Free but not Accessible to All:
Free Maternity Care, Access, Equity of Access, and Barriers to Accessing and Using Skilled Maternal and Newborns Healthcare Services in Ghana

Thesis submitted in partial fulfilment of the requirements for the Degree of Doctor of Philosophy in Public Health

By

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CONTENTS

Title Page 1

Contents 2

Abstract 12

CHAPTER 1: WHEN PREGNANCY AND CHILDBIRTH HARM 13

1. Background to the Research 13

1.2 Research Objectives 20

1.3 Research Questions 21

1.4 Conclusion and Thesis Structure 23

CHAPTER 2: THE STRUGGLE TO IMPROVE MATERNAL AND NEWBORN HEALTH: A LITERATURE REVIEW 26

2. Introduction 26

2.1 Maternal and Newborn Health: Past, Present and Historical Memory 27

2.1.1 War and the Birth of MNH 28

2.1.2 In the Throes of Moralism: The UN and MNH 31

2.1.3 Saving Mothers, Delivering Justice: The Safe Motherhood Initiative & MNH 33

2.1.3 Reframing the Debate: The 1994 ICPD and MNH 35

2.1.4 The MDGs and MNH 37

2.2 Averting Maternal and Newborn Deaths: What do We Know or Not Know? 39

2.3 The Problem of Access and Equity of Access 45

2.3.1 The Meaning of Access in Health Care 46

2.3.2 The Meaning of Equity in Health Care 47

2.3.3 Access and Equity of Access: Justification and Counter-Justification 51

2.4 Barriers to Access and Equitable Use of Maternity Care Services 54

2.4.1 Socio-demographic Factors 56

2.4.2 Health Care System Factors 60

2.4.3 Socio-cultural Factors 63

2.5 Global Health Mandates, Local Health Realities: MNH in Ghana 65

2.5.1 Problem of MNH in Ghana: Scale and Causes 66

2.5.2 Responding to the Challenge of MNH in Ghana: Progress, Perils and the Birth of Free Maternity Care 68

2.5.3 Free Maternity Care, Access, and Equity of Access: Examining the Evidence 77

2.6 Conclusion, Research Gaps and Contribution of this Research 79

CHAPTER 3: METHODS **85**

3. Introduction 85

3.1 Methodological Orientation and Research Design 85

3.2 The Research Setting 90

3.3 Data Types and Sources of Information 95

3.4 The Quantitative Research – The GMHS, 2007 95

3.5 The Qualitative Research 98

3.5.1 Choosing Where to Go 98

3.5.2 Research Participants 101

3.5.3 Accessing Research Communities, Participants and Data 102

3.5.3.1 Ethical Clearance 102

3.5.3.2 Community Entry and Engagement Processes 104

3.5.3.3 Institutional Entry Protocols 105

3.5.3.4 Sampling and Recruitment Procedures 106

3.5.3.5 Research Instruments 109

3.5.4 Informed Participant Consent 110

3.5.5 Qualitative Data Collection Methods 111

3.5.5.1 Focus Group Discussions (FGDs) 111

3.5.5.2 In-Depth Interviews (IDIs) 117

3.5.5.3 Direct Observation 119

3.6 Data Processing, Analyses and Presentation 121

3.6.1 Quantitative Research: Survey Data Processing and Analysis 121

3.6.2 Qualitative Data Processing and Analysis 124

3.7 Speaking with My 'Brothers', 'Mothers', and 'Sisters': Reflections on the and Ethical Dilemmas of an Insider/Outsider Researcher 135

3.8 Conclusion 140

CHAPTER 4: FREE MATERNITY CARE, ACCESS, AND EQUITY OF ACCESS AND USE OF SMNHS IN GHANA **141**

4. Introduction 141

4.1 Selected Socio-demographic Characteristics of Respondents 141

4.2 Overview of MNH Services Access and Use in Ghana: Evidence from Survey Data 145

4.3 Access and Equity of Access and Use of ANC Services 149

4.4 Access and Equity of access to Tetanus Toxoid Immunization 153

4.5 Access and Equity of Access and Use of Delivery Care Services 155

4.6 Access and Equity of Access and Use of Postpartum Care Services 160

4.7 Access and Equity of Access and Use of Abortion Care Services 162

4.8 Trends in Access and Equity of Access and Use of SMNHS in Ghana 167

4.9 Conclusion 171

CHAPTER 5: 'WE ARE HUMAN BEINGS, BUT THEY NEVER ASK HOW WE FEEL': HEALTH SYSTEM BARRIERS **174**

5. Introduction 174

5.1 Women's Experiences of Accessing and Using SMNHS in Ghana: An Overview 174

5.2 Why Don't Some Women Access and Use SMNHS in Ghana? 181

5.2.1 Service Availability, Distribution and Access 181

5.2.2 Quality of Care and Access 186

5.2.3 Trust and Access 188

5.2.4 Power, Intimidation, Choice, and Access 191

5.2.5 Silent Care, Ill-treatment, and Access 194

5.2.6 Privacy and Access 197

5.3 Conclusion 199

CHAPTER 6:'THE SOCIAL PRESSSURES ARE INCESSANT': SOCIO-CULTURAL BARRIERS **201**

6. Introduction 201

6.1 Overview and Context of Socio-cultural Barriers to Access 201

6.1.1 Intra-familial Decision-making, Women's Autonomy and Access 204

6.1.2 Religion and Access to Skilled Care 207

6.1.3 Hospital Delivery, Moral Judgement, and Access to Skilled Care 211

6.1.4 Pre-marital Pregnancy, Legitimacy of the Unborn Child and Access 214

6.1.5 Primiparas, Pregnancy Rituals, and Access to Skilled Care 216

6.2 Conclusion 220

CHAPTER 7: TOWARDS INCREASED AND EQUITABLE ACCESSS: STAKEHOLDERS' PROPOSED SOLUTIONS **222**

7. Introduction 222

7.1 Towards Increased and Equitable Access to SMNHS in Ghana: Overview of Stakeholders' Proposed Remedies 222

7.2 Stake Holders' Proposed Solutions to Health System Barriers 225

7.2.1 Improving Coverage and Quality of Services 225

7.2.2 Humanizing Hospitals and Doctor-patient Relationships 228

7.2.3 Expanding Free Emergency Ambulatory Services 231

7.2.4 Promoting Choice 233

7.2.5 Training and Motivating more Midwives 234

7.2.6 Building Partnerships 235

7.3 Stakeholders' Proposed Solutions to Cultural Barriers 238

7.3.1 Cultural Adaptation of Birthing Services 238

7.3.2 Promoting Male Involvement 240

7.3.3 Domesticating Skilled Maternity Care 243

7.3.4 Health Education 245

7.4 Conclusion 247

CHAPTER 8: FREE BUT NOT ACCESSIBLE TO ALL: DISCUSSION **248**

8. Introduction 248

8.1 Free but not Accessible to All 248

8.1.1 Research Overview 249

8.1.2 Summary of Main Findings 251

8.2 More than a Problem of Money: Reflections on Access Barriers 259

in the Context of Free Maternity Care
8.2.1 Differential Socio-economic Status (SES) and Access 260

8.2.2 The Healthcare Delivery System as a Barrier to Access 268

8.2.2.1 Too Many Here, Too Little There: A Question of Unequal Distribution? 270

8.2.2.2 Quality of Care: A Neglected Dimension? 274

8.2.2.3 Women-Health Provider Relationships 279

8.2.2.4 The Trust Crisis in Skilled Care: Institutional Failure or Sceptical Patients? 281

8.2.2.5 Free Maternity Care, Choice and Access: State Altruism or Paternalism? 285

8.2.2.6 Chasing out TBAs: In the Interest of Modernity or Mothers? 288

8.2.3 Culture as a Barrier to Access 292

8.2.3.1 Cultural Beliefs and Practices and Skilled Care Access 293

8.2.3.2 Culture, Gender Equity, Intrafamilial Power and Access 296

8.2.3.3 Religion and Access 303

8.3 Conclusion 308

CHAPTER 9: FREE AND ACCESSIBLE TO ALL: THE CASE FOR DIVERSITY RESPONSIVE CARE 310

9**.** Introduction 310

9.1 Free and Accessible to All: An Egalitarian Moral Illusion? 311

9.2 Free and Accessible to All: The Case for a Diversity Responsive Care 319

9.3 Developing a Diversity Responsive Maternal Healthcare Model 322

9.3.1 Levels of Responsiveness 322

9.3.1.1 Organizational and Policy Responsiveness 323

9.3.1.2 Cultural Responsiveness 324

9.3.2 Interventions 327

9.3.2.1 Health System Interventions to Promote Organizational Responsiveness 329

9.3.2.2 Health System Interventions to Promote Cultural Responsiveness 333

9.3.3 Outcomes 334

9.4 Conclusion and Future Development 334

CHAPTER 10: CONCLUSION **336**

10. Introduction 336

10.1 Implications of the Research Findings 338

10.1.1 Public Health Ethics and Distributive Justice 338

10.1.2 Public Health Policy and Practice 339

10.1.3 Future Research 343

10.2 Getting Closer to the Ideal? Reflections on the Research and Potential Limitations 347

10.3 Conclusion 350

BIBLIOGRAPHY **352**

APPENDICES

1. Questions and topic guide for focus group discussion (women) 385

2. Questions and topic guide for in-depth interview (healthcare providers) 391

3. Observation questions and topic guide 399

TABLES

2.1: Important historical milestones in the global struggle to improve MNH 30

2.2: Evidence-based interventions and strategies to improve maternal and newborn survival 42

2.3: Summary of barriers to access and equitable use of SMNHS 57

2.4: Regional distribution of health-facility maternal mortality in Ghana (1996-2000) 70

3.1: Selected demographic, socio-economic and health indicators 92

3.2: Distribution of study communities 100

3.3: Distribution of Research Participants Across Communities and Institutions 102

3.4: Steps in developing a thematic network analysis 129

3.5: Thematic network analysis framework for studying access and barriers to equitable access and use of SMNHS 134

4.1: Distribution of women Aged 15-49 who participated in the survey by background characteristic 143

4.2: Per cent distribution of women aged 15-49 by highest level of education attended or completed according to selected background characteristic 144

4.3: Selected socio-demographic characteristics of women who participated in the qualitative research 144

4.4: Per cent distribution of most recent live or stillbirth in five years preceding the survey by whether mother received ANC, DC, and PNC from medically trained persons. 148

4.5: Per cent distribution of women who had a live or stillbirth in the five years preceding the survey by whether mother received ANC from a skilled provider 152

4.6: Per cent distribution of number of ANC visits and median number of visits for the most recent live birth or stillbirth in the five years preceding the survey 153

4.7: Tetanus toxoid immunization during pregnancy for the last birth in the five years preceding the survey 154

4.8: Tetanus toxoid immunization during pregnancy for the last live birth or stillbirth in the five years preceding the survey by Religion and Ethnicity 154

4.9: Per cent distribution of live or stillbirth in the five years preceding the survey by person providing assistance during delivery 156

4.10: Per cent distribution of most recent live or stillbirths in the five years preceding the survey by place of delivery 157

4.11: Per cent distribution of most recent live or stillbirths in the five years preceding the survey by place of delivery according to Religion and Ethnicity 158

4.12: Per cent distribution of most recent live or stillbirth in the five years preceding the survey by whether delivery was caesarean section according to Religion and Ethnicity 159

4.13: Per cent distribution of postnatal care provider among women with a live or stillbirth in the five years preceding the survey 161

4.14: Per cent distribution of whether postnatal care was received among women with a live or stillbirth in the five years preceding the survey, according to Religion and Ethnicity 161

4.15: Per cent distribution of women who have heard about abortion but have not had an abortion by whether they felt they were able to get abortion care if they wanted 165

4.16: Per cent distribution of women who have heard about abortion but have not had an abortion by whether they felt they were able to get abortion care if they wanted to according to religious and ethnic affiliation 166

4.17: Per cent distribution of women who have heard about abortion but have not had an abortion by whether they knew specific places where they thought they could get abortion care 166

4.18: Per cent distribution of women who have heard about abortion but have not had an abortion by whether they knew specific places where they thought they could access abortion care according to religious and ethnic affiliation 167

4.19: Trends in actual skilled ANC coverage by region (2002-2009) 169

4.20: Trends in actual supervised institutional delivery by region (2002-2010) 170

4.21: Trends in actual skilled institutional PNC by region (2002-2009) 170

4.22: Trends in equity of access and use of skilled delivery care services (2003 & 2007) 171

5.1: Nature and distribution of care experiences across study communities 179

5.2: Regional distribution of health facilities by type and ownership in Ghana, 2009 184

5.3: Distribution of Number of Hospital beds by Region and Ownership, 2009 184

5.4: Distribution of health workers by region, 2009 184

5.5: Doctor to population ratio (2008-2009) 185

5.6: Nurse to population ratio by region (2008 -2009) 185

6.1: Final decision makers in skilled care services accessibility and utilization 205

7.1: Stakeholders proposed solutions 224

FIGURES

2.1: Main causes of maternal mortality in Ghana during the last 10 years 67

3.1: Structure of Ghana's health delivery system 93

3.2: Map of Ghana showing study regions and districts 100

4.1: Percentage distribution of coverage of ANC, DC and PNC by skilled provider for the most recent live birth or stillbirth in the 5 years preceding the survey 145

4.2: Percentage distribution of completeness of access and use of skilled maternity care services in Ghana. 146

4.3: Per cent distribution of most recent live or stillbirth in the five years preceding the survey for which skilled ANC, DC, and PNC were received by Region and Residence 147

4.4: Per cent distribution of most recent live birth or stillbirth in the 5 years preceding the survey for which ANC, DC & PNC were received 148

4.5: Percentage distribution of antenatal care provided by doctor or nurse/midwife/auxiliary midwife by region 150

4.6: Median number of ANC visits by Region and Residence 151

4.7: Per cent distribution of most recent live or stillbirth in the five years preceding the survey by person providing assistance during delivery 155

4.8: Per cent distribution of women who ever had an abortion in the five years preceding the survey by background characteristic 163

4.9: Per cent distribution of women aged 15-49 who had an abortion in the five years preceding the survey by place where the abortion was undertaken 164

4.10: Per cent distribution of women aged 15-49 who had an abortion in the five years preceding the survey by person performing the abortion 164

4.11: Trends in ANC from any skilled provider 168

4.12: Trends in place and person providing delivery care 169

5.1: Women's last experience of seeking and/ or receiving ANC, Delivery or PNC care services at a healthcare facility 178

6.1: Women’s experiences of socio-cultural barriers to skilled care access and use 203

6.2: Healthcare providers’ perceptions of socio-cultural barriers to skilled care access and use 203

9.1: A Diversity Responsive Maternal Healthcare Model 328

Free but not Accessible to All:
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ABSTRACT

Limited and inequitable access to skilled maternal and newborn healthcare has been identified as a major contributory factor to poor maternal and newborn health in sub-Saharan African countries, including Ghana. To address the problem of access, the government of Ghana, in 2003, pioneered and is implementing a new maternal healthcare policy that provides free maternity care at the point of delivery in all public and mission health facilities to ensure increased and equitable access and use of skilled maternal and newborn healthcare services.

The aim of this doctoral study is to explore how the introduction of the free maternal health policy in Ghana affects access, equity of access, and to investigate barriers to accessibility and utilization of skilled maternal and newborn health services. It does this using data from the Ghana Maternal Health Survey 2007, in combination with qualitative data generated from ethnographic-style in-depth interviews and focus group discussions that the author originally conducted with a total of 185 expectant and lactating mothers, and 20 healthcare providers and policy-makers in six communities in Ghana between November 2011 and June 2012.

Survey data suggest that accessibility to, and utilization of skilled antenatal care, delivery in a health facility, delivery with a skilled birth attendant, as well as other post-natal care services have increased by an average of 8% since the introduction of the policy (i.e. between 2003 and 2007). However, both survey and qualitative data indicate that while the free maternity care policy in Ghana removes important financial barriers to access and use of life-saving maternal and newborn health services, most skilled care services remain underutilized, while inequities in skilled care services accessibility and utilization persist. Qualitative findings suggest that this is largely because not only is the provision of skilled maternal and newborn healthcare services in Ghana very limited and unequally available to the population, but also even where these services are available at no or minimal cost, and can be physically accessed, they can be unfriendly, culturally unacceptable, socially degrading or even abusive to women. These factors have combined to discourage a disproportionate number of expectant mothers from accessing and using skilled maternal and newborn health services although these services are free.

This doctoral research argues for a move beyond free maternity care and stresses the importance of organizing and delivering services in ways that are medically appropriate, socially sensitive, and culturally responsive. The thesis also argues that the development of a *diversity responsive maternal healthcare system* would go a long way to first redress the health system and socio-cultural barriers to equitable access, and then promote increased and equitable access for different groups of women.

Chapter 1

WHEN PREGNANCY AND CHILDBIRTH HARM

1. Background to the Research

Neither pregnancy nor childbirth is a disease. Indeed, both are events, which are often celebrated: occasions for dancing, fireworks, and flowers or gifts. Despite this, over 0.36 million women worldwide die every year due to complications of pregnancy and labour or immediately after giving birth (WHO, 2010). An additional 300 million women live with, and suffer various debilitating conditions of pregnancy and childbirth (Lewis, 2008). These include chronic anaemia, obstetric fistulae, urinary and/ or faecal incontinence, foot drop or palsy, and urine prolapse or pelvic inflammatory disease. Research shows that most women who suffer these conditions are isolated and rejected by their husbands, families and communities (*ibid*).

But the dangers of pregnancy and childbirth extend beyond childbearing women. It is estimated that, globally, 4 million stillbirths and 3 million newborn deaths occur within the first 28 days of life (the neonatal period) every year (WHO, 2012). Indeed, neonatal deaths constitute about 40% of the under-five mortality globally (Lawn *et al*, 2005).

Together, the global burden of maternal deaths (the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes), stillbirths and neonatal deaths far exceeds the total of 5 million estimated global deaths due to HIV/AIDS, tuberculosis and malaria combined (Nyamtema *et al*, 2011).

The greatest share of this high global burden of maternal and neonatal deaths is borne by low-income countries (Gething *et al*, 2012; WHO, 2012). Nearly all-maternal and newborn deaths

(99%) occur in low-income countries (AbouZahr & Wardlaw, 2003), This makes maternal mortality one of the health indicators with the largest disparity between high and low-income countries (van den Broek & Falconer, 2011).

Sub-Saharan Africa (SSA) particularly epitomizes the enormity of the challenge of poor maternal and newborn health (MNH) as well as the unequal gains attained in MNH outcomes over the years (Stephenson *et al*, 2006). Despite heightened global, regional and country-specific efforts to reduce maternal and neonatal mortality, the risk of dying during pregnancy or childbirth remains particularly significant for women and newborns in SSA (Campbell & Graham, 2006; Cross *et al*, 2010). In 2010 for example, SSA accounted for more than half of the burden of maternal and newborn deaths in low-income countries (WHO, 2010). Similarly, in 2000, maternal mortality ratio (MMR) - the number of maternal deaths during a given time period per 100, 000 live births during the same time period - in SSA was estimated to be 1000 per 100 000 live births (Ronsmans & Graham, 2006). This ratio was almost twice that of South Asia, four times as high as Latin America and the Caribbean, and nearly 50 times higher than in high-income countries (*ibid*). Also, while other low-income regions like Latin America and the Caribbean, and North Africa, respectively reduced MMR by 41% and 59% between 1990 and 2008, SSA had only reduced it by 26%. Furthermore, the estimated annual decrease of 1.7% in MMR in SSA is far below the 5.5% annual decline rate, which is thought to be necessary for the attainment of improved maternal health by 2015. Currently, 1 in 43 and 1 in 30,000 women living in south Asia and Sweden, respectively, has a lifetime risk (i.e. the accumulated chance of dying from complications of pregnancy and childbirth during a woman's reproductive life) of dying during pregnancy or shortly after delivery compared to 1 in 16 in SSA (Brazier *et al*, 2009; Zere *et al*, 2010).

Like many countries of SSA, Ghana is one country in which for the majority of women, the experience of pregnancy and childbirth can still in fact be equivalent to a death sentence, characterized by fear, anxiety, anguish and pain. Ghana has had a persistently high MMR, estimated to range from a low of 200 to a high of 1,300 per 100,000 live births (Witter *et al*, 2007). The latest WHO (2012) estimates suggest 350 maternal deaths per 100, 000 live births in Ghana, with an uncertainty range of 210- 630. Maternal mortality, which accounts for 14% of all female deaths, is the second largest cause of female deaths in Ghana (Abor *et al*, 2011). A Ghanaian woman's risk of dying from pregnancy and childbirth over the course of her reproductive lifetime is estimated to be 1 in 45, although there are regional variations within the country.

At both global and regional levels, there are different explanations for the persistence of poor MNH (See Thaddeus & Maine, 1994; Maine & Rosenfield, 1999; Lawn *et al*, 2005; Ronsmans & Graham, 2006; Lewis, 2008; Bhutta *et al*, 2010; Zere *et al*, 2010; Zere *et al*, 2011). But one prominent explanation, which has recently been highlighted and debated in both academic literature and in the policy context, is limited and unequal access and use of skilled maternal and newborn healthcare services (SMNHS) (Say & Raine, 2007; Lewis, 2008; McNamee *et al*, 2009; Zere *et al*, 2010; Zere *et al*, 2011). Globally, about 63% of women receive support and care during birth from a skilled health worker (Lewis, 2008). While in high-income countries coverage of skilled birthing services is almost universal, in Africa and Asia, only 47% and 61% of mothers, respectively, give birth with a skilled care provider.

Within the empirical research literature, evidence suggest that access to, and use of SMNHS,

particularly skilled attendance at birth, is associated with substantial reductions in mortality and morbidity for both mother and newborn over home births (Starrs, 2006; Essendi *et al*, 2010; Abor *et al*, 2011). Consequently, both lack of access and unequal access to essential care has been identified as one fundamental cause of maternal and newborn mortality and morbidity across the world, but specifically in SSA (Ridde & Diarra, 2009; Witter *et al*, 2009; *Zere et al*, 2010). The WHO for example, argues that women are dying during pregnancy, childbirth and in the postpartum and postnatal periods because they have no or limited access to health services (WHO, 2005). One recent study also concludes that limited access to health facilities staffed by appropriately trained personnel and offering midwifery competencies and life-saving obstetric interventions at birth is known to be a key driver of maternal mortality (Gething *et al*, 2012).

To address the problem of access to SMNHS during pregnancy and childbirth, health policymakers in many low-income countries have begun experimenting with different strategies, including voucher schemes, conditional cash transfers, health insurance and total user-fee abolition. It is within this context that the government of Ghana, in 2003, pioneered and is implementing a new maternal healthcare policy that provides free maternity care at the point of delivery in all public and mission health facilities to ensure increased and equitable access and use of SMNHS. Ghana's free maternal healthcare policy is premised on the notion that financial barriers are one of the most important causes of low and inequitable access to, and use of skilled maternity care services (Penfold *et al*, 2007). The policy therefore aims to reduce both the financial barriers to access and inequities in access and use of SMNHS (*ibid*). It is expected that the policy would lead to an increase in the proportion of women accessing and using skilled and professionally delivered antennal, delivery and postnatal care services in a formal health setting, thereby leading to a reduction in maternal and newborn mortality (Penfold *et al*, 2007; MoH,

2008).

Despite the popularity of this new policy intervention, it is not clear to what extent SMNHS have become widely accessible and used in Ghana. It is also not clear whether variations in accessibility and utilization of skilled care have been eliminated following the implementation of the free maternal healthcare policy. At the commencement of this research, and indeed to date, few studies have systematically investigated the impact of Ghana's free maternal healthcare policy on access and equity of access to skilled care. Like most parts of SSA where there is generally a 'scarcity of good qualitative evidence' on the effect of such policies (Lagarde & Palmer, 2008), there is as yet insufficient evidence of the effect of Ghana's free maternal healthcare policy on access to skilled maternity care. One recent assessment of the policy observed that rigorous evaluations of the policy are lacking and that there is limited evidence, particularly concerning the impact of the policy on access and service utilization: whether it increases access to skilled care, whether it eliminates access barriers and whether it assures universal access by eliminating inequities in access and service utilization? (Dzakpasu *et al*, 2012).

In addition, while inequity in access and use of skilled maternity care services is a growing global concern (as it impedes progress towards improvement in maternal health and attainment of the MDG 5 target of reducing maternal mortality ratio by 75% between 1990 and 2015), no systematic studies exist in Ghana that rigorously describe and account for inequities in SMNHS accessibility and utilization. To the author's knowledge, empirical research on maternal health in Ghana more generally (see Addai, 2000; Senah, 2003; Gyimah *et al*, 2006) and evaluative studies of Ghana's free maternal healthcare policy more specifically (see Bosu *et al*, 2007; Witter *et al*,

2007), have not examined the equity dimension of access, and the ethical and moral questions that efforts to redress inequity through the free maternal healthcare policy may raise. Thus little is known about whether free maternity care does eliminate access inequities and the factors contributing to inequities in access and use of skilled maternity care services. This is reminiscent of findings from several analyses of health sector reforms in Africa, which conclude that the equity impact of public health policies has been neglected (Nanda, 2002). Ridde and Morestin (2011) put the issue more starkly when they observed that there is still hardly any data available in Africa on the distributive effect of user-fee exemption policies for deliveries. Thus far, empirical evidence of the equity implications of free maternity care for access comes from Asia and Latin America (see Dmytraczenko *et al*, 1998; Ensor, 2005; Borghi *et al*, 2006). However, given the wide socio-cultural, political and economic differences between Asia, Latin America and Africa, it is doubtful whether the results from Asia and Latin America hold true for Africa more generally, and Ghana in particular. As Say & Raine (2007) observed lack of access and variations in access to skilled care is often framed by contextual issues. This highlights the need for continuous research to investigate and assess context-specific impact of such policy interventions as well as the causes of varying use of SMNHS in low-income countries and to identify strategies for redress.

The need to undertake such research in the context of Ghana is particularly compelling not only because maternal health is seen as a 'national emergency', but also because Ghana presents an interesting ideal case study. It is an interesting ideal case study because it is one of only a handful of countries in SSA to actively started implementing both universal maternity care and health insurance policies at the national level. As a result, Ghana is often considered 'an example of global good practice' (WHO, 2010; Schieber *et al*, 2012).

In addition to being an example in relation to the delivery of MNH, the economic and political conditions in Ghana also make the country an interesting case study. Ghana is situated within the predominantly economically marginalized and politically unstable region of West Africa, but forms an exception. Relatively, Ghana is a small fledgling multicultural, multi-ethnic, multi-religious, and multi-party constitutional democracy, characterized by vibrant civil society activism and media pluralism. It is politically stable; a rebasing of its economy in November 2010 saw the country leap into the category of lower-middle-income countries (Schieber *et al*, 2012); it also recently started producing oil in commercial quantities; and is often touted as one of the most politically and economically progressive countries in the region.

Despite the 'exceptional status' Ghana enjoys in the sub-region, MMR has remained persistently high. Studies undertaken before or at the time that the present study was being carried out suggest that Ghana is off track to achieving the MDG 4 and 5 targets despite implementing the free maternity care policy (Schieber *et al*, 2012). In fact Schieber *et al* (2012) found that among countries with similar levels of income and health expenditure, Ghana performs worse than average with respect to neonatal, infant, under-five, and maternal mortality.

Yet, interest in, and pressure to improve MNH outcomes through innovative policy intervention including user-fee removal continues to grow in Ghana and across the African sub-region. More resources also continue to flow into the design and execution of Ghana's free maternity care policy, and discussions of the need to achieve universal access to care so as to propel progress towards the attainment of MDG 4 and 5 feature prominently in national policy discourses. In this way, the lacuna in the literature and in the understanding of how Ghana's free maternity care

policy affects access and equity of service accessibility and utilization weakens the empirical basis for justifying such a policy intervention (Dzakpasu *et al*, 2012). This knowledge gap also breeds unnecessary speculation, thus posing frustrating barriers to decision-makers and researchers looking to draw evidence and lessons to inform debates or the design of future policies. It is against this background that this study aims to contribute to a better understanding of how free maternal healthcare policies affect access, equity of access and barriers to access in the Ghanaian context.

1.2 Research Objectives

The general aim of this doctoral research is to combine empirical quantitative evaluation with qualitative exploration and analysis to identify the extent to which SMNHS have become widely used in Ghana, and whether variations in accessibility and utilization of skilled care have been eliminated following the implementation of the free maternal healthcare policy, and the explanations for both none and differential access and use of skilled services in the context of Ghana's free maternal healthcare policy. Specific objectives of the research are to:

1. Describe and analyse, using a nationally representative survey data, the patterns of SMNHS accessibility and utilization to determine whether access differentials exist, and how Ghana's free maternal healthcare policy has affected and continues to affect access and differences (if any) in access;

2. Explore, using women's experiences of seeking SMNHS, and through a careful study of the organization of Ghana's maternal healthcare system, why and how (if any) differentials in access and use of SMNHS are brought about;

3. Investigate local and contextual barriers to uptake of skilled care services by mothers and their newborn, and determine the extent to which factors limiting service accessibility and utilization are the product of well or ill-informed individual or collective choices; whether they result from health system and structural constraints such as cultural dissonance or disjunctions between healthcare policy practices and women's needs and experiences of pregnancy and childbirth; and

4. Identify potential remedies

1.3 Research Questions

In pursuing the research agenda outlined above, the research will explore very specific questions. First, understanding the patterns of access to SMNHS within and across geographical regions, districts, communities, and socio-demographic groups in Ghana in the context of the free maternal healthcare policy is important for understanding the impact of Ghana's fee-exemption policy for maternity care, monitoring equity in access and use of SMNHS, and targeting scarce resources to those with more need (Zere *et al*, 2011). Therefore, and in relation to the first research objective, three main research questions are addressed:

1. In the context of Ghana's free maternal healthcare policy, do all women in need of skilled antenatal, delivery and post-delivery care service have access?

2. Which categories of women have more access than others?

3. How has Ghana's free maternal healthcare policy affected access and equity of access and use of SMNHS?

Second, investigating women's perspectives and experiences of seeking maternity care holds out the potential for advancing competent explanations for why and how access may not be the same for all. Such experiences also provide a lens through which to understand important contextual constraints. It is known, for example, that health services experience and patient satisfaction is a major determinant of health services utilization (Hotchkiss *et al*, 2000; Aldana *et al*, 2001; van Teijlingen *et al*, 2003; Simkhada *et al,* 2007), while understanding the remaining barriers to access within the context of a free maternal healthcare policy is said to represent the first step towards the establishment of comprehensive policies for the reduction of maternal and neonatal mortality in SSA (De Allegri *et al*, 2010). For the second and third research objectives, therefore, two related research questions are investigated. The key aim is to create an operative understanding of access by focusing not only on factors that restrict access or create unequal access, but also on identifying factors that if avoided may prevent non-access or differential use of services.

4. How and why (if any) do differences in SMNHS access and use exist in Ghana despite the free maternal healthcare policy?
5. What barriers militate against universal access and use of SMNHS; and in particular, what role do differences in women's experiences of seeking SMNHS play; and how do the healthcare system, cultural norms, belief systems, and the choices that individual childbearing women make and/ or not make, affect access to skilled care?

Finally, how to effectively deliver SMNHS to women is one of the key challenges currently facing many low-income countries (Liljestrand, 2000). To respond to this challenge, two research questions, which relate directly to the fourth objective above, would be investigated, namely:

6. What factors enable and promote access and use of SMNHS in Ghana?

7. How can access be increased, and inequities (if any) in access and use of SMNHS reduced in Ghana?

1.4 Conclusion and Thesis Structure

With an estimated 0.36 million deaths globally in the year 2010 - 99% of which occurred in low and middle-income countries - maternal mortality remains one of the most important public health challenges facing low and middle-income countries, including Ghana. This chapter has provided a background to the research - introduced the research problem and its significance, set out the research objectives, and articulated seven distinct but inter-related research questions. The rest of this thesis is organized into nine distinct but related chapters.

Chapter two reviews and explores the relevant literature to situate the current research in context and identify research gaps. It does this in the belief that having a broad awareness of the state of existing knowledge and theory in one's area of chosen research acts not only as an important guide to relevant potential research topics and research destinations, but, in fact, also forms the basis for new research.

Chapter three presents a detailed reflection on the study's methodology. The intent is to allow the reader to follow the processes through which information for this research was obtained and to assess the reliability of data that informed the analysis thereof.

In the context of Ghana's free maternal healthcare policy, do all women in need of SMNHS have access? Which categories of women have more access than others; and how has Ghana's free maternal healthcare policy affected access and equity of access and use of SMNHS? Based on analysis of survey data, these questions, which are also the first three research questions that this thesis sought to address, constitute the subject matter of empirical investigation in chapter four.

On the backdrop of the findings presented in chapter four, and drawing on the experiences and local narrative accounts of expectant and lactating mothers, healthcare workers, and the researcher's own scientific observations in two of Ghana's ten administrative regions, chapter five considers the question of unequal access and barriers to access and use of SMNHS. The chapter specifically focuses on the way in which a gamut of health system factors interplay to mount barriers to equitable access and use of SMNHS.

Like chapter five, chapter six also draws on women's experiences and rich narrative accounts to consider the role of socio-cultural factors at the individual, family and community levels in explaining why access to skilled care may remain limited and unequal despite the free maternal healthcare policy in Ghana.

Chapter seven considers the question of what ought to be done to eliminate the remaining barriers to access and to secure equal access for all women in need of life-saving child birthing services in

Ghana. Drawing on thick and rich contextual accounts provided by child-bearing women and healthcare workers, the chapter presents and discusses several proposals to redress existing barriers to access, reduce inequities in service utilization, and ultimately progress towards the MDG 5 target of dwarfing MMR by 75% by 2015.

Chapter eight is a discussion of the findings presented in chapters 4-7. Its aim is to synthesize and reflect further on the research findings – their strengths and limitations - and their specific and/ or broad ramifications for public health policy and future research.

Based on findings in chapters four, five, six and seven, and the discussion in chapter eight, chapter nine proposes a new model of maternity care – *A Diversity Responsive Maternal Healthcare Model* – which could potentially serve as a catalyst for meeting the diverse but legitimate needs and expectations of childbearing women, increasing access, and reducing disparities in access and use of SMNHS.

Chapter ten draws the thesis to a close by reflecting on, and considering the broad policy, research and ethical ramifications of the research findings. Directions for further research are then suggested, while some tentative conclusions are drawn out.

Chapter 2

THE STRUGGLE TO IMPROVE MATERNAL AND NEWBORN HEALTH: A LITERATURE REVIEW

2. Introduction

Over the last three decades, improving maternal and newborn health (MNH) has become a global priority, and quantified reductions in maternal and neonatal deaths have been included in the Millennium Development Goals (MDGs). Despite this, maternal and neonatal mortality has fallen only slightly in low-income countries. This chapter aims to review the state of knowledge and debates around the global struggle to improve MNH. The primary objectives are to 1) assess and synthesize existing knowledge related to MNH care access; and 2) identify research gaps and provide a context for a possible redress of such gaps in the literature.

While there are probably more ways than one to conduct a literature review on the subject of MNH care access, the approach chosen here is *narrative*. According to Jones (2007), a narrative review aims to provide an overview of what is known about a subject and what the knowledge gaps are. It emphasizes 'identifying the key concepts or specific terms used in the literature and the particular theoretical approaches adopted by different authors to understanding a phenomenon' (p.33). Furthermore, 'in a narrative review the reviewer offers a critique in order to assess, analyse and synthesize previous research, and place it in its current context' (p.34). The narrative here therefore involves both a chronological interpretation of historical events and a critical appraisal of the empirical research literature. This approach is taken in the belief that the memories and histories of the global struggle to improve MNH lead to new manifestations of the past within the present, suggesting that looking into the present and future efforts to improve MNH outcomes, may involve a serious excavation of the buried past.

2.1 Maternal and Newborn Health: Past, Present and Historical Memory

For the purposes of situating this review and providing a context for the rest of the thesis, this section offers a brief historical account of the evolution of MNH. It does this through a chronological examination of significant events, policies and programmatic initiatives that demonstrate the ways in which the global agenda to improve MNH has evolved.

Broadly conceived, MNH can be viewed as the professional and academic field which focuses on the determinants, mechanisms, and systems that operate and maintain the health, safety, well-being and appropriate development of mothers and their babies (Alexander, 2004). Within more contemporary literature, MNH is often discussed as one of the important strands of the broader field of reproductive health, which is defined as:

> A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (UN, 1994, paragraph 7.2).

As already noted, in the last three decades improving MNH has become a global priority, and MDGs 4 and 5 contain quantified targets for reduction in maternal, neonatal, infant and child deaths. Despite this recent preponderance, historians of women's health and reproductive medicine have noted that prior to the 20th Century the health of mothers and newborns was generally considered a domestic concern (Ruzek, 1978; Dwork, 1987; Zapata & Bennett, 1997). The reproductive life of women was embedded in a female culture, and maternity was understood as part of women's domestic and social responsibility (Ruzek, 1978; Zapata & Bennett, 1997).

Towards the late 1800s however, politicians and doctors alike across Europe took a keen interest in the health of women and their children (Dwork, 1987; Rosenfield & Min, 2009). Accordingly,

it was from this generalized interest in the health of women and children in the late 19th Century that the idea of a formalized maternity care system emerged (Dwork, 1987).

But why did European politicians develop an interest in the health of women and their children during this time? The work of the American social-cum-medical historian, Deborah Dwork (1987) - which is summarized below - provides one of the most persuasive answers to this question.

2.1.1 War and the Birth of MNH

In her book *War is Good for Babies,* Dwork (1987) discusses questions about family, the role of women, and the concept of children's rights in the context of the development of the modern welfare system. She locates the initial interests in maternal health in Europe in the exigencies of war and ideology at the time. According to Dwork, the period before the late 1800s witnessed high maternal and infant mortality rates. These high rates, combined with declining rates of birth, aroused fears among politicians across Europe that their nations would fall behind in the race for economic and military supremacy, which required a robust adult population. Fears of national deterioration were especially strong among the French in the wake of their defeat in the Franco-Prussian War (1870-1871), and later among the British after their poor showing in the Boer War (1899-1902) due partly to difficulties in recruiting able-bodied soldiers.

The exigencies of war and the quest for economic and military prowess, Dwork argues, collided and coalesced with powerful philosophical thoughts of the French surgeon, Jacques-René Tenon (1996, original publication in 1788), who argued that no one is more worthy of care than the pregnant woman who carries within her the support of empires and the gem of future generations.

In retrospect, the 2005 World Health Report, *Make Every Mother and Child Count,* re-echoes this point by arguing that children are the future of society, and their mothers are the guardians of that future (WHO, 2005).

As maternal and infant mortality became a marker of the vitality of the nation and a widely used indicator of general standards of health, Dwork (1987) suggests that the need for healthy children – with the potential to grow into a healthy adult population - and healthy mothers to bear them was imperative. Consequently, by the early 20th century, local health authorities were providing maternal and infant healthcare and welfare services in the industrialized countries of Europe and USA in a more formalized manner. For example, in Paris, Pierre Budine organized the first *consultation de nourrisons* (infant health consultation) in the Charité Hospital in 1892 (see table 2.1). In Europe and America, the loss of lives during the 1st and 2nd World Wars (WW) particularly hastened the development of more comprehensive maternal, infant and child welfare programmes (Dwork, 1987). In Eastern Europe, the revolution in maternity and child care was even more dramatic as 'a political revolution had ordained that social and economic betterment was to be achieved through systems of planning and control by experts, and betterment in maternal and infant welfare through a system of childbirth care planned and controlled by medical experts' (Tew, 1995:1).

It is on the premises above that Dwork (1987) argues rather controversially that war is good for babies and other young children and their mothers. In contemporary global health however, it is doubtful whether such an argument can be sustained. In addition to ethico-moral objections, an evidential argument can be adduced to contest Dwork. For example the top six countries with the worst MNH outcomes - Sierra Leone, Afghanistan, Niger, Chad, Somalia and Nigeria - have

suffered or are suffering from wars and civil unrest (Ronsmans & Graham, 2006; Lewis, 2008; Bryce *et al*, 2008; Fotso *et al*, 2009; Hogan *et al*, 2010). But given the context within which Dwork writes, it is possible that the imperatives of war and military conquest did inaugurate efforts to improve MNH.

Table 2.1: Important historical milestones in the global struggle to improve MNH

Year	Milestone
1892	Pierre Budine organized the first *consultation de nourrisons* or infant health consultation in the Charité Hospital in Paris.
1894	Léon Dufour opened a milk station (*goutte de lait*) in Fécamp, Normandy, where sterilized milk was distributed and weekly infant medical care provided.
1946	The United Nations International Children's Emergency Fund (UNICEF) was founded to provide relief to children and orphans of the world wars.
1948	The World Health Organization (WHO) was founded to help all people attain 'the highest possible level of health', including a function 'to promote maternal and child health and welfare'.
1978	The WHO and UNICEF co-sponsored the International Conference on Primary Health Care in Alma-Ata, Kazakhstan, which led to the Alma-Ata Declaration that argued for universal access to primary healthcare.
1982	UNICEF, under the directorship of James P Grant, launched the Child Survival Revolution, which called for massive coverage of four main interventions – growth monitoring, oral rehydration therapy, breastfeeding, and immunization - that could rapidly increase progress in child health and nutrition.
1984	A task Force on Child Survival and Development was launched to coordinate immunization activities of major international donors.
1987	The WHO, World Bank and United Nations Population Fund (UNFPA) sponsored an International Conference in Nairobi, Kenya, during which the Safe Motherhood Initiative was launched.
1990	The World Summit for Children set goals to be achieved by the year 2000, including a goal to reduce under-five child mortality rate by one-third or to 70 deaths per 1,000 live births.
1994	The International Conference on Population and Development (ICPD) took place in Cairo, Egypt, during which the current definition of reproductive health and reproductive rights were articulated.
1995	Fourth World Conference for Women in Beijing, China, reaffirmed women's right to reproductive health care services.
1996	UNICEF and WHO introduced the Integrated Management of Childhood Illness Initiative (IMCI), an initiative that continues to be one of the predominant strategies for addressing child health issues in low and middle-income countries today.
1997	A Safe Motherhood Technical Consultation was convened in Sri Lanka, during which new priorities for safe motherhood were set.
1999	Bill and Melinda Gates Foundation financed Columbia University's Mailman School of Public Health to launch the Averting Maternal Death & Disability (AMDD) initiative.
2000	Millennium Development Goals (MDGs) developed and adopted at the UN Millennium Summit; goals four and five of which aim to reduce child mortality and improve maternal health respectively.
2000	The WHO launched the Making Pregnancy Safer Initiative.
2001	The African Union made a declaration in Abuja (The Abuja Declaration) in which African heads of state committed their governments to increase health financing to at least 15% of national budgets, so as to address health challenges including maternal and child morbidity and mortality, HIV/AIDS, Malaria and Tuberculosis.
2002	UN Sectary General commissioned the Un Millennium Project to develop actionable plans to achieve the MDGs.
2003	The WHO launched the African Regional Reproductive Health Task Force.
2004	The WHO launched a Road Map for Accelerating the Attainment of MDGs Related to Reduction of Maternal and Newborn Morbidity and Mortality.
2005	The WHO launched the Partnership for Maternal, Newborn and Child Health to harmonize and accelerate progress towards attaining MDGs 4 and 5.
2005	'Count Down to 2015 for Maternal, Newborn and Child Survival Initiative' – an independent supra-institutional collaboration between scientist, UN agencies, governments and civil society which aims to gather and present data for use by countries and the global health community to stimulate country action by tracking coverage for interventions that are essential for the attainment of MDGs 4 and 5 – is launched.
2006	The African Union (AU) launched the Maputo Plan of Action in which heads of African states reaffirmed their commitment to the Abuja declaration (2001) with regards to budgetary allocation for health, universal access to comprehensive sexual and reproductive health services in Africa by 2015, and access to quality safe motherhood and child survival services.

Source: Author's construct based on Dwork (1987), World Health Organization (2005), African Union (2006), and Rosenfield & Min (2009).

2.1.2 In the Throes of Moralism: The UN and MNH

While the exigencies of war and utilitarian ethics initially necessitated the provision of MNH care services across Europe and America, the end of WWII ushered in a new era of international cooperation in health, within which the health of mothers and children became an issue of right and of moral obligation (Rosenfield & Min, 2009). The United Nations (UN) was established during this period (1945) and the United Nations Children's Emergency Fund (UNICEF) was founded to provide relief to the thousands of children and orphans left vulnerable by the war. The World Health Organization (WHO), a specialized arm of the UN, came into being in 1948 to help all people attain the highest possible level of health including a function to promote maternal and child health and welfare (WHO, 1948).

In fact the founding of the UN and its agencies was crucially important in giving actionable meaning to maternal health (Rosenfield & Min, 2009). For example, the UN General Assembly's adoption of the Universal Declaration of Human Rights in 1948 included an acknowledgement that motherhood is entitled to special care and assistance (UN, 1948). This catapulted maternal health into an international health priority, though the exact strategies for promoting it would be debated and transformed repeatedly in the coming decades.

During the first half of the 20th Century, many of the nations now designated as developing countries were colonies and protectorates. After the independence movements in the late 1940s to the early 1960s, industrialized nations began to provide aid directly to these countries on a one-to-one basis, a form of assistance known as bilateral aid (Rosenfield & Min, 2009). The US Agency for International Development (USAID) was, for example, established in 1961 to provide economic and social development assistance to poor nations, including funding a number of

maternal health programmes in developing countries (Rosenfield & Min, 2009). By this time, NGOs and civil society organizations, operating under the rubrics of humanitarianism and the imperative to reduce suffering, had also been influential in shaping the global maternal health agenda (Rosenfield & Min, 2009).

Thus while the economic exigencies of war and utilitarian ethics necessitated the provision of maternal health services in Europe and America, post-war public interest in maternal health was largely motivated by humanitarian concerns. In particular, new and more comprehensive reports on the high levels of maternal morbidity and mortality in England and the USA stimulated action at the local and national levels. As Rosenfield & Min (2009) observe, medical associations, charities, women groups, and other segment of civil society took active interest, often as part of social reform movements of that era. Advocacy was often instrumental in introducing legislation and securing funds to address the issue (van Lerberghe & De Brouwere, 2001). In this way, forces of moralism and humanitarian ethos co-functioned to produce the institutionalization and reconfiguration of maternal health during the post-war period.

In most newly independent states however, it has been noted that the institutionalization of maternity care in the immediate post-war period did not achieve much (Rosenfield & Min, 2009). This is largely because global effort and cooperation between nations on matters of health at this time heavily focused on the control of communicable diseases to facilitate trade and commerce (Rosenfield & Min, 2009). In addition, it has been suggested that part of the reason for the neglect of maternal health emanated from the fact that the scale of the problem of maternal morbidity and mortality was unclear in most low-income countries until the 1980s because of poor or non-existent vital registration systems (*ibid*).

2.1.3 Saving Mothers, Delivering Justice: The Safe Motherhood Initiative & MNH

In the early 1980s, the neglect of maternal health in post-war international health policy was met with several criticisms. These criticisms were furthered to the extreme by a very provocative paper that Rosenfield & Maine (1985) published in *The Lancet.* In this paper titled 'Maternal mortality – a neglected tragedy. Where is the ''M'' in MCH?' Rosenfield & Maine problematized previous global efforts to make pregnancy and childbirth safer by highlighting the tragedy of maternal mortality and the fact that many low-income countries were neglecting this important problem. They argued that poor rural women, who have right to access effective maternal health care, have nevertheless been ignored in the global campaign to improve population health and called on the World Bank and other stakeholders to make maternity care a priority.

At the same time that Rosenfield & Maine paper was published, Harrison (1985) analysed 22,776 hospital births in Zaria, Northern Nigeria, and showed that an appalling morbidity and mortality of women was associated with pregnancy and childbirth. Almost immediately, these new analyses highlighting the enormity of the problem of maternal morbidity and mortality gave rise to calls by medical associations, charities, women groups, women's health advocacy groups, and civil society for more action to prevent a 'preventable tragedy' (Senah, 2003). This call was bolstered by new and more comprehensive research evidence, which also showed high levels of maternal morbidity and mortality in England and the USA (Rosenfield & Min, 2009).

These criticisms culminated in the launch of a Safe Motherhood Initiative (SMI) in 1987. The SMI resulted from a World Bank-WHO-United Nations Population Fund (UNFPA) co-sponsored international conference in Nairobi, Kenya, which sought to raise global awareness of the poor state of maternal health especially in low-income countries and to galvanize support for

improvement. As the first coordinated global effort to address high rates of maternal and neonatal mortality (Smith & Sulzbach, 2008), the SMI set a goal to reduce maternal mortality in low and middle-income countries by 50% by the year 2000.

In the early years of the SMI, UN agencies, donors and national ministries of health supported two strategies: antenatal care with a focus on screening, and the training of traditional birth attendants (TBAs) in safe and hygienic practices during delivery (Rosenfield & Min, 2009). Antenatal screening embodied the idea of persuading all women to attend at least one antenatal visit during their pregnancy. A screening test would then be conducted and those women identified as high risk could then be monitored and treated or advised to give birth at a health facility (ibid). Antenatal screening was so heavily promoted by the WHO that, 'it became accepted wisdom despite some evidence of its ineffectiveness' (Rosenfield & Min, 2009:11). Similarly, the training of TBAs was considered a rational approach to reducing maternal mortality in countries where there was a shortage of professional health workers and where the majority of women delivered at home. At the time, it was argued that both of these interventions were not only cost-effective, but also they fitted well with the ideals of the 1978 Alma Ata Declaration on primary health care (*ibid*).

These two interventions nevertheless became deeply problematic sooner rather. First, the idea of antenatal screening became discredited because many direct obstetric complications could neither be predicted nor prevented (Maine & Rosenfield, 1999). Second, most TBAs training programmes neither ensured effective supervision nor provided the appropriate linkages to referral services (Rosenfield & Min, 2009). For most of the complications of pregnancy and

childbirth that led to maternal death or severe morbidity, it was also argued that there is little that TBAs could do to save women (*ibid*).

2.1.4 Reframing the Debate: The 1994 ICPD and MNH

At the same time that this furore of debates engulfed both academic and policy circles as regards the global agenda on maternal health more generally, and SMI more specifically, many feared the economic and social consequences of rapid population growth (Rosenfield & Min, 2009). Therefore, in the 1960s, governments declared national population policies and established family planning programmes with support from a variety of donors, including UNFPA and USAID.

Disenchanted by the focus on meeting demographic targets however, an international women's health movement emerged in the early 1990s that sought to problematize the focus of population policies by shifting the ideology and rationale for family planning programmes from *population control* to *women's health and rights* (Yamin & Maine, 1999, emphasis mine). This culminated in an International Conference on Population and Development (ICPD) in 1994 in Cairo, Egypt, which was attended by over 180 country-delegates and approximately 1,200 NGOs.

During the ICPD, family planning, safe motherhood, and women's sexual health were brought together under the concept of *reproductive health* (Yamin & Maine, 1999). Significantly, the ICPD was the first major international forum to articulate a human rights approach to the provision of reproductive health services (Yamin & Maine, 1999). Maternal mortality was framed as a matter of right and justice, and governments were obligated to use all political and legal means available to provide appropriate maternity care services to women (Yamin & Maine,

1999). The ICPD Programme of Action called on countries to reduce maternal mortality by one-half of their 1990 levels by the year 2000, and a further one-half by 2015.

Sadly, the ICPD did not result in any real integration of family planning and maternal health programmes (Rosenfield & Min, 2009). Similarly, the idea of maternal health as a matter of right remained poorly articulated, and considerable ambiguity and debate continue to surround it today (Liljestrand, 2000).

In the wake of the forgoing limitations, a Safe Motherhood Technical Consultation was convened in 1997 in Colombo, Sri Lanka, to review the SMI. Starrs (1998) notes that one key action message from the Sri Lanka meeting that altered the global agenda on MNH was the recognition that every pregnancy faced risks and therefore, programmes should stop using risk-screening tools as a means to reducing mortality or morbidity. Instead, ensuring skilled attendance at birth was emphasized. The WHO (2005) defines a skilled health personnel as an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period and in the identification, management, and referral of complications in women and newborns. The argument in relation to skilled birth attendance, as summarized by Filippi *et al* (2006) is that, the clustering of mortality around delivery mean that all women should have access to skilled attendants at birth and immediately after, and to timely referral for emergency care.

Despite the important contribution the Safe Motherhood Technical Consultation meeting made to debates regarding how to attain the objectives of the SMI, critics have argued that the aftermath of the consultation caused further confusion (Maine & Rosenfield, 1999; Rosenfield & Min;

2009; Child & Ehiri, 2009). More specifically, Child & Ehiri (2009) argue that strategic priorities were not clearly defined and some even broadened the SMI to include a range of activities, including nutrition, education and general economic development. Many SMIs also gave little attention to the management of complications from unsafe abortion due to the political sensitivities and legal rancour surrounding the issue (Maine & Rosenfield, 1999).

2.1.5 The MDGs and MNH

At the turn of this century, the focus on maternal health became more sharpened as demonstrated by the recognition of the need to improve MNH during the Millennium Summit in 2000. The Millennium Summit saw 189 countries endorse and sign up to meeting eight global Millennium Development Goals (MDGs), of which goal four and five are related to maternal and child health. Specifically MDG 4 and 5 respectively commit national governments to reducing the mortality rate of children younger than 5years by two-thirds, between 1990 and 2015, and MMR by three-quarters, between 1990 and 2015. MDG 5 further aims to achieve universal access to reproductive health by 2015. For MDG 4, the indicators and health outcomes for measuring progress are 1) mortality rate in children less than 5years; 2) infant mortality rate; and 3) proportion of 1 year-old children immunized against measles. For MDG 5, the indicators include 1) MMR; 2) the proportion of births attended by skilled health personnel; 3) contraceptive prevalence rate; 4) adolescent birth rate; 5) ANC coverage (at least one visit and at least 4 visits); and 6) unmet need for family planning.

Other important international MNH initiatives that have accompanied the Millennium Summit include the launch of ‘The WHO Making Pregnancy Safer Initiative’ in 2000; ‘The WHO Road Map for Accelerating the Attainment of MDGs Related to Reduction of Maternal and Newborn

Morbidity and Mortality' in 2004 (WHO, 2004); and the 'Partnership for Maternal, Newborn, and Child Health (MNCH)' in 2005 (WHO, 2005).

In SSA, a number of regional MNH initiatives have also been launched. These include 'The African Union (AU) Abuja Declaration' in 2001 (during which African heads of state committed their governments to increase health financing to at least 15% of national budgets, so as to address health challenges including maternal and child morbidity and mortality, HIV/AIDS, Malaria and Tuberculosis) (AU, 2001); 'The African Regional Reproductive Health Task Force' in 2003 (WHO, 2003); and 'The African Union Maputo Plan of Action' in 2006 **(**during which African heads of state reaffirmed their commitment to the Abuja declaration (AU, 2006).

Within all these initiatives, the WHO argues for a reconfiguration of the traditional notion of maternal and child health into maternal, newborn and child health to reflect a more seamless continuum of care for mothers and children from pregnancy to childbirth, and from the immediate postnatal period to childhood (WHO, 2005; Freedman & Waldman, 2005). The argument here is that many stillbirths and early neonatal deaths are due to complications mothers sustain during pregnancy or childbirth (Lawn *et al*, 2005). It is within this continuity of care argument that the idea of MNH in this doctoral research is situated.

But in addition to emphasizing continuity of care, skilled attendance at birth is also advocated as the single most important factor in preventing maternal and newborn deaths (Gabrysch & Campbell, 2009). The reasoning here is that:

> Most obstetric complications occur at the time of delivery and cannot be predicted. Therefore it is important that all pregnant women have access to a skilled attendant… who is able to manage normal delivery and who can recognize and manage obstetric complications, or refer in time if needed (Gabrysch & Campbell, 2009:2).

Although the argument for skilled attendance at birth acknowledges that skilled attendants can offer services at home, in health centres or hospitals, it has been argued that the most efficient strategy for low-income countries is to place skilled care services in health centres (Campbell & Graham, 2006). In practice therefore skilled attendance in most low-income countries is synonymous with health facility care (*ibid*).

To conclude the review on the historical background of MNH, two central points need restating. First, the global struggle to improve MNH has been conducted within a context of shifting ideologies and ethico-moral standpoints. Second, the campaign for improved MNH appears also to be one of a struggle over ideas and power, and over control and entitlement. And it is the combination of these two that continue to define and shape the ways in which efforts to improve MNH is conducted around the world.

2.2 Averting Maternal and Newborn Deaths: What do We Know or Not Know?

Put together, the Millennium Declaration and the accompanying initiatives to make motherhood safer have thrown MNH into the centre-stage of debates about global health and development. Yet, in addition to funding challenges at both global and national levels, progress towards attainment of MDG 5 has been characterized as 'a patchwork of progress, stagnation and reversal' (Lewis, 2008:3) or 'mixed' (Bhutta *et al*, 2010:2043). The 2008 *Lancet's* 'Countdown to 2015' report for example, showed that only 16 of 68 priority countries were making progress towards achieving MDG 5 (Bryce *et al*, 2008;), while that of 2010 indicated that 'progress towards reduction of neonatal deaths has been slow, and maternal mortality remains high in most countdown countries, with little evidence of progress' (Bhutta *et al*, 2010:2032). In the case of

SSA, motherhood is still very unsafe: in most parts of Africa, MMR has hardly changed; it has even reversed in some countries (Horton, 2008).

The irony is that in the literature, we know why maternal and neonatal deaths occur and what works to prevent or reduce them (Campbell & Graham, 2006; Johnson *et al*, 2009; Burchett *et al*, 2009). For example, several studies show that women die because of obstetric haemorrhage, sepsis, hypertensive disorders, unsafe abortion, and prolonged or obstructed labour (Ronsmans & Graham, 2006; Campbell & Graham, 2006; Froese, 2007; Lewis, 2008; Islam & Yoshida, 2009; Cross *et al*, 2010). It is also known that 80% of maternal deaths in low-income countries are due to direct obstetric causes and 20% due to indirect causes (Maine & Rosenfield, 1999; Lewis, 2008; Ronsmans & Graham, 2006; Bryce *et al*, 2008; Fotso *et al*, 2009; Hogan *et al*, 2010). Direct obstetric deaths are those resulting from obstetric complications of the pregnant state, or from interventions, omissions or incorrect treatment, or from a chain of events resulting from any of the above (Cross *et al*, 2009). Indirect obstetric deaths are those resulting from a previously existing disease or a disease that develops during pregnancy and which is not due to direct obstetric causes but which is aggravated by the physiological effects of pregnancy (*ibid*).

In most low-income countries, haemorrhage, obstructed labour, eclampsia, sepsis, amniotic fluid embolism, ectopic pregnancy, thromboembolism and unsafe abortion are major direct causes of maternal deaths (Lewis, 2008; Cross *et al*, 2009). In a recent systematic review of the causes of maternal deaths for instance, haemorrhage was the leading direct cause of death in Africa (33.9%) and Asia (30.8%), while hypertensive disorders were the most common causes in Latin America and the Caribbean (25.7%) (Khan *et al*, 2006).

In high-income countries such as Canada and the UK however, pulmonary embolism and hypertension were the leading direct causes of maternal mortality (Froese, 2007). Similarly, rates of maternal and foetal death due to abortion are highest in Latin America and the Caribbean (12%) and lower in Asia (5.7%) and Africa (3.9%). In high-income countries where safe abortion is usually more accessible, abortion's contribution to maternal deaths is negligible (Khan *et al*, 2006).

Research also shows that a large proportion of all maternal and newborn deaths take place in hospitals or within a healthcare facility, and that the timing of most deaths is clustered around labour, delivery, and the immediate postpartum period, especially within 24 hours of delivery (Ronsmans & Graham, 2006). In this regard, there is evidence that the causes of maternal and newborn deaths are facilitated by Thaddeus and Maine (1994) classic Trinitarian metaphor of the 'Three Delays', namely delay in the recognition of an obstetric problem such as complications; delay in the decision to take appropriate action to seek care; and delay in arriving at a health facility to receive appropriate care (Senah, 2003). What remains unclear though is why the so-called 'Three Delays' occur in the first place in different contexts? (Graham *et al*, 2008a).

But it is not only that much is known about what kills women during pregnancy and childbirth; there is also a decent amount of research on how maternal and newborn deaths could be averted. For example, researchers such as McCarthy & Maine (1992) point out that efforts to reduce maternal mortality 'must either (1) reduce the likelihood that a woman will become pregnant; (2) reduce the likelihood that a pregnant woman will experience a serious complication of pregnancy or childbirth; or (3) improve the outcomes for women with complications' (p.23). In fact the literature suggests that at least 80% of all maternal deaths are preventable, and that a large range

of simple, costless or cost effective interventions that can significantly improve survival and quality of life exist, even in resource-poor settings (Lewis, 2008; Bhutta *et al*, 2008; De Brouwere *et al*, 2010; Nyamtema *et al*, 2011). One systematic review of new evidence on potentially useful interventions and delivery strategies identified about 37 key promotional, preventive, and treatment interventions (table 2.2) (Bhutta *et al*, 2008). Accordingly, when properly delivered, these interventions have proven to possess evidence of positive effect in terms of reduction of maternal and newborn morbidity and mortality as well as cost effectiveness in different settings (*ibid*). In addition, there are known evidence-based interventions which can save the newborn life, including identification and management of mal-presentation and prolonged labour, the use of resuscitation techniques for asphyxiated infants, proper management of neonatal sepsis, and skin-to-skin kangaroo care for preterm infants, and immediate and exclusive breastfeeding (De Brouwere *et al*, 2010).

Table 2.2: Evidence-based interventions and strategies to improve maternal and newborn survival.

Promotional Interventions	Preventive Interventions	Treatment Interventions
• Promotion of reproductive and family planning • Promotion of appropriate care seeking and antenatal care during pregnancy • Promotion of skilled care for childbirth • Promotion of exclusive breastfeeding advice and support • Social marketing strategies and health promotion including health days and special campaigns • Community mobilization through provision of information on availability of quality health services, adhesion of community leaders, behavior change campaigns, community health education, and organization of community transports.	• Provision/availability of contraceptive for birth spacing and safe sex • Cord care and clean delivery kits • Iron foliate or multiple micronutrients during pregnancy • Balanced protein-energy supplements during pregnancy in food-insecure populations • Calcium supplementation for pregnancy-induced hypertension (PIH) • Low-dose aspirin in pregnancy for at-risk women • Antenatal steroids in preterm labour • Antibiotics for preterm rupture of membranes • Antiretroviral drug for HIV-infected individuals to prevent mother-to-child transmission (MTCT) • Antibiotics for preterm labour • Vitamin A supplementation in children • Preventive zinc supplementation/fortification for children • Insecticide-treated bed nets for family • Intermittent preventive treatment (IPT) for prevention of malaria in pregnancy	• Promotion and use of skilled birth attendants in first-level and second level facilities • Interventions for prevention of post-partum haemorrhage and use of oxytocic agents • Basic newborn resuscitation with self inflatable bag and mask • Improved diarrhoea management (zinc & ORT etc) • Community detection and management of pneumonia with short course amoxicillin • Improved case management of malaria including ACTs • Use of MgSo4 for management of PIH or preterm labour

Source: Author's construct based on Bhutta *et al* (2008) and Nyamtema *et al* (2011).

Besides these known interventions, the last three decades have also witnessed the development of increasingly 'high-tech' reproductive technological procedures (e.g. episiotomies, induction, ultrasound and amniocentesis), which have been widely deployed especially in high-income countries to avert complications that could otherwise result in maternal and newborn death and disability (Tew, 1995). In the light of the fact that the causes of maternal and newborn mortality and morbidity are so clear, and effective interventions to combat them are well known (Islam & Yoshida, 2009), the question that remains is why women and newborn babies continue to die, especially in low-income countries? In what follows, I shall briefly review and synthesize various perspectives on this question.

Halfdan Mahler (1976; cited in Rosenfield & Min, 2009), former director-general of WHO is one of the earliest authorities to have attempted to grapple with the question of why women and their newborn babies continue to die even though the knowledge and technology to prevent such deaths exist. Mahler argues that women are dying from pregnancy and childbirth-related complications because they (women) were a neglected people, who not only have the least resources, power and influence over how national resources shall be spent, but also who live in societies which, to date, have not invested in maternal health. According to this account, women die because they are poor, malnourished, lack contraception, have little or no education, have no voice and control over their lives, and in many instances, have to defer decision-making including those related to maternal healthcare access to the males or elderly women in their families and communities.

Several authors have furthered Mahler's idea of neglect. For instance, Donnay (2000) argues that:

> While many other health indicators have improved over the last two decades, maternal mortality rates and ratios have remained stagnant. The causes are rooted in the absence of

> high-level commitment to protecting women's health in many countries, and in the powerlessness of women (p.90).

For Graham and Ronsmans (2006), limited political and funding commitments to improving MNH is at the heart of why women and their babies continue to die. Horton (2008) agrees and puts the argument rather more starkly that women and newborns are still dying because those who have the power to prevent their deaths choose not to act. More recently, Islam and Yoshida (2009) also argue that 'maternal and newborn mortalities remain the world's most neglected problems' (p.120). For these authors, it is difficult to avoid the conclusion that poor MNH has remained unaddressed for so long because of women's disadvantaged social, political and economic status in many societies.

But beyond neglect and lack of funding and political commitment to improving MNH, other reasons have been advanced. In relation to low-income countries where the burden of maternal and newborn mortality is particularly high, Liljestrand (2000) succinctly summarizes the problem as one of lack of access to essential maternity care services. For Liljestrand, the challenge [of MNH] today is not the lack of knowledge of key, effective interventions to save mothers. The problem, Liljestrand argues, is 'how to deliver' (p.514); it is a problem of *access*, and in particular *equitable access* to timely quality care during pregnancy, childbirth and the postpartum and postnatal periods (Lawn *et al*, 2005; Islam & Yoshida, 2009; Babalola & Fatusi, 2009; emphasis mine). In the case of SSA, one recent study argues that 'the high prevalence of maternal illnesses, near misses, and other potentially devastating and acute obstetric complications suffered by women in the region have generally been linked to their poor access to emergency obstetric service' (Essendi *et al*, 2010:S357).

Indeed, responses to why women die during pregnancy in the context of the MDGs appear to revolve around the question of access. For example, Parkhurst *et al* (2005) argue that despite a large international focus on delivering cost-effective technical maternal health interventions, many middle and low-income countries seem unable to establish health systems that effectively provide these required solutions. Graham *et al* (2008a) expound this argument to suggest that maternal and newborn deaths result from health system failures. Lewis (2008) also argues that women are not dying during pregnancy and childbirth of complicated conditions that are hard to manage. Rather, women are dying because 'they do not have access to basic or emergency maternity care and skilled attendant during birth' (p.3).

In conclusion, the review in this section suggests that 1) much is known in terms of why and where maternal and newborn deaths occur; and 2) evidence-based strategies and remedies exist for improving MNH. Despite this fact, the review also indicates that limited and unequal access to skilled care services has largely undermined global and national campaigns. For this reason, the next two sections would consider the access problem, focusing on what *access* and *equity of access* mean, and why women lack access to SMNHS.

2.3 The Problem of Access and Equity of Access

In order to properly situate the research, this section aims to briefly provide conceptual clarity to the concepts of access and equity of access, which will be returned to and critically reflected upon throughout this thesis.

2.3.1 The Meaning of Access in Health Care

'Accessibility' is the term geographers and planners use to describe the ease or difficulty of reaching a place or a service (Haynes, 2003). In its geographic sense, access is about the location of a [health] service relative to a given population and the mobility or means of reaching the service (Gulliford *et al*, 2003).

However, in one of the early discussions of healthcare access, Aday & Anderson (1975) define access in terms of whether those who need care get into the system or not. While acknowledging in their discussion that having access to healthcare necessarily requires an adequate supply of healthcare services, Aday and Anderson (1981) argue that service availability is a rather limited measure of access to healthcare, for an individual or a population group in need may often have access to services, and yet encounter difficulties in *utilizing* services. They therefore suggest that access is most meaningfully defined either as the potential to utilize a service if required (access) or actual entry (utilization) of a given individual or group into the healthcare delivery system.

Developing this argument further, Pechansky and Thomas (1981) suggest that the concept of access describes the 'degree of fit' between clients or patients and the health system, and not simply the presence of a health facility. This 'degree of fit', might be influenced by the acceptability, affordability and accommodation of services (Gulliford *et al*, 2003). Thus Pechansky and Thomas' approach extends the concept of access beyond measuring service availability to consider the personal, cultural, organizational and financial aspects of accessibility and utilization (*ibid*). For this reason, in discussing access to SMNHS in this thesis, Aday and Andersen definition will be combined with the further elaborations offered by Pechansky and Thomas. Specifically, the use made of the term 'access' in this thesis shall be concerned with the

potential to utilize skilled antenatal, delivery and post-delivery care services; the actual initiation into the process of utilizing these services when they are wanted or needed; and the 'degree of fit' between expectant mothers' maternity care needs and the maternal healthcare system.

2.3.2 The Meaning of Equity in Health Care

Like the concept of access, that of equity derives from diverse fields, including philosophy, ethics, economics, medicine and public health (see Daniels, 1982; Evans, 1984; Whitehead, 1992; Macinko and Starfield, 2002; Gulliford *et al*, 2003; Starfield, 2001; Starfield, 20011). It is not my intention here to review all the rich literature that addresses the subject of equity. What is important to note for the purpose of this thesis is that, understanding the concept is a complex undertaking (Sen, 2001; Ridde, 2008), and very often understanding depends on the context and the epistemological position of the speaker (Ridde, 2008).

My review of the literature suggests that despite this diversity, common to most conceptions is that equity is a *positive comparative* principle, a judgement about how a person or a group of persons is situated relative to others in terms of access to a given healthcare service (Daniels, 1982). In the context of healthcare access, most views about equity suggest the idea of 'fairness' or 'justice' (Macinko & Starfield, 2002). In other words, equity of access concerns *fairness* in access for individuals or groups with equivalent healthcare need (Gulliford, 2003), while inequity describes differences in healthcare access for equivalent need deemed unfair or unjust. Need here is defined as healthcare consumption that an individual on average is expected to receive given age, gender, and various measures of self-reported health (van Doorslaer *et al*, 2000).

Within public health, two main forms of equity are identified: vertical equity (preferential treatment for those with greater health needs, or the unequal, but fair treatment of unequals), and horizontal equity (equal treatment for equivalent needs). Considerations of equity in the health policy literature have however mainly focused on horizontal equity while overlooking vertical equity (Macinko & Starfied, 2002). In this thesis, reference to the concept of equity shall involve evaluation of both vertical and horizontal equity.

Along the lines of horizontal and vertical equity, the literature also describes three broad areas of equity in the context of public health: equity in health [outcomes], equity in health care financing, and equity in healthcare services accessibility and utilization (Zere *et al,* 2010). Although the three are interconnected – e.g. the need to attain equity in MNH outcomes may lead to health financing or care policies that promote equity - this thesis is primarily concerned with equity in access and use of healthcare services

In the literature, the idea of equity as being primarily concerned with fairness has raised two important issues. First, a concern with fairness imbues the concept of equity with moral and value judgment (Macinko & Starfield, 2002) According to Starfield (2011) it is this value-laden character of the concept of equity that distinguishes it from the broader and value-neutral concept of in/equality – differences among individuals, some of which are not remediable, at least with current knowledge. Although the difference between in/equity and in/equality is acknowledged in the literature, many authors are inconsistent in their use of the two terms (Macinko & Starfield, 2002).

Second, a concern with fairness has also raised an important question: how is fairness to be judged? This indeed, is one of the challenging questions about which philosophers, health economists and public health experts continue to debate (See Whitehead, 1992; Sen, 2001; Macinko & Starfield, 2002). This notwithstanding, Whitehead (1992) argues that criteria for assessing which health differences are unfair and unjust should include whether the differences are due to 1) inherent biological variation; 2) informed individual choices, and 3) whether such differences are potentially avoidable. Starfield (2001) develops this argument further to add that health inequities must be potentially remediable and affect the health status of groups in a systematic way. Thus of the determinants of healthcare access differentials between individuals or groups, those related to biological variation and freely chosen health-damaging behaviour are not likely to be considered inequitable because they are either unavoidable or fair. However, differentials due to health damaging behaviours not based on informed choices, exposure to unhealthy living and working conditions, or inadequate access to healthcare, information, and social services ought to be judged avoidable, unfair, unjust, and thus constitutive of inequity (Macinko & Starfield, 2002).

Taking a cue from Whitehead and Starfield's discussion, the definition of equity in this thesis follows that of the International Society for Equity in Health (ISEqH): equity is the absence of potentially remediable, systematic differences in access and use of one or more aspects of MNH services across socially, economically, demographically, or geographically defined population groups or subgroups (Macinko & Starfield, 2002; Starfield, 2011). This definition is particularly useful for two main reasons. First, it means that non-medical features of individuals or groups (such as their geographic location or ability to pay) should not determine their access to skilled maternity care services (Muraleedharan, 1993). Second, it implies a situation in which individuals

or groups face equal or equivalent access and costs of utilization for equal or equivalent needs (Gulliford, 2003).

One other key issue –which is related to the question of how to judge equity - is whether an assessment of equity in the delivery of healthcare ought to focus on *access* or *utilization*. For example, in a series of papers published in the *Journal of Health Economics,* Mooney *et al* (1991) engage Culyer *et al* (1992a, 1992b) in a rather acrimonious debate about the propriety of measuring equity according to either access or utilization. In their paper, 'utilization as a measure of equity: weighing heat?' Mooney *et al* (1991) berate the fact that equity has always been measured in terms of healthcare utilization. They go on to counter argue for the assessment of equity base on *accessibility.* Accordingly, defining and assessing equity in terms of:

> 'Equal access for equal need' provide individuals with the *opportunity* to use needed healthcare services. This criterion may legitimately lead to different patterns of use (and expenditure) for equal need, as individuals may choose to comply with treatment in various ways. It does not rely on coercion and, therefore, is not elitist. As a result, we would argue that equal access for equal need is the superior equity criterion (p.479; emphasis on original).

The authors liken focusing only on utilization in an assessment of equity to what Evans (1984) calls 'moving the target to hit the bullet'. That is, it is a case of measuring the measurable.

In response to Mooney *et al* (1991) however, Culyer *et al* (1992a) counter argue that a concern about access to healthcare stems from a concern about utilization of healthcare, which in turn may stem from a more fundamental concern about health itself or some yet more ultimate concern such as human flourishing and wellbeing. While acknowledging that the rules determining access play an important role in helping to reach an equitable distribution of health, the authors argue that since other factors, such as individual values or preferences and the decisions taken by policymakers and physicians, will affect the treatment people receive, rules

concerning access will never be sufficient to generate an equitable distribution of healthcare. Therefore, focusing on only access in an assessment of equity will inevitably give a partial picture as people may have access yet encounter difficulties in utilization (Culyer *et al* 1992b). For this reason, the authors maintain that assessment of equity ought to be based on utilization of health services, for the proof of access is in utilization.

Le Grand (1982) and van Doorslaer *et al* (1992) however suggest a need to focus on both access and utilization at the same time in an assessment of equity. Indeed, Le Grand's (1982) examination of British health policy allows for a convincing argument to be made for a 'mutuality' or 'ambivalence' position when it comes to whether equity should be judged solely on the basis of access or utilization. Le Grand's study finds that some British health policies on equity imply commitment to equity of treatment/utilization for those in equal need; others express a commitment to equity of access, while others encapsulate both. Such ambivalence, van Doorslaer *et al* (1992) observe, is not confined to Britain; the same is true of several organization for economic co-operation and development (OECD) and non-OECD countries. This suggests that equity assessment based on both access and utilization offers a better opportunity to arrive at an acceptable, efficient and ethically superior judgment (*ibid*). For this reason, this thesis would adopt the mutuality argument whereby the line between the two contrasting claims of accessibility and utilization is blurred.

2.3.3 Access and Equity of Access: Justification and Counter-Justification

But what is access and equity of access to healthcare good for? In this section, the aim is to briefly synthesize various perspectives on the importance and/ or justification for access and equitable access to healthcare services more generally, and SMNHS in particular. This is

important because it might provide a context for understanding the rationale behind certain contemporary health policy initiatives, including Ghana's free maternal health policy.

In the healthcare literature, access and equity of access to healthcare has been justified in a number of ways. Bunker *et al* (1994) argue that access to healthcare provides information about diagnosis and prognosis. Gulliford *et al* (2003) justifies access and equity of access on grounds that it performs a more utilitarian function of contributing to the improvement of health and the relief of sickness. But access, particularly equitable access, also has a more specific normative value that is not fully measured in terms of improving health or facilitating diagnosis or prognosis. The US President's Commission for the Study of Ethical Problems in Medicine and Biomedical Behavioural Research Report, *Securing Access to Health Care* (1983), argues this point thus:

> The prevention of death and disability, the relief of pain and suffering, the restoration of function: these are the aims of healthcare. Beyond its tangible benefits, healthcare touches on countless important and in some ways mysterious aspects of personal life and invest it with significant value as a thing in itself (p.1).

For instrumental and normative reasons therefore, Starfield (2011) argues that ensuring access and equity of access to healthcare must constitute the positive goal point on the moral compass of public health practitioners that should be strived for. The polar opposite of this conceptualization is inequity, the negative point on the moral compass that must be avoided.

But access, especially equitable access to healthcare, is also regarded as a basic human right (Gulliford *et al*, 2003). The UN for example espouses this view in its Universal Declaration of Human Rights, and the Covenant on the Economic, Social and Cultural Rights, and argues for governments to create conditions, which would assure all medical service and medical attention in the event of sickness.

Margolis (1982) and Daniels (1985) also justify access and equitable access to healthcare on the basis of the importance of health in achieving normal human functioning. According to this account, the need for access and equitable access to healthcare derives from the right to fair equality of opportunity. The fair equality of opportunity account, suggests that access and equitable access [to SMNHS] is special because it has important effect on the 'normal opportunity range' open to women to choose reasonable plans of life (Daniels, 1985). For this reason, Daniel argues that the fair equality of opportunity account provides a principled way of justifying access as well as characterizing the healthcare services needed to maintain, restore, or compensate for the loss of normal species-typical functioning. In turn, 'normal functioning contributes substantially to defining the share of the normal opportunity range open to individuals' (Daniels, 1985:79). Thus Daniels believes the fair equality of opportunity framework provides a basis for argument about the necessity of making access and equity arrangements in healthcare.

In the case of maternity care more specifically, access and equitable use of SMNHS is justified on the basis of it association with improved MNH outcomes (Babalola & Fatusi, 2009). In particular, empirical evidence establishes that access to focused antenatal care provide opportunities for early detection of potential risks and, through counselling and education, motivate women to seek skilled attendance at birth (Babalola & Fatusi, 2009; Gabrych & Campbell, 2009). In turn, there is an inverse relationship between skilled attendance at birth and the occurrence of maternal and neonatal death (Lawn *et al*, 2005).

Within the context of the MDGs, arguments for access and equity of access to SMNHS have also

largely been founded on the realization that lack of access as well as inequities in the use of skilled obstetric care services is undermining progress towards making pregnancy and childbirth safer (Lewis, 2008; Zere *et al*, 2010; Zere *et al*, 2011).

Despite these different justifications, libertarians have challenged the universal right to healthcare argument on grounds that insisting on the right to healthcare access may be an assault on the right to individual freedom and liberty (Hornberger, 2000, cited in Gulliford *et al*, 2003). Others also argue that medical care does not necessarily guarantee health, and that in some instances access to healthcare may cause ill-health through clinical iatrogenesis or adverse and unanticipated side effects of medical care (Gulliford *et al*, 2003). Notwithstanding the criticisms, national and international efforts to reduce maternal and newborn deaths today intensely focus on ensuring access and equity of access to emergency obstetric care for all women, particularly skilled attendant at all deliveries (Rosenfield & Min, 2009). The challenge though is that arguments about the necessity of access continue to be undermined by the presence of multiple barriers hampering women's access and use of SMNHS (*ibid*). These barriers are considered in the next section.

2.4 Barriers to Access and Equitable Use of Maternity Care Services

Several studies on healthcare seeking behaviour more generally (see Beech, 2003; Hughes, 2003), and MNH care access more specifically (see Matsuoka *et al*, 2010; Essendi *et al*, 2010; Oyerinde *et al*, 2012), have examined barriers to access and use of services. Surprisingly, the term 'barrier' is not often defined. In the few studies where an attempt is made to delineate the term, it has often been portrayed as neutral and apolitical. For example, Thaddeus and Maine (1994) used the term, 'barriers' or 'constraints', to describe factors that [negatively] affect the

decision to seek care.

However, Gulliford *et al* (2003) draw attention to the fact that the term is relative and value-laden. The authors therefore urge conceptual clarity in the usage of the term and proceed to define it as reflecting either the consumer's (in this case expectant mothers') *actual experience* or *perception* of obstacles to gaining access to health services (emphasis mine). Accordingly, this conception takes cognizance of the fact that healthcare may be organized or provided in a way that presents access 'barriers' to potential service users such as pregnant women in the context of maternity care services. Yet from the perspective of healthcare providers or policymakers, such service organization may be an effective mechanism for meeting a particular goal of the health service such as reconciling supply and demand (Gulliford *et al*, 2003). In recognition of the relativity involved in understanding what may constitute 'barriers' to access and use of skilled maternity care services in Ghana, therefore, the use of the term 'barriers' in the title of this thesis and throughout this thesis follows the usage of Gulliford and colleagues (2003).

While access and equity of access require that healthcare services are fairly and equitable distributed (Gulliford, 2003), access and utilization choice is a complex behavioural phenomenon (Chakraborty *et al*, 2003), often dependent on several factors including the care offered (such as cost and quality) and the population being served (such as their wealth, education and culturally mediated perceptions) that interact with one another in complex ways (Gething *et al*, 2012). Indeed, a large body of literature exists that examines access decisions and the barriers to accessing and using healthcare services (see Haynes, 2003; Hughes, 2003; Beech, 2003). For the purposes of the current research, however, the review here will focus on the 'barriers' to access and equitable access and use of SMNHS.

Empirical studies, particularly in several low-income country contexts, have identified a number of factors that act as barriers to access and equitable use of SMNHS. Table 2.3 summarizes factors that previous studies found to be important barriers to access and equitable use of SMNHS. In the literature, these factors are broadly categorized into *predisposing* (socio-demographic), *supply-side* (health system) and *demand-side* (socio-cultural) factors (Fosu, 1994; Addai, 2000; Gabrysch & Campbell, 2009; Matsuoka *et al*, 2010; Abor *et al*, 2011). Under each of these broad categories are a number of specific factors, which may act alone or in concert with others to limit access or create access inequities. To these specific barriers I now turn.

2.4.1 Socio-demographic Factors

The first category of barriers to access and equitable uptake of SMNHS is related to socio-demographic factors. Broadly speaking, these are predisposing factors that may differentially affect different women's ability to access and use skilled maternity care services (Fosu, 1994). Studies by Obermeyer & Potter (1991), Manocha *et al* (1992), Brieger *et al* (1994), Haddad & Fournier (1995), Mondal (1997), Celik & Hotchkiss (2000), Bloom *et al* (2001), Griffith & Stephenson (2001), Chakraborty *et al* (2002), Erci (2003), Glei *et al* (2003), Mathole *et al* (2004), Cicekliogl u *et al* (2005), Simkhada *et al* (2007), and Babalola & Fatusi (2009) find that socio-demographic factors such as maternal education, husband's education, marital status, household income/wealth, women's employment, media exposure, and parity are important determinants of access and use of SMNHS.

Table 2.3: Summary of barriers to access and equitable use of SMNHS.

Factor*[1]	Rationale and/or Mode of Operation	Research Evidence
Socio-demographic Factors		
Maternal age+++	Age as a proxy for accumulated experience. Older women more experienced in using services, more confident, and more say in household than young women	No difference, or older women more likely to use services in multivariate studies
Birth order+++	First birth: more difficult, help from natal family, high value on pregnancy, or unplanned/unwanted. Higher order births: previous experience, confidence if no problems previously, difficult to leave home with several small children, poorer families	No difference or first births and lower order births more likely to have skilled care than higher order births in majority of studies
Marital status++	Single mothers more autonomous, more use; but maybe poorer, more stigmatized and less use because of anticipated negative treatment at health facilities	No association or association in either direction
Ethnicity+++	Discrimination against certain ethnic groups may decrease service use	Mixed results. Large differences in some studies, none in others
Religion+++	Certain religious beliefs and practices such as the requirement for seclusion may decrease care-seeking	Mixed results. Large differences in some studies, none in others
Family composition+	Small children at home and no extended family to care for should increase access	Mixed findings: some studies found less skilled care if higher number of births, others found no effect
Mother's education+++	Knowledge, access to un/written information, exposure to more ideas, more confident, higher earnings, more control over resources, better participation in household decision-making etc. should increase access and use	Consistently found to be strong and dose-dependent positive effect on access and use of SMNHS
Husbands education++	Knowledge, modern attitudes, better communication between spouse, higher autonomy for wife, higher earnings, should increase access and use for wife	Higher husband's education consistently increases skilled care access, but effect smaller than that of women's own education
Mother's occupation+	Own earnings, range of movement, and access to information should increase access. Decreased access expected if work is poverty-induced	No effect in several studies, or association in either direction
Husbands occupation++	Higher paying jobs, more financial resources and health insurance should increase service access and use	Mixed results: Increased access and service use if higher status occupation found in many studies but not all
Household Wealth+++	Higher wealth groups more likely to have more access and use than poorer wealth groups	Consistently found to be strong in most studies
Health System Factors		
Service availability and distribution between regions, or urban/rural areas+++	Availability and distribution of services between different regions, social conditions such as poor infrastructure more poverty in rural areas will decrease access and service use	Nearly always moderate to large differentials with less service use in rural areas
Physical accessibility (distance, transport, road network) ++	Bad environmental and physical conditions, long distance, poor road and transport network as disincentive and actual obstacles to access and use of skilled services	Mixed results: less service use when further away or no difference
Service affordability+++	Costs for care, transport, and opportunity costs decrease use by the poor	Poorer women less likely to have access in many studies, but no effect in others
Service quality+	Poor medical and personal quality of care may be a disincentive for service access and use	Qualitative studies suggest low quality of care decreases access
Socio-cultural Factors		
Cultural beliefs and practices+	Certain cultural backgrounds, beliefs, norms, values and practices including requirements for seclusion, delivery position and handling of placenta may decrease care-seeking	Mixed results: large differences in some studies, none in others
Need (e.g. complications)+	Pregnancy complications, complications during delivery, and previous experience of complications should increase access and use of skilled care services	Few quantitative studies suggest women with complications more likely to seek skilled care; many qualitative studies found complications as an important factor decreasing the significance of other barriers
Information availability+	Information about risks of childbirth and about service availability using radio or TV should increase access	Mixed results
Perceived quality of care+	Perceived poor personal and medical quality of care clashes with culture and fear of procedures may decrease access and use of services	Qualitative studies generally find that perceived low quality of care decreases access, some studies describe interaction with distance and cost
Women's decision-making autonomy++	Decision-making power, mobility, and control over resources should increase access	Mixed results: some studies found some aspects to increase access while others found no effect

Source: Author's construct based on Thaddeus and Maine (1994), Fosu (1994), Addai (2000), Gabrysch and Campbell (2009), and Abor *et al* (2011). *1 Frequency of inclusion in quantitative studies: + = rarely; ++ = sometimes; and +++ = usually.

What is debated though is the relative importance of these factors in varying contexts. Babalola & Fatusi (2009) make this point when they note that in some cases, even when a strong association has been reported, such as in the case of the positive relationship between education and the use of skilled birth attendants, the extent and nature of the relationship are not uniform across social settings. For example, whereas studies in Peru (Elo, 1992) and Guatemala (Goldman & Pebley, 1994) show that women with primary level education, compared with those without any formal education, were more likely to utilize SMNHS, studies in Thailand (Raghupathy, 1996) and Bangladesh (Dharmalingam *et al*, 1999) record no significant difference between the two groups.

Also, whereas many studies find a positive correlation between older age and use of skilled attendants at birth (Obermeyer, 1993; Gertler *et al*, 1993; Pebley *et al*, 1996; Celik & Hottchkiss, 2000; Magadi et al, 2007), others find a curvilinear relationship (Obermeyer & Potter, 1991; Gage, 1998). Similarly, while some researchers in Botswana (Letamo & Rakgoasi, 2003), Zambia (Stekelenburg *et al*, 2004), and Nigeria (Onah *et al*, 2006) find less use of SMNHS among unmarried/unwed women, others in Ethiopia (Mekonnen & Mekonnen, 2003) and Ghana (Gyimah *et al*, 2006) find no association. In relation to parity/birth order, women with higher birth order pregnancies in China are less likely to access SMNHS due to the one-child-policy (Short & Zhang, 2004).

Being in a minority ethic group has also been found to be a barrier to access and use of SMNHS. In Guatemala (Pebley *et al*, 1996; De Broe, 2005) and Mexico (Brentlinger *et al*, 2005), indigenous women are less likely to have skilled attendance at delivery. Ethnic minorities in China (Short & Zhang, 2004), Kurds in Turkey (Celik & Hotchkiss, 2000), scheduled

castes/tribes in India (Navaneetham & Dhharmalingam, 2002) and non-whites in South Africa (Burgard, 2004) also access and use less of SMNHS.

Religion also shows variable patterns of association. For example, survey-based studies find that Muslim women are less likely to use reproductive, sexual health, and SMNHS (Mishra, 2004). In Ghana, Addai (2000) finds that the range for consultation of a health worker for prenatal care among religious groups is 12.8 points, from 10.3% among women of traditional African religious orientation to 23.1% among Catholic and Protestant women. Similarly, Gyimah *et al* (2006) find that Moslem and Traditional women were less likely to use SMNHS in Ghana compared with Christians. On the contrary, in Vietnam, Catholics are less likely to receive skilled care than other religious groups (Toan *et al*, 1996).

Interestingly, very few studies, including the two studies on Ghana above, explore how issues in Muslim culture or Traditional African religious beliefs act as barriers to use of SMNHS services. Put differently, we actually do not know what it is about Islam or Traditional African religion that prevents women from seeking SMNHS services, neither do we actually understand why Christians such as Catholic women in Ghana for example, patronize SMNHS more than Muslim women or women with Traditional African religious orientation. Similarly, many of the studies on ethnicity have not examined why belonging to a minority ethnic or tribal group is a barrier to access and use of SMNHS. In this regard, Addai (2000) and Gyimah *et al* (2006) suggest that there is a need for research into aspects of religion and ethnicity particularly in SSA that discourage access and use of SMNHS.

2.4.2 Health System Factors

Several researchers have also identified health system factors including the cost, nature, availability, organization, and delivery of SMNHS as constituting important access barriers. For instance, financial cost of services has been identified as a major barrier to access and equal use of maternity care services (Ensor. 2005; Witter *et al*, 2010; Jehan *et al*, 2012; Dzakpasu *et al*, 2012). In Sierra Leone, Oyerinde *et al* (2012) find that prohibitive, inconsistent and unpredictable financial cost was the main barrier to access for all women. Others also point to the 'significant nonfinancial costs' that may be involved in institutional deliveries, including social costs. For example, in Ghana, Bazzano *et al* (2008) show that women who deliver by caesarean section are often stigmatized, while in Sierra Leone, Oyerinde *et al* (2012) report that stigmatization of unwed pregnant women at healthcare facilities creates problems of unequal access.

In addition, distance to healthcare facilities has been found to influence access and equitable uptake of SMNHS. For instance in Guatemala (Celik & Hotchkiss, 2000), Kenya (Felkin *et al*, 2009), Zambia (Le bacq & Reitsema, 1997), India (Griffiths & Stephenson, 2001; Navaneethan & Dharmalingam, 2002), and Ghana (Mills *et al*, 2008), a strong association between long distance to a health facility and limited access and use of SMNHS has been found. This relationship is characterized as the 'dose-response relationship' (Le bacq & Reitsema, 1997) or 'distance-decay effect' (Felkin *et al*, 2009), whereby long distance to health facilities discourages access and services use.

Related to distance is transportation. Transportation scarcity is, indeed, a major barrier to accessing and using SMNHS especially in rural settings in low-income countries (Castro *et al*, 2000). In India for example, Griffiths & Stephenson (2001) find that the problem of limited or no

access to maternity care services often has very little to do with a lack of interest or desire to participate in the formal biomedical system. Rather, women, particularly in remote places, face difficulty not only from high user-fees or outright unavailability of transportation, but also from inappropriateness of the types of transport that are available. A Gambian study reports that lack of transport significantly contributed to non-use of maternity care services (Walraven *et al*, 2000). In Uganda, Atuyambe *et al* (2009) also reveal that the bulk of transportation is by bicycle or motorbike - modes of travel that are difficult or impossible for a pregnant woman or a woman in labour to use even if she could afford them.

A 2005 study on facility choice and patient preferences in the UK also points to another barrier in relation to transportation that others have previously overlooked: the effort involved in arranging the means of transport (Burge *et al*, 2005). When combined with the kind of severe and endemic poverty that exists in many low-income countries, the distance and transportation related barriers have their most devastating impacts on access and use of SMNHS. Barnes-Josiah *et al* (1998) describe how women in such impoverished settings, when faced with vital trade-offs in balancing the time lost in domestic labour and childcare, the costs of transportation, services, meals, bribes, and fees, and the emotional stresses of travel, with the dubious benefits of unproven care, may elect not to visit a formal health facility even in situations where medical attention is badly needed. However, other studies find that the disincentives to access SMNHS arising from long distance, lack of transport and poor roads is less serious if women have serious complications or if the target facility or care provider is perceived to have good reputation as regards offering superior quality of care (Anson, 2004).

Besides costs and distance, other health system barriers have been identified. In Ivory Coast,

Lasker (1981) finds corruption and under-hand dealings of healthcare providers to be a disincentive to seeking skilled care. Accordingly, where 'little presents' help to get medicines and supplies, corruption delay the decision to seek care by swelling the costs of seeking care and increasing patient dissatisfaction. In Mexico, Castro *et al* (2000) show that lack of personnel and supplies at local health facilities led to patients being funnelled into an inefficient process of referral and counter referral, creating disastrous delays for patients, especially those for whom reaching the next facility may be difficult or impossible

Unfriendliness of healthcare workers and poor treatment meted out to expectant mothers by healthcare workers acted as a disincentive for seeking maternity care from health facilities in Palestinian hospitals (Hassan-Bitar & Wick, 2007), Uganda (Atuyambe *et al*, 2009), urban slums in Nairobi, Kenya (Essendi *et al*, 2010), and Sierra Leone (Oyerinde *et al*, 2012). A recent study in Ghana reports that disrespectful care, including disrespect for women's privacy was a major barrier to access and use of maternity care services (Yakong *et al*, 2010). In Sierra Leone, maternity care facilities were not used due to the fear of having to wait in long queues to be served (Oyerinde *et al*, 2012).

One other barrier in relation to the health system is that of the quality of care. In Zimbabwe, Mathole *et al* (2004) find that poor quality of care is a barrier to utilization of SMNHS. In Tanzania, Klemick *et al* (2009) find that in some cases, out of the desire to provide more accessible health facilities, governments have overreached: either by spreading resources too thin, or by failing to take sufficient measures to promote efficiencies, thereby creating healthcare facilities with such low capacity and poor service quality that they fail to attract women – except, perhaps, to increase the number of referrals. For Klemic *et al*, the issues of quality care and

facility capacity must therefore be an integral part of analysis of barriers to accessing and using SMNHS.

Lack of trust between women and healthcare providers has also been identified as a barrier to access and use of SMNHS. In Haiti, Barnes-Josiah and colleagues (1998) find that the impression of incompetent, costly, unpleasant, or dangerous treatment at nearby facilities limited women's access and drove down maternity care services utilization. In Sierra Leone, Oyerinde *et al* (2012) find that lack of trust in the skills and practices of maternity care providers, discouraged access.

2.4.3 Socio-cultural Factors

Socio-cultural beliefs, preferences and practices of women and communities have also been implicated as important barriers to access and equitable use of SMNHS (Addai, 2000; Babrysch & Campbell, 2009). For example, Griffiths & Stephenson (2001) and Stephenson *et al* (2006) find that home birth and non-use of SMNHS carry a higher prestige in local communities in India and Africa respectively. One study in Ghana also finds that the ability to deliver at home successfully is associated with strength as well as good moral character (Bazzano *et al*, 2008). Similarly, Kyomuhendo (2003) reports from Uganda that while pregnancy and childbirth are perceived as dangerous events, a woman who delivers by herself is highly respected. As a result, women often opt for unassisted home delivery. Kyomuhendo's study also finds that beliefs that birth is a test of endurance, and care seeking a sign of weakness, constituted a barrier to skilled care access.

In Bangladesh, results of an anthropological study show that blame was placed on women who needed to ask for assistance or have delivery in a health facility, as they were believed to have

done something wrong to cause the difficulties, which lead to the problems requiring assistance (Afsana *et al*, 2000). Methole *et al* (2004) also find that shame associated with the pregnant state deterred visiting the clinic for SMNHS. Mrisho *et al* (2007) show that in Tanzania beliefs that obstructed labour is due to infidelity hinder skilled care seeking. Oyerinde *et al* (2012) report that in Sierra Leone, beliefs in destiny, religious teaching regarding faith in divine healing, as well as the cultural preference of delivering at home for some ethnic groups, caused unequal access and use of skilled care. In Hausa culture in Nigeria, belief in 'God Will' is a strong barrier to access and use of SMNHS (Adamu & Salihu, 2003).

Other barriers include women's low social status in their communities in Uganda (Atuyambe *et al*, 2009) and women's lack of decision-making autonomy within their families in northern Ghana (Baiden *et al*, 2006). In Nigeria (Adamu & Salihu, 2002) and Bangladesh (Chakraborty *et al*, 2003), husbands' and mothers-in-law's refusal is one major reason for non-access and use of ANC services. However, one study in Ethiopia demonstrated a lack of association between women's autonomy level and access and use of ANC services (Woldemicael & Tenkorang, 2010).

Wantedness of pregnancy and its impact on uptake of care is rarely studied (Gabrysch & Campbell, 2009), but a few studies demonstrate conflicting findings. A quantitative study investigating this question finds no association of wantedness with home deliveries in Bolivia or Philippines, a 20% increase in the odds of home delivery in Peru, a borderline significant increase by 35% in Kenya, and borderline significant decrease by 20% in Egypt (Marston & Cleland, 2003). Another quantitative study finds that wantedness at the time of birth increases the odds of having a doctor at delivery in South Africa, but shows no such association in Brazil (Burgard,

2004). In Kenya also, one quantitative study finds that the odds of home delivery are increased by 40% when pregnancy is either unwanted or not wanted at the time of birth (Magadi *et al*, 2000), while in Thailand, Raghupathy (1996) observes no association between wantedness and use of SMNHS.

To conclude this review of the extant literature on the barriers to access and equitable use of SMNHS, three central observations need highlighting. The first is that an enormous amount of research and knowledge exist on the barriers to women's access and use of skilled maternity care services. The relative significance of each of the barriers however varies greatly from context to context. Second, what remains to be done is context-specific research to investigate and isolate the relative importance of these barriers and the mechanisms by which they operate to limit access or create unequal access and use of SMNHS (Nanda, 2002; Babalola & Fatusi, 2009). Finally, much research also remains to be done to identify factors that enable or promote access and use of services (Parkhurst *et al*, 2006).

2.5 Global Health Mandates, Local Health Realities: MNH in Ghana

Since the Millennium Declaration of 2000, the desire to show progress in the reduction of the burden of maternal and newborn mortality has heightened, particularly in low and middle-income countries including Ghana (Graham *et al*, 2008a, 2008b). Ironically, Ghana's maternal mortality ratio has remained persistently high (Witter *et al*, 2007). In this section I shall review the literature related to MNH in Ghana, focusing on the causes and magnitude of the problem of maternal mortality as well as the historical evolution and progress as regards efforts to promote safe motherhood.

2.5.1 Problem of MNH in Ghana: Scale and Causes

Like many low-income countries, understanding the scale of the exact burden of maternal morbidity and mortality in Ghana is fraught with problems, including the fact that we do not know about all deaths of women of reproductive age; we do not know the cause of death; and we do not know whether or not the woman was pregnant at the time of death or had recently been so (Senah, 2003). However, as noted in chapter one, with an estimated contribution of 14%, maternal mortality is the second largest cause of female mortality in Ghana (Zakariah *et al*, 2006; Asamoah *et al*, 2011). The WHO's most recent maternal mortality estimate suggests 350 maternal deaths per 100, 000 live births in Ghana, with the range of uncertainty being 210-630 (WHO, 2012). Graham *et al* (2008a) have argued that this high level of uncertainty makes MMR unsuitable for monitoring maternal mortality and maternal health trends in settings such as Ghana.

Difficulties with understanding the exact scale of the problem of MNH aside, research shows that the main causes of maternal deaths in Ghana during the last 10 years (see figure. 2.1) are severe anaemia, post-partum haemorrhage, eclampsia, obstructed labour, puerperal sepsis, and unsafe abortion (Addai, 2000; Gyimah *et al*, 2006; Bosu *et al*, 2007; Witter *et al*, 2007; MoH, 2008).

One disturbing feature of the maternal health problem in Ghana that my review of the literature found is that there are significant variations both in the burden and cause of maternal deaths. For example, one of the most recent analyses of the distribution of causes of maternal mortality among different socio-demographic groups in Ghana finds that maternal deaths were highest in the age group 25-29years (22%), followed by 30-34years (19.2%) and 20-24years (19%) (Asamoah *et al*, 2011).

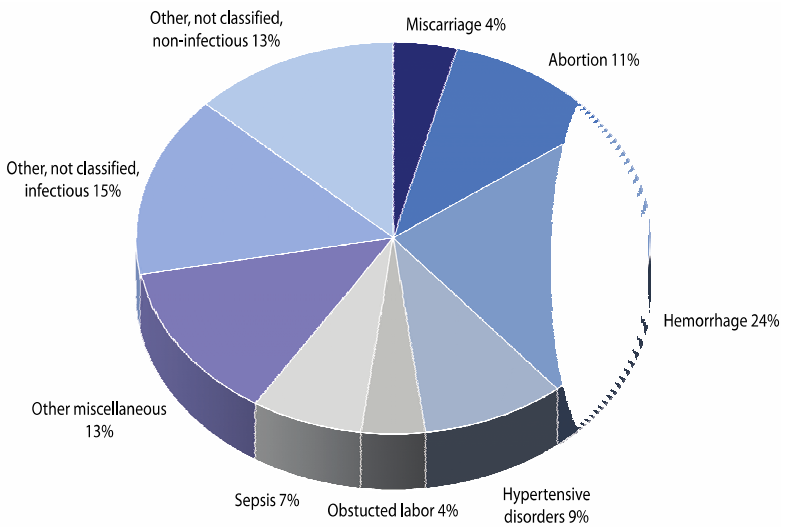


Figure 2.1: Main causes of maternal mortality in Ghana during the last 10 years. **Source:** Ministry of Health, 2008.

The authors also observe an inverse relationship between maternal mortalities and increasing educational level. For instance, whereas 54.9% of maternal deaths occurred in women whose education ended at the basic level, only 2.1% was ascribed to those whose education ended at the tertiary/higher level. Most maternal deaths also occurred among women who resided in rural areas (64.1%) compared to those in urban residence (35.9%), as well as among married (83.6%) women compared to single women (16.4%). Similarly, the three Northern regions had the highest maternal mortality and morbidity rates - Upper West, Upper East and Northern region in descending order.

As regards the distribution of causes of maternal mortality, haemorrhage was highest in the age group 35-39 years (27.5%), followed by 30-34 years (22.5%), 25-29 years (20.3%) and 20-24 years (14.5%). In contrast, abortion as a cause of maternal mortality is highest in the age group of 20-24 years (26.5%), followed by 15-19 years (20.5%), 30-34 years (16.5%) and 25-29 years (13.3%). Married women in Ghana have higher risk of dying from haemorrhage compared to their single counterparts. Additionally, the authors find that 28.6% of deaths from infectious

diseases related to pregnancy occur in the age group 20-24 years; 22.6% in the age group 25-29 years; 17.9% in the age group 30-34; and 6% in the 40-44 age group. The major infectious diseases that caused pregnancy-related deaths were malaria (53.6%), viral hepatitis (13.1%), and tuberculosis (2.4%).

What Asamoah and colleagues analysis fails to point out, though, are the reasons for the variability in the burden and distribution of maternal mortality in Ghana? In order to formulate policies to deal with the causes of the mortality differentials among different socio-demographic groups, detailed qualitative analysis of these reasons would be essential. As no research has yet been done in this regard – to the best of my knowledge - further research is clearly required.

2.5.2 Improving MNH in Ghana: Progress, Perils and the Birth of Free Maternity Care

Historical accounts of maternity care and maternal health policy-making in Ghana are very scant. As far as I am aware, only two authors – Ofosu-Amaah (1981) and Patterson (1981) – have attempted to give an historical commentary on formal maternity care in Ghana. However, the authors mention only in passing the fact that maternity care started with the British colonial rule, during which time Missionaries and the colonial government established infant welfare centres and maternity clinics in southern Ghana to demonstrate proper pregnancy and child care to mothers as well as treat pregnant women, new mothers and infants (Patterson, 1981). There is then a big leapfrog into the early post-independence era (i.e. after 1957) where, as a result of local and international pressures, hospitals and maternity care centres were built and a campaign against maternal and infant mortality initiated (Ofosu-Armaah, 1981).

Evidence from these authors and other related research (e.g. Senah, 2003; Addai, 2000; Gyimah *et al*, 2006) suggests that the formative years of Ghana's post-independence era witnessed significant policy and programmatic initiatives as well as some progress in the reduction of maternal morbidity and mortality. For instance, in 1969, Ghana became the third country in Africa to institute a national population policy, which had goals for improving reproductive health (GSS *et al*, 2009). Since 1985, Ghana's law has also permitted abortion for pregnancies that result from 1) rape; 2) incest; and 3) 'defilement of the female idiot'; or 4) where there is risk that the child would suffer from a serious deformity; or 5) if the pregnancy threatens the woman's physical or mental health (MoH, 2008). The 1994 ICPD also sparked important changes in Ghana's reproductive health policy, including a focus on providing comprehensive package of reproductive health services (Mayhew, 2004). In 1997, Ghana's national health objectives as outlined in the first Ministry of Health's Five-year (1997-2001) programme of work included an aim to decrease MMR to 100 per 100,000 by 2001 (Gyimah *et al*, 2006). Starting in 1997, free ANC services were also offered through out the country.

Following the Millennium Summit of 2000, Ghana also developed a 'Reproductive Health Strategic Plan' (2007-2011) with six high level objectives under its Safe Motherhood Policy, the first of which is to reduce maternal mortality and morbidity (MoH, 2008). The strategies for attaining this first objective are 1) improve access to comprehensive and basic essential obstetric care; 2) improve the capacity of family and community members in home-based life-saving skills; 3) increase the proportion of deliveries conducted by skilled attendants; 4) increase ANC and PNC coverage and improve equity, content, and quality of services; and 5) ensure the availability of comprehensive abortion care services as permitted by law.

Regrettably, while it was anticipated that the Ghanaian state would develop sharp and locally suited policies to combat maternal morbidity and mortality, maternal health outcomes deteriorated during the 1990s and 2000s. Ironically, this period also saw Ghana participating in some of the regional and global maternal health policy initiatives discussed earlier. Table 2.4 shows regional distribution of health-facility maternal mortality statistics between 1996 and 2000.

Table 2.4: Regional distribution of health-facility maternal mortality in Ghana (1996-2000).

Region	1996	1997	1998	1999	2000
Upper East	52	42	45	43	56
Upper West	13	33	14	22	30
Northern	38	39	61	73	60
Brong-Ahafo	70	89	80	91	62
Ashanti	141	128	140	134	177
Eastern	85	101	78	121	108
Central	57	93	117	106	108
Western	44	53	78	98	104
Volta	48	60	70	97	88
Greater Accra	37	49	93	28	63
National	**585**	**687**	777	**813**	**851**

Source: Senah (2003).

As the table demonstrates, maternal mortality occurs in all of Ghana's ten administrative regions irrespective of the number of health institutions and trained health personnel available (Senah, 2003). Rather than reducing, the table also largely indicates an increasing maternal mortality trend in most of the regions since the 1990s. In addition to this worsening maternal mortality situation, conservative estimates in 2006 suggest that only 44% of births are attended to by a skilled health personnel of any kind although there is variation (79% in urban and 33% in rural areas); traditional birth attendants (TBAs) supervise 31%; and the remaining 25% are unsupervised (Gyimah *et al*, 2006; Witter *et al*, 2007). Similarly, although Ghana's law permits abortion under certain circumstances, in practice, the law tends to be interpreted as prohibiting abortion hence availability of abortion care is limited (GSS *et al*, 2009). In fact, Ghana's 2010 MDGs Report projects that if the current trends continue, maternal mortality will reduce to

only 340 per 100,000 by 2015, and it will be unlikely for Ghana to meet the MDG target of 185 per 100,000 by 2015. Similarly, although acknowledging that there has been significant reduction in neonatal, infant and under-five mortality rates in Ghana, the report notes that it is unlikely that the 2015 target will be achieved unless there is an effort to scale-up and sustain child survival interventions.

There are several suggestions as to why Ghana is struggling to improve MNH. In addition to factors already discussed in section 2.2 of this chapter, Senah (2003) argues that increasing maternal mortality in Ghana is because programmes and policies to address the problem are heavily skewed toward a medicalized healthcare system that does not necessarily address the heart of the problem. Researchers also allude to austerity measures implemented in 1985 as part of cost-recovery under World Bank and International Monetary Fund (IMF) stabilization and structural adjustment programmes (SAPs) which required sharp cuts in public spending, including health (van Den Boom *et al*, 2008). Under the dictates of SAPs, the Hospital Fees Regulations Legislative Instrument (LI 1313) was passed in 1985 in Ghana, and this mandated fees to be charged for health services, a practice dubbed 'cash-and-carry' (Asante & Aikins, 2007). At the time, user-fee's proponents argued that fees would ensure cost sharing and increase revenue to improve the quality of health services and expand coverage (Hsiao & Liu, 2001, Chuma *et al*, 2009; Ridde & Diarra, 2009; Ridde & Morestin, 2011). The introduction of user-fees however culminated in a general decline in accessibility to, and utilization of health services, and maternal healthcare services more specifically (Witter *et al*, 2007; Asante & Aikins, 2007; van Den Boom *et al*, 2008).

Others believe poor education opportunities for women, poverty, unaffordability, and inaccessibility as well as socio-cultural factors act as barriers to rapid progress (Gyimah *et al*, 2006). What remains unclear today is the exact nature of these barriers: how they act to impede progress, and the relative significance of each of these barriers in differing segments of the Ghanaian society.

More recently, Johnson and colleagues (2009) discussed the problem as one of access: 'hospital based studies in Ghana show that both maternal and perinatal mortality continue to remain stagnantly high, which are primarily attributed to the lack of skilled care in maternal health services. It can be argued that the concept of a planned institutional delivery is almost non-existent particularly in the rural Ghanaian context' (p.64-5).

In response to the continuing high maternal and neonatal mortality rates, the slow progress on raising the proportion of women receiving skilled attendance at delivery as well as international calls to improve MNH by reducing barriers to SMNHS, several different policies and strategies are being experimented with. But one area of policy focus felt to be of particular importance to the reduction of maternal and newborn mortality is to increase the proportion of women who attend and receive skilled antenatal care, deliver with a skilled health professional in attendance, as well as seek postnatal care from a skilled health professional (Penfold *et al*, 2007). Along side increasing overall access to skilled care is a call to actively promote equity in accessibility to, and utilization of SMNHS (Johnson *et al*, 2009).

It is in this regard that Ghana's government made a political decision to reduce financial barriers to access through the introduction of a free maternal healthcare policy. The policy was first

introduced in the four most deprived regions of the country (Northern, Upper East, Upper West, and Central) in September 2003, and in April 2005, the policy was extended to Ghana's remaining six regions, albeit without any formal evaluation (Witter *et al*, 2008). Prior to this, health financing in Ghana relied on user-fees to cover recurrent costs at public health facilities (Witter *et al*, 2010). Consequently, all care was paid for out-of-pocket (cash-and-carry) unless the service was exempt such as in the case of tetanus toxoid immunization for pregnant women or the person had private health insurance (*ibid*).

Rather than target the poorest women, Ghana's free maternal health policy is universal, ostensibly for egalitarian reasons, though universal targeting is also both politically popular and easier to manage (Jehan *et al*, 2012). Under the policy, women are entitled to a 'Maternal Benefit Package', which includes:

- Six (6) free antenatal visits;
- Additional medically necessary visits captured as out patient department (OPD) visits;
- Free delivery at a health facility, including all emergencies and complications arising from the delivery;
- Two (2) postnatal visits within 6 weeks; and
- Care for the newborn up to three months, including various immunizations and extra care for low weight babies or babies born to HIV-positive mothers or babies with other special needs.

Initially, the policy was funded through Highly Indebted Poor Country (HIPC) debt relief funds (USD 2 million) and a £42.5 million bilateral UK grant to Ghana, which were channelled to districts to reimburse public, mission and private facilities according to the number and type of

deliveries they attended monthly (Witter *et al*, 2007; Bosu *et al*, 2007). Later on however, there were problems not only with obtaining funding but also with the disbursement of funding to health facilities such that by October 2005, some regions had exhausted funds, resulting in some health facilities reverting to cash-and-carry (*ibid*). In 2005, the free maternal health policy was therefore incorporated into a new National Health Insurance Scheme (NHIS), which was funded, and is still being funded, through value added taxes and levies, contributions from the Social Security and National Insurance Trust, and premiums paid by individuals (Scieber *et al*, 2012). Under the NHIS, pregnant women are exempted from contributing regular annual premiums but are still entitled to the maternal benefit package described above (Witter *et al*, 2007). Currently, the NHIS is established in all of Ghana's 212 districts, and it is estimated that the proportion of NHIS members increased from 15% of the Ghanaian population in 2005 to 38% in June 2007, approximately 3.2 million and 8.2 million people respectively (Asante & Aikins, 2007). It is expected that the policy would reduce both the financial barriers to access and inequities in access and use of SMNHS, thereby leading to an increase in the proportion of women accessing and using SMNHS, particularly supervised delivery in a health facility setting (MoH, 2008).

But Ghana's case is neither novel nor is it in isolation. Since the adoption of the MDGs, user-fee abolition is one of the popular demand-side financing interventions that have emerged as a strategy to promote access (Sidney *et al*, 2012). In SSA in particular, there is increasing consensus that the financing mechanisms of many MNH services, are largely responsible for limited and inequitable access to skilled maternity care services (Chuma *et al*, 2009; Ridde & Diarra, 2009; Gabrysch & Campbell, 2009; De Allegri *et al*, 2010). In fact, like most low-income regions of the world, use-fees abolition in SSA now constitutes a *sine qua non* to advancing progress towards MDGs 4 and 5 (Prata *et al*, 2004; Kippenberg *et al*, 2008). For

example, the final report of the Health Systems Knowledge Network of the WHO Commission on the Social Determinants of Health recommends the removal of user-fees for public health services (Gilson *et al*, 2007). In relation to MNH, a group of researchers recently argued that alleviating financial barriers must become a priority for policymakers if their will is really to accelerate the reduction of maternal and perinatal mortality in the developing word (Meda *et al*, 2008). Another group of researchers also write that 'the introduction of user-fees has done great damage to the use and quality of maternity-care services, particularly for the poorest women. We call on countries to adopt policies to protect the poorest families from catastrophic consequences of unaffordable delivery charges' (Filippi *et al*, 2006:1538).

In the main, the argument in support of user-fees abolition is founded on equity grounds: that the poor would not and have not been able to afford to pay for the use of necessary services. The argument also invokes the famous 'inverse care law', whereby the wealthiest who have relatively less need for healthcare, actually accesses and consumes more of the services (Chuma *et al*, 2009; Ridde & Diarra, 2009).

Consequently, several countries in Africa are experimenting with similar user-fees exemption interventions to tackling inequities and barriers to maternal healthcare access (De Allegri *et al*, 2010). Within SSA, about 11 countries have implemented policies incorporating the reduction of, or total abolition of fees for skilled care services, the use of community health and social insurance as well as conditional cash transfer programmes for maternal health. For example Senegal started a scheme to provide free deliveries, including deliveries by CS to pregnant women in all regions outside the capital in 2005 (Witter *et al*, 2010). In Burkina Faso, a scheme to progressively reduce household cost related to maternity care included abolition of ANC user-

fees in 2002; hospital admission without pre-payment for emergency obstetric cases in 2006; subsidy for CS in 2006; and subsidy for all deliveries in 2007 (De Allegri *et al*, 2010; Ridde *et al*, 2012). In Mali, a community-based health insurance scheme was introduced in 2001 and 2002 to cover 75% of facility charges for prenatal care and normal deliveries in selected urban centres and 100% of complicated delivery charges, including transportation (Smith & Sulzbach, 2008). In 2005, an intervention to abolish user-fees for prenatal care, deliveries, CS, and medical evacuation was introduced in two districts of Niger (El-Khoury *et al*, 2012). Tanzania is also implementing a user-fees exemption policy for maternal and child health services in all government facilities (Kruk *et al*, 2008), while in Kenya, a reproductive health voucher programme was introduced in 2006 to subsidize comprehensive safe motherhood services, including CS and treatment of maternal and neonatal complications (Obare *et al*, 2012).

Outside Africa, Nepal is exploiting a policy that combines subsidies for all deliveries with free deliveries and assistance with costs such as transport for women in poorer regions (Ensor, 2005; Borghi *et al*, 2006). There is experience in rural China and Bangladesh in using vouchers that entitle poor women to free delivery services (Kelin *et al*, 2001). In Bolivia, a social insurance scheme entitles pregnant women to free care. In Cambodia, a voucher scheme was implemented in 2007 to offer poor pregnant women full or partial support with user-fees and transport costs for ANC, delivery and post-delivery services (De Brouwere *et al*, 2010). In addition, various conditional cash transfer and voucher schemes are being implemented in South Asia to reduce cost barriers impeding women's access to care, including the *Janani Suraksha Yojana* (Safe Mother Scheme) in India, the *Chiranjeevi Yojana* (Scheme for Long Life) in India; the Maternal Health Voucher Scheme in Bangladesh, and the *Sehat* (Health) Voucher Scheme in Pakistan (Jehan *et al*, 2012; Sidney *et al*, 2012).

While alleviating financial barriers to maternity care access is the dominant orthodoxy, often recommended by scholars and the global health community to decision-makers as a 'magic bullet' to redress access inequities (Chuma *et al*, 2009), it remains to be widely demonstrated what impact the various fee-exemption schemes have on access and equity of access to skilled care particularly in SSA (Jehan *et al*, 2012). The next section briefly reviews empirical research evidence relating to the effect of user-fees abolition and access and equity use of SMNHS.

2.5.3 Free Maternity Care, Access, and Equity of Access: Examining the Evidence

Thus far, evidence on the impact of user-fees abolition on access and equity of access is not only insufficient but also mixed (Jehan *et al*, 2012). For example, in Bolivia, a social insurance scheme, which provides free care for pregnant women, has shown increases in access and use of services as well as improvement in maternal health outcomes across the population (Dmytraczenko *et al*, 1998). In Bangladesh, the Maternal Health Voucher Scheme reports a rapid increase in access and use of ANC, DC, and PNC services (Ahmed & Khan, 2011). One evaluative study of the same scheme also reports that the likelihood of women having a skilled institutional delivery had increased almost twofold following the implementation of the scheme (Nguyen *et al*, 2012). Large declines in maternal mortality and morbidity as well as access and utilization differentials in rural China and Bangladesh have been linked to the use of vouchers that offer poor women free delivery services (Kelin *et al*, 2001). Equity of access was also reported in the Bangladesh's Maternal Health Voucher Scheme (Ahmed & Khan, 2011), while in Senegal and Ghana initial evaluations of free maternity care policies report an increase in the number of women accessing institutional deliveries (Penfold *et al*, 2007; Witter *et al*, 2008; Perkins *et al*, 2009).

However, some researchers have questioned these findings, pointing to countervailing evidence and the possibility of confounding factors influencing the entire or some aspects of the causal relationship (Schmidt *et al*, 2010). In Nepal for example, one study found that the scheme was still struggling to reach women in remote areas, while confusion persisted over the purpose of the scheme and women were unsure exactly what purpose the cash transfers were meant for (Bhusal *et al*, 2011). Similarly, in Bangladesh (Ahmed & Khan, 2011; Schmidt *et al*, 2010) and Nepal (Powell-Jackson *et al*, 2009), untimely reimbursement of cash incentives for beneficiaries under the conditional cash transfer programme, and the difficulties most poor women face in gaining access to the programme are reported as undermining the programme's impact on access and equity of access. For India's Safe Motherhood Scheme, evidence suggests that while institutional deliveries increased by 8% in rural areas six years after the introduction of the scheme, increasing poor quality of care was being recorded (Subha *et al*, 2012). As a result, service users' trust in the care offered is declining and this is in turn dissuading access.

Similar mixed results are reported from Uganda (Deineinger & Mpuga, 2004; Yates *et al*, 2006). In Kenya, one study found that although the reproductive health voucher programme increased access and use of services, the inequity gap between the poor and non-poor was not reduced (Obare *et al*, 2012). One study in Ghana also showed that birth-related maternal mortality failed to decline after the implementation of free maternal healthcare policy (Bosu *et al*, 2007). Other evaluative studies in Ghana, Kenya, Tanzania, and Burkina Faso show that once user-fees are removed, women continue to encounter other financial and non-financial barriers to access, including under-the-table fees and geographic access barriers (Asante *et al*, 2007; Kruk *et al*, 2008; De Allegri *et al*, 2010). Indeed, one study in Mali concluded that 'while fee exemptions

remove important financial barriers to accessing priority maternal health services, they are insufficient to ensure equal access' (El-Khoury *et al*, 2012:1).

To conclude the review of literature related to MNH in Ghana, two key findings need to be highlighted. The first is that lack of access and unequal access to SMNHS has, and continues to undermine efforts to attain safe motherhood in Ghana. The second is that, while providing free maternity care has become popular in low-income countries such as Ghana, much research remains to be done to establish the effects of such policy interventions on access, particularly equity of access and barriers to access and use of SMNHS.

2.6 Conclusion, Research Gaps and Contribution of this Research

Reducing maternal mortality has been at the top of the global health agenda for the last 30 years or so. However, the burden of maternal mortality in low-income countries is still enormous (Nyamtema *et al*, 2011). This chapter has reviewed and appraised the empirical research literature related to MNH access for the purposes of identifying research gaps in the literature and providing a context for addressing such gaps. This concluding section aims to highlight and summarize specific knowledge and research gaps identified in the review, and the ways in which the research reported in this thesis will aim to contribute to filling these research gaps.

It has been argued that enough is known to inform global action when it comes to ensuring the survival of mothers, neonates and infants (Ronsmans & Graham, 2006). To a large extent, this review has highlighted this point in a number of ways. On the backdrop of this, perhaps, the only obvious question that lingers in the mind of a reader of yet another academic piece of research on access, equity of access and barriers to accessing skilled maternal health services may be why?

In addition to contributing to the healthcare access and equity debate more broadly, this research aims to make a significant contribution to both the methodological and empirical research literature on MNH care access in a number of ways. In relation to the empirical research literature, this study attends to an important research gap in the literature, namely the limited and mixed research evidence on how demand-side financing interventions impact access and equity of access to SMNHS, and the concomitant call by several researchers for more empirical research and evaluation of these interventions to generate a better understanding of both their impact and factors which may operate to undermine them (Bosu *et al*, 2007; Witter *et al*, 2010; Ridde & Diarra, 2009; Ridde *et al*, 2011; Ridde *et al*, 2012; Jehan *et al*, 2012).

As one of the first studies to attempt to systematically describe and investigate the problem of access and equity of access in maternity care in Ghana within the context of an evolving health policy environment using quantitative survey data and qualitative research methods, this research uniquely contributes to the empirical research literature and debate. As noted earlier, the Ghana government has in recent years adopted a policy stance aimed at reducing barriers to accessing and utilizing skilled maternity care services, including the introduction of the free maternal healthcare policy in 2003. Against this background, it is striking, as Johnson and colleagues (2009) observed, that Ghana continues to register high MMR. Thus a compelling need has arisen for empirical research to understand both the impact of the policy on access decisions, and the barriers to accessing and using SMNHS. This is more so when the exact effects of most of the barriers to access and equitable use of SMNHS are not known in Ghana. The present study therefore comes at an opportune moment to fill this research gap.

In addition, it is of utmost importance to understand who continues to remain excluded from

access to maternal care services following user-fee exemption (De Allegri *et al*, 2010). Therefore, consideration of questions of equity as well as the equity implications of Ghana's free maternal healthcare policy in this research respond well both to this research need and a long-standing critique that the equity aspect of public health policies has been neglected in most analyses of health sector reforms in Africa (Gilson *et al,* 2000; Standing, 2002; Ridde, 2008). Such a research agenda is in fact distinct from the normative or theoretical debates that have so far characterized debates on equity in healthcare access. Rather, this line of inquiry is an effort to link healthcare policy reform and/ or financing to the issue of equity in healthcare access, thereby allowing for a more dispassionate evaluation of the policy via the juxtapositioning of empirical evidence against theory, from which policy and theoretically relevant conclusions and claims could be made. This not only has the potential to contribute to innovative theoretical thinking, research, and debate, but may also lead to the production of knowledge with 'social value' or the generation of knowledge that can lead to improvements in health. This is particularly important because as Emanuel *et al* (2004) argue, without social value research exposes participants to risks for no good reason and wastes resources.

Furthermore, and as shown above, there is still considerable disagreement in the literature about the relative importance of different access barriers in different contexts (Nanda, 2002). Therefore, some researchers have underscored the need for more context-specific research to investigate and isolate the relative importance of these barriers and the mechanisms by which they operate to limit access and/ or create unequal access and use of services (Babalola & Fatusi, 2009).

Compounding the problem is the near exclusive focus of the extant literature on clinical, and individual factors, neglecting in the process, macro-structural or wider household, community

and state-level factors that may limit access and affect rates of service utilization differently (Gil-González *et al*, 2006; Babalola & Fatusi, 2009). Yet, factors influencing SMNHS accessibility and utilization often operate at various levels: individual, household, community and state (ibid). The implications of this omission are that not only are some disabling factors inadvertently missed, but also failing to consider the role of factors operating beyond individual levels may also result in biased and misguided policy, for individuals are nested within families, which are in turn nested within communities and states (Babalola & Fatusi, 2009).

It is therefore important to take this nested structure into account. This demands contextual, multilevel, and polyvalent analyses (Babalola & Fatusi, 2009). The more situated and multilevel examination of the barriers to maternity care access in Ghana, and the way in which they interact to limit access and reproduce unequal use of SMNHS in this research, offers an opportunity for producing findings that may respond to this research gap. Besides, given the large gaps in the literature regarding the factors affecting the accessibility and utilization of SMNHS, this research responds to calls for high priority to be given to field-based research that can elaborate the factors leading to delay, non-access and differential access in different settings by focusing simultaneously on circumstances facing women in the community and in the health facility (Thaddeus and Maine, 1994).

Last but not least in relation to gaps in the empirical research literature, many studies examining norms of childbirth and care seeking behaviours have focused on describing the norms of non-use of services, rather than factors, which enable or promote service use (Parkhurst *et al,* 2006). Consequently much remains to be done to identify the enablers of access (*ibid*). As this study considers the related questions of how access may be increased, and inequities in access reduced,

as well as factors that enable and promote access and use of SMNHS in Ghana, it would hopefully respond to this lacuna in the literature.

From a methodological standpoint, some researchers have offered damning critiques of the nature and design of previous research on access and access barriers, and the kinds of research evidence such studies have produced (Parkhurst *et al*, 2006; Essendi *et al*, 2010). For Parkhurst *et al* (2006), existing studies focusing on users of services have tended to be quantitative surveys, identifying statistical correlates of use, including socio-demographic elements such as income, education and age. Important as these types of studies are, they 'cannot illustrate how decisions are made, or the key enabling factors behind these decisions' (p.439). Essendi *et al* (2010) takes this further and argue that:

> While seeking to understand the barriers to [maternal] healthcare services by sub-Saharan African women, many studies have focused on individual, household, community, and health system-level barriers. From these, a lot is known...The bulk of the data used in these studies has, however, been collected using quantitative measures that ignore the direct views and accounts of the people who themselves use or not use these services' (p. S357).

Commenting on current research evidence on access to SMNHS in SSA, Simkhada *et al* (2007:258) expound the problem like this: 'there are few qualitative studies of women's views or experiences' of maternal and child healthcare in developing countries.

Related to this methodological critique is the lack of attention in these quantitative analyses to the situated practices, politics, and ethics of MNH services access in current research (Shankar *et al*, 2008). Lewis (1990) highlights this problem in a discussion of 'mothers and maternity policies in twentieth century Britain'. Lewis shows how there has always been a gap between the perceptions and demands of women in respect of maternity care policies and practices, and what policymakers have offered: policy makers have always tended to abstract childbirth from the

fabric of women's lives. In their recent book, *Tensions and Barriers in Improving Maternity Care: The Story of a Birth Centre in the UK*, Deery *et al* (2010) present a fascinating illustration of Lewis' argument by showing how a birth centre trapped in a medicalized system is threatened and rapidly destroyed. They tell of how midwives are pitted against each other, the failure to stimulate widespread support from the local community, and the use of already overworked community midwives to staff the birth centre. For the authors, it was not the birth centre that failed, but lack of leadership, support, vision, plain dealing, and an authoritarian and bureaucratic hospital-based maternity system that was insensitive both to women's experiences and to midwives' values and relationship.

In advancing knowledge on access, equity of access and barriers to access and use of SMNHS in Ghana therefore, the experiences and views of women as well as attention to local policy practices are very critical (Shanker *et al*, 2008). As this study aims to deploy qualitative methods alongside the use of survey data (see the next chapter), it is hoped that detailed and thick empirical descriptions would be produced not only to give meaning to the quantitative results, but also to aid the exploration of women's experiences as well as understanding of the barriers to SMNHS access. Such a methodological approach also has the potential to enable understanding of the links between barriers to access and use of SMNHS and questions of choice and structure. Qualitative methods can also help explore and expose any heterogeneous, contingent and sometimes-contradictory practices, which might be embedded in the MNH care politics in Ghana.

Chapter 3

METHODS

3. Introduction

This chapter presents a detailed reflection on the study's methods. It aims to highlight the epistemological and practical underpinnings of the research design, the choice and selection of research participants, the methods of data collection and analysis, the strengths and limitations of the various data collection techniques deployed, and the ways in which certain ethical dilemmas arose, and were handled.

3.1 Methodological Orientation and Research Design

Broadly conceived, the theory and praxis of this doctoral research are at the interface between Social Science and Public Health. That is, it is a social science enquiry into a public health problem, drawing particularly on methodological and analytical insights from health services research, sociology and public health ethics. Its epistemological foundations and methodological design generally fall within the *mixed methods research tradition* (Creswell & Clark, 2011). Mixed methods research has been defined as a type of research in which a researcher melds elements of *qualitative* and *quantitative* research approaches (in this case, using quantitative and qualitative data, analysis and inference techniques) for the purposes of complementarity, breadth and depth of understanding, and corroboration (Creswell & Clark, 2011).

Qualitative research varies between and within disciplines, but can broadly be viewed as a nuanced approach to knowledge acquisition and generation, concerned with how a phenomenon is viewed, experienced or constructed by social actors. Anchored theoretically in phenomenology and interpretivism (Duffy, 1987), qualitative research attempts to provide access to the opinions,

aspirations and power relationships that help to explain how people, places and events arise in identifiable local contexts which 'privilege individual's lived experiences' (Karnieli-Miller *et al*, 2009:279). Within a qualitative research tradition, rather than the collection of 'facts' by a neutral researcher, research is seen as generating its own meanings and experiences, which are transformed into data (Ellen, 1984). It is further acknowledged that the identity, values, and beliefs of both researcher and research participant cannot entirely be disentangled from the process of gathering and analysing data and from the generation of theories (Foddy, 1993; Denscombe, 1998). For this reason, some argue for more critical reflexivity or self-referential awareness of the interests and motivations of qualitative researchers and research participants in relation to the research objectives and processes of data collection and analysis (Bourdieu, 2004). I shall return to this issue later.

While qualitative research upholds the view that knowledge is value-bound, quantitative research emphasizes a value-free framework, focusing on the measurement and analysis of causal relationships between variables, not processes. Such a focus allows quantitative researchers to theorize and make claims that are considered to be broadly applicable across a wide variety of circumstances (Denzin & Lincoln, 2003).

The decision to blend these two seemingly distinct approaches to research is first influenced by this research's unique location within the confluence of the disciplines of social science and public health, and the researcher's commitment to a methodology that is pragmatic and capable of providing an opportunity for drawing on different research and analytical techniques. Here, the researcher was particularly influenced by the works of mixed methodologist, John W. Creswell (2008, 2011, 2012 & 2013), who stresses the importance of matching research problems to

appropriate design, and who suggests pragmatism as one route to achieving this.

Methodological pragmatism, as discussed by Creswell, is a methodological approach that moves beyond 'methodolatry' (the slavish attachment, devotion and preoccupation with selecting and defending methods to the exclusion of the story being told) to choosing methods and data collection and analytical techniques based on their particular merits and limitations in explicating particular research questions. For Creswell, instead of methods being important, the research problem is the most important issue and individual researchers have freedom of choice regarding the methods, techniques and procedures of research that best meet their needs and purposes. In terms of the mode of enquiry, pragmatism embraces the two extremes normally espoused by positivism/post-positivism and those supported by interpretivists. The former emphasizes quantitative methods as opposed to interpretivists' qualitative approaches. Thus pragmatism rejects the forced choice between positivism (including post-positivism) and interpretivism with regard to methods, logic and epistemology. It is for this reason that methodological pragmatism has traditionally been cited as providing the relevant philosophical basis and justification for mixing methods in a research endeavour (Tashakkori & Teddlie, 1998; Teddlie & Tashakkori, 2003; Scott & Briggs, 2009).

The second, and perhaps most important reason for employing a mixed methods design is its appropriateness for answering the research questions and redressing the gulf in the methodological and empirical research literature on maternal and newborn (MNH) care access that were identified in chapter two. The majority of previous empirical research on MNH care access in low-income countries to date has been quantitative (Parkhurst *et al*, 2006; Shankar, *et al*, 2008; Essendi *et al*, 2010). Such studies, although very important, have had difficulty in

focusing attention on the context within which pregnancy and childbirth occurs, describing women's experiences of pregnancy and childbirth, as well as analysing and addressing the nuances of the processes through which women reach the decision to either access health services or not (Parkhurst *et al*, 2006). This gap has to date been filled primarily by small-scale, community-based qualitative research studies (e.g. Parkhurst *et al*, 2006; Reitmanova & Gustafson, 2008; Oyerinde *et al*, 2012). While such small-scale qualitative studies have provided data on factors underlying women's reproductive choices and behaviours, attempts to extend the findings of such research to broader populations have been hampered by their small-scale and socio-cultural specificity (Edmeades *et al*, 2010).

Given the relative strengths and weaknesses of quantitative and qualitative research designs in previous MNH research, I believe, as have Edmeades *et al* (2010), that a new research design that exploited the complementarity of qualitative and quantitative approaches is needed to maximize the insights and advantages of both research traditions. In fact the potential for exploiting the strengths and trading off the weakness of qualitative and quantitative methods in a mixed methods research remain one fundamental reason for an increasing support base for this type of research approach (Sofaer, 1999; Bamberger, 2000; Tashakkori & Cresswell, 2007a; Creswell & Clark, 2011). Moreover, there is recognition in the health policy evaluation literature that the traditional reliance on utilization rates as a statistical indicator of the success or otherwise of a health policy intervention such as Ghana's free maternal health policy is not sufficient (Hardley, 2011). Rather, attention has been drawn to the need to credit the perspectives of stakeholders on policy measures and to 'get in touch' with local practices that impact on policy (*ibid*). To gain contextual knowledge of local practices, and to provide a more comprehensive understanding of access, equity of access and barriers to access and use of skilled maternal and newborn healthcare

services (SMNHS) following user-fees abolition in Ghana, it is important to combine empirical quantitative statistical analysis with qualitative exploration.

Of course, critics of mixed methods research have often invoked the so-called 'incompatibility thesis' to argue that mixing research methods can create argumentative incoherence by attempting to blend paradigms with incommensurable epistemic and ontological functions (Johnson & Onwuegbuzie, 2004). Similarly, methodological pragmatism is berated for paying less attention to questions of ontology and epistemology in the research process and the way in which these shape research inquiry and the type of research evidence produced (Bryman, 2007; Fries, 2009). Some methodologists are also wary of the difficulties that might arise in a mixed methods research design when conflicting findings are produced (Slonim-Nevo & Nevo, 2009).

Genuine as the above criticisms may be, it can be argued that both epistemology and ontology can be empirical rather than foundational, and methodological pragmatism offers a practical starting point for achieving this (Scott & Briggs, 2009). In this regard, a mixed methods research design espouses an epistemological orientation that emphasizes 'overcoming the antimony of objectivism and subjectivism' that have often characterized the quantitative-qualitative research divide (Wacquant, 1998:220). Besides, it is my view that mixing methods performs another important function: it advances a methodological approach that is pragmatic in terms of giving the research an opportunity to choose methods and analytical techniques that best address the questions. This argument is supported by other researchers who observe that within health services research, a mixed methods approach is justified on pragmatic rather than ideological grounds, to help researchers to engage with the complexity of health, healthcare, and the environment in which studies take place (O'Cathain *et al*, 2007; O'Cathain, 2009). Clearly, the

aims of this research and the nature of the questions investigated meant that relying solely on either quantitative or qualitative approach would fall short of providing the breadth and depth required to fully explicate the research problem.

In relation to the difficulties that conflicting results may pose to mixed methods researchers, my argument is that there is even more value in taking and interpreting any resulting conflicting findings from a mixed methods study as providing yet another lens through which the research question may be meaningfully answered. Besides, the persistence of poor MNH outcomes in Ghana despite the implementation of free maternal healthcare policy presents enormous methodological challenge in terms of what methods of inquiry are scientifically possible and ethically acceptable, for producing the most robust, valid, credible and reliable research evidence. Therefore, I came to the conclusion that the kinds of reasoning and methods of inquiry required for investigating such a complex research problem must necessarily involve judgments (theoretical, methodological and pragmatic), deliberation, and assembly of a variety of empirical evidence, as well as ethical and political considerations (see also Smith, 2012).

3.2 The Research Setting

Empirical research was conducted during a total of 6 months between November 2011 and May 2012 in Ghana. Ghana is a West African country, situated about 750 km north of the equator on the Gulf of Guinea. It has a total land area of 238,305 square kilometres, and is bordered on the south by the Gulf of Guinea, on the north by Burkina Faso, on the west by Ivory Coast, and on the east by Togo. Administratively, the country is divided into 10 regions and 212 districts.

Tables 3.1 gives a summary of selected demographic, socio-economic, and health indicators of the study setting. Note in particular the differences in the distribution of some of these indicators between the two study regions (more on this later), which are highlighted in blue colour. Ghana is a low-income country, with an estimated total population of 24,658, 823 (GSS, 2012). The population structure is typical of a low-income country: about half of the total population is below age 15. High fertility and decreasing mortality rates are the two factors shaping the age structure of the population (*ibid*). Average life expectancy at birth is 60 (59 for male and 60.7 for females). Adult literacy - defined as the proportion of population aged 15 years and above who can read and write in English and a Ghanaian language - is 57.9%. There are however significant variations between the sexes, regions, urban-rural areas, and districts. Ghana has a human development index (HDI) of 0.526 and a multi-dimensional poverty index of 0.14. Ghana's HDI is higher than the sub-Saharan African average of 0.389. In 2005, about 30% of the population was estimated to live on less than US$1 per day.

Like many low-income countries in SSA, the burden of disease in Ghana has not changed significantly for decades (Zere *et al*, 2012). Communicable diseases account for about two-thirds of out patient department (OPD) visits, and malaria is the main cause of outpatient morbidity (*ibid*). National HIV prevalence in 2009 was estimated at 1.9%. The burden of non-communicable diseases including cardiovascular disorders, diabetes, and cancers is emerging as a major challenge to service delivery and a threat to health and national productivity (Zere *et al*, 2012). Mental health and neurological disorders are also increasing while trauma and other injuries, especially road traffic injuries, are significant among outpatients (GSS, 2007).

Table 3.1: Selected demographic, socio-economic and health indicators.

Demographic Indicators	**Statistic**
Total population (2010)	24,658 823 (48.8% male; 51.2% female)
Ashanti Region population (2010)	4,780,380 (2,316,052 males; 2,464,328 females)
Northern Region population (2010)	2,479,461 (1,229,887 males; 1,249,574 females)
Central Gonja District population (2010)	93,910 (44,793 males; 49,117 females)
Bosomtwe District population (2010)	87,877 (43,860 males; 44,017 females)
Proportion of population below 15 years (%) (2010)	38.3
Proportion of population above 60 years (%) (2010)	4.7
Proportion of population living in urban areas (%) (2010)	50.9
Socio-economic Indicators	
Adult literacy rate (%) (2008)	57.9
Percentage of Population with No Education (2008)	13.3 (male); 21.2 (female)
Percentage of Population with No Education (Rural) (2008)	19.9 (male); 30.8 (female)
Percentage of Population with No Education (Urban) (2008)	5.6 (male); 10.9 (female)
Percentage of Population with No Education (Ashanti) (2008)	6.6 (male); 9.9 (female)
Percentage of Population with No Education (Northern) (2008)	48.4 (male); 65.7 (female)
Total gross domestic product (US$) (2009)	34.04 Billion
Gross national income (GNI) per capita (US$) (2009)	700
Annual economic growth rate (%) (2009)	6.3
Population living on less than 1 US$ dollar per day (2005)	30
Multi-dimensional poverty Index (2008)	0.14
Human development Index (2009)	0.526
Health Indicators	
Adult mortality rate (15 - 60 years) per 1,000 population (2007)	343 (male); 291 (female)
Life expectancy at birth (in years) (2009)	59 (male); 60.7 (female)
Infant Mortality Rate (per 1,000 live births) (2008)	50
Infant Mortality Rate (per 1,000 live births) in Ashanti Region (2008)	54
Infant Mortality Rate (per 1,000 live births) in Northern (2008)	70
Under 5 Mortality Rate (per 1,000 live births) (2008)	80
Under 5 Mortality Rate (per 1,000 live births) in Ashanti Region (2008)	80
Under 5 Mortality Rate (per 1,000 live births) in Northern Region (2008)	137
Neonatal Mortality Rate (per 1,000 live births) (2008)	30
Post-Neonatal Mortality Rate (per 1,000 live births) (2008)	21
Crude Birth Rate (per 1,000) (2008)	29
Crude Death Rate (per 1,000) (2008)	9.4
Total Fertility Rate (2008)	4

Source: Authors construct based on Ghana Population and Housing Census 2010 (GSS, 2012); The World Health Statistics 2009 (WHO, 2009); and Ghana Demographic & Health Survey 2008 (GSS, 2008).

Ghana's healthcare system is organized under four main categories of delivery systems: public, private-for-profit, private-not-for-profit, and traditional systems (see figure 3.1) (Abor *et al*, 2008).

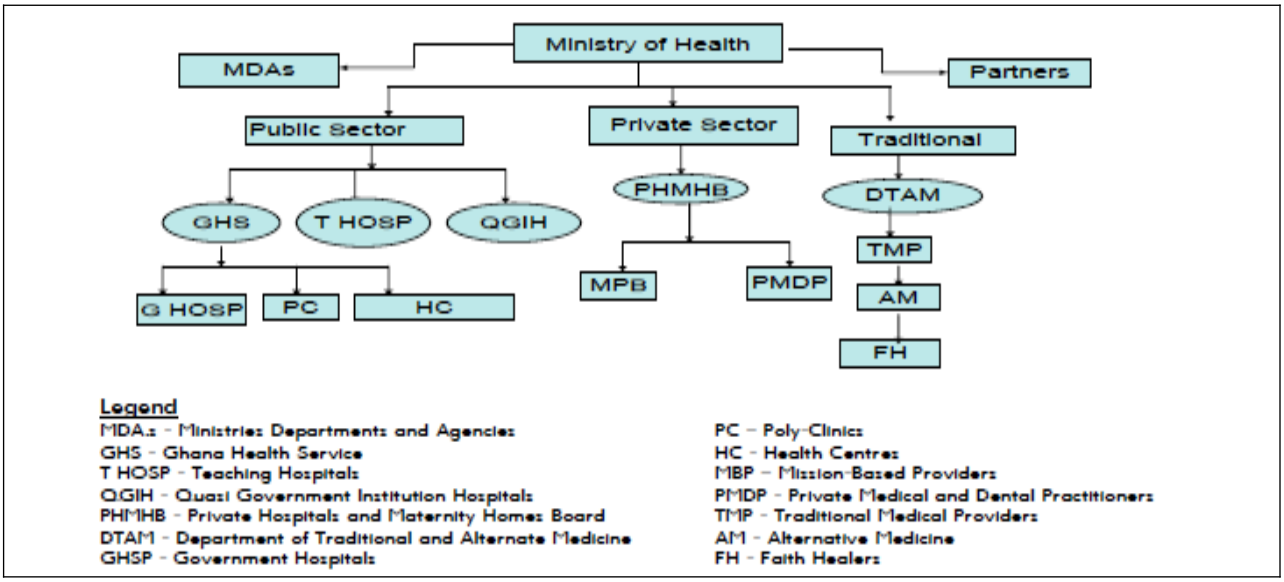


Figure 3.1: Structure of Ghana's health delivery system. **Source:** Adapted from Abor *et al* (2008).

Bour (2004) and Abor *et al* (2008) characterize Ghana's health system as one of pluralism, consisting of the popular, folk, and professional sectors. The popular sector does not involve consultation; all therapeutic options are used. Both herbal and orthodox medicines are used without restraint. In the folk sector, individuals specialize in forms of healing that are either sacred or secular, or a mixture of the two. Practitioners are not part of the official medical system. Integration efforts are however made by governments on the basis that traditional or folk medicine is widely accepted and used by a good majority of the population, particularly in rural areas (Bour, 2004). The professional sector comprises organized and legally sanctioned professions in western medicine. It includes physicians and recognized paramedical professions such as nurses, midwives, pharmacists, and physiotherapists.

The delivery of preventive and curative care services is generally decentralized; characterized by hierarchically organized structures, from the national to the regional, district and the local community level under the Ghana Health Services (GHS), and superintended by the Ministry of

Health (MoH). The MoH has the primary responsibility to make policy and determine priorities for the health sector, while the GHS is responsible for developing implementation guidelines for the 10 regions and 212 districts. The regions are responsible for providing coordination and assistance to the districts (GSS *et al*, 2009). At the district level, District Health Management Teams (DHMTs) have been created to plan and implement health service delivery. The DHMTs also have the authority to seek additional funds from donors (*ibid*).

By far, health centres, health posts, mission clinics and private midwifery homes provide basic obstetric and antenatal care in most communities in Ghana. Each health centre or post serves a population of approximately 20,000 (Witter *et al*, 2007). In the rural areas, traditional birth attendants (TBAs) carry out deliveries, though some are trained to refer more complex cases. Comprehensive emergency obstetric care is available from district hospitals and regional hospitals, as well as national referral hospitals. Most are run by the GHS, though the mission sector plays a significant role, especially in more remote regions. Payment mechanism for healthcare is a combination of fee-exemption, health insurance and out-of-pocket (Schieber *et al*, 2012; Saleh, 2013; Zere *et al*, 2013.

In addition to the fact that MNH outcomes continue to be poor in Ghana, the choice of Ghana for this research was influenced by the fact that the researcher comes from Ghana, and has also previously conducted research in the country. Thus familiarity of context and previous research experience bolstered the selection of Ghana for this research. As would be shown later, both familiarity and previous research experience were instrumental in the success of data access and data collection processes as well as the smooth negotiation and resolution of certain ethical dilemmas that emerged during the course of the research.

3.3 Data Types and Sources of Information

This study uses both quantitative and qualitative data. The *quantitative* data comes from secondary survey data - the Ghana Maternal Health Survey (GMHS) 2007 – sourced from the Ghana Statistical Service (GSS), one of the custodians of the data, through an official written request. The *qualitative* data – which is the primary data source and on which a bulk of the analysis is undertaken – comes from 1) focus group discussions (FGDs) and in-depth interviews (IDIs) with different stakeholders connected with maternal and newborn health (MNH) in Ghana; and 2) direct observation throughout the period of the author's engagement with research participants and immersion in the study communities.

To complement and/ or triangulate some of the data and information obtained from the GMHS and the qualitative research, relevant secondary documentary reviews were also completed. As Hoddinott (1992) argues documentary evidence is an important indicator of the state of existing knowledge and theory, and acts as a guide to relevant topics and research destinations. An extensive literature review was therefore conducted, before, during, and after data collection. While in Ghana, the author also undertook documentary research, which involved collating and analysing health policy documents and annual health reports produced by the MoH and GHS at the national, regional, and district levels. This yielded valuable information on such issues as the actual number of women accessing and using maternity care services. In what follows, the approaches adopted in obtaining and analysing the quantitative and qualitative data are described in greater detail.

3.4 The Quantitative Research – The GMHS 2007.

As noted above, the quantitative component of this research relies on analysis of quantitative data

extracted from the GMHS, details of which are discussed below. The decision to use the GMHS data relates to its practical relevance to this research. The survey is the first nationally representative, high-quality population-based survey to collect information specifically on MNH services accessibility and utilization since the implementation of the fee-free maternal health policy. The GMHS was thus one of the best readily available, and up-to-date databases on MNH in Ghana at the commencement of this research. The main strengths of the data are the large sample size and its representativeness of the population. Both of the two attributes are known to increase precision of estimates of study subgroups (Hofferth, 2005).

Briefly, the GMHS is a retrospective five-year (2003-2007) nationally representative survey of 10,858 households and 10,370 individual women aged 15-49 that was carried out to:

- Collect data at the national level that will allow an assessment of the level of maternal mortality in Ghana;
- Identify specific causes of maternal and non-maternal deaths;
- Measure indicators of access and utilization of maternal health services in Ghana.

The survey was conducted in two phases. In phase I, a short nationally representative household survey questionnaire was administered to 240,000 households from 1,600 clusters or primary sampling units within the ten administrative regions of Ghana and across urban and rural areas. The 1,600 clusters were selected from a pre-existing list created for Ghana's 2000 Population and Housing Census. On average each of the selected sampling units yielded 150 households.

Out of the 240,000 households sampled in phase I, 226,209 households completed the questionnaire, with a 94.3% response rate. Reasons for nonresponse were related to dwellings being vacant or inhabitants being gone for extended period at the time of the survey (GSS *et al*,

2009). The purpose of the Phase I survey was to identify deaths to women aged 12-49 in the five years preceding the survey. A total of 5,931 female deaths were identified out of which 4,203 were deaths at ages 12-49.

In Phase II, the households that reported one or more deaths of women aged 12-49 years in the five years preceding the Phase I survey were followed-up with a verbal autopsy questionnaire. The verbal autopsy questionnaire asked additional questions in relation to all the 4,203 female deaths aged 12-49: whether death occurred at ages 12-49; whether the woman was pregnant at the time of death, whether the woman died during childbirth or within two months after delivery. Of the 4,203 female deaths, 605 were maternal deaths.

Apart from the verbal autopsy survey, Phase II also involved interviews with individual women. To achieve this, 400 clusters were randomly selected from the 1600 clusters identified in Phase I. Households with women aged 15-49 were selected from these 400 clusters and were stratified by region and urban-rural residence. The 400 clusters produced a total of 11,579 randomly selected households (independent of the households identified in Phase I as having experienced a female death), of which 10,994 were occupied at the time of the survey. Of the 10,994 occupied households, 10,858 households were successfully interviewed, giving a response rate of 99%. Here too, the primary reasons for nonresponse were same as those in Phase I above. In the 10, 858 interviewed households, a total of 10,627 women were identified as eligible for individual interview (i.e. women aged 15-49). However, interviews were completed for 10,370 women - 98% response rate - using a questionnaire for individual women to collect information on key demographic and MNH indicators such as access and use of antenatal and emergency obstetric care in the event of a birth, abortion, or miscarriage. Reasons for nonresponse among eligible

women were either related to refusal or the failure of the interviewing team to find women at home, despite repeated visits to the household (GSS *et al*, 2009).

For the purposes of this research, data from the interviews with individual women (i.e. data relating to access and use of antenatal, maternity, emergency obstetric care and abortion care) generated in the second part of Phase II of the survey is used. The method of analysis of the quantitative data is described later in section 3.6.1, while the results of my analysis are reported in chapter four.

3.5 The Qualitative Research

In section 3.3, it was indicated that qualitative data was the primary empirical data I used to examine the questions of access, equity of access and barriers to accessibility and utilization SMNHS in the context of Ghana's free maternity care policy. This section aims to describe the qualitative research processes as well as the methods and techniques used to gather and/or generate the qualitative data.

3.5.1 Choosing Where to Go

Having justified why Ghana was chosen as the country in which to implement the study, the next task involved choosing regions, districts and communities to undertake actual empirical qualitative research. As mentioned before, Ghana has ten administrative regions, which are further subdivided into 212 decentralized metropolitan, municipal and district assemblies. But there is also a divide between a relatively destitute north and a relatively prosperous south. This divide, though usually not articulated formally, is perhaps one of the most distinguishing features of the country.

In deciding on a field to implement the research, it was necessary to choose areas that will fairly represent this essential characteristic of the country. I therefore started the site selection process by dividing the country into north and south. Three regions constituted the north and the rest made up the south. One region each from the north and south was then randomly selected. These are the Northern and Ashanti regions (Figure 3.2). The Northern region had a total of 19 metropolitan, municipal and district assemblies, while the Ashanti region had 27. One district was then randomly selected from each region, namely Bosomtwe and Central Gonja from the Ashanti region and Northern region respectively. From these two districts, six communities - Kuntanase, Abono, and Piase in the Bsomtwe district of the Ashanti region; and Mpaha, Sankpala and Tidrope in the Central Gonja district of the Northern region - were randomly selected. These six communities offer a diversity of social and health situations that are largely representative of the country, Ghana.

To capture any differences that may exist between urban and rural communities as well as communities with at least one government or mission healthcare facility and those without, the selection process also involved classification of communities into urban and rural, and communities with or without healthcare facility. A standardized population-based criterion was used to determine the urbanity or rurality of a community, while data on the distribution of healthcare facilities by community in each district was obtained from the respective district health directorates. I then decided that for each district, one urban community and two rural communities would be randomly chosen.



Figure 3.2: Map of Ghana showing study regions and districts.

Since all urban communities in Ghana have at least one government or mission healthcare facility, one of the rural communities was to have at least a healthcare facility and the other without. Table 3.2 shows the distribution of the six communities into urban, rural with healthcare facility, and rural without healthcare facility.

Table 3.2: Distribution of study communities

District	Urban Community	Rural Community with Health Facility	Rural Community without Health Facility	Total
Bosomtwe	Kuntanase	Piase	Abono	3
Central Gonja	Sankpala	Mpaha	Tidrope	3
Total	**2**	**2**	**2**	**6**

Source: Author's construct, 2012.

3.5.2 Research Participants

The research participants were drawn from a population of pregnant women and lactating mothers from the six research communities, and from health personnel from the two regional and district health directorates (see table 3.3). For the purposes of this research, the study population was classified into two groups: Women and Healthcare Providers. 'Women' here refers to women who were pregnant at the time of this research or had given birth (lactating mothers) between January 2011 and May 2012 in the six studied communities. Thus the study sampled women who have had direct encounter or personal experience of pregnancy and childbirth, and who were fully qualified to have benefitted from MNH interventions such as the free maternity care policy. Healthcare providers encompassed health professionals (doctors, nurses, midwives, healthcare managers, and health policy makers or implementers) from health facilities in the study communities, health departments, health directorates, and GHS at the national, regional, and district levels who are directly or indirectly involved in MNH policy-making or implementation, service provision, or campaigning for safe motherhood.

The rationale for interviewing diverse actors at multiple levels was to allow for an exploration of multiple perspectives as well as take account of the nested nature and structure of the MNH care access problem, which as noted in chapter two, requires contextual, multilevel, and polyvalent analyses (Babalola & Fatusi, 2009).

In all, 205 participants took part in the study. Of this number, 90% (185) were pregnant women and lactating mothers. The remaining 10% consisted of community health nurses, midwives and healthcare professionals and/ or managers from the Bosomtwe and Central Gonja district health

directorates, the Ashanti and Northern regional health directorates, and officials from the GHS headquarters in Accra.

Table 3.3: Distribution of research participants across communities and institutions

Communities		Research Participants	Number of Participants	Data Collection Methods
1	Kuntanase	Pregnant women & Lactating mothers	24	Focus Group Discussion
			21	In-Depth Interviews
2	Abono		20	Focus Group Discussion
		✔	**11**	In-Depth Interviews
3	Piase	✔	**15**	In-Depth Interviews
4	Sankpala		22	Focus Group Discussion
		✔	**12**	In-Depth Interviews
5	Mpaha		21	Focus Group Discussion
		✔	**13**	In-Depth Interviews
6	Tidrope		17	Focus Group Discussion
		✔	**9**	In-Depth Interviews
Institutions				
1	Ghana health Service Headquarters (Accra)	Directors of policy planning, monitoring and Evaluation & Maternal and Child Health	**3**	In-Depth Interviews
2	Ashanti Regional Health Directorate (Kumasi)	Public Health Director & Public Health Nurse	**2**	In-Depth Interviews
3	Northern Regional Health Directorate (Tamale)	Public Health Director & Public Health Nurse	**2**	In-Depth Interviews
4	Bosomtwe District Health Directorate (Kuntanase)	Director & Public Health Nurse	**2**	In-Depth Interviews
5	Central Gonja District Health Directorate (Buipe)	Director & Public Health Nurse	**2**	In-Depth Interviews
6	Tamale Teaching Hospital	Public Health Nurse	**1**	In-Depth Interviews
7	Kuntanase Hospital	Midwife	**1**	In-Depth Interviews
8	Piase Health Centre	Midwife	**1**	In-Depth Interviews
9	Buipe Rural Clinic	Midwife & Medical Assistant	**2**	In-Depth Interviews
10	Sankpala Health Centre	Midwife	**1**	In-Depth Interviews
11	Mpaha Health Centre	Community Health Nurses	**3**	Focus Group Discussion
TOTAL			**205**	

Source: Author's construct, 2012.

3.5.3 Accessing Research Communities, Participants and Data

3.5.3.1 Ethical Clearance

Like most empirical biomedical research projects involving human subjects, one of the first steps to accessing research participants was the need to gain ethical clearance from a reputable ethics review committee. Two ethics committees reviewed this study's protocol. The first is the University of Oxford Social Sciences and Humanities Inter-divisional Research Ethics Committee (IDREC). Here the review process took approximately two weeks, and was generally unproblematic. The only condition was for the study to be co-reviewed by a local ethics committee in Ghana. Consequently, I approached the Ghana Health Service Ethical Review Committee (GHS-ERC) for a second review of the protocol.

The GHS-ERC is part of the research and development unit of the GHS and has responsibility for reviewing all health-related research conducted under the ambit of the GHS. Since this research came directly under the auspices of the GHS, the GHS-ERC was indeed the most appropriate ethics review committee to approach. The ethics review in Ghana lasted approximately two months. The committee made three recommendations.

First, the committee required the nomination of a competent local researcher or academic who would act as a local collaborator. The duties of such a local collaborator included advising on the appropriateness of using different data collection techniques in different local contexts as well as helping the researcher to negotiate access and appropriately respond to any research-related challenges that may arise. After several days of consultations with different researchers in the field of maternal and reproductive health, Dr. Easmon Otupiri of the Department of Community Health, Kwame Nkrumah University of Science and Technology Medical School, was nominated.

The second requirement was for the researcher to demonstrate evidence of stakeholder and institutional consultation as well as community engagement. This evidence took the form of a letter from the relevant institutions or community addressed to the chairman of the GHS-ERC confirming that the researcher has duly discussed the details of the proposed research with them and that they were happy for the research to proceed. This requirement too was successfully met (see next two sections).

The last recommendation was for the researcher to incorporate newborn health into the research. The GHS-ERC noted:

> This is a very good study for MDG 4 & 5 and addresses policy. We suggest that you include newborns.

Per the protocol that was submitted to the GHS-ERC, the study focused only on MDG 5, particularly women's experiences with accessing and using skilled ANC, DC and PNC services. Following this recommendation however, the research scope was redefined to incorporate women's experiences with newborn healthcare services accessibility and utilization. This decision was arrived at following consultations with the researcher's advisors at Oxford as well as his local collaborator.

Of course, the researcher could in theory have rejected this modification to the research. Note however that the recommendation was not merely a suggestion, but one that was to be fulfilled if the researcher wanted the research to be approved. Therefore, the choice was really limited. Apart from broadening the scope of the research, however, the inclusion of newborn healthcare did not affect the objectives of the research and focus of the research questions in any negative material sense. Rather, the incorporation accorded well with the WHO's argument for a reconfiguration of maternal health into maternal and newborn health to reflect a continuum of care for mother and child from pregnancy to birth and in the immediate post-partum period (WHO, 2005).

3.5.3.2 Community Entry and Engagement Processes

Having selected the study communities and obtained ethical clearance, one initial challenge was how to access these communities. This challenge derived from the fact that the researcher had no personal knowledge of the communities or contact persons in these communities. Given this background, the researcher discussed the issue with the district health directors, who graciously recommended the researcher to the Community Based Surveillance Volunteer (CBSV) in each

community. Typically, CBSVs are recruits (mostly men) from local communities who are trained by the DHMTs in various aspects of community health, including but not limited to reporting the outbreak of any disease, and recording births and deaths in their communities. Because of the CBSVs' affinity with the DHMT, they often wield considerable influence in their communities[1].

The researcher contacted each of the CBSVs to discuss the purpose of the research and how best to introduce the research into the community. Following series of discussions with the CBSVs, it was decided that a letter informing the divisional sub-chief (*Odikro*) and the assembly member of the community about the research and its purpose as well as asking for permission to carry out the research in the community was the best strategy. Generally, in all the study communities, chieftaincy is a respected institution, and the highest political authority at the community level is the chief. But other important authority figures include the assemblyman/woman and local unit committee members. Together, they constitute the main source of local law, order and justice, and are the major gatekeepers to these communities.

After the chiefs and assembly members were written to, a follow-up visit was then made to each community, during which the researcher explained the purpose of the research and responded to questions from the gatekeepers. This reciprocal process greatly facilitated the researcher's ability to gain the community's consent and acceptance of the project.

3.5.3.3 Institutional Entry Protocols

Like the study communities, to visit any of the healthcare institutions or obtain data from their employees required official permission. In all cases, this official permission was obtained after

[1] In some communities, CBSVs were given the name 'small doctors', a name that commands respect.

the researcher wrote formally to the head of each of the institutions, usually introducing himself, the research and asking for permission to speak to some specific staff. Such request letters were supported with various introductory letters from the researcher's University and local collaborator as well as evidence of ethical clearance. These supporting documentations were often demanded as part of the process of determining the research's significance and the researcher's credibility and competence. In fact, but for these supporting documentations, it would have been impossible to obtain data from any of the institutions. In some instances, the researcher was made to make a brief presentation on the research to staff of the institution as part of the engagement process. This introduction and engagement process also helped galvanize institutional support for the project.

3.5.3.4 Sampling and Recruitment Procedures

The strategy for recruiting research participants involved both probability and non-probability sampling procedures. For all research participants under the 'healthcare providers' category, a purposive sampling technique was used. This was a judgmental selection based on the participant's role in the institution, the participant's knowledge of the subject of study, and the researcher's evaluation and/ or perception of the relevance of that role and knowledge to the research topic (Kumekpor, 2002).

For the women however, a simple random sampling procedure was used. The researcher's initial strategy for sampling and recruitment was a combination of convenience, purposive and snowball sampling. However, following initial engagement and consultations with healthcare providers at the Bosomtwe district health directorate, concerns were raised about appropriateness and acceptability of such sampling procedures. In addition to arguing for the need to assure justice

and minimize discrimination and the potential for social tension in study communities by using a fair and transparent sampling procedure, these healthcare professionals were worried that using only convenience, purposive or snowball sampling techniques could produce participants whose experiences and accounts are far from representing that of the generality of the women population in the district. In particular, concerns were raised about the potential for self-selection, whereby only participants with similar experiences are sampled into the study, thereby producing bias research findings.

Indeed, within the methodological literature, the potential for these sampling procedures to produce biased research samples and findings is acknowledged (Bowling, 2009)**.** It was therefore suggested that a complete listing or enumeration of pregnant women and lactating mothers in the selected communities be undertaken. From this list, a random sample could then be drawn. This, at least, would ensure that every pregnant woman or lactating mother had a fair chance of taking part in the research. This indeed was one of the most productive suggestions to come out from the many community/stakeholder engagement exercises that had to be undertaken before the actual start of the research.

Of course, the decision to accept this recommendation was not an easy one to arrive at, and during the initial stages, I was filled with trepidation. Indeed, given that the emphasis of qualitative research is not always on representation or generalization (Denzin & Lincoln, 1994; Silverman, 2001), my immediate inclination was to argue against the concerns that healthcare professionals raised. However, in living up to the spirit and letter of community engagement and a pragmatic research methodology, I accepted and proceeded to implement this recommendation. The decision to follow this rather unconventional approach proved beneficial as the sampling

process was started during which I became convinced that not only was the decision necessary, but also it was in consonance with the reflexive and pragmatic research approach argued for earlier, whereby researchers remain flexible in terms of choosing methods that generate quality data for the purpose of providing comprehensive and acceptable answers to particular research questions.

Fortunately, just when I was about to independently undertake the enumeration exercise, the Bosomtwe district health directorate was also embarking on a district-wide household survey to list the names of each member in every household in the district. The enumeration was meant to provide an estimate of how many 'sleeping places' there were in each household. This was to facilitate the distribution of insecticide treated mosquito bed nets district-wide. The listing was to be undertaken by trained CBSVs, and lasting for two weeks. Following a few more consultation with senior management of the Bosomtwe district health directorate, I was permitted to design a five-item short questionnaire that asked whether a woman was currently pregnant or had given birth since January 2011, the name of the woman, age and house number/name. This was administered alongside the 'number of sleeping places survey' by the CBSVs in the three study communities in the Bosomtwe district.

After the listing was completed, I firstly, retrieved the completed questionnaires from the CBSVs. Secondly a random selection was then done to determine the required number of participants from the pool of names for each community. The required number of participants was pre-determined (5% of the enumerated population) by the researcher taking into account the size of the community's population, and the availability of time and resources. Third, the randomly chosen participants were further randomly allocated to either focus group discussions (FGDs) or

in-depth-interviews (IDI). Finally, the researcher together with his research assistants and the respective CBSVs took the randomly selected names to the various communities wherein the research was introduced and the selection procedures thoroughly explained to each of the randomly selected women[2]. Thereafter, the women were invited to participate in the study. Where any of the randomly selected women was not available or declined to participate in the study – and there were only 2 of such cases - the selection process was repeated to get a replacement.

Although the overall sampling procedure was laborious, it worked really well. For example, and with regards to the concerns that district health authorities raised, the selection process minimized potential for producing bias research findings. For the women, the sampling procedure, particularly the idea of chance, helped to eliminate questions and suspicion about why one woman was included and another excluded from the study. Thus as each enumerated woman had a fair chance of participating in the research, the sampling procedure was deemed transparent and fair. Given the relative success of this sampling procedure in the Bosomtwe district, the same procedures were prudently repeated in the Central Gonja district, even though here the initial enumeration exercise had to be organized by the researcher himself and carried out by CBSVs and his research assistants.

3.5.3.5 Research Instruments

Two main instruments (see appendices 1 and 2) were used. For the FGDs and IDIs with women, an open-ended thematic topic guide was designed to ensure that the same themes were covered in each interview. The instrument however had built-in flexibility that allowed questioning to flow

[2] The rationale for engaging research assistants and their role is discussed later.

naturally while permitting the interviewer to pick at random and probe more in-depth on certain pertinent but unexpected issues that arose during the interview process. The instruments focused primarily on exploring women's experiences of seeking or not seeking maternity care services, their interaction with MNH services, the barriers and non-barriers to access and use of services, and perceptions of in/equities in maternal health services accessibility and utilization. In addition, a more structured questionnaire instrument that sought to collect specific socio-demographic information as well as elicit specific response (e.g. did you or will you give birth at the hospital, clinic or home?) from all women was designed and administered individually to all women. For the IDIs with healthcare providers, an open-ended thematic topic guide, similar to the one used for FGDs and interviews with women, was used (see appendix 2).

Although a formal pre-test of the instruments was not undertaken due to time and resource constraints, the researcher together with his research assistants engaged in a continuous review of the questions and the interview process to ensure that they were reliable and were eliciting the right answers to the right questions. This proved valuable in enabling the researcher to reframe questions, clarify and use more appropriate or easily understandable concepts as the research progressed.

3.5.4 Informed Participant Consent

In both FGDs and IDI, participants' verbal and written consent was gained in advance. Consent was also sought to take notes, audiotape, and in some case, video record the interviews. Although the ethics committees that reviewed the study protocol emphasized written consent, it was not possible to insist on it in all situations. For example, many women simply felt it was inappropriate to sign a signature or thumbprint on a consent form after they have already said yes

to the research. Previous researchers have found that such a posture is often fuelled by fears that written consent forms could be used for other purposes such as taxation (Hill *et al*, 2008)**.** It was not however clear to the researcher whether this was the case, as many of the respondents who opted to give verbal consent did not give any specific reasons. In all cases where verbal consent was given, the consent process was either audiotaped or witnessed by another person - usually a friend or relative, and detailed notes written about the process.

3.5.5. Qualitative Data Collection Methods

3.5.5.1 Focus Group Discussions (FGDs)

Khan & Manderson (1992) define FGDs as a qualitative method of primary data collection in which the researcher uses pre-determined line of questioning to stimulate discussion among participants on a subject of inquiry, with the primary aim of understanding perceptions, interpretations, and beliefs of a select population. This data collection technique was adopted in this project due to its capability to reproduce women's experiences of seeking maternity care in a normal peer-group interpersonal exchange.

But the choice was also based on the methodological literature and other practical considerations. FGDs are contextual (they avoid focusing on the individual) and non-hierarchical methods (they shift the balance of power away from the researcher towards participants) (Morgan & Krueger, 1993). For Morgan (1996), because FGDs have the ability to 'give a voice' to the respondents, they should be used where there is the need to identify participants' perspectives and frames of meaning. Green (2007) argues that a group setting often works well for generating talk about health and healthcare services, and that FGDs provide broader views about health and illness meanings (Kitzinger, 2005). Indeed, within feminist research, it has been argued that FGDs can

facilitate rather than inhibit discussion (Oakley, 1981, cited in Farquhar, 1999). The argument here is that, by foregrounding inherent power differentials between researchers and participants, women in particular, can feel relatively more empowered in a group situation than one-to-one survey type interviews (*ibid*).

In the context of this research, what makes the outcome of FGDs relatively better than individual interviews is that, because FGDs were interactive, participants were able to query and challenge each other as well as explain themselves; hence offering validated data on the extent of consensus or diversity, and demonstrating a sense of self-confidence and empowerment. Thus FGDs were a form of gaining collective testimony. Rina Benmayor (1991, cited in Madriz, 2003) is one of the few to have pointed out the transformative experience of the collective testimony that FGDs generate. Benmayor argues that group testimonies empower people, either individually or collectively, and this empowerment enables people to speak and speaking empowers: 'Focus groups, as a form of collective testimony, can become an empowering experience for women' (Madriz, 2003:375). Although FGDs in this research was envisioned to be only a method for generating data, the interactions that occurred within the group accentuated empathy and commonality of experiences, and fostered self-disclosure and self-validation. Of significance was the openness with which women articulated the issues at hand, with many sharing deeply personal experiences.

As shown in table 3.3 above, five (5) FGDs - involving 104 pregnant women and lactating mothers - were completed. Groups consisted of between 17-24 participants. All FGDs were held in the study communities, at venues chosen in consultation with participants and community gatekeepers. Each FGD lasted 1.30 to 2 hours, and ended when a point of saturation was reached

i.e. when no new ideas and issues seemed to arise. All discussions were conducted in the local dialects – *Twi* in Kuntanase, Abono and Piase; *Dagbani* in Sankpala and Tidrope; and *Gonja* in Mpaha. This is not only because the literacy [written or spoken English] rates are low among the study participants, but also because it ensured that the interview language was not a barrier to effectively exploiting the full benefits of FGDs.

One female research assistant from each community facilitated the interviews. The decision to use only female research assistants was informed by the researcher's past experiences: a female interviewer, interviewing another female, often works better in many Ghanaian settings by reducing the negative effects of gender dynamics that may be encountered by a male researcher asking women questions. But the decision to engage these female research assistants was not unproblematic, however. First, the researcher feared that it may create a kind of social distance – by reducing the amount of space for personal interaction and relationship building - between him, the data that was collected, and the data sources (women), and this may have negative implications for the researcher's understanding of the strengths and limitations of the data (Devereux & Hoddinott, 1992).

Second, given that the researcher wanted to be present during all interviews (and he indeed was), engaging these female research assistants seemed like an exercise in contradiction. In other words, if women were less willing to speak directly to the researcher because he is male, they probably would do the same if the researcher were present in any interviews between respondents and the female research assistants. Nevertheless, as the research progressed, the researcher immediately realized that the so-called social distance that may have been created had a limited negative bearing on the data. Similarly, his presence during interviews did not also significantly

alter women's responses to questions in any negative sense. In fact, in some instances, such as in the Bosomtwe district where the researcher understood the interview language and therefore was occasionally able to ask questions, women wanted a direct conversation with the researcher and were often more responsive to probing questions from the researcher. It is not exactly clear to the researcher why this was the case, but it seems that some women viewed the researcher as having the potential to change the way maternity care services were organized and delivered to them, hence they just wanted to relate their stories directly to the researcher.

On the issue of understanding the interview language, the researcher found Devereux & Hoddinott's (1992b) argument about having basic knowledge and understanding of the interview language extremely useful. The researcher understands and speaks *Twi* fairly fluently, but not *Dagbani* or *Gonja.* Therefore, throughout interview sessions in Kuntanase, Abono and Piase, it was possible for the researcher to know and appropriately intervene where research assistants were mistranslating, omitting or misinterpreting questions or responses. The researcher was also able to pick-up certain vernacular expressions and analogies, which illuminated obscure concepts and practices. Such imagery and analogies, the researcher believes are 'part of the truth' (Devereux & Hoddinott, 1992b: 34), and without a basic understanding of *Twi* he certainly would have missed part of this truth in Kuntanase, Abono and Piase as he probably has in Sankpala, Mpaha and Tidrope.

Furthermore, whatever limitation the use of these research assistants may have imposed on the research appears to have been beneficially traded off by the very nature of these research assistants and the role they played. Having grown up in the study communities, these research assistants were very conversant with the local dialects and cultural nuances and thus interpreted

interview responses, familiarized the researcher with local customs and sensitivities, provided explanations that went far beyond interpreting: they passed on a wealth of information to which they already had access, and negotiated solutions to potential and actual problems. In addition, many acted as ambassadors, introducing the researcher to the local community and discreetly explaining the reason for the researcher's presence to community members who were either too shy to ask or suspicious. In many instances, these research assistants also provided a guide to the sensitivity of different topics and screened questions that respondents might resent. Also, because all these assistants had formal education, and were very often more exposed and assertive, and were roughly of the same age (except one) as the researcher himself, not only was it less difficult to negotiate any gender and age-hierarchy conflicts, but also these research assistants were able to advice the researcher, and in many instances offered useful criticisms.

Overall, the FGDs produced contextually rich and 'thick descriptions' of women's experiences of seeking SMNHS. However, the use of FGDs is not without challenges. In their papers 'why things (sometimes) go wrong in focus groups', and 'focus groups as research method: a critique of some aspects of their use in nursing research', Morgan (1995) and Webb & Kevern (2001) respectively, detail a number of these challenges. First, results from FGDs may be unduly influenced by 'group speak or thinking effect', whereby respondents give 'socially desirable' responses or simply endorse the views of dominant participants (see also Carey & Smilth, 1994; Morgan, 1996). This was observed in some of the FGDs in this study, particularly when ''a big woman'' (usually educated or richer) spoke.

A second challenge relates to how much personal information participants can disclose within the group context. In the Central Gonja district for example, a few women declined to tell their

reasons for not accessing and using SMNHS offered at healthcare facilities in the group. Similarly, in instances where the issues of abortion and contraceptive use came up for discussion, few women were willing to share their personal experiences. They considered that those reasons and experiences were personal and preferred not to talk about them among their peers. Instead, they suggested that if the researcher wanted to know, they were happy discussing those reasons and personal experiences privately with the researcher. In a number of instances where the researcher made a follow-up on such participants, it was discovered that the reasons often bordered on the actions and inactions of another person in the family (mostly husbands and mothers-in-law), for which reason these women felt that openly discussing them may threaten the stability of their family. Similarly, such women feared that publicly talking about their personal experiences of abortion or contraceptive use could lead to undesirable consequences, including gossips and possible spousal confrontation and abuse.

To minimize these limitations, all participants were constantly encouraged, especially the quieter ones, to speak, share their opinions as well as disagree with others where they felt necessary. Coupled with a mix of directed and non-directed facilitation, the effects of these challenges on the results were also greatly minimized. In addition, themes and issues raised and discussed during FGDs were summarized and orally presented to participants to confirm, alter or reject at the end of the discussion. This was meant to ensure accurate representation of participants' perspectives in the data.

3.5.5.2 In-Depth Interviews (IDIs)

To further explore the research question, a total of 101 IDIs were conducted – 81 with pregnant women and lactating mothers and 20 with selected healthcare providers.

Marshall & Rossman (2006) characterize IDIs as a conversation with a purpose, which allows the researcher to explore a few more specific topics with an interviewee. It is an interactional encounter in which negotiated, contextually based results are produced, so that the narrative or story, which emerges from the interview process, is one, which is jointly constructed (Charmaz, 2002).

Given the primacy of interpersonal relationships and the role of negotiation in IDIs (Bowling, 2009), questions can be asked in the context of this research where research assistants were involved in conducting IDIs with women: whether these assistants had the appropriate relationship building and negotiation skills to facilitate the joint production of data? Prior to conducting interviews, the researcher trained all research assistants in the areas of building rapport and relationships with research respondents, asking questions as well as negotiating with respondents to elicit responses to even the most sensitive questions. In Kuntanase, Abono, and Piase where the researcher understood the interview language, the researcher observed that his assistants were applying these skills very well. The researcher became even more convinced about the ability of his assistants to build relationships and negotiate the joint production of data with respondents when no major systematic differences were observed in the nature and details of the data that was obtain between communities where he (the researcher) understood the interview language and those he did not.

The choice of this data collection technique was informed by a belief that the different participants have unique interests, knowledge and roles within the particular set up of Ghana's maternal health sector, and hence constituting a good repository of vital data that could proffer answers to the questions raised in this research. Moreover, it was simply impossible to organize a FDG with people such as healthcare providers. This created special recruitment problems – problems that were overcome more appropriately by individual interviews.

By being flexible in terms of the order in which issues and questions were considered, interviewees within IDI settings were able to consider the questions more widely and develop appropriate independent ideas and responses (Denscombe, 1998). Also, the dialogical nature of IDIs helped redistribute power and control between the researcher and participants; a phenomenon often problematic in one-way survey type interviews (May, 2001). This provided IDIs with a built-in capability to challenge the researcher's own preconceptions, and enabled interviewees to answer questions according to their own frames of reference. Another advantage of the method was its ability to address sensitive issues such as personal experiences and perceptions of fairness or equity in distribution, accessibility to, and utilization of maternity care services.

One challenge of this approach is that the data produced is difficult to manage and interpret due to its variegated and non-standardized nature (May, 2001). Nevertheless, throughout the data analysis and presentation process, I endeavoured to draw out areas of consensus and disagreement, while remaining committed to accurately portraying the meanings that interviewees attached to their responses as much as possible.

3.5.5.3 Direct Observation

One of the strengths of empirical primary research is 'being there' (Devereux & Hoddinott, 1992b: 25). Being there per se does not guarantee that good research will be done. However, establishing a physical presence in a study setting does allow the researcher to observe subtle, obscure and messy practices, which can otherwise elude the armchair researcher.

According to Marshall & Rossman (2006), observation entails the systematic noting and recording of events, behaviours and artefacts in the setting chosen for the study. It varies from complete active immersion into local life with or without revealing one's status as a researcher, to simply passively observing events. Although a complete immersion (participant observation) yields more nuanced insights, the researcher chose only to observe the doings, debates and practices of the different stakeholders who are engaged in providing, delivering and using SMNHS in Ghana. This choice was informed by the short research timespan.

Kumekpor summarizes the benefits of this data collection technique thus:

> Observation brings the investigator into contact... with the phenomenon being studied. In this way, it becomes an effective means of recording what is observed more precisely and with a greater reliability (2002:65).

Observation was indeed one of the best ways to understand the complexity of the birthing environment in Ghana and to create relationships of trust with care providers (Hassan-Bitar & Wick, 2007). For example, the researcher was able to attend and observe the conduct of antenatal clinics at Buipe rural clinic and Sankpala health centre. Through direct observation, the researcher was able to collect information about actual practices – practices that otherwise would have been hard for research participants to reconstruct - and to discover complex interactions that reveal patterns of useful relationships. Observations were often triangulated with informal

discussions with women, healthcare providers, ward managers and even cleaning staff. This helped validate and/ or disprove aspects of the data already gathered.

A major strength of this approach lies in the ease with which the researcher gained *entrée* to hard-to-reach research data (Adler & Adler, 1994). Because the method is relatively less obstructive and does not require direct interaction with research participants, observation was conducted to gain valuable data without generating serious observer effects.

The less obstructive features of observational research make it a good, easy to use data collection technique. Yet, its strength is also its weakness: lack of obstructiveness renders it liable to possible abuse in the invasion of privacy and raises questions of ethical malpractice (Adler & Adler, 1994). Although the researcher was conscious, and indeed took steps to ensure that no participant's privacy was intruded, it is possible that this might have inadvertently happened in some occasions.

Entirely avoiding researcher influence on the behaviour of those being observed is perhaps an idealistic improbability. For instance the mere presence of this researcher in healthcare facilities will inevitably have altered behaviour and relationships in a number of significant ways that the researcher might not be aware of.

Also, Marshall & Rossman (1999) have pointed to the difficulties of managing a relatively unobtrusive role and identifying the big picture while finely observing huge amounts of fast moving and complex behaviours at the same time. The argument here is that, researcher bias may set in, in which case observation becomes a problematic enterprise of self-fulfilling or self-

negating prophesy. The researcher was able to minimize the effects of these difficulties through a continuous process of deep reflection, guided by the use of a structured pre-designed observation guide (see appendix 3) and a strong commitment to remaining objective while conducting observations.

3.6 Data Processing, Analyses and Presentation

3.6.1 Quantitative Research: Survey Data Processing and Analysis

In attempting to understand the patterns of MNH care access and use as well as assess inequities in access, the quantitative data processing and analysis procedure follows a three-step process outlined by Eyob Zere and colleagues (2010, 2011, 2012). These steps are: (i) identification of the care intervention whose distribution is to be measured; (ii) classification/grouping of the population into different strata by a selected equity stratifier; and (iii) measuring the degree of inequality.

First, the indicators of the healthcare interventions whose distribution are to be measured were identified. These indicators included antenatal and postnatal check-ups, tetanus toxoid injection, delivery at a health facility, skilled attendance at delivery, caesarean sections, and abortion care.

Second, women were classified by variable stratifiers against which the distribution of antenatal, delivery and postnatal care services was then assessed. These variables were mother's education, mother's age at birth, birth order, place of residence (urban/rural), region of residence, wealth quintiles, religion and ethnicity. Except wealth, which often presents measurement problems and which is discussed below, the rest of these stratification variables were properly captured in the GMHS data.

The GMHS does not contain data on household income or consumption income. Rather, wealth index is used as a proxy. This wealth index is constructed from household ownership of assets and consumer goods (radio, television, telephone and refrigerator), dwelling characteristics, type of drinking water source, toilet facilities, electricity, wall and floor materials of house, cooking fuel, and means of transport. Each asset was assigned a weight (factor score) generated using the methods of principal component analysis (Zere *et al*, 2011; Wagstaff *et al*, 2011), and the resulting asset scores standardized in relation to a normal distribution with a mean of zero and standard deviation of one (see also Zere *et al*, 2012). From here, each household was given a score for each asset and these asset scores were then summed up for each household. Finally, individual women were ranked according to the total score of the household they came from; the sample was then divided into quintiles from lowest (one) to highest (five). Following this, a single asset index was developed for the whole sample, with no separate indices prepared for different regional or urban and rural populations.

Some critics argue that gauging the wealth status of households base on assets may be flawed (e.g. Wagstaff *et al*, 2011). For example, ownership of consumer goods such as television or refrigerator is partly a function of taste and choice, and may therefore be independent of wealth. Nevertheless, research has shown that household assets often approximate the long-run economic status of households (Houweling *et al*, 2003),

Third, access patterns, and equity in access and use of SMNHS were assessed by analysing and comparing accessibility and utilization rates across the variable stratifiers among different population groups using descriptive statistical tools. Within the healthcare literature, there is still considerable debate regarding the development of appropriate methods for assessing inequities in

health and differentials in access among social groups (see Wagstaff *et al*, 1991; Gulliford, 2003; Zere *et al*, 2010; Zere *et al*, 2011). However, Gulliford's (2003) recent work summarizes the different debates to suggest three main approaches, namely those depending on simple comparison of rates of access for different groups; those depending on the use of regression methods; and those that rely on the development of Gini-like coefficients.

Given that the aim of the project is describing and understanding patterns of access and access differentials, as well as giving an account of why there is inequitable or non-access across different groups, the first approach was chosen. Indeed, simple quantitative comparison of rates of healthcare utilization in different socio-economic groups is one of the popular approaches that earlier evaluations of equity relied on (Gulliford, 2003). In this thesis rates of access were compared for different population groups using both absolute measures (the difference in rates between the selected group and the reference group), and relative measures (the ratio of rates between selected and reference groups). Access and equity of access to antenatal care was assessed by the timing, number of visits and type of care provider, and measured by the percentage of women in different socio-demographic receiving these types of services. Postnatal care was accessed by whether a woman sought care after delivery and from whom. Delivery care was measured by skilled attendance at delivery (i.e. percentage of births delivered by skilled providers including doctor, nurse, midwife, auxiliary midwife and community health officer), delivery in a health facility (i.e. percentage of births delivered in a public or private sector health facilities), delivery at public facility (i.e. percentage of births delivered in public sector health facilities), and home delivery (i.e. percentage of births delivered at home). Similarly, CS was assessed by the percentage of live births in the five years preceding the survey delivered by CS.

All the processes involved in the quantitative data processing and analysis were aided by the IBM SPSS Statistics data analysis software package (version 20.).

3.6.2 Qualitative Data Processing and Analysis

While qualitative research is increasingly common in health services research, no single appropriate way of conducting qualitative data analysis exists in the literature (Attride-Stirling, 2001). One of the most widely used data analysis methods is the grounded theory method (GTM) developed by Glaser and Strauss (1967). GTM comprises a systematic, inductive, and comparative approach for conducting inquiry for the purposes of constructing theory (Charmaz, 2006).

The theory and praxis of the current thesis, however, made GTM a very unsuitable approach notwithstanding its popularity. For example, the requirement integral to following GTM as outlined by Glaser & Strauss (1967) and other authors (e.g. Wiener, 2007; Hood, 2007; Bryant & Charmaz, 2007) demands that 1) data collection, analysis and theory construction proceed simultaneously and each informs the other; 2) coding starts with first interview; 3) memo writing also begins with first interview or field notes; 4) theoretical sampling is the disciplined search for patterns and variations; 5) the development of theory via theoretical saturation of categories rather than substantive verifiable findings be the focus; and 6) the resulting theory is developed inductively from data rather than tested by data. Clearly, neither is the development of theory through theoretical saturation of categories the main focus of the present research, nor did data collection, analysis and theory construction proceeded simultaneously in this research. For the simple reason that the design of this research failed to comply with many of the ‘essential properties of Grounded Theory’ (Hood, 2007:154), it was clear that a different, if related, analytical strategy would be needed. Therefore, and taking cognizance of the fact that there is

some agreement in the literature that if qualitative research is to yield meaningful results, it is important that data analysis process be theoretically grounded, methodical, transparent, iterative and ongoing (Attride-Stirling, 2001; Bradley *et al*, 2006), the analytical approach adopted here follows an innovative, systematic and robust qualitative data analysis method described by Jennifer Attride-Stirling of the Commission for Health Improvement, England.

In her paper 'Thematic networks: an analytic tool for qualitative research', Attride-Stirling (2001) details a method for conducting thematic analysis of textual data, herein called the Attride-Stirling Thematic Network Analysis (ATNA), which allows for open and methodical discovery of emergent concepts, themes and relations through the application of principles of inductive reasoning to generating themes while also employing predetermined (deductive) code types to guide data analysis and interpretation. As an analytical tool, the ATNA draws several parallels with the popular GTM, but its theoretical grounding is founded on the principles of Toulmin's (1958) argumentation theory.

Argumentation theory, Toulmin (1958) argues, aims to provide a structured method for analysing negotiation processes. It defines and elaborates the typical, formal elements of arguments as means of exploring the connections between explicit statements and implicit meanings in people's discourse (Atride-Stirling, 2001). Within this structure, Toulmin describes argumentation as the progression from accepted *data* through a *warrant* to a *claim.* Data per Toulmin's formulation consist of evidence, empirical or otherwise, given to support a conclusion or claim. A claim is the conclusion to an argument, the merits of which is to be established, while warrants are principles and premises upon which the arguments in support of the claim are constructed. However, Toulmin suggests that claims do not necessarily follow logically from the

data and warrants at hand, and for this reason there are *backings* or supporting arguments, *qualifiers* or elements of doubt in claims, *rebuttals* or conditions which falsify the claim, and *alternative claims* (Attride-Stirling, 2001). With these essential components, Toulmin (1958) argues that arguments can be disentangled and presented intelligibly, thereby facilitating the process of negotiation in decision-making and problem solving.

Drawing an analogy with Toulmin formulation, Attride-Stirling (2001) argues that the ATNA aims to explore the understanding of an issue or the signification of an idea, hence Toulmin's terms (claim, warrant, backing) provide the background logic and an organizing principle for conducting thematic network qualitative data analysis. In fact, Attride-Stirling suggests rather convincingly that this core structure has significant parallels with the three basic elements of grounded theory, namely concepts, categories and propositions. For Attride-Stirling, the ATNA does not aim or pretend to discover the beginning of arguments or the end of rationalization; 'it simply provides a technique for breaking up text, and finding within it explicit rationalizations and their implicit signification' (p.388). Attride-Stirling concludes that thematic analysis can be usefully aided by and presented as thematic networks i.e. web-like illustrations that summarize the main themes constituting a piece of text.

As a practical step, and following Toulmin's claim, warrant and backing, the ATNA framework proposes the extraction of: (i) lower-order premises (Basic Themes) evident in the text; (ii) categories of basic themes grouped together to summarize more abstract principles (Organizing Themes); and (iii) super-ordinate themes encapsulating the principal metaphors in the text as a whole (Global Themes). Themes are simply recurrent unifying concepts or statements about a particular subject of inquiry (Boyatzis, 1998). Thus themes are fundamental concepts that

characterize specific experiences of individual research participants, which enable more general insights to be gained from the whole of the data (Ryan & Bernard, 2003).

The ‘basic theme’ in the context of ATNA is the most basic or lowest-order theme that is discovered from the textual data. ‘It is like a backing in that it is a statement of belief anchored around a central notion (the warrant) and contributes towards the signification of a super-ordinate theme’ (Attride-Stirling, 2001:389). In this way, basic themes on their own say very little about the text or group of texts as a whole. To make sense beyond its immediate meaning, a basic theme needs to be read within the context of other basic themes, and together, they represent an organizing theme.

An organizing theme is a middle-order theme that organizes the basic themes into clusters of familiar issues (Attride-Starling, 2001). Thus organizing themes are clusters of signification that summarize the principal assumptions of a group of basic themes, hence they are more abstract and more revealing of what is going on in the data (*ibid*). Like Toulmin’s warrant, organizing themes are the principles on which a super-ordinate claim is based. Therefore organizing themes not only enhance the meaning and significance by simultaneously grouping the main ideas proposed by several basic themes, but also they dissect the main assumptions underlying a broader theme that is especially significant in the data as a whole. Thus a group of organizing themes constitutes a global them.

Global themes refer to overarching themes that encompass the principal metaphors in the data as a whole. Like Toulmin’s claim, a global theme is a concluding or final tenet. Therefore, global themes group sets of organizing themes that together present an argument or an assertion about a

given issue. And each global theme is the core of a thematic network that summarizes the main themes and revealing interpretation of the qualitative data (Attride-Starling, 2001).

The ATNA is therefore developed starting from the basic themes and working towards a global theme. Accordingly, once a collection of basic themes has been derived, they are classified according to the underlying story they are telling and these become the organizing themes (Attride-Stirling, 2001). Organizing themes are then interpreted in the light of their basic themes, and are brought together to illustrate a single conclusion or super-ordinate theme that becomes the global theme. Once a thematic network has been established, Attride-Stirling suggests that it be used to serve as an organizing principle and an illustrative tool in the interpretation of the text to facilitate disclosure for the researcher and understanding for the reader.

Although the ATNA framework is relatively new, it has been used in a number of health research contexts including studying masculinity as a barrier to men's use of HIV services in Zimbabwe (see Skovdal *et al*, 2011). The ATNA framework is particularly suited for the analysis here because it allows the primary methods of deductive analysis (searching for information to answer the research questions using pre-set coding) to be combined with inductive analysis as new themes emerged from the data. Also, as thematic network analysis takes content, context and interaction seriously and attempts at identifying recurring themes within the data, exploring typologies of these themes and looking at the variations and relationships between and within themes, the technique is particularly useful in allowing the researcher to move between the empirical data and theoretical literature. This iterative process of moving back and forth between empirical data, theoretical literature and emerging analysis makes the collected data and analysis progressively more focused. As Tobin & Begley (2004) argue, this interactivity, applied

throughout the process of qualitative research, is the overarching principle of 'goodness' in qualitative data analysis.

Following the ATNA, the rest of this section outlines the step-by-step process that was followed to develop a thematic networks analytical framework for use in the data analysis in this thesis. The process involved several steps before the analysis proceeded to an interpretative phase in which the units were connected into an explanatory framework consistent with the text (Fereday & Muir-Cochrane, 2006). These steps are categorized into three main analytical stages: reduction/breakdown of text, text exploration, and integration of exploration (Attride-Stirling, 2001). The various stages and steps are outlined in table 3.4 and discussed below.

Table 3.4: Steps in developing a thematic network analysis

STAGE	STEPS
1. Text Reduction/Breakdown	**Step 1:** Reading for Overall Understanding
	Step 2: Data Coding -Devising a coding structure -Dissecting text into text segments using coding structure
	Step 2: Themes identification -Abstraction of themes from coded text segments -Refinement of themes
	Step 3: Thematic Network Construction -Arranging of themes -Selection of basic themes -Rearranging of basic themes into organizing themes -Deducing global themes -Illustrating, verifying and refining thematic networks
2. Text Exploration	**Step 4:**Description and Exploration of Thematic Networks -Describing the network -Exploring the network
	Step 5: Summarizing Thematic Networks
3. Integration of Exploration	**Step 6:** Interpretation of Patterns

Source: Author's construct based on Attride-Stirling (2001), and Bradley *et al* (2006).

Stage 1: Text Reduction/Breakdown Stage

- *Reading for Overall Understanding*

The first step in the qualitative data processing and analysis involved reading transcripts and field notes for overall understanding. During and after qualitative data collection, the researcher and three other language specialists - *Twi, Dagbani* and *Gonja* – transcribed all tape-recorded interviews. The researcher then immersed him self in all transcripts and interview notes through

reading and reviewing for overall understanding and comprehension of meaning. Reviewing data without coding in this first step helped identify emergent themes without loosing the connections between concepts and their context (Bradley *et al*, 2006). This first step was completed with a separate summary of each transcript outlining the key points participants made in response to questions and queries either by the interviewer or a co-participant.

- Data Coding

Once the data was reviewed and a general understanding of the scope and contexts of key experiences was attained, the interview transcripts were exported to NVivo 9 qualitative data analysis software, where the data was both deductively and inductively coded. Codes, according to Miles and Huberman (1994) are labels, which are assigned to whole or segments of transcripts and interview notes to help catalogue key concepts while preserving the context in which these concepts occur. Coding provided the researcher with a formal system to organize the data, uncovering and documenting additional links within and between concepts and experiences in the data (Bradley *et al*, 2006). The coding process involved the development of a code structure, finalization, and application of the code structure to develop themes for analysis.

Within the literature related to qualitative data coding, there seems to be an unhealthy division between those who argue for a more inductive coding approach on the one hand and those who believe coding should be more deductive on the other (see for example Glaser, 1992; Boyatzis, 1998; Heath & Cowley, 2004). The approach followed in this thesis is integrative/hybridize, employing both the data driven inductive (ground-up) approach of Boyatzis (1998) and the deductive (start list) a priori template of codes framework outlined by Crabtree & Miller (1999). This hybrid approach allowed deductive thematic analysis to be integral to the process while

allowing for themes to emerge directly from the data via inductive coding. Five broad code categories formed the deductive, a priori template of codes. These included:

1. *Participant characteristics codes* – these identified participants' characteristics such as age, socio-economic status, education and professional background. Participant characteristic codes aided a comparative analysis of concepts across types of participants.
2. *Settings codes* – these identified characteristics such as participants' location and cultural background, hospital delivery versus homebirth, midwife versus traditional birth attendant, fee-for-service versus no fee-for-service, government versus private or mission health facility etc. These codes facilitated comparison of key concepts across types of settings.
3. *Conceptual codes* – which generally identified key concept domains and essential dimensions of these concepts necessary for developing themes.
4. *Relationship codes* – these identified links between other concepts coded with conceptual codes.
5. *Participant perspective codes* – these identified whether a participant was positive, negative, or indifferent about particular experiences related to MNH care access.

These predetermined code categories were useful for generating themes about MNH service accessibility and utilization as well as women's experiences. During the coding process, inductive codes were assigned to data that described a new concept or theme separate from the predetermined codes or that expanded a predetermined code (Boyatzis, 1998).

- Finalizing and Applying the Finalized Code Structure

The development of the codes and code structure continued until a point of theoretical saturation had been reached. This is where no new concepts emerged from successive reviewing of data

(Glaser & Strauss, 1967; Bradley *et al*, 2006). At this stage, the code structure was deemed finalized and then applied to develop and report themes.

- Identification of Themes

Once all the transcripts were coded, themes were abstracted from the coded data. Themes, as already mentioned, capture something important about the data in relation to the research question, and represent some level of patterned response or meaning within the data set (Boyatzis, 1998). The finalized codes were assembled into potential themes. Themes naturally evolved mainly from the conceptual, relationship and participant perspective codes as well as the inductive coding process. The development of themes was particularly aided by a comparative analysis of concepts coded in different participant groups and setting codes. In this way, the author was able to compare themes across transcripts and different participant groups to establish the range of similarities of participants' experiences and views (Kwambai *et al*, 2013). This comparative approach also enabled themes to be refined so that themes became specific enough to be discrete, and broad enough to capture all the ideas contained in the coded transcripts.

- Construction of Thematic Networks

Here, the themes identified in the previous steps were assembled and a thematic chart was drawn. The aim here was to group themes into similar and coherent sets and networks – basic themes, organizing themes, and global themes. In most instances, decisions about how to group themes were informed by content and theoretical background (Attride-Stirling, 2001). Once the grouping of themes was completed, the author went through the data segments related to each basic, organizing, and global theme to ensure that it reflected and supported the data. Where necessary, refinements were made. The final result is presented in table 3.5. In total, 51 codes were

identified. These were grouped into 35 basic themes, which were further clustered into 7 organizing themes, and 3 global themes. These global, organizing and basic themes form the structure of analysis and presentation of the research findings and discussion in chapters 5-9.

Stage 2: Text Exploration

- Description and exploration of Thematic Networks

In the second stage of the analysis, I then described and explored the thematic networks as the first part of data analysis proper. Here, I returned to the original transcripts, but rather than reading to gain general understanding, the aim was to delve deep into the original data to explore it in relation to the emergent global, organizing and basic themes. The main focus was on describing the contents of the themes, supporting and exemplifying the description with excerpts or quotes from participants' accounts, identifying underlying patterns, and bringing together the data, analysis and interpretation for the reading audience. Where appropriate, verbatim quotations from interview transcripts are used to illustrate responses related to relevant themes and issues. In few instances too, qualitative responses are aggregated and presented in a quantitative fashion to facilitate easy understanding.

- Summarizing Thematic Networks

Having explored the various thematic networks in full, this step summarizes the main themes and patterns characterizing them. The main objective here was to synthesize the principal themes that emerged in the description and exploration of the thematic networks (Attride-Stirling, 2001).

Table 3.5: Thematic network analysis framework for studying access and barriers to equitable access and use of SMNHS

Codes	Basic Themes Identified	Organizing Themes	Global Themes
-There is joy in pregnancy & Childbirth. -Women feel accomplished in giving birth safely. -Giving birth safely absolves a woman from blame. -Getting pregnant and giving birth is normal for every woman. -Women are naturally made to get pregnant and to give birth without asking for assistance. -A pregnant woman needs care, love and empathy to be able to deliver safely	1.Pregnancy & childbirth are normal fulfilling biological functions women have to perform 2. Care during pregnancy is important for safe delivery	Pregnancy & childbirth as role fulfillment, self actualization and empowerment	**Women's experiences of pregnancy & childbirth**
-A woman can die while pregnant or giving birth -Pregnancy and childbirth is an anxious phase of a woman's life -Pregnancy makes women highly dependent on others	3. Pregnancy & Childbirth is dangerous – you either die or live	Pregnancy & childbirth as a perilous journey	
-Poor women do not have money to travel to seek care -Illiterate women face abuse in health facilities -Poor women are given less attention in health facilities -Women from minority groups are not treated with respect in health facilities	4. Differentials in education, wealth, and place of residence affect access levels differently 5. Poor women experience greater difficulty in access than rich women 6. Women from minority ethnic groups experience greater difficulty in access 7. Discrimination against poor and minority women hinder access	Socio-economic inequalities	**Barriers to access & equitable access**
-Some places do not have health facilities -There are no nurses/midwives/doctors at some health facilities. -Services are far away - It is difficult to travel -Nurses are disrespectful -Caregivers do not ask how women feel -Maltreatment and scolding is dehumanizing -Caregivers want women to obey instructions without question -Poor communication between women and caregivers leads to misunderstanding -There is overcrowding in maternity wards -Women do not believe their problems can be solved by some caregivers/health facilities -TBAs advise women about what to do in an obstetric emergency, but health system does not recognize and reward TBAs -There is privacy in homebirth but not in hospitals	8. Unequal availability and/ or distribution of SMNHS gives rise to differential access 9. Long distance travel & difficulties with arranging transport to health facilities discourage access 10. Poor service quality discourages women from using SMNHS 11. Lack of choice in health facilities is a disincentive to use of SMNHS 12. Women's distrust in the ability of health care institutions & professionals reduces their willingness and ability to access SMNHS 13. Caregivers disrespect and disregard for women's preferences and cultural values relating to pregnancy and childbirth hinder equal access 14. Culturally and linguistically inappropriate health information does not promote effective communication between caregivers & women 15. Lack of recognition of the role of TBAs by the health system breeds mistrust and discourages cooperation even in times of obstetric emergencies	Health system failures	
-Older women don't want to be treated by younger nurses/midwives -Hospital birth means questionable moral character -Assisted birth is a sign of physical weakness -Unwed expectant mothers fear being recognized -Muslim women don't want to be attended to by men -Husbands are major decision makers -Mother-in-laws are influential -Homebirth preserves tradition -First time mothers need to observe certain rituals -God's medicine is the best	16. Age hierarchy conflicts between elderly mothers and young nurses/midwives limit access 17. Rituals, cultural prescriptions and proscription during pregnancy & childbirth limit equal access 18. Religious beliefs & practices, especially beliefs in divine healing, hinder equal access 19. Women's lack of decision-making power in the family and household limit access. 20 Cultural preferences for home births undermine skill care seeking. 21. Negative social and cultural conceptions of health-facility birth make women want to avoid giving birth in health facilities 22. The legitimacy of a pregnancy – unwed women who get pregnant are stigmatized and this limit such women's ability to access care 23. Gender conflicts	Socio-cultural constraints	
-More maternal health resources are necessary -Redistribution is key -Targeting -Women need more education on the danger signs of complications -Caregivers need to respect patients -Women need to be consulted and given more choice -Positive relationships are needed -Increase health workforce -Care quality is key -Trust building -Collective responsibility -Partnership building	24. Expansion and redistribution of existing maternal health resources to ensure equitable coverage and access for all women 25. Improving doctor-patient relationships in maternity wards 26. Improving the quality of maternity care services provided 27. Promoting more birthing choice at health facilities 28. Respect for privacy and patient dignity in maternity wards 29. Training of more skilled maternity caregivers 30. Instituting special programmes to target women most in need 31. Building partnerships with TBAs and other non-state actors	Health system responsiveness (Policy & organizational)	**Facilitators of access and equitable access**
-Women's autonomy in the family is key -Men as partners in maternity care -Domiciliary care is important to take care of women's cultural values and privacy issues	32. Cultural adaptation of skilled health facility-based maternity care services 33. Promotion of male involvement in the delivery of maternity care 34. Domestication of skilled maternity care 35. Health education	Culturally responsive care	

Source: Author's construct, 2012.

Stage 3: Integration of Exploration

- Interpretation of Patterns

In this final step, the deductions deriving from the synthesis of networks were brought together with relevant theory to explore the significant themes, concepts, and patterns that emerged from the data. The aim of this last step was to revisit the research questions and the theoretical interests and rationales underlying them so as to address them with arguments grounded in patterns that emerged through the description, exploration and synthesis of the data.

Of course, I acknowledge that this analytical framework, like many qualitative data analysis techniques, will have limitations. For example because of the nature of this doctoral research, the author alone coded the data and identified the relevant themes, while the analysis was discussed with his two supervisors. While coding the data and identifying themes alone allowed for consistency in method (Fereday & Muir-Cochrane, 2006), the process did not provide for multiple perspectives on the development of the coding and analytical framework. However, the author believes the combination of inductive and deductive coding, coupled with the constant re-reading and interaction with transcripts, greatly helped to obviate any potential negative impact that this sole coding and theme development may have on the analysis.

3.7 Speaking with My 'Brothers', 'Mothers', and 'Sisters': Reflections on the Identity and Ethical Dilemmas of an Insider/Outsider Researcher

This section briefly reflects on the identity of the researcher in the research process, and some moral dilemmas which arose either from the nature of the research itself or from the researcher's rather distinctly odd and temporary relationship with research participants.

To begin with, throughout the period that the researcher spent gathering data in Ghana, his

identity was one of an 'insider'/'outsider' researcher. An insider because Ghana is his home country; and 'outsider' because he has not lived in the study communities to adequately understand their unique and subtle cultural predispositions, and because his role here was that of 'researcher'. In the researcher's experience, working in one's own culture has many advantages. Apart from the obvious benefit of language, it was fairly easy for the researcher to understand the men and women he was studying not only by some of the words they used, but also by their gestures and tone of voice, as well as the way they reacted to certain questions. This understanding was made possible by the researcher's cultural affinity with research participants as well as the store of knowledge he had acquired about the Ghanaian society over the years. Crucially, this familiarity helped the researcher to appropriately behave and react with greater sensitivity. Indeed, this familiarity worked both ways, as participants were also familiar with the researcher's own world. In the Central Gonja District for example, the researcher was very often referred to as 'our northern brother' who has come from the 'Whiteman's land'. Similarly, some of the health professionals shared their experiences of working in the researcher's home region in Ghana – the Upper West Region. This made the researcher less of a stranger, so that interviews and relationships became more relaxed.

On the negative side however, being seen as 'one of them' had the potential to limit some of the freedoms that an outsider would have as the researcher was overly conscious of whatever he was doing. This limitation however did not affect the quality of the actual data gathered. But even then, to what extent are the information collected and the analysis thereafter distillable from the researcher's personal experiences of, familiarity with and prejudices about rural women or healthcare workers in Ghana? Also, given that this study is a doctoral research project conducted in a foreign university, the results of which may be available for reading by a wider international

audience, should the researcher go all out with his research findings even if they paint a damning image about his country?

Within the methodological literature and in relation to the questions raised above, opinions are divided about whether research is best conducted by an insider or an outsider (Razavi, 1992). While some believe that being an insider erodes objectivity and analytical abilities, others argue for the closeness and subtlety of understanding that arise from researching as an insider (Monaghan & Just, 2000). As an insider, the researcher certainly felt that he had much empathy with research participants. However, his previous training as a social scientist permitted sufficient detachment to allow critical analysis. In fact through constant reflexivity, it became clear to the researcher that being an insider did not mean that he was incapable of performing objective analysis on the behaviour and practices of pregnant women and lactating mothers and healthcare professionals. Again, this arose from the simple fact of being a researcher, which distances him from the participants with whom he felt affinity.

Another ethical dilemma the researcher confronted was how to manage participant expectations about the research as well as properly acknowledge and compensate participants for their time. Although the researcher explained to participants and the leaders of the study communities that the research was only a student-project meant for academic purposes, certain unrealistic expectations were still built-up. Throughout the research, rural communities viewed the researcher as a son of the land, who is educated, has travelled to the Whiteman's land, and has the potential to take their 'case' to the government and the Whiteman who sent him to come and ask them the questions he did ask. In particular, women in Abono and Tidrope – where there is no health facility – had hopes of using this research to draw immediate government attention to their

plight. In Kuntanase women had high expectations that this research would lead to a change in the way healthcare workers treated them anytime they seek care. Even community health nurses in Mpaha had hopes of using this research to improve their working conditions. In some instances also, the researcher was expected to contribute materially either to the welfare of certain individuals or the entire community.

Clearly, given the remits of the research and the resource capabilities of the researcher, most of these expectations were beyond his ability to fulfill, at least in the short to medium term. Yet, this did not totally absolve the researcher of all his responsibilities towards research participants. Therefore, for all participants who had to travel in order to participate in the research, they were appropriately reimbursed for transport expenses. In all the six research communities also, research participants were refreshed with non-alcoholic beverages and snacks. This decision was taken following consultations with the chiefs, CBSVs and research assistants. Little as the refreshment seemed, it was its symbolic significance that mattered: the idea of sharing. It is interesting to note that although the researcher had decided against monetary payment to individual participants for fear of inducement, most participants reached the same conclusion, although for a different reason[3]. In Mpaha and Tidrope for example, participants were of the view that monetary compensation implies that they had sold the information, a practice deemed exploitative and unacceptable. The researcher was particularly intrigued by the idea that research participants could exploit researchers. This is because within the research ethics literature, discussions have tended to focus on the potential for researchers to exploit research participants and not the other way round, and some ethics guidelines and ethicists have pontificated several ways to avoid this. See the various contributions to the book, *Exploitation and Developing*

[3] My research assistants and the CBSVs were however paid cash according to a pre-arranged charge to which both parties agreed.

Countries: The Ethics of Clinical Research, edited by Hawkins & Emanuel, 2008. This issue is also central to Alan Wertheimer's (1999) project in *Exploitation*. In the future, the research ethics community might benefit from an investigation to document the extensiveness of this idea and describe it in detail.

Finally, researching sensitive topics like health seeking behaviour and health policy outcomes often provokes sentiments and the disclosure of highly personal and confidential information, hence offering possibilities for identification, sanctions and stigmatization (Brannen, 1988). Therefore, maintaining confidentiality (not revealing facts about participants elicited through data collection) and anonymity (not revealing the identities of informants) (Wilson, 1992) is a key ethical responsibility that those researching sensitive topics owe to research participants (Farquhar, 1999). This proved very problematical in the context of this research. During interviews, some women openly criticized certain healthcare workers, and insisted that the researcher conveyed their identities and their criticisms to those healthcare workers. Generally, women simply did not seem to want their anonymity protected. In fact, they wanted the author to publicize their stories, experiences and living conditions! Similarly, certain healthcare workers tagged some of the study communities as 'ignorant', 'traditional', 'patriarchal', 'violent', and 'less amenable to change'.

How should the researcher present these findings such that this seeming antagonism is not shelved and yet avoid exposing participants to possible victimization? Also even though the women were happy to bear any consequences that their request to have their identities revealed may have, does the researcher have responsibility to carry or not carry out this request? In the analysis and presentation of findings, the researcher has endeavoured to accurately portray the

views and meanings that participants attached to their responses without explicitly revealing their identity. But even then, there seems to be no guarantee that confidentiality and anonymity have been maintained. This is because both research assistants and women themselves (in the case of FGDs) had access to data at the point it was being produced. Of course, the researcher did warn research assistants and encourage women not to reveal anything they are discovering about other research participants. However, since these are all permanent members of the study communities it seems impossible for them not to learn about the people they live with or to ignore anything they learnt through the study and not to use this knowledge in their relationships within the community (Wilson, 1992).

3.8 Conclusion

Empirical research involving human subjects is very often a moral and an emotional encounter as much as it is a scientific and intellectual enterprise. This makes the process of data collection and analysis dialectic, between immediacy and reflection, and between moral judgment and intellectual rigour. This chapter provided an audit trail of the researcher's design decisions before, during and after fieldwork.

Although the research design and data collection and analysis processes were tortuous, they forced the researcher to reflect deeply on the entire research and to appreciate the challenges that come with conducting empirical research in familiar, bureaucratic and resource constrained settings. Through the methodological account provided in this chapter, it is hoped that the reader will also be able to follow the processes through which data was obtained and to judge the validity of data, the internal consistency of accounts and the credibility of the evidence, analysis and findings that are presented in the next chapters.

Chapter 4

FREE MATERNITY CARE, ACCESS, AND EQUITY OF ACCESS AND USE OF SKILLED MATERNAL AND NEWBORN HEALTH SERVICES IN GHANA

4. Introduction

Access to, and use of healthcare services contributes to the relief of sickness and the improvement of health (Gulliford *et al*, 2003). In particular, accessibility to, and utilization of skilled maternal and newborn health services (SMNHS) is said to play a vital role in achieving improved reproductive health outcomes for women and newborns (Abor *et al*, 2011). It is for this reason that the government of Ghana introduced and is implementing the free maternal health care policy.

Based on my analysis of data from the Ghana Maternal Health Survey (GMHS), this chapter empirically investigates the question of access to SMNHS within a context where services are provided free at the point of delivery. The objective is to describe the patterns of SMNHS accessibility and utilization and to understand whether access differentials exist despite SMNHS being provided free-of-charge.

4. 1 Selected Socio-demographic Characteristics of Respondents

The chapter begins the presentation of findings from the GMHS data by briefly reflecting on the background characteristics of the women who participated in the survey. Tables 4.1 and 4.2 below provide an overview of selected socio-demographic attributes of the women interviewed for the GMHS by age, place of residence, marital status, region, educational attainment, religion and ethnicity. It can be seen that a higher proportion of women (57%) live in rural areas than in urban centres (43%). About 26% of the survey respondents have never been to school; 21% have

only attended primary school; 40% have attended middle/Junior secondary school while 13% had secondary or a higher level of education. Note however that there are significant differences in terms of educational attainment between different socio-demographic groupings (see table 4.2). For example, older women have lower educational attainment than younger women, while urban women are three times more likely to have been to school than rural women. Another significant differential is that between regions and wealth quintiles. Whereas only about 13% of women in the Ashanti region had no education, the figure for the northern region is as high as 68%. Similarly, whereas 55% of women in the lowest wealth quintile have no education, only 7% of those in the highest wealth quintile have no education.

Whilst the qualitative research undertaken for this thesis is reported fully in later chapters, it is worth noting at this point nonetheless that, the selected socio-demographic characteristics of participants in the GMHS are similar to the 185 pregnant women and lactating mothers who participated in the qualitative research undertaken in the Bosomtwe and Central Gonja districts between November 2011 and May 2012 (Table 4.3). Maternal age ranged from 17 to 42 years, with a mean age of 24.2. Consistent with the regional differences between northern and southern Ghana, women in Bosomtwe district appeared better educated than their counterparts in Central Gonja. Women in Central Gonja also appeared to be more likely to get pregnant at a fairly early age; engaged in a polygamous marriage; and have more children than women in Bosomtwe district.

Table 4.1: Distribution of women Aged 15-49 who participated in the survey by background characteristic[4].

Background Characteristic	Weighted Per cent	Number of Women Weighted	Unweighted
Age			
15-19	19.9	2,064	2,052
20-24	16.9	1,756	1,772
25-29	16.2	1,677	1,694
30-34	14.5	1,508	1,472
35-39	13.6	1,405	1,404
40-44	9.6	996	1,011
45-49	9.3	962	965
Marital Status			
Never Married	30.6	3,172	3,265
Married	49.9	5,175	5,143
Living Together	10	1,039	984
Divorced/Separated	7.6	787	770
Widowed	1.9	193	205
Missing	0	3	3
Residence			
Rural	56.9	5,905	5,410
Urban	43.1	4,465	4,960
Region			
Ashanti	18.2	1,888	1,723
Brong Ahafo	10.3	1,073	911
Central	10.1	1,048	891
Eastern	12.2	1,267	1,565
Greater Accra	13.5	1,402	1,850
Northern	10.5	1,090	818
Volta	9.4	976	836
Upper East	4	418	526
Upper West	2.6	271	415
Western	9	937	835
Education			
None	25.8	2,670	2,588
Primary	21.3	2,208	2,169
Middle/JSS	39.6	4,107	4,055
Secondary+	13.3	1,383	1,557
Missing	0	1	1
Religion			
Catholic	14.8	1,535	1,496
Protestant	1.8	192	195
Methodist	8.4	876	817
Presbyterian	8	828	802
Pentacostal/Charismatic	28.2	2,925	3,066
Other Christian	15.4	1,599	1,600
Moslem	16.1	1,668	1,626
Traditional/Spiritualist	2.9	301	308
No religion	4.2	437	449
Other	0	5	7
Missing	0	4	4
Ethnicity			
Akan	48.9	5,068	4,886
Ewe	13.5	1,398	1,422
Ga/Dangme	7.5	775	922
Gruma	5.5	573	562
Grussi	3.6	371	451
Guan	2.3	239	223
Hausa	1.3	136	141
Mole-Dagbani	9.4	971	890
Other	8.1	835	869
Missing	0	3	4
Total	**100**	**10,370**	**10,370**

Source: Author's construct based on GMHS data.

Table 4.2: Per cent distribution of women aged 15-49 by highest level of education attended or completed according to selected background characteristic.

[4] Education here refers to the highest level of education attended irrespective of whether that level was complete or not.

Background Characteristic	No Education	Some Primary	Completed Primary	Some Secondary	Completed Secondary	More than Secondary	Total	Number of Women
Age								
15-19	10.3	15.6	10	57.3	6.5	0.3	100	2,064
20-24	15.4	12.8	5.9	45.2	15.1	5.6	100	1,756
25-29	25.2	13.8	6	41.4	7.9	5.6	100	1,677
30-34	34.6	15.4	6.6	34.7	6.1	2.7	100	1,508
35-39	34.1	17.3	5	38.8	2.8	1.9	100	1,405
40-44	37.9	15.5	3.7	37.6	1.2	4.3	100	996
45-49	40	15.5	3.6	36.6	1.9	2.5	100	962
Residence								
Rural	35.6	17.3	7	36.9	2.5	0.7	100	5,905
Urban	12.7	12	5.3	51.3	12.2	6.5	100	4,465
Region								
Ashanti	**12.6**	**16.6**	**6.3**	**54.7**	**7.1**	**2.8**	**100**	**1,888**
Brong Ahafo	27.7	16	6.3	44.8	4	1.3	100	1,073
Central	19.1	18	6.6	47.8	6.2	2.3	100	1,048
Eastern	12.3	16.3	9.1	54	6.4	1.9	100	1,267
Greater Accra	13.5	13.1	5.8	45.2	13.9	8.5	100	1,402
Northern	**67.5**	**8.7**	**2.9**	**14.1**	**4.5**	**2.4**	**100**	**1,090**
Volta	23.4	18.3	7.2	43.6	4.8	2.7	100	976
Upper East	68.5	8.9	4.8	13.9	2.7	1	100	418
Upper West	59.9	9	4.2	20.5	4.3	2.1	100	271
Western	19	17.1	7.1	47.2	6	3.7	100	937
Wealth Quintile								
Lowest	54.6	18.5	5.2	20.9	0.7	0.7	100	1,741
Second	39	16.9	7.4	35.5	1.2	0	100	1,839
Middle	23	17.5	7.8	48.5	2.5	0.7	100	2,025
Fourth	16	14.9	6.9	52.3	7.7	2.2	100	2,306
Highest	6.8	9.2	4.4	51.4	17.4	10.8	100	2,459
Total	**25.8**	**15**	**6.3**	**43.1**	**6.7**	**3.2**	**100**	**10,370**

Source: Author's construct based on GMHS data.

Table 4.3: Selected socio-demographic characteristics of women who participated in the qualitative research (n = 185).

Variable	Community						Total	Percentage
	Kuntanase	Abono	Piase	Sankpala	Tidrope	Mpaha		
Age (yrs)								
≥20	3	6	2	8	11	12	42	22.7
21-25	9	9	5	11	9	8	51	27.6
26-30	20	11	6	7	2	4	50	27
31-35	6	3	2	3	1	3	18	9.7
36-40	3	1	0	1	1	1	7	3.8
41-45	1	0	0	0	0	1	2	1.1
Don't know	3	1	0	4	2	5	15	8.1
Education								
None	4	3	1	22	18	23	71	38.4
Primary	29	17	11	7	6	9	79	42.7
Middle/JSS	10	11	3	4	2	2	32	17.3
Secondary+	2	0	0	1	0	0	3	1.6
Occupation								
Farming	9	19	7	9	11	19	74	40
Petty trading	17	5	3	7	5	5	42	22.7
Housewife	8	4	2	13	7	8	42	22.7
Head dresser	6	1	2	1	1	1	12	6.5
Seamstress	4	2	1	3	2	1	13	7
Teacher	1	0	0	1	0	0	2	1.1
Marital Status								
Married	21	19	8	30	21	29	128	69.1
Widow	3	1	2	1	0	2	9	4.9
Separated	6	4	1	2	3	1	17	9.2
Single	15	7	4	1	2	2	31	16.8
Type of Marriage								
Monogamous	18	17	8	9	7	11	70	54.7
Polygamous	3	2	0	21	14	18	58	45.3
Number of Children								
None	7	2	1	2	3	2	17	9.2
1-3	31	19	13	12	11	13	99	53.5
4-6	7	10	1	20	12	19	69	37.3
Number of Pregnancies								
1-3	35	21	9	13	14	14	106	57.3
4-6	6	8	5	19	10	17	65	35.1
7-9	4	2	1	2	2	3	14	7.6
Age at first Pregnancy								
15-20	10	4	2	18	16	21	71	38.4
21-30	32	26	13	12	8	8	99	53.5
Don't know	3	1	0	4	2	5	15	8.1

Source: Author's construct based on qualitative research sample.

4.2 Overview of MNH Services Access and Use in Ghana: Evidence from Survey Data

Despite Ghana's implementation of a free maternal healthcare policy, do all women in need of SMNHS have access? If not, which categories of women have more access than others? And do inequities in access and use of SMNHS exist in Ghana despite the implementation of the free maternal health care policy - a policy primarily designed and implemented to remove access inequities and barriers? The aim of this section is to present an overview of the levels of accessibility and utilization of SMNHS in Ghana in the five years preceding the GMHS in 2007.

Figure 4.1 shows the national coverage of access to antenatal care (ANC), delivery care (DC), and postnatal care (PNC) services in Ghana by skilled provider in percentage terms as at 2007. At the national level, 96% of pregnant women in the five years preceding the survey (2003-2007) received at least one ANC from a skilled provider. This percentage dramatically decreases to 55 each for skilled assistance during delivery and postnatal care following delivery.

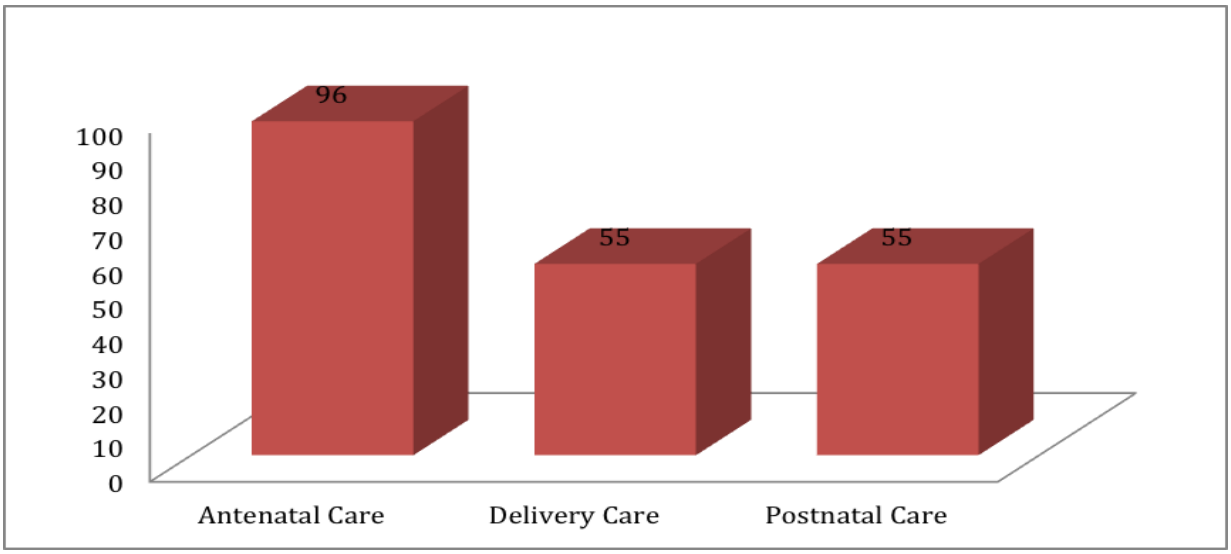


Figure 4.1: Percentage distribution of coverage of ANC, DC and PNC by skilled provider for the most recent live birth or stillbirth in the 5 years preceding the survey. **Source:** Author's construct based on GMHS data.

In terms of the distribution and completeness of access and use of SMNHS in the five years preceding the survey at the national level, only one in two women (48%) accessed and used all three maternity care components, i.e. ANC, DC and PNC (see Figure 4.2). About 4% of women

did not receive a single component of maternity care at all, while 34% of women received ANC only. Similarly, 7% of the women received both ANC and DC or ANC and PNC only.

Although the above statistics are useful in giving a broad understanding of the levels of skilled maternity care coverage at the national level, what is important albeit not easily discernable through these national level statistics, is that large gradients of inequities in complete coverage of maternity care service accessibility and utilization exist for the different categories of respondents (see Figures 4.3 and 4.4, and Table 4.4). For example, less educated women, rural women and women in poorer households are less likely to receive complete maternity care than urban, more educated and wealthier women.

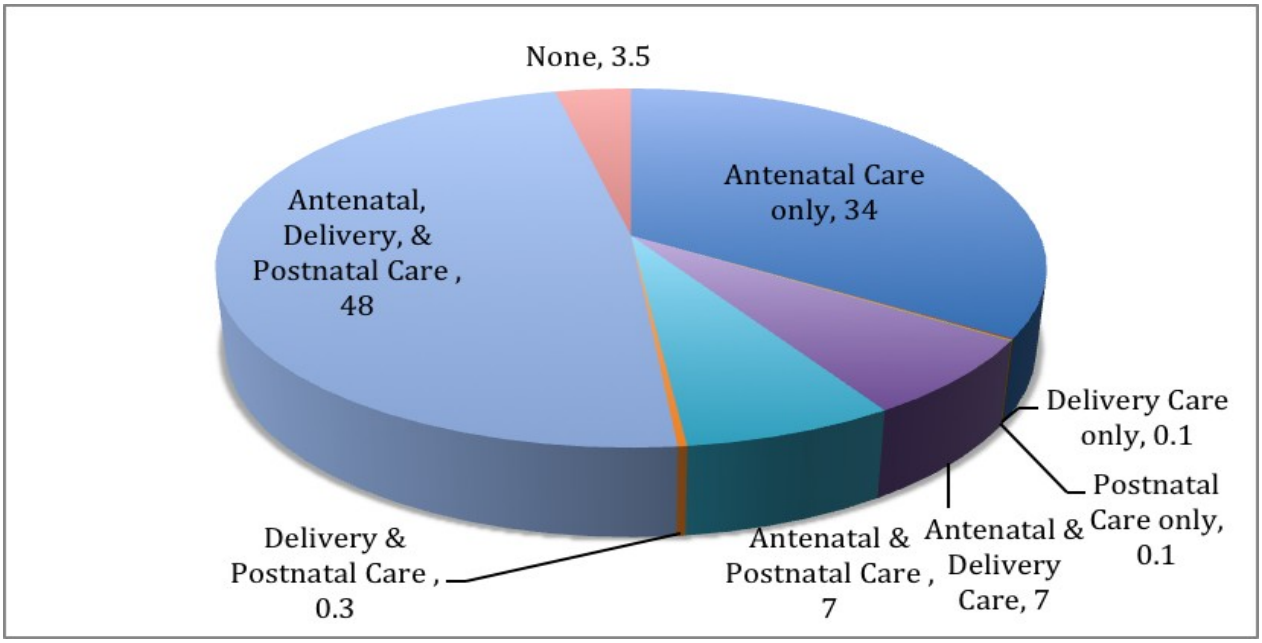


Figure 4.2: Percentage distribution of completeness of access and use of skilled maternity care services in Ghana. **Source:** Author's construct based on GMHS data.

Complete coverage of maternity care also declines with birth order from 58% for first births to 34% among births of six or higher, and is highest among mothers aged 20-34 years. In comparative regional terms, complete coverage of maternity care ranges from a high of 62% in

the Central region to a low of 24% in the Northern region. In other words, in the five years preceding the study, whereas 62% of all births in the Central region received all the three main maternity care components, only 24% of births in the Northern region did. But the inequities in completeness of maternity care access between geographic regions, urban and rural areas, and different socio-demographic, religious and ethnic groupings appear to be reproduced by inequities in the individual maternity interventions. For this reason, the next sections focus on examining the nature of these access inequities separately for ANC, tetanus immunization, DC, delivery at a health facility, skilled attendance at delivery, caesarean sections (CS), PNC, and abortion care.

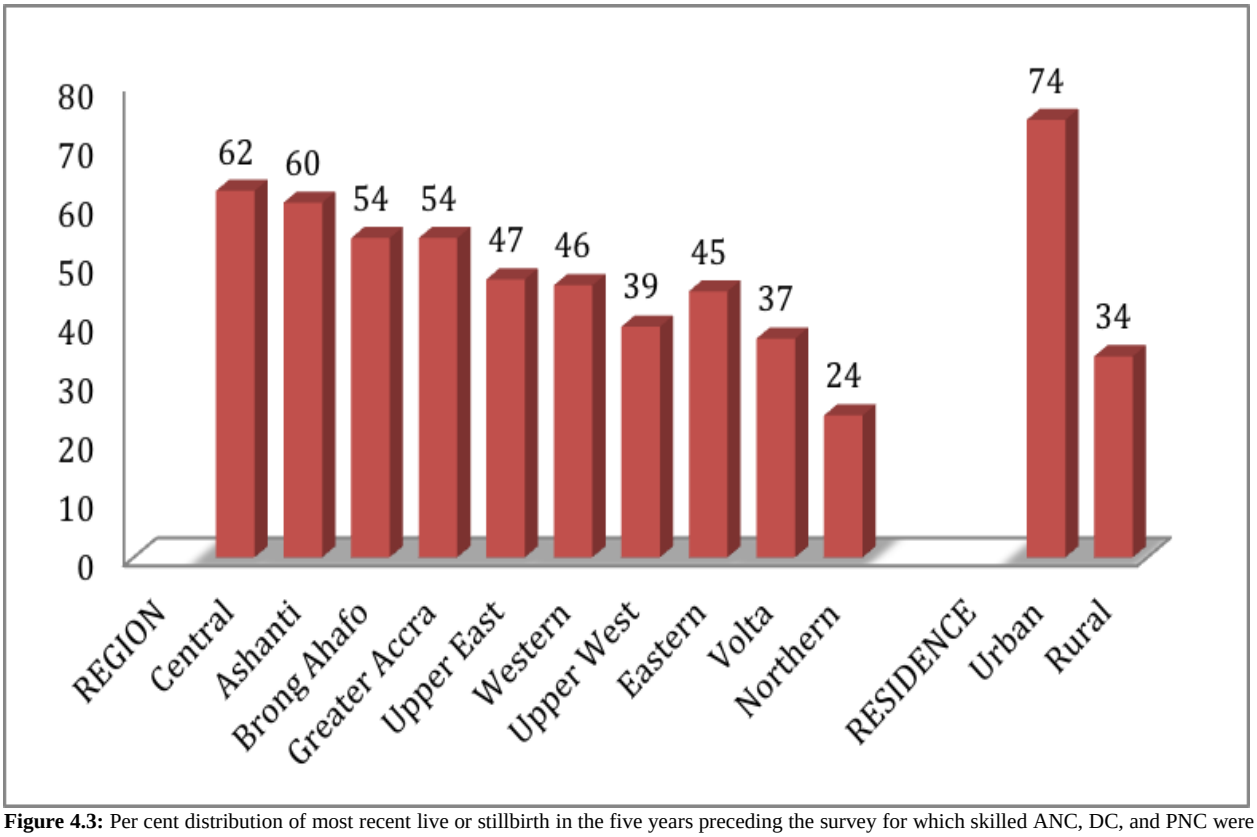


Figure 4.3: Per cent distribution of most recent live or stillbirth in the five years preceding the survey for which skilled ANC, DC, and PNC were received by Region and Residence. **Source:** Author's construct based on GMHS data.

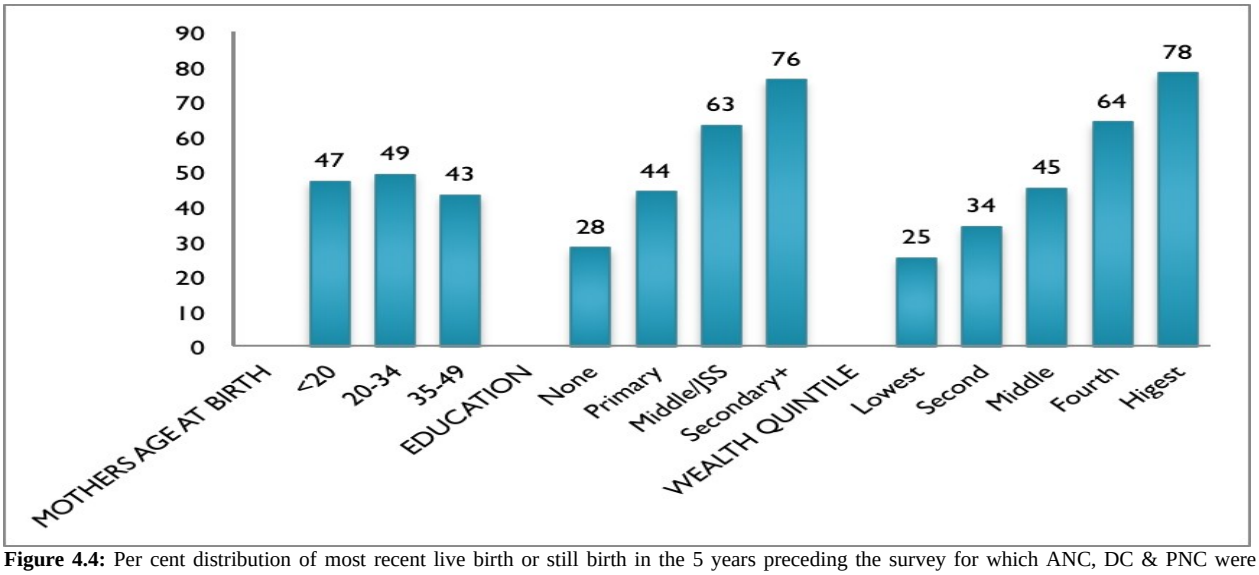


Figure 4.4: Per cent distribution of most recent live birth or still birth in the 5 years preceding the survey for which ANC, DC & PNC were received. **Source:** Author's construct based on GMHS data.

Table 4.4: Per cent distribution of most recent live or stillbirth in five years preceding the survey by whether mother received ANC, DC, and PNC from medically trained persons.

Background Characteristic	ANC Only	DC Only	PNC Only	ANC and DC	ANC and PNC	DC and PNC	All ANC, DC, and PNC	Neither ANC, DC, nor PNC	Missing	Total	Number of Births
Age of Mother at birth											
<20	36.3	0.2	0	7.7	5.9	0.3	46.9	2.7	0	100	534
20-34	32.6	0	0.2	7.3	7.2	0.4	49	2.9	0.4	100	3,391
35-49	39	0	0	6.4	5.3	0.2	43.4	4.5	1.1	100	1,003
Birth Order											
1	26.7	0.1	0.1	8.9	4.7	0.4	57.5	0.9	0.6	100	1,051
2-3	31.6	0	0.1	6.9	7	0.1	51.3	2.7	0.3	100	1,769
4-5	36.2	0	0.2	7.8	8.1	0.1	43.9	3.3	0.4	100	1,161
6+	45.5	0	0.2	5.1	6.7	0.9	34.2	6.6	0.9	100	948
Residence											
Rural	47.1	0	0.1	4.7	8.6	0.3	34.2	4.5	0.4	100	3,245
Urban	9.7	0.1	0.1	12	3	0.3	73.5	0.8	0.7	100	1,683
Education											
None	52.8	0	0.3	3.8	7.9	0.2	28.3	6	0.7	100	1,678
Primary	36.8	0.1	0.1	8	7.4	0.6	43.5	2.8	0.8	100	1,102
Middle/JSS	20.8	0	0	8.9	5.8	0.3	62.6	1.4	0.1	100	1,797
Secondary+	7.4	0	0	12.2	2.9	0	76.3	0.5	0.7	100	350
Region											
Ashanti	**19.1**	**0**	**0.2**	**8.2**	**10.3**	**0.7**	**59.7**	**1.4**	**0.2**	**100**	**922**
Brong Ahafo	31.2	0	0	2.8	9.1	0	54	2.3	0.6	100	564
Central	32.2	0	0	1.3	1.7	0.2	62.1	2.1	0.4	100	479
Eastern	28.4	0	0.4	11.3	10.9	0.7	45.4	2.5	0.4	100	567
Greater Accra	14.7	0.1	0	25.1	2.2	0.4	53.6	3.2	0.5	100	470
Northern	**62.4**	**0**	**0**	**3.1**	**1.9**	**0.2**	**24**	**7.9**	**0.5**	**100**	**699**
Volta	54	0	0	3.7	1.1	0	37.4	3.5	0.3	100	451
Upper East	31	0	0.2	0.6	19.3	0	46.5	1.6	0.8	100	225
Upper West	36.2	0.3	0.9	2.6	16.1	0	39.3	4.1	0.4	100	152
Western	37.6	0	0	7.6	4.1	0.1	46	3.1	1.5	100	400
Wealth Quintile											
Lowest	55	0	0.2	3	9.3	0.3	25.1	6.8	0.4	100	1,074
Second	50.8	0	0.1	2.9	6.8	0.3	33.7	5	0.4	100	1,061
Middle	36	0	0.3	7.9	8.9	0.1	44.8	1.7	0.4	100	975
Fourth	17.7	0	0	10.6	4.8	0.6	64	1.3	0.9	100	983
Highest	4.4	0.1	0	13.1	2.9	0.3	78.3	0.5	0.6	100	835
Total	**34.3**	**0**	**0.1**	**7.2**	**6.7**	**0.3**	**47.6**	**3.2**	**0.5**	**100**	**4,928**

Source: Author's construct based on GMHS data.

4.3 Access and Equity of Access and Use of ANC Services

Ensuring equitable access and use of skilled ANC services is a major policy objective of the free maternal healthcare policy in Ghana. Antenatal care facilitates the detection and treatment of problems during pregnancy and provides an opportunity to inform women, and their families, about their health and the danger signs associated with a pregnancy (Tew, 1995). It is during an antenatal care visit that screening for complications and advice on a range of maternity-related issues take place, including counselling about healthy lifestyles (Titalay *et al*, 2010). Studies have also suggested that early and regular contact with a formal healthcare system during pregnancy may also contribute to timely and effective use of services during and after delivery or in the event of an obstetric complication (Guliani *et al*, 2012; Yesuf & Calderon-Margalit, 2013).

In this section, the aim is to examine whether all women in Ghana receive the minimum standard of ANC when pregnant. Figures 4.5 and 4.6, and tables 4.5 and 4.6 show the distribution of ANC service accessibility and utilization by women who either had a live or stillbirth in the five years preceding the survey according to various background characteristics.

Generally, and compared to other maternal health interventions e.g. delivery and postnatal care, inequities in levels of antenatal care access among subgroups of women in Ghana appear to be smaller, at least in the five years preceding the survey. Yet, as figure 4.5 and table 4.5 show, the percentage difference between antenatal care from a skilled provider (doctor) for the best performing region (Greater Accra, 46%) and the worst (Upper East, 2%) is 44%. Differential access can also be observed for the median number of ANC visits between regions as well as urban and rural areas (Figure 4.6). For instance, whereas the median number of ANC visits for women in Greater Accra is 7.5, those of Volta and Northern regions are 4.8 and 5.5 respectively.

ANC access is also more common among mothers who have had a live birth (96%) than among mothers who have had a stillbirth (88%), and is highest among births to mothers aged 20 and below and among first order births (Table 4.5).

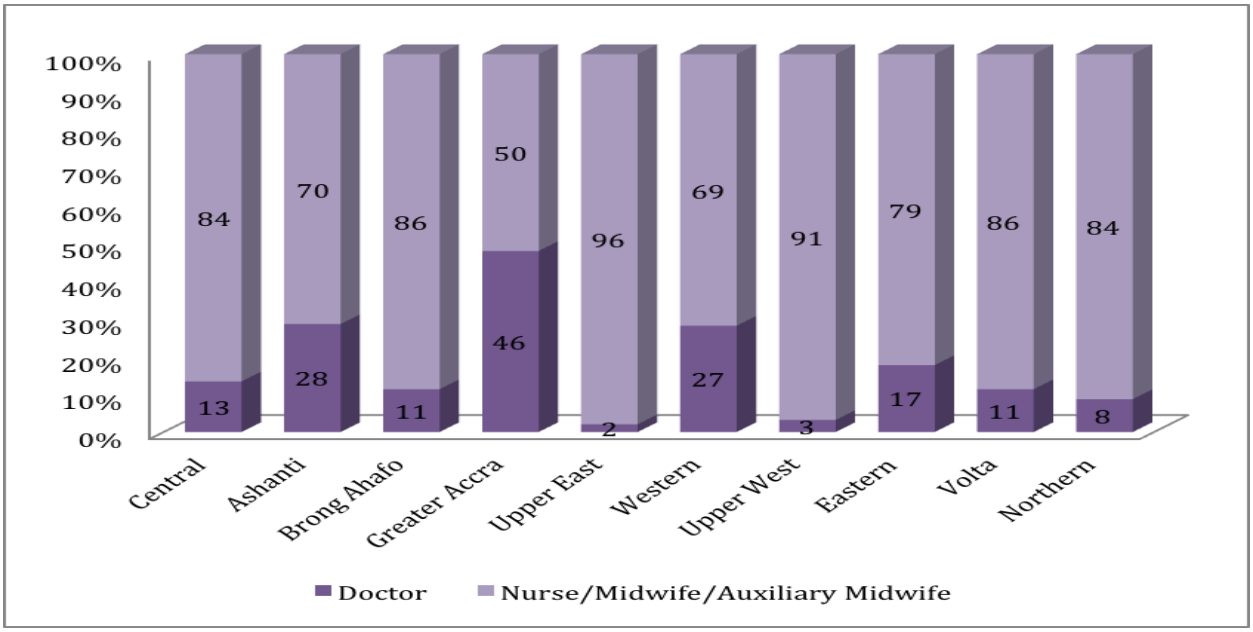
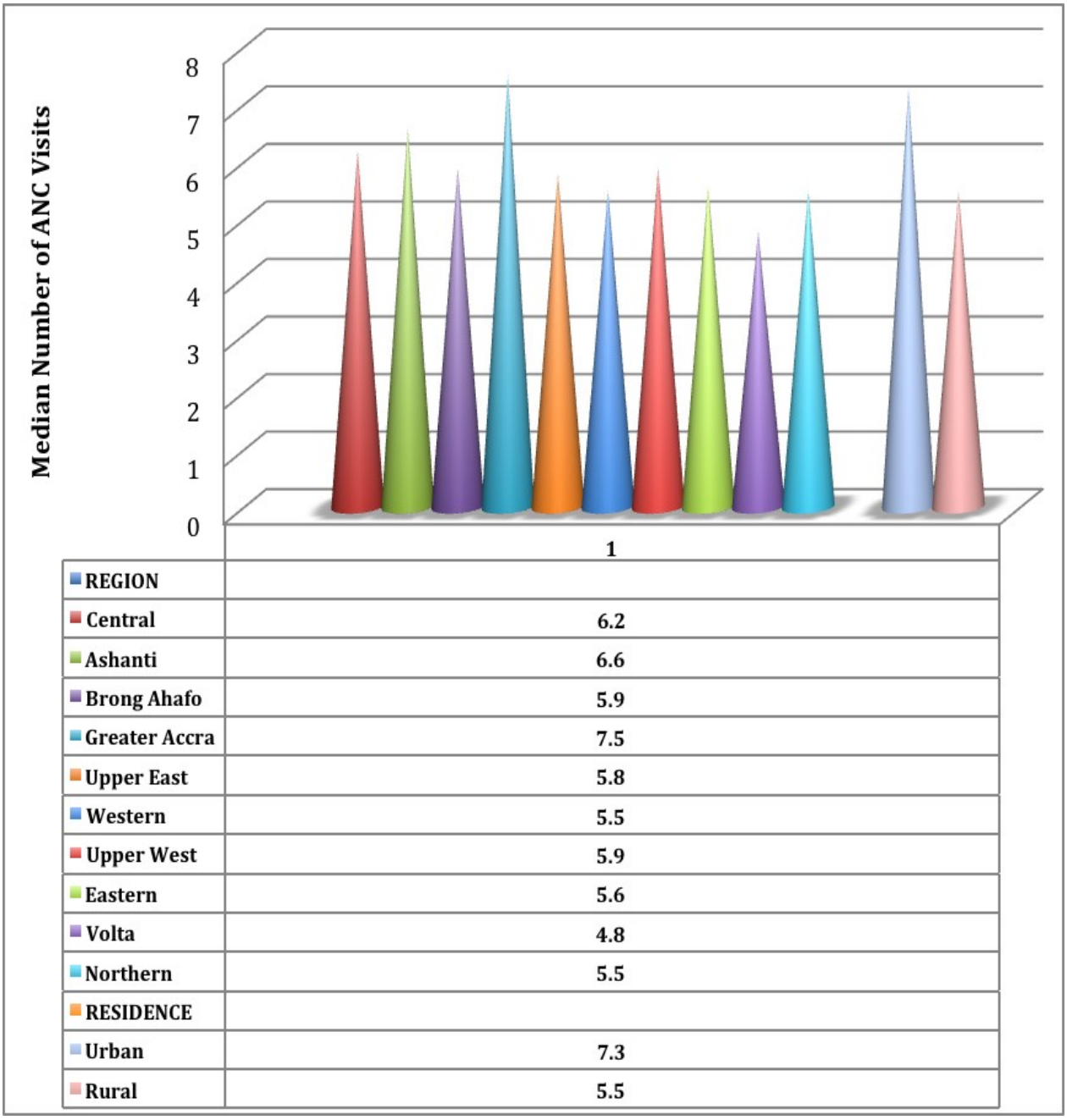


Figure 4.5: Percentage distribution of antenatal care provided by doctor or nurse/midwife/auxiliary midwife by region. **Source:** Author's construct based on GMHS data.

Less surprisingly, the frequency of ANC visits is higher in urban than rural areas, with 89% of urban women seeking care at least 4 times, compared with 70% of rural women (see table 4.6). Differences by region range from a low median of 3.4 months in the Upper West to a high of 4.3 months in the Northern region for seeking initial antenatal care. Antenatal care access is also higher among women with secondary and higher level of education (7.9) than women with no education (5.3), and among those in the highest wealth quintile (8.3) than those in the lowest quintile (4.9).



	1
REGION	
Central	6.2
Ashanti	6.6
Brong Ahafo	5.9
Greater Accra	7.5
Upper East	5.8
Western	5.5
Upper West	5.9
Eastern	5.6
Volta	4.8
Northern	5.5
RESIDENCE	
Urban	7.3
Rural	5.5

Figure 4.6: Median number of ANC visits by Region and Residence. **Source:** Author's construct based on GMHS data.

Table 4.5: Per cent distribution of women who had a live or stillbirth in the five years preceding the survey by whether mother received ANC from a skilled provider.

Background Characteristic	Received any ANC	Doctor	Nurse/ Midwife/ Auxiliary Midwife	Trained Traditional Birth Attendant	Untrained Traditional Birth Attendant	Other	No One	Missing	Total	Per cent Receiving ANC from a Skilled Provider	Number of Women
Birth Outcome											
Live Birth	96.7	18.5	77.8	0.2	0.1	0.1	3.2	0.1	100	96.3	4,847
Stillbirth	87.9	23.1	64.7	0	0	0	10.2	2	100	87.9	81
Age of Mother at birth											
<20	97	14.7	82.1	0.1	0	0	3	0	100	96.8	534
20-34	96.8	19.2	77.2	0.2	0.1	0.1	3	0.1	100	96.4	3,391
35-49	95.2	18.1	76.6	0.3	0.1	0	4.4	0.4	100	95	1,003
Birth Order											
1	98.6	20.7	77.7	0.1	0	0.2	1.2	0.2	100	98.4	1,051
2-3	97.2	20.5	76.4	0.2	0	0	2.7	0.1	100	96.9	1,769
4-5	96.9	18.3	77.8	0.2	0.4	0.2	2.9	0.2	100	96.1	1,161
6+	92.4	12.7	79.4	0.2	0.1	0	7.3	0.2	100	92.1	948
Residence											
Rural	95.4	12.1	82.8	0.2	0.1	0.1	4.6	0	100	94.9	3,245
Urban	98.7	30.8	67.6	0.1	0.1	0	0.9	0.4	100	98.4	1,683
Education											
None	93.5	11.1	82.1	0.2	0.1	0	6.3	0.1	100	93.2	1,678
Primary	96.7	18.2	77.9	0.2	0.4	0.1	2.8	0.4	100	96.1	1,102
Middle/JSS	98.6	21.3	76.9	0.3	0	0.1	1.4	0	100	98.2	1,797
Secondary+	99.5	40.8	58.6	0	0	0	0.5	0	100	99.5	350
Region											
Ashanti	**97.9**	**27.6**	**69.8**	**0**	**0.1**	**0.3**	**1.9**	**0.2**	**100**	**97.5**	**922**
Brong Ahafo	98	11.4	86.3	0	0.3	0	2	0	100	97.7	564
Central	97.8	13.2	84.4	0.2	0	0	2.2	0	100	97.7	479
Eastern	97.2	16.9	79.4	0.7	0.2	0.1	2.7	0.1	100	96.2	567
Greater Accra	96.4	45.7	50.1	0.2	0.4	0	3.2	0.4	100	95.8	470
Northern	**91.7**	**7.6**	**84**	**0.1**	**0**	**0**	**8.2**	**0.2**	**100**	**91.6**	**699**
Volta	96.4	10.7	85.7	0	0	0	3.5	0.1	100	96.4	451
Upper East	98.7	2.4	95.9	0.5	0	0	1.3	0	100	98.3	225
Upper West	94.3	3.4	90.9	0	0	0	5.7	0	100	94.3	152
Western	97	27.2	69.2	0.7	0	0	2.5	0.5	100	96.3	400
Wealth Quintile											
Lowest	93.1	7.9	84.8	0.2	0.3	0	6.9	0	100	92.7	1,074
Second	94.9	9.4	85	0.3	0.1	0.1	5	0.1	100	94.4	1,061
Middle	98.2	16.2	81.7	0.3	0	0.1	1.8	0	100	97.9	975
Fourth	98.1	25.5	72.2	0.2	0	0.2	1.5	0.3	100	97.7	983
Highest	99	38.2	60.6	0	0.2	0	0.6	0.4	100	98.7	835
Total	**96.5**	**18.5**	**77.6**	**0.2**	**0.1**	**0.1**	**3.3**	**0.2**	**100**	**96.1**	**4,928**

Source: Author's construct based on GMHS data.

Table 4.6: Per cent distribution of number of ANC visits and median number of visits for the most recent live birth or stillbirth in the five years preceding the survey.

Background Characteristic	0	1	2-3	4+	Don't Know/ Missing	Total	Median Number of Visits	Number of Births
Birth Outcome								
Live Birth	3.2	3.4	16	77	0.5	100	5.9	4,847
Stillbirth	10.2	9.7	13.8	63.3	3.1	100	5.6	81
Age of Mother at birth								
<20	3	3.9	20.9	71.7	0.5	100	5.2	534
20-34	3	3	14.9	78.5	0.5	100	6.1	3,391
35-49	4.4	4.8	16.6	73.3	0.8	100	5.7	1,003
Birth Order								
1	1.2	2.9	14	81.5	0.4	100	6.2	1,051
2-3	2.7	2.9	14.2	79.6	0.5	100	6.1	1,769
4-5	2.9	3.4	16.2	76.8	0.6	100	6	1,161
6+	7.3	5.1	20.8	66	0.8	100	5.2	948
Residence								
Rural	4.6	4.5	20.3	70.3	0.4	100	5.3	3,245
Urban	0.9	1.5	7.5	89.1	1	100	7.3	1,683
Education								
None	6.3	5.2	19.2	68.6	0.8	100	5.3	1,678
Primary	2.8	4.4	21.1	70.5	1.1	100	5.4	1,102
Middle/JSS	1.4	1.7	11.8	85	0.1	100	6.5	1,797
Secondary+	0.5	1	5.2	92.9	0.4	100	7.9	350
Region								
Ashanti	**1.9**	**3.1**	**11.5**	**83.2**	**0.3**	**100**	**6.6**	**922**
Brong Ahafo	2	4.3	15.8	77.7	0.1	100	5.9	564
Central	2.2	3.1	10.1	84.3	0.2	100	6.2	479
Eastern	2.7	4.3	20.1	72.8	0.1	100	5.6	567
Greater Accra	3.2	1.9	12.2	80.9	1.7	100	7.5	470
Northern	**8.2**	**4.7**	**14.8**	**71.6**	**0.8**	**100**	**5.5**	**699**
Volta	3.5	5.9	29.9	60.6	0.1	100	4.8	451
Upper East	1.3	0	10.6	87.6	0.6	100	5.8	225
Upper West	5.7	2.1	20	68.9	3.5	100	5.9	152
Western	2.5	1.5	19.3	76.1	0.5	100	5.5	400
Wealth Quintile								
Lowest	6.9	7.2	23.6	61.9	0.5	100	4.9	1,074
Second	5	4.3	20.8	69.4	0.5	100	5.2	1,061
Middle	1.8	2.6	18.7	76.7	0.2	100	5.5	975
Fourth	1.5	1.4	9.9	86.5	0.5	100	6.7	983
Highest	0.6	0.9	3.7	93.7	1.1	100	8.3	835
Total	**3.3**	**5.3**	**15.9**	**76.7**	**0.6**	**100**	**5.9**	**4,928**

Source: Author's construct based on GMHS data.

4.4 Access and Equity of access to Tetanus Toxoid Immunization

Ensuring that pregnant women and neonates are fully protected against tetanus is one important component of ANC. Neonatal tetanus is an important cause of death among neonates and infants (Titaley *et al*, 2010). To prevent this, tetanus toxoid injections are given during pregnancy. For full antenatal protection, the WHO recommends that a pregnant woman should receive at least two doses of tetanus toxoid.

Tables 4.7 and 4.8 show that nearly 62% of Ghanaian women who took part in the survey received at least two doses of tetanus toxoid during pregnancy for their most recent birth. Similarly, about four in five women (79%) were protected against tetanus for their last birth.

There are however significant differences in access and use levels between different ethnic and religious groups (see table 4.7).

Table 4.7: Tetanus toxoid immunization during pregnancy for the last birth in the five years preceding the survey.

Background Characteristic	Per cent Receiving Two or more Injections during last Pregnancy	Per cent whose last Birth was Protected against Neonatal Tetanus	Number of Mothers
Birth Outcome			
Live Birth	61.9	79.6	4,847
Stillbirth	47.3	69.4	81
Mother's Age at Birth			
<20	59.5	72.4	534
20-30	62.2	80.4	3,391
35-49	61.1	79.9	1,003
Birth Order			
0-1	66.2	73.8	1,051
2-3	60.4	81.4	1,769
4-5	60.3	81.8	1,161
6+	60.8	79.1	948
Residence			
Urban	64.9	82.7	1,683
Rural	60	77.7	3,245
Region			
Ashanti	60.7	85.5	922
Brong Ahafo	59.5	80.8	564
Central	64.6	84.9	479
Eastern	57.7	78.4	567
Greater Accra	57.6	74	470
Northern	67	69.8	699
Volta	54.6	78.5	451
Upper East	73.7	77.7	225
Upper West	71.4	79.1	152
Western	62.4	83.5	400
Education			
None	60.6	72	1,678
Primary	58.5	80.1	1,102
Middle/JSS	63.2	84.8	1,797
Secondary+	69.2	84.8	350
Wealth Quintile			
Lowest	61.6	74.1	1,074
Second	57.3	75.5	1,061
Middle	61.2	81.6	975
Fourth	62.1	82.6	983
Highest	67.6	85	835
Total	**61.7**	**79.4**	**4,928**

Source: Author's construct based on GMHS data.

Table 4.8: Tetanus toxoid immunization during pregnancy for the last live birth or stillbirth in the five years preceding the survey by Religion and Ethnicity

Background Characteristic	Had Tetanus Toxoid Injection	No Tetanus Toxoid Injection	Don't Know	Total	Number of Births
Religion					
Catholic	88.7	10.8	0.3	100	694
Protestant	90	10	0	100	80
Methodist	93.4	6	0.6	100	348
Presbyterian	91.2	8.8	0	100	317
Pentecostal/Charismatic	90.2	9	0.8	100	1404
Other Christian	87.8	11.8	0.4	100	836
Moslem	92.5	7.5	0	100	896
Traditional/Spiritualist	72.5	27.5	0	100	207
No Religion	85.7	14.3	0	100	293
Other	100	0	0	100	1
Ethnicity					
Akan	91.8	7.7	0.6	100	2248
Ga/Dangme	85.9	13.9	0.2	100	404
Ewe	85.6	14.3	0.2	100	644
Guan	86.6	13.4	0	100	119
Mole-Dagbani	88.9	11.1	0	100	548
Grussi	91.9	7.7	0.4	100	246
Gruma	84.3	15.5	0.3	100	343
Hausa	95.2	4.8	0	100	62
Other	88.6	11.4	0	100	463
Total	**89.3**	**10.3**	**0.3**	**100**	**5077**

Source: Author's construct based on GMHS data.

4.5 Access and Equity of Access and Use of Delivery Care Services

One of the most important indicators used in measuring progress towards the maternal health Millennium Development Goals (MDGs) is the proportion of births attended by skilled health personnel in a health facility. The use of this indicator is founded on research evidence, which suggests that there is an inverse relationship between skilled attendance at birth and maternal and newborn mortality (Babalola & Fatusi, 2009; Zere *et al*, 2010). A critical component of effort to reach MDG 5 under Ghana's free maternal healthcare policy is therefore to increase the proportion of babies delivered in a health facility and under medical supervision. This section examines the levels of access to skilled delivery care services in Ghana in the five years preceding the GMHS in 2007.

Figure 4.7 shows that skilled providers (i.e. a doctor, nurse/midwife or auxiliary midwife) deliver just a little over one in two births (55%) in Ghana.

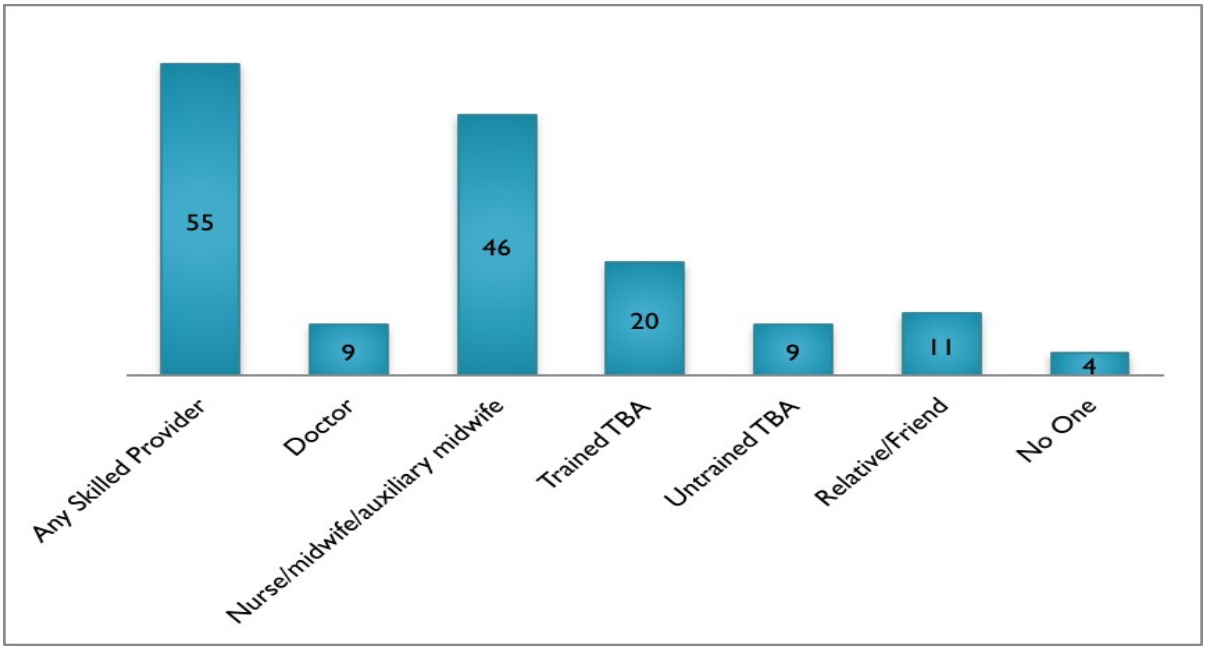


Figure 4.7: Per cent distribution of most recent live or stillbirth in the five years preceding the survey by person providing assistance during delivery. **Source:** Author's construct based on GMHS data.

However, this national statistic tells little about the fact that pervasive access inequities exist

between women of different socio-demographics as can be observed in tables 4.9, 4.10, 4.11 and 4.12. For instance, living in the Greater Accra, Ashanti and Western regions increases the likelihood of delivering in a health facility with a medical doctor in attendance among rural residents by two-folds compared with the Northern and Upper regions (table 4.9).

Table 4.9: Per cent distribution of live or stillbirth in the five years preceding the survey by person providing assistance during delivery.

Background Characteristic	Doctor	Nurse/ Midwife/ Auxiliary Midwife	Trained Traditional Birth Attendant	Untrained Traditional Birth Attendant	Relative/ Friend	No One	Other	Missing	Total	Percent Delivered by a Skilled Provider	Percent delivered by CS	Number of Births
Birth Outcome												
Live Birth	8.9	46.1	20.3	9.5	11.2	3.7	0	0.3	100	55	6.3	4847
Stillbirth	28.6	40.8	11.5	1.6	7.5	5.3	2.8	2	100	69.3	18.9	81
Age of Mother at birth												
<20	8.6	46.5	22.2	9.1	11.7	1.9	0	0	100	55.1	6.5	534
20-34	9.3	47.4	19.6	9.4	11	3.1	0	0.2	100	56.7	6.6	3391
35-49	9.2	41.1	21	9.4	11.5	6.8	0.2	0.9	100	50.2	6.3	1003
Birth Order												
1	12.4	54.6	16.8	7.6	7	1.1	0	0.5	100	67	9.4	1051
2-3	9.2	49.2	19.5	8.6	11.3	2.1	0	0.1	100	58.4	6.4	1769
4-5	8.1	43.8	21.1	9.8	12.6	4.2	0.1	0.2	100	51.9	5.9	1161
6+	6.9	33.3	23.8	12.1	13.8	9	0.2	0.8	100	40.3	4.2	948
Residence												
Rural	5.4	33.8	27.4	13	15.1	4.8	0.1	0.3	100	39.2	4	3781
Urban	16.5	69.5	6.1	2.3	3.6	1.5	0	0.5	100	86	11.3	1683
Education												
None	4	28.3	25.8	16.6	18.5	6.1	0.1	0.5	100	32.4	3.4	1678
Primary	8.6	43.6	21.8	9.3	11.8	4.2	0.1	0.6	100	52.2	6.4	1102
Middle/JSS	11.8	60	16.3	4.1	5.9	1.8	0	0.1	100	71.7	7.9	1797
Secondary+	22.6	66.6	7.4	1.5	1.4	0.5	0	0	100	89.2	14.6	350
Region												
Ashanti	**13.8**	**54.8**	**13.2**	**6.2**	**9**	**2.6**	**0.1**	**0.2**	**100**	**68.7**	**8.6**	**922**
Brong Ahafo	6.3	50.6	18.2	7.9	11.1	5.6	0	0.3	100	56.9	5.1	564
Central	6.1	57.8	25	4.5	2.8	3.7	0	0.2	100	63.8	6.3	479
Eastern	8.8	48.9	22.2	8.3	8.2	3.6	0	0.1	100	57.7	8.4	567
Greater Accra	24.2	55.1	10.2	2.9	3.7	3.6	0	0.4	100	79.3	13.1	470
Northern	**4.8**	**22.5**	**21**	**24.5**	**21**	**5.6**	**0.3**	**0.2**	**100**	**27.3**	**3.1**	**699**
Volta	2.7	38.7	22.4	5.5	26.9	3.8	0	0.1	100	41.3	3.5	451
Upper East	2.2	45	31.6	9.7	9.3	1.5	0	0.8	100	47.1	2.4	225
Upper West	3.2	39	33.3	5.7	13.8	4.6	0	0.4	100	42.2	3.7	152
Western	10.5	43.1	26.3	12.8	4.4	1.5	0	1.5	100	53.7	6.1	400
Wealth Quintile												
Lowest	3.2	25.2	26	17.6	21.5	6.3	0	0.2	100	28.4	2.7	1074
Second	4.6	32.3	28.8	13.3	15.3	5.1	0.3	0.2	100	36.9	3.1	1061
Middle	6.4	46.5	24.8	8.5	9.7	3.9	0	0.2	100	52.9	4.7	975
Fourth	12.5	63	13.7	3.5	5.3	1.5	0	0.6	100	75.5	8.7	983
Highest	22.1	69.6	3.8	1.6	1.4	1	0	0.5	100	91.8	15.4	835
Total	**9.2**	**46**	**20.1**	**9.4**	**11.2**	**3.7**	**0.1**	**0.3**	**100**	**55.2**	**6.5**	**4928**

Source: Author's construct based on GMHS data.

Similarly, 88% of births to women with at least secondary education occur in a health facility, compared with 31% of births to women with no education, while 92% of women in the highest wealth quintile have institutional deliveries, compared with 27% of women in the lowest wealth quintile (Table 4.10). Also a child born in an urban area in Ghana is more than twice as likely to

be delivered at a health facility as a rural child. For instance, four in five births in Greater Accra are delivered in a health facility, compared with one in four births in the Northern Region. Notice the striking differential in health facility delivery between the Ashanti (68%) and Northern (26%) regions in table 4.10 – the two regions where qualitative research was undertaken?

Table 4.10: Per cent distribution of most recent live or stillbirths in the five years preceding the survey by place of delivery.

Background Characteristic	Public Health Facility	Private Health Facility	Home	Other	Missing	Total	Percent Delivered in a Health Facility	Number of Births
Birth Outcome								
Live Birth	42.9	11.1	45.4	0.4	0.1	100	54.1	4847
Stillbirth	61.5	6.3	26.1	4	2	100	67.9	81
Age of Mother at birth								
<20	43.9	10.3	45.7	0.1	0	100	54.2	534
20-34	44.5	11.2	43.8	0.4	0.1	100	55.7	3391
35-49	38.8	10.8	49.3	0.7	0.4	100	49.6	1003
Birth Order								
1	53.3	13.7	32.4	0.3	0.2	100	67.1	1051
2-3	46.3	10.6	42.8	0.1	0.1	100	56.9	1769
4-5	40.2	11.2	47.7	0.8	0.2	100	51.4	1161
6+	30.1	8.6	60.3	0.8	0.2	100	38.7	948
Residence								
Rural	31.6	6.6	61.2	0.5	0	100	38.2	3245
Urban	65.8	19.5	14.1	0.2	0.4	100	85.3	1683
Education								
None	25.7	5.5	68	0.6	0.2	100	31.2	1678
Primary	41.6	10.2	47.4	0.3	0.4	100	51.8	1102
Middle/JSS	56.6	14.2	28.7	0.4	0	100	70.8	1797
Secondary+	64	23.8	12.1	0	0	100	87.9	350
Region								
Ashanti	**54.5**	**13.2**	**31.3**	**0.8**	**0.2**	**100**	**67.7**	**922**
Brong Ahafo	43.1	13.6	42.8	0.4	0.1	100	56.7	564
Central	42.6	15.9	41.2	0.3	0	100	58.5	479
Eastern	47.9	10.4	41.4	0.1	0.1	100	58.3	567
Greater Accra	55	24	20.1	0.5	0.4	100	79	470
Northern	**21.9**	**4.4**	**72.9**	**0.7**	**0.2**	**100**	**26.3**	**699**
Volta	35.3	5.8	58.7	0	0.1	100	41.2	451
Upper East	45.8	0.9	53.4	0	0	100	46.6	225
Upper West	40.2	1	58.8	0	0	100	41.2	152
Western	43.8	9.4	45.8	0.5	0.5	100	53.2	400
Wealth Quintile								
Lowest	24.3	2.7	72.7	0.2	0	100	27	1074
Second	30.2	5.6	62.8	1.2	0.1	100	35.8	1061
Middle	41.4	10.5	47.9	0.2	0	100	51.9	975
Fourth	58.3	16.3	24.6	0.4	0.4	100	74.6	983
Highest	68.6	23	8	0	0.4	100	91.6	835
Total	**43.3**	**11**	**45.1**	**0.4**	**0.2**	**100**	**54.3**	**4928**

Source: Author's construct based on GMHS data.

Two other important dimensions of equity of access are religion and ethnicity. As shown in table 4.11, the range for consultation of a health worker for prenatal or delivery care among religious groups is 50.9 percentage points, from a low of 24% among women of traditional African religious orientation to 75% among Pentecostal and Charismatic Christians. Overall, women

professing traditional/spiritualist and Moslem religious faiths accessed and used less of health facility delivery services compared with Christians. As regards ethnicity, few Hausa (13%), Ga/Dangme (22%) and Akan (23%) women gave birth at home compared to women of the Ewe (44%), Guan (57%), Grussi (60%), Mole-Dagbani (61%) and Gruma (66%) ethnic extractions.

Table 4.11: Per cent distribution of most recent live or stillbirths in the five years preceding the survey by place of delivery according to Religion and Ethnicity

Background Characteristic	Own's Home	Other Home	Government Hospital/ Polyclinic	Government Health Center	Government Health Post/ Clinic	Other Public Health Facility	Private Hospital Clinic	Private Maternity Home	Other Private Health Facility	Other	Total	Number of Women
Religion												
Catholic	39.3	5.3	30	9.4	4.3	0.1	6.8	3.9	0.4	0.4	100	694
Protestant	30	1.2	41.2	13.8	3.8	0	6.2	2.5	0	1.2	100	80
Methodist	28.7	5.5	35.9	10.1	4.6	0	9.5	5.2	0	0.6	100	348
Presbyterian	28.4	6.6	38.2	9.5	4.4	0.3	7.3	5.3	0	0	100	317
Pentecostal/Charismatic	25.4	8	36.3	9.5	4	0.1	9.6	5.9	0.9	0.3	100	1404
Other Christian	31.3	7.1	31.1	11.1	5.5	0	8.1	5.1	0.1	0.5	100	836
Moslem	47.5	2.5	27.6	8.4	2.5	0	7.3	3.9	0.1	0.3	100	895
Traditional/Spiritualist	76.3	5.3	6.3	6.8	2.9	0	1	0.5	0	1	100	207
No Religion	65.2	5.5	10.6	9.6	4.4	0	2.4	1.7	0	0.7	100	293
Other	0	0	100	0	0	0	0	0	0	0	100	1
Ethnicity												
Akan	**23.3**	**7.2**	**36.8**	**10.8**	**5.4**	**0**	**9.7**	**5.9**	**0.5**	**0.4**	**100**	**2,248**
Ga/Dangme	21.5	11.4	37.1	8.7	3.7	0.2	9.2	6.4	1.2	0.5	100	404
Ewe	43.5	5.4	28.3	8.2	2.8	0	6.4	5	0.2	0.3	100	644
Guan	57.1	9.2	19.3	2.5	2.5	0	5.9	1.7	0	1.7	100	119
Mole-Dagbani	**60.7**	**2.4**	**20.3**	**7.5**	**2.6**	**0**	**3.8**	**2.2**	**0**	**0.5**	**100**	**547**
Grussi	59.8	0.4	22.4	8.5	2.8	0	5.7	0.4	0	0	100	246
Gruma	66.8	2.9	15.5	9.3	1.5	0.3	2.6	0.9	0	0.3	100	343
Hausa	12.9	3.2	59.7	3.2	0	0	12.9	8.1	0	0	100	62
Other	44.3	4.5	23.5	11.9	5	0	6.5	3.7	0.2	0.4	100	463
Total	**37**	**5.9**	**30.5**	**9.6**	**4.1**	**0.1**	**7.6**	**4.6**	**0.4**	**0.4**	**100**	**5076**

Source: Author's construct based on GMHS data.

One important component of effective delivery of care is access to caesarean section (CS) services in situations where normal vaginal delivery is not possible. Within the literature, there is a long-standing debate about the acceptable level at which a given population should be receiving CS (Dumont *et al*, 2001). Recently however, it has been argued that the proportion of deliveries by CS in a geographical area is a measure of access to, and use of, obstetric emergency care for averting maternal and newborn mortality, and that a population-based rate of 5-15% is considered as the acceptable level of CS to ensure the best outcomes for mothers and newborns (Zere *et al*, 2010).

Table 4.9 above and table 4.12 below contain information about access and use of CS services among women who had a live or stillbirth in the five years preceding the survey. There are large

disparities for this indicator too. Whereas the percentage of women delivering by CS is as high as 13.1% in the Greater Accra region for example, the Northern and Upper East regions have 3.1% and 2.4% respectively. The differences in terms of wealth quintiles are also striking: 15.4% for the highest and 2.7% for the lowest.

Also, whereas about 15% of Presbyterian Christians accessed and used CS services, only 6% of women professing traditional/spiritualist religion did. Moslem women also accessed and used CS services less compared with their Christian counterparts. In terms of accessibility and utilization according to ethnic affiliation, 16% (the highest) of Ewe and only 6% (the lowest) of Gruma women delivered their last baby by CS.

Table 4.12: Per cent distribution of most recent live or stillbirth in the five years preceding the survey by whether delivery was caesarean section according to Religion and Ethnicity.

Background Characteristic	Delivery by CS	Other	Total	Number of Births
Religion				
Catholic	12.9	87.1	100	380
Protestant	11.1	88.9	100	54
Methodist	11.6	88.4	100	225
Presbyterian	14.5	85.5	100	207
Pentecostal/Charismatic	12.5	87.5	100	928
Other Christian	12.4	87.6	100	510
Moslem	10.9	89.1	100	440
Traditional/Spiritualist	5.7	94.3	100	35
No Religion	9.6	90.4	100	83
Other	0	100	100	1
Ethnicity				
Akan	12.4	87.6	100	1551
Ga/Dangme	12.6	87.4	100	269
Ewe	16	84	100	326
Guan	10.5	89.5	100	38
Mole-Dagbani	13.3	86.7	100	195
Grussi	7.2	92.8	100	97
Gruma	5.8	94.2	100	103
Hausa	11.5	88.5	100	52
Other	9.1	90.9	100	231
Total	**12.2**	**87.8**	**100**	**2862**

Source: Author's construct based on GMHS data.

4.6 Access and Equity of Access and Use of Postpartum Care Services

One intervention for which equity assessment can also be made in the context of Ghana's free

maternal healthcare policy is postpartum care. It has been observed that a considerable number of problems that lead to maternal and newborn death occur during the postpartum period (Titaley *et al*, 2010). In particular, the first forty-eight hours following delivery are critical for detecting and monitoring potential complications that if unattended, could result in the death of mothers and newborns (*ibid*). Access and use of post-delivery care services is therefore recognized as integral to achieving improved maternal and newborn health outcomes. This is because PNC services enable health professionals to identify post-delivery problems, including potential complications, and to provide treatments promptly.

This section aims to investigate the extent to which Ghanaian women access and use PNC services, and whether inequities in the uptake of PNC services exist even after user-fees have been eliminated. Table 4.13 shows the percentage distribution by timing of first postnatal check-up among women with a live or stillbirth in the five years preceding the survey, while table 4.14 illustrates the per cent distribution of whether postnatal care was received among women with a live or stillbirth in the five years preceding the survey, according to religion and ethnicity.

While about 76% (3 in 4) of women reported receiving post-delivery care for themselves and their babies during their last birth in the five years preceding the survey, a cursory analysis of tables 4.13 and 4.14 reveals significant differences and/ or inequities. Broadly, the differences in postpartum care access by demographic, socio-economic and residential background attributes mirror differences already seen for ANC and DC.

Table 4.13: Per cent distribution of postnatal care provider among women with a live or stillbirth in the five years preceding the survey.

Background Characteristic	Received PNC	Received PNC from Medically Trained Provider	Doctor	Nurse/ Midwife/ Auxiliary Midwife	Trained Traditional Birth Attendant	Untrained Traditional Birth Attendant	Relative/ Friend	Other	No One	Missing Provider Information	Missing PNC Information	Total	Number of Births
Birth Outcome													
Live Birth	75.9	54.8	12.9	41.8	11	4.7	5.2	0.2	23.9	0	0.2	100	4847
Stillbirth	73.3	61.9	35.8	26.1	5.9	0	5.5	0	24.8	0	2	100	81
Place of Delivery													
Health facility	87	86.5	23.6	63	0.5	0	0	0	12.8	0	0.2	100	2675
Elsewhere	62.7	17.3	1.1	16.3	23.5	10.1	11.3	0.3	37.2	0.1	0.1	100	2244
Had problems before, during or after Delivery													
No	74.9	52.5	11.1	41.4	11.6	5.2	5.3	0.1	25	0.1	0.1	100	3908
Yes	80	64.3	21.8	42.5	8.5	2.2	4.8	0.2	19.9	0	0.1	100	1011
Residence													
Rural	72.2	43.4	7.9	35.6	14.9	6.5	7.1	0.2	27.7	0.1	0.1	100	3245
Urban	82.7	76.9	23.7	53.2	3.4	0.9	1.4	0	16.6	0	0.6	100	1683
Region													
Ashanti	**79.9**	**71**	**17.3**	**53.8**	**5.9**	**1.3**	**1.2**	**0.4**	**20**	**0**	**0.2**	**100**	**922**
Brong Ahafo	90.9	63.4	8.2	55.1	14.8	4.5	8.2	0	8.7	0	0.3	100	564
Central	92.8	64.2	9.5	54.7	22.7	3.9	2	0	7	0	0.2	100	479
Eastern	66.1	57.4	14.6	42.8	5.7	1.5	1.3	0.2	33.4	0	0.4	100	567
Greater Accra	64.2	56.3	25.7	30.6	4.5	1.5	1.9	0	35.2	0	0.5	100	470
Northern	**79.6**	**26.1**	**6.6**	**19.5**	**15.5**	**18.2**	**19.2**	**0.3**	**20.2**	**0.3**	**0.2**	**100**	**699**
Volta	56	38.5	12	26.5	9.2	1.1	7.1	0	43.7	0	0.3	100	451
Upper East	77.1	66.8	4.7	62.1	10.3	0	0	0	22.9	0	0	100	225
Upper West	61.2	56.4	2	54.4	4.8	0	0	0	38.8	0	0	100	152
Western	72.7	50.6	21.6	29	14.9	5.8	1.4	0	26.8	0.1	0.5	100	400
Wealth Quintile													
Lowest	65.8	35	5.4	29.7	12.3	8.4	9.7	0.2	34.2	0.1	0	100	1074
Second	73.8	41	6.4	34.6	17	6.8	8.6	0.3	26	0.1	0.2	100	1061
Middle	77.3	54.1	8.6	45.4	15.6	4.1	3.6	0	22.5	0	0.2	100	975
Fourth	80.2	69.8	20.2	49.6	6.3	1.6	2.3	0.2	19.2	0	0.6	100	983
Highest	84.3	81.5	29.6	51.9	1.7	0.9	0.3	0.1	15.1	0	0.5	100	835
Total	**75.8**	**54.9**	**13.3**	**41.6**	**11**	**4.6**	**5.2**	**0.1**	**23.9**	**0**	**0.3**	**100**	**4928**

Source: Author's construct based on GMHS data.

Table 4.14: Per cent distribution of whether postnatal care was received among women with a live or stillbirth in the five years preceding the survey, according to Religion and Ethnicity[5].

Background Characteristic	Obtained PNC	No PNC	Total	Number of Births
Religion				
Catholic	77.7	22.3	100	694
Protestant	78.8	21.2	100	80
Methodist	85.3	14.7	100	346
Presbyterian	72.9	27.1	100	317
Pentecostal/Charismatic	77.5	22.5	100	1402
Other Christian	75.2	24.8	100	836
Moslem	77.5	22.5	100	893
Traditional/Spiritualist	65.7	34.3	100	207
No Religion	63.1	36.9	100	293
Other	1	0	100	1
Ethnicity				
Akan	81.8	18.2	100	2244
Ga/Dangme	66.6	33.4	100	404
Ewe	66.5	33.5	100	644
Guan	81.4	18.6	100	118
Mole-Dagbani	78.3	21.7	100	548
Grussi	67.1	32.9	100	246
Gruma	66.8	33.2	100	343
Hausa	87.1	12.9	100	62
Other	76.6	23.4	100	461
Total	**76.1**	**23.9**	**100**	**5070**

Source: Author's construct based on GMHS data.

4.7 Access and Equity of Access and Use of Abortion Care Services

[5] Total includes 142 women with missing information on PNC.

Induced abortion, if improperly done and under unhygienic conditions, adversely affects a woman's health, reduces her chances of future childbearing, and contributes to maternal and perinatal mortality (Grimes *et al*, 2006; Haddad & Nour, 2009). In the context of Ghana as was shown in chapter two, an estimated 11% of maternal mortality is attributable to unsafe abortion[6].

Based on pregnancy histories and information about induced abortion as well as perceived access to abortion care collected from women aged 15-49 during the GMHS, this section attempts to investigate access to abortion care in Ghana.

Figure 4.8 shows the distribution of women who had an abortion in the five years preceding the survey by background characteristics. Figures 4.9 and 4.10, respectively, illustrate the place where the abortion was undertaken, and the person who performed the abortion. Abortion is generally highest among the youngest cohort of women of reproductive age and steadily decreases with age: 16% of pregnancies among women under 20 end in abortion compared with only 3% among those age 45-49. First pregnancies are also more likely (11%) to end in abortion than second or higher order pregnancies (7%), an indication that perhaps abortion is often used more to delay the start of childbearing rather than reduce the number of children.

Women in urban centres are twice as much more likely to have abortion than those in rural areas. Similarly, the proportion of women who reported ever having an abortion range from a high of 21% each for Greater Accra and Ashanti regions to a low of less than 1% in the Upper East and

[6] More recent data, most of which is anecdotal, even point in the direction of a worsening situation. For example, in some leading hospitals in the country, unsafe abortion is the second leading cause of maternal mortality, accounting for 25 to 30 per cent (*Daily Guide*, 2012). The researcher's analysis of health facility level data also shows that 16,185 girls and young women in Ghana caused unsafe abortion in 2011, compared to 10,785 in 2010 and 8,717 in 2009. Particularly alarming is the increasing incidence of abortion among adolescent girls and young women in urban centres. For instance, 216 cases of abortion involving girls aged 10 to 14 years were recorded in 2009, 331 cases in 2010 and 582 in 2011. In the case of girls between the ages of 15 and 19 years, 5,525 abortion cases were recorded in 2009, while 6,679 and 7,800 were recorded in 2010 and 2011 respectively.

West regions. Curiously, the percentage of women reporting ever having abortion generally increases with level of education and wealth, while divorced, separated or widowed women reported more abortion incidence (25%) compared to women currently married (17%) and those who have never married (7%).

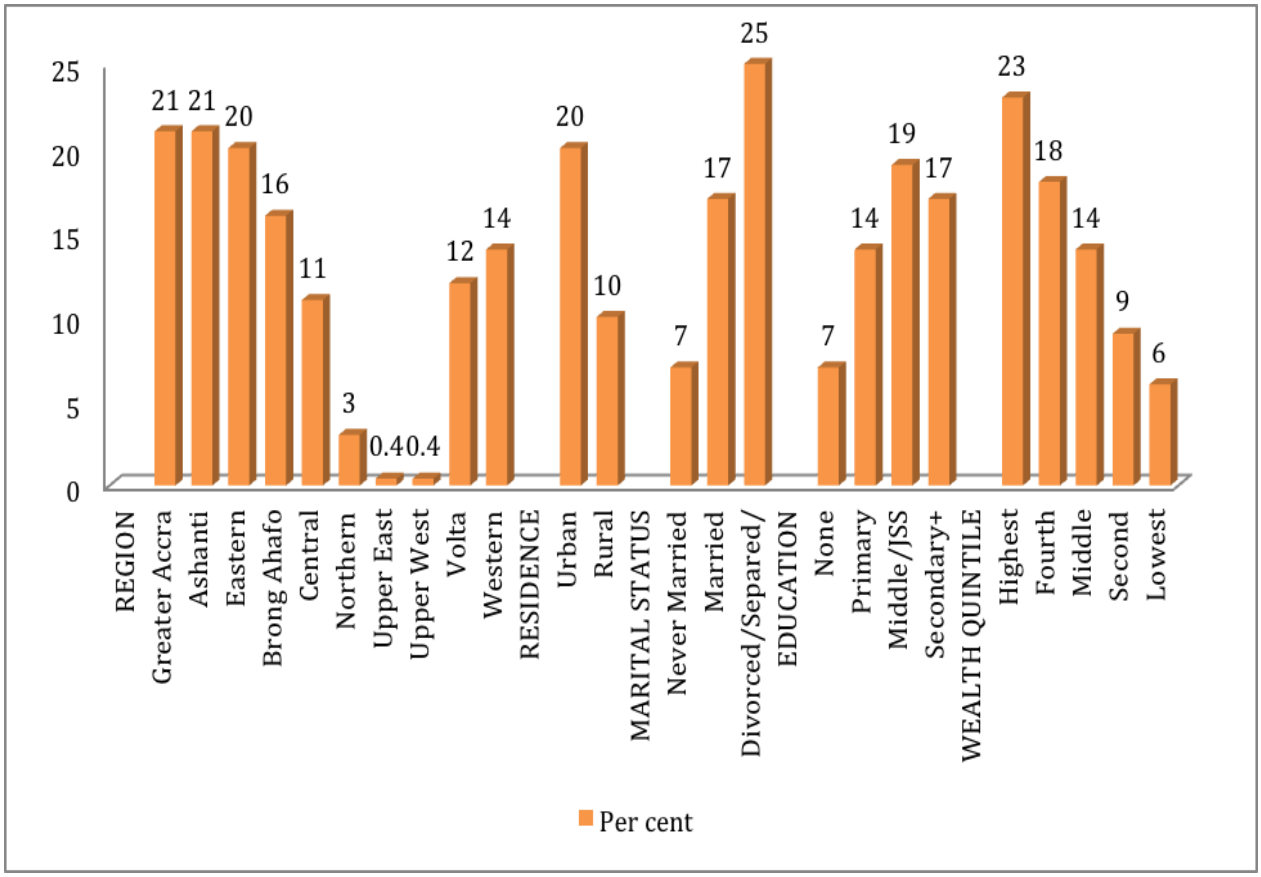


Figure 4.8: Per cent distribution of women who ever had an abortion in the five years preceding the survey by background characteristic. **Source:** Author's construct based on GMHS data.

The majority (38%) of abortions occurred in private hospitals and clinics (Figure 4.9). A significant number (33%) of abortions however occurred outside of any health facility setting i.e. at the women's own home or someone else's. Doctors conducted about 57% of all abortions, while a friend/relative and self conducted a combined total of 19% of abortions.

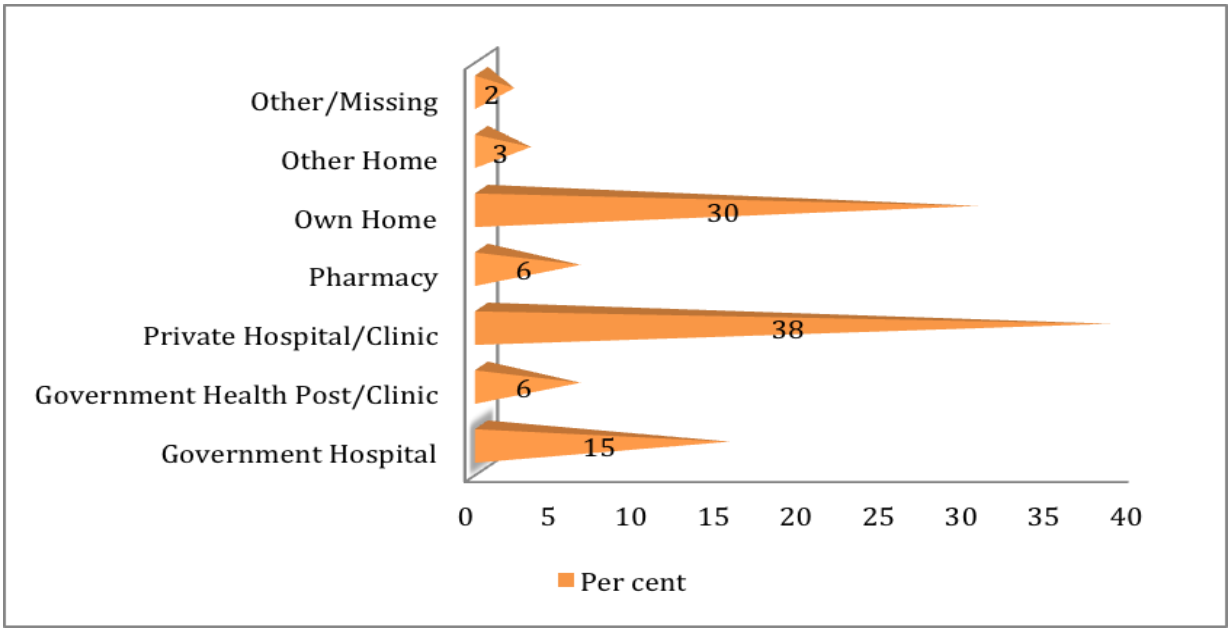


Figure 4.9: Per cent distribution of women aged 15-49 who had an abortion in the five years preceding the survey by place where the abortion was undertaken. **Source:** Author's construct based on GMHS data.

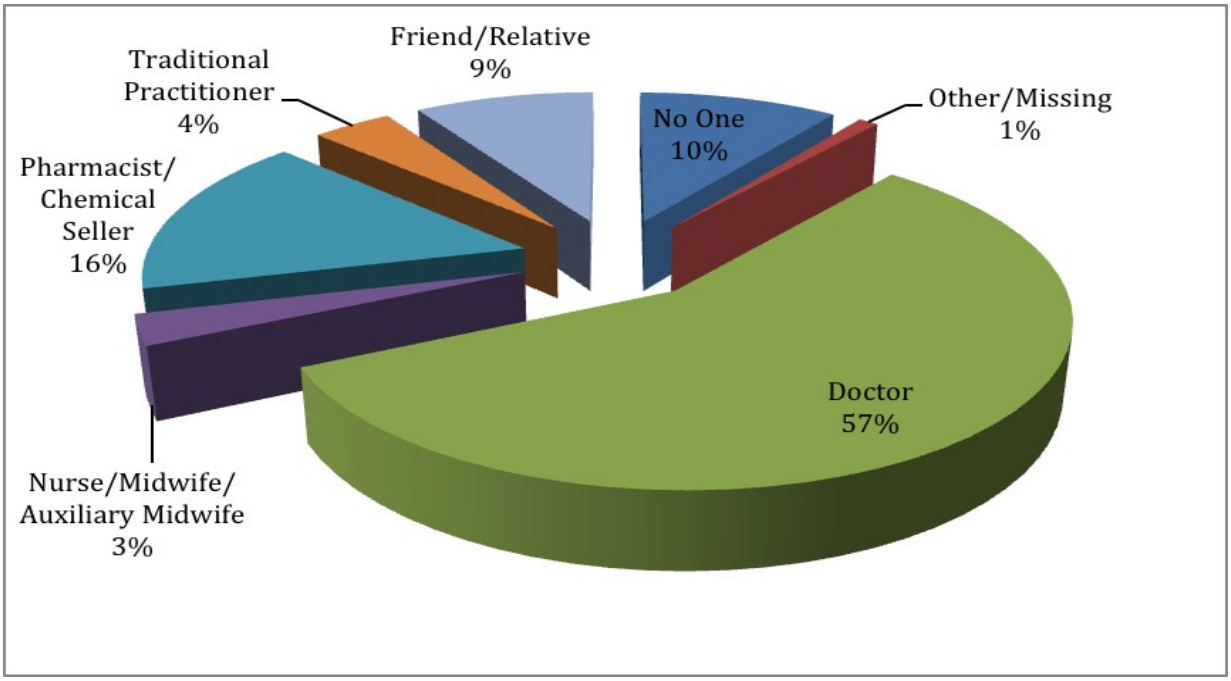


Figure 4.10: Per cent distribution of women aged 15-49 who had an abortion in the five years preceding the survey by person performing the abortion. **Source:** Author's construct based on GMHS data.

Of critical interest to this research, however, is women's perception of their ability to access abortion care if they needed it and their knowledge of places where they could access care. The GMHS asked women who had heard of abortion but have never had one whether they could get an abortion if they wanted to, and whether they knew a place where they could access abortion

care. The results are shown in tables 4.15, 4.16, 4.17, and 4.18.

Table 4.15: Per cent distribution of women who have heard about abortion but have not had an abortion by whether they felt they were able to get abortion care if they wanted.

Background Characteristic	Able to access abortion care	Unable to access abortion care	Don't Know	Total	Number of women who have heard of abortion but have not had abortion
Religion					
Catholic	9.6	88.2	2.2	100	1152
Protestant	13.7	85	1.3	100	153
Methodist	10.9	87.5	1.7	100	654
Presbyterian	14	85.2	0.8	100	600
Pentecostal/Charismatic	12.4	85.9	1.6	100	2339
Other Christian	11.4	87.6	1	100	1255
Moslem	7.9	91.1	1	100	1118
Traditional/Spiritualist	2.7	96.4	0.9	100	223
No Religion	8.3	88.6	3.1	100	325
Other	0	100	0	100	5
Ethnicity					
Akan	**13.2**	**85.5**	**1.3**	**100**	**3850**
Ga/Dangme	11.6	85.9	2.6	100	700
Ewe	7.9	90.7	1.3	100	1123
Guan	5.3	94.2	0.6	100	171
Mole-Dagbani	**5.1**	**93.5**	**1.3**	**100**	**525**
Grussi	6.1	92.9	1	100	297
Gruma	8.6	88.7	2.6	100	417
Hausa	5	95	0	100	121
Other	10.8	87.4	1.8	100	621
Total	**10.8**	**87.7**	**1.5**	**100**	**7825**

Source: Author's construct based on GMHS data.

As table 4.15 shows, approximately one in eight women (12%) felt that they could get abortion care if they wanted to. However, significant differences exist. For example, younger and older women, women with no children, women who have never married, and women in urban areas reported lower ability to access abortion care if they wanted to. The regional differences in terms of women's ability to access abortion care are equally wide: from less than 3% for women in the Northern, Upper East and West regions to 20% and 29% for the Ashanti and Brong Ahafo regions respectively. Women of Traditional, Moslem and Catholic religious faiths also reported lower ability to access abortion care compared to women of other denominations (Table 4.16). The Hausa, Mole-Dagbani, and Guan ethnic groups also reported much lower access levels compared to the Akan and Ga/Dangme ethnic groups.

In terms of women's knowledge of places where they could access abortion care if they wanted

it, more than half (59%) of women who have heard about abortion but have not had an abortion know of no place where they could access this service (Table 4.17). The differences in women's knowledge of where to get abortion (Table 4.18) according to religious or ethnic affiliation mirror that of their perceptions of abortion care access in table 4.16.

Table 4.16: Per cent distribution of women who have heard about abortion but have not had an abortion by whether they felt they were able to get abortion care if they wanted to according to religious and ethnic affiliation[7].

Background Characteristic	Able to access abortion care	Unable to access abortion care	Don't Know	Total	Number of women who have heard of abortion but have not had abortion
Religion					
Catholic	9.6	88.2	2.2	100	1152
Protestant	13.7	85	1.3	100	153
Methodist	10.9	87.5	1.7	100	654
Presbyterian	14	85.2	0.8	100	600
Pentecostal/Charismatic	12.4	85.9	1.6	100	2339
Other Christian	11.4	87.6	1	100	1255
Moslem	7.9	91.1	1	100	1118
Traditional/Spiritualist	2.7	96.4	0.9	100	223
No Religion	8.3	88.6	3.1	100	325
Other	0	100	0	100	5
Ethnicity					
Akan	**13.2**	**85.5**	**1.3**	**100**	**3850**
Ga/Dangme	11.6	85.9	2.6	100	700
Ewe	7.9	90.7	1.3	100	1123
Guan	5.3	94.2	0.6	100	171
Mole-Dagbani	**5.1**	**93.5**	**1.3**	**100**	**525**
Grussi	6.1	92.9	1	100	297
Gruma	8.6	88.7	2.6	100	417
Hausa	5	95	0	100	121
Other	10.8	87.4	1.8	100	621
Total	**10.8**	**87.7**	**1.5**	**100**	**7825**

Source: Author's construct based on GMHS data.

Table 4.17: Per cent distribution of women who have heard about abortion but have not had an abortion by whether they knew specific places where they thought they could get abortion care[8].

Place to Get an Abortion	Percentage of Women
Government Hospital/Polyclinic	28.6
Government Health Center	4.2
Government Health Post/Clinic	2.2
Public Mobile Clinic/Fieldworker	0.3
Private Hospital/Clinic	13.9
Private Doctor	2.5
Private Mobile Clinic/Maternity Home	0.8
Pharmacy/Chemist/Drug Store	2.2
Friend/Relative	3
Other	1
Knows Any Place	38.8
Knows No Place	58.8
Don't Know	2.2
Missing	0.2
Total Number of Women	**7,849**

Source: Author's construct based on GMHS data.

Table 4.18: Per cent distribution of women who have heard about abortion but have not had an abortion by whether they knew specific places

[7] Total excludes 24 women with missing information on perception of access to abortion care.

[8] Note that percentages may not add up to 100 per cent as multiple responses were allowed for this question.

where they thought they could access abortion care according to religious and ethnic affiliation[9].

Background Characteristic	Knows where to access abortion care	Does not know where to access abortion care	Don't Know	Total	Number of women who have heard of abortion but have not had abortion
Religion					
Catholic	37.4	60.2	2.4	100	1152
Protestant	41.8	57.5	0.7	100	153
Methodist	43.9	52.8	3.4	100	654
Presbyterian	45.6	53.1	1.3	100	599
Pentecostal/Charismatic	40.5	57.4	2.1	100	2338
Other Christian	39.8	57.8	2.4	100	1253
Moslem	28	68.2	3.8	100	1121
Traditional/Spiritualist	27.9	68.9	3.2	100	222
No Religion	27.1	68.9	4	100	325
Other	60	40	0	100	5
Ethnicity					
Akan	**43.2**	**55.2**	**1.6**	**100**	**3849**
Ga/Dangme	37.8	57.9	4.3	100	699
Ewe	42.5	55.3	2.2	100	1122
Guan	34.7	64.2	1.2	100	173
Mole-Dagbani	**24.9**	**72.2**	**3.1**	**100**	**524**
Grussi	18.4	78.3	3.3	100	299
Gruma	24	71.4	4.6	100	416
Hausa	38	56.2	5.8	100	121
Other	28.3	67.1	4.5	100	621
Total	**38**	**59.5**	**2.5**	**100**	**7823**

Source: Author's construct based on GMHS data.

4.8 Trends in Access and Equity of Access and Use of SMNHS in Ghana

The preceding sections of this chapter have shown that despite increases in access and use of SMNHS following user-fee exemption in Ghana, large gradients of access inequities still exist in antenatal, prenatal and postnatal check-ups, delivery at a health facility, skilled attendance at delivery, caesarean sections and abortion care by wealth quintiles, area of residence, education, region, age, religion and ethnicity, and between geographic regions, and urban and rural areas. This section briefly reflects on trends in access and equity of access and use of SMNHS in Ghana. It does this by comparing the GMHS data with similar data from the four Ghana Demographic and Health Surveys (GDHS) conducted between 1988 and 2003. Particular attention is paid to changes in access levels between 2003 and 2007, a period, which witnessed, perhaps, the most significant policy change in the history of maternity care in Ghana. The objective is to understand what has been happening to equity in terms of access and uptake of SMNHS between 2003 and 2007.

Figure 4.11 shows the trend in access to skilled antenatal care between 1988 and 2007. Generally,

[9] Total excludes 25 women with missing information on perception of access to abortion care, and 1 woman with missing information on knowledge of where to access abortion care.

there has been an incremental change in access to ANC from 82% in 1988 to 96% in 2007. In particular, the percentage of women receiving antenatal care from a skilled provider increased by 4% from 92% in 2003 to 96% in 2007. The percentage of women receiving antenatal care 4+ times for any single pregnancy also increased from 69% in 2003 to 77% in 2007, while the number of women visiting or seeking antenatal care during the first trimester of pregnancy increased from 46% in 2003 to 53% in 2007. Similar increases are observed for delivery assistance from skilled providers, in a health facility, and protection against tetanus. For example, the percentage of pregnant women receiving 2+ doses of tetanus toxoid protection increased from 50% in 2003 to 62% in 2007. Delivery assistance from skilled providers increased from 47% in 2003 to 55% in 2007, while delivery in a health facility increased from 46% in 2003 to 54% in 2007 (see figure. 4.12).

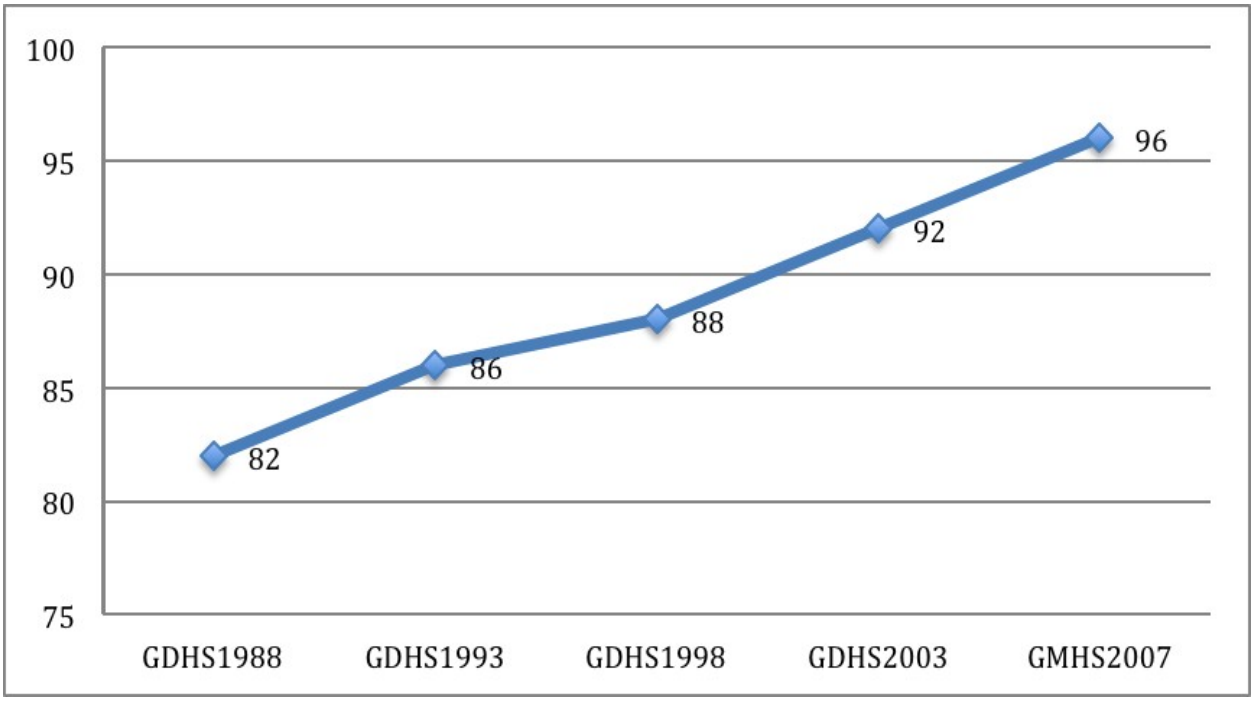


Figure 4.11: Trends in ANC from any skilled provider. **Source:** Author's construct based on GDHS (1988, 1993, 1983, 2003) and GMHS data.

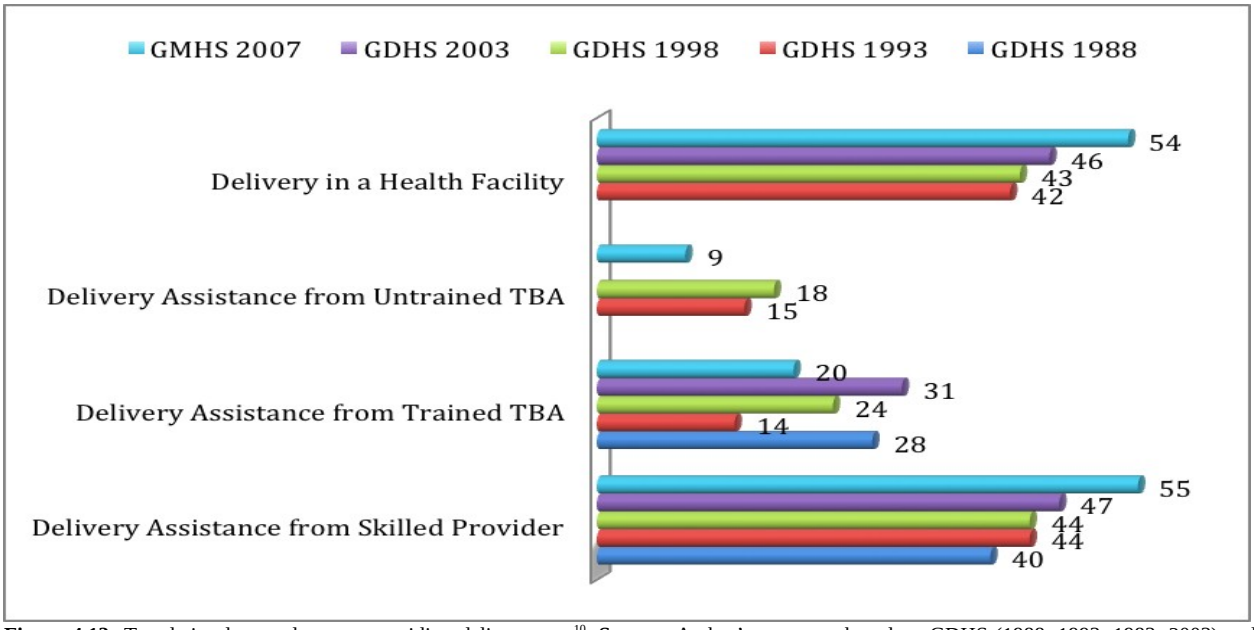


Figure 4.12: Trends in place and person providing delivery care[10]. **Source:** Author's construct based on GDHS (1988, 1993, 1983, 2003) and GMHS data.

There is however the need for caution in the interpretation of these increases. For instance, anecdotal data in relation to the actual number of skilled ANC, institutional delivery and PNC show lower percentages for the national and regional levels (see table 4.19, 4.20, and 4.21).

Table 4.19: Trends in actual skilled ANC coverage by region (2002-2009).

Region	Actual Institutional ANC Coverage (%)							
	2009	2008	2007	2006	2005	2004	2003	2002
Ashanti	**80.7**	**86.1**	**76.1**	**74.0**	**76.6**	**79.0**	**83.6**	**81.3**
Brong Ahafo	97.9	102.1	101.8	97.4	90.0	90.0	97.1	99.7
Central	109.1	115.5	108.7	103.8	103.6	107.7	102.8	103.0
Eastern	93.4	98.2	87.2	86.0	82.0	81.4	94.6	107.8
Greater Accra	77.4	85.2	77.2	77.2	83.1	77.7	81.0	88.9
Northern	**120.8**	**127.7**	**116.8**	**109.0**	**116.6**	**110.4**	**102.7**	**97.2**
Upper East	100.1	102.1	111.7	104.2	95.3	102.0	100.2	98.6
Upper West	88.9	93.5	96.3	90.3	86.1	94.7	88.7	87.5
Volta	88.9	93.4	87.4	87.1	84.1	86.1	86.3	89.4
Western	93.5	98.8	91.7	93.0	90.2	94.7	93.5	96.8
Ghana	**92.1**	**97.8**	**91.1**	**88.1**	**88.7**	**89.2**	**91.2**	**93.7**

Source: Author's construct based on GHS (2010), *The Health Sector in Ghana: Facts & Figures, 2010*, Accra: GHS.

[10] Note that while data on delivery care collected in the four GDHSs were restricted to live births, the GMHS 2007 included live births and stillbirths. The GDHS 1988 did not collect data on delivery in a health facility, while the GDHSs 1988 and 2003 made no distinction between trained and untrained TBAs. Also, delivery care data in the 1988 and 1998 GDHS, and the GMHS 2007 was with reference to births in the five years preceding the surveys, while the GDHS 1993 was with reference to births in the three years preceding the survey.

Table 4.20: Trends in actual supervised institutional delivery by region (2002-2010).

Region	Supervised Delivery (%)								
	2010	2009	2008	2007	2006	2005	2004	2003	2002
Ashanti	53.4	42.4	35.0	26.7	40.8	54.3	56.2	56.2	55.7
Brong Ahafo	54.0	53.7	49.8	34.5	47.4	62.0	57.8	56.0	58.2
Central	51.6	52.5	56.3	22.3	74.0	77.1	76.3	67.1	66.6
Eastern	48.2	52.1	48.0	43.1	38.7	58.4	47.2	50.6	55.0
Greater Accra	54.4	47.9	50.3	43.1	42.2	48.6	46.2	49.4	54.6
Northern	36.8	36.1	26.0	27.7	25.1	57.5	48.2	39.2	41.3
Upper East	59.7	52.6	40.4	43.5	38.4	53.5	71.2	44.9	42.5
Upper West	46.5	36.7	40.6	32.9	28.8	66.5	71.2	67.4	67.5
Volta	36.9	39.4	37.5	33.3	35.4	42.0	39.7	49.0	40.1
Western	49.6	42.6	39.1	17.6	34.8	35.8	46.2	47.6	46.6
Ghana	49.5	45.6	42.2	32.1	44.5	54.2	53.4	52.1	52.6

Source: Author's construct based on GHS (2010), *The Health Sector in Ghana: Facts & Figures, 2010*, Accra: GHS.

Table 4.21: Trends in actual skilled institutional PNC by region (2002-2009).

Region	PNC							
	2009	2008	2007	2006	2005	2004	2003	2002
Ashanti	38.4	51.6	50.6	51.9	47.1	52.8	58.1	58.6
Brong Ahafo	53.7	57.2	57.1	53.8	57.0	55.0	54.1	54.1
Central	71.4	77.6	73.4	68.5	76.4	70.6	67.0	63.1
Eastern	67.0	61.5	61.5	60.8	62.9	67.1	63.1	59.3
Greater Accra	51.7	48.7	48.5	44.8	47.6	40.9	47.3	51.0
Northern	84.9	80.7	76.8	70.8	73.2	62.9	62.0	51.9
Upper East	77.8	57.3	66.9	60.7	56.9	48.4	50.1	48.2
Upper West	64.9	68.7	70.1	54.3	62.0	94.1	75.8	73.6
Volta	47.3	50.5	55.6	53.9	53.9	45.7	59.1	44.6
Western	49.5	45.6	37.6	35.5	35.5	32.8	36.8	40.6
Ghana	56.4	57.5	56.7	53.7	55.0	53.3	55.7	53.7

Source: Author's construct based on GHS (2010), *The Health Sector in Ghana: Facts & Figures, 2010*, Accra: GHS.

Similarly, recent health facility level statistics on access and use of skilled delivery care services not only show access levels that are much lower than those found in the GDHS and GMHS but also for most regions and districts in Ghana, access levels are actually declining. Some of these declines can even be observed for the Central, Eastern and Volta regions in tables 4.19, 4.20 and 4.21.

More importantly, a *before* and *after* comparative analysis (i.e. before the policy in 2003 and after the policy in 2007) using data from the 2003 Ghana Demographic and Health Survey and the 2007 Ghana Maternal Health Survey suggests that while there seems to be increases in access levels for health facility delivery for most women, the inequity gaps between most of the socio-demographic groupings of women have actually marginally widened between 2003 and 2007.

Table 4.22 illustrates this point.

Table 4.22: Trends in equity of access and use of skilled delivery care services (2003 & 2007).

Background Characteristic	Public Sector Health Facility Delivery 2003	Public Sector Health Facility Delivery 2007	Private Sector Health Facility Delivery 2003	Private Sector Health Facility Delivery 2007	Unskilled Home Delivery 2003	Unskilled Home Delivery 2007
Mothers Age at Birth						
<20	35.70	43.90	10.90	11.10	52.80	45.70
20-34	36.70	44.50	9.50	11.20	52.90	43.80
35-49	35.10	38.80	8.00	10.80	55.40	49.30
Birth Order						
1	45.70	53.30	12.60	13.70	41.20	32.40
2-3	35.70	46.30	11.10	10.60	51.80	42.80
4-5	33.20	40.20	7.50	11.20	58.20	47.70
6+	30.10	30.10	4.80	8.60	64.40	60.30
Residence						
Rural	24.00	31.60	5.30	6.60	69.70	61.20
Urban	61.00	65.80	17.60	19.50	20.40	14.10
Education						
None	22.90	25.70	4.90	5.50	71.00	68.00
Primary	35.40	41.60	7.50	10.20	56.40	47.40
Middle/JSS	50.10	56.60	13.30	14.20	35.50	28.70
Secondary+	60.20	64.00	28.80	23.80	11.00	12.10
Region						
Ashanti	56.30	54.50	13.70	13.20	38.80	31.30
Brong Ahafo	47.00	43.10	9.00	13.60	42.60	42.80
Central	27.70	42.60	10.10	15.90	61.60	41.20
Eastern	36.30	47.90	7.90	10.40	54.10	41.40
Greater Accra	58.50	55.00	21.10	24.00	19.60	20.10
Northern	14.70	21.90	1.70	4.40	83.10	72.90
Volta	40.80	35.30	4.10	5.80	54.60	58.70
Upper East	23.20	45.80	2.50	0.90	73.30	53.40
Upper West	32.00	40.20	1.60	1.00	65.00	58.80
Western	24.00	43.80	11.40	9.40	63.90	45.80
Wealth Quintile						
Lowest	17.00	24.30	2.40	2.70	79.60	72.70
Second	24.10	30.20	6.00	5.60	69.00	62.80
Middle	32.80	41.40	7.90	10.50	58.50	47.90
Fourth	57.30	58.30	15.50	16.30	26.40	24.60
Highest	68.00	68.60	21.40	23.00	9.20	8.00

Source: Author's construct based on GDHS (2003) and GMHS data.

4.9 Conclusion

Limited and inequitable access to, and use of SMNHS is one major factor said to be impeding progress towards improvement in maternal and neonatal health outcomes in low-income countries including Ghana (Zere *et al,* 2010). In 2003, Ghana introduced a free maternal health care policy, with an overarching aim to increase access and ensure equitable use of health facility-based skilled care for the reduction of maternal and neonatal morbidity and mortality.

The primary aim of this chapter was to use quantitative survey data to describe and analyse the patterns of SMNHS accessibility and utilization to understand whether in the context of Ghana's free maternal healthcare policy, all women in need of skilled maternity care service have access, and whether inequities in access and service uptake exist despite the presence of the free maternal health care policy.

Findings show an average increase of 8% in access and use of skilled ANC, DC, PNC services between 2003 and 2007. However, in addition to the fact that nearly half of the women in Ghana continue to deliver their babies outside any health facility and without the supervision of any trained health personal, substantial differences in access and service use characterizes Ghana's maternal healthcare system. In other words, both *under* access and *inequitable* use of SMNHS still persist in Ghana despite the implementation of the free maternity care policy.

Due to the absence of appropriate data for comparative analysis, it is hard to make any judgement about the relationship between Ghana's free maternal healthcare policy and the inequities in accessibility to, and utilization of skilled maternity care services that are observed, especially between 2003 and 2007. This said, the findings in this chapter raise a number of important questions: why do so many women still give birth at home or fail to access post delivery care services from a skilled provider in a health facility where services are actually offered free of charge? How and why do differences in SMNHS access and use exist in Ghana despite the free maternal healthcare policy? What barriers militate against universal access and use of SMNHS? What factors enable and promote access and use of SMNHS in Ghana? And how can access be increased, and inequities (if any) in access and use of SMNHS reduced in Ghana? In other words, how can the observed *under* access and *unequal* access and use of SMNHS be explained in the

context of Ghana's free maternal health care policy?

Clearly, answers to the above questions are needed if progress towards attainment of the MNH - related MDGs is to be made at a faster pace in Ghana. But finding appropriate responses to the questions would require moving beyond the statistics presented in this chapter. As several authors have noted, in-depth qualitative research on the experiences and perspectives of both service providers and users is required to understand why SMNHS may not be accessed or inequitably accessed in a context where services are free (Parkhurst *et al*, 2006; Simkhada *et al*, 2007; Essendi *et al*, 2010). For this reason, a qualitative research project on these issues was a key component of the research reported in this thesis. In the chapters that follow, the experiences and accounts of different actors within Ghana's MNH sector are analysed to shed light on the reasons for non-access and/ or differential use of services in a context where care is free.

Chapter 5

‘WE ARE HUMAN BEINGS, BUT THEY NEVER ASK HOW WE FEEL’: HEALTH SYSTEM BARRIERS

5. Introduction

A central objective of this research was to explore women’s experiences of accessing and/ or not utilizing maternal and newborn health (MNH) care services in Ghana, with the hope of identifying factors that hinder access and equitable access and use of skilled maternal and newborn health services (SMNHS) in the context of Ghana’s free maternal health care policy. To document women’s experiences, 5 focus group discussions (FGDs) involving a total of 104 pregnant women and lactating mothers, and 101 qualitative in-depth interviews (IDIs) with women and healthcare providers and policy-makers in 6 communities across 2 regions in Ghana were conducted between November 2011 and June 2012. This chapter begins the process of reporting that data.

Based on expectant and lactating mothers’ accounts about their experiences of seeking skilled antenatal, delivery and postpartum care services in the Bosomtwe and Central Gonja districts of Ghana, this chapter specifically aims to examine factors at the level of the health system that undermine access and equitable access and use of SMNHS in a context where these services are provided free-of-charge.

5.1 Women’s Experiences of Accessing and Using SMNHS in Ghana: An Overview

In order to provide a context for discussing the health system barriers to access and equitable uptake of SMNHS later in this chapter and those that follow, this section gives a brief overview of women’s experiences of pregnancy and childbirth, as well as women’s own evaluation of their experiences of seeking care.

The FGDs and IDIs carried out with women as part of this research show that childbirth is of special value to men and women in Ghana, whether they are married or not. A woman needs to have children to ensure the perpetuity of her own lineage in a matrilineal society, or that of her husband's, in a patrilineal society in Ghana. For this reason, not only is there joy in pregnancy and childbirth, but also most women spoke of pregnancy and childbirth as role fulfilment, self-actualization and empowerment.

> For me, I was really happy when I became pregnant and finally gave birth safely. It made me felt fulfilled and accomplished because people now respect me more. It also absolved me from any blame…because in this community if you are unable to bring forth a child, then trouble for you (Lactating Mother, FGD, Kuntanase, 28/02/2012).

Because of the importance of childbirth in the life of a Ghanaian woman, several women interviewed for this research reported that a pregnant woman needs care, love and empathy to be able to deliver safely.

But while many women spoke of the need to have children and the joy that childbirth brings, there were also stories about the grimmer side of pregnancy and childbirth. More specifically, women noted that pregnancy and childbirth was dangerous as 'you either die or live'. Women also related how the death of a woman from pregnancy-related complications is 'a tragic event', or 'a bad omen', sometimes requiring elaborate ritual purification of the whole society. Accordingly, the death of a woman due to pregnancy or childbirth [maternal death] is viewed as a result of uncleanliness so that in their communities, elaborate dietary and behavioural codes are instituted for expectant women in order to ensure not only safe delivery but also the delivery of normal children.

Thus in the communities in which this study took place, it is the combination of the need to procreate, the joy and fulfilment that childbirth comes with, and the fear that one might die in the process of giving birth, that sometimes warrant care-seeking. In the remainder of this section, an overview of women's experiences of seeking SMNHS is presented. This is done in the belief that an understanding of women's experiences of accessing and using SMNHS, especially their relationships with the healthcare system and healthcare providers, provides an enabling analytical framework for investigating and understanding both their healthcare seeking behaviours and accessibility and utilization barriers (Yakong *et al,* 2010).

In both the FGDs and IDIs carried out for this study, pregnant women and lactating mothers were first asked whether they felt seeking skilled care during pregnancy, childbirth, and immediately after childbirth was necessary. Women were also asked to describe their last experience of seeking and/ or receiving antenatal care (ANC), delivery care (DC) or postnatal care (PNC) services at a healthcare facility or from a healthcare provider. In relation to the first question, several women reported that hospital-based maternity care offers one alternative route to safer pregnancy and childbirth. In particular, several accounts were given about how skilled ANC and ultrasound scanning has made it possible to detect and in some cases correct defective pregnancies. Similar narratives were told about hospital-based delivery especially delivery by caesarean section (CS) which saved several women's lives. Thus, there was a general sense of awareness among women about the potential benefits of seeking skilled ANC, DC and PNC services from a health facility. One participant illustrates:

> I believe it is important for every pregnant woman to go to hospital. I am saying this because of my own experience. When…when I was pregnant, I never went for [ANC] check-up for about seven months. But some friends advised me to go to hospital and check if everything was fine. I went and when the doctor had finished examining me, she said my blood was small [anaemic] and that this can affect my baby. She then gave me

> some blood medicine [blood tonic] and asked me to eat well especially egg, meat, beans, vegetables and fruits… She also said my baby was not lying properly in my womb, and proceeded to turn [referring to palpation] the baby's position well. I believe it is because of this that I didn't suffer much during labour. Maybe…if I did not go to hospital I could have died or I couldn't successfully give birth to my boy. That's why I think it's good for all women to go to hospital when they are pregnant (Lactating Mother, IDI, Tidrope, 29/03/2012).

Indeed, coupled with the numerous maternal health education campaigns that are being undertaken by the Ghana's ministry of health (MoH) and Ghana health services (GHS), the birth place choice of a significant number of Ghanaian women appears to have shifted from the home (where skilled-birth attendants are not available) towards formal healthcare institutions (where skilled-birth attendants are likely to be available).

At the same time however, and in relation to the second question above, the majority of women reported how the organization and delivery of SMNHS was making it extremely difficult or impossible for some women to access and use these services. In both FGDs and IDIs, women gave both collective and deeply personal accounts of their encounters with the healthcare system. While several of these encounters were characterized by both negative and positive accounts, negative experiences and relationships dominated women's daily encounters. Figure 5.1 illustrates the distribution of statements in relation to women's responses to a question that sought to gauge women's last experiences of seeking/receiving skilled maternity care services. Note that figure 5.1 and table 5.1 are neither representing the number of women reporting negative or positive experiences, nor are they the basis upon which the discussion in this chapter is based. Rather, they represent a summary count of statements that women made in both FGDs and IDIs when they were asked to describe their experiences of seeking SMNHS for their last pregnancy or birth. Indeed, I acknowledge that this quantitative representation of the accounts women gave is perhaps not a conventional way of presenting qualitative data. Nonetheless, I

employ it in this chapter and in the next two chapters as a pragmatic technique to facilitate easy communication and understanding of the data.

A majority of statements (107) characterized women's last experiences of seeking and/ or receiving ANC, delivery or PNC care services at a healthcare facility or from a healthcare worker as negative. Fifty-seven (57) of the statements however described women's last experiences as positive, while 21 of the statements suggested mixed experiences.

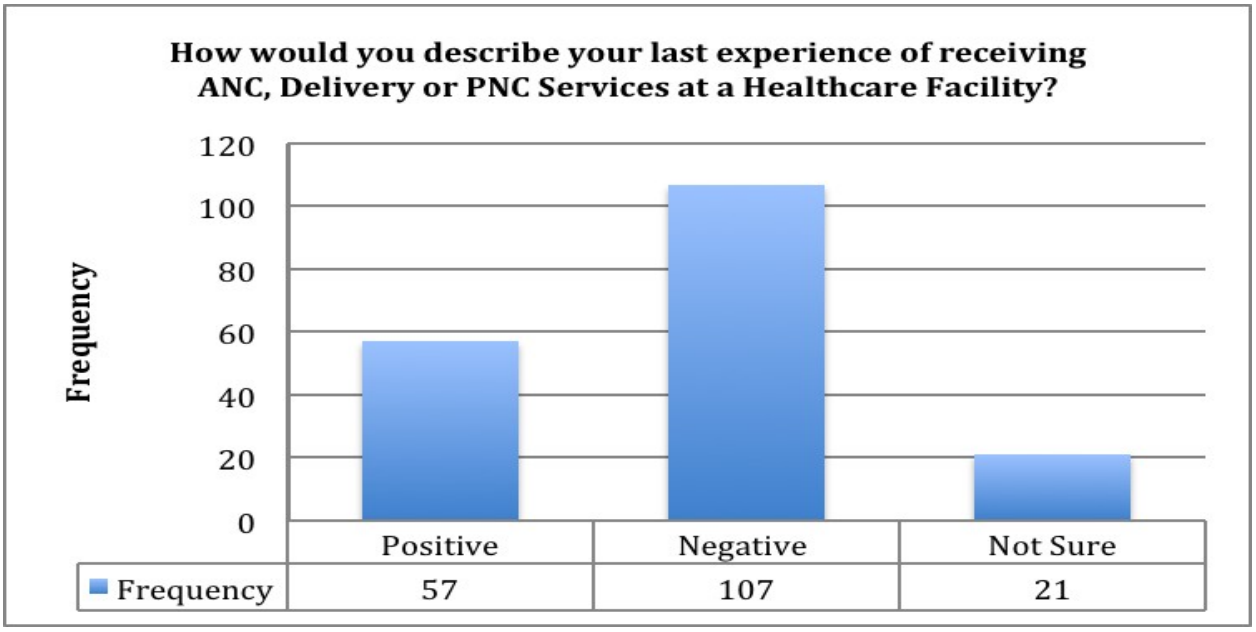


Figure 5.1: Women's last experience of seeking and/ or receiving ANC, Delivery or PNC care services at a healthcare facility. **Source:** Author's construct based on qualitative research sample.

Table 5.1 also describes the nature of the care experiences as well as the distribution of statements about particular care experiences across all the six study communities. On the positive side, 8.6%, 9.2%, 8.1%, and 4.9% of statements respectively, described women's experiences as positive because healthcare workers were friendly and welcoming, women received hot drinks (usually tea) after birth, both bathing and drinking water was readily available at the health facility for women and their accompanying relatives to use, and women were given some

freedom to choose the position they wanted to be in while giving birth. For the women who made these statements, these experiences resonated well with their traditional maternity care practices such as those offered by TBAs, friends and family members in their communities. These experiences were deemed profoundly enabling for the pregnant or parturient woman. Accordingly, these positive experiences constituted the most important reasons why they will continue to access and use maternal healthcare services at the health facility. One participant makes the point:

> With this kind of treatment [referring to the four positive experiences above] why wouldn't we go to the midwife or nurse to check how our babies are doing in our stomachs when we are pregnant or go to the clinic for the doctor to deliver our baby? (Pregnant Woman, FGD, Kuntanase, 28/02/2012).

Table 5.1: Nature and distribution of care experiences across study communities

Nature of Care Experience	Community							
	Kuntanase	Abono	Piase	Sankpala	Tidrope	Mpaha	Total	Percentage
Positive								
-Friendly and welcoming healthcare workers	5	3	2	3	2	1	16	8.6
-Received hot drinks after birth	3	1	1	4	4	4	17	9.2
-Availability of water for bathing & drinking	4	5	0	3	1	2	15	8.1
-Had freedom to choose birth position	2	1	2	2	1	1	9	4.9
Negative								
-Intimidation	5	3	1	4	2	4	19	10.3
-Unfriendly healthcare workers	6	4	2	3	1	2	18	9.7
-Limited choice	8	6	4	5	6	5	34	18.4
-Ill-treatment	4	2	1	2	2	3	14	7.6
-No privacy	6	3	2	3	3	5	22	11.9
Not Sure	2	3	0	5	4	7	21	11.3
Total	**45**	**31**	**15**	**34**	**26**	**34**	**185**	**100**

Source: Author's construct based on qualitative research sample.

The women reporting positive experiences particularly gave graphic descriptions of how the abolition of fees for maternity care produced ''peace of mind'' as they no longer had to think about the cost of paying for ANC, DC and PNC services at the health facility. In the Central

Gonja district for example, women corroborated this view by relating how it used to be common occurrence for families to pawn their fields or borrow money in order to obtain money to pay for maternity care services. In particular, these women spoke positively about the fact that the implementation of the policy has eliminated what may be characterized as *maternal detention* in health facilities. Maternal detention simply refers to the practice whereby healthcare providers disallow patients from leaving a health facility after care has been provided and the patient is unable to meet all her financial obligations to the health facility. Accounts from both women and healthcare providers suggest that the practice used to be one of the characteristic features of Ghana's cash-and-carry healthcare system, which existed prior to the implementation of the free maternal healthcare policy. For women, the possibility that one could easily become a *maternal detainee* was one serious disincentive to SMNHS utilization under the previous cash-and-carry regime. In this context women spoke of maternal detainees as people whose poverty and misery has been publicly admitted, and this open display of one's poverty was deemed shameful and undignified.

In contrast with these positive experiences, intimidation (10.3%), hostile healthcare workers (9.7%), limited choice in relation to delivery positions and post-delivery treatment options (18.4%), ill-treatment (7.6%) and lack of privacy (11.9%) were on the negative side of the experience spectrum (see table 5.1). Other unpalatable experiences included difficulties with arranging transport to healthcare centres, delayed referrals from one health facility to another, long waiting time before treatment as well as difficulties of negotiating bureaucratic processes involved in receiving care. In both their collective and individual response, these women were unanimous that these negative experiences were not only endemic under the current free maternal healthcare policy regime, but also that they were so disabling for the majority of women that

some women now prefer not to seek any care during pregnancy and labour, or opt for alternative care (e.g. TBAs). In fact a substantial number of statements (60) women made especially in Bosomtwe district suggested that they were better off without the free maternity care policy. The reasons for such statements derived from what women characterized as their negative or bitter experiences of seeking SMNHS under the fee exemption policy. These negative experiences, in turn, emanated from a number of health system factors, to which I now turn.

5.2 Why Don't Some Women Access and Use SMNHS in Ghana?

Why do some women in Ghana have access to SMNHS and others do not? The FGDs and IDIs carried out with women for this study revealed that part of the answer to this question resides in the organization and delivery of SMNHS itself. Specifically, the data show that unavailability and/ or unequal distribution of SMNHS, difficulties relating to arranging suitable transportation, women's experiences of intimidation, unfriendly healthcare providers, limited birthing choices, poor care, and lack of privacy at healthcare facilities remain fundamental to understanding why many Ghanaian women continue to deliver their babies at home or outside the appropriate government and non-government healthcare facilities without skilled care despite government efforts to ensure that all births take place in a health facility under the supervision of a trained health professional. In the next sub-sections, I shall present in detail, women's accounts about how these different health system factors inhibit access and equitable use of SMNHS.

5.2.1 Service Availability, Distribution and Access

For women to have the ability to access and utilize SMNHS requires an adequate supply or availability of services (Gulliford *et al*, 2003). Qualitative interviews with women and healthcare providers, which were independently corroborated by the systematic observations and anecdotal data gathered for this research, revealed that this is not the case in many districts and

communities in Ghana. For example, in Tidrope and Abono, there is no health facility hence the provision of SMNHS is not readily available except periodic outreach ANC or national vaccination programmes. In these communities, pregnant and lactating women tell of how a consideration of the prohibitive costs involved in travelling to access or utilize SMNHS often lead several families to decide in favour of non-access and use or resort to self medication or other unapproved (at least according to GHS standards) healthcare providers. A lactating mother illustrates the argument:

> You see, in this community there is no doctor or nurse whom we can easily go to for help. Sometimes, we really want to go and check if all is well with our pregnancies or babies. Some women even want a doctor or nurse to deliver them, but look at where the hospital is…very very far away. Even some times when we want to go, how to get car is a problem. Sometimes your husband will sympathize with you and pick you on a bicycle or motorbike. Otherwise, you have to walk, but because of the long distance, many women just stay at home (Lactating Mother, FGD, Tidrope, 29/03/2012.

Another woman agrees and explains further:

> …Even if your husband or somebody else sympathizes with you and pick you with a bicycle or motorbike, just look at the road…you will be jumping up and down…and this is not good for a pregnant woman…A friend lost her pregnancy [referring to miscarriage] because of this type of thing. And the other thing is that you can't sit on a bike or motorbike if you are about to give birth… that is not possible! Now even if you can call a taxi from Sankpala or the hospital car [referring to ambulance] from Tamale, you can't pay the cost…it is too high for us (Pregnant Women, FGD, Tridrope, 29/03/2012).

In the event of an emergency such as a woman getting into difficult labour during the night, women also described how in most cases 'by the time they arrive at a health facility, the harm is already done'.

> The worse thing for all of us around the lake [referring to settlements around Lake Bosomtwe] is that after struggling to get transport, you may not even get to the hospital before things go bad… like the death of the mother or the baby. In this case is it not better to remain at home, save the small money you have and take care of any eventualities or use it to seek the best alternative in the community? (Pregnant Woman, IDI, Abono, 24/02/2012).

The difficulty of coping with the huge financial and opportunity costs and the probability that negative outcomes may be had even if one were to go to a healthcare facility particularly with a woman in complicated labour, therefore deter accessibility and utilization of services.

IDIs with healthcare providers in the two study districts on the subject of availability and distribution of SMNHS corroborated the accounts given by several women. However, most healthcare providers related the problem to resource constraints and the geographic spread of communities.

> The thing is, not all the communities in this district have health facilities. Our aim is to get to a point where it shouldn't be too difficult for women in every community to have access to the services they need through out pregnancy and childbirth. But the problem is that the resources to do this are limited. Even if we do have resources, it is not feasible to have a community health planning services (CHPS) compound in every community due to the scattered nature of settlements (District Health Director, Central Gonja, IDI, 04/04/2012).

In fact, available anecdotal data also corroborates both the women and healthcare providers' accounts. Tables 5.2, 5.3, 5.4, 5.5, and 5.6 illustrate the argument. Notice in particular the differences (highlighted in blue colour) in the distribution of health facilities (table 5.2), hospitals beds (table 5.3), health workers (table 5.4), doctor-population ratio (table 5.5) and nurse-population ratio (table 5.6) between the two geographic regions (Ashanti and Northern) where this study took place. Whereas the doctor to patient ratio in 2009 was 1:8,288 in Ashanti region, the Northern region had 1:50,751. Similar trend is observed for the nurse to population ratio.

FGDs with women and IDIs with healthcare providers in Mapaha, as well as the researcher's own systematic observations in Buipe, graphically illustrate the effect of the unequal distribution of services on access to SMNHS. Women and healthcare providers in Mpaha alike revealed that the absence of a trained midwife, coupled with the incompetence of existing available nursing staff to

manage deliveries was a major factor impeding access to skilled care at the Mpaha health centre.

Table 5.2: Regional distribution of health facilities by type and ownership in Ghana, 2009

REGION	TEACHING HOSPITALS	REGIONAL HOSPITALS	PSYCHIATRIC HOSPITALS	HOSPITALS					POLY CLINIC	HEALTH CENTRE AND CLINICS					MATERNITY HOMES	CHPS	GRAND TOTAL
	GOVT	GOVT	GOVT	CHAG	ISLAMIC	GOVT	PRIVATE	QUASI GOVT	GOVT	CHAG	ISLAMIC	GOVT	PRIVATE	QUASI GOVT	PRIVATE	GOVT	
ASHANTI	1	0	0	17	3	22	48	2	0	32	2	141	161	9	106	4	548
BRONG AHAFO	0	1	0	10	1	8	6	1	1	11	0	149	24	2	46	8	268
CENTRAL	0	1	1	4	1	9	7	1	0	9	0	80	75	2	34	43	267
EASTERN	0	1	0	5	0	12	5	3	0	19	0	166	63	7	47	44	372
GREATER ACCRA	1	1	2	3	2	7	79	6	7	5	1	44	232	17	55	4	466
NORTHERN	1	1	0	6	0	9	0	2	0	33	0	122	20	3	8	95	300
UPPER EAST	0	1	0	1	0	4	0	0	0	15	0	54	11	1	2	55	144
UPPER WEST	0	1	0	2	2	3	1	0	0	14	3	60	4	0	6	39	135
VOLTA	0	1	0	8	0	11	7	1	1	9	0	192	23	0	24	19	296
WESTERN	0	1	0	3	1	11	3	6	2	21	2	98	119	28	61	65	421
GRAND TOTAL	**3**	**9**	**3**	**59**	**10**	**96**	**156**	**22**	**11**	**168**	**8**	**1106**	**732**	**69**	**389**	**379**	**3217**

Source: Author's construct based on GHS (2010), *The Health Sector in Ghana: Facts & Figures, 2010*, Accra: GHS.

Table 5.3: Distribution of Number of Hospital beds by Region and Ownership, 2009.

Region	Government	CHAG	Islamic	Quasi Government	Private	Total	% By Region
Ashanti	1,961	1,115	144	204	677	**4,101**	**18.50**
Brong Ahafo	657	1,101	68	44	9	**1,879**	**8.48**
Central	1,292	359	32	54	0	**1,737**	**7.84**
Eastern	1,505	993	0	177	0	**2,675**	**12.07**
Greater Accra	3,181	29	0	859	593	**4,662**	**21.03**
Northern	905	390	0	0	0	**1,295**	**5.84**
Upper East	522	289	0	0	72	**883**	**3.98**
Upper West	376	316	10	0	0	**702**	**3.17**
Volta	1,240	892	0	47	0	**2,179**	**9.83**
Western	1,191	419	52	363	26	**2,051**	**9.25**
Total	**12,830**	**5,903**	**306**	**1,748**	**1,377**	**22,164**	**100.0**
% By Ownership	**57.89**	**26.63**	**1.38**	**7.89**	**6.21**	**100.0**	

Source: Author's construct based on GHS (2010), *The Health Sector in Ghana: Facts & Figures, 2010*, Accra: GHS

Table 5.4: Distribution of health workers by region, 2009.

PROFESSION	REGION										
	Ashanti	Brong Ahafo	Central	Eastern	Greater Accra	Northern	Upper East	Upper West	Volta	Western	Grand Total
Medical Officers	499	106	76	140	820	38	34	18	72	77	1880
Dental Surgeons	7	2	0	3	13	0	0	0	2	4	31
Pharmacists	322	92	47	90	304	60	47	33	61	73	1129
Medical Assistants	85	50	38	47	70	59	34	15	29	37	464
Professional Nurses	1604	764	740	1009	2624	714	459	346	827	688	9775
Auxiliary Nurses	731	474	644	1031	1350	509	403	251	797	667	6857
Physiotherapists	11	8	2	4	30	3	2	0	5	3	68
Health Educators	10	14	5	0	18	2	1	2	3	2	57
Dispensing Officers	66	42	37	65	84	20	14	10	56	27	421
Research Officers	2	9	1	0	16	0	11	1	1	0	41
Dental Technologists	4	0	0	0	3	1	0	0	1	0	9
Biostatistics Officers	77	53	49	65	128	28	13	9	71	53	546
Dieticians	2	1	1	1	2	0	1	0	1	0	9
Nutrition Officers	137	55	63	85	366	70	72	39	61	44	992
Health Planner	0	0	2	0	14	0	1	0	0	0	17

Source: Author's construct based on GHS (2010), *The Health Sector in Ghana: Facts & Figures, 2010*, Accra: GHS.

Table 5.5: Doctor to population ratio (2008-2009).

	2009		2008	
	Number of Doctors	Doctor Population Ratio	Number of Doctors	Doctor Population Ratio
Ashanti	589	8,288	495	9,861
Brong Ahafo	134	16,919	103	22,012
Central	84	22,877	72	26,689
Eastern	148	16,132	134	17,817
Greater Accra	839	5,103	827	5,177
Northern	46	50,751	33	70,744
Upper East	29	35,010	30	33,843
Upper West	14	47,932	15	44,736
Volta	73	26,538	68	28,490
Western	77	33,187	78	32,761
National	**2033**	**11,929**	**1855**	**13,074**

Source: Author's construct based on GHS (2010), *The Health Sector in Ghana: Facts & Figures, 2010*, Accra: GHS.

Table 5.6: Nurse to population ratio by region (2008 -2009).

REGION	2009		2008	
	Number of Nurses	Nurse Population Ratio	Number of Nurses	Nurse Population Ratio
Ashanti	4,161	1,173	3533	1382
Brong Ahafo	2,283	993	1940	1169
Central	2,369	881	2104	913
Eastern	2,871	832	2454	973
Greater Accra	4,897	874	4656	919
Northern	1,708	1,367	1480	1577
Upper East	1,262	805	1051	966
Upper West	895	750	758	885
Volta	2,421	800	2132	909
Western	2,107	1,213	1753	1458
National	**24,974**	**971**	**21861**	**1109**

Source: Author's construct based on GHS (2010), *The Health Sector in Ghana: Facts & Figures, 2010*, Accra: GHS.

At the Buipe rural clinic, it was also observed that the number of nurses attending to women who had come for ANC was not only very limited, but also they [nurses] were regularly intermittently called upon to attend to other patients presenting with different ailments. The midwife at the Buipe rural clinic summed the issues thus:

> You are doing research on maternal health access…you have been here, you have seen our staff strength and you have seen the kind of resources and equipment we are working with. How can we ensure that all women have access to good care? Just look at me, I am the only midwife, and look at all the women sitting outside, how can one person take proper care of all of them. Sometimes, I believe the women are right for not coming to us (Midwife, Female, IDI, Buipe, 04/04/12).

5.2.2 Quality of Care and Access

But whether a woman accesses and uses SMNHS ought to be looked at beyond the availability of the service in question. In the communities where this research was conducted, the availability of SMNHS did not in itself ensure access and utilization. Rather, the researcher's engagement with women indicated that the quality of maternal healthcare offered and the time it took to receive it at a health facility or from a skilled provider is another more important factor determining access and utilization. FGDs and IDIs with women in Kuntanase, Piase, Sankpala and Mpaha - where skilled maternal healthcare services are readily available - showed that women's experiences of overcrowding and delays in maternity wards, inefficient referral systems, substandard care, and lack of critical healthcare staff to provide needed care have led to widespread dissatisfaction and unwillingness to access and use SMNHS despite these services being free. A lactating mother makes the point thus:

> I don't know whether I should say the *apimfuo insurance* [the free maternity care policy] has come to help heal our sickness or kill us. When we used to pay, the doctors were taking good care of us. But now that it is free and we don't pay, you go to hospital and they tell you there is no medicine because the government didn't give them more money…so now most of us will even travel far to Pramso or Gee [referring to Akomfo Anokye Teaching Hospital in Kumasi] just to get good care… yes, it is far, but even if there is good hospital overseas where we can get good care, we're happy to go there. That is why those with money will travel to Gee just to check their pregnancy (Lactating Mother, IDI, Piase, 25/02/2012).

This pregnant woman agrees:

> These days, we don't know whether we should go to hospital or not. If you don't go to hospital to check-up your pregnancy or baby and something bad happens, both doctors and people in this community will say you are irresponsible. But if you go too, the people are many…everywhere is crowded, you have to wait for long hours or even a whole day. When you see the doctors too they just rush and say you should go home or if you are lucky they'll ask you to go for some medicine (Pregnant Woman, FGD, Sankpala, 23/03/2012).

Another young mother explains further:

> Why I didn't go to hospital?...uh, the problem is even if I go they [referring to health centre workers] will tell me that the one who is in-charge of pregnant women and delivery [referring to midwife] is not there. If they decide to help you too, they will just rush and say go home...no blood testing...no medicine...nothing! I don't know...but I think because the nurses no longer collect money from us, they are very reluctant to help us (Lactating Mother, IDI, Mpaha, 26/03/2012).

Furthermore, women reported that standards of care were particularly poor in government healthcare facilities compared to private or non-government facilities. Thus the idea that, government healthcare centres offered low quality maternal healthcare services was widely cited for both non-use of the services and a high level of preference for services offered by non-government healthcare providers.

While many women believed the quality of care they were receiving under the free maternal healthcare policy was generally poor, a number of the healthcare workers interviewed gave conflicting answers. For example, the director of policy, planning, monitoring and evaluation unit of the GHS in Accra puts the quality of care problem this way:

> Perhaps, I should make the cynical conclusion that the pregnant women are smart: they know that they can benefit from ANC or DC services and therefore they come to the clinic/hospital. At the same time they know that in an ANC clinic or a labour ward in a health facility they are hardly better off, so they choose not to come or simply deliver at home (Male, IDI, Accra, 15/05/2012).

Others however believed quality of care had actually improved. Even where they acknowledged the care that was being offered women was sub-standard, they often justified it by reference to lack of monetary resources to purchase medical equipment and drugs or limited number of health staff or the increased workload wrought by the free maternity care policy itself.

> One of the good things about this policy [referring to the free maternity care policy] is that we have been able to considerably improve the quality of the services we now provide. As you may know, the policy itself have led to more patients coming to the

> hospitals…therefore, sometimes workers and the facilities are over stretched [Public Health Nurse, IDI, Tamale, 22/03/2012).

It is not possible for me based on the data collected to make a conclusive determination as to whether the over crowding, delays and poor quality of care women reported receiving are caused by the free maternal healthcare policy. However, my observations, coupled with interviews with nurses and midwives as well as reviews of secondary literature suggest that the quality of maternal healthcare may indeed be deteriorating. At both Buipe rural clinic and Sankpala health centre where I was able to systematically observe the doings of ANC clinics, overcrowding and long delays were evident. Women were found sleeping on benches or sitting on cemented floors for long hours before they were hurriedly attended to.

5.2.3 Trust and Access

A pre-requisite for effective patient-provider interaction is the patient's trust that the provider is knowledgeable and motivated to provide the best care available (Oyerinde *et al,* 2012). It can therefore be deduced that within the maternal healthcare problematic in Ghana, women's trust and confidence in and/ or acceptance of both the competence of maternity care providers and the efficacy of the care provided is essential for a well-functioning healthcare system and for facilitating access and use of SMNHS. In the districts where this research took place however, women's narratives and testimonies - which were largely, corroborated by healthcare workers – showed that increasing distrust in the knowledge, skills, practices and competence of maternity care facilities and caregivers (nurses and midwives) and the safety and efficacy of the ANC, delivery and post-delivery care they provide to women, is undermining access.

> I think many women are not going to hospitals because of the people there…I mean the nurses. Some time ago we had good nurses and midwives at the hospital… they understood what it is like to be pregnant or be in labour because they themselves have been through it. But nowadays, all those old nurses are not there… the place is filled with small…small…small nurses and midwives who don't know how to take care of

> pregnant women because they have no experience of giving birth. So such people when you go to them for help, you are in trouble… they don't take proper care of you (Pregnant woman, FGD, Kuntanase, 28/02/2012).

A lactating mother concurs:

> It is true…those young nurses and midwives at the hospital are not doing well at all. Normally they feel that they know book, but in fact they don't know how to deliver a woman properly because they all have never given birth. One of the midwives…she is younger than my daughter, how can she deliver me? Ehh…how can they help you deliver when they have never even been pregnant themselves? Look… Antie Maggie [referring to a TBA] who doesn't even know book, when you go to her with a problem or when you are in labour and they call her to come and deliver you, you will see how she will run to you…even the way she will talk to you, ahh…you will not even be aware and the baby will just come out (FGD, Kuntanase, 28/02/2012).

Another participant adds:

> Are you asking why I didn't go to check my pregnancy?…the thing is that I believe the value is the same…whether I go to antenatal care or not. I have seen people who went for antenatal clinic so many times, but when they were giving birth, they suffered a lot… some even died. If you ask me, I will say that some of the nurses are to blame…why?… because they don't take good care of us like some time ago. You see those days the nurses were matured and they understood us better…they knew how it felt like to be pregnant or be in labour. Unfortunately, these days, we don't see them any more…they no longer come to us. I don't know whether they are no longer working here or what. It is only the young ones you'll see if you go to hospital, or when they come here to weigh our babies. These young ones…they don't know a lot about what it means to be pregnant or be in labour, so they just treat us anyhow…some times you don't know whether what they are telling you is correct or wrong (Pregnant Woman, IDI, Mpaha, 26/03/2012).

Interestingly, women's lack of trust in caregivers was based on other criteria than strict evaluation of whether caregivers have been adequately trained to obtain the required clinical skills to give maternity care. During FGDs, women often made a distinction between having experiential knowledge of pregnancy and childbirth on the one hand, and acquiring book knowledge about pregnancy and childbirth on the other. Women argued that although book knowledge is necessary, to be a good midwife or doctor and to be able to help women successfully live through their pregnancy or childbirth, a midwife ought to have had a personal

experience of pregnancy and childbirth. Such a midwife, the women suggested, did not only possess the 'technical know how' of pregnancy and childbirth particularly in times of complications, but also is well positioned to empathize. Empathy and sharing of personal experiences are two elements that all the women in this study believed were important, especially for safe natural delivery. However, the women noted that most of the young midwives possess only book knowledge, but are unable to empathize or relate to their [women] experiences. It is therefore the absence of empathy and sharing in the maternity care practices of young female midwives more generally, and male midwives in particular, that makes older female midwives and TBAs highly preferred.

Indeed the fact that women distrust the competence of young midwives and nurses as well as lack confidence in hospital-based maternity care, is an open secret. Interviews with both frontline midwives/nurses and healthcare personnel in senior management capacities revealed their awareness of women's diminishing trust in the healthcare system and the care it provides.

> We really don't know why they don't come to us. We have done all the education and sensitization we are suppose to do at the community level, yet some don't come for ANC at all and the few who come also end up giving birth at home. We really don't know why, what we have heard from our CBSVs and other women are that, they [pregnant women] say we are small/young and have no experiences of childbirth…that we only have book knowledge. To some extent, the women are right. Look at this health centre we serve about 64 communities, and yet there is no midwife. The midwife they posted here last year didn't come, because I understand she is old, she is about going on retirement, and also I understand she said the place was too remote. So many times we the community health nurses are the ones conducting ANC, deliveries and post-delivery clinics. And I believe the same thing is happening in many other health facilities in this district and across the entire region. But as you know, we all have not had training in midwifery, so sometimes there are some problems we are unable to solve because of our training. Even there is a lot of new equipment in our stock that we don't use because we don't actually know how to use them. So, when we try our best and still there is a problem and we refer the patient to Tamale teaching hospital or Kintampo, the community people say we don't know anything (Community Health Nurse, FGD, Mpaha, 26/03/2012).

District and regional health directors as well as public health nurses are similarly aware of this trust issue. But they explained that they are now caught between scarcity/necessity and rejection at the same time. On the one hand over 50% of the already limited qualified midwives are retiring from active service. This has necessitated the need to replenish or repopulate the midwives population through the training of young midwives. On the other hand however, these young midwives are facing rejection in their various healthcare facilities by the very communities they are suppose to help.

> It is a really difficult situation for us…we know because of the perception that some of these young midwives have no experience of childbirth or that they are not friendly enough, many women prefer the older midwives, and if they are not there, the women choose not to attend ANC care or deliver at the health facility. But, you see we are short of midwives already and there is urgent need to train more so they can take over from the older ones who are leaving the system. So the only thing we have to do is continue our education of the women so they can understand that these young midwives can equally take good care of them if they [women] come to them [midwives] (Regional Public Health Nurse, Female, Kumasi, 14/03/2012).

That there is a trust problem in the maternal healthcare system in Ghana is therefore no exaggeration. But it is not just the existence of the trust problem per se that is of the essence, rather the fact that women distrust or lack of confidence in hospital-based maternity care constitutes an enormous barrier to equitable access and use of SMNHS.

5.2.4 Power, Intimidation, Choice, and Access

The implementation of free maternal healthcare policy in Ghana has been accompanied by a progressive and aggressive medicalization of the human reproductive process – from fertility control, family planning and pregnancy management, to medical interventions during childbirth and postpartum period. Within this is the paradoxical subjection of pregnancy and childbirth to a barrage of medical and pharmacological control and interventions as potentially abnormal

activity rather the ‘natural’ and ‘normal’ physiologic process that majority of women pass through.

Although this aggressive medicalization of human reproduction and the obstetrical claim to expertise and control over the management of pregnancy and childbirth is generally seen as essential to reducing maternal and neonatal mortality in Ghana, FGDs and interviews with women show that many have found this process intimidating and choice restricting in antenatal, labour and postpartum care clinics. Consequently, and as a way of both resisting this progressive medicalization and reclaiming control over their reproductive health, many women are not accessing and using the SMNHS that Ghana’s free maternal healthcare policy provides at healthcare facilities or designated outreach stations.

During my interviews with them, women spoke passionately about the naturalness of pregnancy and childbirth. Many believed that, as much as possible, there should be limited ‘unnatural’ intervention or interference during pregnancy and childbirth. It is in part the idea of the naturalness of pregnancy and childbirth that causes childbearing women in Ghana to be apprehensive of any interventions believed to be ‘unnatural’, including CS, episiotomy, internal/external version and controlled birthplace. Of particular emphasis is the need for choice in terms of place and position of birth as well as the desirability of limited intimidation and stress during pregnancy and childbirth. These were thought to greatly facilitate the natural processes of pregnancy and childbirth. Many however lamented that the care that healthcare facilities and healthcare providers offer were often less choice enhancing and less stress-free. First, intimidation. For women, the hospital – itself an unnatural environment - with all its modern technological edifices is a rather intimating and disabling environment to give birth. One woman relates:

> The issue is that I don't like the hospital. All those funny funny machines that the doctors use make me fear the place. When I had my first son, it was in the hospital and the doctor put this huge thing … it was like a big scissors [referring to forceps] into my private part. It was terrible! Also, the smell of medicine and the screaming of other patients…it just makes me sicker. So unless I am really suffering or dying, I prefer not to go (Pregnant Women, IDI, Kuntanase, 28/02/2012).

A lactating mother adds:

> I didn't deliver at the clinic because…because I am not used to the place. I wanted to be at a place like my house where I can feel free to spit, urinate, cry and do anything that I feel like doing. In the hospital, the nurses would not allow you or they will even insult you, and this makes it hard for you to relax and deliver well (Lactating Mother, FGD, Abono, 14/02/2012).

Another participant continues:

> …The other thing is that, the nurses, they think they know it all. They have the power, because that is their job. So when you go there they use their machines on you. Even if you don't like it, they don't care, they wouldn't ask and you too you cannot say anything because you want to be well (Pregnant Women, FGD, Abono, 14/02/2012).

But intimidation is not the only thing that prevents women from accessing and using SMNHS. The restrictions placed on their ability to decide on where and how to give birth, is another reason. Women believed that nurses, midwives and doctors limited their choices related to labour and birthing as well as who should witness their birth. For example, women particularly expressed their preference for delivering in an upright position including sitting on a stool or chair, squatting or sitting upon the side of the bed or being held by other women that come to labour. Women who have had home delivery and therefore the opportunity to choose their birth position noted that delivering in an upright position facilitated birth of the baby as well as removal of the placenta. They however noted that the recumbent position favoured by nurses and midwives contributed to general difficulty of delivery. Despite this, delivering on the hospital bed, usually a flat and non-inclining bed, in a supine or recumbent position is the accepted birth position in most healthcare facilities in Ghana. Similarly, family members and friends are not permitted into the labour ward in many instances. Yet, many women said they feel more

confortable delivering with their family members present to offer support. Since nurses and midwives did not usually allow this in the health facility, they found home birth more confortable.

> For me, giving birth at home is more confortable. My friend…gave birth at the clinic last year, and the nurses will all go back home everyday after their work. So my friend was there alone and she felt very bad. Since I don't want to be left alone, I gave birth at home where my mother, my mother-in-law and other neighbours were available to support and care for me (Lactating Mother, IDI, Tidrope, 29/03/2012)

For the women in this study, successful pregnancy and delivery therefore requires that women be given the chance to choose where to deliver and in which position.

5.2.5 Silent Care, Ill-treatment, and Access

Any time that a woman in Ghana makes the decision to access and use SMNHS at a healthcare facility, her general expectation is to be able to enter into a positive relationship with the healthcare provider so as to enable her address her healthcare needs and concerns. Women expect warm conversation, sharing, and empathy to develop between them and their healthcare provider. Women also expect that when they seek care at the health facility, not only should nurses/midwives/doctors offer them the necessary treatments but also they [caregivers] should help them [women] to understand their health problems, provide guidance needed for making informed decisions about their health as well as answer their questions or respond to any health concerns they may have. Because most women have limited education, they strongly depend on the oral advice and information from healthcare workers.

Unfortunately, women's expectations are very often not met. Rather, authority and passivity heavily characterize the interactions between healthcare workers and women, especially in the

ANC clinic or labour ward. In other words, doctor-patient relationships are structured around power and control.

Several women interviewed for this study recounted their experiences of how they were chided and scolded for not coming to the healthcare facility early to seek care or when they did not attend ANC clinics or when they used an alternative medicine or when they failed to practice birth control or when they asked the nurses/midwives/doctors questions related to their (women) health or that of their baby. Particular reference was made to nurses, midwives and female health providers in general, as exhibiting poor attitude towards pregnant and labouring women. Others related how they were often offered 'silent treatment' and treated like 'children' and in some instances threatened with treatment withdrawals if they failed to adhere to advice and instructions from healthcare workers. One participant relates her experience thus:

> I have made up my mind not to go to that hospital [referring to Kuntanase hospital] again. Because, the nurses are suppose to know and tell me what is wrong. But the last time I went, they told me to go spit my saliva into a container and bring, I did and they asked me to go and bring my urine too. So I asked the nurse what was wrong. She didn't say anything but that I should do as I am told. But I asked again, and then she became angry and started to say I was a villager and that I don't know anything. I was embarrassed and became very angry because everybody at the clinic was looking at me and laughing. We are human beings with emotions and feelings, but they never ask how we feel…they don't…they really don't care (Pregnant Woman, IDI, Kuntanase, 28/02/2012).

Another woman narrates:

> I have sworn not to ever go and deliver at that clinic. When my sister went into labour last year, her husband and I took her to see the nurse. It was in the night and the nurse had closed and gone to sleep. So when we asked her to help my sister, she came and was very annoyed. She started saying why did my sister not come early, is she the one who impregnated my sister that we are asking her to stop sleeping and deliver her. My sister was suffering a lot, but the nurse was just relaxed, walking about and brushing her teeth and complaining. That's why I don't want to go to her again (Pregnant Woman, FGD, Mpaha, 26/03/2012)

Women noted that scolding, maltreatment and silent treatment were particularly worse in government healthcare facilities than in private facilities - a phenomenon, women said, discouraged them from seeking skilled care services when in need. Discussants said that health workers in private health facilities (i.e. facilities not owned or run by governments) were more hospitable than their counterparts in state-run services who often abused patients. In this way, ownership of a health facility emerged as an important determinant of the nature of treatment received.

But women further related that in most government health facilities, differential treatments were often offered to patients depending on their social status:

> The nurses and midwives in this community also don't treat people fairly. If you go to the clinic and you are rich…you have money, they always treat you nicely and promptly. But if you are poor, they will delay as if they don't want to help you and when you complain, they will even insult you. That is why those of us who are poor don't want to go there (Pregnant Woman, IDI, Sankpala, 23/03/2012).

Consequently, women revealed that they were often filled with fear whenever they were going to the government health facility to see a nurse/midwife help. Indeed, in Sankpala health centre and Buipe clinic where the researcher observed the conduct of antenatal and post-natal clinics, several medical procedures including blood pressure and temperature check-ups, weighing, and immunization were conducted on women and their babies without any accompanying explanations of the purpose of the medical procedure or its functions. Women also regularly stood up when responding to questions from nurses. At the same time, nurses seemed unperturbed by the precarious condition of most pregnant women neither did they seem to be mindful of the fact that some of these women were far older than they (nurses) were. Note that age within most Ghanaian societies is not just a figure or the number of years one has lived. Rather age has social significance. It confers on older persons a right to particular treatment,

including respect from society especially from younger people as well as responsibilities. As the researcher later learnt, nurses' failure to respect elderly women at the clinic is one reason why some women choose not to consult nurses and midwives. A few women however revealed that in order to receive the care and treatment they needed or avoid getting into conflicts with nurses; they often have to accept the scolding, intimidation and disrespect in maternity wards without openly expressing their feelings.

Most of the healthcare workers interviewed appeared quite aware of what the women called the silent care and maltreatments they were receiving during ANC, DC and PNC visits. However, they either underestimated the effects this has on women's health seeking behaviours or justified it by reference to work overload and tiredness, which often stressed healthcare workers. Others also justified silent treatment on grounds of language differences between healthcare workers and patients, which sometimes made it difficult for nurses and midwives to effectively communicate health information and treatment procedures to women. Be that as the justifications may be, it is clear that poor patient-doctor relationships do have a disabling effect on access and equitable uptake of services.

5.2.6 Privacy and Access

Women also reported that under the current maternal and newborn healthcare regime in Ghana, hospital and clinical structures and practices made it extremely difficult to maintain privacy during pregnancy and childbirth and for them to discuss their healthcare concerns with nursing staff.

> You see, I can get up and go to Antie Maggie [referring to a community TBA] to check my pregnancy and nobody in this house even my husband, would not know. But if I go to the clinic, there are so many other people sitting there. Everybody is listening to what you

> are telling the nurses…sometimes, there are things you want to tell only the nurse or you want to ask the nurse alone. But because there are other patients, you can't (Pregnant Woman, IDI, Piase, 24/02/2012).

One participant also relates:

> I didn't deliver at the hospital because the first time I gave birth at the hospital…it was not too good for me. I didn't like the way the place was open. There were other patients, nurses, midwives and doctors in the labour ward. So everyone could see you or hear what you are doing. I think it would be better if every patient had their own delivery room, or even if they can use curtains to cover you (Lactating Mother, FGD, Sankpala, 22/03/2012).

Indeed observations around ANC clinics and maternity wards showed that privacy was neither ensured nor given serious importance. For example, case histories and clinical examination of pregnant women took place in the midst of others waiting to be attended to. This was confounded by nurses' penchant for interviewing women in loud voices. This made it very easy for those waiting to hear the health problems or concerns of other women.

For fear of ones health problems being subjects of gossip, many women said they felt constrained telling nurses all their health concerns within those settings. Some therefore wondered what the essence of going for ANC or PNC was if they were unable to discuss their concerns with caregivers. During physical examination also, pregnant women noted they were often palpated with open doors or curtains, which also made it easy for others to see their abdomen. This was very concerning for most women especially Muslim women in the central Gonja district. Lack of privacy in ANC clinics and labour wards therefore constituted an important factor negatively affecting women's healthcare-seeking behaviours. For these women, the limited privacy within the health facility setting and the way in which caregivers ignored this crucial aspect of care was an important barrier to accessibility and utilization of SMNHS.

Despite the importance women attached to privacy, interviews with nurses, midwives and healthcare managers showed that ensuring privacy was often not an issue of primary concern. The few who acknowledged the relevance of preserving privacy in ANC clinics and labour wards even countered the argument by highlighting the limitations imposed by infrastructural constraints.

> I think that it is good that we maintain some level of privacy in our maternity wards. But the issue is, when you don't have space or when you have only one person attending to several hundreds of women, how are we supposed to maintain privacy? We really can't, unless we choose to take care of few women and ignore the rest (Midwife, IDI, Sankpala, 22/03/2012).

5.3 Conclusion

Why do some women in Ghana access SMNHS and others do not; and what role does the maternal healthcare system in Ghana play in under access and inequitable use of skilled maternity care services? These were the questions that this chapter aimed to examine using qualitative data generated from FGDs and IDIs with women and healthcare providers in Ghana.

My analysis of the interviews and focus groups conducted for this study suggest that although Ghana's free maternal healthcare policy appears to have increased accessibility to, and utilization of SMNHS, the experiences of women in the encounters between women and the healthcare system constitute an important barrier to equitable access and use of skilled maternity care services. In particular, as the analysis in the chapter revealed, fundamental to understanding why many women continue to deliver their babies at home or outside designated government healthcare facilities without skilled care despite government efforts to ensure that all births take place in a health facility under the supervision of a trained health professional, are a number of health system barriers. These include the unavailability and/ or unequal distribution of SMNHS,

difficulties relating to arranging suitable transportation, women's experiences of intimidation, unfriendly healthcare providers, limited birthing choices, poor care, and lack of privacy at healthcare facilities. By implication, the findings make an important point that because of the negative ramifications these experiences have for women's ability and willingness to access and use SMNHS, Ghana's progress towards achieving MDG 4 and 5 would greatly benefit from holistically engaging with, and addressing these negative attributes of the healthcare system.

But pregnancy and childbirth, as shown in chapter two, is situated at the junction of nature and culture, making accessibility to, and utilization of SMNHS a complex phenomenon, influenced by the healthcare system and socio-cultural factors. In this way, an obsession with the deficiencies of Ghana's maternal healthcare system only provides an unsophisticated partial account at best, and a bias and dangerous account at worse. For this reason, the next chapter engages with different socio-cultural factors that limit women's ability to access and use SMNHS in Ghana.

Chapter 6

‘THE SOCIAL PRESSSURES ARE INCESSANT’: SOCIO-CULTURAL BARRIERS

6. Introduction

What is the role of socio-cultural factors in the access and use of skilled maternal and newborn health services (SMNHS) by women in Ghana? How do cultural beliefs and practices affect the choices that individual childbearing women make and/ or not make in relation to access and use of skilled care? And what role do differences in women’s cultural beliefs and practices play in explaining differences in access and use of SMNHS in Ghana?

The aim of this chapter is to draw on qualitative data generated from focus group discussions (FGDs) and in-depth interviews (IDIs) with women and healthcare providers in the Bosomtwe and Central Gonja districts of Ghana to investigate the way in which socio-cultural factors intermingle with the biological phenomena of pregnancy and childbirth to reproduce and determine women’s decisions and choices about access and use of hospital-based maternal and newborn care services.

6.3 Overview and Context of Socio-cultural Barriers to Access

As a background to the discussion on the socio-cultural barriers to access and equitable use of SMNHS in Ghana, this section offers an overview of the context and nature of women’s experiences as well as healthcare providers’ perceptions of the way in which cultural factors constrain accessibility to, and utilization of skilled maternity care services in Ghana.

Once pregnant, Ghanaian women can theoretically make use of prenatal, antenatal, delivery and

postpartum care services in a wide range of locations or what Jordon (1993) calls birth territories - from the home with family members, friends and traditional birth attendants (TBAs) to rural clinics and ultra-modern hospitals with nurses, midwives, doctors and specialized obstetrical-surgeons. However, the interviews and discussions with women and healthcare providers carried out as part of this study in the districts of Bosomtwe and Central Gonja revealed that in practice, several socio-cultural factors and considerations significantly influenced women's decisions regarding whether to seek care, place of birth, birth position, and even how the mother may or may not behave during this period.

Figures 6.1 and 6.2, respectively, show a summary of statements women and healthcare workers made in response to a question that sought to understand personal, family and community levels barriers to maternal and newborn care services in Ghana beyond health system factors such as service availability and costs. Apart from the health system barriers that were examined in the previous chapter, figure 6.1 shows that at the individual, family and community levels, and in relation to why women do not access SMNHS, 26% (55) of the statements suggested that women do not do so because they lack the decision-making power. Twenty-five per cent (25%) or 52 of the statements also indicated that women are failing to access and use SMNHS due to their religious and other forms of beliefs; 22% (46) of the statements said because of women's fear of being gossip subjects or attracting negative moral judgement from family and community members; 16% (33) of the statement attributed women's inability to access skilled care to the illegitimacy of the pregnancy; while 11% or 23 statements suggested that women are failing to access skilled care because of traditional rituals around pregnancy and childbirth.

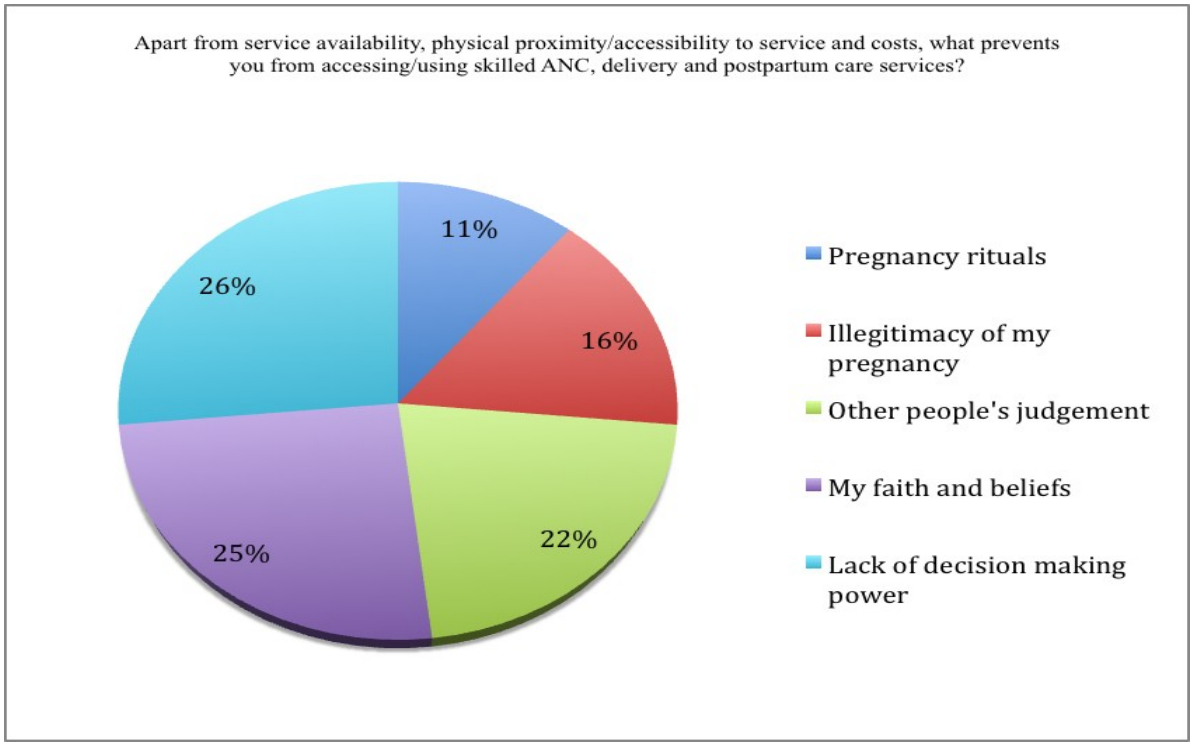


Figure 6.1: Women's experiences of socio-cultural barriers to skilled care access and use (n = 209). **Source:** Author's construct based on qualitative research sample.

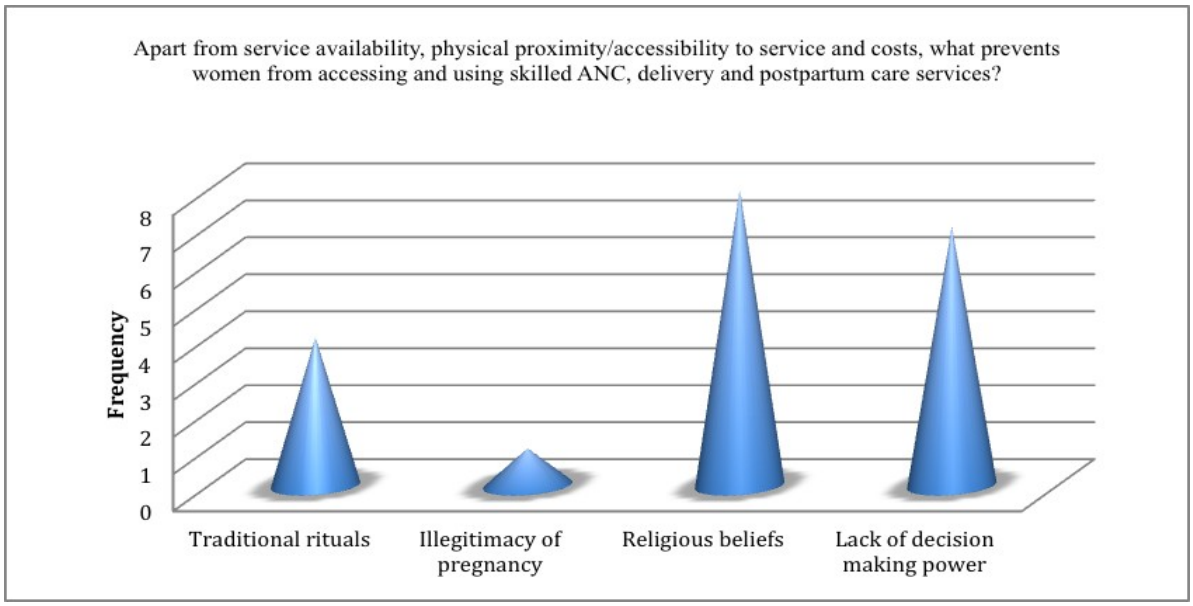


Figure 6.2: Healthcare providers' perceptions of socio-cultural barriers to skilled care access and use (n = 25). **Source:** Author's construct based on qualitative research sample.

Figure 6.2 also indicates that of the 25 cumulative number of statements counted from IDIs with the 20 healthcare providers, 40% (10 statements) suggested women were not accessing and using skilled maternity care services due to religious beliefs; 35% (9 statements) thought it was due to

women's relative lack of decision making power at the family level; 20% (5 statements) said it was related to traditional beliefs and rituals that restrict women's decisions around skilled care accessibility and utilization; while 5% (1 statement) attributed it to the illegitimacy of pregnancy or the newborn child.

Again, it is important to remember that figures 6.1 and 6.2 are not representing the number of women or healthcare providers who responded to the question, neither are they the basis upon which the discussion in the next section is conducted. Rather, the figures simply illustrate a summary tabulation of statements that women and healthcare providers made in relation to what socio-cultural barriers they experienced or believed were preventing women from accessing and using SMNHS in a context where services are offered free at the point of delivery. This explains why it is that figure 6.1 shows a total of 209 statements (n=209) instead of 185, which is the number of women participants. It also illustrates why figure 6.2 presents 25 statements (n=25) rather than the number of healthcare providers interviewed, which is 20. In what follows, the chapter turns to an in-depth examination of the specific ways in which these socio-cultural factors functioned to hinder access and equitable utilization of SMNHS in Ghana despite such services being offered free-of-charge.

6.3.1 Intra-familial Decision-making, Women's Autonomy and Access

One socio-cultural factor that was found to profoundly limit women's access and use of skilled maternity care services relates to women's autonomy in relation to decision-making and physical mobility within the family set-up. As figure 6.1 showed, the majority of statements indicated that women were unable to access or utilize skilled maternal or newborn care services because they lacked the independence to make decisions even in situations where they felt they needed care. In this regard, table 6.1 below summarizes a count of statements women made in relation to the

principal decision-maker(s) or final arbiter(s) in episodes where a woman was unable to access or use skilled ANC, delivery and post-delivery care during her last pregnancy.

In nearly half (49.2%) of the cases, the final arbiter was the husband. In the second highest (16.2%) number of cases, mothers-in-law made the final decision regarding non-access, while in 12.4% of the cases husband plus mother-in-law were the final decision makers. Strikingly, only in 5.4% of the cases were women themselves the final decision-makers.

Table 6.1: Final decision-makers in skilled care services accessibility and utilization.

The last time you were unable to access or use skilled ANC or Delivery or Postpartum care service, who in your household, family, or community made the final decision?	Frequency of Statement	Per cent
Self	10	5.4
Husband	88	49.2
Mother-in-law	29	16.2
Mother	14	8.1
Self + husband	5	2.7
Self + mother-in-law	3	1.6
Self + mother	2	1.1
Husband + mother-in-law	22	12.4
Husband + mother	1	0.5
Mother-in-law + mother	2	1.1
Self + husband + mother-in-law	3	1.6
Total	**179**	**100**

Source: Author's construct based on qualitative research sample.

In FGDs and IDIs, women reported that although they were often expected to nurture their pregnancies and successfully give birth to healthy normal babies, the power to make decisions regarding how and when to seek pregnancy and birthing care is mostly not entirely theirs. Accordingly, such powers are dispersed among a complex network of actors, with husbands and mothers-in-law being seen to have the greatest share of authority as final arbiters.

> The problem is that as a pregnant woman, you can't just get up on your own and say you are going to hospital to check your pregnancy. You have to consult your husband because he is the one taking care of you and he is the one who made you pregnant. So even if you don't feel fine and your man says no you can't go to the hospital, what can you do…you have to wait till he tells you ok, now you can go (Pregnant Woman, FGD, Tidrope, 29/03/2012).

Another participant narrates her experience:

> …When I was pregnant…I didn't go to hospital until it was 8months. I wanted to go but my mother-in-law said I was ok. When it was time for me to give birth too, she said I should deliver at home. I was thinking of delivering at the hospital, but she and my husband were not in favour, so I had no option. I didn't want any problems (Lactating Mother, IDI, Sankpala, 24/03/2012).

One participant also said:

> Are you asking if I went to antenatal? Hummm…I didn't ooo. I wanted to, but the rains had come and everybody was planting their crops and tending their farms. So my husband and mother-in-law said I couldn't leave the farm work and go for antenatal, after all, I was not sick. And when it was time for me to deliver my baby…I had problems…it was difficult. It took some time before my mother-in-law finally told my husband to get a car and take me to the hospital (Lactating Mother, IDI, Abono, 24/02/2012).

A few women however related their experiences, which indicated defiance or at least the potential for defiance in situations where they faced medical emergencies but their male partner or mother-in-law had decided against using health facility services.

> When I was first pregnant, I was not going for antenatal care …my mother-in-law didn't want me to go; she always said I was ok. But inside me I felt like I should go because my friend [Julie] was going all the time. So one day I told my mother-in-law that I must go to see the midwife whether she likes it or not, and I went (Lactating Mother, FGD, Abono, 14/02/2012).

While a few women reported that they defied the decision and wishes of their partner and/ or mother-in-law outright, others said that they found an influential person in the community or a bosom relative or friend of their spouse' to plead on their [women] behalf.

A substantial number of the healthcare providers interviewed for this research (see figure 6.2) also mentioned women's lack of autonomy and control over decisions concerning the use of skilled pregnancy or delivery care services as a major challenge to improving maternal and newborn health.

> You see part of the reason why the women are not coming [to hospital] is because they depend on other people like their husbands to make that decision (District Public Health Nurse, Female, IDI, Kuntanase, 14/02/2012).

> One of the biggest reasons is that many of our women are powerless when it comes to healthcare. This is particularly so with childbirth where husbands, mothers-in-law, TBAs and other family or community members are part of the decision-making process (Midwife, Female, IDI, Sankpala, 23/03/2012).

6.3.2 Religion and Access to Skilled Care

FGDs and in-depth interviews with lactating mothers, pregnant women, nurses, midwives and healthcare managers in the Bosomtwe and Central Gonja districts of Ghana also revealed that within the maternal and newborns healthcare problematic, religious beliefs constitute one significant cultural barrier to equitable access and use of skilled care. As both figures 6.1 and 6.2 respectively show, 25% of the statements women made, and 40% of the statements nurses, midwives and healthcare managers made suggested that women were not accessing and using skilled maternity care services due to religious beliefs.

But how do religious beliefs affect women's decisions regarding access and use of skilled maternal healthcare services? And which religious denominations are less likely to access and utilize skilled care services? Discussions with women and healthcare providers found that the effects of religious beliefs on maternal and newborn healthcare services accessibility and utilization operate via the concept of *faith healing*, the doctrine of maintaining the sanctity of the female body in Islam, as well as the social support networks provided by religious groupings.

> I haven't gone for check-up yet…why? …I believe the best medicine comes from the creator [God]. As a believer [Christian] …I know strongly that there is no medicine that heals better than God's. That is why I pray, and my church members, we all pray to God to protect my baby in the womb from all evil and infirmity, and when it is time for me to give birth, I pray that God will grant me safe delivery without any problems…Of course other women go to hospital all the time to check their pregnancy, but for me, I believe

> everything depends on God and my faith…you can go to hospital thousand times, but if God wishes your pregnancy or delivery not to be successful, no medical doctor can help you (Pregnant Woman, IDI, Kuntanase, 28/02/2012).

In the communities where this research was undertaken, faith healing is practiced among believers of virtually all the religious denominations. However, the first element that this research found to have had profound material bearing on maternal healthcare accessibility and utilization was the beliefs and proselytization of various syncretic Christian religious sects belonging to the Zionist and Pentecostalist denominations.

In all the FGDs with women as well as IDIs with healthcare providers in the Bosomtwe district, it was widely acknowledged that these Pentecostalist and Zionist churches have been growing in Ghana both in terms of the establishment of new branches and in the number of new converts (most of whom are women). Examples included the Apostolic Revelation Society, Jehovah Witness, and *Kyiribentua.* Mention was particularly made of the proliferation of Zionist prayer and healing camps - places where faith healing was mostly practiced. Indeed, not only did the researcher observe the presence of these churches in different parts of Ghana during the course of research, but also several of these prayer and healing centres were noted - usually at very obscure locations on the outskirt of towns and villages. However, because congregants of these religious sects are usually apprehensive of topics relating to medicine, the pregnant woman quoted above was the only participant of a Zionist orientation who accepted to take part in this research. Nevertheless, several focus group discussants in Abono and Kuntanase mentioned women they personally knew who would not access or use any form of orthodox medical care during pregnancy, labour or after delivery by virtue of their membership of one Zionist congregation or the other.

> You know…there are some of the women, no matter how sick they are, they will never take any *abrofu duro* [western medicine] because their faith forbids them from taking

> medicine or going to a hospital. So for such women, when they are pregnant, they never go for ANC let alone think about going to hospital to give birth. I live close to one woman…she is like that… she goes to one church call *Kyiribentua*, and in that church, they don't believe in hospital medicine…even people who are rich and have been to school…all of them don't use hospital medicine (Pregnant Woman, FGD, Kuntanse, 28/02/2012).

Interestingly, some participants also pointed out that women from other mainstream religious denominations including Catholics, Muslims and followers of Africanist traditional religion were increasingly patronizing the prayer and healing services of these Zionist religious sects. According to this account, most of these women initially go to these prayer and healing camps for the sole purpose of finding solutions to problems related to infertility or inability to conceive. However, once conception takes place and a pregnancy emerges, such women feel indebted to these prayer and healing centres and are therefore compelled to obey and live by their dictates and teachings, including upholding a fervent belief in faith healing while rejecting orthodox medicine.

But it is not only the beliefs and practices of Zionists Christians in Ghana that negatively limit women decisions regarding accessibility to, and utilization of SMNHS. In the predominantly Muslim-dominated district of Central Gonja where this research was also conducted, certain Islamic religious beliefs and practices were found to also limit women's ability to access and use health-facility-base maternal and newborn care services. But first note that unlike the Zionists who completely reject western medicine, the researcher did not encounter any Muslim women with such views. There were however sporadic speculations about the existence of few fundamentalist Islamist who also eschew western medicine.

Several personal and interpersonal narratives from women in Mpaha, Sankpala and Tidrope indicated that the Islamic religious faith significantly and negatively impacted women's access to SMNHS mainly through what participants approximated as ''the doctrine of maintaining the sanctity of the female body in Islam''. Basically, the doctrine enjoins Muslim women, especially those who have entered into properly constituted marriages or unions in accordance with Islamic practice, to preserve their physical body away from the prying eye of the public, particularly from the opposite sex with whom they bear no intimate relationship. This is achieved through such putative material practices as proper dressing.

> …The reason why we don't go to the hospital sometimes is that, if you go there they will see your body…your private parts. You know we are Muslims, and it is not proper for people…the men in particular to see us naked just like that. It is not proper Muslim behaviour. We are supposed to dress well and cover our bodies. If you are married, the only male who should see your nakedness is your husband. But as you know, some of these hospitals have men in the place where women go to check their pregnancies or even in the rooms where we are suppose to give birth (Pregnant Woman, FGD, Sankpala, 23/03/2012).

One discussant concurs:

> That is the problem for us here. Sometimes, some pregnant women want to go and check their pregnancy or even give birth at the clinic, but they fear that maybe a male nurse, midwife or doctor will be there or will be made to perform operation [CS] on them. Because Allah - the greatest, the merciful and the benevolent - does not like us to leave our bodies open just anyhow, we feel it is not proper for the doctor to see us naked. Even our husbands would not be happy if that happens (Lactating Mother, FGD, Sankpala, 23/03/2012).

Another participant related:

> For me … when I was having my first child, one day I went to the clinic for antenatal. The midwife told me to go into one room so that she can examine me and turn the baby well [referring to palpation]. When I went into the room, there were two other nurses in there…one was a man. But the midwife asked me to remove my dress and lie down. But the man was there, so I said no I'd wait until the man and the other nurse go out. The nurse was angry and started speaking bad words…me too I became very annoyed and walked out of the room. I never went back there again till I delivered (Lactating Mother, FGD, Sankpala, 23/03/2012).

In this way, some Muslim women found it simply sacrilegious and unacceptable to either undress before a total stranger like a nurse or midwife or allow a male doctor to examine their bodies for the purpose of receiving ANC or delivery care. By contrast, women noted with satisfaction the fact that in some home births, TBAs and other family members who are usually all women, sometimes avoided seeing the labouring woman's vagina while delivering the baby. Accordingly, the perineal area of the labouring woman is covered using a piece of cloth. For them, this was very consistent with their belief in the Islamic doctrine of upholding the sanctity of the female body.

6.3.3 Hospital Delivery, Moral Judgement, and Access to Skilled Care

Interviews with women also revealed that although the Ghana government's position is that all birth must now take place in a healthcare institution under the supervision of trained health personnel, in some communities, a woman who delivers at a health facility is often seen as lacking in self-sufficiency and moral character. One participant explains:

> They will say you are weak or irresponsible if you go there to deliver your baby. That is why some women do not go to hospital to deliver (Lactating Mother, IDI, Kuntanase, 19/02/2012).

Accordingly, the cultural ideal of unassisted labour, including non-health facility delivery, reflects a belief that a woman is typically created competent and self-sufficient enough to give birth unaided or with limited medical support. A common theme that ran through most of the discussions here was that pregnancy is a condition that prepares a woman for a ''battle'' – the battle of childbirth. And there is enormous expectation for every woman to win this battle. How a woman wins this battle is significant in determining her social status in the community. According to this account a ''proper woman'' should never lose the battle of childbirth; for if she

does, it is symptomatic of personal failure. But a woman who delivers by herself is seen as a valiant warrior and is highly respected.

> It was a really great feeling. It was not easy…it was very difficult, but I felt so great after the final push that made the baby slide out. I felt like a hero when I saw my baby because I did it myself without the help of any body (Lactating Mother, FGD, Abono, 14/02/2012).

Another mother relates:

> Me…I have concluded that any woman who can give birth by herself is not a wimp, because if you can give birth you can do any thing. After I had my baby, I felt great. I felt like me too I am capable of succeeding in bringing forth a new life all by myself (Lactating Mother, IDI, Piase, 24/02/2012).

A woman who delivers via the assistance of a medical doctor or by CS is however viewed as failed and weak. It is in this context that some women believe a deliberate movement into a health facility for the purposes of giving birth is an admission of a woman being unable to perform a natural duty and therefore being obliged to rely on medical interventions. Although most participants admitted that sometimes, medical intervention remains the only way to bring about safer birth, the desire to avoid being socially stigmatized as weak helps quell the need for seeking care during pregnancy and labour. Also, the belief that pregnancy and birthing is test of resilience, endurance and tolerance of pain provides the necessary context within which women's decisions and options for seeking care modulate.

In addition, once a woman delivers at a health facility, it is not only her physical competence that is questioned, but also her moral character.

> I believe another reason why we [women] feel reluctant to go and give birth at the health centre is because our husbands and family members will say we have something to hide. You see, here if you go into difficult labour, people believe that you have done something wrong…something like having an extramarital affair outside your legitimate marriage. So this is the time they expect you to confess all your sins…therefore if you go to the hospital and the nurses help you deliver, you will have problems with your family (Pregnant Woman, FGD, Mpaha, 26/03/2012).

Another discussant continues:

> I agree…when I was giving birth to my baby, it was difficult, I was in the house for the whole day and I was feeling so much pain. But the TBA and my mother-in-law kept asking me whether I was hiding something regarding my pregnancy. I said no…but they didn't believe me. They kept on saying I should confess until they noticed that I was starting to bleed a lot. So they took me to the hospital where an operation [CS] was performed to deliver the baby. But since I got back home I have been having few problems with my husband and mother-in-law (Lactating Mother, FGD, Mpaha, 26/03/2012).

Several woman also gave graphic accounts of how in the event of a woman going into a difficult labour, TBAs, mothers-in-law and husbands often spend considerable amount of time waiting to resolve fidelity issues while the lives of both mother and foetus deteriorate.

Indeed, an interview with one of the midwives at the Buipe Rural clinic corroborated the experiences women related above. In one instance for example, the midwife tells of a pregnant woman from a polygynous union who went into a difficult labour and was brought into the clinic by her (the pregnant woman's) mother. Three days after the woman delivered, her husband visited the clinic. However, instead of the usual joy that fathers express when their wives deliver safely, the man became furious upon seeing his wife. As if that was not enough, the man demanded to take his wife home. But as soon as the couple left the premises of the clinic, the man told the wife that he was sending her back to her parents. The reason: the man told the wife that none of his first two wives has ever given birth at hospital or health facility, and that the woman was not only weak but also she was irresponsible for conniving with her mother to go and deliver at the clinic so as to bring him debt. According to the midwife, but for the intervention of community elders, the district director of health and she (the midwife) herself, the couple would have been divorced.

Consequently, although most participants admit that moral judgment and stigma become detrimental to their bodily health and health-seeking behaviour, they tell of the fact that unassisted birth not only earns them respect but also makes their marriages stable. In this way, women's feeling of empowerment and self-worth comes not from the availability of new birthing options and their ability to access or utilize them, but from a desire to maintain stable familial relationships and from a lifestyle seen by others as morally responsible.

6.3.4 Pre-marital Pregnancy, Legitimacy of the Unborn Child and Access

Within the socio-cultural milieu of the communities in which this research occurred, pregnancy, childbirth and parenthood are valued and fulfilling roles. And women who experience these at the right time and in an accepted manner and within a supportive healthcare, family and social network system regard them as positive experiences, which enhance their self-esteem and self-actualization.

> The best thing about conceiving and being pregnant is that you become the centre of attention for everyone around you. That is a really good feeling…you don't think so? Look, in the family, in society, at work, in the market and even at ANC clinics, everyone is very careful with you (Pregnant Woman, IDI, Mpaha, 26/03/2012).

But for a woman to experience this phenomenon at a time and in a manner deemed wrong is the very antithesis of the joy, fulfilment and self-actualization that these roles may confer. Premarital and extramarital pregnancy is one such example. Among the different ethic and cultural groupings as well as religious traditions in the six research communities, premarital and extramarital pregnancy is generally abhorred.

> In most of the communities we serve…a woman who gets pregnant outside or before a legitimately constituted marriage is not only likely to face rejection and ridiculing from her family and the wider society, but also her opportunities for seeking proper medical care during pregnancy, labour and post-labour may be heavily restricted. So sometimes it's not the fault of the women, the social pressures are incessant (Public Health Nurse, IDI, Tamale, 03/04/2012).

Figure 6.1 above lucidly illustrated this point. As high as 16% (30) of the statements the women interviewed made in response to the question of why they failed to access care suggested that several women were unable to access or use skilled birthing services at one point during their last experience of pregnancy or labour due to the fact that their pregnancies were considered illegitimate.

But why should the fact that a pregnancy is conceived before or outside of a legitimate union limits a woman's ability to attend ANC or deliver her baby at a health facility with a skilled birth attendant? This participant explains:

> I gave birth at home. I didn't go to hospital. Why?...I was very ashamed...you see I'm not married, and in this community once you are not married and you become pregnant, people will say you are immoral. Some will even insult you and call your unborn baby bastard. So it is very shameful if anybody ever discovers that you are not married yet you have gotten pregnant. I wanted to avoid all the shame, gossip and ridicule. That is why I kept everything to myself. I was only praying to God to forgive me and help me deliver safely. I thank God that even though I didn't go to see the nurse with my pregnancy, when it was time for me to give birth, everything went fine (Lactating Mother, IDI, Abono, 21/02/2012).

Another continues the explanation:

> The problem is that it's not that I didn't want to go for antenatal or even deliver my baby at the hospital. The issue is that I'm married and we had one child. But my husband travelled to Libya for two years now. I...I...I was lonely and I thought I needed to have a bit of company. Everything was done in secret. Unfortunately, I got pregnant and I didn't want to abort the pregnancy. But at the same time...I didn't want anybody to know. I am a Christian, and you know...I was afraid that if my family and church people get to know I was finished! I was so afraid my father would ban me from coming near him. I was also afraid that people, especially my church members would gossip about me and say that I have been committing adultery. Because of all these things I never wanted anybody to know. I basically went into hiding as well as wearing cloths that made it hard for people to know that I was pregnant...So you see if I went to the hospital to see the nurse about my pregnancy, then people would have seen me and everything would have gone wild (Lactating Mother, IDI, Piase, 25/02/2012).

Another woman adds:

> I think one reason why some women in Mpaha do not go for antenatal or give birth at the hospital is because of shame. This is because when they get pregnant at the wrong time or not in the correct way…what I mean by wrong time and correct way? I mean when they are not married…when they are still too young, maybe still in school or even when they are married and yet they go out to become pregnant for another man. The thing is most people here are Muslims and Islam frowns on premarital or extramarital sexual affairs on the part of women (Pregnant Woman, FGD, Mpaha, 26/03/2012).

The situation was often exacerbated if the pregnant woman was an adolescent. Several women reported that adolescent pregnancies were particularly problematic because such young girls do not usually want people to know about their pregnancy. Health workers were also reported to regularly abuse or ridicule teenagers and unwed mothers. Indeed, on all the occasions that women spoke of the illegitimacy of their pregnancy as a barrier to skilled care access or use during interviews, the researcher was particularly struck by how women focused on what others would think, say and do when they learn of their pregnancy. Women were especially concerned about the stories and gossip that would be told of, and circulated about them, and the way these would be full of negative judgements. In an effort to minimize shame and ridicule as well as maintain their dignity, such women felt that they needed to keep secret their so-called illegitimate pregnancy by not accessing and using skilled care while faithfully enduring what some characterized as ‘‘quiet suffering’’.

6.3.5 Primiparas, Pregnancy Rituals, and Access to Skilled Care

In chapter four, it was shown that while access and use of skilled ANC services is generally high across all segments of the pregnant women population in Ghana, access and use of skilled health-facility delivery and postpartum care services are relatively low. Primiparas (first-time mothers) are one sub-population known to be less likely to attend ANC, deliver at a health facility or seek skilled postpartum care. Indeed, it has been observed that primiparas constitute a crucial target population for skilled maternity care services, because once a first time mother has had a

successful non-skilled maternity care experience, it is five to seven times more difficult to convince her to use skilled care services in future pregnancies (Yanagisawa *et al*, 2006).

FGDs and IDIs with women in the Bosomtwe and Central Gonja districts of Ghana suggest that cultural beliefs and rites of passage around first-time pregnancy limit such women's ability to access and use SMNHS. As was shown in figure 6.1, 11% of statements the women interviewed made in relation to the reasons why they did not access care attributed women's inability to access and use skilled maternity care services in part to restrictions imposed by certain pregnancy rituals. One such cultural ritual is the practice of *trigibu* among the Gonjas and Dagombas – the two main ethnic groups of the Central Gonja district.

Basically, *Trigidu* describes the practice whereby after the first and second trimesters or first six months of pregnancy, primiparas are formally and openly declared pregnant. One woman gave an account of *trigibu* thus:

> *Trigibu*…it is our tradition…our culture that our forebears handed down to us. It usually involves series of elaborate ritual preparations that culminate in a communal ceremony during which a sister-in-law (where the primigravida is married) or an elderly woman (where the pregnant woman is not married) jokingly and publicly slaps the pregnant woman and openly declares that from today, you [pregnant woman] shall be called pregnant. After this open declaration, food and drinks are shared (Pregnant Woman, FGD, Sankpala, 23/03/2012).

Fundamentally, *trigibu* is grounded in the Dagomba's and Gonja's belief that exposing one's pregnancy during the early stages makes them vulnerable to attack by evil spirits, witchcraft and jealous community members. It is the idea of vulnerability of mother and unborn child during pregnancy and the need to protect mother and foetus, that provide context for proscribing, instituting and enacting myriad of rituals and behavioural codes for expectant women. Consequently, under the dictates of *trigibu*, a primigravida is culturally prohibited from making

her pregnancy public during the first and second trimesters. Rather, she is expected to carry and nurture her pregnancy in secrecy until after such a time that the family is able to organize and perform *trigibu*.

In addition, during this period, primiparas are expected not to travel out of the home for relatively long distances including visiting a healthcare centre. This travel restriction is meant to prevent a situation whereby a ‘‘stranger’’ would incidentally address the primigravida as a pregnant woman prior to the performance of *trigibu.* Benign as this cultural ritual may be, majority of the women were unanimous in their responses that it does serve three purposes: to protect mother and foetus during this period of vulnerability, ensure safe delivery, and to enhance the delivery of normal healthy children.

But the researcher’s engagement with women and healthcare providers especially in Mpaha, Sankpala, Tidrope and Buipe reveals that *trigibu* indeed does impose significant limitations on women’s ability to access and use skilled birthing services in a number of ways. The need for secrecy and the limitations imposed on travel by the non-performance of *trigibu* means that primiparas usually avoided getting prenatal check-ups, at least during the first six months of pregnancy. Similarly, the need to protect oneself socially through compliance with the dictates of *trigibu* as well as the resources required to perform *trigibu* overwhelmingly outweigh the need to protect oneself biologically. One participant illustrates:

> *Trigibu* is our tradition. It is good, because it helps protect our unborn babies and us from evil. It is just that sometimes it is not too good. When I was pregnant, I wanted to go and see our nurse early, but I did not go to see the nurse during the first five months because my husband was not ready for the family to perform *trigibu*. It was only after the first six months when *trigibu* was performed and both the secrecy of pregnancy and travel ban were lifted that I was able to openly declare my pregnancy as well as go to the nurse to check my pregnancy (Lactating Mother, FGD, Sankpala, 23/03/2012).

Another woman interjects:

> I agree… *trigibu*…it is the tradition here. It is good, but you see it is not always easy to organize and perform *trigibu* because you need money. So sometimes for some pregnant women, *trigibu* is done very late or it is not done at all. In that case such women cannot go to hospital even when they are sick (Lactating Mother, FGD, Sankpala, 23/03/2012).

For fear of receiving reprisals from healthcare providers for either seeking ANC service late or totally missing out on ANC due to late or non-performance of *trigibu*, participants related how several pregnant women often reneged on seeking skilled care but resort to other home-based self-medication including giving birth at home with the assistance of TBAs and family members.

Findings from IDIs further revealed that once a primigravida failed to attend ANC or deliver at the health facility due to delayed or total non-performance of *trigibu*, but all the same goes on to have a safe home birth, such women often tended to access and use less of skilled care services in future pregnancies or labour. One participant relates her experience:

> Are you asking why I didn't go to give birth at the hospital? I didn't go because when I was pregnant with my first son, I didn't go to hospital for check-up or delivery. I gave birth at home and my delivery was ok and my boy too was fine…For my first son, I didn't go to the nurse to deliver because I didn't go for check-up when I was pregnant. I was unable to go for check-up at that time because by the time my family performed the necessary ceremonies [referring to *trigibu*], I thought it was too late. I feared that if I went to the nurses, they would be asking me too many questions. That is why I decided to give birth at home. But for this one [referring to her three-month old baby], because I didn't have problems with my first delivery, I imagined that this one too would be the same. I thought it was not really necessary to go and see any nurse (Lactating Mother, IDI, Tidrope, 29/03/2012).

In this way, the negative effect of *trigibu* on skilled care accessibility and utilization extends far beyond primigravidae and ANC. In fact, the effect among primiparas is rather undesirably self-perpetuating.

6.4 Conclusion

In a country of more than 24 million people with multiple ethnic, tribal, and religious groupings, it is hard, if not impossible, to say anything about phenomena such as pregnancy, childbirth or the factors that limit access and use of skilled birthing services that would hold true all the time and for the different regions, districts, communities and peoples of Ghana. Based on thick and fine-grained accounts of pregnant women, lactating mothers and healthcare providers in two districts however, this chapter aimed to examine the role of socio-cultural factors in accessibility to, and utilization of SMNHS in Ghana.

My findings suggest that social expectations, women's religious beliefs, cultural beliefs and practices, negative conceptions of health-facility birth, as well as women's relative lack of power and freedom to make decisions regarding access and use of skilled birthing services have particularly combined to limit some women's ability to access and use skilled birthing services. In this way, the chapter not only demonstrated that childbirth in Ghana is uncomfortably situated at the junction of biology and cultural politics, but also that pregnancy and childbirth is perhaps one of the most culturally ritualized rites of passage in family life. Like death and disease, childbirth is a natural biological event, so that in bearing a child, a woman performs an important biological function of procreating and reproducing the human species. Yet, the biological act of childbirth is everywhere socially marked and accomplished in and significantly shaped by socio-cultural politics. In this cultural politics, the biological act of childbirth becomes a diffuse social entity constructed in discursive practices and shaped and reshaped by cultural, social and political influences that all determine women's access and use of birthing care services.

Therefore, whether a pregnant woman goes for antenatal check-up at the health facility, and/ or utilize skilled delivery and postpartum care services depends not only on whether these services are readily available in close proximity and at an affordable price, but importantly on both the cultural acceptability of the service and a woman's agency or ability to negotiate these societal norms, cultural proscriptions and religious dictums and discursive practices that govern and regulate decisions and behaviour during pregnancy, labour or immediately thereafter.

The findings in this chapter therefore suggest that the benefits to be had from any birthing policies can be enhanced and made more useful to women if such policies are attentive to the circumstances of women. In particular, the findings highlight the important point that effective progress towards equitable access to SMNHS in Ghana would require healthcare providers to acknowledge not only the limitations imposed by health system barriers, but also cultural factors as well such as *trigubu,* and then devise public health strategies to redress them. For this reason, the next chapter considers different proposals made by women and healthcare providers alike to redress the challenge posed by health system and cultural barriers to access and use of SMNHS in Ghana.

Chapter 7

TOWARDS INCREASED AND EQUITABLE ACCESSS: STAKEHOLDERS' PROPOSED SOLUTIONS

7. Introduction

A central objective of this research is to identify potential strategies for tackling poor and inequitable access and use of skilled maternal and newborn health (SMNHS) in Ghana. Based on women's and healthcare providers' experiences and accounts of what works to promote safer pregnancy and childbirth, this chapter presents a number of proposed solutions by the women and healthcare providers interviewed for this research. The aims of the proposed strategies are, first, to counter and correct the negative aspects of the maternal healthcare system in Ghana that dis-incentivize accessibility and utilization of existing skilled care services, and second, to accelerate increased and equitable access and use of skilled care services.

7.1 Towards Increased and Equitable Access to SMNHS in Ghana: Overview of Stakeholders' Proposed Remedies

Recent global maternal and newborn health (MNH) policies for reducing mortality and morbidity emphasize the need for skilled attendants and equity in access to health facility birthing services. In my focus group discussions (FGDs) and in-depth interviews (IDIs) with women and healthcare providers in Ghana however, it became clear, as discussed in the previous chapter that, not only are such potentially life-saving care services limited and/ or unequally available to the population, but also that where they readily exist and can easily be accessed and used at no or minimal cost, they can be unfriendly, culturally unacceptable, degrading or even abusive to women. My research suggests that this experience and perception is at the heart of under-accessed and inequitable use of SMNHS in Ghana despite these services being free. In addition, cultural factors such as women's religious beliefs, cultural beliefs and practices, negative conceptions of health-facility birth, and women's relative lack of power and freedom to make decisions have also combined to constrain some women's willingness and ability to access and use SMNHS.

The natural questions flowing from this are: How can these access barriers be eliminated or reduced so as to increase access and reduce inequities in access and use of SMNHS in Ghana? How can the unfriendly, culturally unacceptable, degrading or even abusive care that women experience in and outside of the maternity healthcare system in Ghana – experiences which negatively affect women's healthcare access and usage choices and behaviours - be redressed? What factors enable and promote access and use of SMNHS in Ghana? And what strategies can maternal healthcare providers in Ghana pursue to accelerate increased and equitable access and use of skilled antenatal, delivery and postpartum care services? These were questions that the researcher kept asking during the six-month-long period of interviews and discussions with pregnant women, lactating mothers and healthcare providers in Ghana.

Table 7.1 gives an overview of participants' responses, grouped into pregnant women and lactating mothers on the one hand, and healthcare providers on the other. The proposed solutions are further subdivided into 'solutions to health system barriers', and 'solutions to cultural barriers'. Of course, this dichotomization is rather arbitrary as some of the proposed solutions (e.g. health education) have the potential not necessarily to be mutually exclusive to any one of the two categories. However, this subdivision serves as a pragmatic way of aligning the proposed solutions directly with the access barriers discussed in chapters 5 and 6.

Of particular significance are the different ways in which women's priorities and proposed remedies diverge and converge with those of healthcare providers. For instance the majority of the statements (31%) the healthcare providers made believed that women needed more health education to understand both the risks of pregnancy and childbirth and the importance of seeking skilled care.

Table 7.1: Stakeholders proposed solutions.

Proposed Solution	Pregnant Women & Lactating Mothers		Healthcare Providers	
	Frequency of Statement	Percentage	Frequency of Statement	Percentage
Solutions to Health System Barriers				
Improving coverage and quality of skilled maternity care services	35	9.2	10	15
Expanding free emergency ambulatory services	29	7.6	7	10
Humanizing hospitals & doctor-patient relationship	83	22.2	6	9
Promoting choice in skilled maternity care	32	8.6	0	0
Training and motivating more midwives	4	1	13	20
Building partnerships with TBAs, community leaders and other non-state actors	2	0.6	3	5
Solutions to Cultural Barriers				
Promoting male involvement in maternity care	48	12.9	3	5
Domesticating skilled maternity care	63	16.8	3	5
Cultural adaptation of birthing services	79	21.1	0	0
Health education	0	0	20	31
Total	**375**	**100**	**65**	**100**

Source: Author's construct based on qualitative research sample.

On the contrary, none of the statements the women made in relation to how to reduce barriers to access and use of SMNHS suggested that more health education was needed. Similarly, whereas the statement most commonly made by women interviewed emphasized the need for 'humanizing hospitals and doctor-patient relationship' (22.2%) to promote patient-centred care, only 9% of the statements the healthcare workers interviewed made suggested poor doctor-patient relational practices at healthcare facilities as a disincentive to skill care access and therefore needed immediate redress.

Again, whereas 20% of the statements healthcare providers made emphasized the need for training and motivating more midwives to provide skilled and responsive care, only 1% of the statements women interviewed mentioned training more midwives as a strategy to ensure increased and equitable access to SMNHS. Furthermore, whereas 21.1% and 8.6% of the statements women made, respectively, emphasized the need to adapt modern maternity care services to ensure cultural acceptability, and the promotion of more options and choices during

birth, none of the statements made by healthcare providers believed these were important for accelerating access and use of skilled care services.

These seeming disjunctions clearly have implications for successful organization and delivery of maternal health care services. And this issue will be returned to in the next chapter. For the moment, in this chapter, I now turn to a detailed presentation and discussion of the proposed solutions to tackle the challenges of maternal and newborn healthcare access in Ghana, which emerged in my interviews and focus groups.

7.2 Stakeholders' Proposed Solutions to Health System Barriers

At the level of the healthcare system, participants in this study proposed a number of potential solutions to tackling access barriers, promoting access, and reducing inequities in access and use of SMNHS. These have been grouped under six main headings, namely 1) improving coverage and quality of services; 2) expanding free ambulatory services; 3) humanizing hospitals and doctor-patient relationships; 4) promoting choice in skilled maternity care; 5) Training and motivating more midwives; and 6) building partnerships with traditional birth attendants (TBAs), community leaders and other non-state actors. Each of these is examined below.

7.2.1 Improving Coverage and Quality of Services

Throughout the period that qualitative research for this thesis was undertaken, women and healthcare providers highlighted the importance of safe pregnancy, childbirth and mother-child survival and argued that abolition of user fees for MNH care services was the right thing to do. This was bolstered by what health policy makers at the Ghana Health Services' (GHS) headquarters in Accra termed the 'vulnerability' or 'social justice argument': that women and children are often poor and vulnerable in society hence easing the financial burden on their

healthcare needs, was only fair and just. Many healthcare providers particularly made reference to increases in more complex live-saving interventions such as caesarean section s (CS) that were now offered free-of-charge to women who may need such services but who may otherwise be unable to afford them due to the high costs associated with such services.

However, both the women and healthcare workers sampled acknowledged that Ghana was still a country characterized by unbalanced distribution of maternal health services (between and within regions, districts, and communities) and poor quality of care. They acknowledged that this has resulted in some women lacking complete access or experiencing grave difficulty when it comes to access and use of SMNHS. To remedy the situation therefore, a significant number of the study participants recommended the expansion of coverage of skilled maternity care services to improve access.

> They [government] must build more clinics…it is not this community alone; there are so many villages in this area who don't have clinics. This makes it hard for many of us especially when it is rainy season to go to antenatal let alone think about going to hospital to give birth. But if we have one and there is a nurse around, then things will be better…many women may go to hospital (Pregnant Woman, FGD, Abono, 14/02/2012).

One woman also opines:

> The solution to me is, they [government] should bring a clinic or a nurse to this place. That way, people will not feel lazy or they will have no problems travelling again (Lactating Mother, IDI, Tidrope, 30/03/2012).

But in addition to improving coverage of services, several women also argued for more attention to be paid to improving the quality of care at existing health facilities.

> …Well, if you ask me, I will say that the health people must make sure that they take good care of pregnant women when they [women] go to them. They should make sure all the things they need like medicines or blood are available…sometimes, you struggle to go to the hospital only to be told that there is no medicine or they will just ask you to go to a drug store and buy. This is not fine…it makes us very reluctant to go to hospital (Pregnant Woman, IDI, Kuntanase, 19/02/2012).

Another woman said:

> The health people should change…because now that the government is saying it is free for us pregnant women, when you go there they don't care for you well. But if you go to a private hospital, they will charge you a lot of money, but they will also give you good medicine…they will care for you well. That is why I always go to a private clinic…that place, things are better. So the government hospitals should copy the private hospitals, that way, things will be better and more women will go there (Lactating Mother, IDI, Kuntanase, 19/02/2012).

Within the top hierarchy of the GHS, many of the respondents the researcher interviewed supported the view that coverage and quality of skilled maternity care services should be improved. Indeed, a few believe it was wrong in the first place to start a free maternal healthcare policy when service coverage was already limited and quality of care sub-standard.

> I can tell you that we still have the old problems…we haven't solved them, I mean we're still faced with the old problems of limited coverage and mal-distribution of services as well as poor quality of care. I believe this is what we should actually have done first before embarking on the free maternal health policy. We should have extended service coverage to every part of the country and also invest more resources into improving the standards of antenatal and delivery care that the health facilities provide. That is what we really need to do now, otherwise, we're not going to make any good progress…I can tell you that because the service distribution is very unbalanced, especially in the northern parts of the country, we have not been able to solve the problem of access inequities with this policy. So you see, we need to go back to the basics. I think it might even be better to let women pay a token for readily available quality services than say the services are free, and yet the women can't access them (Male, Deputy Director, Policy Planning, Monitoring and Evaluation, GHS, IDI, Accra, 27/04/2012).

Another participant relates:

> We have made progress in the past years, but to make better progress, we have estimated that we need about US$52million worth of investment into maternal health. We need this investment to expand service coverage and improve quality as well. This is one area that we must focus on…we have to be able to expand service coverage to correct the inequities in the distribution of services and health personnel between urban and rural areas, especially in the northern part of the country (Acting Director, Policy Planning, Monitoring and Evaluation, GHS, IDI, Accra 04/05/2012).

In the northern region and Central Gonja district, the issues of redistribution and targeting were particularly emphasized.

> I think the problem we have in the health sector is how we distribute health facilities and allocate resources and personnel to different regions and districts. Right now, most allocation decisions are based on how many hospitals you have in an area and not about whether the people there are in more need. So if we want to make progress, we must be able to redistribute resources…we must stop concentrating all the resources and personnel in Accra and Kumasi or the other urban areas. We have to make sure that there is equity in the distribution, otherwise, how are we going to achieve equity in the outcomes that we want? In this region [referring to the northern region], I don't think we can do much if we do not look at the way we allocate health personnel…we need to target more resources to deprived communities so that they too can have access (Male, Regional Director of Public Health, IDI, Tamale, 20/03/2012).

Indeed, my analysis of the survey data and the interviews and focus groups I conducted suggest that the fee exemption policy has not changed much of the dynamics of access to SMNHS since many of the women who were hitherto excluded from the formal healthcare system continue to be excluded. It is for this reason that these participants identified the availability of good-quality maternal health services as crucial for improving equity of access and maternal health outcomes. If Ghana is to reap the full rewards of the free maternal healthcare policy, there will not only be the need to initiate efforts to redistribute maternal healthcare services and personnel but also consideration to provide free or subsidized transport or ambulance services as well as reimbursements of patient transport costs.

7.2.2 Humanizing Hospitals and Doctor-patient Relationships

The word 'hospital' derives its original meaning from the Latin *hospitalis*, which generally connotes 'hospites', 'guest' and the notion of hospitality (Turner, 1987). Despite this, for majority of the women interviewed in this study, the hospitals, and health centres or clinics in Ghana come with a sense of fear. This sense of apprehension originates not only from the unfamiliarity and anxieties women faced from mammoth structures of exotic buildings (buildings

which usually do not bear resemblance to the small houses in their own communities) to teaming crowds of patients, but also from the austerity of maternity ward surroundings and the poor quality relationships that often characterize the encounter between patients and caregivers. This has resulted in many women opting out of the formal healthcare system where SMNHS are provided free-of-charge.

To reverse this, the women interviewed argued for promoting a regime of care that is patient-centred. Within this idea of putting the needs of patients at the centre of care, women called for healthcare facilities and doctor-patient relational practices to be 'humanized' through softening the austerity in maternity wards to make them patient-friendly.

> One problem is that the health facilities and the workers are supposed to serve our needs. Unfortunately, you will go to the hospital and the workers will treat you like *a boar bi* [some animal]…I mean they are not friendly and so they make the whole hospital or clinic very hostile to the very patients they are put there to help. I believe if they really want us [women] to come regularly to check our pregnancy or even born our babies in the hospital, then they have to change the way they treat us, they should be more friendly, compassionate and treat us like human beings (Pregnant Woman, FGD, Kuntanase, 28/02/2012).

Another participant agrees:

> I totally agree with Maame Yaa. And I can give you an example here. At Kuntanase hospital, there used to be one midwife…she was very nice to all the women who go to her…she will chat with you nicely when examining you and she will take her time to advise you very well. Even when you make a mistake, she will not just shout at you, but she will take her time to talk to you. So a time came that all the pregnant women wanted only that midwife to attend to them. In fact, when I was pregnant, I went specifically to see her. But now, she is no more. She has been sent to a different place. And most of the new people are not friendly at all. That is why many people are not going there [Kuntanase hospital] these days. That is why (Lactating Mother, FGD, Kuntanase, 28/02/2012).

Another woman adds:

> Another thing is… I believe if the nurses can change and treat us nicely or if they can make the clinic look like home…say if they can provide kitchen and utensils so that family

> members can prepare food for the woman after delivery or even if they can provide a place where accompanying family members can wait comfortably for the pregnant woman to deliver, that will be good. You see, many people come from far away villages and they don't have any place in Mpaha here where they can rest or sleep while waiting for the woman to deliver. At times, you will come here and see people sitting outside under trees or leaning against corridor walls or even sitting on the floor of corridors. This is not good (Pregnant Woman, FGD, Mpaha, 26/03/2012).

Among healthcare managers within the GHS, there is indeed a recognition that improving the doctor-patient relationship at healthcare facilities is an important approach to attracting more women into the formal healthcare system to receive SMNHS. One of the regional directors of public health spoke of the need to pursue a 'Labour-Ward-Friendly-Concept'.

> To move forward, I believe we the healthcare providers need to focus on how we treat the women who come to us. We must focus on making all our facilities and especially labour wards patient-friendly…this is basically an idea to provide friendly maternity care services, clean healthcare facilities including bedding in labour wards, as well as friendly wall paintings in antenatal clinics and labour wards. In fact, we have started piloting this at the major hospitals, and the reports we are getting is very positive. So I think if we can roll-out to cover all the health facilities at the district and community levels to ensure that our caregivers and healthcare facilities are patient-friendly and meet the needs of pregnant women, then we will be on course to removing all the negative experiences that women go through when they come into our facilities and ensuring that every woman in the region accesses and uses skilled antenatal, delivery and post-delivery services as and when they need them (Male, IDI, Kumasi, 13/03/2012).

One regional public health nurse also recommends:

> As a regional health directorate, I think we need to focus on improving the relationships between pregnant women and caregivers. I mean, more patient-centred care that is able to address the special needs of women, accord them respect and assure dignity anytime they visit a health facility (Female, IDI, Tamale, 03/04/2012).

Humanizing hospitals and doctor-patient relationships, these participants noted, will require emphasizing basic relational practices in maternity care as well as training and constantly retraining health facility managers, nurses, midwives and doctors in patient-centred care and enforcing good and ethical codes of practice in antenatal clinics and labour wards. In addition, it was reported that such a system of care would require the institutionalization of a sanctions

regime whereby caregivers whose practices contravene good practice and ethical standard of care, thereby obstructing women's healthcare seeking choices, are penalized.

7.2.3 Expanding Free Emergency Ambulatory Services

One strategy that both women and healthcare providers proposed is the expansion of free ambulatory services to all parts of the country. Under the current regime of care, ambulatory services are not covered by the fee exemption policy. Moreover, ambulatory services are very limited, often ineffective, and usually restricted to urban centres. In communities such as Abono and Tidrope where there are no formal healthcare facilities, and where transportation is difficult and expensive to arrange in the event of medical emergency, women noted that providing free and responsive ambulance services would make it possible for more births to take place in hospitals.

> One thing they should help with is the issue of transportation…I mean how to get car when labour sets in unexpectedly or in the night. Right now, they say it is free if you go to hospital to deliver, but you see it is not easy to get to the hospital…the cost is huge… and if you can't reach the hospital, how can you benefit from this free thing. If the government is serious, then it should also provide transportation or even if they can pay for that, it will encourage more women to go to hospital when they are pregnant (Lactating Mother, IDI, Tidrope, 30/03/2012).

One woman also said:

> What they [government] can do? Is that what you are asking me?…ok, I think the health people should do something about transportation. Here it is even better but if you go to most of the communities around this lake [referring to Lake Bosomtwe], things are bad… they can't get car when there is problem, and even if they get, it is very expensive. So the government should help us with a car [referring to ambulance] that can come and help when there is problem. Or they can even choose some of the taxi drivers in this community and give them something…like money or petrol so that anytime there is a problem they will be ready to help. If they don't do that, the whole thing [free maternity care] will not work well, because if people can't get to the hospital in good time, then it is only free for nothing or only for those who have the means to get to the hospital (Pregnant Woman, IDI, Abono, 24/02/2012).

Although many community health nurses and midwives acknowledge the constraints imposed by resource scarcity, there was still consensus that providing free ambulance services that can serve rural women who face transportation problems is one effective way to increase hospital delivery by facilitating prompt referrals and transfer of patients to health facilities where needed care could be provided.

> Look around here…what can you see? We have only one vehicle, a pick-up car, which our in-charge uses, and some motorbikes. But even now our car is broken and there is no ambulance too at Buipe, the district capital. So if there is an emergency that we have to refer, it is a big problem because even if you refer the woman, where will she get the means to go to… say Buipe, Tamale or Kintampo hospital? So it is true that the maternal health services we offer are free, but at times how to get women to the health facilities where they can enjoy these services is not easy…sometimes, we can't blame these women. Maybe the resources are not enough, but the government and Ghana Health Service have to do something about this…like provide ambulances for all clinics, health centres and even CHPS zones so that it will be easy to respond to emergencies at the community level (Female, Community Health Nurse, IDI, Mpaha, 26/03/2012).

Even in urban settings where public and private transport services are mostly available, both expectant mothers and frontline healthcare workers reported urban public transport presents its own challenges when it comes to it use for maternal healthcare purposes. For instance, it was reported that in many instances a pregnant woman still has to walk or be hand-carried either from home to bus terminus or from bus terminus to the healthcare facility when public transport is used. In other cases, pregnant women may even stand in the vehicle when it is full. Delays associated with the operations of these transport services often cause further delays in reaching a health facility too. Moreover, expectant mothers often endure traffic jams on the way, and this also results in delays in getting to healthcare centres. Thus there is widespread support in both rural and urban Ghana for the provision of free ambulatory services, or at least a system that will reimburse women with transport costs whenever they access skilled ANC or delivery services at a health facility.

7.2.4 Promoting Choice

Within reproductive medicine, 'choice' or 'right to choose' is a term very explicitly associated with the need for women to exercise control over their reproductive health decisions. For several of the women sampled in this research however, there are limited birthing choices offered by the modern Ghanaian maternity healthcare system, and this has largely acted to exclude several women who desire some choice and freedom during pregnancy or labour. For this reason, some women in this study are of the opinion that ensuring increased access and use of SMNHS for all women would require offering them some choice and the right to choose how, where, and with whom to give birth.

> Another thing they [referring to health caregivers] can do to encourage more women to attend ANC regularly or give birth at hospital is to permit pregnant women to choose… like the nurse or midwife they want to go to or the position they want to be in to deliver. This is because if you go to the hospital to give birth, they normally put you on a small straight bed…you can't even turn. Sometimes, they even tie your hands to make sure you don't move. But in the house…you know…you can move around, lean against the wall, squat, sit down or even lie down while you are in labour or when delivering the baby. But in the hospital, it is only one way …you have to lie down on their bed. For me this makes things difficult (Lactating Mother, IDI, Piase, 24/02/2012).

Another participant recommends:

> I believe if the nurses want more pregnant woman to come to the clinic, then they must be willing to listen to us sometimes. I am saying this because when you go to the clinic the nurses do things like they know everything…they always want you to do what they want you to do whether you can do it or not or whether you like it or not. For example, when I went to the clinic to deliver my second baby, they put me on the bed and asked be to lie on my back. But I said I am not used to lying on the bed and delivering and that if I did that it would be hard for me to push well. I wanted to squat like I did at home when I was delivering my first baby. But the nurses said no…they forced me to lie down… hhmm…that day how I suffered before the baby came out! So, when I became pregnant gain, I told myself…me, I am not going back to that clinic where they will put me on that bed again which will make things hard for me. So if they want us to come, they must allow us to choose some things (Lactating Mother, IDI, Sankpala, 22/03/2012).

One participant also said:

> This policy [free maternal healthcare policy] is good, but the problem is that if you want to enjoy the benefits, then you have to go to the hospital even if you don't like it. But in the hospital too, not all the nurses and doctors are correct, and yet you can't choose the one you want to care for you. Even sometimes, if you prefer a woman nurse, midwife or doctor to examine your stomach or deliver your baby, you will not be given that chance, maybe they will tell you that the only person there is a man. And you know as Muslim women, it is bad for a man to unlawfully touch you. When this happens, then you would not like to go there again. So I think that the hospital workers should listen to us more to understand our problems so that they can best give us the help we need (Lactating Mother, FGD, Sankpala, 23/03/2012).

While a significant number of women believed that giving more opportunities to women within the formal healthcare system to decide how, where, and with whom skilled maternity care services is accessed and used was vital for improving maternal and newborn health outcomes, the concept of choice appears removed in the context of Ghana's free maternal healthcare policy. Throughout the period of empirical research in Ghana for example, little was heard either among frontline caregivers like nurses and midwives or among senior healthcare managers like district and regional health directors about the need for women to be offered choice in relation to how, where, and with whom skilled care may be obtained.

7.2.5 Training and Motivating more Midwives

About a quarter of the statements healthcare workers interviewed made diagnosed the problem of poor maternal health in Ghana as two-fold: limited numbers of trained qualified personnel such as nurses and midwives to provide care at the community level; and poor remuneration. As a remedy, these participants proposed that more midwives be trained, remunerated and motivated highly to deliver quality service to patients.

> As you can see, I am the only midwife, so any time I am not available there is nobody around to attend to the women. I have written to the health directorate to ask for an assistant, but they say there are few midwives in the district…some health facilities don't even have resident midwives. I believe if we want to improve care, we have to change; we must be ready to train more midwives and give them incentive packages like good accommodation so that they can stay in the communities to provide care (Female, Midwife, IDI, Piase, 24/02/2012).

One participant also narrates:

> Here in the northern region, we lack midwives and doctors. A lot of them do not accept postings to this place, when they do come they all want to stay in big towns like Tamale. For example, in 2010/2011, about 13 new doctors were posted here but none of them has reported…we have followed up several times, but nothing has been done…How can we provide quality care if we don't have trained personnel? We need to put priority on training more midwives so that we can flood the system, that way we will be able to improve access to care (Male, Regional Director of Public Health, IDI, Tamale, 20/03/2012).

Another participant also recommends:

> At this facility [referring to Mpaha Health Centre], there's no midwife…one came but took a transfer to the city…why? Well, she said conditions here were harsh…no electricity and all that. So we need more midwives…the government must train more… they should also give them more incentives, especially those who accept posting to remote areas. If the government doesn't do that, then it will be hard to improve maternal health (Female, Community Health Nurse, IDI, Mpaha, 27/03/2012).

In all the above recommendations, there were emotive accounts of how inadequate staffing of health facilities, coupled with poor working conditions, often led to stress, overwork and lack of enthusiasm among the few healthcare providers in the system. For example, there were reports of healthcare staff working long hours (80 hours per week for public midwives, 110 for doctors and 127 for medical assistants) in contexts where they are in-charge of health centres.

7.2.6 Building Partnerships

In chapter five, the tensions that exist between women's cultural values, preferences, and religious beliefs and practices on the one hand, and accessibility and utilization of SMNHS during pregnancy or labour on the other hand, was shown. Indeed, within the highest and lowest echelons of the GHS, there is widespread acknowledgement of the different ways in which women's preference for TBA birthing services at home and faith healing services offered by Zionist Christian religious denominations co-mingle to undermine efforts to extend skilled

birthing services to all women in Ghana. Despite this recognition, there is little discussion as to how to redress the tension and challenges posited by women's traditional and religious beliefs and practices. Indeed, as one participant noted:

> The subject remains a no go area for healthcare mangers and policy makers…we all know that women's religious beliefs and some traditional practices negatively affect their willingness and ability to access and use maternal healthcare services at our various health facilities. The issue is we don't know how best to tackle it, and many healthcare workers don't even want to talk about it' (Female, Regional Public Health Nurse, IDI, Tamale, 03/04/2012).

In the rural community of Piase in the Bosomtwe district of the Ashanti region, however, one midwife is convinced that improving access to maternal and newborn healthcare services in Ghana would require the formal healthcare system forcefully engaging with traditional and religious leaders at the community level.

> My own experience over the years (as a woman who has experienced birth as well as worked at both urban and rural settings providing maternity care services) has shown that if we want to make progress with maternal health, then we must begin to foster more collaboration between nurses, midwives, TBAs and religious leaders at the community level (Female, Midwife, IDI, Piase, 24/02/2012).

For this midwife, this recommendation is born out of the positive results she has had from implementing a community-based participatory maternity care approach.

> When I first came to this community two years ago, attendance at ANC clinics was low. Women were also delivering their babies at home. So I became very worried. I started asking a lot of questions…and then I discovered that the women were not coming because of certain things, which were happening in the community. For example, I found out that they were using TBAs and the TBAs were actively discouraging the women from coming to the facility. The surprising thing I also found was that some religious leaders…I mean pastors were discouraging their congregants from using the services through prayers and spiritual healing. I was indeed very worried, and this was so because the person who was here before did not relate well with the TBAs. The stories I've heard are that the TBAs were complaining that the nurse had come to take away their jobs. So I didn't really know what to do to make things better (Female, Midwife, IDI, Piase, 24/02/2012).

From this state of despair, the midwife tells of how she gradually and successfully engaged TBAs, traditional authorities and religious leaders on the issue of maternal health.

> After thinking through the problem, I decided that I would reach out to these actors. So I visited each of the TBAs and pastors in the community to first introduce myself to them as the new midwife. From there I also asked each of them about what they thought the problems of maternal health care were…The TBAs were very surprise that I was asking for their opinions because I was the midwife and I was supposed to know everything. But I said that, well I may not know everything and given that I am new in the community, I believe they [TBAs] could be of immense help. I did the same thing with the pastors…in fact, I organized a meeting and invited all the pastors, TBAs and community leaders to discuss how best we could ensure that no woman suffer or die as a result of pregnancy and childbirth.

The midwife narrates further:

> During the meeting I made it clear that they should see the problem of maternal health as belonging to all of us, and that they too could help. Because of the problems my predecessor had with the TBAs and also because Ghana Health Service in the district does not recognize TBAs as skilled caregivers, I reassured all the TBAs that I was not put here to take their jobs, but to work with them so that together we can make things better. For the pastors too, I said that their prayers too were still important during pregnancy or labour. I told them that I was ready to assist them with the physical and biological aspects of the health of mother and foetus while they [pastors] deal with spiritual matters. After that meeting, I held further discussions with each of them. I even went to help one of the TBAs conduct a delivery at home. It was through this that they came to realize that I have some skills that they don't have. Gradually, the TBAs started encouraging pregnant women to come for ANC. Now, they themselves will even bring the women to the clinic to deliver…I am really surprised. And the same thing is happening with the pastors. They are also encouraging the pregnant women in their various churches to attend ANC. When a woman goes into labour too, they usually come along to pray for smooth delivery. So now, we are all working like a team, and I can say that it has contributed a lot to all the progress we are making (Female, Midwife, IDI, Piase, 24/02/2012).

Although this midwife admitted that her approach was unconventional and may not be feasible in some contexts, she believed the health service needed to do more to build partnerships with traditional midwives or TBAs, traditional and religious leaders as well as communities on the issues of maternal health. For her, partnerships means shared responsibility between healthcare providers and individual women and communities, and that such an approach offers opportunities

for changing beliefs and attitudes towards hospital-based maternity care services. 'This is the only way to enhance the potential for cooperation between healthcare workers and religious leaders and as well increase opportunities for nurses and midwives to provide training for TBAs to increase their skills to offer competent and safe maternity care services, including responsive referrals of cases at the community level'.

7.3 Stakeholders' Proposed Solutions to Cultural Barriers

Participants also made recommendations for addressing cultural barriers to access. In what follows, these have also been categorized into four thematic areas: 1) cultural adaptation of birthing services; 2) greater male involvement in maternity care; 3) domestication of skilled maternity care; and 4) health education. The next subsections discuss these proposed solutions.

7.3.1 Cultural Adaptation of Birthing Services

A significant number of women in this study reported that cultural insensitivities of the health care system to the values and preferences (including privacy) of childbearing women is one reason why many opt for non-skilled, home-base maternity care. To make the healthcare system culturally responsive, participants argued for a 'culturally appropriate birthing care model' in which there is adaptation and/ or integration of modern birthing services with traditional and culturally acceptable pregnancy and childbirth practices to ensure that skilled maternal and newborn healthcare services are attentive to the specific needs and concerns of individual women.

In particular, women spoke passionately about the need to make antenatal clinics and labour wards more private and home-like for the purposes of 1) reducing the apprehension that the set-

up of maternity wards including the apparatuses for technological intervention, inspire, and 2) providing a reassuring environment that guarantees familiarity and comfort.

> I believe if the nurses want more women to come to them to deliver, then they should realize that most women come from communities where there are rules or should I say there are ways in which childbirth is conducted… So I think it will be good for the nurses to ask the women and include some of the things that women are already used to (Pregnant Woman, FGD, Tidrope, 29/03/2012).

This participant agrees and explains further:

> …I support what my sister is saying. Look, in this community for example, when you go into labour, you are kept in a quiet, dark or shielded room where nobody can enter anyhow and see your nakedness except if the woman wants. But in the hospital, the whole place is open and everybody inside the ward can see you. There is no privacy at all (Lactating Mother, FGD, Tidrope, 29/03/2012). .

Another discussant continues:

> Also, if a woman is delivering at home, she wears her own clothing, but in the hospital, they will not allow, they will give you things that so many people have already worn. This is not proper. After delivery at home too, your family members usually bury the placenta in a very warm place so that the woman's recovery can go on well, but in the hospital, you don't even know where your placenta is send to…whether it is burnt, thrown into the toilet or to the dogs, you would never know. If they want more women to come to them, they can try and make it possible for women to wear their cloths during delivery. They should also provide quiet and dark rooms and after delivery, they should hand over the placenta or at least ask the woman and her family members how they want it disposed (Lactating Mother, FGD, Tidrope, 29/03/2012).

Another participant concurs:

> What my sisters are saying is very true. For us Muslim women, it is important nobody sees your naked body anyhow. But sometimes, in the palpation or delivery room, the whole place is open and people can see you lying on the bed. There is no privacy. This is not good. So I think the authorities must make changes to the clinics and routine nursing practices to create conditions and private spaces where consultation can take place so that women's concerns can be addressed (Pregnant Woman, FGD, Tidrope, 29/03/2012).

In addition, several women shared their positive experiences of how TBAs and family members usually provide labouring women with not only physical and emotional support but also continuous companionship when birth took place at home. In the hospital however, it was

reported that nurses and midwives often concentrated on using their instrument or only on the physical aspects of parturient mother's health to the neglect of women's emotional needs. The women therefore suggested that community TBAs and family members should be allowed into delivery wards where they can offer the needed emotional support and physically help with pushing out the baby.

> I think it will also be good if the nurses can allow family members or even those elderly women who help to deliver babies in the community [TBAs] to stand by the woman and help her during delivery…like wiping her sweat and encouraging her. You know if you give birth at home in this community that is what happens…your mother or mother-in-law will usually be there to give some morale. It happened to me when I was delivering my baby at home…my mother was there and at a time that I was tired of pushing, she kept encouraging me and saying all sorts of appellations just to make me believe that I could also do it (Lactating Mother, IDI, Abono, 24/02/2012).

But like several other remedies that the women interviewed proposed, the idea of adapting birthing services to preserve privacy and take account of women's specific cultural values and practices regarding childbirth appears less favoured by the formal healthcare system in Ghana. As shown in table 7.1, no participant from the healthcare providers' category made statements, which suggested that cultural adaptation of birthing services was necessary for encouraging more women to patronize skilled ANC or delivery care services.

7.3.2 Promoting Male Involvement

In my research with women in the Bosomtwe and Central Gonja districts, it became clear that in Ghana, maternal and newborn health issues, including access to skilled care during pregnancy or childbirth, are still largely treated as a uniquely feminine matter, and maternity units as spaces exclusively meant for women. As a result, there is very little focus on males and their involvement in efforts to ensure increased and equitable skilled care accessibility and utilization. However, not only do males at the household level influence women's healthcare-seeking decisions, but also they wield and exercise considerable power in either permitting or restricting

women's access to, and use of services. It is in the context of the overwhelming feminization of maternity care on the one hand, and the powerful role men continue to play in determining whether care is sought and from whom during pregnancy, delivery or immediately after delivery on the other hand, that participants called for the defeminisation of maternity care and the promotion of male involvement in maternal healthcare.

> I think that if they [healthcare providers] want every woman in this community to attend antenatal clinics or deliver their babies at the hospital, then they need to talk to our men and involve them to understand why it is important for their women to go for skilled care. I say this because although we the women get pregnant and give birth, men are often responsible for our pregnancy and therefore they have a lot of say in terms of how the pregnancy is cared for or how the baby should be born (Pregnant Woman, FGD, Abono, 14/02/2012).

A lactating mother adds:

> Our men too must be involved…they must be educated to understand the implications of their women failing to seek skilled care promptly. If our men understand, I believe they themselves will encourage their women or even support the women to go to hospital regularly (Lactating Mother, FGD, Abono, 14/02/2012).

Another participant at Mpaha also opines:

> You see some women don't go to see the nurses for check-up or delivery not because of their own will, but because their husbands don't allow or support them. I…I can use myself as an example. When I was pregnant, I didn't go to check my pregnancy for almost six months because my husband said it was time wasting for me to be going to the clinic when I was not sick. I only went when I fell very sick. It was my husband who picked me on his bike to the health centre. When we got to the clinic and the nurse saw me, she was very angry. She was angry because I did not attend antenatal care. But when I told her I didn't come because I didn't want to have problems with my husband, she called my husband to come and then she talked a lot to him. She explained that I was suffering from very bad malaria which could affect my baby, and that it was all because I didn't attend antenatal early. Since then, my husband understood the whole thing…in fact he is always asking when my next visit will be, and he is now very supportive (Lactating Mother, FGD, Mpaha, 26/03/2012).

One discussant concurs

> Thank you my sister…what you said is very true, and I believe if the government wants women to go to the nurses to check their pregnancy and have safe delivery, it should talk to our men so that they too can understand why it is important for women to go to

> see the nurse at the clinic or hospital for pregnancy check-ups and delivery. If not, we will continue to have this problem (Pregnant Woman, FGD, Mpaha, 26/03/2012).

Another participant adds:

> I believe one way that women can be made to visit the clinics regularly for ANC or delivery is for the authorities [healthcare providers] to also educate men in this community about the importance of attending antenatal clinics or giving birth with the midwife. I am saying this because most men don't understand why their wives should leave work to go to the clinic for pregnancy check-up when they [pregnant women] are not sick. So if the nurses can also meet with the men and talk to them about this or encourage them to come to the clinics with their wives, I think it will help because if they [men] get to understand, then they will let their women go for care (Pregnant Woman, IDI, Tidrope, 01/04/2012).

Among healthcare providers, however, the idea of promoting male involvement in maternal healthcare in Ghana is yet to be popular. Only one participant from the twenty healthcare providers interviewed was emphatic that policies directed towards improving women's access and use of skilled maternity care services must necessarily involve males. For this nurse, Ghana is still a country in which machismo is manifested in both public and private lives, so that males especially husbands are usually the most influential household decision-makers, including regulating women's mobility and autonomy in accessing and using skilled care services.

> I think one problem is the failure of the healthcare system to actively engage all stakeholders…especially the men in all efforts to promote good maternal health. But as you know…we're still living in a country where men have more control over household decisions, including reproductive health decisions like how many children to have and whether a woman should give birth at the hospital. So I believe that if progress will be made in terms of ensuring that all women have access to or use skilled maternal healthcare services at the time that the services are most needed, then we the healthcare providers must also engage the men in the process. Many men still don't understand the importance of seeking early care, particularly when a pregnant woman is not sick. But if we can start to engage them…I mean educate them and even encourage them to attend ANC classes that we offer to pregnant women during antenatal clinics, I am sure it will greatly eliminate some of the barriers and delays women face when they want or need care (Female, Public Health Nurse, IDI, 14/03/2012).

For this participant, promoting male involvement is particularly important because in most communities, women still require the permission of a husband or another male to pursue

activities outside the home, including attending ANC clinic or giving birth at a health facility. While acknowledging that cultural perceptions about the role of men as bread winners, and maternity care as a feminine domain may hinder male involvement, this participant believed encouraging men to attend antenatal classes with their wives is not only important for increasing in males an understanding of the relevance of accessing and using skilled care services in a timely manner during pregnancy or labour, but it is also critical to increasing the effectiveness of maternal and newborn health policy interventions. This participant therefore suggested that future designs for construction of maternity care units in the various health facilities must be made couple-friendly, such that both men and women can be accommodated or if need be create separate waiting areas for couples or men alone.

7.3.3 Domesticating Skilled Maternity Care

Within the framework of Ghana's free maternal healthcare policy, hospitals, clinics, health centres, CHPS compounds and other government or privately designated health posts or outreach points are the only birth territories where women may receive free SMNHS. FGDs and interviews with women however suggest that the exigencies and the unpredictability of the onset of labour, coupled with difficulties embedded in arranging transportation as well as the unfamiliarity and apprehension that these health facilities often inspire, often greatly limit the ability of many women to access these facilities and utilize their services. For this reason, a significant number of women (see table 7.1) recommended and greatly favoured a maternity care system that supported and promoted supervised *domiciliary delivery* by skilled birth attendants. This, the women argued, would not only eliminate the complications that may arise due to delays associated with travel arrangement and costs, but will also directly address the issues of fear and privacy as well as tailoring birthing services according to individual women's special needs within the familiar environment of their home.

> What they [government] should do?…I think if the government really wants this programme [free maternity care] to work well, then they should make it possible for the nurses to come to our houses to help. This is because, when you are pregnant, you don't normally know when the baby will come. It can come at any time…even midnight. So if the government can make it possible…say if the nurses can give out telephone numbers that we can call or even the community-based surveillance volunteers (CBSVs) can call them to come when we go into labour suddenly, then that will help since nurses usually have cars or motor bikes (Pregnant Woman, FGD, Abono, 14/02/2012).

One participant supports the recommendation with an example:

> …In fact I know a woman who really wanted to go to the hospital to deliver her baby, but she got into a difficult labour without knowing…she was bleeding a lot and it was in the night too, and there were no cars. And the TBA too was not there. Her husband called somebody at Kuntanase and asked the person to go and inform the nurses at the hospital about the problem, but the nurses said unless the husband brought the woman, they could not help…her family really suffered. When the woman was finally sent to the hospital, an operation was done to remove the baby, but the baby was already dead. If the nurse came fast, this would not have happened (Lactating Mother, FGD, Abono, 14/02/2012).

Another participant agrees and continues:

> That is very correct…it will really help because it will be possible for every women to be delivered by a nurse or doctor even if the woman is unable to go to hospital or if she doesn't want to go there at all (Pregnant Woman, FGD, Abono, 14/02/2012).

In calling for supervised domiciliary delivery, some women acknowledged that in some instances (e.g. a situation where CS is required), it may not be possible for healthcare givers to offer all the needed birthing services to a labouring woman at home. However, several women drew positive analogies of their birthing experiences with community-based TBAs, and noted how the same approach could be adopted to deliver skilled maternal healthcare services. One participant relates:

> Another thing is that if the health people can come to give help in our own houses, it will be nice because if they deliver your baby in your own house, there will be no problem concerning who will take care of you, and even nobody will see you. This is what the TBAs do…they will come to your house if you have problem with your pregnancy or if you go into labour and help you (Pregnant Woman, IDI, Mpaha, 26/03/2012).

Among the healthcare providers interviewed, there appears to be widespread resistance to the idea of supervised domiciliary delivery. Only one participant thought domiciliary delivery was a

feasible strategy that could increase access and use of skilled maternity care services. Apart from arguments that it would be difficult for nurses, midwives and doctors to properly and safely conduct births at home, this participant also noted that the idea is unpopular because of its rather political nature.

> As a woman who has experienced childbirth myself as well as played a frontline role in the labour ward, I have always believed… and indeed I have always argued for supervised domiciliary delivery. After all, we conduct child welfare clinics and sometimes, antenatal clinics right in the communities, and the results have been very good. But…I don't know… a lot of colleagues are very uncomfortable with the idea because they fear it will be difficult or they will lose all the respect they get when patients come to them in the health facility. So it is a potentially good strategy; the problem is acceptance (Public Health Nurse, IDI, Kumasi, 14/04/2012).

Accordingly, there is widespread fear and anxiety among nurses, midwives and doctors that they may lose the power and control they command within healthcare facilities if domiciliary midwifery were incorporated into the healthcare system.

7.3.4 Health Education

> …There is still ignorance on the part of many women in the district…about health issues including maternal health. I believe the way to make progress is to increase our health education campaigns using the radio and community durbars to educate women about the need to attend ANC and hospital delivery. We have already started this in a number of communities (Midwife, Female, IDI, Sankpala, 22/03/2012).

One district health director adds:

> As you know, there are many women…especially in rural areas who have no formal education. Such woman do not always understand the risks involved in getting pregnant and giving birth…they also have funny cultural beliefs about hospital births. So if we want to make progress towards MDGs 4 and 5, then we must intensify our health education campaigns at every corner of the district. We must let the women know the risks involved in giving birth at home or being delivered by a TBA, and why it is important for them to attend ANC clinics and come into the health facility to be supervised by trained and qualified health personnel during delivery. We must educate them to do away with traditional and cultural beliefs that don't help. That is what we must do (District Health Director, Female, IDI, Buipe, 04/04/2012).

A district public health nurse also relates:

> We have already identified a number of issues…one of the biggest is women's lack of education and awareness about the dangers associated with pregnancy, and especially home births. So I believe we need to increase our educational programmes using different means including radio, community durbars, drama and role-plays, peer-to-peer education and the CBSVs. If we can do this well, things will certainly improve (District Public Health Nurse, Female, IDI, Kuntanase, 14/02/2012).

One regional public health nurse further suggests:

> …Education…more health education of the women! This is critical if we want to make progress (Regional Public Health Nurse, Female, IDI, Kumasi, 14/04/2012).

The forgoing is a representation of perspectives on one strategy - the need for more health education - that majority of the healthcare providers sampled proposed. In searching for an explanation for the persistently high maternal mortality as well as low numbers of skilled maternal healthcare services accessibility and utilization, these healthcare providers reasoned that most of the damaging factors lay with women. Specifically, women's limited health knowledge and backward cultural beliefs were implicated in non-attendance at clinics for any or enough antenatal care as well as home deliveries. According to this account, the ability of the healthcare system to attract more women and improve uptake of SMNHS must necessarily be preceded and/ or accompanied by a very aggressive education of the target population – pregnant women.

Given the low levels of female education particularly in the Central Gonja district, the diagnoses and prognoses offered by these healthcare providers here might indeed be valid in some instances. This notwithstanding, the quotations above and the other data gathered as part of this project did not produce any evidence that could support either the diagnosis of the problem or the solution to it. Indeed, as table 7.1 shows, none of the women thought they needed more health education either for the purposes of helping them understand the risks of pregnancy and child birth or for encouraging them to seek SMNHS in a health facility.

7.4 Conclusion

In this chapter, the aim has been to present potential solutions; arising from the researcher's engagement with expectant and lactating mothers as well as healthcare providers, to the twin problem of under utilization and unequal access to skilled maternity care services in Ghana.

From recommendations for training and motivating midwives, expanding coverage of skilled care services and cultural adaptation of birthing services to the promotion of male involvement in maternity care, the chapter suggests that women's past positive and negative experiences of receiving both home and skilled hospital maternity care provide an opportunity to both improve the content, quality and effectiveness of prenatal care, and to draw useful lessons to help ensure increased access and use of skilled facility delivery and post-delivery care services.

But the chapter also showed the ways in which the priorities of women differed and/ or aligned with those of healthcare providers. These disjunctions and alignment could potentially have implications for the way in which maternity care services are thought of, organized, and delivered to women. They also could potentially affect the determination of what kinds of strategies get pursued to address under and inequitable access to SMNHS. This issue would be returned to in the next chapter.

Chapter 8

FREE BUT NOT ACCESSIBLE TO ALL: DISCUSSION

8. Introduction

Ghana's unprecedented policy response to secure universal access to skilled maternal and newborn health services (SMNHS) through the free maternal health policy certainly puts her

among the small community of African countries, which have, at least, managed to transcend the discourse and political rhetoric of making motherhood safer. Not only is it therefore vital to undertake scientific research to understand the policy impact of Ghana's free maternity care policy on access, equity of access, and the barriers that impede equal access and how to redress them, but also to reflect on the way in which this national pursuit of equity goals in maternity care access may align with and/ or come into tension with the pursuit of other individual or communal interests, and the implications all this may have for equity debates and health policy-making. This is the task the present chapter seeks to undertake by reflecting on the research questions raised, how they were answered, the kind of answers that emerged to respond to the research questions, the adequacy and weakness of these answers, and their implications for health policy debates and future research.

8.1 Free but not Accessible to All

For the purposes of reminding the reader and providing a context for the discussion in this chapter, I shall commence with a brief restatement of the research problem and questions investigated, the methods used, and the main research findings presented in each of the results chapters, and the aspects of the research questions that these findings addressed.

8.1.1 Research Overview

This doctoral research combined empirical quantitative evaluation with qualitative exploration and analysis to investigate the problem of access, equity of access and barriers to accessibility and utilization of SMNHS in Ghana in a context where services are free. With an estimated 0.36 million deaths globally in the year 2010, 99% of which occurred in low and middle-income

countries, maternal mortality remains one of the most formidable public health challenges facing low and middle-income countries, including Ghana. In September 2003, Ghana made a political decision to provide free maternal health services to all women. This decision was not only a response to international calls to improve access to skilled care for all pregnant women and those in labour within the framework of goals 4 and 5 of the Millennium Development Goals (MDG), but also a direct response to the country's own experience of having persistently high maternal and neonatal mortality rates and an abysmally poor record in terms of progress towards raising the proportion of women receiving skilled care and attendants during pregnancy, labour, delivery and in the early postpartum period within a relatively well equipped health facility setting. The policy received widespread support both in and outside the country at the time. This promised renewed hopes for Ghana to rapidly reduce financial barriers to access, scale up accessibility to, and utilization of skilled care, reduce inequities in accessibility and utilization of services, and ultimately reduce maternal mortality. Indeed, by committing herself politically, legislatively, and fiscally to providing free SMNHS, Ghana appeared to have transcended the discourse and political rhetoric of making motherhood safer in SSA.

After nearly a decade of free maternity care in Ghana, however, many women continue to lose their lives through pregnancy and childbirth. The overarching objective of this doctoral research was therefore to examine the extent to which SMNHS have become widely used in Ghana; whether variations in accessibility and utilization of skilled care have been eliminated or reduced following the implementation of the free maternal health policy; and the barriers to accessibility and utilization of SMNHS. To achieve this objective, seven distinct but inter-related research questions were empirically investigated, namely:

1. In the context of Ghana's free maternal healthcare policy, do all women in need of skilled antenatal, delivery and post-delivery care service have access?
2. Which categories of women have more access than others?
3. How has Ghana's free maternal healthcare policy affected access and equity of access and use of SMNHS?
4. How and why (if any) do differences in SMNHS access and use exist in Ghana despite the free maternal healthcare policy?
5. What barriers militate against universal access and use of SMNHS; and in particular, how do the healthcare system, cultural norms, belief systems, and the choices that individual childbearing women make and/ or not make, affect access to skilled care?
6. What factors enable and promote access and use of SMNHS in Ghana?
7. How can access be increased, and inequities (if any) in access and use of SMNHS reduced in Ghana?

These questions were addressed using a mixed methods study design, employing a nationally representative retrospective household survey data in combination with qualitative exploration using data generated from anthropological research techniques of focus group discussions (FGDs), in-depth interviews (IDIs) and structured field observations. Empirical findings from my analysis of the quantitative and qualitative data were presented in chapters four, five, six and seven, with each chapter addressing some aspects of the seven research questions.

8.1.2 Summary of Main Findings

In chapter four, the main objective was to describe and analyse the patterns of SMNHS accessibility and utilization to determine whether access differentials exist, and how Ghana's free

maternal health policy has affected and continue to affect access more generally, and inequities (if any) of access in particular.

Results from my descriptive analysis of survey data showed that the implementation of the free maternal health policy in Ghana appeared to have been accompanied by marginal increases in the proportion of women who accessed and used antenatal care (ANC), delivery care (DC), and postnatal (PNC) services from skilled health professional in a health facility setting. Specifically, results showed an average increase of 8% in terms of the number of women who accessed and used skilled ANC, DC, PNC and health facility delivery services during the first five years of the policy implementation, i.e. between 2003 and 2007. For example, the percentage of women who received ANC from a skilled provider rose from 92% in 2003 to 96% in 2007. The percentage of women who received at least four ANC for any single pregnancy in the five years preceding the survey also increased from 69% in 2003 to 77% in 2007, while the number of women who sought ANC during the first trimester of pregnancy rose from 46% in 2003 to 53% in 2007. Similar incremental changes occurred for protection against tetanus, delivery assistance from skilled providers, and delivery in a health facility during the same period. The percentage of pregnant women who received at least two dosages of tetanus toxoid protection also increased from 50% in 2003 to 62% in 2007. Skilled attendance at delivery also went up from 47% in 2003 to 55% in 2007, while delivery in a health facility rose by 10% (i.e. from 46% in 2003 to 54% in 2007).

Despite the increases in service uptake, my further analysis of the survey data found that the twin-problem of *under* and *unequal* access and use of SMNHS persisted, and in some cases the situation had been exacerbated by the implementation of the policy of free maternal healthcare itself. Except for ANC, the data showed that the proportion of women who had access to or utilized DC, PNC and abortion care services was still lower and significantly even lower for

women of certain socio-demographic groupings such as the poor. For example 45% of births in the last five years before the survey took place at home without skilled attendance. Similarly, 45% of the women who gave birth during the same period did not also receive any form of postpartum care.

In addition to the fact that nearly half of the women in Ghana continued to deliver their babies outside any health facility and without the supervision of any trained health personnel, my analysis also showed that substantial differences in access and service use characterized Ghana's maternal health delivery system. For instance, 40% more urban women than rural women, 53% more women in the highest wealth quintile than women in the lowest, 38% more women in the best performing geographic region (Central Region) than the worst (Upper East Region), and 48% more women with at least secondary education than those with no formal education, accessed and used all skilled ANC, DC, PNC services. In general, skilled care at birth, deliveries in a health facility, caesarean section (CS), and post-delivery services all indicate gradients that are in favour of the wealthiest. Less surprisingly, women in the poorest wealth quintile used more unskilled home delivery and services offered by traditional birth attendants (TBA). Furthermore, fewer women from majority ethnic groups such the Akan (23%) and Ga/Dangme (22%) gave birth at home compared to women from minority ethnic groups such as the Ewe (44%), Guan (57%), Grussi (60%), Mole-Dagbani (61%) and Gruma (66%).

Before proceeding to outline the main conclusions from the above findings, two main caveats need acknowledging. The first caveat is that the universal nature of Ghana's free maternal health policy made it hard to conduct robust comparative analysis, as data needed to control for possible confounders and for such comparative analysis did not exist at the time of this research. As a

result, it is difficult to disentangle the effect of other factors or interventions, distinct from the free maternal health policy on the observed increases in SMNHS uptake. Therefore, correlation here must not necessarily be interpreted to mean causation. This said, and proceeding on the basis that no other major policy intervention was pursued during the period these increases occurred, the findings support previous research in Ghana and elsewhere which found similar incremental changes in skilled care access and utilization following the abolition of user-fees for maternal health services (Asante *et al*, 2007; Penfold *et al*, 2007; Witter *et al*, 2007; Lagarde & Palmer, 2008; Witter *et al*, 2010; Ridde *et al*, 2012; Dzakpasu *et al*, 2012).

The second caveat is that it is equally difficult to make any judgement about the relationship between Ghana's free maternal health policy and the observed inequities in access to SMNHS. It is plausible that access among poor or rural women for example, improved from an even more inequitable distributive baseline following the implementation of the policy or vice versa. The lack of relevant comparable data before the introduction of the policy did not permit these hypotheses to be further explored in this research. Nevertheless, that inequities in skilled care services accessibility and utilization exist across different sub-population groups in Ghana is interesting. It is interesting because Ghana's free maternal health policy is universal, and should therefore, at least in theory, have benefitted all women equally according to their maternity care needs. In practice, as the findings demonstrated, however, many women continue to deliver their babies at home or outside the provided government and non-government healthcare facilities without skilled care.

In summary, the discussion in chapter four showed how Ghana's free maternal healthcare policy has affected access and equity of access and use of SMNHS. Three main conclusions are

discernible from the findings presented in chapter four. The first is that many components of SMNHS are still *under* accessed in Ghana despite the implementation of the free maternal health policy. The second is that accessibility to, and utilization of SMNHS is still *not equitable*. The final conclusion is that differences in *socio-economic status (SES)*, as represented by differentials in socio-demographic variables such as educational attainment, wealth, type of residence, and geographical location, are still important in the determination of women's ability to access and use SMNHS in Ghana. Together, the findings in chapter four responded to the question of whether in the context of Ghana's free maternal healthcare policy, all women in need of skilled antenatal, delivery and post-delivery care service have access.

In chapters five and six, the focus was on understanding why women may not access and use SMNHS in Ghana despite these services being provided free. My analysis of qualitative data from interviews with women and maternity caregivers found that women faced two kinds of barriers, which interacted in a rather very complex fashion, to limit access and use of SMNHS. These were *health system* and *cultural* barriers. In order to gain a deeper understanding of the nature of these barriers and how they affected access and equitable access, chapter five considered the health system barriers while chapter six examined the cultural barriers.

In chapter five, it was found that in addition to limited and unequal distribution of SMNHS, women's experiences of intimidation, unfriendly healthcare providers, long waiting time before care is received, limited birthing choices, poor care quality, and lack of privacy at healthcare facilities were important barriers to increased and equitable access and use of SMNHS in Ghana. In other words, at the level of the health system, under utilization and access inequities resulted from some women's decision not to access and use health facility-based maternity care services

not only because these services were not readily available and physically accessible at a reasonable distance, but also because of their [women's] negative past experiences with the modern health system in Ghana, including maltreatment and poor quality of care.

But apart from negative experiences with the healthcare system, in some cases it was found that women simply did not trust the ability of the healthcare system and in particular the competence of healthcare providers to address their maternity care needs, partly because essential consumables are not available. Thus the anticipation of attending an inadequately equipped and dysfunctional health facility, where the potential for further referrals to more distant hospitals with significant costs implications was rife, led to non-use of services. In other cases, women's explanations for not accessing skilled maternity care services at healthcare facilities were similar to those documented in many previous studies, namely the fact that issues and practices that enhance the experiences of mothers including convenience, privacy, and respect are better addressed in home-based maternity care (see Imogie *et al*, 2002; Hildingsson *et al*, 2003; Bazzano *et al*, 2008; Wendy, 2009; Margaret *et al*, 2009; Gao *et al*, 2010; Kruk *et al*, 2010). But interviews with health care providers also indicated that some times women's decisions not to access and use health facility-based skilled maternity care services were founded on rumours about poor quality of care at health facilities as well as perceptions that healthcare providers did not pay sufficient attention to traditional norms and practices of childbirth.

In contrast with the findings in chapter five, it was found in chapter six that non-financial and non-health system factors were responsible for under access and inequities in service utilization. Specifically, it was found that cultural preferences for home births, social expectations regarding women's conduct during pregnancy and childbirth, women's religious beliefs and practices

including faith healing and observance of religious dictums, cultural norms and traditions including rituals around pregnancy, negative conceptions of health-facility birth, the legitimacy of a pregnancy, as well as women's relative lack of power and freedom to make decisions regarding access and use of skilled birth services even in cases where they wanted or preferred to use such services, were the most important cultural factors that combined to limit accessibility to, and utilization of SMNHS. Healthcare providers' lack of knowledge about, and sensitivity to women's religious and cultural practices, as well as the provision of limited health information or information that lacked the cultural and religious specificity to meet the needs of women were similarly found to have discouraged access and created access inequities as well.

Again, before drawing out the main conclusions from the findings in chapter five and six, I shall make three observations. First, women experienced both the health system and cultural barriers to access and use of SMNHS at multiple levels, including the individual, family, household, community, and health facility level.

Second, it is problematic to draw any direct logical link between the implementation of Ghana's free maternal health policy and women's negative experiences and relationships with the healthcare system as documented in chapter five. This is because these negative attributes of the healthcare delivery system may well have existed prior to the implementation of policy. This said, my engagement with both women and healthcare workers showed that the free maternity care policy did exacerbate the situation.

Third, many of the findings in chapter five have resonance with previous research on the subject elsewhere, including Uganda (Xu *et al,* 2006), Senegal (Witter *et al,* 2010), and Ethiopian

(Shiferaw *et al*, 2013). Similarly, many of the socio-cultural barriers documented in chapter six such as women's lack of decision-making power have been identified internationally as key reasons for which women do not seek SMNHS in a timely manner (Elo 1992; Ngom *et al*, 2003; Parkhurst *et al*, 2006). This suggests that the findings in chapters five and six of this thesis may not be peculiar to Ghana.

Put together, the findings in chapters five and six shed light on the barriers militating against equitable access and use of SMNHS in Ghana. In particular, findings in chapter five suggested that the maternal healthcare system itself in Ghana constituted a significant access barrier, while chapter six underscored the complex role culture plays in undermining increased and inequitable access to SMNHS.

Finally, drawing on an analysis of the views of participants in interviews and focus groups, chapter seven considered the question of how access to SMNHS in Ghana might be increased, and inequities in service access and use reduced. My analysis of data generated from the experiences and accounts of both women and healthcare providers about what worked to promote safety for mothers and newborns during pregnancy and childbirth identified a number of strategies that could potentially be adopted. These included health education, domestication of skilled maternity care, cultural adaptation of skilled health facility-based maternity care services, improving doctor-patient relationships in maternity wards, expansion and redistribution of existing maternal health resources and infrastructure, improving the quality of maternity care services provided, promotion of choice, privacy and patient dignity in maternity wards, promotion of male involvement in the delivery of maternity care, training of more skilled maternity caregivers, instituting special programmes to target women most in need, and building

partnerships with TBAs and other non-state actors. In this way, chapter seven not only improves understanding of what the barriers to skilled care accessibility and utilization are, but also significantly adds new ideas about how these barriers could be addressed.

Cumulatively, two overarching conclusions can be drawn from the findings in chapters 4-7. The first of these is that the problem of access to skilled maternity care extends far beyond fiduciary considerations alone. Under this particular conclusion, the following crosscutting themes emerged as important in the debate about maternal and newborn health services accessibility and utilization, namely the roles of 1) socio-economic status, 2) the healthcare delivery system, and 3) culture. The second overarching conclusion is that the different factors (i.e. socio-demographic, health system, and cultural) enabling or disabling access to SMNHS in Ghana are not only complex in nature, but also the processes by which they operate to either enhance or limit access is even far more complex than meets the eye. This means that there is the need for more careful and rigorous contextual reflection and analysis on these processes in order to properly understand how and under what circumstances the effects of these factors on skilled care access may be manifested. For this reason, and in order to bring out the nuances in the various answers to the research questions, the rest of the discussion below will focus on these two overarching conclusions and their implications for debates about access, equity of access and barriers to accessibility and utilization of SMNHS. In this way, the analysis undertaken in the four previous chapters, together with the background, literature review and methods chapters, provide the foundation upon which the present chapter is built.

8.2 More than a Problem of Money: Reflections on Access Barriers in the Context of Free Maternity Care

Like many health policies that address financial barriers to healthcare access, Ghana's free maternal health policy was based on an assumption that users would avail themselves of SMNHS if only these services became more affordable (Witter *et al,* 2010). The research undertaken for this thesis on the barriers to access and use of SMNHS within a context in which financial access has been addressed to a greater extent challenges this dominant axiom.

Qualitative data generated from FGDs and interviews with expectant and lactating mothers provided insights into a range of factors that limited accessibility and utilization of services. In some contexts and for some women, user-fees were the main access and use barriers, in which case Ghana's free maternal healthcare policy was an appropriate remedy. In many other situations and for many other women, however, my research found that service availability, and financial and physical access did not always result in the uptake of skilled care services. While this resonates well with other previous research findings (see Magoma *et al,* 2010; Shiferaw *et al,* 2013), it allows for scepticism to be raised about the assumptions Ghana's maternal healthcare policy made. More importantly, this finding raises questions about the role of non-financial barriers in accounting for under-utilization and unequal access and utilization of SMNHS. In what follows, I reflect more on the issue of service under-utilization and inequitable access, focusing on the roles of socio-demographic factors, the healthcare system, and culture.

8.2.1 Differential Socio-economic Status (SES) and Access

Within the maternal healthcare literature relating to Ghana and elsewhere, maternal healthcare access and utilization differentials have been seen and explained in terms of differentials in SES variables such as differences in educational attainment, age, residence, wealth, ethnicity, marital status, religion and occupation (see Addai, 2000; Bour, 2004; Gyimah *et al,* 2006). My analysis

of survey data, findings of which were presented in chapter four and reiterated in section 8.1.2 of the present chapter, highlighted the importance of socio-demographic variables as determinants of SMNHS accessibility and utilization in Ghana. Qualitative data presented in chapter five further suggested that nurses and midwives provided differential treatments to women according to their socio-economic status. This not only confirms the findings of previous studies which showed that differential treatments were meted out to patients in Ghana's hospitals (Yakong *et al*, 2010), but also once again illustrates the critical role of socio-economic status variables in maternal and newborn health (MNH) care access.

In this section, I reflect further on the role of these socio-demographic variables in maternity care access and the implications for equity. The aim is two-fold. First, I aim not only to demonstrate the importance of socio-demographic variables but also to make a point that the mechanisms by which these variables operate to either enhance or totally undermine access to skilled care and create inequities in access are far more complex than what is often suggested by analysis of survey data alone. The second aim is to draw attention to the fact that most of these socio-economic status variables lie outside the confines of the healthcare delivery system as they are related to the wider context of economic, social and political disadvantage. Therefore efforts to increase access to, or reduce inequities in access to, MNH services must necessarily extend beyond the maternal healthcare system to include considerations for improvements in these aspects of women's lives.

In relation to the first aim of this section, the survey results in chapter four clearly suggested that women's socio-economic status in Ghana played a crucial role in the continued practice of service under-utilization, and unequal access to skilled care and homebirth. Indeed within the

healthcare literature, the links between many of the SES variables and accessibility to, and utilization of SMNHS are clearly established (See Thaddeus & Maine, 1994; Addai, 2000; Ronsmans *et al*, 2003; Say & Raine, 2007; Ahmed *et al*, 2010). For instance, education has been found to be positively associated with access and use of many of the elements of skilled maternity care such as delivering in a hospital (Addai, 2000; Ronsmans *et al*, 2003; Say & Raine, 2007; Ahmed *et al*, 2010). Influences of maternal education on maternal healthcare access can be effected in several ways, including improving the ability of women of reproductive age to produce good maternal health outcomes without even relying on health services by influencing their reproductive behaviours such as contraceptive use, increasing women's use of maternity care services through improved knowledge, attitude and practice, empowering women to be able to leverage decision-making power regarding reproductive choices and access to birth services within the household and community (Ahmed *et al*, 2010).

My analysis of survey data in chapter four appeared to strongly support this conclusion: it suggested that more educated women were more likely than those with less education to access and use SMNHS.

The fact that difference in women's socio-demographic attributes influences women's ability to access and use SMNHS in Ghana clearly violates one of the fundamental requirements for equity of access discussed in chapter two, namely that non-medical or non-biological features of individuals or groups should not determine their access to healthcare (Muraleedharan, 1993). But more important for the purposes of the discussion here is the fact that FGDs and IDIs with women in the six communities in which this research was conducted showed that a woman's socio-demographic background did not act independently to determine her choice and or ability

to access and used SMNHS. For example, qualitative interviews with women in Sankpala, Tidrope and Mpaha revealed that in most instances the benefit of women's education for SMNHS accessibility and utilization was undermined by traditional practices and norms of pregnancy and childbirth management such as *trigibu* (see section 6.1.5 of chapter six). Similarly, as shown by the experiences of Muslim women in the Central Gonja district, in some instances women are unable to access skilled care not because they are poor, uneducated or live in a rural area, but because they wish to avoid the possibility of being attended to by a male health worker so as to preserve bodily sanctity in accordance with Islamic religious dictates.

Furthermore, the potential benefits of maternal education, wealth or area of residence on access to skilled care were often diminished by the powerful roles of husbands, mothers-in-law and TBAs in the decision-making processes. In many instances as documented in chapter six, the power-play between women, their husbands, mothers-in-law and TBAs has often resulted in women either not accessing needed care or reporting to a health facility only when complications such as protracted obstructed labour or postpartum haemorrhage have set in. Such unbalanced power relationships between women and husbands or mothers-in-law at the household level (micro) and how they influence access and use of maternal health services (macro) capture the ambiguity and complexity of socio-demographic factors in influencing women's ability to access SMNHS in Ghana.

My qualitative research with women in Kuntanase also provides a better understanding of how living in an urban area in Ghana where the ready availability of free maternal and newborn health services did not by itself encourage access. For example, women's accounts suggested that although they lived in a relatively urbanized area where SMNHS were readily available and

physically accessible, considerations of quality of care were also taken into account in the making of decisions about whether to access and use such services. In many instances, women travelled outside their communities to other more distant places where they believed they would get good care. Such a phenomenon is not only an irony of the urban context where maternal health services are supposed to be within reach, but it also points to the emergence of an *urban penalty* in maternity care access, whereby rapid changes in urban populations produced poor and marginalized urban sub-groups who lacked access to care as well as overcrowded maternity care facilities with poor and substandard quality of care. Such an understanding challenges simplistic assumptions about the positive relationship - the so-called *urban advantage* - between living in an urban area and SMNHS access and utilization in low-income countries as has been documented in the literature (Thaddeus & Maine, 1994; Addai, 2000; Ronsmans *et al,* 2003; Say & Raine, 2007) and suggested by survey data in this thesis.

In addition, qualitative data presented in chapter six illustrate yet another way in which the beneficial effects of predisposing socio-demographic factors such as maternal education, proximity to health facility, living in an urban area or wealth on access to, and use of SMNHS may be undermined. For many of the women interviewed, pregnancy and childbirth represented a rare opportunity for a woman to demonstrate courage and to bring dignity and honour to both her natal family and that of her husband's or male partner. As a result, a woman who went through pregnancy and childbirth without calling for medical assistance is highly esteemed. In this way, the desire for a woman to gain self-esteem and/ or bring honour to her family sometimes overrode the need to seek SMNHS irrespective of whether the woman lived in an urban area where services may be accessible or whether she has material and financial resources that can be

used to offset any costs of accessing care. The situation was even more exacerbated for women who did not derive status and prestige from roles other than motherhood.

Besides the above, there is even some evidence in the literature that suggests that sometimes, higher SES does have a perverse effect on accessibility and utilization of skilled care services. For instance, it has been found that higher levels of education may not guarantee higher levels of service access and use because with increasing education, individuals depend more and more on self-care and self-prescribed medication and postpone the visit to a health facility until after these methods fail to produce a cure (Thaddeus and Maine, 1994). Although this phenomenon was not observed in the current study, what the discussion above suggests is that 1) the role of some of the socio-demographic factors in accessibility and utilization of SMNHS is not clear-cut and sometimes context-specific; and 2) the mechanisms through which they play a role is complex and sometimes not well understood.

By showing that the mechanisms through which socio-economic status affects access to SMNHS are not at all straightforward, this study sharply contrasts many quantitative analysis of the determinants of MNH services utilization, which often succeed in only identifying what variables are statistically significant but are unable to understand how these socio-demographics may operate to limit access in different contexts. In this way, the qualitative analysis in this research broadens the concept of access beyond socio-demographics and highlights the importance of contextual research to understand the specific circumstances under which the expected impact of SES variables on access to SMNHS may be effected or undermined. It also offers the possibility of an explanation which goes beyond women's socio-economic status variables to focus on the mechanisms and channels of operation including women's decision-making power, autonomy

and relational status in their families, particularly in settings where males or other individuals wield greater decision-making power than childbearing women themselves. This suggests that there is a danger of letting 'off the hook' other equally important factors such as the deficiencies in the healthcare system if one concentrates solely on SES variables as the main determinants of access and service utilization.

The second issue to consider in relation to the role of SES in skilled maternity care assess in Ghana is that differences in SES variables are related to broader questions of economic, social and political disadvantage. My engagement with women and healthcare providers suggested that most of the categories of women among whom the rates of SMNHS access and utilization levels are lowest are women who have also largely been marginalized in the processes of Ghana's economic development and modernization. For example, those most likely to give birth at home without skilled attendance or with a TBA, attend fewer antenatal clinics or seek no postpartum care are women from impoverished geographical regions and districts of northern Ghana where the worst records of human development index, including educational attainment, exist. As observed earlier in chapter three, women in northern Ghana generally suffer multiple deprivations including poverty. This deprivation in and of itself puts women in a very disadvantaged position in terms of their ability to get formal education, earn a decent income or access healthcare. For instance, while decisions regarding the management of pregnancy and childbirth are considered to be within the territory of females, access to money and resources such as bicycles and motor bicycles for transport in the event of an obstetric emergency often made men central in the entire decision-making process regarding access.

Furthermore, most of the women likely to give birth at home without skilled attendance or with a TBA, attend fewer antenatal clinics or seek no postpartum care are also women from *minoritized*[11] ethnic and religious groupings. While it is less clear whether belonging to a majority group such as the Akan or a minority group such as the Gruma automatically implies more access and less access to SMNHS respectively, such a finding resonates with one previous study in Ghana which found that while almost equal proportions of women of the Ga-Adangbe, Fante and Akan ethnic groups used the hospital or health facility as place of delivery, lower proportions are observed for women of Ewe, Guan, Gruma and other minority ethnic backgrounds (Addai, 2000). The finding is also in agreement with other studies elsewhere, including Nepal (Matsumura & Gubhaju, 2001).

What is important for the purposes of the argument here is that although many healthcare providers appeared oblivious to this fact, several women related how women from these minority ethic and religious groups were often likely to suffer discrimination and abuse upon entry into the MNH system. For this reason, the social imperatives for such women to avoid the formal healthcare system simply are powerful. Indeed, that one is likely to receive poor care, maltreatment and abuse in a health facility without the intervention of a personal friend or relative in position of power or who is connected to the particular health facility is a theme that repeatedly recurred in interviews with women about their decision-making in relation to access and use of SMNHS. Elsewhere in Bangladesh, Schuler and colleagues (2002) have documented a similar phenomenon. In Ghana, this seems to be the case because many aspects of social life are structured by patron-client relationships or what is known in the local parlance as 'whom you know', so that a poor, less powerful, and less connected woman's ability to access resources

[11] The term *minoritized* is used instead of the more conventional concept of 'minority group' to emphasize the relative lack of access to material and social resources and opportunities that determine the health of some populations rather than on the numerical size of the group that is often suggested by the minority-majority binary (Reitmanova and Gustafson, 2008).

including access to SMNHS, typically requires a link with someone more influential. In this way, economic, social and political disadvantage is reproduced and reinforced by this 'whom you know' phenomenon.

Naturally, and as demonstrated by qualitative findings in this research, differences in social, economic and political disadvantage increase the maternity care needs of women who suffer the worst forms of disadvantage. Differences in disadvantage further introduces differential costs of accessing care for different people, and this violates the second requirement of equity of access which argues for a situation in which individuals or groups face equal or equivalent access and costs of utilization for equal or equivalent needs.

Taken together, the discussion here suggests that a focus on socio-demographic factors through statistical analysis of access patterns and differentials alone would be likely to miss the complexities of unequal access to SMNHS. For example, in the context of this research, one is unable to recognize from my analysis of quantitative data in chapter four the fact that majority of the women with the lowest access rates are first of all *minoritized* groups, and secondly, they come from regions such as Upper West and East, Northern and Volta that generally suffer the worse forms of multiple deprivation including wealth, knowledge and health (GSS, 2007). This line of thinking would suggest that the observed access patterns are not just the product of differences in SES variables alone. Rather, such access patterns are also the manifestation of the *double disadvantage* these women face. Double disadvantage in the sense that these women belong to *minoritized* groups, which has been shown elsewhere and in this thesis to be associated negatively with accessibility and utilization of SMNHS, and for living in an impoverished region where the prospects of service availability and of getting access to services is heavily constrained.

Perhaps, it is the lack of recognition of the differences in social, economic and political disadvantage that different women face in Ghana that is grossly undermining efforts to ensure equity in access to skilled care. Clearly, if equity in access to SMNHS is to be achieved and the maternal and child health-related MDGs attained in Ghana, there would be the need for efforts to move beyond user-fee abolition and the maternal healthcare system to engage with the social determinants of health as well as address the wider issue of economic, social and political disadvantage.

8.2.2 The Healthcare Delivery System as a Barrier to Access

As early as 1989, the WHO recognized the central role of a functioning healthcare system in the attainment of the objectives of the Safe Motherhood Initiative (SMI). As a blueprint to guide policy, the organization outlined the main characteristics of a functional health system for the delivery of safe motherhood services to include 1) total population coverage so that the services are fairly distributed throughout the region being served; 2) all deliveries attended by trained personnel using suitable facilities; 3) facilities not only accessible but also equipped to cope with pregnancy complications; 4) provision of family planning services; 5) transport managed efficiently in order to support the primary level of care for supervision, supply and referral of emergencies; and 6) health facilities functioning in such manner as to instil confidence in the people being served. More recently, others have also reiterated the argument that the delivery of effective MNH services is dependent on a functioning health system (Purkhurst *et al*, 2005; Bhutta *et al*, 2010).

In chapter five however, findings from my analysis of interviews - many of which I independently and systematically observed during fieldwork - and interpretation of several

narrative accounts from both women and healthcare providers in Ghana revealed that the maternal healthcare delivery system in Ghana lacked many attributes of a functional healthcare system. For example, the maternal healthcare system is still characterized by limited and unequal distribution of maternity services, poor quality of care, distrust in the healthcare system, and lack of transport facilities to facilitate efficient referrals. These attributes of the maternal healthcare system have remained fundamental to understandings of why many women continued to deliver their babies at home despite government efforts to ensure that all births take place in health facilities under the supervision of trained health professionals.

In this section, I shall reflect more on the health system as a barrier to the promotion of universal access to SMNHS. In particular, I shall examine the roles of unequal services distribution, women-health provider relationships, quality of care, trust, choice, and the tension between the health system and TBAs and the way in which this tension has acted negatively upon access to skilled care. I do this with a view to advancing two fundamental arguments. Firstly, that health system failure in Ghana, and by extension Africa, has been a major contributory factor to lack of access and inequitable access to SMNHS. And secondly, that the processes and mechanisms through which these health system failures operate to impact access to skilled maternity care services are not only scientifically complex but also they involve highly complex political and ethical considerations as well.

8.2.2.1 Too Many Here, Too Little There: A Question of Unequal Distribution?

Having access to healthcare necessarily requires an adequate supply of healthcare services (Gulliford *et al,* 2003). A fundamental assumption of Ghana's free maternal health policy is that an adequate supply network of SMNHS are available and if only such services could be made

costless or affordable, all women would access and use them. In chapter five however, findings from FGDs and IDIs data suggested that while the policy of free maternity care should in principle benefit all women, in reality the success of the policy depended on access to health facilities which many women, especially poor rural women, lacked because of long distance or transport and other opportunity costs constraints during referrals and other emergency situations. Findings from qualitative data, which have been corroborated by systematic field observation as well as government health statistics, suggested that variations in access to SMNHS were therefore partly explained by structural distributional imbalances.

Availability and distribution of SMNHS may be measured using such indicators as the number of health facilities, doctors, midwives or hospital beds per unit population. In Ghana, there is widespread variation in the distribution of general healthcare services, with the differences in SMNHS even more exacerbated - southern Ghana relatively more endowed than northern Ghana, and urban districts or communities more endowed than rural communities. Tables 5.2, 5.3, 5.4, 5.5 and 5.6 in chapter five gave a graphic illustration of this argument. Of particular interest to the discussion here is the differences (highlighted in blue colour) in the distribution of health facilities (table 5.2), hospitals beds (table 5.3), health workers (table 5.4), doctor-population ratio (table 5.5) and nurse-population (table 5.6) between the Ashanti and Northern regions where this research was conducted. Whereas the doctor to patient ratio in 2009 was 1:8,288 in Ashanti region, the Northern region had 1:50,751. A similar trend is observed for the nurse to population ratio.

As indicated by women's accounts in chapter five, the unequal distribution of services between these regions was often compounded by transportation-related difficulties such as poor road

conditions, lack of readily available appropriate means of transport, and sparse population distribution across geographic regions, which made provision of health facilities and services extremely difficult. In the Central Gonja district for example, and this is true for the entire Northern region, it is very common to find a one or a three-man community at a considerable distance away from another or a health facility. Consequently, it neither made economic sense nor was it viable to ensure that healthcare was within the reach of such communities.

Within the healthcare literature, unbalanced distribution of health workforce between and within countries is acknowledged as a worldwide problem (Dussault *et al,* 2006). Conventionally, health economists' approach to understanding imbalances in geographic distribution is the use of economic theory of labour market behaviour: that distributional imbalances arise when there is disequilibrium between supply and demand for labour in a given area (Dussault *et al*, 2006).

In the context of Ghana however, interviews with healthcare providers suggest that this theory is less useful in explaining the situation as the distribution of maternal health resources and workforce does not adhere to the logic of demand and supply only. This is largely because entry into the healthcare system is regulated and income levels are also relatively similar. Therefore rather than demand and supply, historical reasons of unequal development and resource distribution, coupled with professional, personal, educational and social lifestyle-related factors were mentioned as the main factors driving the imbalances observed between regions. Some of the professional, personal, educational and social lifestyle-related factors reported included opportunity for leisure, educational prospects for children, distance to central cities, and presence of a major hospital.

Unfortunately, many areas in the northern part of Ghana are poor and lack these opportunities hence the unwillingness of health personnel to assume posts in these areas. For example, IDI with the regional director of public health at the Northern regional health directorate revealed that while about thirteen (13) medical doctors were officially assigned to the region between 2010 and 2011, only two (2) accepted their postings to the region. Although the reasons why these doctors refused posting to the region were not openly made known, the regional director's account from the interview revealed that their reasons were similar to the ones discussed above, including fears of overwork due to the few health workers in the region. Similar accounts were given in Mpaha where young midwives often refused to take up postings. At the Mpaha health centre for example, community health nurses lamented over the absence of a midwife at the facility and how they were often compelled to give maternity care services to women even though their training did not equip them with the requisite skills. They also tell of how maternity care equipment including forceps and partographs were wasting away at the health centre because they lacked the skills to use them.

While the mere availability or equal distribution of MNH services did not and probably will not guarantee automatic access or utilization for all women as I have already argued above, my engagement with women in the two study districts showed that the unavailability of SMNHS in several communities, coupled with the related problems of long travel distance and time, difficulties with arranging transport, the high cost of arranging transportation as well as the opportunity costs of travelling long distances in order to seek care, constituted a major barrier to access and equitable uptake of SMNHS.

To the extent that inequality in the distribution of MNH services has resulted in and/ or exacerbated inequity in access levels and differential health benefits for different population groups - with poor and marginalized groups benefitting the least - the existing distribuendum ought not be tolerated. This line of argumentation can be sustained by the invocation of the 'difference principle' or the 'maximin' in Rawlsian theory of justice and equity, which suggests that social and economic inequalities or inequalities in access and use of SMNHS in the case of this research, should only be accommodated if they inure to the greatest benefit of the least advantaged (Rawls, 1971). This implies that in addition to its direct negative effect on equitable access, the unequal availability and/ or distribution of SMNHS in Ghana also raises critical economic and ethical questions about the level of resources required, the distributional principles needed to aid the allocation of MNH resources and workforce to different parts of the country. To these questions I shall return later. For the moment, it suffices to say that if equity in access to skilled maternity care services is to be achieved, there is the need for redistribution of MNH services in order to compensate and meet the needs of those who have been disadvantaged by the current system of distribution. Put another way, either pregnant women would have to be enabled to move closer to the services, or the services have to move closer to the women.

8.2.2.2 Quality of Care: A Neglected Dimension?

Pechansky and Thomas (1981) have drawn attention to the fact that the ability to access or not access healthcare services ought to be looked at beyond the availability of a particular health service. Accordingly, access should be viewed as describing the 'degree of fit' between patients and the healthcare system, and that this degree of fit is influenced by such factors as service quality and acceptability. This is, in fact, what qualitative findings presented in chapter five of

this thesis demonstrated: service availability and affordability did not necessarily ensure acceptance, increased access and equitable access and utilization.

In this section, I shall reflect more on the issue of service quality. I aim to show that 1) women's perception of the quality of maternal and newborn health services offered at health facilities in Ghana is an important determinant of access; 2) the issue of care quality has largely been neglected under Ghana's free maternal healthcare regime nevertheless; and 3) the lack of attention to the quality of maternity care services offered at health facilities in Ghana may be part of the reasons why efforts to increase access and reduce inequities in access are not yielding the desired results. But first, two issues need clarification.

The first is that in the literature, the relationship between quality of care and access is an ambiguous one. For example, whereas Maxwell (1984) identified access as one aspect of quality in healthcare, Gulliford *et al* (2003) see quality as an aspect of access. My research found good enough theoretical and practical reasons to argue in favour of quality as an aspect of access. First, access can be independently viewed as concerned with how healthcare is distributed in a population, hence issues of inequality and equity becomes relevant. Second, and on the contrary, quality of care [in maternal and newborn healthcare] focuses attention on the clinical and interpersonal content of individual women's contacts with the healthcare system. Indeed, women and healthcare workers in this study spoke of quality in terms that emphasized the appropriateness and effectiveness of clinical care provided or that ought to be delivered.

The second issue is that determination of quality of care is political much as it is scientific. And depending on who is making the judgement, the judgement approach adopted, and the purpose for making such judgement, different results can be had from an assessment of a particular

service. Measuring women's perception and satisfaction with care quality is particularly problematic because it can be highly subjective or be unnecessarily influenced by factors such as previous experiences, physical and psychological health, and personal and societal values, which may not be generalizable to other women's experiences. For this reason, one of the widely used 'quality of care frameworks' developed by Bruce (1990) argues that high quality care should include aspects relating to information given about the woman's condition and the treatment protocol. Women should also have the opportunity to ask questions and receive clear and satisfactory answers, have their decision-making rights respected, and have the chance to express worries.

In this research, both clinical standards (e.g. general clinical management, care during emergency, availability of infrastructure, appropriate health personnel, equipment, consumables and information provided in clinical case notes), and psychosocial approach (e.g. patient perception and satisfaction) to care quality assessment were used (see Ansong-Tornui *et al*, 2007 also on the use of this approach). The assessment was particularly guided by van der Wal's (2002) suggestion that quality should not only be based on the availability of essential consumables, professional knowledge, skills and values, but also quality has to be imbued with the concept of caring, including the humanistic attributes of competence, confidence, commitment, compassion and conscience.

Findings from my research in Ghana on the issue of quality of care clearly showed that most of the components of quality care are lacking from the pregnancy and childbirth experiences of the women interviewed for this research. As shown in chapter five, women in Kuntanase and Sankpala preferred to go elsewhere for SMNHS instead of those provided in the health facilities

within their community because of poor care quality. In other words, poor quality care acted as a disincentive for women's access to skilled care. Elsewhere, other researchers have drawn attention to the recurrent problem of bad quality care as a barrier to accessing and using skilled care services in low-income countries (Jewkes *et al*, 1998; d'Oliveira *et al*, 2002).

Interestingly, both women's and health providers' accounts suggested that paradoxically much of the problem of poor care quality has been occasioned by the implementation of Ghana's free maternal healthcare policy itself. This is largely because of the incremental effect the policy has had on access and the fact that not enough investment was made to expand existing infrastructure to accommodate the increases in the number of women who were now entering into the formal healthcare system to use skilled maternity care services. This has led to overcrowding or what women described in chapter five as the 'new slums' in health facilities, long waiting time before care is received, and excessive workload on healthcare providers. Indeed, that Ghana's free maternal healthcare policy has contributed to the deterioration of care quality re-echoes the findings of one previous clinical evaluation of hospital-based maternity care in Ghana which suggested that on admission women often received poor care (Ansong-Tornui *et al*, 2007).

But my analysis of literature related to the overall performance of Ghana's healthcare delivery system suggests that the issue of poor maternity care quality may also be linked to a generalized health delivery system problem. For instance, in a 2006 review of six research projects commissioned by the Health Research Unit of the Ghana Health Services (GHS) (cited in the 2007-2011 Strategic Plan of the Quality Assurance Department in the Institutional Care Division of the Ghana Health Service), it was found that while the majority of users of health services were generally 'very satisfied' with specific programmes and services, many were 'dissatisfied'

with long waits times, poor personnel attitudes, illegal charges, and unclean environments. These findings were corroborated by a study by Turkson (2009). One recent World Bank evaluation (Saleh, 2013) of the health sector in Ghana similarly concluded that Ghana's health facilities do not meet appropriate standards of care: 'most clinics, health centres and maternity homes did not have appropriate standards for emergency obstetric and neonatal care' (p.48).

It is within the above context that some of the women interviewed for this study were willing in some instances to travel further in order to access quality care. That women were willing to commute longer distances to access quality care is particularly interesting because it shows that women sometimes consider the quality of care more than the cost. This is one of the central arguments Thaddeus and Maine (1994) made in their well-known 'three delays model' of accessing maternity care services. But it is also interesting for another reason. It challenges the relevance or primacy of geographic distance - the so-called 'distance decay effect' which has long been upheld as an important determinant of health service access and utilization (see Bour, 2004) - in contemporary discussions of maternal health services accessibility and utilization in Ghana.

Much as the genesis of these substandard care practices within the maternal healthcare system in Ghana is difficult to trace, my research findings are significant in highlighting the fact that poor quality of SMNHS, real or perceptual, does prevent women from accessing and using care services even if such services are freely available. This conclusion is in direct discord however, with one exceptional study in the Kassena-Nankana district of the Upper East region of Ghana, which found that community perceptions of quality of care was not associated with use of health professionals for delivery (Mills *et al*, 2008). Given the many challenges associated with the

health system in Ghana, it is simply curious that quality of care was not a determinant of delivery care utilization in Mills and Colleagues study. Perhaps, such a finding illustrates the possible existence of some under-studied events or mechanisms such as the development of *adaptive preference*, whereby in a situation where poverty is rife, and healthcare services and resources limited, patients simply become content with the status quo. Be that as it may, the findings in this study clearly show that quality matters and that service availability and physical proximity to services may be necessary but insufficient conditions for access and utilization to occur.

If access to skilled care is to be increased in Ghana and in other similar low-income countries, there is the need for improvement in care quality. This is more so because it would be unethical to continue to promote access to known bad maternal health services (De Brouwere *et al*, 2010). Besides, the focus in the past few decades on encouraging a shift from home-based to institutional delivery will be misplaced if efforts to improve the quality of care a women receives in a health facility is not improved (Knight *et al*, 2013). Further research to not only assess the quality of maternity care provisioning, but also to develop simple, replicable assessment tools and techniques that could be used to evaluate the quality of care provided at health facilities would therefore be important. For example, the development and use of such tools could enable maternity care providers and healthcare managers to easily identify maternity care facilities that deliver sub-standard or sub-optimal care. This would be important for both making and monitoring the desired levels of improvements.

8.2.2.3 Women-Health Provider Relationships

Previous studies have shown that patient-provider relationships influence access and utilization of SMNHS (Mathole & Shamu, 2009). Qualitative data presented in chapter five of this thesis corroborated this literature to a very large extent: women's previous experiences of seeking

maternity care from a health facility and the nature of their encounters with caregivers determined to a large extent future use of such services. In this section, I want to highlight one dimension of the patient-provider relationship that many previous researchers and healthcare providers in Ghana have overlooked, but which nevertheless negatively affected women's willingness to access and use SMNHS. This dimension relates to the conflict between women's psychosocial needs such as social support and privacy during labour on the one hand and healthcare providers' emphasis on the technical regime of rigid routine procedures and regulations of obstetric care on the other hand.

As shown in chapter five, a majority of the women interviewed in this study valued relationships with care providers that were characterized by warmth, support and good communication. Most women also preferred supportive and caring attitudes from healthcare providers, and avoided health facilities and healthcare providers who were rude, disrespectful, unsupportive or those who used abusive and reprimanding language even when it was not necessary. Despite this, in ANC clinics and labour wards, healthcare providers often gave importance to the application of technical procedures in the management of pregnancy and birth in health facility settings. Because of systematic attempts to completely medicalize all the features of childbirth, clinical consultations were heavily characterized by ritual and symbolic elements of power and control in which healthcare providers not only dominate the process, but also reduce the level of women's participation in decisions relating to obstetric care, and as well ignore the emotional processes women undergo during pregnancy or labour.

As a result, both the clinical consultations and the general relationship between women and maternity caregivers within health facility settings in Ghana have not only become transactions

between lay and professionals, but also transactions between two parties separated by differences in social and symbolic power. Doctors, midwives, and nurses determine what is wrong with pregnant women or those in labour, they offer treatment remedies and instructions, and women are expected to accept and comply with these diagnostic and prognostic regimes. Although this is very consistent with empirical research findings from other parts of SSA where the interactions between healthcare workers and women in ANC clinics and labour wards are heavily characterized by authority and passivity (Jewkes *et al*, 1998), it is a very intimidating experience for many of the women interviewed in this research. This created significant gaps between existing maternal health services and women's requirements for supportive care, and linguistically and culturally appropriate information. This gap was often compounded by the cultural and functional adjustments women often have to undergo when a visit or referral is made to an unfamiliar health facility setting or healthcare provider. The combined effect of this has been to discourage access and utilization of SMNHS. This supports the findings of other studies in SSA which showed that the bad relational practices of healthcare providers have a negative effect on access and equitable use of skilled care (Jewkes *et al*, 1998; d'Oliveira *et al*, 2002).

Surprisingly, many MNH care providers in Ghana remained unaware of, or simply ignored the impact of their relational practices on women's maternity care seeking behaviours. With growing global emphasis on the principle of autonomy (the idea that people should be able to reflect on their own best interests and make decisions for themselves) and patients involvement in healthcare, it is particularly interesting that Ghana's maternal health system follows the traditional model of doctor-patient relationship in clinical practice where the physician has a paternal role, making decisions about what is believed to be in the best interest of the patient, and the patient is expected to accept treatment or advice without question (Burls, 2000).

8.2.2.4 The Trust Crisis in Skilled Care: Institutional Failure or Sceptical Patients?

Aside from imbalances in the distribution of health resources, perceptions of declining quality of care, and a healthcare system that is technocratic and impersonal, one of the recurrent themes from qualitative data is the issue of trust in both the healthcare system and the providers of care.

Trust can simply be understood as the anticipation that other people will reason and act in one's interest. Nobel Price Laurent, Kenneth Arrow is one of the early scholars to have articulated a formal theory of trust and its role in human relationships. In *The Limits of Organization* (1974), Arrow argues that trust is an important lubricant of the social system. 'It is extremely efficient, it saves a lot of trouble to have a fair degree of reliance on other people's word' (pp.23). For Arrow, it is the existence of 'invisible institutions' i.e. the principles of ethics and morality which constrain individual behaviour and encourage trust.

While Arrow wrote within the realms of economics and organizational behaviour, the concept of trust can be, and indeed, has been extended to the field of medicine and healthcare (Shore, 2007). In medicine, trust is commonly thought to play a vital role in the patient-doctor relations: 'Trusted doctors are those believed to act in the interest of their patients by providing competent advice, responsible treatment, and compassionate care that contributes effectively to patients' wellbeing' (Norris, 2007:32)

In the context of this research, trust extended beyond the doctor-patient relationship to the healthcare delivery system itself. Qualitative data presented in chapter five suggested that women's trust in the ability of some healthcare institutions and types of care providers to help

them [women] address all possible vulnerabilities and dangers that come with pregnancy and childbirth was an important factor that not only facilitated patient-physician communication in ways that enhanced diagnoses, treatment, and compliance, but also influenced care-seeking decisions. FGDs and interviews with women and healthcare providers showed that where there was erosion of trust or confidence, whether in a health institution or a healthcare provider, the political legitimacy and scientific and therapeutic authority of such institutions or persons was not only undermined, but also women failed to access and utilize SMNHS offered by such institutions or care providers. This notwithstanding, the data further showed that trust in both maternal health care institutions and caregivers is generally on the decline. It is for this reason that the analysis provided in this thesis speaks of a *trust crisis* in Ghana's maternal healthcare system.

But understanding the trust deficit and how it acted to limit access to care demands an understanding of the knowledge world of the women who participated in this research. As shown in chapter five, women's evaluation and distrust of caregivers was not based on whether caregivers have been adequately trained to obtain the required clinical skills to give maternity care. Rather, women based their judgements on experiential knowledge of caregivers, empathy and sharing of personal experiences. Such a finding is very consistent with one recent qualitative study in Cambodia, which reported that women's perception of the limited midwifery competences of skilled birth attendants at health centres undermined their decision and willingness to access and use SMNHS (Matsuoka *et al*, 2010). In fact, women's distrust in the skills of caregivers and maternity care institutions is supported by the findings of one clinical evaluation panel in Ghana, which reported that the competence and ability of health personnel to deal with obstetric emergencies was inadequate; hence they seemed ill prepared to deal with

some of the common obstetric conditions (Ansong-Tornui *et al*, 2007). Institutional failures and professional incompetence may therefore partly explain this trust deficit.

But one other potential explanation is what I call the *sceptical patient syndrome*. The idea here is that there seems to be a general process of value change, at least in the communities where this study was done, whereby populations, especially in urban settings, seem to have developed increased and sophisticated cognitive skills and abilities to become more critical of the performance of public institutions and other non-traditional sources of authority, including healthcare facilities and healthcare workers. For example, while acknowledging the benefits the free maternal health policy has brought in terms of significantly easing the financial burden on MNH services accessibility and utilization, some women were weary of the benign consequences that have attended the implementation of the policy such as overcrowding and delays in maternity wards, inefficient referral systems, substandard care, lack of critical healthcare staff, and ill-treatment of patients by health workers.

Such a development appears to be fuelled by rapid urbanization, technology and mass media, which have made information sharing much cheaper and easy. The tendency of mass media to report scandals and corruption in public institutions has been particularly significant in this process in Ghana. For example, healthcare providers talked about the fact that patients have become rather more demanding, often insisting on the treatment of their choice even in situations where healthcare facilities were not capable of providing those services. In many instances where healthcare facilities were unable to offer a particular healthcare service, there were often massive suspicion and rumours among patients regarding the belief that health workers were involved in siphoning public funds and medicines for personal or private gains at the expense of patients.

Interviews with healthcare providers indicated that these rumours and suspicions have provoked certain ‘‘undesirable behaviours’’ among patients including, patients’ lack of appreciation for the services rendered as well as an increase in the number of patients who attempt to abuse and undermine the system.

That there is a trust crisis in Ghana’s maternal health system, which is increasingly undermining efforts to ensure increased and equitable access to SMNHS is therefore no exaggeration. What is unclear however is the source of this trust crisis, and in particular, its relationship with the implementation of the free maternal healthcare policy. It is reasonable and perfectly plausible to argue that distrust in the care system may have existed prior to the implementation of the free maternity care policy. The evidence from my engagement with both maternal healthcare providers and service users is that the period of free maternity care in Ghana is also a period of widespread distrust in skilled health facility-base maternity care. Both women and healthcare providers’ accounts suggest that the marginal increase in demand for SMNHS initially occasioned by the implementation of the policy, and the concomitant training and deployment of young midwives to both augment and replace aging midwives, may have aggravated the trust crisis.

8.2.2.5 Free Maternity Care, Choice and Access: State Altruism or Paternalism?

Within reproductive medicine, ‘choice’ and ‘right to choose’ are terminologies very explicitly associated with women’s control over their reproductive decision-making. In many high-income countries in the West, a shift from highly medicalized hospital births to women-friendly midwifery approaches to childbirth has occurred during the last two decades, as governments’ health policies became more cognizant of the importance of the psychosocial aspects of maternity

care (Kabakian-Khasholian *et al,* 2000). In the UK for example, government recommendations about the choice of maternity care since the early 1990s have been that, the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety and that women's choices should be allowed (*ibid*).

However, as was shown in chapter five, for several of the women sampled in this research there are limited birthing choices which the modern Ghanaian system of healthcare offered, and this has largely acted to exclude several women who desired some choice and freedom during pregnancy or labour. By choice, women talked about freedom and opportunity to decide and to disclaim, and to accept and to repudiate. Unfortunately, women said these were all options often denied them under the current maternal healthcare system in Ghana. For example, despite years of advocacy for domiciliary delivery with skilled health personnel in attendance to address women's special needs, the hospital remains the only sanctioned birthplace where women are expected to be delivered and to be covered by the free maternal health policy. In instances where women have expressed a desire to be delivered at home by a trained birth attendant, healthcare workers do not often support such desires. Similarly, nurses and midwives would usually not go to women's homes to conduct deliveries even if they were called upon to do so. Rather, nurses expected the labouring woman to either walk or be carried to the health facility before help was offered.

Related to the above, interviews with women also showed that women had concerns with privacy issues, including difficulties of communicating private health information to healthcare providers in the presence of other patients, sharing of hospital room with other women, and lack of rest due to roommates' frequent visitors. While many desired privacy, it was not always possible to have

it either because space for clinical consultation was limited or the space was inappropriately designed.

That women desired privacy was largely because of its symbolic and practical importance in the management of pregnancy and childbirth. As shown earlier in chapter five, within the socio-cultural milieu of the communities in which this research took place, pregnancy and childbirth are phenomena often consigned to the private sphere. The processes leading from conception to birth, and even immediately after birth, are shrouded in secrecy, and all efforts are made to shield the process from the prying public eye. It is within this context that women insisted on keeping what is private, private. It is also in this light that women found SMNHS offered at clinics, health centres and hospitals lacking in offering choice, protecting their privacy or simply keeping the private, private.

Of course, it is true that limiting women's birthing choices to a health facility setting in Ghana may have some positive outcomes. As has been argued severally by the WHO, the global health community, and the medical profession in Ghana, it is in accordance with the protection of women's best interests. An argument for choice would therefore have to be counterbalanced by arguments founded on promoting and enhancing the wellbeing of women or the ability of the health system to effectively promote the particular choice. Indeed, given that current global consensus on improving MNH puts emphasis on health facility delivery, it is perhaps out of fashion, if not controversial, to raise the point about where childbirth takes place.

However, as shown by qualitative in-depth engagement with pregnant women and lactating mothers in Ghana, the provision of specific skilled maternity care services free-of-charge at

designated places, although may be in the long term interest of birthing women, limited their choice. This was often complicated by the fact that birth territories are not just simply locations for giving birth; they are spaces imbued with cultural interpretations and moral significations, so that the way in which a particular birth territory is viewed - positively or negatively – greatly determined women's decisions and willingness to access and use the birthing services offered at such birth spaces. For this reason, a libertarian critique can be made of the Ghanaian state's morality and approach as regards where and how childbirth should take place. Specifically, the state, and by extension, the health system, can be critiqued for being altruistic and paternalistic – *paternalistic altruism* – at the same time in its approach. In other words, while the state, through the provision of free care to pregnant and labouring women engages in some altruistic acts of solidarity meant to wish women and their babies well, it engages actively in paternalism by making the free care conditional upon a woman seeking care from a health facility and from particular providers – acts that involved limiting, changing and aligning the choice and preference set of women in line with those of the state and the health system.

8.2.2.6 Chasing out TBAs: In the Interest of Modernity or Mothers?

Traditional birth attendants (TBAs), who are often illiterate elderly women and who usually learn their midwifery craft from personal experience and from older women in their community, have historically operated throughout Africa and Asia. However, it was during the 1970s-1990s that the WHO, UN, and donor agencies mooted the idea of formally recognizing and training TBAs as a strategy to reduce maternal and neonatal mortality and improve maternal and perinatal health in low and middle-income countries (Ana, 2011). Since then, the pros and cons of TBAs have been the subject of fierce debate among maternal healthcare professionals worldwide and several

repeated assessments have been conducted to ascertain whether the strategy works (see Sibley *et al*, 2004; Sibley *et al*, 2007; Darmstadt *et al*, 2009; Ana, 2011; Harrison, 2011).

In this study, my analysis of both quantitative and qualitative data in chapter four, five, six and seven showed the relatively important position TBAs occupy in maternal healthcare provisioning in Ghana. Qualitative data suggested that TBAs are often seen as easily accessible and culturally competent and acceptable providers of maternity care services, particularly births at home in rural Ghana. Particularly insightful was the revelation that TBAs are able to attend to some of the longstanding traditional practices of pregnancy and childbirth, which are rooted in the beliefs and cultures of expectant mothers such as burying the placenta around home or in a warm place. These findings are in agreement with other previous studies elsewhere which reported TBAs as preferred maternity care providers because of their cultural sensitivity, easy accessibility and cheaper services (Titaley *et al*, 2010; Warren, 2010; Shiferaw *et al*, 2013). They are however in discord with Mbaruku *et al* (2009), who found in rural Tanzania that, women were very dissatisfied with the services and practices of TBAs.

But what is also unique about the research that I carried out in Ghana is the demonstration of how discourses of home birth, and in particular the role and practice of TBAs in the process, has been characterized by ambiguity and uneasy tension among both childbearing women and healthcare workers in a progressively modernizing Ghana. From a more sociological perspective, homebirths and the role of TBAs have presented both a site of struggle whereby the state (through the GHS) and childbearing women and their kin groups negotiate for control, and a cultural space where social meanings are produced and reproduced. This is because while several women expressed their satisfaction with, and desire for both home birth and the services of TBAs, a few women and most health workers criticized TBAs on account that they are usually

uneducated elderly women who often have had no training and have only limited understanding of the complexity of the anatomy and physiology of pregnancy and birth, and who often engaged in very dangerous and life-threatening practices during labour. Others even blamed women's preferences for TBA services on the backwardness of such women who continued to patronize TBA services.

Such local criticisms resonate with some opinions in the literature, which argue that TBAs do more harm than good (Harrison, 2011). In Ghana, this criticism of TBAs and their practices has led to a split between the formal health system and the activities of TBAs. Even in regions such as the Northern region where the formal health system continues to officially acknowledge TBAs as partners in maternity care the relationship is neither clearly delineated nor cordial.

Yet, experiences from other countries, and indeed from one of the communities where this research was conducted – Piase in the Bosotwe district - indicated that access and use of SMNHS could be better promoted in a system that integrated TBAs with the modern health system (Ofili & Okojie, 2005; Gabrysch & Campbell, 2009). Various evaluations of programmes, which promoted trained TBAs, have indicated that TBAs' services could increase women's use of antenatal care and emergency obstetric care, and decrease perinatal and neonatal mortality (Sibley *et al*, 2004). A Cochrane review based on four studies from Pakistan, Bangladesh, Guatemala and Malawi involving 2000 TBAs and 27000 women concluded that the potential of TBA training to decrease newborn death is promising, when combined with improved health services (MacArthur, 2009). This raises questions as to why stronger partnership has not been forged between GHS and TBAs?

Of course the issue of which type of healthcare providers should be recognized and or included in the maternal healthcare delivery system should be a pragmatic one, base on cost, quality, acceptability and coverage. However, from the evidence presented thus far, it seems that criticisms and objections to the practices of TBAs emanated from a maternal health system that is increasingly haunted by, and intolerant of, fears of the ‘‘old ways’’. Ghana is progressively aiming to be a modern state, and therefore the power of modernity shapes ideas and practices relating to reproductive health policy and planning. For instance, Ghana’s Reproductive Health Strategic Plan (2007-2011) emphasizes the reduction of maternal and neonatal mortality and morbidity through the modernization of obstetric care.

Like Harrison (2011), I would concede that the optimal intervention to improve maternal and newborn health outcomes might be to increase the proportion of births attended by skilled birth attendants (SBAs). However, given the shortage of SBAs in Ghana and across SSA as indicated by the latest WHO report on the 'state of the world's midwifery' (WHO, 2011), it is clear that this ideal is not feasible or achievable in the short term. Led by the best available evidence at the moment, reasonably acceptable equity and efficiency arguments can be made for the building of working partnerships with, and incorporation of TBAs into the maternal healthcare system.

First, TBAs typically work in remote settings, where women may not be able to access healthcare facilities even if they needed such care and if such care was free. Second, the costs associated with the services TBAs provide are relatively cheaper. Third, and as shown in this research, there are often strong cultural preferences for home births and the services of TBAs, partly because TBAs are trusted members of the community who speak the woman's language and understand her tribal culture. Indeed, to the extent that the practices of TBAs persist and are desired in

Ghana, they do so largely because of their interconnectedness with their clientele. Finally, the current available evidence is that TBAs do more good than harm hence they can be engaged as an effective complementary alternative solution for many women, particularly in rural areas in low-income settings such as those communities who participated in this research.

To conclude my discussion on the healthcare delivery system, it is clear that fundamental weaknesses in Ghana's maternal healthcare delivery system have contributed to the twin problem of *under* and *inequitable* access and use of SMNHS. This knowledge not only enhances the answer to part of the fifth research question relating to how the healthcare system affects access to SMNHS, but it also reinforces the findings of other studies in some parts of Africa that have identified lack of access and inequitable access to skilled maternity care services as a function of poorly functioning health systems (Mbaruku & Bergstrom, 1995; Urussa *et al*, 1997; Walraven *et al*, 2000; Stekelenburg & Roosmalen, 2002; Cham *et al*, 2005). The findings from my research are also unique in challenging efforts that concentrate on providing free maternity care without the needed regard for availability, accessibility, acceptability and the quality of care provided. As the discussion illustrated, in instances where health facility care was sub-optimal because of poor care quality, distance, lack of courtesy or lack of privacy, traditional home birth made sense to women. This aspect of the discussion further highlights how a focus on patient-side or demand-side factors in the decision to access skilled care can conceal the fact that many health systems and maternity healthcare facilities in low-income settings such as Ghana are still chronically under-resourced and incapable of effectively providing an acceptable minimum quality of care in the event of serious obstetric complications.

8.2.3 Culture as a Barrier to Access

Culture, understood broadly as the dynamic and 'complex whole' that refers to the learnt and shared pattern of thoughts and behaviour characteristics of a social group (Brown, 1998), is one of the recurrent themes in this research. Qualitative narrative accounts of women and healthcare providers in the Bosomtwe and Central Gonja districts, which I presented in chapter six, highlighted the crucial role socio-cultural beliefs and practices play in maternal healthcare access among different cultural groups.

In this section, I shall reflect more on the role of culture as a barrier to equitable access and use of SMNHS. I shall particularly examine the role of cultural beliefs and practices, women's decision-making power, and religion as they relate to, and affect accessibility and utilization of SMNHS in Ghana. I do this with a view to enhancing understanding of the importance of cultural factors in maternity care as well as demonstrating the fact that the processes and mechanisms through which these cultural factors function to limit access to SMNHS are rather more complex than most epidemiological survey data analyses would usually suggest.

8.2.3.1 Cultural Beliefs and Practices and Skilled Care Access

As already noted above, qualitative findings from my research suggested that differential access and utilization of SMNHS could be related to differences in *cultural beliefs* and *practices* among different cultural groupings. In simple terms, cultural beliefs encapsulate the ideas, norms, values, standards, thoughts and expectations a given culture has generated for its participants (Davis, 1949). Cultural beliefs often aid the definition of what is right or wrong, hence they govern interaction among participants in a given culture as well as interactions with other groups. While in general, cultural beliefs become identical and commonly known through the socialization process by which culture is unified, maintained, and communicated, cultural beliefs are dynamic

and changes in cultural beliefs due to historical and individual events often form the basis for cultural evolution and change (Bandura, 1977).

Related to cultural beliefs are cultural practices, which may be viewed as patterns of behaviours, conducts and social interaction that are generated by the everyday enactment of cultural beliefs. In other words cultural practices are the manifest embodiments of what to do, when and where in a given cultural milieu.

Culture, cultural beliefs and cultural practices, however senseless or destructive they may appear from the personal and cultural stand point of others, always have meaning and fulfil a function for those who believe and practice them (Bandura 1977). The problem however is that sometimes they can compromise the physical and psychological health, dignity and integrity of certain individuals in society. This is exactly what qualitative data from my research in Ghana showed: in the name of preserving culture, a lot is done which sometimes eroded the ability of women to access and use SMNHS. For example, due to cultural beliefs and norms of age and age hierarchy conflicts among the Akan, Dagbani and Gonja ethnic groups, older women sometimes chose to give birth at home to avoid being attended to by young midwives and health workers who are of the same age as their own children. In Sankpala, Tidrope and Mpaha - areas inhabited mainly by people of Mole-Dagbani ethnic background – cultural practices such as *trigibu* made it difficult for first-time-mothers to access and use skilled care because of the need to maintain secrecy about their pregnancy until such rites of passage were performed.

In other instances, cultural beliefs, which viewed pregnancy and childbirth as a test of endurance and tolerance of physical pain, limited women's ability to access and use SMNHS. Similarly, the

belief that a woman who gave birth in a health facility was 'not woman enough' or had a questionable character was found to discourage a significant number of women from giving birth in health facilities. In other cases, the shame and public ridicule associated with pre-marital or extramarital pregnancy made it difficult for some women to seek skilled ANC, DC or PNC services. In addition, many women believed pregnancy and childbirth were natural reproductive events and therefore did not require routine medical interventions. This type of conceptualization, as my research showed, had the fatalistic consequence of discouraging women from accessing and using health services.

That cultural beliefs and practices negatively affected women's ability to access maternity care services has two implications. First, it suggests that much as it is important to recognize and criticize the limits imposed by local health systems barriers to SMNHS as I have done above, pregnancy and childbirth management in these communities must also be understood as a cultural artefact within which decisions regarding access and use of SMNHS are influenced not just by skilled care services availability, physical accessibility or costs (affordability), but also by socio-cultural beliefs and directives which influence how childbearing care services are perceived and used. And second, it shows that for some women the decision to access SMNHS is not always based on the availability, affordability, efficacy, and acceptability of these services. Rather, basing decisions on factors such as the avoidance of shame or waiting for *trigibu* to be performed can be a legitimate and logical way of trying to minimize different kinds of threats.

While it is undoubtedly clear that cultural factors are playing an important role in the problem of under access and inequitable use of SMNHS in Ghana, it is important not to unduly ascribe a deterministic power to these cultural factors. This is critical because culture itself is dynamic, and

as demonstrated by qualitative research findings in chapter six, the processes by which culture exerts its influence on access and use of SMNHS are sometimes ambiguous and malleable. For example, in some instances women were found to have defied age hierarchy norms to access ANC, DC and PNC services from female midwives or other female healthcare providers who were young enough to be their children. Similarly, some women who became pregnant in a manner deemed culturally unacceptable defied all public ridicule and sought care in a health facility. Likewise women were found to be constantly shifting between traditional home-based maternity care and modern maternity care services during one pregnancy to the other depending on outcome and experience. Often, the shifts from traditional forms of maternity care to more modern forms of care were neither unidirectional nor do they just result from increasing enlightenment and complete behavioural and attitudinal change towards a particular system of care. Rather, these shifts were sometimes precipitated by the nature of the pregnancy (whether 'legitimate' or 'illegitimate'), availability of transportation, the presence of relatives, links with a TBA, and the immediate circumstances under which labour started.

The above suggests that use and non-use seem to be in constant flux, dictated to by both cultural conditioning and pragmatic or practical weighing of alternatives rather than irrational attachment to culture or tradition. Such an eclectic pattern of service accessibility and utilization calls into question explanations of healthcare services utilization as a consistent choice of individuals or communities (Obermeyer, 1993). Such shifts also dull any attempt to see culture as mounting an insurmountable barrier to SMNHS access and use. Therefore, instead of considering women's decisions regarding access and use of skilled birthing services to be determined by cultural beliefs and practices, it is perhaps more helpful to consider women's choices and preferences as influenced by variety of cultural factors over which they have varying degrees of discretion and control. That way, what is required understanding is how cultural barriers to access evolve and

change over time and how this changes women's ability and willingness to access and use SMNHS.

8.2.3.2 Culture, Gender Equity, Intrafamilial Power and Access

Women's ability to make decisions either alone or in consultation with other people at the level of the family or household regarding access to SMNHS is another recurrent theme in this research. This section reflects on the role of women's decision-making power (autonomy) at the family, household and community level and how this affects their ability to access and use SMNHS. The aim is to show how the goal of providing free maternity care can be undermined by women's lack of decision-making autonomy through complex processes of gender inequality and social power.

Within the literature related to maternal health, women's decision-making ability as regards access and use of health services is often discussed using the concept of autonomy (see Balk, 1994; Matthews *et al*, 2006; Fotso *et al*, 2009; Woldemicael & Tenkorang, 2010; Hou & Ma, 2012). Autonomy is a multidimensional concept and my analysis of the literature suggests that there is a range of theories concerning what autonomy is and how it should be understood (Mason, 1995; Beauchamp and Childress, 2009). Notwithstanding the complexities of these philosophical debates, perhaps for the purposes of the discussion here, autonomy may simply be viewed as the idea that people should be able to reflect on their own best interests and make decisions for themselves. In the words of Beauchamp and Childress,

> Personal autonomy encompasses, at minimum, self-rule that is free from both controlling interference by others and from certain limitations such as inadequate understanding that prevents meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan…A person of diminished autonomy, by contrast, is in some respect controlled by others or incapable of deliberating or acting on the basis of his or her desires and plans (2009:99).

In the specific case of women's autonomy, it means that a woman has the capacity and freedom to act (e.g. the ability to go to a health facility alone or without asking anyone's permission) independently on her own. The essential conditions for autonomy in this definition, and indeed which most theories on the concept acknowledge, are *liberty* (independence from controlling influences) and *agency* (capacity for intentional action) (Beauchamp & Childress, 2009).

In the fields of healthcare and health services research, the concept of autonomy has recently been operationalized and attempts made to evaluate its effects on for example, women's ability to access maternal healthcare services (See Fotso *et al*, 2009; Woldemicael & Tenkorang, 2010; Hou & Ma, 2012). It is within this context that my research – which is largely about healthcare and the organization and delivery of health services – investigated how women's decision-making autonomy affected their ability to access and use SMNHS.

In this research, as was pointed out in chapter six, women's participation in decision-making regarding access and use of SMNHS at the family, household and community level was used as an indicator of autonomy. This was informed by the findings of previous research in other low-income settings, which suggested that women's active participation in domestic decision-making is a reflection of their power and autonomy within the household, and may increase their chances of making the right reproductive choices including accessing and utilizing health services (Balk, 1994; Matthews *et al*, 2006; Woldemicael & Tenkorang, 2009). Rather than following the quantitative approach of these previous studies, however, this research used a qualitative approach, which allowed for an in-depth understanding of the processes through which women's autonomy affected their ability to access SMNHS. The lack of this kind of depth of

understanding is a fundamental weakness of previous studies that adopted a quantitative approach to the evaluation of the role of women's autonomy in maternal health care access.

Data from my qualitative research with women and healthcare provides in Ghana largely supports the view that women's inability to make decisions regarding when to access skilled ANC, DC, PNC and other newborn care services constituted a grave barrier to access. For example, data presented in chapter six showed that more than a quarter (26%) of statements relating to women's inability to access SMNHS suggested that women were unable to access skilled care because somebody else made the decision. As many as 35% of the healthcare providers interviewed similarly mentioned women's relative lack of decision-making power at the family level as a barrier to access.

FGDs and IDIs with women suggested that in many instances husbands, mothers-in-law, and TBAs were the major decision makers, especially when an obstetric emergency set in. In several cases as documented in chapter six, the power-play between women, their husbands, mothers-in-law and TBAs has often resulted in women either not accessing needed care or reporting to a health facility only when complications have set in. Such unbalanced power relationships between women and husbands or mothers-in-law at the household level (micro) and the effect on access and use of SMNHS (macro) demonstrate how access can be undermined by women's lack of decision-making autonomy even if such services are free and easily accessible.

But that many women lacked the independence to decide whether to access and use SMNHS in the Bosomtwe and Central Gonja districts of Ghana needs to be understood within two broad contexts, namely gender in/equity (i.e. the allocation of *fair* shares, be it in material resources,

social resources or political power, rather than gender equality, which suggests allocation of *equal* shares) and the culture of communal decision-making.

In relation to the first context, many of the accounts provided by women and healthcare providers noted that a patriarchal ideology, coupled with low levels of female education and high levels of economic marginalization among women particularly in rural Ghana, has created a social, economic and political environment in which women are chronically dependent on men. In this regard, it is important to note one significant difference in terms of social organization between participants in Bosomtwe and those in Central Gonja. Unlike the women from Central Gonja where the predominant mode of socio-political organization is patrilineal, participants from the Bosomtwe district, who were mainly of the Ashanti/Akan ethnic extraction, have historically organized themselves along matrilineal kinship lines. However, as Gray (1982) argues, even in matrilineal societies, men always exercised greater control over the processes of decision-making and resource allocation. In practice therefore, men significantly dominate both the private and public spheres of decision-making in Ashanti culture.

Although many of the research participants acknowledged that the patriarchal ideology, and the low levels of female education and high levels of economic marginalization among women were fast changing especially in urban societies and among the younger generation, they said a combination of machismo, the culture of female submissiveness and women's economic dependence on men still created an unequal power relationship in both public and private spheres. In this unequal power relationship, women often ceded their autonomy and decision-making power to men, including decisions concerning access and use of SMNHS.

But there is another context in which women's maternity care seeking decision-making needs to be understood. Many aspects of life in the communities in which this study took place are organized around the family, household and the community. Within this frame, people tended to be interdependent, and decision-making on matters of importance such as seeking healthcare for a sick person tended to be communal in nature. It is this sense of interdependence and communal decision-making that seem to explain why women lose their autonomous decision-making power to other family members. For example, in the event that a decision has to be made on whether to deliver in a health facility, women's accounts described in earlier chapters show that consultation usually starts with a woman and her husband or the father of the unborn child. From there, and depending on the outcome and situation of the pregnancy, mothers-in-law may then be involved. Other persons such as TBAs, brothers, sisters, and other people in the community may also be invited to help with the decision-making. In rural settings such as Tidrope, FGDs with women revealed that even a person alien to the community may be invited to help with decision-making if such a person is deemed to have some knowledge in pregnancy and childbirth or commanded some respect and authority in some other unrelated fields.

That interdependence and communal decision-making framed some women's ability or inability to access care is clearly in discord with the emphasis on self-rule or independence in discussions around the idea of autonomy. As interdependence and communalism are valued and acceptable ways of social organization and decision-making not only in the communities in which this research was done, but which have also been widely acknowledged and discussed in African philosophical thinking around the relationship between humans (Kamwangamalu, 2007), the concept of autonomy perhaps needs broadening. This said, interdependence and communal

decision-making in the context of this research might be understood further if one invokes the famous but controversial *uBuntu* concept.

uBuntu, variants of which has been found in many African societies, including Ghana, Kenya, South Africa, Tanzania, Angola and the Democratic Republic of Congo (Gyekye, 1987; Masolo, 2004), albeit not necessarily under the same name, is understood as a moral and an ethical ideal representing collective solidarity whereby the self is perceived primarily in relation to others i.e. a person is a person through other people (Maluleke, 1999; Le Roux, 2000). Communalism and interdependence are two central core values of *uBuntu* (Kamwangamalu, 2007). In describing the concept of *uBuntu*, Gyekye (1987) for example quotes Sekou Toure as saying 'Africa is fundamentally communocratic. The collective life and social solidarity give it a basis of humanism…the human qualities means that an individual cannot imagine organizing his life outside that of the family, village or clan' (pp. 2009). Jomo Kenyatta, speaking about the life of the Kikuyu people in Kenya similarly pointed out that 'nobody is an isolated individual. Or rather, his uniqueness is a secondary fact about him; first and foremost he is several people's relative and several people's contemporary…this fact is the basis of his sense of moral responsibility and social obligation' (Kenyatta 1965:297, cited in Gyekye, 1987:209).

Thus the essence of *uBuntu* is that an individual owes his or her existence to the existence of others: 'I am because you are and not you are because I am' and 'a man can only be a man through others' (Mbigi & Maree, 1995:2). It has been suggested that this interpersonal character of *uBuntu* is the source of many of its distinctive virtues that have been highlighted in the literature, including patience, endurance, respect for any human being, for human dignity and for human life, collective sharing, obedience, loyalty, humility, solidarity, sympathy, caring,

hospitality, interdependence and communalism (Gyekye, 1987; Bhengu, 1996; Masolo, 200; Venter, 2004; Kamwangamalu, 2007).

Of course, one has to admit that as a result of contacts with Western cultures through processes of urbanization, information communication technology and globalization, *uBuntu* may have changed or may be changing especially in some parts of urban Africa. My research in Ghana however suggests that it is still a strong binding force. For example, a member of any of the communities where this research took place could use the term 'sister' or 'brother' to refer to any female or male and not necessarily to one's biological siblings. Similarly, a man could also call the wife of his brother's, his wife, while children must never refer to anyone who is of similar age as their father or mother by the person's name; rather they must refer to such persons as 'father' or 'mother'. Indeed, I believe it is in the spirit of *uBuntu* that during my research in the Central Gonja district, I was often addressed as 'a northern brother' as I discussed earlier on in chapter three.

In conclusion, the findings here provide important insights into the relationship between women's autonomy and their maternity care seeking behaviours in Ghana. While acknowledging that the relationship is naturally complex (Woldemicael & Tenkorang, 2010), my research with women and healthcare providers in Ghana showed an important discernible pattern: women who participated more in household decision-making regarding access to maternity care services were more likely to access and use SMNHS than those who took less part in household decision-making. Gender inequity, economic marginalization, and communal decision-making were found to be fuelling women's dependence on men as well as their [women] inability to autonomously make decisions about access and use of MNH services. This suggests that efforts to improve women's economic status and promote gender equity among Ghanaian women may have

potential benefits for increased and equitable access and use of SMNHS. Of course, this is neither suggesting that women's enjoyment of equal decision-making rights at the family or household level will necessarily result in increased access, nor is it suggesting that non-egalitarian gender ideologies necessarily correlate with worse maternal healthcare access for women.

8.2.3.3 Religion and Access

Religious beliefs and practices are another set of cultural factors identified in this study as having significant influences on accessibility and utilization of SMNHS. My analysis of quantitative survey data in chapter four, complemented by qualitative data in chapter six, showed that women professing traditional/spiritualist and Islamic religious faiths accessed and used less of health facility delivery services compared with Christians. That difference in religious beliefs and practices influenced accessibility to, and utilization of, SMNHS is of course not novel. Previous studies in Ghana found that Roman Catholic congregants were more likely to use antenatal care services, take all two doses of TT vaccine, choose a health facility as a place of delivery, and use postnatal care services as compared to other religious groups (Addai, 2000; Gyimah *et al*, 2006; Abor *et al*, 2011). Elsewhere in Zimbabwe, one study also found that women belonging to some Pentecostal Christian religious groups including John Morange Apostolic, Christ Church, and *Mugodhi* were more likely to refrain from use of antenatal care (van den Heuvel *et al*, 1999).

What is novel though is that the qualitative methods employed in this thesis shed more light on the relationship between religion and access and utilization of SMNHS in two important ways that previous studies have not done namely, the mechanism by which the relationship is effected, and the ambiguities embedded in the relationship.

In relation to the first contribution, my analysis of qualitative data from FGDs and IDIs with women and healthcare providers in chapter six suggested that the explanations for why women of certain religious groups are more likely to use SMNHS than others may be sought in differential orientations to theological teaching and different life-style and pragmatic orientations. For example, the findings pointed to why Catholics and other orthodox Christians are more likely to use health facility maternity care services. Generally, the orthodox churches including the Catholic, Methodist, Presbyterian and Anglican churches are by far the largest Christian denominations in Ghana. However, that women from these religious groups access more services is not only linked to their size in terms of membership and coverage, but also their unique historical background in Western medical civilization and the role they have played in healthcare delivery and education in Ghana. As shown in chapter five, of the total of 22,164 hospital beds, which were available in Ghana's formal health delivery system, 5,903 (27%) belonged to the Christian Health Association of Ghana (CHAG). Conservative estimates suggest that the Catholic, Methodist, Presbyterian and Anglican churches provided nearly 99% of the 5,903 hospital beds belonging to CHAG (Schieber *et al*, 2012; Saleh, 2013).

Again, it is not just about the role of these orthodox churches in the provision and delivery of healthcare delivery in Ghana. In addition, their influence appears to stem from a theological orientation that emphasizes the unity of body and soul. In other words, for souls to be saved for God, there needs to be living bodies or healthy humans to be evangelized. As the success of evangelization depends on maintaining a healthy congregation, evangelization has always gone hand-in-hand with the provision of healthcare to their congregants.

Indeed, medical historians who have commented on this subject traced it to the early colonial missionaries who used health and education as a means to converting indigenous Ghana populations to Christianity (see for example Okyere, 2000). It is therefore plausible to reason that women of Traditionalist African religions, whose concept of health and disease aetiology may be different, and who may possibly have resisted Christian conversion, would also be less likely to accept to use health services provided by Christian organizations. Of course, the alternative exists for such people to resort to government and other non-religious, non-government providers, including private providers. However, given that for many communities including those in which this research was conducted, these orthodox churches are a major source of orthodox medical provisioning, such alternatives are heavily constrained.

In contrast, data presented in chapter six illustrated that the upsurge in the number of certain Zionist Christian churches and their membership in Ghana has contributed to both under and unequal access and utilization of SMNHS. Oosthuizen (1989) and Piot (2010) have written of these Christian religious sects as less dogmatic, very charismatic and personalistic, and generally hew to the absolute and literal interpretation of scripture, to the need to accept Christ as personal saviour, to the efficacy and concrete embodiment of the Holy Spirit in the life of the believer, and to the 'End Time narratives'. In addition, the authors characterized these religious sects as emphasizing a break with older narratives and authority structures of the orthodox churches, 'prosperity gospel', healing by faith, plus in some extreme cases, a rejection of medicine and hospital attendance, and alcohol and tobacco consumption.

Many of the features identified above hold true in the context of Ghana. For example, qualitative findings presented in chapter six revealed how among certain charismatic Christian sects

including the Apostolic Revelation Society and *Kyiribentua,* beliefs in faith or divine healing encouraged negative attitudes towards orthodox medicine more generally and hospital-based maternity care in particular.

But it is not only the beliefs and practices of congregants of charismatic Christian denominations that negatively affected access to SMNHS. The religious beliefs and practices of some women who professed Islam were found to equally influence willingness to access and use SMNHS at health facilities in ways that were largely negative. For instance, although Muslim women in the Central Gonja district did not in principle object to receiving skilled care in a health facility, their in/ability to access care was often conditioned by a religious obligation to maintain bodily sanctity through modest dressing and the avoidance of unlawful bodily exposure or contact with certain people including male caregivers. In several instances, this requirement made it difficult for some Muslim women to access care due to the fact that such prerequisite was unlikely to be met in a health facility setting. These findings support previous studies of the maternity care needs and barriers to maternity care access among Muslim women in England (Ali, 2004), New Zealand (De Souza, 2006) as well as among Indo-Canadian and Vietnamese-Canadian Muslim women (Spitzer, 2005). This suggests that some of these religious barriers to skilled maternity care are not unique to Muslim women in Ghana or low-income countries. It also means that countries such as Ghana can learn from other countries, which may have successfully found ways to address this unique maternity care need of Muslim women.

The second significant contribution that the findings in this research make is in relation to the ambiguities that can be uncovered through qualitative analysis of the relationship between religion and MNH care access. Put differently, this research draws attention to the fact that some

times religious affiliation per se does not limit access and that the relationship can be more ambiguous and complex than most epidemiological surveys determine. Instead, the effect of religion on access is mediated by series of intermediary variables, some of which are based on pragmatic reasoning and action. For example, FGDs and IDIs with women in Bosomtwe district revealed that women who were confronted with infertility problems often tapped into different solution regimes, some of which involved the blending and re-blinding of religious identity, beliefs and practices. In this process of shifting religious identity, the relationship between religion and access to care was often manipulated and blurred, so that it was not exactly clear whether it was the nature of the problem and solution a woman faced that determined access to skilled care or religious affiliation per se. This challenges any assumption that asserts religious beliefs and practices as static, such that membership of a particular religious community would always automatically mean access or non-access.

8.3 Conclusion

The complementary quantitative and qualitative methods employed in this research project have proved valuable in revealing the degree to which SMNHS are accessed and used among different segments of the population of women of reproductive age in Ghana. The findings provide an understanding of why some women accessed and used skilled care services while others do not despite these services being provided free or at a minimum cost.

The discussion in this chapter suggests that the feasibility of creating and successfully implementing a maternity care model that is inclusive and creates enough opportunity and incentive for all women to access and use SMNHS in Ghana will depend on how much balance is

achieved between women's own circumstances and valuation of their healthcare needs, priorities and preferences during pregnancy and childbirth on the one hand, and those of state and of healthcare providers on the other hand. This implies that to promote increased and equitable access among different groups in Ghana, there is need for new sets of policies, priority actions, and more inclusive skilled care delivery models simultaneously targeted at different groups in addition to the free maternal healthcare policy.

As a first step towards the development of an inclusive MNH care system, my next chapter reflects on the different solutions for addressing access barriers and promoting equity - which stakeholders proposed in chapter seven - to propose what I shall refer to as a *diversity responsive maternal healthcare model.* Although additional work beyond this thesis may be required to further develop it, the model combines empirical findings from this research with theoretical discussions in the healthcare literature to outline a maternity care system that has the potential to respond to the diverse legitimate needs, expectations, and values of childbearing women in Ghana.

Chapter 9

FREE AND ACCESSIBLE TO ALL: THE CASE FOR DIVERSITY RESPONSIVE CARE

9. Introduction

Ghana's free maternal health policy arose from a positive concern for the health and wellbeing of mothers and newborns, and the policy adopted an egalitarian or a horizontal equity approach to addressing the problem of inequity in access to skilled maternal and newborn healthcare services (SMNHS). While this egalitarian distributive approach may seem equitable, the existence of widespread inequities of access and use of SMNHS in Ghana as shown in the previous chapters of this thesis calls into question the effectiveness of the egalitarian distributional strategy.

The aim of this chapter is to further reflect on the quest by the Ghanaian state to ensure equity in accessibility to, and utilization of SMNHS within the context of the different barriers to accessing SMNHS and the varying strategies for both addressing access barriers and promoting equity, which my research has identified in the previous chapters. It does this to propose and outline a new model of care – *A Diversity Responsive Maternal Healthcare Model* – which is informed by the research carried out for this thesis and that could be used to guide a more equitable organization and delivery of skilled maternity care in Ghana. While acknowledging that the model is largely a theoretical construct and that further research will be needed to develop, test and evaluate its feasibility in real world context, the chapter argues that the model has the potential to address the diverse legitimate needs, expectations and values of expectant mothers in Ghana, and act as a catalyst for increasing access and reducing disparities in access and use of SMNHS.

9.1 Free and Accessible to All: An Egalitarian Moral Illusion?

When Ghana made the decision to remove user-fees for SMNHS in 2003, it was viewed as a step that could reduce prohibitive financial barriers to skilled care, increase access and eliminate inequities in access and use of skilled care by encouraging service utilization among hitherto excluded populations.

The quantitative and qualitative data presented in this study have however suggested that despite the almost one decade of the implementation of the free maternal health policy, SMNHS are still both *under* and *inequitably* accessed and utilized in Ghana. My analysis of the qualitative data have revealed that a number of factors other than money still negatively affected equitable access to skilled care.

What is even more interesting is that, together, these challenges have begun to create a sort of schism among both healthcare providers and women, with some increasingly questioning the usefulness of the free maternal health policy. For example, while many healthcare providers favoured fee abolition because of its potential for increasing accessibility to, and utilization of services, doubts have emerged as regards the efficacy of the policy and the state's capacity to continually and adequately sustain the policy. For instance, concerns have been raised about shortfalls and unpredictability of funding. Accordingly, funds were often released at the start of the financial year with no direct guidance to healthcare managers about how funds have been calculated and should be allocated, and how long they should last as well as when funds would be replenished. In the Central Gonja district health directorate for example, healthcare providers lamented over the fact that inadequate funding or delayed reimbursement had produced negative consequences. Hitherto, fee for MNH services constituted one main source of internally generated revenues for most of the health facilities in the district. However, the decoupling of fees for MNH services under the free maternal healthcare policy denied health facilities this important revenue source.

As a result of the inadequate and erratic flow of funding, healthcare providers have been caught between health facilities accumulating debt on the one hand, and the need to persist with the provision of fee-free maternity care services on the other hand. Having been made aware that maternity care services were free, women were reported to be angry and in many cases were pitted against healthcare workers any time healthcare workers were unable to provide certain desired services such as ultrasound scan or delivery by caesarean section (CS). These experiences from the Bosomtwe and Central Gonja districts support previous international reviews and recommendations on user-fee exemption for health programmes, which underline the importance

of providing funding to reimburse facilities for lost income (Bitran & Giedion, 2003; Witter *et al*, 2007).

Together with the different socio-demographic, health system and cultural barriers to access, the forgoing raises the question of whether it is possible to attain equitable access to skilled care in Ghana with or without the free maternal health policy. Or whether the desire to attain equity in access is simply an egalitarian moral illusion, a desired ideal with strong moral basis but very problematic to achieve in practice?

Both theory and the experiences of many high-income countries (e.g. Sweden) and some middle-income countries (e.g. Sri Lanka and Malaysia) suggest that universal access to skilled care in Ghana is possible. Indeed, based on women and healthcare providers experiences and recommendations on what should be done to counter the negative aspects of the maternal health care system in Ghana that dis-incentivize accessibility and utilization of existing skilled care services, and accelerate increased and equitable access and use of skilled care services, it is plausible to think that universal access can be attained in Ghana.

Against this background, it is important to note that during the course of my research several potential solutions were proposed by women and healthcare workers, including education, domestication of skilled maternity care, cultural adaptation of skilled maternity care services, improving doctor-patient relationships in maternity wards, expansion and redistribution of existing maternal health resources to ensure equitable coverage and access for all women, improving the quality of maternity care services provided, promotion of choice, privacy and patient dignity in maternity wards, promotion of male involvement in the delivery of maternity

care, training of more skilled maternity caregivers, instituting special programmes to target women most in need, and building partnerships with TBAs and other non-state actors. My analysis of qualitative data in chapter seven suggested that women's past positive experiences of home and health facility-based maternity care, coupled with the already relatively high levels of skilled antenatal care services access and usage in Ghana, provides an opportunity to improve the content, quality and effectiveness of prenatal care, and to draw useful lessons to help ensure increased access and use of SMNHS in Ghana.

But inevitably, the various proposals for increasing access and reducing access inequities themselves present unique challenges to the attainment of equitable access in Ghana. And in the rest of this section, I shall highlight three of these challenges and their practical implications for policy.

My analysis of the proposed solutions discussed in chapter seven and the present chapter reveal three problematic thematic issues. The first issue is that majority of these recommendations were based on assumptions, rather than evidential knowledge that if implemented, they would counter and/ or correct the health system and cultural barriers that inhibited access and equitable use of SMNHS. Thus, many of these proposals neither considered the question of feasibility, the existence of an evidence-base, nor the cost and the broader implications of implementing any of the proposed solutions.

The second challenge is that, women's priorities and proposed remedies diverged as well as converged with those of policymakers and healthcare providers in significantly interesting ways. For example, many women believed it was important to maintain the free maternity care policy

but improve quality of care. Rather than totally abolishing fee-for-service altogether, however, many healthcare providers and policymakers said they would have preferred a policy that targeted specific groups such as the poor, allocated resources to expanding health facilities and equipping these facilities with both equipment and personnel, and made essential medicines and consumables more available at lower cost to patients. For them, even a tokenistic, symbolic payment by patients would have been more desirable since the population's financial participation in the healthcare system is an important way of instilling a sense of ownership and respect for the health services they received. Similarly, whereas the health centre or hospital is a place where women felt a loss of status and therefore argued for health centres and hospitals to be made more into places where women feel at home and higher status, healthcare professionals gain status within health facilities, hence are very resistant to recommendations for SMNHS to be domesticated.

Convergence in terms of women's and healthcare providers' priorities clearly offers an opportunity for instituting the necessary policy actions. However, the seeming disjunctions in the various proposals point to the potential for conflict, and provide another lens through which policy failure or success could be gauged or anticipated. The divergence also significantly contributes to helping the reader understand why government efforts (including the deployment of the free maternity care policy) to stimulate increased and equitable access to skilled care can easily fail to meet the needs and priorities of childbearing women in Ghana.

The third challenge is related to the fact that differences in pregnancy and childbirth management choices and preferences would likely continue to exist. It is therefore likely that some women would continue to prefer home births for cultural, religious or other pragmatic reasons

irrespective of whether skilled services are made available free or not. This poses the question whether in such circumstances equity in access and use of SMNHS is attainable, or to stress the argument further, the quest for equity in maternity care is morally justified?

Clearly, the inequities in skilled care access documented in this research are morally troubling because obstacles to some women's ability to access and use SMNHS has the potential to reduce their capability to attain normal human flourishing and agency or what Sen (1999) calls alternative 'doings' and 'beings'. Following Rawls' original fair equality of opportunity principle (Rawls, 1971), Daniels' extended notion of equal opportunity (Daniels, 1985), and Sen's capability approach (Sen, 2002 & 2009), I would argue that the intrinsic nature of health and the instrumental function healthcare performs in bringing about individual person's or groups of persons' life prospects, make a strong case for providing equitable access to SMNHS in Ghana. As Daniels (1985) and Sen (2002, 2009) have argued, the special nature of health, and the important role healthcare access performs in bringing about health - which then expands individual's opportunity range and enable individuals to flourish and function to realize their capabilities - provides strong moral grounds for wanting to ensure equity of access. Indeed, health economists have suggested that when in need of cure, say a caesarean section to advert the possibility of a woman or her baby dying due to obstructed labour, there are few, if any, substitutes (Dolan & Olsen, 2002). This, together with the intrinsic and instrumental character of healthcare and of health, clearly justifies any quest to promote equity in access and use of SMNHS in Ghana (see also Nagel, 1991, and Parfit, 2002).

The challenge though is that realizing these kinds of equity objectives in MNH in the context of Ghana may be problematic for two main reasons. The first is that it may depend unrealistically,

on a belief that people have the same preferences for healthcare; people's preferences for wanting or not wanting healthcare are irrelevant or that patients consume healthcare irrespective of their own preferences (Mooney *et al*, 1991). In actuality, as amply shown in this research, different women do have different needs and exercise different preferences with respect to MNH service access and utilization. In this regard, several related challenges also come up. For instance, if the choices, preferences and competing values expressed by some of the women in this study have detrimental consequences on both individual women's health and that of others (unborn or newborn children), is it ethically justifiable to offer a healthcare service which responds to and supports such choices and preferences? Does the state or the health system has any moral obligation to change or attempt to modify individual women's choices and preferences when such choices and preferences have adverse outcomes either for individual women or their babies, even if they are culturally valued or valued by individual women? How should the tension that may arise between autonomy, individual choice and preferences in maternity care service accessibility and utility be reconciled with solidarity as expressed in the free maternal health policy?

Besides, groups with different needs require access to services which are appropriately differentiated in terms of volume and quality, a practice Mooney (1996) labelled 'vertical equity' or the 'unequal treatment of unequals'. Therefore, tension could be generated between the desire for a universal standard service with equality of access and the development of services based on local needs and priorities. This potential conflict implies that conditions must be in place to enable individual women with the capability to achieve a certain threshold level of skilled care access within the limits of their circumstances, provided such efforts do not violate what Norheim and Asada (2009) characterized as 'the weak principle of health equity'. That is every woman or group of women should have equal access to skilled maternity care services except if such an

achievement would only be possible by reducing or levelling down the capacity of other women to access skilled care below a minimally acceptable level.

The second reason is related to the distributional challenge that may be encountered. As shown in the previous chapter, the egalitarian resource allocation approach adopted in Ghana's free maternal healthcare policy has served to undermine the need for vertical equity since no adjustments are made for variations in health needs and geographical inequities in service distribution. In fact, in some instances, this egalitarian approach perpetuated and exacerbated existing inequities in access, especially between rich and poor, and between north and south. Clearly, the extent to which Ghana is able to achieve increased and improved equity of access will depend on the level and distribution of resources by geographical and rural and urban areas as well as among different ethnic, religious and wealth groups in the population. Such a conclusion is borne by the evidence in this research. At the same time however, the question is raised about whether the Ghanaian state has the resource capacity to equitably meet the different maternal health needs of all women. Even if the Ghanaian state does have the capacity to do so, to what extent does the state have a well-defined legal or ethical responsibility to do so? And do local health authorities have the capacity to efficiently utilize these resources?

Thus the quest for equity in access and use of SMNHS in Ghana raises ethical questions about value judgment and resource allocation decision-making regarding what distributional principles ought to guide the provision of maternal health services to different parts of the county. Undoubtedly, the above challenges and the questions they raise are important for both equity debates and the organization and delivery of maternal health services. Addressing these questions would however require rigorous and principled reasoning and ethical and moral argumentation,

backed by practicable strategies for mediating and satisfying the claims of different people in proportion to their strength. This places any attempts to adequately respond to the above questions over and beyond the scope of the current study except to say that this research supports the need for such reflection as a key element in policy development in this area of practice.

But as a way forward, I propose below, the development of a *Diversity Responsive Maternal Healthcare Model* as a first step towards addressing the health system and cultural barriers to accessibility and utilization of SMNHS, promoting equity in uptake of SMNHS as well as resolving potential conflicts that might arise from the Ghanaian state's attempt to provide universal access to skilled maternity care on the one hand, and the need for the development of services based on local needs and priorities on the other hand.

9.2 Free and Accessible to All: The Case for a Diversity Responsive Care

Given the differences in the levels of access to SMNHS in Ghana, and the diversity in culture as well as pregnancy and childbirth needs of women, it is incumbent on the maternal healthcare system and healthcare providers to ensure equitable provision and access to quality care. This requires that the organization and delivery of MNH services is able to respond appropriately to the diverse health needs of the communities it serves. A *Diversity Responsive Maternal Healthcare Model* (figure 9.1) provides one potential avenue for meeting the varying needs of childbearing women and for potentially increasing access and reducing inequities in access to skilled care services.

A model of diversity responsive maternal healthcare places greater emphasis on identifying institutional and socio-cultural barriers and effecting systemic changes while acknowledging the

impact of personal values, beliefs and practices on everyday relations between individual women and healthcare providers (Reitmanova & Gustafson, 2008). The overarching goal of a diversity responsive maternal healthcare model is the development of a health system and work force that are capable of delivering the highest quality and appropriate quantity of SMNHS to every women in need of such services regardless of socio-economic status, cultural background, ethnicity, religion and place of location.

In the context of Ghana, the objective of a diversity responsive maternal healthcare model would be to develop a system of care that makes quality maternity care services available, accessible, acceptable, and effective for addressing the needs of an increasingly diverse and complex population of expectant and lactating mothers. Such a model would aim to evolve a care regime that promotes patients' 1) dignity - as defined by women being shown respect by healthcare providers, and having physical examination conducted in privacy; 2) autonomy – as defined by women being involved in deciding on their care, and having providers ask them for permission before starting treatments or conducting tests; 3) confidentially – as defined by women having the opportunity to hold conversations with caregivers where other people cannot overhear; 4) culturally and linguistically appropriate communication – as represented by women having caregivers listen to them carefully or having health providers explain things so they [women] can understand or women or their family members given opportunity and time to ask caregivers questions; 5) prompt care – as defined by women getting needed care as soon as wanted, short waiting times for treatment, and convenient travel; 6) access to social support – as represented by women's ability to have family members or friends around, or women being able to observe cultural, social and religious practices in the course of seeking treatment in health facilities; 7) quality of basic amenities – as defined by women being given treatment in clean facilities, having

enough space, waiting room and clean water; and 8) choice of provider – as represented by women being able to get to see a caregiver they are happy with or women being able to choose the institution where they want to receive care.

The case for a diversity responsive maternal healthcare delivery model in Ghana is particularly strong not only because of the continuing problem of low and inequitable access to skilled care, but also the case can be supported by a number of findings from the research conducted for this thesis. For instance, this research showed that 1) different groups of women even within the same community have different maternity care needs and expectations; 2) different groups of women face different access barriers; 3) free maternity care alone is neither sufficient nor appropriate for increasing access and reducing inequity in service use in some contexts; 4) the current maternal healthcare system in Ghana lacks the flexibility and responsiveness to address the different needs of all women; and 5) understanding the link between culture and access and embedding this understanding in the healthcare system is a viable approach to addressing women's needs and expectations, increasing access, and reducing disparities in access which may be exacerbated by cultural factors.

Before discussing the model in detail, I shall say a few words on the choice and use of two important concepts in the model: *diversity* and *responsiveness.* The terms 'diversity' and 'responsiveness' were chosen for two reasons each. In relation to 'diversity', I chose it to first reflect the fact that the users and/ or targets (i.e. women of reproductive age) of maternity care services in Ghana are simply diverse. Second, and perhaps as a result of the first reason, the term is also used as a response to the fact that the needs and expectations of MNH service users are multiple.

With respect to the term 'responsiveness', I chose it because my engagement with women in Ghana suggested that the current maternal healthcare delivery system lacked the flexibility, sensitivity and resilience to address the different needs of service users. But the term was also chosen for another reason: it is a term that has considerable support in the healthcare and health services research literature as well as in the global health community. In its 2000 World Health Report titled *Health Systems: Improving Performance*, the WHO (2000) widely promoted the term 'responsiveness' by introducing it as one of the goals of a health system (Hsu *et al*, 2006; Jones *et al*, 2011). The WHO argued that in addition to improving the health of populations and ensuring financial protection against the cost of poor health, an intrinsic goal of a health system performance measurement is 'responsiveness' (Luo *et al*, 2013). Responsiveness is defined as how well the health system meets the legitimate expectations of the population for the non-health enhancing aspects of the health system (Forouzan *et al*, 2011; Sirven *et al*, 2012; Ebrahimipour *et al*, 2013)[12].

While acknowledging that the WHO concept of responsiveness provided important conceptual pillars for the current model, the two differ significantly however. For example, in the WHO's concept of health system responsiveness, only benchmarks are outlined for the purposes of assessing whether a particular health system is responsive or not. Thus it does not tell how responsiveness itself may be achieved and at what level. The model herein proposed however focuses on outlining and specifying practical ways by which responsiveness may be achieved, particularly in the delivery of SMNHS. Indeed, as an intrinsic goal, responsiveness has a unique

[12] Note however that prior to the WHO's introduction of 'responsiveness' as a health system goal, the concept already had grounding in an established body of social science, quality of care, and patient satisfaction research literature as well as in such principles within medical ethics as autonomy, beneficence justice (Hsu *et al*, 2006). In fact the WHO (2000) acknowledges that these areas are the original sources of the concept.

appeal in the context of the current research in the sense that even if reductions in maternal and newborn mortality do not occur, responsiveness in and of itself is a desirable goal. And not to make the health system more responsive is, in fact, undesirable. One of the unique features of the diversity responsive maternal healthcare model is that although it emerged from a study of MNH care access within the context of Ghana, its relevance could be extended beyond the contexts of Ghana and maternal health. This is because it is capable of being adopted and adapted for use in differing contexts to resolve similar or different healthcare access problems.

9.3 Developing a Diversity Responsive Maternal Healthcare Model

9.3.1 Levels of Responsiveness

As a first step to developing and providing a diversity responsive maternal healthcare, the model envisages a minimum level of activity and responsiveness at two broad levels: *organizational and policy responsiveness and* social-cultural or simply *cultural responsiveness*. These two broad levels provide a structured mechanism to addressing the various health system and cultural factors found in this research to be affecting access and equity of access.

9.3.1.1 Organizational and Policy Responsiveness

By organizational and policy responsiveness, reference is made to a situation in which the maternity care services, which are organized and delivered by healthcare institutions, are in accord or at least loosely correlated with the expressed legitimate needs, expectations and preferences of expectant mothers and their newly borne babies. For example, most Muslim women strongly wanted a female attendant at birth. Healthcare facilities would be more responsive to Muslim women's needs if this were recognized in policy and organizational procedures were put in place to make available a female attendant as well as inform women of

the options available to them. Organizational and policy responsiveness is therefore meant to take cognizance of the fact that several health system factors at the level of health policy and healthcare organization impede equal access and uptake of services in Ghana.

Indeed, it is not just the empirical findings from this research that support a call for organizational and policy responsiveness. In the literature, it has been observed that health disparities and lower quality care are exacerbated when healthcare organizations fail to address the links between culture and health service provision (Wilson-Stronks *et al,* 2008). There has similarly been some good evidence that people from diverse backgrounds, particularly patients from minority social groups and those whose language may be different from the language used by healthcare providers, can receive poorer quality healthcare compared to mainstream patients (Matsumura & Gubhaju, 2001). Such people are also more likely to experience a 'trajectory of accident opportunity' or adverse events in their journey through the health system (*ibid*). Furthermore, there is considerable agreement in the literature that culturally responsive healthcare (more on this in the next section) cannot be effectively delivered without a systemic and whole-of-organization approach to responsiveness (Betancourt *et al,* 2002; Chrisman, 2007). According to this argument, a key weakness in developing culturally responsive healthcare practices is the tendency to deal with cultural diversity in an ad hoc way rather than developing high-level strategic organizational structures and policies that can deeply embed culturally responsive care practices across the whole health service (*ibid*). There is therefore a sense in which an argument for organizational and policy responsiveness is justified by arguments for cultural responsiveness. In this way, the two levels of responsiveness proposed under the diversity responsive maternal healthcare model are mutually reinforcing.

But as data presented through out this thesis showed, women who do not access and use SMNHS do not do so only because of health system factors. Rather, socio-cultural factors also impeded equal access and uptake of services. Therefore, a model of diversity responsive maternal healthcare must necessarily recognize that the problem is not just about lack of organizational responsiveness. Hence, an essential component of a diversity responsive maternal healthcare model is *cultural responsiveness.*

9.3.1.2 Cultural Responsiveness

Cultural responsiveness involves acknowledging and respecting cultural values and preferences of groups that impact their health and health-seeking behaviours and applying this awareness to healthcare delivery (Herman *et al*, 2007). A culturally responsive health system is therefore one in which healthcare services are respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs of diverse patient populations.

In the context of maternal health in Ghana, cultural responsiveness acknowledges that cultural diversity in Ghana poses unique challenges to MNH care access: it influences the experience, expression, care-seeking behaviours, and response to maternal health promotion and care interventions. As such, there is need for culturally responsive care which not only understands and works with patients whose beliefs, values, and histories may be significantly similar or different from those of the healthcare system, but also cultural responsiveness means the provision of care in a manner that is acceptable and relevant to the needs and expectation of pregnant women. In the context of Sankpala, Mpaha and Tidrope where rituals and secrecy around pregnancy limit access to skilled ANC care for example, culturally responsive care would argue for an appreciation of this fact by caregivers so as to be able to deal effectively with

women who report late for ANC in ways that are respectful, acceptable and enabling for such women. Thus cultural responsiveness is also about the capacity to respond to the healthcare needs of diverse communities.

From the above, cultural responsiveness can be seen distinctly from what is popularly known as the *cultural competence* model of care (Callister, 2001; Campihna-Bacote, 2002; Gustafson, 2005; Kirmayer, 2012). The cultural competence model of healthcare is a common approach to promoting better health access for disadvantaged and minoritized populations (Kirmayer, 2012). The model, which was originally developed in the US as a strategy to improve the skills of clinicians to address the challenges posed by ethno-cultural diversity in healthcare, assumes that healthcare providers can learn a quantifiable set of attitudes and communication and practice skills relating to particular cultures that will enable them to work effectively with diverse individuals and families from those cultural contexts (Kirmayer, 2012).

The cultural competence model of care is therefore a descriptor of practitioners (as it places emphasis on healthcare providers becoming cultural experts). Unlike the cultural competence model which only focuses on individual characteristics and behaviours of the healthcare provider (Herman *et al*, 2007), cultural responsiveness is a descriptor of the provider-patient-environment interactions that result in the delivery of care in a manner that is culturally acceptable and relevant to the needs and expectation of patients. Cultural responsiveness thus requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual, and not just about healthcare professionals becoming culturally competent. For this reason, cultural competency is considered one of many interventions to promote cultural responsiveness in the diversity responsive maternal healthcare model.

Again, it is not just the empirical findings from this research that can be invoked to justify the argument for cultural responsiveness. One key argument in the international health research literature is that lack of culturally responsive care is, in fact, a major contributor to health disparities (Wilson-Stronks *et al,* 2008). There is also some evidence that suggests that providing culturally responsive care has the potential to lead to improved access and equity for all groups in the population (*ibid*).

Of course, while it is important for SMNHS to be organized and provided in a culturally responsive manner, it is equally important to acknowledge that the diversity in women's cultural values, preferences and practices in relation to the management of pregnancy and childbirth are in themselves a challenge. This is because it may be impracticable for healthcare workers to be aware of all the beliefs and practices of women as well as know what may already have happened at home before a woman reports to a health facility. Indeed, the challenges that some of these cultural practices pose for policymakers and practitioners are simply grave: how might they work with and honour Ghanaian women's cultural practices and choices relating to the management of pregnancy and childbirth without seeing culture itself and the choices women currently make as monolithic, predestined and unchanging? How might they reconcile the social and economic assumptions driving conventional, bio-medically oriented MNH interventions with the need to be attuned to the specific realities of Ghanaian women? And how might they acknowledge and/ or work to change the structural inequalities underlying the bare truth that many Ghanaian women do not yet have access to skilled birthing services and that many women and children die in and around the time of birth? This notwithstanding, I believe the emphasis on both organizational and

cultural responsiveness in the diversity responsive maternal healthcare model provides opportunities for addressing some of the challenges highlighted above.

9.3.2 Interventions

In order to achieve organizational and cultural responsiveness in maternity care, the Diversity Responsive Maternal Healthcare Model proposes several *health system interventions.* These are represented schematically in the diagram below (figure 9.1). These are practical and potentially actionable interventions. The list of interventions here is not meant to be definite or exhaustive. Its function is to suggest direction as to how responsiveness in the delivery of skilled maternity care services in Ghana may be achieved in practice. In what follows, I explain the key elements and relationships of the diversity responsive model.

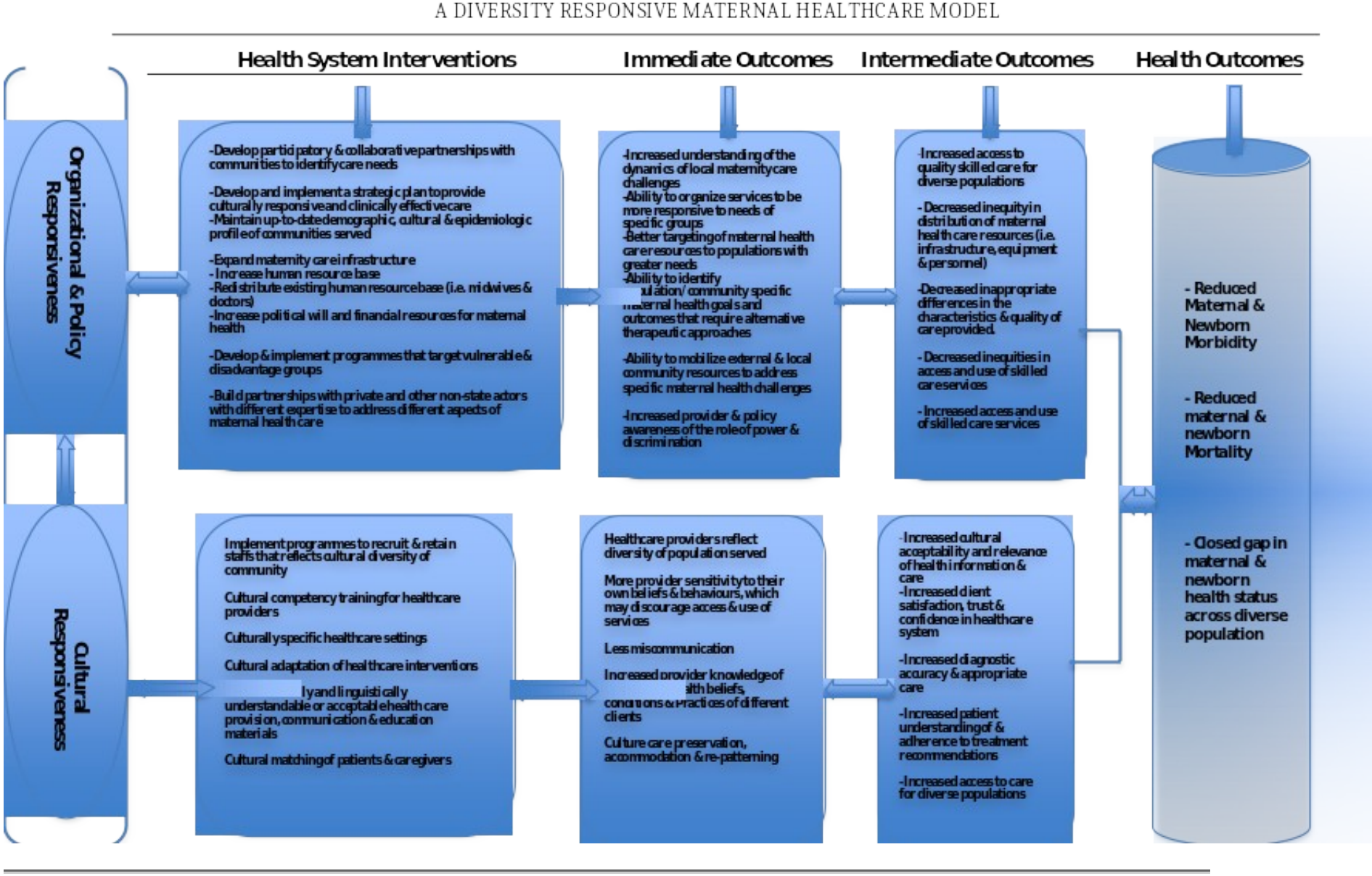


Figure 9.1: A diversity responsive maternal healthcare model. **Source**: Author's construct, 2013.

9.3.2.1 Health System Interventions to Promote Organizational Responsiveness

Organizational and policy responsiveness can be achieved by instituting a number of *health system interventions*, including but not limited to the use of participatory approaches to maternal health service planning, needs assessment, and service delivery; targeted approaches such as redistribution of health resources between and within groups; commitments in policy and practice to providing diversity responsive care; and partnership building. In addition, the model suggests a research and action agenda to develop explicit maternity care policies with equity goals as well as gain better understanding of societal or public views on equity and redistribution of resources to facilitate equitable access to skilled maternity care.

The recommended health system interventions are based on findings from both quantitative and qualitative data presented in this study and arguments advanced thereafter, as well as experiences from similar research findings in the literature. For instance, the recommendation for resource redistribution and targeted programming is based on the fact that although maternity care in Ghana is free, different women face different disadvantages, and these disadvantages affect their ability to access and use SMNHS. Redistribution further addresses the geographical imbalances in maternal health infrastructure and personnel in Ghana.

Similarly, targeted programming responds well to the distributional problem that was raised in both the previous and current chapters. As Sen (1999) has argued, targeting should be informed by 'the emergence of a shared recognition' of an injustice. Clearly, the fact that some women in Ghana are unable to access SMNHS because such services are not available, are too far away or are of poor quality is unjust. But not only unjust; it also highlights the limitation of the universal nature of Ghana's free maternal healthcare policy, namely that the policy appears to have lost

momentum even before reaching disadvantaged groups and this may have contributed to inequities in access and use of services.

Targeting in the model can take several forms, including direct targeting (whereby the focus is on identifying poor and disadvantaged individuals and groups and getting services to them). For example, one can target programmes and resource efforts at geographic areas that are especially poor such as in northern Ghana or on population subgroups with special need such as religious and ethnic minorities. Poor women or those in communities where health facilities are not available could be targeted with vouchers that entitled them to free or subsidized transport and ambulatory services any time they visited a health facility for ANC, DC or PNC purposes.

Of course targeting has its limitations: it is typically difficult to administer in practice; it can be stigmatizing by drawing attention to the disadvantaged status of prospective beneficiaries; and there are situations where targeting may be completely politically inappropriate (Victoria *et al,* 2003). Nonetheless, evidence suggests that targeted programmes are usually effective (For illustrative examples, see Victoria *et al*, 2003; Gwatkin, 2003; Por *et al,* 2008;).

Indeed, redistribution and targeting within the context of the diversity responsive maternal healthcare model is not founded only on empirical data. It also takes a cue from Aristotelian justice and political conception of a parametric consideration of human diversity, which calls for like cases to be treated alike and different cases differently (Aristotle, 1987). This principle of proportional justice applied to maternal healthcare access requires the healthcare system to reduce barriers to access by weighing the needs of the worse-off against those of the better-off and then applying what Aristotle characterizes as disproportionate effort (such as redirecting or

targeting more resources to disadvantaged and needy groups) which aims to bring disadvantaged women as close to a threshold level of access as their circumstances permit (Ruger, 2006). In other words, targeting is directly supported by a vertical distributive approach to equity rather than the current horizontal equity approach followed in Ghana's free maternity care policy.

Vertical equity, as was noted in chapter two, is an approach that recognizes that different groups have different starting points and therefore require different treatment (McIntyre & Gilson, 2000; Macinko & Starfield, 2002). Thus a vertical equity and distributive approach in the context of Ghana's maternity care would suggest that the most historically disadvantaged regions and social groups command an even greater claim on state resources than that reflected in the current maternity care policy. In this way, targeting not only acknowledges a popular concern in the normative literature - that strict equality in access for all women may not be an attractive view or an unattainable objective because of its potential to 1) deny personal choice; 2) become unrealistically expensive; and 3) fail to acknowledge that some determinants of MNH access are simply beyond human control (see Brock, 2002; Asada, 2005) – but also attempts to redress inequity by *levelling up* all those women with less than average access to an average or an acceptable standardized threshold.

The recommendation for political will and financial resource commitment to MNH also takes cognizance of the leadership and resources challenges that attended the implementation of Ghana's free maternal healthcare policy as highlighted in chapters 2 and 8. Indeed, it has been widely acknowledged that although effective health interventions exist for mothers and babies, and several proven means of distribution are available that can be used, none of them will work if political will or financial commitment is absent (Filippi *et al*, 2006; Shiffman & Okonofua, 2007; Shiffman & Ved, 2007; Nyamtema *et al*, 2011). It is therefore in recognition of the crucial role of

leadership for mobilizing political will and resource commitment, enhancing creativity and innovation in the domain of reproductive health, establishing performance management and accountability and appraisal systems, as well as for initiating and strengthening public and community participation, integrating non-state actors into safe motherhood programmes, sharing of information and empowering women in terms of education, autonomy and economy (Nyamtema *et al*, 2011), that a recommendation regarding political will and resource commitment in the model is further grounded.

The idea of building partnerships with a variety of other actors and institutions to respond to different aspects of MNH also takes a cue from the relative success that the midwife in Piase in the Kuntanase district of the Ashanti region achieved when she engaged traditional birth attendants (TBAs), pastors and community leaders on the issue of maternal health. Partnership in the context of this model therefore implies shared governance of maternal health, whereby the state, individuals, families and communities along with other non-state actors, whether international or local, share the responsibility for correcting inequities in access and use of SMNHS. Indeed, in Hawai (USA) and Quargaye (Burkina Faso), Affonso *et al* (1999) and Hounton *et al* (2009) respectively described examples of very successful partnerships between healthcare providers and local communities that greatly improved general use of maternity care services and wellbeing of expectant mothers and newborns. Similar partnerships have the potential to bridge the gaps between mismatches in women's maternity care needs and the priorities of the health system in many of the communities where this research was conducted, and ultimately improve access and equitable use of SMNHS.

9.3.2.2 *Health System Interventions to Promote Cultural Responsiveness*

As shown in the model, cultural responsiveness can also be achieved through several *health system interventions.* These include the development and implementation of programmes to recruit and retain maternity care staffs that reflect cultural diversity of the communities they serve, cultural competency training for healthcare providers, culturally specific healthcare settings, cultural adaptation of healthcare interventions, use of culturally and linguistically understandable or acceptable healthcare provision, communication and education materials, and cultural matching of patients and caregivers.

Again, these interventions are grounded in the empirical findings of this research, which show among other things that lack of cultural responsiveness in Ghana's maternity care system results from such factors as lack of cultural competency training for healthcare providers, absence of culturally specific healthcare settings, and lack of adaptation of healthcare interventions to meet specific individual and communal cultural needs relating to pregnancy and birthing care. For example, many Muslim women were reluctant to seek skilled care from health facilities for fear of being unlawfully seen or touched by a male healthcare provider. Similarly, because of age hierarchy conflicts, many women were reluctant to access services offered by young midwives and nurses. Through cultural matching, a diversity responsive maternal healthcare system can enable Muslim women to be matched unto female caregivers. Similarly, cultural matching can allow elderly women to be matched unto elderly midwives and nurses. In this way, a diversity responsive maternal healthcare model has the potential to reduce the *social distance* (i.e. differences in culture, age, language, ethnicity, religion, behaviour and expectations) between maternity caregivers and women. This is supported by the findings of one previous study in Ghana, which found that women preferred to travel further, and face higher opportunity costs to

see providers who were the same ethnic or religious group as them (Prevention of Maternal Mortality Network, 1992). The study revealed that this was because a provider from the same ethnic or religious group was perceived as having a smaller social distance and therefore worth travelling the extra distance for.

9.3.3 Outcomes

The Diversity Responsive Model might perhaps be expected to lead to two different, but related, kinds of outcome. These are represented in the model (see figure 9.1) as *immediate* and *intermediate* outcomes. Both outcomes are non-health outcomes, but important process outcomes that enable the model to self evaluate the extent to which progress towards building of diversity responsive healthcare system is made. This enables the model to feedback unto itself and to modify or initiate entirely new interventions. In addition, although responsiveness is about the non-medical aspects of the healthcare system, it acknowledges that the combined effect of providing responsive healthcare may actually produce direct health benefits such as the reduction of maternal morbidity and disability, the reduction of maternal and newborn mortality, and the narrowing of the gap in maternal health status across diverse populations. These types of outcomes are designated as *health outcomes*.

9.4 Conclusion and Future Development

In this chapter, my main objective has been to offer a more direct answer to one of the research questions with which I began this thesis, namely how access to skilled maternity care services may be increased and inequities reduced in Ghana. The chapter has proposed and discussed a model of maternity care – a diversity responsive maternal healthcare model - that could be used in Ghana to promote access and reduce inequities in access to skilled maternity care services

through the addressing of the diverse legitimate needs, expectations and values of expectant mothers in Ghana. A number of potential benefits that could be had from providing a diversity responsive maternity care services were identified and discussed, including improved access and equity of access, consumer/user 'health literacy' which can reduce delays in seeking care, improved communication and understanding between health service users and providers leading to better compliance with treatment recommendation, improved user satisfaction, reduced medical errors and adverse events, clearer expectations, and improved patient safety and quality assurance. Other benefits include more provider sensitivity to their own beliefs and behaviours which may discourage access and use of services; less miscommunication; increased provider knowledge of variation in health beliefs, conditions and practices of different clients; culture care preservation (i.e. integrating client's wishes into care when there is no risk of harm); and culture care re-patterning (i.e. assisting clients in adopting new patterns of care behaviour if instituting a particular cultural practice would bring harm to the client or anyone else) (Gustafson, 2005).

Notwithstanding the model being a potential catalyst for improving access and disparities in access and use of SMNHS, it remains largely a theoretical construct at this stage. Clearly, further work would be required to, for example, develop and specify an inventory (i.e. measurable indicators) for assessing each of the health system interventions as well as the various outcomes. Following from this, the model could then be implemented in a real world context and further research conducted to evaluate its feasibility, practical applicability and relevance for increasing healthcare access and reducing access inequities.

Chapter 10

CONCLUSION

10. Introduction

For many decades in Ghana, the family home was the primary birthing place for most women. The authoritative knowledge of childbirth rested with the parturient or expectant mother and her attendants, usually family members, friends and traditional birth attendants (TBAs). However, by the year 2000, the government, through the Ministry of Health (MoH) and the Ghana Health Services (GHS), had come to a consensus that childbirth must now take place in a healthcare institution under the supervision of skilled health personnel. Within this is the view that 1) childbearing is a time of vulnerability and risk rather than a normal physiologic process for the majority of women; 2) home births are unsafe; and 3) that it is the combination of the prevalence of home birth and the difficulty of accessing skilled maternal and newborn health services (SMNHS) that is responsible for the persistent and alarmingly high maternal and neonatal mortality rates in the country. These ideas, together with both national and international pressure to achieve the targets set forth in the fourth and fifth Millennium Development Goals (MDGs) by 2015, drove the government of Ghana into rolling out and implementing a free maternal healthcare policy in 2003, the aim of which was to reduce financial barriers to access so as ensure increased and equitable access and use of SMNHS.

Using data from the Ghana Maternal Health Survey in combination with qualitative data from ethnographic-style in-depth interviews (IDIs), focus group discussions (FGDs) and direct observations that the author conducted in six communities across two administrative districts in two geographic regions of Ghana between November 2011 and June 2012, this study explored

how the introduction of the free maternal health policy in Ghana affected access, equity of access, and barriers to accessibility and utilization of SMNHS.

Findings from survey data suggested an encouraging trend in skilled care uptake in Ghana: access and utilization of skilled antenatal care (ANC), delivery care (DC), and postnatal care (PNC) services have increased since the introduction of the policy. However, both survey and qualitative data also indicated that while the free maternity care policy removed important financial barriers to access to life-saving maternal and newborn health (MNH) services, most skilled care services remained underutilized, while inequities in skilled care services accessibility and utilization persisted. Qualitative data generated from the researcher's in-depth engagement with both maternity care providers and users of maternity care services pointed to the complexity of supply and demand-side factors, which either enabled or disabled equitable accessibility and utilization of SMNHS. For this reason, this thesis argued for a move beyond free maternity care and stressed the importance of simultaneously engaging and addressing supply-side and demand-side factors if access to skilled care is to be increased, inequities in access reduced, and further reductions in maternal and newborn mortality achieved.

The remainder of this chapter briefly reflects on the implications of the research findings, and in particular, the policy and research implications of moving beyond free maternity care in Ghana. As no scientific research project is ever truly complete - for it is always possible to learn more, to expand the temporal and spatial scope of understanding, or deepen the subtlety of that understanding (Monaghan & Just, 2000) – it is important that the conclusions and recommendations made below remain tentative and open to empirical scrutiny by subsequent future research and analysis, leading to possible affirmation, modification or total repudiation.

This is more so as the science of MNH as well as models of healthcare delivery would continue to be in constant flux and evolution.

10.1 Implications of the Research Findings

Cumulatively, the findings in this thesis significantly improve broader understanding of the barriers to equitable access and use of SMNHS in Ghana. In particular, the actionable points elicited from research participants at different levels not only expands knowledge on the barriers and dynamics of access and use of skilled maternity care services at the individual, household, community and health facility level, hence giving this research the potential to inform policy, but also adds new insight and evidence about how the problem of *under* and *inequitable* uptake of MNH services may be addressed. The methodological and analytical approaches employed to document Ghana's experiences of implementing the free maternity care policy, and the way in which the policy has yet to solve the twin-problem of under-use and inequitable access to SMNHS also provide potentially valuable lessons for policy makers and researchers working on similar policies in other sub-Saharan African country contexts. In the next subsections, some of the specific implications of the research findings for public health ethics and distributive justice, public health policy and practice, as well as future research to redress under-access and inequitable access and use of SMNHS are highlighted.

10.1.1 Public Health Ethics and Distributive Justice

One of the first issues that this research highlighted which may have important implications for debates around public health ethics and distributive justice relates to the question of resource allocation and distribution. Given the persistence of widespread inequities in accessibility to, and utilization of SMNHS in Ghana, and the fact that different groups of women face different

disadvantages and needs, it is imperative to understand that resource allocation decisions based on national average statistics and egalitarian distributive principles as contained in Ghana's free maternal healthcare policy may not lead to appropriate targeting of scarce MNH resources such that regions, communities and sub-populations who are disadvantaged beyond the national average and who need more resources may not receive what is due them to enable them achieve the desired level of access and service utilization. This conclusion has broad implications for the global health equity and justice agenda and the maternal health-related MDGs as well, namely that policy goals and targets defined in terms of population averages can result in inequities if efforts are not made to reach disadvantaged and vulnerable populations.

As a way forward therefore, it might be useful for policymakers in Ghana to take the necessary steps to develop comprehensive need-based targeting and resource allocation formula that can gradually redistribute resources towards populations with greatest needs (Asante & Zwi, 2009). This of course is an enormous challenge given the vast disparities in socio-economic development across different regions and districts in Ghana; but it is a potentially sustainable long-term strategy that could be pursued to reduce inequities in access to SMNHS.

10.1.2 Public Health Policy and Practice

This research also has implications for public health policy and practice. First, the findings draw attention to the fact that while having access to healthcare necessarily requires an adequate supply of healthcare services, service availability is a rather limited measure of access. Therefore, discussions of the concept of access ought to extend beyond measuring service availability and affordability to consider what Pechansky and Thomas (1981) characterize as the 'degree of fit'

between clients (in this case expectant mothers) and the health system, which might be influenced by the acceptability and accommodation of the services provided by the healthcare system.

Second, this research suggests that removing user-fees has the potential to improve access to SMNHS. However, it is neither sufficient nor appropriate for increasing access and reducing inequity in service use in some contexts. Therefore the policy debates on user-fees removal ought to proceed beyond broad evaluation of the benefits and/ or impact of user-fees removal towards exploring how best to dismantle the multiplicity of access and utilization barriers in differing contexts. In particular, the findings here suggest that it is very difficult to achieve equity in access with fee-free maternal health policies if the wider issues of *initial disadvantages* and cultural and other barriers are not considered and addressed as part of the policy design process. It is imperative then that addressing both under-utilization and unequal access to SMNHS in Ghana ought not to be confined to the health system alone. Rather, a concerted multi-sectorial approach is needed to correct these initial disadvantages and tackle the social determinants of health, including raising the educational achievement and living conditions of disadvantaged women, improving the availability of physical health infrastructure and human resources as well as addressing disparities in distribution. Such a conclusion attends to the fact that the distribution of uptake of SMNHS is also related to factors outside of the health sector.

Third, findings on the relationship between women and caregivers also indicate the crucial role of provider-client communication and the need to provide culturally responsive care. This directly calls for changes in midwifery and obstetrical and gynaecological practices, including behaviour change strategies for both healthcare providers and service users, improving both

clinical and relational quality of care, enhancing provider competencies, as well as creating an enabling environment to redress cultural barriers to access and service use.

Fourth, the research has also revealed that some of the barriers to skilled care such as traditional values attached to burying of placenta closer to home or in a warm place are highly contexts specific. This suggests that information, education and communication interventions aiming to influence skilled care seeking behaviours and attitudes among women should move beyond one-size-fit-all templates to focus on addressing the specificity of socio-cultural beliefs and concerns of different communities that directly or indirectly negatively impinge access and use of skilled care.

Related to the above, this research suggests that decision-making regarding access and use of SMNHS is not made solely at the individual or the dyadic level. Rather, the values and opinions of other family and community members play a very influential role. This suggests the need for interventions targeting a range of actors at multiple levels, including men (husbands), mothers-in-law, TBAs, and traditional authorities.

Fifth, qualitative findings in this research also show that the treatment expectant mothers and their immediate family receive at healthcare facilities varies and there are no guidelines in relation to such key determining factors of skilled care services utilization as privacy, confidentially and psychological support. As a way to redress the situation and improve women's experience of skilled care within the formal healthcare system, a standard guideline or protocol could be designed - albeit with possibilities for making adjustments to address context-specific

issues - and implemented across all healthcare facilities, as regards the handling of mothers and their family during ANC clinics or labour.

Sixth, this study has shown that TBAs are still highly regarded in many societies in Ghana. It would therefore be prudent if the formal healthcare system engaged them, at least in facilitating early referrals. The GHS, for example, could use innovative incentive mechanisms such as recognition or cash reward to encourage TBAs to promptly refer mothers to healthcare facilities especially during labour. TBAs can, for example, be used to provide early information about pregnancy (through use of rapid pregnancy test kits) thereby facilitating early registration of pregnant women. They can also be given some incentive to facilitate antenatal check-ups and institutional delivery especially in remote areas and among socially discriminated sections of society where skilled health workers are not willing to serve.

Seventh, data presented in chapters 4, 5 and 6 also suggest that progress towards the attainment of MGD 5 cannot be assessed based on maternal mortality alone or by the proportion of births attended by skilled personnel alone. This not only problematizes the benchmarks set forth under MDG 5 for evaluating progress towards achieving the goal of reducing maternal mortality by 75% between 1990 and 2015, but also demonstrates the fact that policy decisions need to build on a good understanding of the mechanisms (such as unequal access to skilled care) that underlie changes in maternal mortality (Filippi *et al*, 2006). Therefore, in addition to using maternal mortality, this study suggests that other indicators to track progress are required, including measuring and monitoring skilled services access and use by equity parameters to evaluate progress in care for populations most in need, availability of basic and comprehensive obstetric care facilities per a given population, midwife to population ratio, proportion of births attended by skilled personnel according to place of delivery, proportion of births with CS and other life-

saving surgery, and proportion of labouring women staying in a health facility for 24 or more hours after giving birth.

Finally, this research also highlights the significant role of abortion in compounding the problem of poor MNH in Ghana. As shown in chapters two and four, more than one in ten maternal deaths in Ghana is attributable to abortion. Despite this, abortion is largely a taboo subject in Ghana, with unsafe abortion particularly among young women, remaining one of the most neglected topics of health and 'unspoken' health issues in Ghana (Lassey & Wilson, 1998; Baiden *et al*, 2006). This silence appears to have been compounded by a very restrictive legal regime (Morhee & Morhee, 2006). Perhaps, this explains why the 'Maternal Health Benefits Package' under Ghana's free maternal healthcare policy excludes free access to abortion care.

However, given that the proportion of maternal mortality contributed to by abortion in Ghana is relatively high, and the fact that abortion-related maternal deaths can be easily prevented through improved access to safe abortion and post-abortion care services as well as effective family planning methods and contraception use to reduce the incidence of unwanted pregnancies, there is an urgent need for an open debate and policy reform to address the challenge posed by unsafe abortion care.

10.1.3 Future Research

The methodological design and analytical techniques used in this research, and the results produced thereafter also have implications for future research. Conventionally, the success of user-fee exemption policies has been measured in terms of increases in service uptake or decreases in inequities to access using population level survey data (Hadley, 2011). However, qualitative findings from my research challenge this by showing that the relationship between

free maternal health policy and access and equity of access in Ghana is rather complex, and that some of the important reasons for non-use of SMNHS cannot be captured in the usual structured questionnaires of population based surveys. This not only suggests that utilization rates as statistical indicators are not sufficient to understand the success or failure of fee-exemption policies, but also highlights the importance of using qualitative research techniques to understand seemingly obscure barriers often captured in large quantitative assessment including the demographic and health surveys as 'unnecessary' or 'not customary' (Shiferaw *et al,* 2013). Therefore, my research reinforces the fact that besides statistical analysis, qualitative insights into local maternal and newborn healthcare practices and healthcare seeking behaviours are needed to understand how user-fee abolition affects individuals and communities. And it is precisely for this reason that a mixed study design was adopted.

Overall, the mixed methods approach used in this research proved valuable in offering both the breadth and depth of understanding required to fully explicate the research problem. For example, the quantitative method using survey-based data enabled the mapping out of trends and patterns in maternal healthcare services accessibility and utilization, including differentials among different socio-demographic segments of the women population in Ghana. However, because survey data provided only a limited scope for understanding why women may continue to deliver their babies at home or outside the appropriate government and non-government healthcare facilities without skilled care, a qualitative, interpretive approach permitted a rich interrogation of the reasons for both non-access and differential access.

One of the great advantages of the qualitative component of this research is that it allowed both service users and service provides to communicate, in their own words, the barriers women face

in accessing and using skilled care services. This enhanced the capacity of this research not only to generate actionable ideas and describe events such as access to SMNHS but also to understand how and why the same events can often be interpreted in a different, sometimes even conflicting manner, by different stakeholders. The qualitative data also enabled the acknowledgement of conflict, on-going struggle, tension, and subjectivity in the maternal healthcare problematic in Ghana.

In addition, while the quantitative technique gave the researcher the capacity to conduct robust group comparisons, such measurements and comparisons typically detached information from its original ecological real-world context. This is where the qualitative technique was useful, offering the tools to generate rich in-depth narratives and accounts of women's experiences that makes possible the examination of such complex phenomenon as decision-making around maternity care services accessibility and utilization. In particular, unlike, population-based surveys, which are mostly conducted with structured questionnaires, the FGDs and IDIs employed allowed the complexity of women's experiences and the barriers women face in accessing and using SMNHS to be explored in depth.

The adoption of a mixed methods research design therefore provided a research approach that was capable of (a) mapping out the nature and levels of access to SMNHS, (b) collecting high-qualitative, in-depth information on process, experience and context, and the way in which Ghana's free maternal healthcare policy affects access and use of SMNHS, (c) retaining the ability to generalize to a broader population through standard sampling procedures. As user-fees abolition and other financial intervention for MNH care evolve in Ghana and across SSA, research using designs similar to the current research's will be required to further understand

whether such interventions are an effective long-term strategy for resolving the twin problem of under and unequal access and utilization of SMNHS.

Clearly, the successful manner in which the mixed methods design was used in this research has significant methodological implications. First, it highlights the importance of methodological pragmatism and reflexivity in empirical research. For example, being methodologically pragmatic enabled the selection of methods and data collection and analytical techniques based on their particular merits and limitations in explicating the research questions**.** This provided the researcher with cognitive tools that could be turned back on the subject of cognition not in order to discredit the knowledge being produced, but rather to check and strengthen it. In other words, while the researcher aimed to be the conduit between women and their experiences and healthcare providers, methodological reflexivity enabled him to be mindful of his own membership of both the academy and the Ghanaian society, and the question of how this grounding may affect the research findings.

Second, this research also challenges the conventional dichotomization of methods. Within the methodological literature, the distinction between quantitative and qualitative research and as to which is a superior approach to producing the most reliable and valid knowledge has sometimes been posited as two incommensurable opposites (Duffy, 1987; Bryman, 2008). This has resulted in the so-called ‘methodological wars’, a sort of schism in which qualitative and quantitative research are deemed incommensurable (Tashakkori & Creswell, 2007b).

The methodological approach followed in this research and the results produced clearly suggest that this dichotomy needs not be, because one method may be no better or no worse than the other; they just simply tell different kinds of stories; and depending on the kinds of research

questions being asked, either qualitative or quantitative methods may be especially appropriate or even complementary. This also suggests that methods by themselves ought not to be seen as neutral tools, neither are research questions to be seen as inherently important and methods automatically appropriate. Rather, it is researchers like this author himself who make choices about what research questions are important and what methods are appropriate for answering those questions. In many cases as amply demonstrated in this research, these choices inevitably involve aspects of personal history, value judgments, cultural and social background, as well as disciplinary and professional assumptions.

10.2 Getting Closer to the Ideal? Reflections on the Research and Potential Limitations

In this section, some of the potential limitations of the research methods employed, and of the research findings, are considered in addition to the more specific shortfalls in the data gathering and analysis techniques that have already been identified and discussed in the methods chapter. The intent here is not to undermine the findings and conclusions of this research. Rather, it is to acknowledge openly that while the methodological approach adopted for the generation of data, the analysis of data, and the interpretation of the findings deriving from the said data, was successful in proffering appropriate responses to the research questions, there were limitations. In addition, it is to identify, articulate and point out areas where future research may be required.

The first potential limitation of this research is that the study design could potentially have made it impossible to isolate the effects (positive or negative) of the free maternal health policy on access and inequity in access just like the potential of the policy to improve maternal health outcome measures such as reduction in maternal and neonatal mortality was not assessed. Ideally, a pre-post evaluation design would have been most appropriate for investigating the impact of

implementing the free maternal healthcare policy on skilled care services accessibility and utilization in Ghana. In particular, pursuing a counter-factual analysis would have been the best approach in determining whether the free maternity care policy actually increased access and improved equity in access and use of services. That is, what would have happened to access and equity in the absence of the policy during the period under consideration (2003-2007)?

However, because the policy was implemented nation-wide, such an analysis was not feasible as there are no appropriate comparison groups against which a comparative assessment can be made. Unfortunately, both the design and remits of this research failed to extend to an evaluation and statistical estimation or quantification of how much of either the increases in overall access and utilization levels or the significant differences in access and utilization are directly attributable to the free maternal healthcare policy. This is certainly a limitation of the current research and future research could exploit new data and use other quantitative analytical techniques such as benefit incidence analysis (BIA), and multivariate logistic regression models to calculate crude and adjusted odds ratios to isolate relevant co-determinants and properly establish effect and causality.

The second potential limitation is related to the data used. Secondary data come with its own strengths and weaknesses, and the Ghana Maternal Health Survey (GMHS) data used in this research is no exception. At the commencement of this research, the GMHS data was the most recent nationally representative dataset available that shows access and use of SMNHS across different groupings in Ghana. This made the GMHS the best under the circumstances. However, given that the GMHS data is almost five years old, its relevance for capturing current access and utilization levels and patterns may be diminished. Also, although the qualitative data used in the

analysis largely focused on the district level, the survey data is aggregated regional data. Other previous components studies have shown that the period and intensity of the implementation of the free maternal health policy was different between districts (Witter *et al*, 2007). This raises the possibility of misclassification of exposure and dilution of any effect (Bosu *et al*, 2007).

A related limitation is that while assessment of access and utilization levels as well as equity analyses was based principally on an aggregate of survey data, the interpretations of the results drew on insights from qualitative research. Given that the qualitative research is done nearly five years after the survey was conducted, and given also that the respondents in these two separate studies may be different, it is doubtful whether the explanations for under-access and inequitable access arising from the qualitative research truly explain the patterns observed in the survey data. Besides, historical and instrumentation biases could also be present since the researchers and the participants involved in these two studies were different. Similarly, much of the data used is self-reported, and this introduces the possibility for recall problems (White *et al*, 2013).

The third potential limitation of this research concerns timing. Like most policy evaluations, which are typically conducted after a relatively short period of implementation (Witter *et al*, 2010), the survey and qualitative data used for the analysis were respectively collected five and eight years after Ghana started implementing the free maternal healthcare policy. On the one hand, one can debate whether five years is a long enough time for any potential gains from the policy to manifest, and for an evaluation of the policy to be conducted. On the other hand, one can also argue that the increases in access and utilization observed from the survey data may be an artefact of the short duration between the start of the policy and the evaluation. This is more so given the possibility that a sudden removal of user-fees for MNH services may within the short

term rapidly attract women who hitherto were not accessing care from the formal healthcare system. On this score, perhaps, the research problem and questions investigated in this thesis ought to be re-asked to focus on access in a more general sense than limiting it to the free maternal healthcare policy.

A final potential limitation of the study relates to the scope and coverage of the qualitative component of this research. Qualitative research was conducted in only six communities and in two districts of Ghana. While focusing on a small number of communities enabled the research to gain a more in-depth understanding, I recognize the limitation of generalizing the findings to other parts of the country, as it may not be representative of what is prevalent in the entire population. Besides, it is possible that some of the barriers to service utilization uncovered are context and culturally specific. This potentially places limiting constraints on the transferability and application of the findings to the general population. The above notwithstanding, important lessons can be drawn from the findings regarding what is actually happening in practice following the implementation of the free maternal health policy Ghana.

10.3 Conclusion

In the course of the 21st century, pregnant and labouring women all over the world have been, and are continuously being persuaded to seek and comply with an ever-widening range of medically organized care regimens and procedures for the purposes of promoting the safety of pregnancy and birth. Yet, as demonstrated in this study, while potentially life saving, the provision of such skilled maternal and newborn healthcare services in Ghana is not only very limited but also these services are unequally available to the population. Even where these services are available at no or minimal cost, and can be physically accessed, they can be unfriendly, culturally unacceptable,

degrading or even abusive to women. In Ghana these factors have combined to discourage a disproportionate number of expectant mothers from accessing and using skilled maternal and newborn healthcare services although these services are provided free at the point of delivery.

As access, especially equity of access and use of skilled maternal health interventions continues to be an essential ingredient to the reduction of maternal and newborn mortality and the attainment of the maternal and child health-related MDGs (Zere *et al,* 2010), there is an urgent need in Ghana to ensure that all pregnant and labouring women have equitable access to skilled care services as and when they need them. There is also the need for these services to be organized and delivered in a way that is medically appropriate, socially sensitive, and culturally responsive. This means that the extent to which the healthcare system in Ghana becomes more responsive to the pregnancy and birthing care needs of women including respect as reflected by the degree to which the health system is sensitive to patients' needs, dignity, confidentiality, choice and autonomy as well as the level of attention given to clients in terms of promptness, quality of environment, and access to social assistance, would be an important determinant of increased and equitable access to skilled maternal and newborn healthcare in Ghana.

Among other things this study concludes that the development of a *diversity responsive maternal healthcare system* will go a long way to first redress the health system and socio-cultural barriers to equitable access, and then promote increased and equitable access for different groups of women.

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APPENDIX 1

QUESTIONS & TOPIC GUIDE FOR FOCUS GROUP DISCUSSION (WOMEN)

Project Title:
Free Maternity Care, Access, Equity of Access, and Barriers to Accessing and Using Skilled Maternal and New-Borns Health Care Services in Ghana

1. Topic Guide For FGDs

1.1. Introduction & Debriefing

- Begin with a song/story
- Self-introduction: Pay attention and note age range, levels of education, occupation, religion, ethnic background, places of residence etc.
- Debriefing: Tell participants again what the research is about, what the role of participants is, and the researchers expectations.

1.2 Getting Started & Ice-breaking - Access & Use of Maternal Health Services at a Glance

- Ok, now that we know who we are and what we've come here to do, can I just ask the pregnant women here to show by hand how many have gone for at least one antenatal check-up at the clinic/health centre/hospital? Can those who have not yet gone for any antennal check-up also show their hands?
- Can I also ask the mothers here: how many of you had your baby at 1) home 2) clinic/health centre and 3) hospital?

1.2.1. Antenatal Care

- But tell me more about your and/ or other women experiences of seeking antenatal care for your current or last pregnancy in this community.
- And could those who did not seek antennal care also describe their experiences for me?
- Generally, do women go for antenatal check up or screening in this community? Why/why not?
- If women go for antenatal care, where and from whom do they go to for care - at home/Clinic/health centre/hospital; and from a doctor, midwife/nurse, TBA or any other person either in this community or in another community?
- Do women in this community have preferences for seeking antennal care at a particular place and from a particular caregiver?
- Why do you think 1) majority or 2) few women prefer seeking antenatal care at the places and from the caregivers you just mentioned?
- On the average, how many times do women go for antenatal check-ups in this community?

- Which women (e.g. poor, rich, Christians, literates) in this community do you believe go for antenatal check ups? What do believe is/are the reason(s) for your answers?
- What do you believe is/are the reason(s) for women to seek antenatal care specifically at clinic/health centre/hospital?
- And what would be the reasons for women not to seek antenatal care specifically at clinic/ health centre/hospital?
- Generally, are antenatal care services available for women in this community? If yes, who provides the services and where are the services located?
- Tell me, are there any particular places and traditional/native forms of antenatal care in this community?
- You have just mentioned a number of places and caregivers that women go to for antenatal care services, tell me, is it easy for women to access antenatal care services in this community? If yes or no, could you explain how in a bit more detail?
- Do women have to travel to access antenatal care services in this community? If yes, can you say how long (in terms of mileage or minutes/hours/days etc.). Is it easy for women to travel to seek antenatal care – availability of media of transport and means to do so?
- Overall, do you think the antennal care services women in this community seek or get is convenient and satisfactory? Could you explain your answer in a bit more detail?
- Ok, tell me more about your own experiences: did you personally go for or seek any antenatal care during your last pregnancy? Or have you personally gone for any antenatal check-up for your current pregnancy? Why/ why not? Did you find/have you found the kind of care you were/are looking for? Could you say more about the sort of care you sought and got?
- If you found care, where and from whom? Is/are there any reasons why you sought care from the place and care giver you mentioned? Did/Do you have preferences when it comes to seeking antennal care at a particular place and from a particular caregiver? Can you explain your answer?
- If you found care, can you tell me about your experiences with receiving that care: was the care helpful? Was it friendly or threatening? Did you have to pay for the care you recieved, and if yes, how much?
- Also, what kinds of information/things were you told about your pregnancy? Did you believe the information? Were you asked or encouraged to deliver your baby at a particular place (say hospital) and by a particular person (doctor)? Do you believe this influenced where you finally delivered your last baby Or do you believe this will influence where and by whom you will deliver your current pregnancy?
- Also, can you tell me, on the average, how many times you went or will go for antenatal check-ups for your last/current pregnancy?
- Did/do you have to travel to access antenatal care services with your last/current pregnancy? If yes, can you say how long (in terms of minutes/hours/days etc.). Was/is it easy for you to travel to seek antenatal care – availability of media of transport and means to do so? Did you or do you travel alone? Could you explain your answer?

- Ok, I don't pray for any bad thing to happen, but did any thing bad happen to you while you were in the process of seeking care or following particular care that you received? If yes, what did you do about it?
- Overall, do you think the antennal care you got or you are currently receiving is convenient and satisfactory? Could you explain your answer in a bit more detail?
- What do you believe are the barriers/difficulties to women's access to antenatal care in this community?
- What do you think, if done, could have made your last/current experience of seeking antenatal care easy, convenient and satisfactory?

1.2.2. Delivery Care

- Can you also tell me more about your or other women's experiences of delivering babies?
- Generally, where and by whom do women in this community deliver their babies? At home/Clinic/health centre/hospital? And from a doctor, midwife/nurse, TBA, family/friend or any other person either in this community or in another community?
- Tell me are there any particular places and traditional/native forms of delivery services in this community?
- Do women in this community have preferences for delivering their babies at a particular place and by a particular person?
- Why do you think 1) majority or 2) few women prefer delivering their babies at the places and by the persons you just mentioned?
- What do you believe is/are the reason(s) for women delivering at specifically at clinic/health centre/hospital?
- And what would be the reasons for women not delivering at specifically at clinic/health centre/hospital?
- Which women (e.g. poor, rich, Christians, literates) in this community do you believe deliver their babies at the 1) home 2) clinic/health centre 3) hospital; and by a 1) doctor 2) nurse/midwife 3) TBA 4) family/friends? What do believe is/are the reason(s) for your answers?
- Generally, are birthing/delivery services available for women in this community? If yes, who provides the services and where are the services located?
- You earlier on mentioned a number of places and caregivers that women go to deliver their babies, tell me is it easy for women to access or go to these places or persons to deliver their babies? If yes or no, could you explain how in a bit more detail?
- Do women have to travel to deliver their babies in this community? If yes, can you say how long (in terms of mileage or minutes/hours/days etc.). Is it easy for women to travel to seek antenatal care – availability of media of transport and means to do so?
- Ok, I know getting into labour is very much sometimes unpredictable; so could you describe to me what happens when women in this community go into labour unexpectedly?

- Overall, do you think the delivery care services women in this community seek or get is convenient and satisfactory? Could you explain your answer in a bit more detail?
- What do you believe are the difficulties/ barriers to women delivering at the hospital or clinic and by a doctor or skilled person in this community?
- **Now,** can you tell me about your own experiences: where did you deliver your last baby? Why?
- Or where and by whom have you or will you personally deliver your baby?
- Is/are there any reasons why you delivered or will deliver at the place and by the person you just mentioned? Did/Do you have preferences when it comes to where and by whom to deliver your baby? Can you explain your answer?
- Ok, tell me a bit more about your experiences of delivery at the 1) home 2) clinic/health centre 3) hospital 4) other place; and by a 1) doctor 2) nurse/midwife 3) TBA 4) family/friends: was the care helpful? Was it friendly or threatening? Did you have to pay for the care you recieved, and if yes, how much?
- Also, what kinds of information/things were you told about your delivery and your baby? Did you believe the information? Were you asked or encouraged to seek particular post-delivery care for yourself or baby at a particular place (say hospital) and by a particular person (doctor)? Do you believe this influenced the kind of post-delivery care services you sought for yourself or baby? Could you give more details?
- Did/do you have to travel to deliver your last/current baby? If yes, can you say how long (in terms of mileage or minutes/hours/days etc.). Was/is it easy for you to travel to deliver you baby – availability of media of transport and means to do so? Did you or do you have to travel alone? Could you explain your answer?
- Ok, I don't pray for any bad thing to happen, but tell me, did any thing bad happen to you or your baby while you were being delivered or following the delivery whether at home, clinic, health centre or hospital? If yes, what did you do about it?
- Overall, do you think the delivery care you received for your last pregnancy was convenient and satisfactory? Could you explain your answer in a bit more detail?
- What do you think, if done, could have made your last delivery experience easy, convenient and satisfactory?

1.2.3. Postnatal Care

- Tell me what happens or what do you do after delivery, particularly within the first six weeks after delivery: do women consult a doctor, nurse, community health worker, TBA or any other person to check-up if every thing is fine with them and their baby? If so why, and if not why not?
- Generally, are postnatal or after-delivery services available for women in this community? If yes, who provides the services and where are the services located?
- What do you believe is/are the reason(s) for women to seek post-delivery care specifically at clinic/health centre/hospital?

- And what would be the reasons for women not seeking after-delivery care specifically at clinic/health centre/hospital?
- What kind of post-delivery care do women seek or not seek? Which women seek or do not seek post-delivery care in this community? Why do you think these women do or do not seek care after delivery?
- Did you personally seek postnatal care after your last delivery? If yes, why, if not why not? What kind of care did you seek? Where and from whom did you seek the care? Why did you choose to seek care from the place or person you just mentioned? Was the care helpful? Was it friendly or threatening? Did you have to pay for the care you received, and if yes, how much?
- Also, what kinds of information/things were you told about yourself or baby? Did you believe the information? Were you asked or encouraged to seek particular post-delivery care for yourself or baby at a particular place (say hospital) and by a particular person (doctor)? Did this influence the kind of post-delivery care services you sought for yourself or baby? Could you give more details?
- Did/do you have to travel to deliver your receive post-delivery care? If yes, can you say how long (in terms of mileage or minutes/hours/days etc.) you had to travel?
- Was/is it easy for you to travel to receive post-delivery care – availability of media of transport and means to do so? Did you or do you have to travel alone? Could you explain your answer?
- Overall, do you think the post-delivery care you received after your last delivery was convenient and satisfactory? Could you explain your answer in a bit more detail?
- What do you think, if done, could have made your last post-delivery experience easy, convenient and satisfactory?

1.2.4. Women Experiences with Ghana's Free Maternal Healthcare Policy

- Now I will like to ask you a few more questions about what the government is doing to make pregnancy and childbirth safer for women in this community.
- Is there any thing your district/hospital/clinic/health centre is doing to make pregnancy and childbirth safer for women in this community? If yes, can you tell me more about these? Have you or other women in your community benefitted from any of these initiatives you talked about?
- Also, I will like to know, have women in this community ever 1) heard through such media as public/community announcement, radio and television or 2) been told by any health personnel that if you go for antenatal check-up, deliver your baby or seek care after delivery at the hospital/clinic/health centre, you do not have to pay?
- The last time you went for antenatal check-ups, deliver your baby or sought post delivery care at the hospital/clinic/health centre, did you have to pay any fees? If yes, tell me about what kinds of fees you pay and why? If not can you tell me more about why you not pay?
- You have told me about the kinds of fees you pay and why, can you tell me how paying for antenatal, delivery and postnatal care affect your decisions to either seek or not seek care? If yes in what ways and why? If no too why,

- Or you have said that you do not pay any fees can you tell me the last time you stopped paying fees? Is it every woman seeking antenatal, delivery or postnatal care that does not pay?
- Does the fact that you no longer pay for antenatal, delivery and postnatal care affected your decisions or those of other women to either seek or not seek care? If yes, in what ways and why, and if no, why?
- Do you believe not paying any fees for antenatal, delivery and postnatal care services at the clinic, health centre or hospital is a good thing or has been beneficial for women in this community? If yes or no, could you explain further?
- Do you believe not paying any fees for antenatal, delivery and postnatal care services at the clinic; health centre or hospital has brought any problems or difficulties for women in this community? If yes or no, could you explain further?
- How do you think these problems can be solved or managed to reduce their negative consequences for women in this community?

APPENDIX 2

QUESTIONS & TOPIC GUIDE FOR IN-DEPTH INTERVIEW (HEALTHCARE PROVIDERS)

Project Title:

Free Maternity Care, Access, Equity of Access, and Barriers to Accessing and Using Skilled Maternal and New-Borns Health Care Services in Ghana

1. Topic Guide for In-depth Interviews

1.1. NATIONAL LEVEL:

Officials from the National Ministry of Health (MoH), Ghana health services (GHS), & Members of the parliamentary select committee on health.

1.*1.1 Introduction & Debriefing*

- What the research is about…

1.1.2. The Problem of Maternal health

- So, can you briefly describe the maternal health situation in Ghana for me?
- To what extent is it a problem for Ghana and your office in particular?
- Is it a priority? Why and why not?
- Are there variations in terms of the burden of maternal mortality in Ghana - between regions, districts, communities and even certain socio-demographic groupings - is this an issue of concern?
- In your experience, what do you believe are the causes? Are these causes unique to particular regions, districts, communities or certain segment of the women population? Why and why not?

1.1.3. What is being done about Maternal Health in Ghana

- How is the health ministry or your office responding to maternal health in Ghana?
- Has Ghana or your office a maternal health policy or programmes?
- Tell me more about Ghana's maternal healthcare policy: what is the focus and why? Are resources and infrastructure available?
- What is the health budgetary allocation? How is budgetary allocation determined? By who?

1.1.4. Free Maternal Health Care Policy

- What about Ghana's free maternal healthcare policy; what are the objectives, its focus and why?
- Has the policy made any impacts on maternal health outcomes?
- Do you believe the free maternity care policy has made antenatal, delivery, and post-delivery services more available and accessible to women in Ghana? How?
- Has the policy/ programmes been evaluated? By who and for whom?
- Has there been local needs assessment and community involvement?

1.1.5. Care Services Availability and Variability in Access

- What kinds of maternal health care services does the ministry provide?
- Do you provide antennal, delivery, and postnatal care services?
- Are there any other traditional forms of birth practices in Ghana that you are aware of? Could you give examples?
- Now tell me, are there variations in terms of maternal healthcare services availability and accessibility - between regions, districts, communities and even certain socio-demographic groupings? Any examples?
- In your experience, and if any, what do you believe is responsible for the differences in maternal healthcare availability and accessibility in Ghana?

1.1.6.Equity & Fairness in Care Accessibility

- Is un/equal availability and accessibility of maternity care services an issue of concern? Why and why not?
- How much is equity a key maternal healthcare policy goal in Ghana?
- Should equity objectives be considered or included the provision and delivery of maternal healthcare services in Ghana
- Do you think Ghana's free maternal healthcare policy has made maternity care services accessible to all women? If yes, could you say how? Any examples?
- If no, could you explain?
- Generally, what do you believe are the challenges/barriers to women's access to maternity care services in Ghana?
- What do you believe are the challenges/barriers to Ghana's free maternal healthcare policy?
- What do you think, if done, could eliminate these barriers and make maternity care services more available, easy and convenient to access for all women in Ghana?

1.2. REGIONAL LEVEL:
Officials from the Regional Health Directorate & Ghana health services (GHS)

1.2.1 Introduction & Debriefing

- What the research is about…

1.2.2. The Problem of Maternal health

- Now, I will like to ask you a couple of questions about your role and/ or that of your office/unit and its relationship to access and barriers to accessing maternal health care services in this region:
- Briefly describe the maternal health situation in this region for me.

- To what extent is it a problem for the region and your office in particular?
- Is it a priority? Why and why not?
- Are there variations in terms of the burden of maternal mortality in this region- between districts, communities and even certain socio-demographic groupings? If yes, is this an issue of concern? Why and why not?
- In your experience, what do you believe are the causes? Are these causes unique to particular districts, communities or certain segment of the women population? Why and why not?

1.2.3. What is being done about Maternal Health in the Region

- How is the regional health directorate or your office responding to maternal health?
- Does the region have a maternal health policy or programmes? If yes, can you say more about these policies and programmes: are they any different from national maternal health policies/programmes? What do they seek to do?

1.2.4 Free Maternal Health Care Policy

- What about Ghana's free maternal healthcare policy?
- Is the policy being implemented in the region – region-wide? In certain districts or communities?
- What is the objectives, focus and why?
- Are resources and infrastructure available? What is the health budgetary allocation? How is budgetary allocation determined? By who?
- Has the policy made any impacts on maternal health outcomes in the region? How? And any examples?
- Do you think the free maternity care policy has made antenatal, delivery, and post-delivery services more available and accessible to women in this region? How?
- Has the policy/ programmes been evaluated? By who and for whom?
- Has there been local needs assessment and community involvement?

1.2.5. Care Services Availability and Variability in Access

- What kinds of maternal health care services do you provide?
- Do you provide antennal, delivery, and postnatal care services?
- Do women in this regional access or use the services you mentioned? Do women in the region generally seek maternity care (antenatal, delivery, and postnatal)? Why and why not?
- What categories of people e.g. by age, occupation, education, ethnicity, religion etc. seek care from you?
- Are there local resistances? Why and why not?
- Are there any other traditional forms of birth practices in the region that you are aware of? Could you give examples?

- Now tell me, are there variations in terms of maternal healthcare services availability and accessibility - between districts, communities and even certain socio-demographic groupings? Any examples?
- In your experience, and if any, what do you believe is responsible for the differences in maternal healthcare availability and accessibility in the region?

1.1.5.Equity & Fairness in Care Accessibility

- Is un/equal availability and accessibility of maternity care services an issue of concern in the region? Why and why not?
- How much is equity a key maternal healthcare policy objective in the region?
- Should equity objectives be considered or included the provision and delivery of maternal healthcare services in regional health policy? Why and why not?
- Do you think Ghana's free maternal healthcare policy has made maternity care services accessible to all women? If yes, could you say how? Any examples?
- If no, could you explain?
- Generally, what do you believe are the challenges/barriers to women's access to maternity care services in this region?
- What do you believe are the challenges/barriers to providing free maternal healthcare in this region?
- What do you think, if done, could eliminate these barriers and make maternity care services more available, easy and convenient to access for all women in region?

1.3. DISTRICT LEVEL:
Officials from the District Health Directorate & Ghana health services (GHS

1.3.1 Introduction & Debriefing

- What the research is about…

1.3.2. The Problem of Maternal health

- Ok, could you briefly describe the maternal health situation in this district for me?
- To what extent is it a problem for the district and your office in particular?
- Is it a priority? Why and why not?
- Are there variations in terms of the burden of maternal mortality in this district - between communities and certain socio-demographic groupings? If yes, is this an issue of concern? Why and why not?
- In your experience, what do you believe are the causes? Are these causes unique to particular communities or certain segment of the women population? Why and why not?
- Do you think local communities are aware of these causes you outlined?

1.3.3. What is being done about Maternal Health in the District

- How is the district health directorate or your office responding to maternal health?
- Does the district have any maternal health policies or programmes?
- If yes, can you say more about these policies and programmes?
- Are they any different from national/regional policies/programmes?
- What do they seek to do?

1.2.4 Free Maternal Health Care Policy

- What about Ghana's free maternal healthcare policy?
- Is the policy being implemented in the district – district-wide? In certain communities?
- What is the objectives, focus and why?
- Are resources and infrastructure available? What is the health budgetary allocation? How is budgetary allocation determined? By who?
- Has the policy made any impacts on maternal health outcomes in the district? How? And any examples?
- Do you think the free maternity care policy has made antenatal, delivery, and post-delivery services more available and accessible to women in this district? How?
- Has the policy/ programmes been evaluated? By who and for whom?
- Has there been local needs assessment and community involvement?
- Overall, would you say the policy or programmes that the district has implemented so far are effective in terms of increasing access and use of maternity care services as well as reducing maternal mortality or improving maternal health in the region? How, could you give more details?

1.2.5. Care Services Availability and Variability in Access

- What kinds of maternal health care services do you provide?
- Do you provide antennal, delivery, and postnatal care services?
- Do women in this district access or use the services you mentioned?
- Do women in the district generally seek maternity care (antenatal, delivery, and postnatal)? Why and why not?
- What categories of people e.g. by age, occupation, education, ethnicity, religion etc. seek care from you?
- Are there local resistances? Why and why not?
- Are there any other traditional forms of birth practices in the region that you are aware of? Could you give examples?
- Now tell me, are there variations in terms of maternal healthcare services availability and accessibility - between communities and socio-demographic groupings? Any examples?
- In your experience, and if any, what do you believe is responsible for the differences in maternal healthcare availability and accessibility in the district?

1.1.5.Equity & Fairness in Care Accessibility

- Is un/equal availability and accessibility of maternity care services an issue of concern in the district? Why and why not?
- How much is equity a key maternal healthcare policy objective in the district?
- Should equity objectives be considered or included the provision and delivery of maternal healthcare services in district health policy? Why and why not?
- Do you think Ghana's free maternal healthcare policy has made maternity care services accessible to all women? If yes, could you say how? Any examples?
- If no, could you explain?
- Generally, what do you believe are the challenges/barriers to women's access to maternity care services in this district?
- What do you believe are the challenges/barriers to providing free maternal healthcare in this district?
- Having worked in this environment for sometime, what do you think, if done, could eliminate these barriers and make maternity care services more available, easy and convenient to access for all women in the district?

1.4. COMMUNITY LEVEL:
Community Health Nurses & workers

1.4.1 Introduction & Debriefing

- What the research is about…

1.4.2.The Problem of Maternal health

- So, tell me, having been working in this community for sometime, how would you describe the maternal health situation in this community: is maternal health a problem for the community and your hospital/clinic/health centre in particular?
- Is it a priority? Why and why not?
- What categories of maternal health problems are you consulted with? Any reasons?
- Do you think the burden of maternal mortality or poor maternal health is borne equally or disproportionately by all or certain socio-demographic groupings of women in this community? If yes, is it an issue of concern? Why and why not?
- In your experience, what do you believe are the causes? Are these causes unique to particular segment of the women population? Why and why not?
- Do you think local communities are aware of these causes you outlined?

1.4.3. What is being done about Maternal Health in the community

- How is your hospital/clinic/health centre responding to maternal health: do you operate any specific maternal health care policy or programmes?
- If yes, can you say more about these policies and programmes: the kind of maternity care services they provide and what do they seek to do/achieve? Are these any different from national, regional or district policies/programmes?

1.4.4 Free Maternal Health Care Policy

- What about Ghana's free maternal healthcare policy? Are you aware of Ghana's free maternal health care policy?
- Is the policy being implemented in this community– district-wide? In certain communities?
- What is the objectives, focus and why?
- Are resources and infrastructure available? What is the health budgetary allocation? How is budgetary allocation determined? By who?
- Has the policy made any impacts on maternal health outcomes in this community? How? And any examples?
- Do you think the free maternity care policy has made antenatal, delivery, and post-delivery services more available and accessible to women in this community? How?
- Has the policy/ programmes been evaluated? By who and for whom?
- Has there been local needs assessment and community involvement?
- Overall, would you say the policy or programmes that you have implemented so far are effective in terms of increasing access and use of maternity care services as well as reducing maternal mortality or improving maternal health in the this community? How, could you give more details?

1.4.5. Care Services Availability and Variability in Access

- What kinds of maternal health care services do you provide?
- Do you provide antennal, delivery, and postnatal care services?
- Do women in this district access or use the services you mentioned?
- Do women in the community generally seek maternity care (antenatal, delivery, and postnatal)? Why and why not?
- What categories of people e.g. by age, occupation, education, ethnicity, religion etc. seek care from you?
- Are there local resistances? Why and why not?
- Are there any other traditional forms of birth practices in the region that you are aware of? Could you give examples?
- Now tell me, are there variations in terms of maternal healthcare services availability and accessibility - between socio-demographic groupings? Any examples?
- In your experience, and if any, what do you believe is responsible for the differences in maternal healthcare availability and accessibility in this community?

1.4.6.Equity & Fairness in Care Accessibility

- Is un/equal availability and accessibility of maternity care services an issue of concern to you? Why and why not?
- How much is equity a key maternal healthcare policy objective for you?
- Should equity objectives be considered or included the provision and delivery of maternal healthcare services in this community? Why and why not?
- Do you think Ghana's free maternal healthcare policy has made maternity care services accessible to all women in this community? If yes, could you say how? Any examples?
- If no, could you explain?
- Generally, what do you believe are the challenges/barriers to women's access to maternity care services in this community?
- What do you believe are the challenges/barriers to providing free maternal healthcare in this community?
- As you have worked in this environment for sometime, what do you think, if done, could eliminate these barriers and make maternity care services more available, easy and convenient to access for all women in this community?

APPENDIX 3

OBSERVATION QUESTIONS & TOPIC GUIDE

Project Title:
Free Maternity Care, Access, Equity of Access, and Barriers to Accessing and Using Skilled Maternal and New-Borns Health Care Services in Ghana

1. ***Community Setting***

- Social and power structures? Patterns of marriage?
- Gender roles?
- Dominant economic activities? Any differences between socio-demographic groupings etc.?
- Health care resources/services?
- Availability of health services/facilities? Any community health committee? Role?

- What health services are available for maternal health? Community drug store provisions? Traditional birth attendants? Clinic/formal health care facilities? NGOs' health care provision? Where? Available times?
- Accessibility: roads? Transportation? Transport options? Cost? Etc?
- Geographic/spatial location?
- Any relationships between economic activities and maternal healthcare services accessibility and utilization, risk of maternal death or disability?
- Any traditional forms of maternity care? Charges?

2. Hospital/Clinic/Health Centre Setting

- Where and how is the Hospital/Clinic/Health Centre set up?
- Where is the reception and waiting area? Is it welcoming?
- What time of day do women come to the Hospital/Clinic/Health Centre (e.g. early morning, afternoon, evening, night etc.)?
- Why do they come at one particular time of the day?
- By what means do women come to the Hospital/Clinic/Health Centre (e.g. bicycle, car, ambulance, donkey, foot/walking etc.)?
- Are women accompanied? Who accompanies the women (e.g. relatives, significant others, men, women, children etc.)?
- What kinds of women come to the Hospital/Clinic/Health Centre (e.g. younger, older, educated, etc)?
- What kinds of people work at the health centre, clinic or hospital?
- What kinds of maternity care services do women seek?
- What is the order of seeing patients?
- What is patient–health professional relationship like?
- How are women received/treated by doctors/nurses/midwives etc.?
- If women are accompanied, how are those who accompany the women treated/received?
- How do doctors/nurses/midwives interact with or relate to the women?
- How do women interact among themselves at the Hospital/Clinic/Health Centre?
- How is information and care delivered to women by healthcare providers?
- What language is used? Are there language barriers?
- Are the women given any privacy?
- Are services available (e.g. drugs, vaccines etc.)? What are the patterns of utilization of these services: frequency of use by age, education, residence (rural/urban), religion, ethnicity, occupation etc?
- How are the routines of the Hospital/Clinic/Health Centre organized? E.g. how much time does a patient have to spend with a nurse (rushing, enough time to talk of problem etc.)?

3. National, Regional & District Settings

- Existence of concrete policies on maternal health care service access, particularly in relation to equal access?
- Congruence and incongruence between policy statements and actual practices?
- Resource allocation for maternal health?
- Relationships among different players?

- Policy/programme coordination?
- Coordination with local community-based strategies?