Religion</u></b>		
Christian	204	85.0
Islam	34	14.2
Traditional	2	0.8

SOURCE: Field Survey Data, 2007

### Availability of Health Facility

Table 4:1

Variables	Frequency (N = 240)	Percentage
<b>Place for maternal service</b>		
Hospital	216	90.0
Health centre	3	1.3
Maternity Home	11	4.6
Herbalist/Spiritualist	2	0.8

Clinic	7	2.9
Don't use any	1	0.4
<b>Services usually patronised (n = 239)</b>		
Antenatal care	189	79.0
Delivery	4	2.1
Child welfare clinic	46	24.3
<b>Availability of providers (n = 239)</b>		
Providers available	223	93.3
Providers not available	16	6.7
<b>Distance to nearest health facility</b>		
Not far	126	52.5
Far	80	33.3
Very far	34	14.1
<b>Means to the facility</b>		
Foot	61	25.4
By lorry	179	74.6
<b>Any facility of preference for delivery</b>		
Yes	148	61.8
No	75	31.1
Don't know	17	7.1
<b>Type of facility of preference for delivery service (n = 148)</b>		
Hospital	118	79.7
Trained midwife	28	18.9
Don't know	2	1.2
<b>Re-visit the facility (n = 239)</b>		
Yes-will revisit	152	63.6
No- will not revisit	32	13.4
Don't know	55	23.0
<b>24hour service at facility (n = 239)</b>		
Yes	186	77.8
No	17	7.1
Don't know	36	15.1

Table 4:1 is a graphical representation of health facility and providers. 52.5% of respondents said the distance to nearest health facility is not far. 33.3% said the facility is far from their homes while 14.1% said it is very far. Majority of respondents (77.8%) said the nearest health facility provides 24 hour service, and 7.1% said the nearest health facility does not provide 24 hour service.

Fig 1: Availability of service (N = 240)

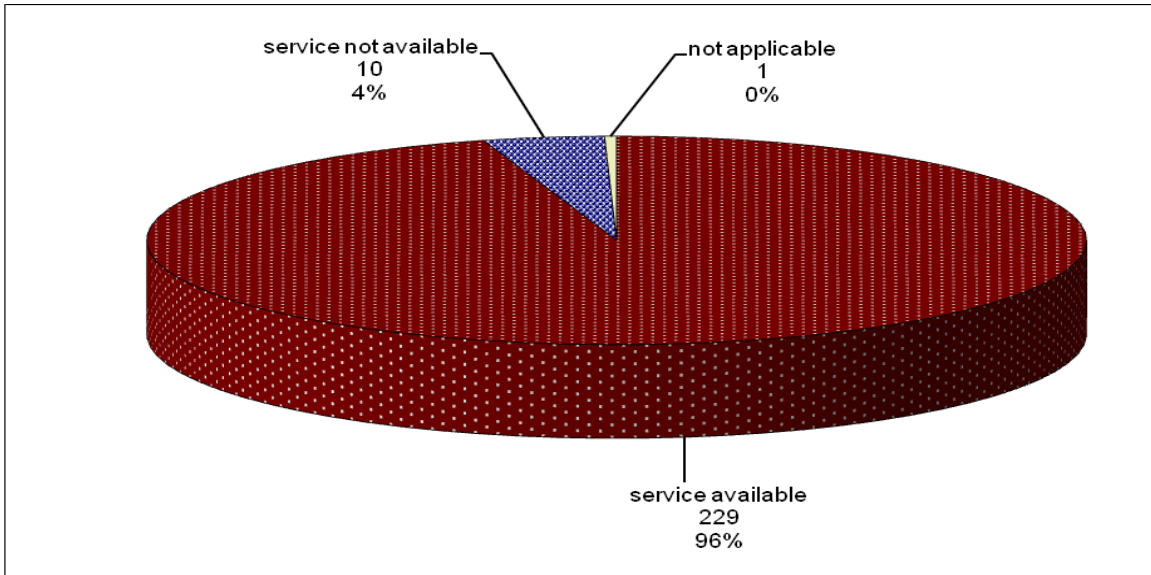
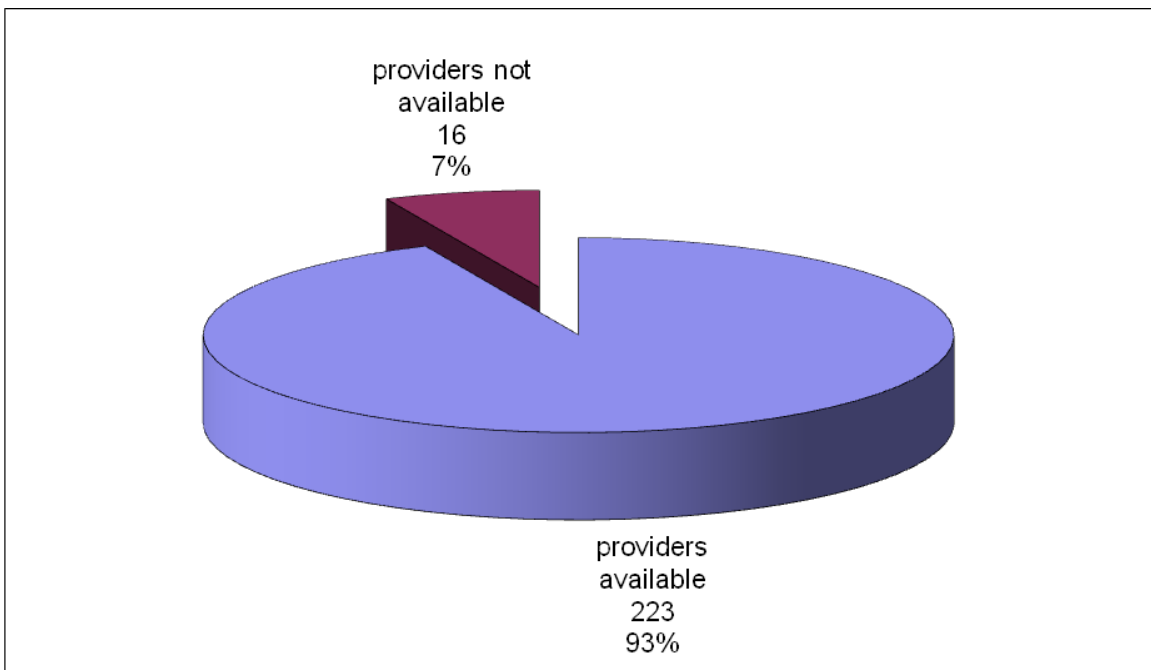
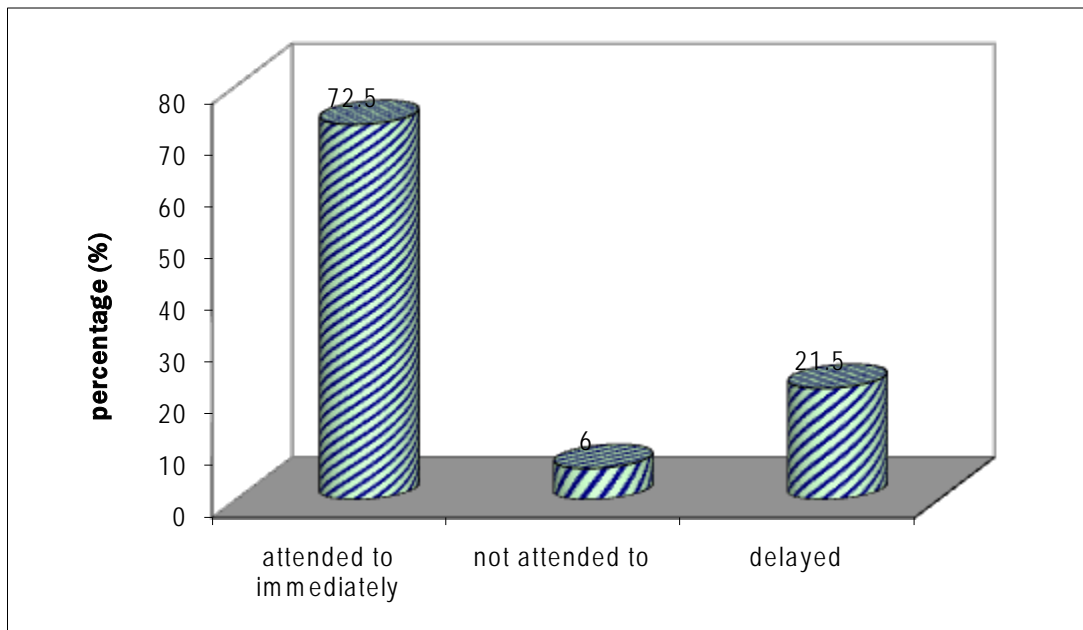


Fig 2: Availability of providers (n = 239)



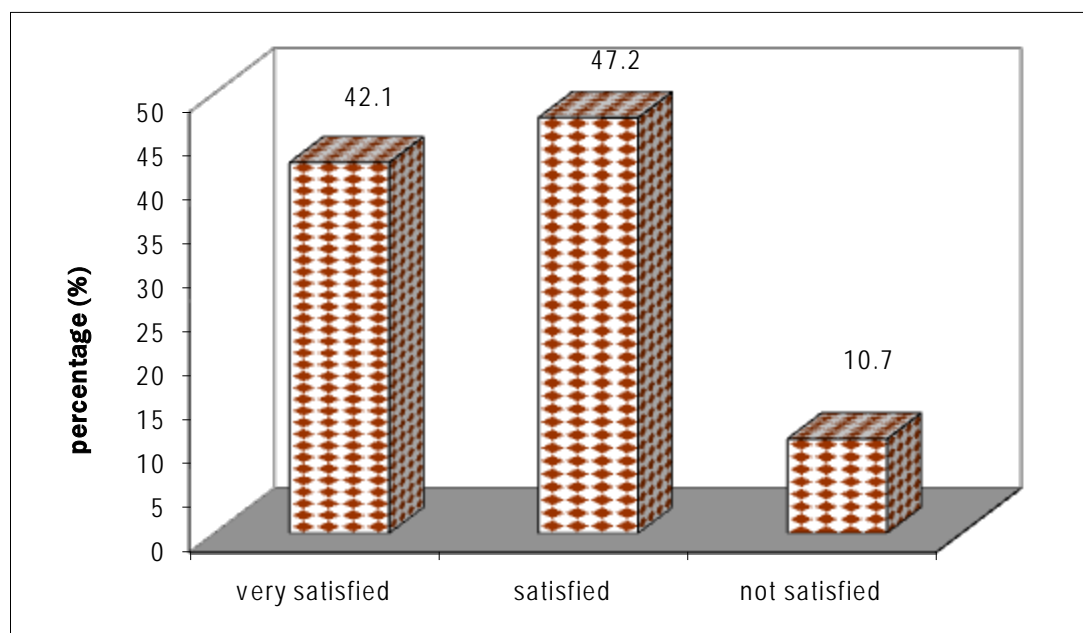
### Quality of Maternal Health Care

Figure 3: Response to clients at visit (n = 233)



SOURCE: Field Survey Data, 2007

Fig 4: Level of satisfaction of services received (n = 233)



SOURCE: Field Survey Data, 2007

**Table 4.2: Quality of services rendered**

Variables	Frequency (N = 240)	Percentage (%)
<b>Place of last delivery</b>		
Hospital	225	93.8
TBA	8	3.3
Spiritualist	4	1.7
Herbal	1	0.4
Home	2	0.8
<b>Attitude of staff (n = 233)</b>		
Very good	108	46.4
Good	77	33.0
Fair	31	13.3
Poor	17	7.3
<b>Re-use this facility (n = 233)</b>		
Yes	184	76.7
No	34	14.2
Don't know	15	6.3
<b>Health worker interacted most (n = 233)</b>		
Doctor	27	11.6

Nurse	151	64.8
Others	55	23.6
<b>Rating of extent interaction (n = 239)</b>		
Maximum	62	26.6
Average	137	58.8
Below average	31	13.3
Minimal	3	1.3
<b>Informed about what is done (n = 233)</b>		
Informed	152	63.3
Not informed	59	25.3
Don't remember	22	9.4
<b>Got all drugs (n = 233)</b>		
Yes	202	86.7
No	31	13.3
<b>Health worker having time for client (n = 233)</b>		
Had time for client	157	67.4
Did not have time for client	57	24.5
Cannot tell	19	8.2
<b>Comment on services at health facility (n = 233)</b>		
Poor attitude of staff	12	5.1
Avoidable delays of clients	24	10.3
Dirty washrooms	56	24.0
Shouting and insulting of clients	45	19.4
Arrogant and rude attitude	34	14.6
Treated well	62	26.6

Figure 4. shows graphical representation of health workers response to clients at visit and client level of satisfaction of service received. Majority, 72.5% of the respondents said they were given immediate attention on arrival at the facility, 21.5% said response was not prompt and immediate, while 6% were not attended to. 42.1% were very satisfied with services received. 47.2% were just satisfied and 10.7% were not satisfied with services rendered.

### **Economic Factors**



Table 4.3 shows transport expenditure spent for delivery and means of financial support.

For transport expenditure, the minimum was ₦500.00 and maximum of ₦50,000.00. For respondents who were not into the national health insurance scheme, 19.7% paid up to ₦5000.00, 22.3% paid over ₦300,000.00 and 25.5% paid between ₦100,000.00 – ₦150,000.00. Only 3.8% of the respondents are on national health insurance, 8.3% depend on family for financial support and 80.4% could not tell their means of financial support.

**Table 4.3**

Variables	Frequency (N = 240)	Percentage %
<b>Transport expenditure</b>		
Mode = 5,000.00; minimum = 1,000; maximum = 50,000		
<b>Amount spent for delivery (n = 157)</b>		
Up to 50,000	31	19.7
50,000 – 100,000	18	11.5
100,000 – 150,000	40	25.5
150,000 – 300,000	33	21.0
300,000 and more	35	22.3
Mean = 103,000.42; SD = 10,123.13		
<b>Means of financial support</b>		
NHIS	9	3.8
Family support	20	8.3
Referred to social welfare	12	5.0
No financial support	6	2.5
Cannot tell	193	80.4

SOURCE: Field Survey Data,2007

## **SOCIO – CULTURAL FACTORS**

Table 4.4 shows respondents beliefs about place of delivery and first point of call when in

labour. Majority, 57.9% did not have any beliefs about place of delivery, 40.8% were not sure about existence of beliefs concerning place of delivery, while 14.6% had beliefs about place of delivery. 65.4% mentioned family members as the first point of call when in labour, 18.8% mentioned a herbalist as their first point of call, 14.6% could not tell their first point of call, while 1.3% said their point of call will be the hospital.

**Table 4.4**

Variables	Frequency (N = 240)	Percentage
<b>Existence of belief about place of delivery</b>		
Belief exist	3	14.6
Belief does not exist	139	57.9
Don't know	98	40.8
<b>Some traditional norms/values relating to maternal health</b>		
Shy to be delivered by males doctors		
<b>Personal beliefs</b>		
Yes	45	18.7
No	84	35.0
Don't know	111	46.3
<b>First point of call when in labour</b>		
Herbalist	45	18.8
Family member	157	65.4
Hospital	3	1.3
Cannot tell	35	14.6
<b>Place that most people deliver in community</b>		
Hospital	177	73.8
TBA	22	9.2
Herbalist	4	1.7
Cannot tell	37	15.4
<b>Some reasons for not delivering at a health facility</b>		
They believe that herbs and concoctions are better than drugs		
Most of them are insulted by the nurses		

SOURCE: Field Survey Data, 2007

### **Knowledge of Complication of Pregnancy and Labour**

Table 4.5. shows the knowledge level of pregnant women on labour and action taken on danger signs in pregnancy. Majority 53% mentioned bleeding as a danger sign of

pregnancy, 42.1% mentioned bodily pains and 20% said high blood pressure. For complications during labour, 42.9% mentioned bleeding, 40.8% said death while 0.8% said pains in the vagina. For actions taken on danger signs in pregnancy, majority 68.8% said they will visit the nearest hospital, 16.2% said they will seek advice while 15% said they will eat good diet.

**Table 4.5.**

Variables	Frequency (N = 240)	Percentage
<b>Danger signs of pregnancy (N &gt; 240)</b>		
Anaemia	75	31.2
High blood pressure	48	20.0
Oedema	59	24.6
Malaria	78	32.5
Bleeding	129	53.7
Loss of liquor	73	30.4
Body pains	101	42.1
<b>Action taken on danger sign on pregnancy</b>		
Visit the nearest hospital	165	68.8
Eat good diet	36	15.0
Seek advice	39	16.2
<b>Complications for not attending ANC</b>		
Death	49	20.4
Anaemia	39	16.2
Congenital malformations	4	1.7
Breech delivery	35	14.6
Post-partum haemorrhage	98	40.8
Don't know	15	6.3
<b>Complications during labour</b>		
Bleeding	103	42.9
Asphyxia	6	2.5
Death	98	40.8
Cephalic-disproportion	5	2.1
Obstructed labour	15	6.3
Maternal distress	11	4.6
Pains in the vagina	2	0.8
<b>Person who deliver in this community</b>		
Midwives	171	71.3
Nurses	45	18.7
Doctors	20	8.3
TBAs	4	1.7

SOURCE: Field Survey Data, 2007

## **CHAPTER FIVE**

### **DISCUSSION**

#### **5.1 Availability of Health Facilities**

Majority (96%) of the respondents indicated that there is availability of health facilities. This may be as a result of the urban nature of Kumasi and the presence of many health facilities (including government and private owned) in the metropolis to cater for the needs of the high population it contains.

#### **5.2.0 Quality of service**

Many (72.5%) of the respondents stated that, they were attended to on time, while few (21%) said they were delayed. This may be due the importance health care providers

attach to caring for pregnant mothers, and the government's request to ensure safe motherhood and bring maternal mortality to barest minimum. The few mothers who were delayed before being attended to may be as a result of increased work load of the health care providers.

### **5.2.1 Level of Satisfaction of Service received.**

Many (47.2%) of the respondents said, they were satisfied with services they received, but few (10.7%) indicated that they were not satisfied. This contradicts a study carried out by Cashin and colleagues, (2002), which found that 21% of women delivered at home because of the rudeness of health staff even though delivery in health facility was safer. Many women described providers in the health care system as rude and uncaring. They rather relied on Traditional Birth attendants for antenatal delivery and post partum care.

### **5.2.2 Attitudes of Staff.**

Many (46.4%) of the respondents stated that the attitudes of the health care providers was very good. This may be as a result of the nature of training they might have received from school in terms of how to provide quality communication with clients as well as provision of support to them in courses such as medical psychology, medical sociology and how they can positively enhance client recovery cooperation and participation.

### **5.2.3 Health Workers having Time for Client.**

Many (67.4%) said health care providers had time for them, whilst less number (57%) of the respondents said, the health care providers did not have time for them. Health care

providers had time for the pregnant mothers (respondent) probably because of importance

they attach to history taken and thorough physical examinations in order to identify any hidden problems pregnant mothers may encounter so that its remedy can be found to avert any birth complications. The few who said ,health care providers did not have time for them is probably as a result of work load on the few health care providers who had to

attend to many clients and for that reason could not spend much time on each client.

### **5.3 Effect of Economic Factors on Utilization of Maternal Health Services.**

More (25.5%) respondents indicated that, they spent between an amount of GH¢10 to GH¢15 (100,000 to 150,000) on delivery while 21.0% of respondents said they spent between GH¢15 to GH¢30 (¢150,000.00 to ¢300,000.00) on delivery. In both situations, they all complained that cost of service is expensive. This is probably because though many (60%) of the respondents are working (trading), economic conditions may not be favourable to them. Besides the respondent may not be enjoying financial support from the spouses because the men may not be employed or simply refused to perform the

economic obligations. They may be single handedly providing for themselves and their children and sometimes other family members. This is attested to by a situation where majority (80.4%) of the respondents could not even tell their means of financial support, apart from their trading and other occupation, some are not able to effectively function or engaged in business because of their state of conditions.(pregnancy)

It is also realized that, out of 240 respondents who were interviewed, only few (3.8) had registered for the NHIS. Therefore they had to bear the cost of health care services themselves. However, if they only registered for the NHIS, complaints about expensive

nature of health care services would have been very minimal.

This is confirmed by a study carried out by Borghi and Colleagues in 2003, which indicated that women in the rural areas earn a little or no income because most live in typically farming communities. Some also may engage in selling of food stuffs in the market. User fees reduced women's use of maternal health services and keep million women from having hospital based deliveries or from seeking care when complications arise. Even when formal fees are low or non existent, there may be informal or under the table fees or other cost that pose significant barriers to the use of health services by women . These may include cost of transportation, drugs and food or lodging for the women or the family members who help care for her in the hospital . The high cost of seeking help for pregnancy or delivery related complications can prevent women from seeking care and have devastating effect on household budgets when they occur.

#### **5.4 Effect of Socio-cultural Factors on pregnant women utilization of Maternal Health Services.**

Many (57.9%) of the respondents stated that, they have no idea of any traditional beliefs concerning place of delivery (hospital/health facilities), whilst a few (14%) said beliefs exist.

This may be due to modernization, advancement in technology and proliferation of the mass media, which are used in carrying out health education on the need for pregnant women to deliver at health facilities to ensure safe delivery. This may be gradually eroding traditional beliefs associated with delivering at the health facilities.

This contradicts a study carried out in Arug district by Amadu 2004, which revealed that, women (multigravida) who had successful home delivery believed that health

facility delivery was a waste of time. It also reported that young girls who got pregnant accidentally “shunned” health facilities for fear of being labeled bad mannered girls by doctors and nurses.

However the few who said they have a traditional belief about place of delivery may be as a result of believing that traditional birth attendants and herbalists at homes are more closer to ancestors and gods, and therefore would effectively enhance safe delivery and prevention of any birth complications.

They also believed that, a woman cannot visit a clinic or hospital without the permission of husband, mother-in-law or the household.

### **5.5 Knowledge of Complications**

More (40.8%) of the respondents said, complications of not attending to ANC is post partum haemorrhage, whilst a few (1.2%) stated it is congenital malformation. Besides, many (53.7%) of the respondents said danger signs of pregnancy is bleeding, while a few (20.0%) stated high blood pressure is a complication. Furthermore, more (42.9%) respondents said, complication during labour is bleeding, while a few (0.8%) said pain in the vagina. Some could mention death, anaemia, loss of liquor oedema, body pain.

Generally their adequate knowledge of complications of pregnancy and labour is probably as a result of the health education they have received during their attendance to

ANC.

This in contravention in a study carried out by WHO 1997, which indicated that, in developing countries many deliveries occur at home and when complications arise, they



may or may not be taken to a facility where the needed care is available. Home deliveries may be attended to by various health workers, by untrained family members and some women deliver completely alone.

### **5.6 Effect of Mothers Educational Level on the Utilization of Maternal Health Services.**

Many (41.3%) respondents educational level was middle or J.S.S. while few (1.3%) had post secondary educational level. Besides, utilization of health facility was very high (93.8%). This may be due to a level of education they have had though they are not highly educated. Such people may be more likely to be convinced through health education on the need to utilize maternal health care facilities. The few (1.3%) who had post secondary educational level may be as a result of the difficulty encountered in convincing such people, probably because they always want to critically analyze situations and facts before they accept them.

This contradicts a study carried out by Constello and Colleagues, (1996) which revealed that, better educated women are more aware of health problems, know more about availability of health care services and use this information more effectively to maintain or achieve good health status.

## **CHAPTER SIX**

### **CONCLUSION AND RECOMMENDATION**

#### **6.1 CONCLUSION**

*Health facilities* in the communities were assessed to be adequate due to the urban nature of Kumasi and seemed to have positive influence on utilization of maternal health services in the metropolis.

Quality of service received by members in the community could be said to be low since more than half were not very satisfied.

*Cost of maternal health* seemed to be high, however, few people have registered with the NHIS which suggest that only few can access the health care facilities in the communities.

Many people do not believe in the *existence of beliefs* about place of delivery. Members of the community are *aware of most danger signs of pregnancy and labour*.

*Most mothers are middle or Junior Secondary School graduates.*

## **6.2 RECOMMENDATIONS**

### *6.2.1 Ministry of Health / Ghana Health Service (MOH /GHS)*

The MOH/Ghana Health Service should organize workshops on periodic basis to educate nurses and midwives on the need for attitudinal change towards teenage mothers. Midwives should learn to be prompt in attending to pregnant women as well as recognize the need to show empathy towards expectant mothers. Education on NHIS should be ongoing and intensified to reach all women in their reproductive ages wherever they are.

The Metro Health Directorate should encourage and also intensify community participation in maternal and child health issues. Such active involvement of the community would go a long way to reduce family influence on pregnancy and delivery issues. The government should put measures in place to ensure that men who put young girls in the family way take full responsibility of the pregnancy. The security and protection of young girls would be guaranteed and this will help young girls who get pregnant to give birth at the hospital.

### **6.2.2 Kumasi Metropolitan Assembly**

They should draw programmes to intensify health education on safe motherhood in the community as well as organize health education programmes on maternal health on the local electronic media (FM radio stations) in order for a wider selection of the population to have access to such programmes.

Consolidation and strengthening of the safe motherhood programme in the school curricula should be done.

### **6.2.3 Ministry of Education**

Formal education for the girl child should continue to equip the girls with meaningful vocation.

The recommendations when implemented would increase the percentage of women who will utilize the health facilities in the communities.

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## APPENDICES

### **INTERVIEW SCHEDULE FOR COLLECTING DATA ON FACTORS CONTRIBUTING TO UTILIZATION OF MATERNAL HEALTH SERVICES IN KUMASI**

#### **RESPONDENTS ASSURED OF CONFIDENTIALITY**

#### **INTERVIEW SCHEDULE FOR COMMUNITY MEMBERS (WOMEN)**

#### **SECTION A - SOCIO - DEMOGRAPHIC DATA**

<b>1. EDUCATIONAL LEVEL</b>	<b>2. OCCUPATION</b>	<b>3. RELIGION</b>
1. No formal Education	1. Farming	1. Christian

2. Primary Education only	2. Trading	2. Islam
3. Middle/JSS	3. Teaching	3. Traditional
4. Secondary/Vocation/Technical	4. Clerical	4. Others
5. Tertiary	5. Artisan	(specify)
6. Other specify	6. Unemployed	
	7. Others	
	(Specify)	

4. Age of respondent .....

5. Ethnicity/Tribe.....

6. How many children do you have? .....

7. Age of your last child.....

**SECTION B - SERVICE AVAILABILITY**

8. Where do you go for maternal health care? .....

9. Are our services available when you need it? Yes  No

10. What service do you usually go for? .....

11. Are service providers available? Yes  No

12. What type(s) of providers do you meet? .....

13. What is the distance between your residence and place of delivery /ANC?

Not far  far  very far

13. How do you get to the facility where you go for antenatal/delivery

Foot  By lorry  other means (specify) .....

14. Is there any facility you would have preferred to deliver?

Yes  No  Don't know

15. If yes, what is that facility?

Trained midwife  Hospital  Trained TBA

16. Would you want to go back to the same facility if given the option?

Yes  No  Don't know

17. Does the nearest health facility provide 24 hour service?

Yes  No  Don't know

**SECTION C - QUALITY OF SERVICES**

18. Where did you deliver your last child?

Hospital  TBA  Spiritualist  Herbalist

19. How early were you attended to on arrival?

Immediately  Not attended to  Delayed

20. What was the attitude of the services provider towards you?

Very Good  Good  Fair  Poor

21. How do you consider the services rendered to you

Very satisfied  Satisfied  Not satisfied

22. Would you want to go back to the same facility given the options.

Yes  No

23. With which health provider did you interact most?

Doctors  Nurse  Lab Tech.  Others

24. How do you rate the extent of the interaction

Maximum  Average  Below average  Minimal

25. Were things explained to you well before been done?

Yes  No  Don't remember

26. Did you get all the prescribed drugs?



Yes  No  other specify.....

27. In your opinion do you think the health provider had time for you (did not appear to be in a hurry)

Yes  No  Don't know

28. How much do you pay for traveling to the health facility?

.....

29. How is a woman in labour supported if she is not financially sound?

.....

30. How much do you pay for delivery/ANC services?

Up to ₦50,000  ₦50 -100,000  ₦100 -150,000  ₦150 - 300,000   
₦300,000 or more

31. Mention anything about the health facility/health worker you did not

like.....

.....

.....

#### **SECTION D - SOCIO CULTURAL**

32. Are there any special norm(s)/values pertaining to maternal health? .....

33. If yes what are some of them.....

34. Traditionally how are issues related to maternal health handled? .....

35. Do you think they are effective? .....

36. Are there some personal beliefs that are associated with where one delivers

Yes No Don't know

37. Where will be your first point of call when in labour spiritualist Herbalist

Family members  Hospital

38. Where do most people deliver in your community?

Hospital  TBA  spiritualist  Herbalist

39. Tell me why they deliver at the place you have mentioned in this community?

.....  
.....

**SECTION E - KNOWLEDGE**

40. Tell me some of the dangers signs of pregnancy.....

41. What must a pregnant woman with any of these signs do?

.....

42. Tell me some of the complications of not going for antenatal clinic .....

43. Mention any signs in pregnancy that requires that a woman sees a doctor or midwife immediately.

44. Tell me of any complication which may occur during labour.

.....

45. Tell me the people who do the delivery or assist them to deliver in this community?

.....

**SECTION F - HOUSEHOLD CHARACTERISTICS**

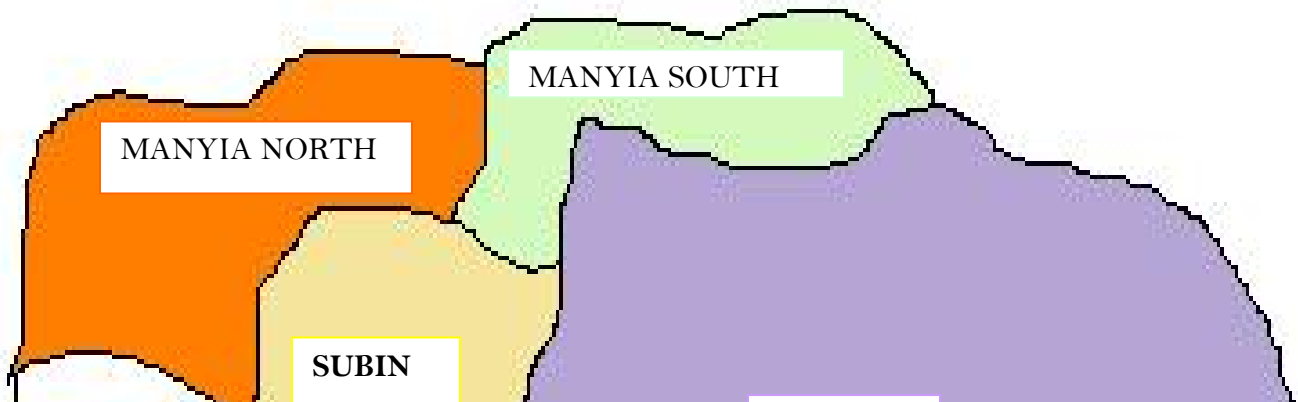
46. Which family system do you have

Nuclear  Extended

47. Who is the head of your household ? .....

48. Who in your home decides where a woman in labour should deliver?.....

**MAP OF KMASI METRO**



**KWAME NKRUMAH UNIVERSITY OF SCIENCE  
AND TECHNOLOGY, KUMASI GHANA  
COLLEGE OF HEALTH SCIENCES  
SCHOOL OF MEDICAL SCIENCES  
DEPARTMENT OF COMMUNITY HEALTH**



**FACTORS CONTRIBUTING TO LOW UTILIZATION  
OF MATERNAL HEALTH SERVICES IN KUMASI**

**JOANA OWUSU-DANSO**

**SEPTEMBER 2007**

