

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY  
INSTITUTE OF DISTANCE LEARNING

A Study of Access to Maternal Health Services in the Fanteakwa District.

KNUST

by

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(MD)

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## DECLARATION

I hereby declare that this submission is my own work towards the commonwealth Executive Master in Business Administration and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the university, except where due acknowledge has been made in the text.

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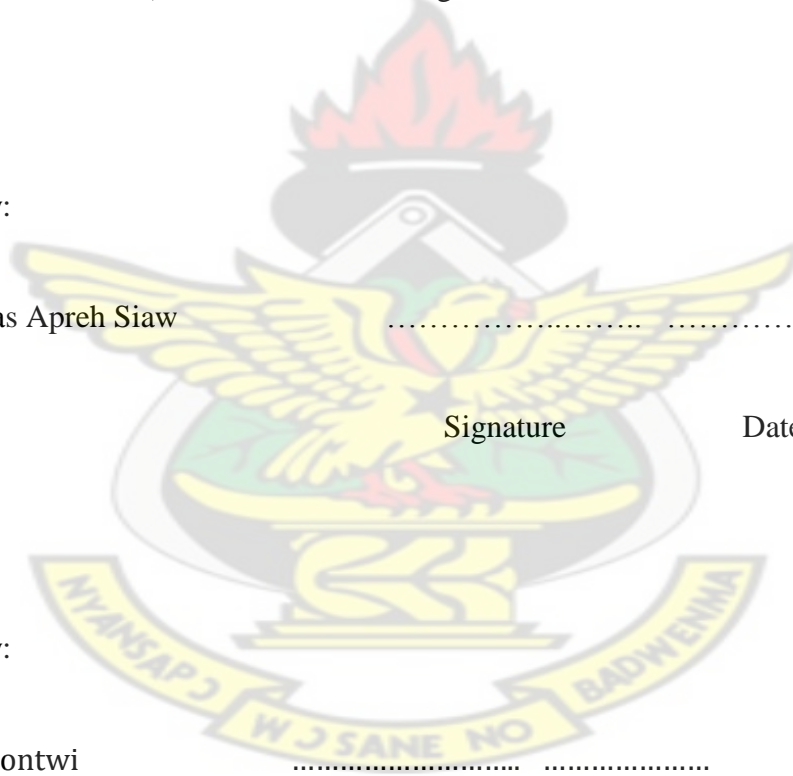
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## ABSTRACT

The main objective of the study is to determine the reason(s) underlying the low utilization of health care services by pregnant women in the Fanteakwa district. This study accessed maternal health services in the Fanteakwa district. This study was motivated by the perception that access to maternal health in the Fanteakwa district is low and as a result supervised deliveries are also low leading to high maternal death in the study area. The study was carried out with the aim of determining the causes of late access to maternal health care, and also analyze strategies to improve access to maternal health care and determine the trends in birth attended to by skilled trained health personnel over the past 5 years. The main design for the study is the descriptive method, which employed the quantitative method of data collection and analysis. The two main sources of data were used for the study. The questionnaire was used to collect the primary data, while secondary data was collected for the trend studies.

A total of 540 expectant mothers were used for the study and were drawn proportionally from 2 randomly selected communities in the Fanteakwa district using the cluster sampling method where each selected community was classified as a group from which the sample was drawn. Data collected was represented using tables and chart and analyzed using percentages. A major finding of the study is that the main cause of late access to maternal health care is financial constraints of expectant mothers and the use of TBAs (Traditional Birth Attendants) and herbalists for maternal health services. It is therefore being recommended that there should be improvement in income levels in general in the study area, and also public education should be intensified on the dangers of using non-skilled health providers for maternal health services.

## DEDICATIONS

The researcher dedicates this work to his Family especially my and children support me throughout the study to undertake this researcher work.

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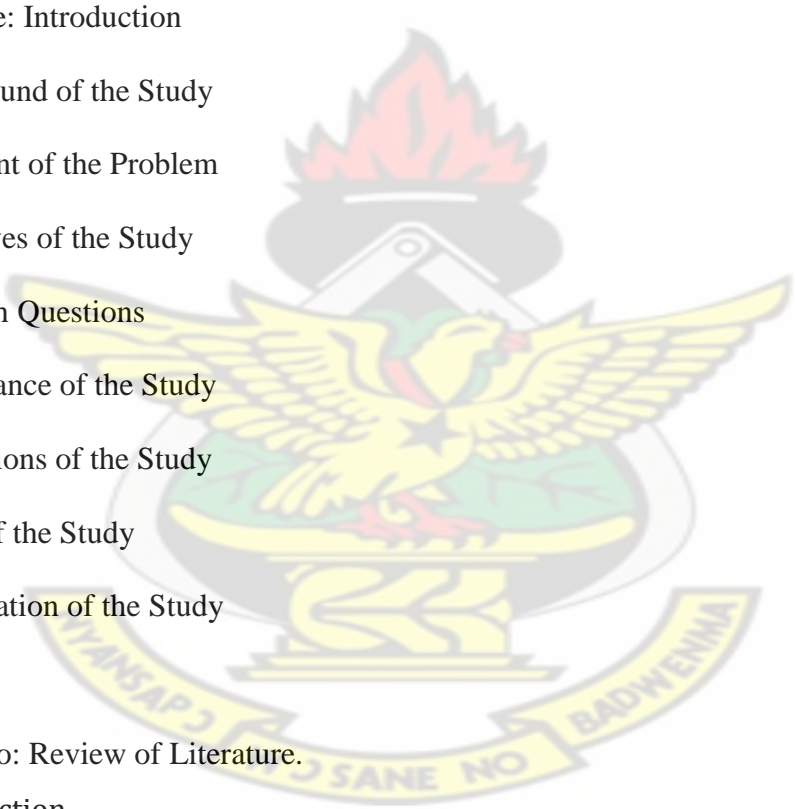
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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background of the Study**

Reduction of maternal death is a global public health concern (WHO, 2006). Based on this concern all member countries of the UN have been tasked to reduce maternal deaths by two thirds by the year 2015 (UNFPA 20120).

Each year it is estimated 529,000 maternal deaths occur. This number is based on calculations for the year 2000, the most recent date for such crude data (Ronsmans & Graham, 2006). Of the estimated total of 536,000 maternal deaths worldwide in 2005, developing countries accounted for 99% (533,000) of these deaths (World Health Organization, 2005). More than half of the maternal deaths (270,000) occurred in the sub-Saharan Africa region alone, followed by South Asia (188,000) (World Health Organization, 2005). Maternal deaths are not uniformly distributed throughout the world, and obstetric risk is highest by far in sub-Saharan Africa was estimated to be nearly 1000 per 100,000 live births: almost twice that of south Asia, four times as high as in Latin America and the Caribbean, and nearly 50 times higher than in industrialized countries. Most maternal deaths occur in sub-Saharan Africa, with a staggering lifetime risk of 1 in 16, and south Asia with a lifetime risk of 1 in 43 (Ronsmans & Graham, 2006).

Globally, around majority of maternal deaths are due to obstetric complications; mainly haemorrhage, sepsis, unsafe abortion, pre-eclampsia and eclampsia, and prolonged or obstructed labour. Complications of unsafe abortions account for 13 per cent of maternal deaths world wide, and 19 per cent of maternal deaths in South America (Lancet 1985).

Almost all cases of maternal mortality are preventable. An estimated 74 per cent of maternal deaths could be averted if all expectant mothers had access to the interventions for preventing or treating pregnancy and birth complications. Emergency obstetric care, in countries with high maternal mortality rates, is a need to increase provision of appropriate quality services if this trend must be reversed. Poverty, gender and other inequalities, a lack of information, weak health systems, a lack of political commitment, and cultural barriers are other obstacles that need to be overcome if women are to access technical services and information that can often prevent maternal mortality and morbidity (LANCET 1985).

In the last twenty years, a series of international commitments and initiatives has pledged to reduce maternal mortality. While many countries have made progress in reducing maternal mortality, progress has stagnated or been reversed in many of the countries with the highest burden of maternal mortality. Most parts of the world are off-track to meet the MDG target of reducing maternal mortality.(WORLD BANK 2008).

Human rights treaty protections relevant to reducing maternal mortality include the Convention on the Elimination of All Forms of Discrimination Against Women which requires parties to: “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation” (Sreen Thaddeus et al 1994).

In recent years, there has been a deepening conceptual understanding of maternal mortality as a human rights issue. Maternal mortality and morbidity are connected to a number of human rights, in particular the right to the highest attainable standard of health. The right to the highest attainable standard of health is legally protected by

international human rights treaties including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). It is also recognized in regional treaties, as well as by the domestic constitutions and laws of many countries worldwide.

Health care services, goods and facilities connected to preventing maternal mortality must be available, accessible, acceptable and good quality. Each of these criteria has particular importance for maternal mortality. An adequate number of goods, services and facilities necessary for maternal health, as well as sufficient numbers of qualified personnel to staff the services are very important. Increasing care and improving human resource strategies including increasing the number and quality of health professionals and improving terms and conditions will be key for reducing maternal mortality in many countries (Ann Afi 2009).

Physical access to, and the cost of, health services often influence whether women are able to seek care. Ensuring women's access to maternal health and other sexual and reproductive health services may require addressing discriminatory laws, policies, practices and gender inequalities in health care and in society that prevents women and adolescents from accessing good quality service behind maternal mortality is a failure to guarantee women's human rights. This is often manifested in, among others, low status of women and girls, poor access to information and care, early age of marriage and restricted mobility. Gender equality has an important role to play in preventing maternal mortality. Gender equality and empowerment lead to greater demand by women for family planning services, antenatal care and safe delivery (Ndola Prata et al 2010).

All health facilities, goods and services must be respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements. Preventing maternal mortality and enhancing access to maternal and other sexual and reproductive health care is not simply about scaling up technical interventions or making the interventions affordable. Also important are strategies to ensure that the services are sensitive to the rights, cultures and needs of pregnant women, including those from indigenous peoples and other minority groups. Maternal health care services must be medically appropriate and good quality. The quality of care often influences the outcome of interventions and it also influences a woman's decision of whether or not to seek care (Ndola Prata et al 2010).

Research shows that liberal abortion laws do not have a noticeable effect on decreasing maternal mortality whereas improving the quality of health care clearly does. Accordingly organizations such as WHO should stop expending time and resources pushing abortion on developing countries and instead use more resources to improve the quality of health care, which is what developing countries really need to rapidly and effectively improve the health of both mothers and their babies (DFID 2005).

In addition, UN agencies and entities, including treaty body monitoring committees, should cease pressuring countries to legalize abortion under the guise of helping to save women's lives, especially since international human rights instruments recognize the right to life of the unborn and discourage abortions as a method of family planning. In order to protect their health, women have the right to be informed of all of the complication and risks associated abortion (DFID 2005).

Historical studies show that maternal mortality ratios decreased in industrialized nations in the beginning of the 19th century. These reductions have not been



attributed to economic growth but to the diffusion and professionalization of obstetric care. In the brief period of fifteen years, maternal mortality fell so steeply in England and Wales in 1950 that the Maternal Mortality Rate (MMR) was only a fifth of the ratio in 1935; Scotland shows a similar trend. Almost all maternal deaths occur in the developing world. This differential in maternal mortality between the developing and developed worlds is often cited as the largest discrepancy of all public health statistics. Just 13 countries account for 70 percent of all maternal deaths. Two regions South Asia and sub-Saharan Africa — account for 74 percent of the global burden of maternal conditions (see table). There are also wide disparities across socioeconomic status within countries, with large gaps between rich and poor. This is seen in table 1 below.

**Table 1.0 World Maternal Mortality**

Estimates of Maternal Mortality by Region, 2000-2001				
	Region	Maternal mortality ratio (maternal deaths per 100,000 live births), 2000	Number of maternal deaths as modeled by WHO, 2000	Lifetime risk of maternal death (1 in number shown)
	Central and Eastern Europe, Commonwealth of Independent States, Baltic states, Europe, and Central Asia	64	3,400	770
	East Asia and the Pacific	110	37,000	360
	Eastern and Southern Africa	980	123,000	15
	Latin America and the Caribbean	190	22,000	160
	Middle East and North Africa	220	21,000	100
	South Asia	560	205,000	43
	Sub-Saharan Africa	940	240,000	16
	Western and Central Africa	900	118,000	16
	High-income countries	13	1,300	4,000
	Low- and middle- income countries	440	527,000	61
	Low-income countries	890	236,000	17
	World	400	529,000	74

Source: Graham, W. L., J. Cairns, S. Bhattacharya, C. H.W. Bullough, Z. Quayyum, and K. Rogo. 2006. "Maternal and Perinatal Conditions." In *Disease Control Priorities in Development Countries*, 2nd ed. D. T. Jamison, J. G. Breman, A. R. Measham, G. Alleyne, M. Claeson, D. B. Evans, P. Jha, A. Mills, and P. Musgrove, table 26.2. New York: Oxford University Press.

Note: The regions are those used by the United Nations Children's Fund.

The sudden and profound decline in maternal mortality was not due to a single factor, but a combination of changes that came into effect during this period. The most important factors that led to the reduction in maternal mortality are: introduction of penicillin, blood transfusion on a large scale, and improved obstetric care in general (Ndola prata et al 2010).

A study in Matlab, Bangladesh has provided support for community based, Emergency Obstetric Care (EmOC) programs. Three years of the maternity-care, program which included services to manage life-threatening complications, demonstrated a significant reduction in direct obstetric mortality compared with the three previous years of no intervention. Direct obstetric mortality was cut in half between 1976-86 and 1987-89 in the northern area where the maternity-care program was initiated. The government recruited and trained nurses and midwives who were able to identify complications related to pregnancy and treat complications when possible, while referring others to the central clinic at Matlab (WHO 2005).

The maternal mortality ratio in Honduras declined by 38 percent between 1990 and 1997, from 182 to 108 maternal deaths per 100,000 live births. Honduras is one of the few Latin American countries that have documented such success in reducing maternal deaths. The Maternal and Child Health program demonstrated that improved EmOC services, referral of high risk women for hospital delivery, and access to and utilization of skilled attendants during delivery led to a vast improvement in the quality of care provided. Between 1990 and 1997 seven new area hospitals, thirteen birthing centers, 36 medical health centers and 266 rural health centers, and five maternity waiting homes were opened. The quality of care improved, and the norms for the “Integrated Care for Women” were institutionalized. These norms include



family planning, emergency contraception, prenatal, delivery and postpartum care, and EmOC (WHO 2005).

Maternal Mortality in Egypt has declined from 174/100,000 to 84/100,000 between 1992-3 and 2000. This dramatic reduction in maternal deaths is a major achievement and proof of Egypt's sustained efforts to improve quality obstetric care while reducing the fertility rate and unwanted births. As of 2001, a total of 75 rural hospitals and primary health care units have been upgraded to offer normal delivery care and to improve linkages with referral centers in the five governorates of Upper Egypt which reaches over 8 million Egyptians. Obstetric services in 25 governorate and district (WHO 2005).

Reproductive health remains a big issue in the health sector in Ghana. Despite the fact that neo- and antenatal care are covered by the national insurance scheme (CBC, 23 June 2005), only 35% of all deliveries are attended by a qualified medical practitioner, the remaining 75% of women either deliver at home or seek traditional help (IRIN, 5 August 2008). According to a conference report on reproductive health and the reduction of maternal and infant mortality and morbidity, available statistics for Ghana "indicate that there are 2,800 midwives working in the various health facilities in the country and it is feared that 90 per cent of the number will retire from the service in the next two to four years. This will also create a gap of 3,500 midwives needed to deal with the critical issues of child mortality and morbidity, as there is already a shortfall of 700 midwives in the country" (Daily Graphic, 15 November 2007).

While a section of the media reported progress in prenatal and antenatal care in early 2008, another section raised a pessimistic eyebrow towards the issue. The newspaper Public Agenda reported in March 2008 that there has been success recorded through

an “integrated approach of cost-effective strategies” combining “immunization, infant and young child feeding, management of childhood illnesses and improved antenatal care” (Public Agenda, 10 March 2008). However, in August of the same year, an article by the Ghanaian Chronicle said “the rate of maternal deaths is on increase, owing to certain incidences beyond the control of those in charge. The WHO estimates that “560 pregnant women will die out of every 100,000 that go into labour” (IRIN, 5 August 2008). The Ghana Health Service (GHS) discloses “in its monthly health programme on reducing maternal death, Partnership for Action that, for every 10,000 births in the country, over 214 Ghanaian women die in the process of delivery” (Modern Ghana, 7 August 2008). IRIN reports that among rural communities in the 10 hardest hit areas in the north of the country, the maternal death rate was 700 per 100,000 live births (IRIN, 5 August 2008).

According to IRIN, observers say that “Ghana has one of Africa’s most liberal abortion laws but because of lingering stigma, fear and misunderstanding, safe, affordable abortion services remain virtually non-existent and unsafe abortion is a major cause of death” (IRIN, 12 October 2007).

In 2003, in an effort to improve maternal health and survival, the government of Ghana implemented a new policy that removed delivery fees in Health facilities in the four most-deprived regions of the country. Less than two years later, the government extended the policy to the rest of Ghana, removing delivery fees in all public, private and mission facilities (Immpact, PRB, 2007). On July 1st, 2008 the president of Ghana announced that the government is providing free maternal care for pregnant women to improve the attainment of MDG 4 and 5. The decision was made to

implement this through NHIS (National Health insurance scheme) so that mothers have the full package of antenatal, prenatal and postnatal care (NHIS, 2008).

Reducing maternal mortality and reaching the MDG5 target by 2015 is proving a serious challenge for many countries, including Ghana. The estimate of MMR in Ghana in 2005 was 560 per 100,000 live births (World Health Organization, 2005). The institutional MMR is around 210 per 100,000 live births. Translating MDG 5 for Ghana, a national target to reduce the (MMR) from 214 in 1990 to 54 by 2015 (MMR = maternal deaths per 100,000 live births) was set (MOH, 2008). Ghana is in the category of countries with a high-burden of maternal mortality. In this year's Aide Memoire, the Hon. Minister of Health declared the high maternal mortality in the country as a national emergency highlighting the need to accord greater priority to reproductive health services (Impact, PRB, 2007)

## **1.2 Statement of the Problem**

AT the beginning of the 21<sup>st</sup> century 189 countries including Ghana endorsed the millennium declaration and signed to commit themselves to meet the 8 goals with the aim of improving the welfare of especially the vulnerable in the society. Critical concern with respect to this study is the 5<sup>th</sup> millennium development goals which seek to improve maternal health with a clear target of reducing maternal deaths by 2/3 by 2015.

Ghana has embarked on a number of initiatives to improve maternal health and also to reduce maternal deaths. Key among such factor is the introduction of free maternal health care, increase intake and training of health care professionals especially mid – wives, training to support of TBAs, provision of ambulance services for emergency care, upgrading and requiring of major hospitals and increasing the number of

teaching hospitals in the country. All these interventions were carried out with the aim of improving the health status of the population in general and expectant mother in particular and also to meet the MDG5 target of reducing maternal deaths by 2/3 by 2015.

Despite these interventions, pregnant women who receive a maternal care from skilled provider in Ghana is quite low with 95 per 1000 women births assisted by skilled providers also stood at 59 per 1000 women birth declined in a health facility also stood at 57 per 1000 women, these trends in maternal care support that Ghana is far from reaching the MDGS target even though we have only three years to achieve this target.

In this case of maternal services in the Fanteakwa district, access to maternal health care is very low. Two out of every 10 expectant mother visiting either the Begoro government hospital, Osino and Bosuso health center, the clinics at Ehiamenkyene Abourso Dedeso Ahomahomasu and the 13 CHP compounds. Access is generally low because most of these mothers live in remote villages with bad roads to health facilities. Poverty is another factor mainly affecting affordability and accessibility of the expectant mother to attend these health centers.

The main problem is that the consequence of late access of maternal health care in the district, which has resulted in, increased number of maternal deaths in the district (ie. 20 in 2009, 21 in 2010 and 18 in 2011 from end of year Fanteakwa district health reports produced by district health directorate).

Based on this the researcher sought to explore the causes of low access and the specific strategies being adopted by the district health directorate to reduce late access and maternal death in the study area.

### **1.3 Objectives of the Study**

The main objective of this study is to determine the reason(s) underlying low utilization of healthcare services by pregnant women in the Fanteakwa district.

The specific objectives are to:

1. To determine causes of late access to maternal healthcare.
2. To determine the trends in births attended to by trained skilled health personnel over the past 5 years.
3. To analyze strategies of Ministry of Health in improving access to maternal healthcare in Fanteakwa district

### **1.4 Research Questions**

1. What are the causes of low access to maternal healthcare in Fanteakwa district?
2. What are the trends in births attended to by skilled health personnel over the past five years?
3. What are the strategies being adopted by the Ministry of Health to improve maternal health services in the Fanteakwa district?

### **1.5 The Significance of the Study**

This study, which seeks to find the causes of late access to maternal health in the study area, is of immense importance, because it can serve as a reference material on case specific strategies to be adopted for different rural communities to improve access to maternal health care as well as to reduce maternal deaths.

This study can also be a recourse material to be used to educate expectant mother on the dangers of late access to maternal health care and the danger associated with supervised deliveries by non-skilled provider. When expectant mother are equipped



with this information it can help to reduce maternal complication and maternal deaths due to poor maternal health care.

This study can also help in providing quality maternal health care service and based on this can help improve maternal health care in general in the Fanteakwa district. It is the concern of the ministry of health that much could be achieved with the MDG goal5 which is to improve on maternal health care and reduce maternal death by 2/3 by 2015. This study basically sought to explore late access to maternal health care and can help achieve these goals since the causes of late access is known to be a major factor leading to maternal deaths.

### **1.6 Limitation of the Study**

The study faced a number of major problems among such problem are;;

Difficulty to locate expectant mother in the various rural communities. It was noted that only a handful of expectant mothers attend maternal health care in the health facilities and as such it was difficult to locate them. The snowball technique was used. In this case effort were made to locate one pregnant woman who also in turn direct the researcher to other pregnant women she knows in the communities. This process took a lot of time even though it was successful.

Another major problem encountered is the poor road to the hinterland. This coupled with the heavy rains in the study area made it difficult to get to the community to get data from the expectant mothers.

### **1.7 Scope of the Study**

The study is limited to expectant mothers residing in the Fanteakwa district at the time of the study.

The study was also limited to expectant mothers who are not accessing maternal health care from hospitals or clinics.

### **1.8 Organization of the Study**

This work is organized into five chapters. The first chapter considers the background of the study, objectives of the study, research objectives significance of the study and the various divisions summed under organization of the study.

Chapter two compromises the theoretical framework which covers reviews literature on the subject area, authoritative and other and other relevant theories propounded which from the bases for the study.

Chapter three includes information on the methodology of the study. This spans the study area, population and the sampled techniques and data collection procedures. It also covers the research instruments, design and data analysis.

Chapter four covers data analysis and discussion of the result obtained.

Chapter five has the summary of the findings obtained, conclusion made based on the results, recommendations, and direction of future research to be taken.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

This chapter looks at Definitions and Overview, Health Status and Health Services in Ghana, Factors Affecting the Accessibility of Maternal Health Services, Accessing Health Services, Access to Maternal health services, User fees and Maternal Health Services, Maternal Mortality

#### **2.1 Definitions and Overview of Maternal Health Services**

**Maternal Death:** Death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of its duration and site, from any cause related to or aggravated by the pregnancy or its mismanagement, but not from accidental causes. (WHO, 1987)

**Maternal Mortality Ratio:** Number of maternal deaths per 100,000 live births, due to complications of, or medical conditions aggravated by pregnancy, childbirth, or postnatal period up to six weeks after delivery.

**Maternity Care Service:** Routine Obstetric care, including ante partum care, vaginal delivery (with or without episiotomy/ caesarean delivery) and postpartum care.

**Quality:** Quality Digest defines Quality as the ongoing process of building and sustaining relationships by assessing, anticipating, and fulfilling stated and implied needs. **Quality of Maternity Care Services:** Quality of maternity care services means; providing a minimum level of care to all pregnant women and their babies; a higher level of care to those who need it; obtaining the best possible medical outcome; providing care that satisfies women and their families and care-providers; maintaining



sound managerial and financial performance and developing existing services in order to raise the standards of care provided to all women (Tinker AG, 1998).

The World Health Organization (WHO) estimates that 580,000 women of reproductive age die each year from complications arising from pregnancy, and a high proportion of these deaths occur in sub-Saharan Africa. The ratio of maternal mortality in the region is one of the highest in the world, reaching levels of 686 per 100,000 live births (World Bank, 1994a). Women play a principal role in the rearing of children and the management of family affairs, and their loss from maternity-related causes is a significant social and personal tragedy.

Studies demonstrating the high levels of maternal mortality and morbidity in developing countries and research identifying causes of maternal deaths have repeatedly emphasized the need for antenatal care and availability of trained personnel to attend women during labor and delivery (Fauveau et al., 1988; Fortney et al., 1988). The importance of tetanus toxoid injections given prior to birth to reduce neonatal mortality has been documented as well (Bhatia, 1989). Since a large proportion of maternal and neonatal deaths occur within the first few days after delivery, safe motherhood programs have recently increased their emphasis on the importance of postnatal care.

## **2.2 Health status and health services in Ghana**

### **2.2.1 Health Status**

According to the Ghana Health Service (2007), the health of Ghanaians has improved over the last few decades. Key health indices of Ghanaians have been improving since independence in 1957. For example, life expectancy at birth has increased from 45 years at independence to 56 years in 2003. Under-five mortality rate (U5MR) has

decreased from about 220 deaths per 1,000 live births in 1957 to 110 deaths per 1,000 live births in 2003 (Figure 1). The prevalence of childhood killer diseases like neonatal tetanus and measles has declined over the last two decades. These trends can be attributed to improved quality and access to health services since the post-independence era as well as to improvements in the general socio-economic conditions of the country.

Trend has stagnated in recent years. In spite of the impressive performance outlined above, here is evidence that some key indicators have stagnated or reversed in recent years. For example after showing a consistent improvement for decades, the Infant Mortality Rates and Under-five Mortality Rates increased from their 1998 levels of 57 and 108 deaths per 1000 live births to their current levels of 64 and 111 deaths per 1000 live births.

Detailed analytical work undertaken in the IMCI analytical review reveals that most of the stagnation is caused by a reversal in trends in neonatal mortality and suggest that future investments (in improving health outcomes ) should mainly be directed at reducing neonatal mortality and mortalities due to malnutrition, malaria and pneumonia.

There are wide variations in the health status of the population especially across geographical location and socio-economic groupings. For example, infant mortality rate shows a three-fold difference between the best (Upper East) and the worst (Upper West) regions; 33 and 105 deaths per 1000 live births respectively (GDHS 2003) with U5MR showing a similar pattern.

The GDHS also reported that under-five mortality rate of the lowest socio economic quintile is 128 per 1000 live births compared to 88 per 1000 live births for the highest quintile. These wide variations suggest the need to develop strategies that specifically

target the worst affected regions and population groups for accelerated or enhanced interventions.

Little impact has been made on existing causes of morbidity and mortality while new ones have emerged. The leading causes of morbidity and mortality four decades ago were predominantly communicable diseases of malaria, respiratory tract infections, diarrheal diseases, in addition to malnutrition and pregnancy related diseases.

Over the last two decades non-communicable diseases like diabetes, cardiovascular accidents and injuries have appeared alongside the old ones as leading causes of morbidity and mortality in hospitals. These are the so-called diseases of life-style and point to the need for strategies that deal effectively with communicable diseases and the so-called life style diseases. The burden of diseases on different age groups is presented in Annex 5. Malaria is by far the leading cause of diseases and death in all age groups followed by respiratory tract infections and diarrheal in younger age groups and hypertension and complications of pregnancy in the older age groups.

The implication for quality assurance is that management and control of these diseases should be a priority if the health system is to make major impact on the health status of Ghanaians.

### **2.2.2 Types of Health Services**

Two broad categories of services are available, namely, curative services and preventive and promotive services.

The curative services provide diagnosis and treatment to a sick client. In more complex facilities like hospitals, these two broad functions may be distributed among several units like outpatients department, inpatient care, laboratory and diagnostic

services, pharmacy, and support services for laundry, catering, transport, and administration.

Preventive and promotive services provide clients and communities with services that aim to keeping them healthy. Programmes under this category include child health, adolescent health, maternal and reproductive health, communicable diseases, non-communicable disease, health promotion and nutrition.

### **2.2.3 Access to Services**

Access to health services also reveals a wide variation between socio-economic groupings and geographical areas. The GDHS of 2003 revealed a five-fold difference in access between the best region, Greater Accra (GAR) and the worst region, Upper West (UW) with 62% and 12 % respectively of population living within 30 minutes walk of a health facility.

### **2.2.4 Health Service Providers**

The two broad categories of public and private health services identified earlier on also describe the main providers of health services in Ghana. There are 2,262 facilities in Ghana. Ghana Health Service, which is the single largest provider, has 1108 facilities (49%) including 10 regional hospitals, 75 district hospitals and 622 health centres.

## **2.3 Factors affecting the Accessibility of Maternal health Care Services**

A review of the literature suggests that in developing countries, the use of modern health care such as maternal health services can be influenced by the socio-

demographic characteristics of women, the cultural context, and the accessibility of these services.

A number of socio-demographic characteristics of the individual affect the underlying tendency to seek care (Addai, 2000). In this regard, good examples are maternal age and parity, which have been examined as determinants of health care use repeatedly (Adekunle et al., 1990; Celik and Hotchkiss, 2000; Leslie and Gupta, 1989). The greater confidence and experience of the older and higher parity women, together with greater responsibilities within the household and for child care, have been suggested as explanatory factors for their tendency to use services less frequently (Kwast and Liff, 1988). Maternal education has also been shown repeatedly to be positively associated with the utilization of maternity care services (Addai, 2000; Addai, 1998; Akin and Munevver, 1996; Beker et al., 1993; Celik and Hotchkiss, 2000; Fernandez, 1984; Stewart and Sommerfelt, 1991). Although, in general, women in higher socioeconomic groups tend to exhibit patterns of more frequent use of maternal health services than women in the lower socioeconomic groups, factors such as education appear to be important mediators (Addai, 2000; Addai, 1998; Leslie and Gupta, 1989).

Another important factor in the utilization of maternity care services, especially in Africa, is the cultural background of the woman (Leslie and Gupta, 1989; Pelto, 1987). The cultural perspective on the use of maternal health services suggests that medical need is determined not only by the presence of physical disease but also by cultural perception of illness (Addai, 2000). In most African rural communities, maternal health services coexist with indigenous health care services; therefore, women must choose between the options (Addai, 2000). The use of modern health services in such a context is often influenced by individual perceptions of the efficacy



of modern health services and the religious beliefs of individual women (Adetunji, 1991). Moreover, in many parts of Africa, women's decision making power is extremely limited, particularly in matters of reproduction and sexuality. In this regard, decisions about maternal care are often made by husbands or other family members (WHO, 1998). Availability of women's time is also important. In developing countries, women spend more time on their multiple responsibilities for care of children, collecting water or fuel, cooking, cleaning, growing food, and trade than on their own health (World Bank, 1994a).

## **2.4 Accessing Health Services**

Accessibility of health services has been shown to be an important determinant of utilization of health services in developing countries. In most rural areas in Africa, one in three women lives more than five kilometers from the nearest health facility (World Bank, 1994b). The scarcity of vehicles, especially in remote areas, and poor road conditions can make it extremely difficult for women to reach even relatively nearby facilities. Walking is the primary mode of transportation, even for women in labor (Williams et al., 1985; World Bank, 1994b). In rural Tanzania, for example, 84 percent of women who gave birth at home intended to deliver at a health facility but did not due to distance and lack of transportation (Bicego et al., 1997). 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 nonexistent, there may be informal fees or other costs that pose significant barriers to women's use of services. These may include costs of transportation, drugs, food, or lodging for the woman or for family members who help care for her in the hospital (Gertler and van der Gaag, 1988; Gertler et al., 1988).

In Ethiopia, studies addressing the factors influencing the utilization of maternity care services are scant. The few studies that do exist focused predominantly on urban areas and have identified some important determinants of use of maternity care services in the country. Kwast and Liff (1988), in their study of maternal mortality in Addis Ababa, showed that women who did not receive maternity care were often poor, illiterate, and unmarried, with limited knowledge of maternity care services. The study also showed that the risk of nonattendance was higher for pregnant women who were first pregnant between the ages of 10 and 18. In a nationally representative sample survey in Ethiopia, receipt of maternity care was found to vary by age, residence, and other socio-demographic factors (CSA, 1993). Another study in Addis Ababa showed that lack of time, absence of illness, and lack of awareness are the major reasons for nonattendance for antenatal care (Mesganaw et al., 1990). Mengistu and James (1996), in their study in the Arsi Zone of central Ethiopia, found maternal age, parity, lack of time, education, marital status, and women's economic status to be significant predictors of utilization of maternity care. A study in Yirgalem Town and in the surrounding Southern Nations, Nationalities, and People's Region (SNNPR) of Ethiopia showed that women's education, inadequate household income, and unwanted pregnancy were important predictors of antenatal care utilization (Belay, 1997). A large-scale community and family survey in SNNPR concluded that although a number of socio-demographic factors are important in urban areas, they are of less relevance in the rural part of the study area. Socio-demographic factors including parity, age, and education appeared to influence the use of maternity care services in urban areas. In contrast, distance and travel time were identified as important factors in the rural parts of the country (Mekonnen, 1998).

## **2.5 Access to Maternal Health Services**

Literature on maternal health seeking during delivery is scant. The decision to deliver in a supervised or institutional setting is influenced by a vector of factors including the availability of the requisite health institutions and accessibility inter alia. Since developed countries are endowed with the appropriate health facilities, the demand for institutional/supervised delivery is more of a developing country phenomenon. Even under special circumstances, home deliveries in developed countries are undertaken with the necessary medical logistics and supervision.

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a context is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of individual women (Adetunji, 1991).

Furthermore, in many parts of Africa, women's decision making power is extremely limited, particularly in matters of reproduction and sexuality. In this regard, decisions about maternal care are often made by husbands or other family members (WHO, 1998). Availability of women's time is also important. In developing countries, women spend more time on their multiple responsibilities for care of children, collecting water or fuel, cooking, cleaning, growing food, and commerce than on their own health (World Bank, 1994a).

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The role of income in health seeking is buttressed by the fact that poverty is generally associated with poor health (Abel-Smith and Leiserson, 1979). In the United Kingdom, McKeown, Brown and Record (1972) posited that mortality decline in the nineteenth century was closely related to improvement in living standards rather than medical breakthroughs. Arriaga and Davis (1965) reported similar findings in Latin America. Recent studies also corroborate that households within the wealthiest quintiles are more likely to seek health care from appropriate providers (Steinhardt, 2008).

In India, Mathiyazhagan (2003) corroborates that health expenditure of household members of rural India is sensitive to changes in household income levels and the elasticity of health expenditure with respect to income is largest for high-income groups. Health status is a direct product of economic power. Sharma (2000), finds that the higher the capacity of persons to purchase health and medical services, the greater the likelihood of better health status. Alternatively, the poorer section of the population suffers badly in the maintenance of health and treatment of ailment due to poor financial status. Emerson et al. (2006) examined the relationship between household income and health status in children and adolescents in Britain and concluded that there is a significant relationship between household income and a range of health outcomes even after controlling for other socio-economic indicators. Warner (1995) investigated health expenditures of poor families and how it affects their nutritional status and thereby their health and the survival probability of women and children. Inability to seek institutional delivery by expectant mothers can cause complications and lower their income earning potentials.

Andy and Cassels (2004) emphasize that ill health can cause poverty via loss of income, catastrophic health expenditures and orphanhood. Thus appropriate health seeking for expectant mothers can make a substantial contribution to the realization of MGD1- which seeks to half the proportion of people earning less than a \$1 a day between 1990 and 2015.

Access to health information is a knowledge acquired whether through formal or informal education. Just like education, access to health information enable women to break away from tradition to utilize modern means of safeguarding the health of their children and themselves including institutional delivery (Cleland, et al. 1988). In addition, it empowers them to make independent decisions regarding children's health

resulting in greater utilization of modern healthcare facilities (Caldwell, 1979). Particularly, women who are educated have a greater understanding of where the health services are located and how to gain access to them (Nag, 1981).

## **2.6 User Fees and Maternal Health Services**

Growing populations and poor economies continue to overwhelm government health care programs. As a result, user fees have attracted considerable attention during the last decade as a potential source of supplementary financing to meet non-salary recurrent expenses. The introduction of user fees in public hospitals has generated mixed experiences in developing countries. Although the results in some instances are encouraging in terms of cost recovery, effective exemption of the poor remains an issue of major concern.

In the late 1980s, many developing countries introduced user fees to help defray the cost of maternal health services. Many of the studies addressing user fees have focused on a broad definition of fees for curative care while few have specifically examined maternal health user fees. These studies do, however, distinguish between formal and informal user fees. Nonrandom rapid surveys in Bangladesh (Killingsworth et al., 1999) found that the average level of informal fees per patient was 12 times the amount expected to be incurred in official payments. The largest payments went for commodities such as medicines, supplies, and surgical equipment (85 percent of the total), with fees for service and improved access to beds or transportation accounting for the remaining 15 percent. Results also suggest that those least able to pay are charged a proportionately higher amount of their disposable income than higher-income groups.

A survey conducted in Ghana, Malawi, and Uganda found that, owing to higher user fees for some services and increased travel costs, routine services cost more in hospitals than at health centers (Levin et al., 2000). The survey also found that, in Uganda, costs to the user other than fees for routine services represented more than 50 percent of total costs. In cases where fees were relatively high, such as in mission facilities in Malawi and all facilities in Uganda, costs other than fees accounted for less than 50 percent of total costs. The study also found that service fees charged by private midwives were higher than those charged at public health centers and sometimes as high as those charged for hospital services.

Most studies focus on the impact of user fees on the demand for curative or preventive care in general, although a few recent studies conducted under the PHRPlus Project have generated information about user fees and maternal health in Ghana, Malawi, and Uganda (Levin et al., 2000; Tien and Chee, 2002). Nahar and Costell (1998) studied unofficial fees for maternal health services in Dhaka, Bangladesh.

### **2.6.1 Impact of fees on Maternal Health Services in Africa**

In Africa, fees have had a negative effect on utilization of maternal health services (Nanda, 2002). In Zimbabwe, use of ANC services declined with the introduction of user fees in the early 1990s. In Tanzania, the introduction of user charges led to a 5.3 percent decline in ANC utilization in three public health facilities. However, suspension of user fees led to an increase in attendance at ANC clinics in South Africa. A study conducted in Ghana by Overbosh and others (2003) found that household income, distance to a health facility, and charges for services significantly influenced demand for ANC services.

The study demonstrated that distance and charges negatively affected the utilization of antenatal care services. A survey carried out in Nigeria showed that the introduction of fees led to a 46 percent decline in the number of deliveries at the main hospital in the Zaria region (Nanda, 2002).

Quick and Musau (1994) found that, with the introduction of user fees (registration fees) in Kenya, ANC attendance declined by 19 percent in three provincial hospitals and by 19 and 28 percent, respectively, in two district hospitals—despite the fact that ANC clients were exempt from the fees. The study also established that the reduction in ANC utilization was followed by a modest financial recovery in provincial and district hospitals. Nevertheless, the sample facilities experienced a gradual long-term decline in ANC utilization from 1990 to 1993. The authors inferred that the decline was attributable to either mother's lack of awareness that the fee program did not apply to ANC or the "one-stop-care" effect, whereby a patient tries to achieve several objectives in one visit. For instance, a mother would travel to a facility for a combined ANC and general clinic visit, with the latter requiring user fees. The authors did not analyze the impact of fees on maternity care services, although they did not find any significant effect of fees on admissions and average length of stay.

Another Kenyan study (Nganda, 2003) used monthly attendance data from selected public facilities and found a decline in average utilization of delivery care services following an upward fee adjustment. The ANC services, however, remained unaffected by the adjustment as average attendance continued to increase.

## **2.7 Maternal Mortality**

Maternal mortality is one of the most sensitive indicators of the health disparity between richer and poorer nations. The lifetime risk of dying due to maternal causes



is about one in six in the poorest countries, compared with about one in 30,000 in Northern Europe (Ronsmans and Graham, 2006). Selection of the maternal mortality ratio (MMR) as the primary indicator for Millennium Development Goal number 5 (MDG-5) on improving maternal health has increased interest in programs to improve maternal health and in having reliable sources of data on maternal mortality rates. The burden of maternal mortality is traditionally measured in terms of the MMR, which is defined as the number of maternal deaths per 100,000 live births. MDG-5 calls for a 75 percent reduction in the MMR between 1990 and 2015 (UNDP, 2003). Estimates of the MMR in Ghana vary widely. Data from the 1993 Ghana Demographic and Health Survey indicate the MMR to be 214/100,000 based on the direct sisterhood method, whereas regression model estimates from the WHO/UNICEF/UNFPA study place the MMR at 560/100,000 (WHO et al., 2007).

### **2.7.1 Causes of Maternal Mortality**

The most prevalent direct medical causes of maternal mortality are thought to be severe bleeding, hypertensive diseases, and infections (Ronsmans and Graham, 2006). However, indirect causes of maternal mortality must also be addressed. The “Three Delays Model” (Thaddeus and Maine, 1994) identifies delays in seeking, reaching, and receiving care as the key factors contributing to maternal death. The delay in seeking care is related to having the knowledge to recognize a life-threatening problem and making the decision to go for care. The delay in reaching care results from inaccessibility of health services due to distance, poor infrastructure, lack of money, or other barriers to access. The delay in receiving care refers to problems in content and quality of maternal health care services.

Most maternal deaths occur during labor, delivery, or the first 24 hours after delivery, and most complications cannot be prevented or predicted (Campbell and Graham, 2006). Skilled care during pregnancy, childbirth, and the immediate postpartum period, by health care professionals with appropriate skills has been recognized as the key intervention to reduce maternal mortality (WHO, 2004a). Family planning and safe abortion services also play key roles in reducing maternal deaths (Campbell and Graham, 2006). Family planning can prevent pregnancies that contribute to a disproportionate amount of mortality, specifically, high parity births, births to very young or older women, and unwanted pregnancies. Prevention of unwanted pregnancies can reduce the risk of dying posed by unsafe abortion. The exact contribution of abortion to maternal mortality is unclear. The World Health Organization (WHO) estimates that in western Africa unsafe abortion could contribute to as many as 90 deaths per 100,000 live births (WHO, 2004b).

Several health indicators in Ghana help us better understand the factors contributing to high rates of maternal mortality. Data from the 2003 Ghana Demographic and Health Survey (GDHS) show that the contraceptive prevalence rate is low; only one-quarter of currently married women are using a method of contraception (GSS et al., 2004). As a result, 34 percent of currently married women have unmet need for family planning, and 40 percent of all pregnancies are unwanted or mistimed. The 2003 GDHS also shows that 47 percent of births are attended by a health care professional. The Ghana Health Service 2007 Annual Report states that the proportion of deliveries attended by a health care professional was 35 percent in 2007, which it notes is a substantial decrease from 45 percent in 2006 (GHS, 2007b). In 2006, the institutional MMR was 244/100,000 live births, which represents an increase over 2005 when the MMR was 197/100,000 (MOH, 2008a). Although abortion is legal in

Ghana under certain conditions, unsafe abortion is still thought to make a significant contribution to the burden of maternal morbidity and mortality, especially among adolescents (Aboagye et al., 2007; Mayhew, 2004).

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## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.0 Introduction**

This chapter present the methods used for gathering data as well as the analysis. It includes the research design, study population, sources of data, sampling methods, sampling size, and instrument of data collection and methods of data presentation.

#### **3.1 Research Design**

The survey method was used for the study. This employed the quantitative methods of data collection and analysis.

#### **3.2 Study Population**

The study unit is pregnant women accessing healthcare in government health facilities in Fanteakwa district.

#### **3.3 Sources of Data**

The two main sources of data were used for the study. The primary sources were through the use of questionnaires and it is made up of both open and closed ended questions. In the case of secondary data books journals report related to access to maternal health were used.

#### **3.4 Sampling Method**

The simple random sampling method was used to select two sub districts out of the seven in the Fanteakwa district. The two districts selected were Begoro and Osino. The cluster sampling method was used to group the two selected sub district after

which a proportionate sample size was drawn from each group to form the total sample for the study.

### 3.5 Sample Size Determination

It is estimated that there are about 1200 pregnant women accessing health care in Begoro. In the case of Osino the estimate is about 600. 30% of each estimate was used as sample size for the study. Based on this calculation a total sample size of 540 was used. The details are summarized in the table below:

**Table 3.1 Sample Size Drawn**

District	Population	Sample size (30%)
Begoro	1200	360
Osino	600	180
<b>Total</b>	<b>1800</b>	<b>540</b>

Source: field work (2012)

### 3.6 Instrument for Data Collection

The main instrument used for collecting data for the study was the questionnaire. The questionnaire was used to collect data on cause of last access to maternal health care, strategies being adopted to improve access to maternal health care in the Fanteakwa district.

A total of 540 questionnaires were self administered to pregnant women in the selected districts. The self administration method was used because of the high illiteracy rate in the district. It was also because the research wanted to achieve high response rate.

### **3.7 Method of Data Collection**

The data collected were summarized and presented using tables and charts, and the analysed using descriptive methods. Trend analysis was also then done to determine the dynamics in relation to pregnancy of women in the Fanteakwa district.

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## CHAPTER FOUR

### FINDINGS AND DISCUSSIONS

#### 4.0 Introduction

This chapter presents the findings and discussions of the study and it relates to two categories of data set (i) socio-demographic characteristics of respondents and (ii) the objectives of the study.

The objectives relates to causes of late access of maternal health care, trends in births attended to by skilled trained health personnel and strategies to improve maternal health care.

#### 4.1 Socio-Demographic Characteristics

The socio-demographic characteristics considered for this study are age, marital status, educational level, level of income, parity and types of marriage.

##### 4.1.1 Age of Respondents

Majority of the expectant mothers (48.7%) are young adult between the ages of 20 to 29years. This is followed by those between the ages of 30 to 39 years (34.6%). The study further found that the percentage of teenage mothers are quite high in the study area(13.2%).The details are presented in table 4.1 below;

**Table 4.1 Age of Respondents**

AGE/YEARS	FREQUENCY	PERCENTAGE
Less than 20	71	13.2
20-29	267	48.7
30-39	187	34.6
40+	19	3.5
<b>Total</b>	<b>540</b>	<b>100</b>

Source: field work (2012)

#### 4.1.2 Marital Status

Analysis on the marital status of respondents indicated that as high as 75.7% of the expectant mothers are married while 23% are single. Expectant mothers who are divorced form as low as 0.4% If the study population. The details are presented in Table 4.2 below.

**Table 4.2 Marital Status**

STATUS	FREQUENCY	PERCENTAGE
Single	124	23
Married	409	75.7
Separated	5	0.9
Divorced	2	0.4
<b>Total</b>	<b>540</b>	<b>100</b>

Source: field work (2012)

#### 4.1.3 Educational Background of Respondents

Educational background of expectant mothers was found to be generally low in the study area. The study found that as high as 47.6% have up to JHS/Middle school leaving certificate. This is followed by another high percentage of 34.1 who have up to primary level of education. The details are presented in table 4.3 below.

**Table 4.3 Educational Background**

LEVEL	FREQUENCY	PERCENTAGE
No Formal Education	33	6.1
Primary	184	34.1
Middle/JHS	257	47.6
Secondary	49	9.1
Post Secondary	17	3.1
<b>Total</b>	<b>540</b>	<b>100</b>

Source: field work (2012)

#### 4.1.4 Level of Income

Majority (55.7%) of the respondents earn 1 monthly income between 250 to 500 Ghana cedis. Another category (22.6%) earns a monthly income between 100 and 250 Ghana cedis. Only a small percentage of respondents (0.9%) earn a monthly income above 1000 Ghana cedis. This signifies that income level of expectant mothers are generally low in the study area and this situation might affect affordability and accessibility of health care services in the study area. The details are presented in table 4.4 below.

**Table 4.4 Income level**

INCOME/GH Cedis	FREQUENCY	PERCENTAGE
Less than 100.00	83	15.4
100.00 - 250.00	122	22.6
250.01 – 500.00	300	55.7
500.01 – 750.00	20	3.7
750.01 – 1000.00	9	1.7
1000.00+	5	0.9
<b>Total</b>	<b>540</b>	<b>100</b>

Source: field work (2012)

#### 4.1.5 Parity

As high as 41.5% of expectant mothers have ever given birth to four children, while 28.1% have three, 16.1% have two and 3.9% have a child. This finding is higher than the national urban parity of 3.4%. The details are presented in table 4.5 below.



**Table 4.5 Parity**

PARITY	FREQUENCY	PERCENTAGE
0	30	5.6
1	21	3.9
2	87	16.1
3	152	28.1
4	224	41.5
5	18	3.3
6+	8	1.5
<b>Total</b>	<b>540</b>	<b>100</b>

Source: field work (2012)

#### 4.1.6 Types of Marriage

Analysis of the types of marriage reveals that as high as 65.0% of the expectant mothers are in monogamous marriages, while 35.0% are in polygamous marriages. The details are presented in table 4.6 below.

**Table 4.6 Types of Marriage**

TYPE OF MARRIAGE	FREQUENCY	PERCNTAGE
POLYGAMOUS	189	35
MONOGAMOUS	351	65
<b>Total</b>	<b>540</b>	<b>100</b>

Source: field work (2012)

#### 4.2 Causes of Late Access to Maternal Health Care

In order to have an intervention to address the issue of late access to maternal health care, the researcher was interested in exploring the causes of late access and the details are presented in Table 4.7 below.

**Table 4.7 Causes of Late Access to Maternal Health Care**

CAUSES	FREQUENCY	PERCENTAGE
Financial constraints	216	40
Cultural practices & beliefs	62	11.5
Ignorance	30	5.5
Seek help elsewhere: (TBAs, herbalists & spiritualists)	182	33.7
Long distance to health facility	27	5.0
Attitude of Health Workers	23	4.3
Total	540	100

Source: field work (2012)

From table 4.7 above, it was found that, the main cause of late access to maternal health care is financial constraints on expectant mothers. This constituted 40.0% of the respondents. It was found that, majority of the expectant mothers come from household with low income, and so have financial challenges that make it difficult for them to travel to their respective designated health facilities for health care. Also some respondent could not afford decent dress and therefore they fail to attend antenatal clinic as required from them. The study further found that though maternal health care is free, a lot of respondents are not able to patronize the health facilities because they had not registered and fear might be tuned away. One reason given is the health insurance package will not cover every bill and so they were hesitant to go to the health facilities if one be asked to pay for the deference. Another cause of late visit to antenatal clinic is their engagement of Traditional Birth Attendants (TBAs) herbalists and spiritualists for professional medical assistance. The study found that even though most herbalists and TBAs have not undergone any professional training in supervised deliveries, most expectant mothers prefer to seek health care from such

practitioners. The reasons to their preference are: easy access, low cost and cultural acceptability.

Due to these factors, most expectant mothers do not visit the hospital for professional health care. The study further found that most often, expectant mothers go to the hospital late in an emergency situation where it is danger to their lives.

Cultural practices and beliefs (11.5%) is another factor inhibiting access to maternal health care. The study found that it is culturally unacceptable for pregnant women to report of their pregnancies to their in-laws and neighbours at early pregnancy (first trimester). This is because it is a belief that a person with a bad eye can easily harm the mother as well as the fetus. Based on this background some expectant mothers find it difficult to access maternal health care on time.

The study also found that in certain cultural enclaves the expectant mothers need to seek for permission and advice on where and where to seek maternal health care from the head of the family and the elderly women in the compound. This situation normally leads to lack of patronage of standard health care services since most often rural folks usually prefer the services of herbalists, TBAs and spiritualists in maternal health care.

Ignorance (5.5%) was another factor associated with late access to maternal health care. Some expectant mothers are of the view that once they are healthy and do not show any visible signs of illness, there is no need for anti-natal care. It was also found that some category of women especially the teenagers are not able to detect early when they are pregnant. This is because they do not know the signs of early pregnancy. It was found that some women are ignorant about threaten signs of

pregnancy as such do not see the need to visit the hospital on time. For instance, some women associate odema to twin pregnancy and so do not see the need to report such a symptom to the hospital.

Distance to health facilities (5.0%) was also identified as a factor to late access to maternal health care. The study found that a category of expectant women reside in the villages where they have to travel long distances on foot before accessing maternal health care. Due to the problem of inaccessibility, some of these women delay until they are in the late trimester before accessing maternal health care from a hospital.

This finding is consistent with Ndidi and Oseremey (2010) findings which indicated that inaccessibility and affordability are major factors inhibiting maternal health care in rural communities in Nigeria.

Poor attitude of health workers (4.3%) was identified to be a minor factor affecting access to maternal health care. The study identified that most often, some expectant mothers who have had prior bad experiences from health professionals and so do not want to attend to that health facility again. The findings also reveal that the long waiting time at the hospital is another factor most expectant mother want to avoid, hence prefer visiting the TBAs who normally offer prompt services.

It can be concluded from the above that there are numerous causes leading to late access to maternal health care and the main factors are financial constraints, engagement of TBAs and herbalists and cultural practices and beliefs.

### 4.3 Strategies for Improving Access to Maternal Health Care

The 5<sup>th</sup> millennium development goal (MDG 5) states that all countries reduce maternal death by two-third by the year 2015. One of the strategies of achieving this is to access the strategies being adopted to improve maternal health care in the study area. The details are summarized in table 4.8 below:

**Table 4.8 Strategies of Improving Access to Maternal Health Care.**

STRATEGIES	FREQUENCY	PERCETAGE
Education Training and Support for TBAs	153	28.3
Increase CHPs compounds	126	23.3
Open baby friendly Healthfacilities in the district.	16	3.0
Upgrade and/or provide more Hospital Equipments.	10	1.9
Improve Ambulance services and Emergency care.	95	17.6
Improve the number and Condition of health workers	61	11.3
Improve Health workers Attitude to work.	79	14.6
<b>Total</b>	<b>540</b>	<b>100</b>

Source: field work (2012)

From the table 4.8 above it was found that a major strategy of improving access to maternal health care is through education training and support for traditional birth attendants (TBAs) in the study area(28.3%). Ghana Health Service (GHS) has trained TBAs in modern midwifery skills and practices with emphasis in early detection of danger signs and the need for prompt referral to health facilities for professional care. It was found that prior to these trainings TBAs hesitate to refer complicated maternal cases to health facilities and as result risk expectant mothers and their babies lives. It was further founded that support in the form of equipment (Delivery set) were given

to support and improve the activities of the TBAs. This finding is in line with Ofili and Okojie (2005) study which identified that, the provision of modern midwifery training and equipment by Oredo local government in Edo state in Nigeria help to reduce maternal death in the rural communities in the Edo state by 4.8%.

The increase in number of CHPs compounds (23.3%) was another strategy to improve maternal health care. It was found that GHS has opened 13 new CHPs compounds in the Fanteakwa district. It will reduce the distance of travel of expectant mothers and help improve health delivery in the rural areas. The GHS and the district assembly have planned and started to build more CHPs compounds in the district as a means to improve maternal health care. This is consistent with Ghana News Agency (GNA) (2012) report which indicated that Eastern Region needs additional 346 CHPs compounds to check maternal deaths. The region recorded high maternal deaths last year and most of the cases come from the rural areas.

Provision of efficient Ambulance service (17.6%) was found to be another major strategy of improving maternal health care. The study found that each CHPs compound and a health centre in the study area has been provided with a communication gadget to call on the ambulance service for prompt attention in time of emergencies. This strategy has helped reduced delays in transporting patients especially pregnant women to health facilities.

The increase in number of health workers had a corresponding increase in number of deliveries attended by skilled health professionals with better health outcomes and 11.3% of respondents had seen increase in number of midwives to health facilities in the study area as a good strategy. It was found that all health posts clinics as well as hospitals have midwives at station.



Improve in work ethics (14.6%) was another strategy of improving access to maternal health care. The study found that as strategy of improving work ethics, quality assurance training has been intensified and enforced in the institutions in the study area. To be able to enforce work ethics, quality assurance committees have been formed in all health institutions to monitor programmes and progress of GHS work guidelines. It was also found that more workshops and seminars were organized for staff to improve on their quality of work. It was also found that peer review was conducted for health facilities in the region on regular bases to improve work quality. The elevation of the district hospital to baby friendly status and adoption of its protocols has gone long way to enhance the maternal health delivery in the district. About 3.0% of respondents see this strategy as a good practice when health workers give baby friendly education to expectant mothers on regular basis and antenatal clinic (ANC) attendance has improved with improved health outcomes. It can be concluded that GHS adopted 4 main strategies of improving maternal health care and they are education and support for TBAs increase CHPs compounds improve ambulance service and improve work ethics.

#### **4.4 Trends in Births Attended by Trained Skilled Health Personnel.**

Trend analysis was conducted on birth supervised by trained health personnel and the details are presented in table 4.9 below Table

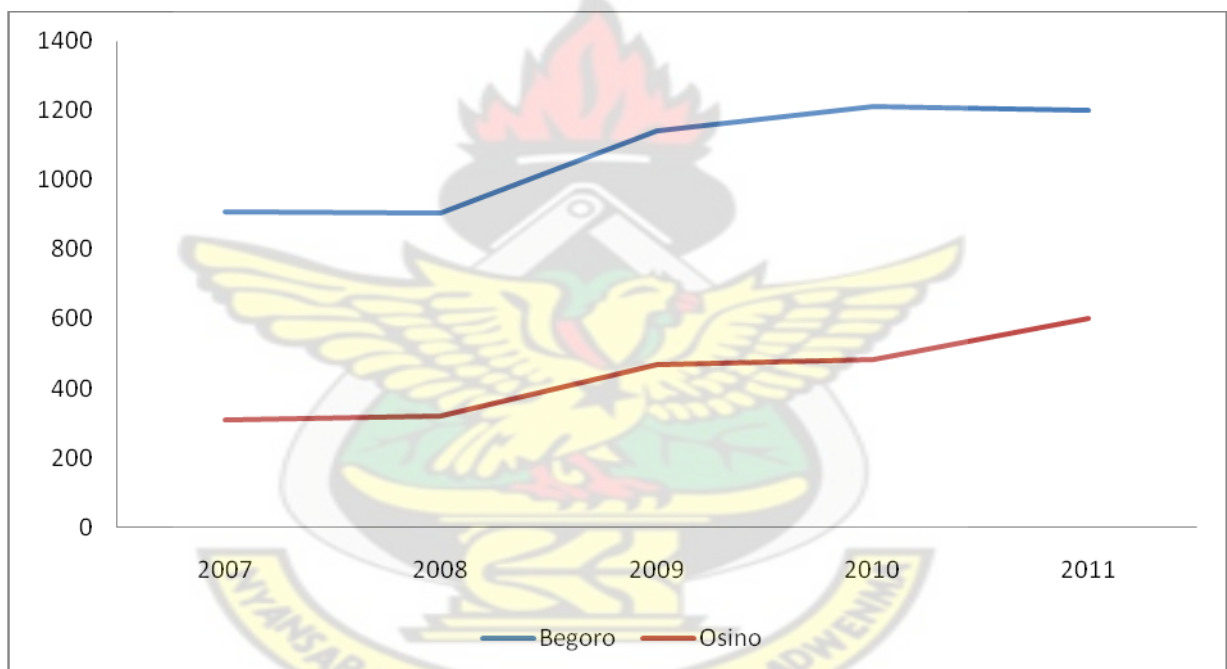
**Table 4.9 Trends in Births Supervised by Skilled Health Persons**

SUB DISTRICT	YEARS					
	2007	2008	2009	2010	2011	TOTAL
BEGORO	908	903	1140	1210	1200	5361
OSINO	309	321	469	483	600	2182
<b>TOTAL</b>	<b>1217</b>	<b>1224</b>	<b>1609</b>	<b>1693</b>	<b>1800</b>	<b>7543</b>

Source: field work (2012)

A group line graph showing the trends has been presented in Figure 4.1

**Figure 4.1 Trends in Births Supervised by Skilled Health Persons**



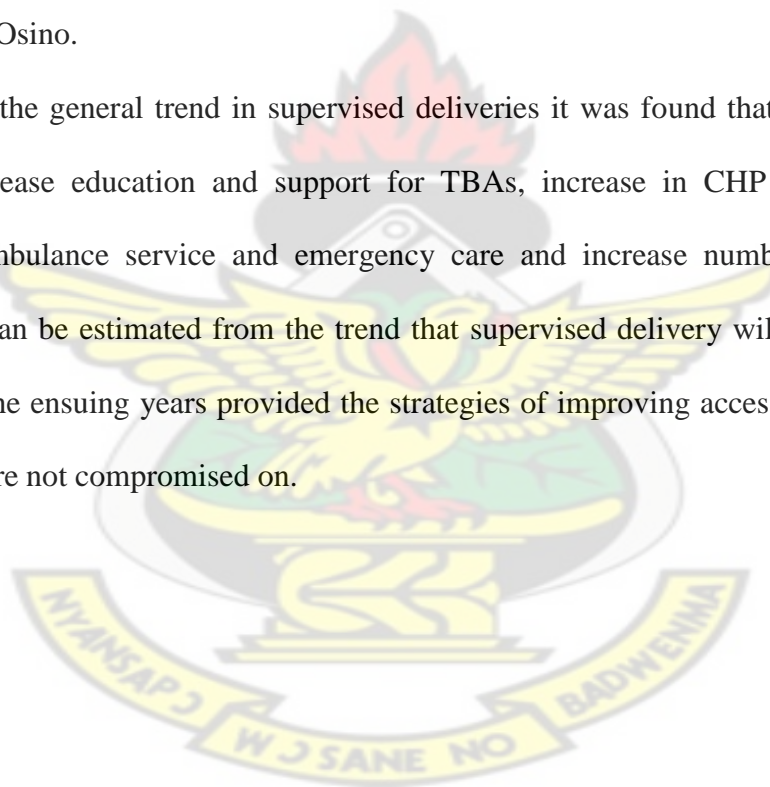
From table 4.9 above it was found that between the two sub districts selected, Begoro had the highest number of supervised deliveries for the five-year trend analysis. The study found that as high as 5361 supervised deliveries were done between 2007-2011 period with the highest recorded in 2011. The lowest supervised deliveries for Begoro sub district was recorded in 2008 with 903. Likely reasons for recording low values

were that there were logistics problems in data collection which lead to under estimation; it can also be attributed to low attendants recorded for that year.

In the case of Osino district it was found that a total of 2182 supervised deliveries were done between 2007-2011. The year with the highest deliveries recorded was 2011 while the year with least supervised deliveries was 2007.

Comparing the number of supervised deliveries between the two selected sub-districts reveals that there were more supervised deliveries in Begoro than that in Osino. This can be attributed to the fact that, Begoto has a larger population than Osimo and also has a larger, catchment area with more manned midwife health centers than Osino.

Considering the general trend in supervised deliveries it was found that there health such as increase education and support for TBAs, increase in CHP compounds, improved ambulance service and emergency care and increase number of health workers. It can be estimated from the trend that supervised delivery will continue to increase in the ensuing years provided the strategies of improving access to maternal health care are not compromised on.



## CHAPTER FIVE

### SUMMARY, CONCLUSIONS & RECOMMENDATIONS

#### 5.1 Summary

This study accessed maternal health services in the Fanteakwa district. This study was motivated by the perception that access to maternal health in the Fanteakwa district is low and as a result supervised deliveries are also low leading to high maternal death in the study area. The study was carried out with the aim of determining the causes of late access to maternal health care, and also analyze strategies to improve access to maternal health care and determine the trends in birth attended to by skilled trained health personnel over the past 5 years.

The main design for the study is the descriptive method which employed the quantitative method of data collection and analysis. The two main sources of data was used for the study. The questionnaire was used to collect the primary data, while secondary data was collected for the trend studies.

A total of 540 expectant mothers were used for the study and were drawn proportionally from 2 randomly selected communities in the Fanteakwa district using the cluster sampling method where each selected community was classified as a group from which the sample was drawn. Data collected was represented using tables and chart and analyzed using percentages.

## 5.2 Conclusion

The following findings were made in line with the conclusion drawn;

1. Majority of the expectant mothers are within the ages of 20 -29 years, while another high percentage is less than 20 years. This signifies that early pregnancy with its associated problems abounds in the study area.
2. Majority of the expectant mothers are married, but with low income status.
3. Expectant mothers who are single are fairly high in the study area, indicating that the likelihood of being single mothers and with its associated problems are high.
4. Majority of the expectant mothers have had 4 children and are expecting their 5<sup>th</sup> child. This signifies that fertility is high in the study area.
5. The main causes of late access of maternal health care are the use of TBAs and herbalists instead of skilled trained health personnel as their first choice and also financial constraints of expectant mothers.
6. Minor causes of late access to maternal health care services identified are some cultural practices and beliefs, ignorance, long distance to health facilities and poor attitude of health workers.
7. Strategies being adopted by GHS to improve access to maternal health care are: education and support for TBAs, increase in CHPs compounds, improvement in ambulance and emergency services and improvement in work ethics of health workers.
8. There is a general increase in the trend of supervised deliveries in Begoo and Osino sub-districts.

9. It is expected that the rise in supervised deliveries will continue in the ensuing years if the strategies of improving access of maternal health care are not down played.

From the above findings it can be concluded that majority of the expectant mothers in the two sub-districts access maternal health care late and the main cause of lateness are financial constraints and the use of TBAs and herbalists for maternal health care services instead of seeking appropriate care from the recognized health care facilities. It can also be concluded that there are a number of strategies of improving access of maternal health services and the key strategies are education and support of TBAs, open more CHPs compounds, equip hospitals and clinics and improve work ethics of health professionals.

These strategies have lead to an increase in supervised deliveries over the past 5 years.

### **5.3 Recommendations**

Based on the findings and the conclusions drawn, the following recommendations are made:

1. Improve in income level of expectant mothers so that they can access maternal health care early.
2. GHS should intensify its public education on maternal and child health so that bad cultural practices and beliefs affecting access to maternal health care be reduced in the population.



3. GHS should not only emphasis on major strategies of improving access to maternal health care but also to consider minor factors like improvement in ambulance services, increase baby friendly centers in health facilities.
4. Supervised deliveries by skilled personnel are increasing in the Fanteakwa district all stake holders must intensify their monitoring and supervision roles so that this momentum can be sustained for a long time.

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## QUESTIONNAIRE

### TOPIC: A STUDY OF ACCESS TO MATERNAL HEALTH SERVICES IN THE FANTEAKWA DISTRICT.

#### HOW TO COMPLETE THE QUESTIONNAIRE

Most of the questions seek response by ticking in the box that corresponds to the appropriate answer. Other questions demand that you provide your own responses.

#### SECTION A: SOCIAL DEMOGRAPHIC PROFILE OF RESPONDENTS

1. In which age Category do you belong?

- ☐ 20 – 29
- ☐ 30 – 39
- ☐ 40 – 49
- ☐ 50+

2. What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

3. What is your highest level of education?

- ☐ No formal education
- ☐ Primary
- ☐ Middle JHS
- ☐ Secondary
- ☐ Post-Secondary

4. How much do you earn in a month?

- ☐ Less than GHC100
- ☐ 100 – 250
- ☐ 25001 – 500.00
- ☐ 500.01 – 750.00
- ☐ 750.01 – 1000.00
- ☐ 1000.00 – 1000.00

5. How many children have you ever had/

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4

- ☐ 5
- ☐ 6

6. What type of marriage are you in?

- ☐ Monogamy
- ☐ Polygamy

## SECTION B: CAUSES OF LATE ACCESS TO MATERNAL HEALTH CARE

1. What are the causes of late access to maternal health care?

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2. Which of these causes greatly affects you?

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## SECTION C: STRATEGIES OF IMPROVING ACCESS TO MATERNAL HEALTH

1. What strategies have you seen that adopt in your area to improve maternal health care?.....

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2. Of the strategies identified in (i) above, which one do you think is very important?

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3. Explain why you think the strategy identified is very important?

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