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Maternal Mortality in Ghana: Prospects of Meeting The UN Millennium Development Goals

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MATERNAL MORTALITY IN GHANA: PROSPECTS OF MEETING THE UN MILLENNIUM DEVELOPMENT GOALS

By

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DECLARATION

I, Comfort Tiwaa Kwarteng, declare that this thesis is a result of my research investigations and findings. Sources of information other than my own have been acknowledged and a reference list has been appended. This work has not been previously submitted to any other university for award of any type of academic degree.

Signature…… Date……

DEDICATION

This thesis is dedicated to the family of Augustine Francis Kwarteng. I appreciate the immense support and prayers from my parents and the entire family through my life. I ask for God's blessings on their lives.

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LIST OF ACRONYMS AND ABREVIATIONS

5YPOW	5-Year Programme of work
AACMA	Asante Akim Central Municipal Assembly
AACM	Asante Akim Central Municipality
AANDA	Asante Akim North District Assembly
AANMA	Asante Akim North Municipal Assembly
AASDA	Asante Akim South District Assembly
ADHA	Duty Hours Allowance
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
CHNs	Community Health Nurses
CHNTS	Community Health Nurses Training School
CHPS	Community-based Health and Planning Services
DACFs	District Assembly Common Funds
DANIDA	Danish International Development Agency
DDFs	District Development Fund
DFID	Department of International Development
DMHIS	District Mutual Health Insurance Scheme
EmOC	Emergency Obstetric Care
GCPS	Ghana College of Physicians and Surgeons
GHS	Ghana Health Services
GLSS	Ghana Living Standard Survey
GPRS 1	Ghana Poverty Reduction Strategy
GPRS 2	Growth and Poverty Reduction Strategy
HIV	Human Immunodeficiency Virus

HSS	Health Salary Scheme
IGFs	Internally Generated Funds
IPT	Intermittent Preventive Treatment
IUD	Intrauterine Device
MCE	Municipal Chief Executive
MDGs	Millennium Development Goals
MDPC	Municipal Development Planning Coordinator
MHD	Municipal Health Directorate
MLGRD	Ministry of Local Government and Rural Development
MMR	Maternal Mortality Ratio
MNHP	Maternal and Neonatal Health Council
MOESS	Ministry of Education, Science and Sport
MOH	Ministry of Health
MPS	Making Pregnancy Safer
MTHS	Medium Term Health Strategy
NAS	National Ambulance Services
NGOs	Non-Governmental Organizations
NHI	National Health Insurance
NHIA	National Health Insurance Authority
NHIF	National Health Insurance Funds
NHIS	National Health Insurance Scheme
PA	Physician Assistant
PHC	Primary Health Care
PMMP	Prevention Maternal Mortality Programme

PMSAP	Prevention and Management of Safe Abortion Programme
SBAs	Skilled Birth Attendants
STIs	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
UDS	University of Development Studies
UNDP	United Nations Development Programme
UN	United Nations
UN ECOSOC	United Nations Economic and Social Council
UDGs	Urban Development Grants
WHO	World Health Organization

ABSTRACT

Maternal health has received continuous attention at the global, national and the local levels over several decades. During the UN Millennium Summit in the year 2000, the UN member states including Ghana adopted eight (8) Millennium Development Goals (MDGs) which are geared towards improving the life of all people across the globe. Improving maternal health became the MDG 5 with two (2) specific targets to be achieved by 2015. In Ghana, the overall pace of progress in maternal health is not encouraging and may likely not meet the MDG 5. This study explores the reasons that account for the slow improvement of maternal health in Ghana towards achieving the goal of MDG 5. The study will serve as a relevant information for policymakers to come out with health policy reforms that will address issues related to maternal mortality.

The study employed qualitative research approach with a case study design, conducted in Asante Akim Central Municipality (AACM). Purposive sample technique was used which involved pregnant women, midwives, Physician assistant (PA), health personnel, Municipal Health Directorate (MHD), Municipal Development Planning Coordinator (MDPC) and representatives of NGOs. These entities were as key informants. However, pregnant women were used in the focus group discussions. Secondary data included research conducted, policy documents and articles related to the research interest area. The gender and power theory by Connell and the gender of power by Davis et al will form the foundation of this study.

It was found that most pregnant women residing in the rural areas have difficulty in accessing skilled health care. They are unable to enrol in the National Health Insurance Scheme (NHIS) and those who are already enrolled find it difficult to renew their insurance cards when they expire due to financial constraints. This group of women fail to attend antenatal care (ANC) regularly which makes it difficult for them to receive education on their health. Moreover, they are not able to detect pregnancy related complications due to the inadequate education and most of them depend on TBAs who sometimes do not handle complications efficiently. It was also found that Inadequate number of health personnel and the refusal on their part to accept postings to the rural areas of the municipality does not allow the steady improvement of maternal health in the municipality. Moreover, the laid down structures and allocation of resources by the government are not adequate enough to make significant improvement in maternal health.

CHAPTER ONE

1.1 Introduction

Maternal health has received continuous attention at the global, national and the local levels over several decades. This is due to the continuous death of pregnant women across the globe. Many are the efforts put in place by various international organizations, leadership of various nationalities as well as organizations operating at the local levels to help provide solid solutions to maternal mortality[1] and save the lives of women across the globe. The year 2000 witnessed the adoption of the eight (8) Millennium Development Goals (MDGs) by the United Nations (UN) member states in the UN millennium summit. This was aimed at enhancing the overall development of humans (Sybley 2014)[2] particularly in the developing countries. In the UN Summit on the MDGs, the UN member states including Ghana adopted the UN Millennium Declaration which captured the ambitions of the global community for the century. The UN General Assembly set eight (8) MDGs out of the Millennium Declaration. These goals were set for a particular time frame with specific target to be achieved.

The international community set up these goals for all the developing countries in all regions including sub-Saharan Africa. The goal for the fifth MDG, which is improving maternal health is to reduce maternal mortality ratio (MMR)[3] by 75% as well as universal access to reproductive health services both by 2015 (United Nations 2014). The global community aimed at improving maternal health by reducing maternal mortality by three quarters (Assembly 2000). However, the current MDGs Report (United Nations 2014) reveals that in spite of the global progress made towards improving maternal health, maternal mortality in developing regions including sub-Saharan Africa still remains high as compared to the developed regions. Ghana within the sub-Saharan Africa has therefore become the focus of the study. Maternal mortality is very prevalent in Ghana and effort for improving maternal health has not been very successful. Whilst several developing countries including Maldives, Bhutan, Cambodia, Romania, Lao People's Democratic Republic, Equatorial Guinea, Timor-Leste, Cape Verde Eritrea, Nepal and Rwanda have made significant improvement in

[1] Maternal mortality is the death of a woman while pregnant, however, a more detailed explanation will be given in the theory section (WHO 2014, p. 4).
[2] More detailed information is given by Lynn Sibley (2014) at https://class.coursera.org/pregnancychildbirth-001/lecture/5
[3] Maternal mortality ratio is defined as the number of maternal deaths during a given time period per 100000 live births during the same time period (WHO 2014, p. 6).

maternal health and are considered as “on track”, Ghana is still far from reaching the goals of MDG 5 (WHO 2014).

Despite the several efforts and interventions by government and other development partners towards achieving the goals of MDG 5, maternal mortality ratio still remains high (United Nations Development Programme 2012). Moreover, maternal mortality is prevalent in Ghana because every woman in Ghana has a 1 in 68 lifetime risk of dying from maternal causes (WHO 2014). As a result of the high incidence of maternal mortality in Ghana, governments, policy makers and stakeholders have introduced a number of policy interventions to radically reduce maternal mortality. These interventions include the National Health Insurance Scheme (NHIS) (Shaw 2007), Safe Motherhood Initiative, Making Pregnancy Safer (MPS), Prevention Maternal Mortality Programme (PMMP) (United Nations Development Programme 2012) that are geared towards improving maternal health in Ghana and meeting the goals of the fifth MDG.

The government of Ghana passed the National Health Insurance (NHI) Act in 2003 and implemented it in 2004 (Shaw 2007). The scheme was introduced with the main aim of providing quality and affordable health services to all residents in Ghana (Dietrich-O’Connor 2010). This was done by the government in consultation with agencies in Ghana, other international health development agencies including World Health Organization (WHO), Danish International Development Agency (DANIDA) and Department for International Development (DFID) (Health Systems 20/20 2010). The central government played a major role in the NHIS by setting the minimum benefits package, licensing and regulating the health insurance schemes, certifying the providers as well as collecting a national health insurance levy which are used to subsidize premium for the poor (Shaw 2007).

1.2 Background to the study

The health of women has significant effects on the family and the society which is relevant for national development. Consuming nutritious and healthy foods ensures a health-promoting lifestyle. However, women in Ghana are affected by negative traditional practices and dietary rules. Majority of women in Ghana have worsened their health conditions by adhering to some food-related superstitions and taboos. There have also been food restrictions for women during childbearing age, pregnancy and lactation. Moreover, following certain traditional practices where women serve the male members of the household with the best part of the meal also contribute to their vulnerable health conditions

(Kwapong & Kwapong 2008). Women in Ghana especially those in the rural areas have limited access to health facilities and health personnel. It has been revealed by Ghana Living Standard Survey (GLSS) 4 (Ghana Statistical Survey 2000) that most pregnant and nursing mothers solely receive services from Traditional Birth Attendants (TBAs)[4] despite the fact that 83% of women receive both antenatal and postnatal care services from health personnel (Kwapong & Kwapong 2008).

The National Health Insurance Authority (NHIA) and its governing council which was established by the NHI Act was mandated to regulate the health care system, management of the National Health Insurance Funds (NHIF) as well as the accreditation of its providers. The three different types of health insurance outlined by the Act included District Mutual Health Insurance Scheme (DMHIS), private commercial health insurance schemes and private mutual health insurance schemes (Dietrich-O'Connor 2010) to enable Ghanaians choose the health insurance of their choice (Shaw 2007). The DMHIS which works at every district with a minimum of 2000 members is eligible for subsidies from the NHIA and all districts across the country receive the same benefit package for paying providers on a fee-for-service basis (Brugiavini & Pace 2011).

Moreover, the scheme was designed to help providers offer a minimum range of services to members covering the basic inpatient and outpatient services at recognized facilities, oral health, eye care, emergencies and maternity care including prenatal, normal deliveries as well as complicated deliveries. It also covered other diseases including malaria, diarrhoea, some respiratory infections, skin diseases, hypertension, asthma and diabetes among others. However, the NHIS did not cover Human Immunodeficiency Virus (HIV) retroviral drugs, cancer treatment and assisted reproduction (Brugiavini & Pace 2011; Ministry of Health Ghana 2004a; Ministry of Health Ghana 2004b). The NHIS exempted indigents including the aged above 70 years, children below 18 years, pensioners and Social Security contributors from paying premium, however, they had to register in order to benefit from the scheme. Furthermore, from July 2008, it also exempted pregnant women from paying premium in order to access free antenatal care, delivery and postnatal health care services under the scheme (Witter & Garshong 2009).

[4]Traditional Birth Attendants (TBAs) in Ghana are mostly people who are not professionally trained but assist pregnant women to deliver in the remote communities where there are no health facilities.

Aside the NHIS is the Safe motherhood initiative which is a significant measure introduced by the government of Ghana through the Primary Health Care (PHC) programme to address the issue of high maternal mortality. The various measures under the safe motherhood initiative programme include Prevention and Management of unsafe abortions, family planning, antenatal care (ANC), labour and delivery care (United Nations Economic and Social Council 2007). The government of Ghana implemented the free ANC in 2003 to scrap away the delivery fees in the various health care facilities (Biritwum 2006).

In addition, the government increased the support of midwives through increased midwifery training programmes (Ghana Health Service 2014). Furthermore, with the main objective of promoting maternal health, PMMP was introduced as integral part of the Safe Motherhood Initiative. The main activities of this intervention included the improvement of easy access to health care and also improving the quality of health care delivery at the various health care centres. Other significant components of the safe motherhood initiative are; MPS Initiative and MNHP.

The MPS Initiative being one of the significant components of the Safe Motherhood Initiative is carried out through the PHC Programme. There are four (4) major interventions underlying the MPS Initiative which include care during and after delivery, community component, postpartum family planning and care during pregnancy. The care during pregnancy is designed to cover ANC, treatment of malaria, severe anaemia, syphilis and other sexually transmitted infections (STIs) including gonorrhoea and chlamydia. Moreover, care during and after delivery which includes delivery by skilled birth attendant (SBA)[5] and it also covers routine new born care. In addition, management of eclampsia, postpartum haemorrhage, obstructed labour and management of basic new born complications are all included in the care during and after delivery. Others include postpartum care management of abortion complication and management of post-surgical care.

Furthermore, postpartum family planning is made to cover condom use, oral contraception, Intrauterine Device (IUD), Depo-Provera, Norplant and sterilisation. Lastly community component is concerned with Community-based Health Planning and Services (CHPS), TBAs, community empowerment programme for making pregnancy safer as well as prevention and management for safe abortion programme. Aside the safe motherhood

[5] A skilled birth attendant (SBA) is 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, child birth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborn (Safer 2004, p. 1).

initiative, other interventions that have been introduced include Ghana VAST Survival Programme, Maternal Health Project (MHP), Prevention and Management of Safe Abortion Programme (PMSAP), Intermittent Preventive Treatment (IPT) and Roll Back Malaria Programme (United Nations Economic and Social Council 2007).

In the year 2008, the ministry of health aimed at increasing the number of health personnel and motivating them in order to distribute them across the country to provide health services to the population. It developed a systematic plan towards supporting appropriate human resource planning, management and training to improve and sustain the health of the population. The plan was aimed at addressing the imbalance of health workers in favour of highly trained professionals. This was done through scaling up the training of middle level and addressing the mal distribution of health personnel (Ministry of Health 2007).

Besides, the ministry in 2007 had implemented a new Health Salary Scheme (HSS) which replaced the additional duty hours allowance (ADHA) with the aim of improving performance. Aside the new health scheme, the ministry of health also introduced other key activities to improve productivity of health personnel. These included implementing the planned human resource strategic plan, conducting impact assessment to ascertain the impact of the new salary scheme and other incentives introduced on staff productivity. Others included reviewing the expansion of middle level training programme and deploying to the recently established human resource observatory to ensure human resource governance issues are complied with. The ministry also collaborated with the Ministry of Local Government and Rural Development (MLGRD), Ministry of Education, Science and Sport (MOESS) and Ghana College of Physicians and Surgeons (GCPS) to effectively train and distribute health personnel all over Ghana. These key activities were expected to achieve the implementation of human resource strategic plan, adequacy of staff mix and functional human resource observatory (Ministry of Health 2007).

Moreover, the Ministry of Health upgraded the Tamale Teaching Hospital as a teaching facility for the University of Development Studies (UDS). It focused on building the needed capacity for tertiary and teaching services. The hospital also aimed at improving quality and affordable referral services to the people by well-trained, highly motivated as well as customer-friendly professional health staff (Ministry of Health 2007). Furthermore, Ghana has over the past decades adopted Medium Term Health Strategy (MTHS) and 5-Year Programme of Work (5YPOW) to guide and improve the health service delivery and the

overall health development. In addition, a second 5YPOW was implemented from 2002-2006 to reduce poverty through the Ghana Poverty Reduction Strategy (GPRS). Both the GPRS and the 5YPOW aimed at bridging health inequality which led to the investment in the CHPS and the construction and equipping of health facilities in deprived areas (School of Public Health 2009).

Moreover, CHPS were strategically implemented by the Ministry of Health as part of its national programme to close the gap that exist in healthcare access. The ministry identified CHPS through the GPRS as a key element in pro-poor health services. In view of this, CHPS were implemented to enable the Ghana Health Service (GHS) to diminish health inequalities and promote equity of health outcomes through the removal of geographic barriers to health care. One of the key elements of the CHPS which is a community-based service delivery focuses on improved partnership with households, community leaders and social groups. This was aimed at addressing the demand side of provision and knowing that households remain the primary producers of health (School of Public Health 2009). Besides, the introduction of CHPS led to the training of Community Health Nurses (CHNs) within the Community Health Nurses Training School (CHNTS) in each region in Ghana. In 2008, the GHS successfully absorbed about 1500 into the sector (School of Public Health 2009).

Lastly, the Ministry of Health has increased access to emergency health care services by providing transport through the establishment of the National Ambulance Services (NAS). NAS has been mandated to prevent delays in accessing emergency health care by transporting women with obstetric emergencies to health facilities and providing pre hospital care for the sick and the injured. It also aimed at providing efficient and timely pre hospital care services to improve the outcome of accidents and emergencies. This has led to the distribution of a number of ambulances to provide emergency services linking various communities within the sub-districts, districts, municipality and the metropolitan (Ministry of Health 2008).

In spite of these interventions and policies that have been introduced by the government of Ghana, there has not been significant improvement in maternal health. Even though the institutional mortality rate has reduced from 216 per 100,000 live births in 1990 to 164 per 100,000 live births in 2010 (National Development Planning Commission 2012), Ghana still needs to cover a distance of 110 in order to reach the target of 54 per 100,000in 2015 (Ghana Health Service 2014).

1.3 Problem statement

Whilst substantial progress has been made in most developing regions and several MDG targets including eradication of extreme poverty, hunger and universal primary education among others have been met, maternal mortality in sub-Saharan Africa is still prevalent and Ghana is not exempted (United Nations 2014). In particular, whilst some key MDG targets such as poverty eradication and food security, education and access to safe water have made significant progress in Ghana, the overall pace of progress in maternal health is not encouraging and may likely not meet the fifth MDG (Ghana Statistical Service 2013a).

There has been a global decline of maternal deaths of 45% from 1990 to 2013, however, developing regions especially sub-Saharan Africa and Southern Asia still account for high maternal deaths. This is because 62% of global deaths occurred in only sub-Saharan Africa and Southern Asia also accounted for 24% (WHO 2014). Moreover, 85% of all maternal deaths in sub-Saharan Africa occur as a result of complications which arise during pregnancy, delivery or puerperium and over 60% home deliveries that occur in rural areas without skilled attendants (Abdoulaye 2006). The developed regions have made significant improvement in maternal health whereas developing regions have seen less significant improvement in maternal health. Developed regions have seen tremendous decline in maternal deaths because of a hard political will and appropriate implementation of programmes concerning prevention and treatment whereas the less significant decline in maternal deaths in the developing regions has been the result of the existence of socio-economic conditions including poverty and unequal distribution of wealth as well as the three delays to provide adequate obstetrical cares concerning acceptability, accessibility and availability (Abdoulaye 2006).

Moreover, the developing regions accounted for MMR of 230 whereas developed regions accounted for MMR of 16 which significantly implies that MMR of the developing regions was 14 times higher than that of the developed countries. About 800 women died every day from maternal causes in 2013 which almost occurred in developing countries. These maternal deaths were as a result of lack of access to quality healthcare by pregnant women before, during and after delivery (WHO 2014). Even within the developing regions, whereas regions like Latin America and the Caribbean, Northern Africa, Eastern Asia, Western Asia and Caucasus and Central Asia have achieved considerable lower MMR of 85, 69, 33, 74 and 39 respectively, the sub-Saharan Africa remains the only region with the highest MMR of 510 implying significantly how the region is far from reaching MDG 5 by 2015. The sub-Saharan

Africa accounted for 91% of estimated 7500 global maternal deaths associated with acquired immunodeficiency syndrome (AIDS) (WHO 2014).

Ghana's progress towards achieving MDG 5 has been slow in spite of the introduction of free maternal health and other similar interventions. Even though the country has made progress in reducing MMR to 164 per 100,000 live births in 2010 (the recent survey conducted in the country was in 2010), it is likely that Ghana may not be able to reduce MMR by three quarters between 1990 and 2015. Maternal mortality is very prevalent in the country and much need to be done. In every year, a large number of women die due to pregnancy related complications which include severe bleeding, hypertension diseases, infections and abortions (Ghana Statistical Service 2013a). It is asserted that supervised delivery is widely known to reduce the risk of complications and infections during childbirth and as a result reduce maternal mortality. In view of this, the provision of skilled care by skilled professionals during pregnancy and childbirth is a vital intervention for safe motherhood.

However, supervised delivery remains low in Ghana. Three out of four of all maternal deaths in Ghana occur during birth and immediate post-partum period. Aside the low level of supervised delivery in Ghana is the significant equity gap existing across regions and within regions as well as urban-rural disparities. Moreover, 62% of births were reported to occur in rural areas in Ghana and out of the 62%, only 43% were assisted by SBA in rural areas as against the expected national average of 57% of births (United Nations Development Programme 2012). In addition, ANC from health professionals including nurses, doctors, midwives and community health offices among others have been one of the relevant ways of reducing maternal mortality. It is noted that 15% of pregnancies develop complications and become emergencies and that early detection can help address such a situation. However, there has been a decline across the country in the number of women who received at least one ANC from 95% in 2008 to 90.6% in 2010 (Ghana Statistical Service 2013a). Furthermore, the gap between the urban and rural as well as the rich and poor with respect to the utilization of health care has widened. Poverty, deprivation and ignorance have also widened the gender gaps in access to health care and the health sector also lacks the suitable legal framework (Government of Ghana 2010).

1.4 Significance of the study

A high rate of maternal mortality persists in Ghana. Nonetheless, less research has been done to improve maternal health. The study will therefore be relevant to policymakers especially

within the health sector to come out with policies that will help address maternal mortality. Moreover, it will benefit the government, non-Governmental Organizations (NGOs) and other stakeholders who are interested in the health sector.

1.5 Delimitation

Maternal mortality is prevalent in the whole of Ghana which requires a careful study, however, the study was limited to only Asante Akim Central Municipality (AACM) due to time and financial constraints. Specifically, within the municipality, I covered Konongo, Dwease and Praso.

1.6 Objective

Based on the target for the UN MDG 5, member states are to improve maternal health, reduce by three-quarters between 1990 and 2015 the maternal mortality ratio and achieve by 2015, the universal access to reproductive health (United Nations 2014). However, the evidence above shows that improvement in maternal health in Ghana is moving at a slower pace and Ghana might not achieve this goal by 2015. In view of this, the objective of the study is to get a better understanding of the reasons that account for the slow improvement of maternal health in AACM in Ghana towards achieving the goal of fifth MDG.

Ghana, a sub-Saharan country in Africa is the main focus of the study. Ghana is located at the west coast of Africa. It shares boundaries with Burkina Faso, Gulf of Guinea, Togo and Cote d'Ivoire at north, south, east and west respectively with a population of about 24.87 million of which 51.2% are females and the rest males. The country is divided into 10 administrative regions: Greater Accra Region, Upper East Region, Brong Ahafo Region, Ashanti Region, Northern Region, Eastern Region, Upper West Region, Western Region, Central Region and Volta Region. The country consists of 6 metropolis and 170 decentralized districts with the aim of bringing governance to the door steps of the people; allow for easy dissemination of information, decision making and participation. Ghana is one of the democratic states in sub-Saharan Africa ruled by a democratically elected executive president, elected legislators and an independent judiciary (United Nations Development Programme 2012). The recent United Nations Development Programme's (UNDP) Human Development Report clearly shows that 350 women die from pregnancy related causes for every 100,000 live birth in Ghana (Malik 2013). This reveals how maternal health is improving at a slower pace in Ghana. The figure below (figure 1.1), is a map of Ghana illustrating the various districts in Ashanti Region including the study area.

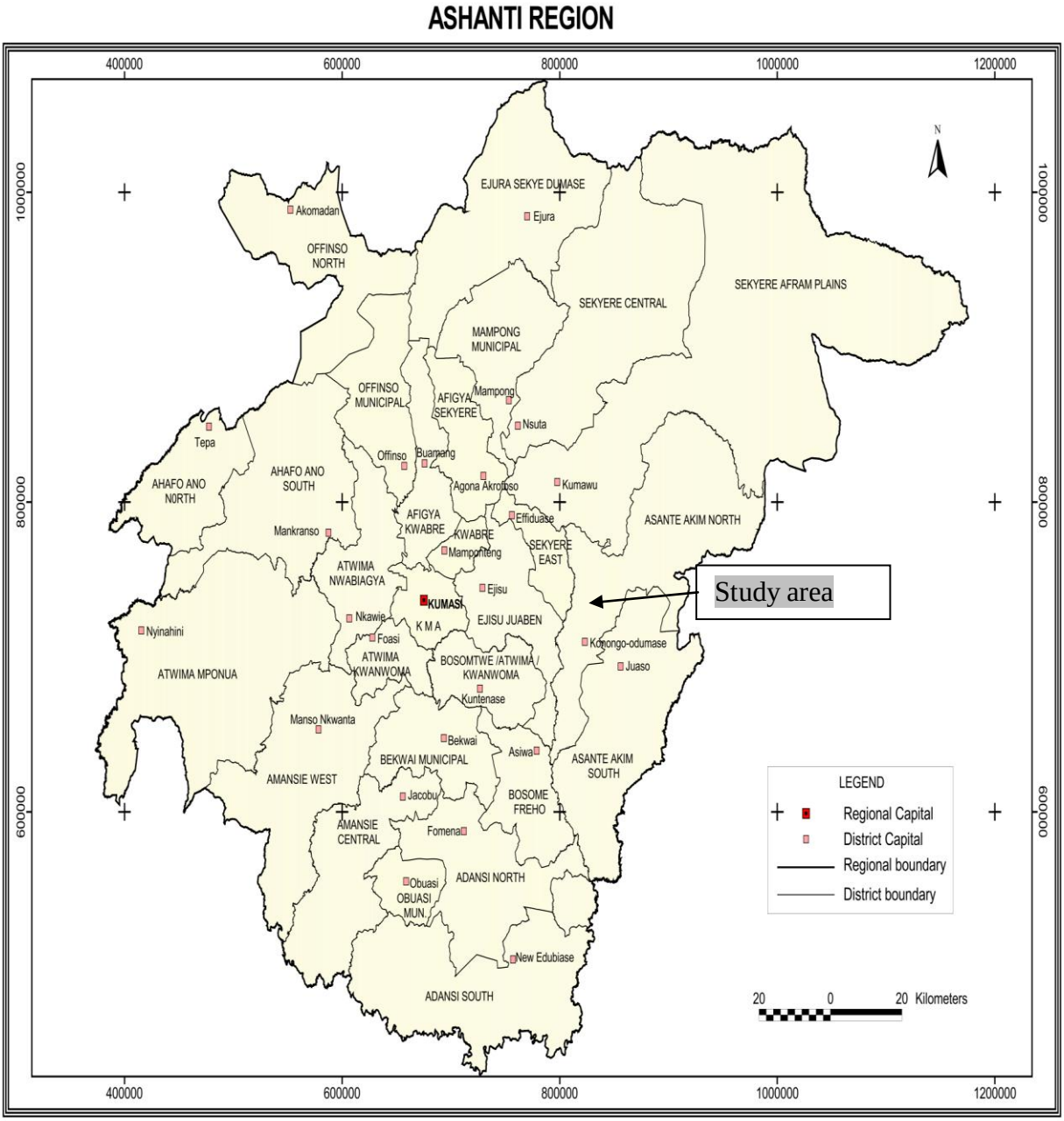

Fig1.1: A map of Ghana showing the districts in Ashanti Region including AACM

Source: Ghana statistical Service (2013b)

1.7 Profile of the study area

In particular the study takes into consideration AACM in Ashanti Region of Ghana which represents the situation at the local level.

1.7.1 Location and size

AACM with Konongo-Odumase as its twin capital town remains one of the 30 districts in Ashanti Region established by the Legislative Instrument (L.I) 2056. It is located within latitude 6 ^{o} 30' north, 7 ^{o}30' North, 0 ^{o} 15' west and ^{o} 20' west. The municipality was created from the then Asante Akim District Council in 1988. In November 2007, it was elevated to a municipal status by L.I 1907. The municipality was formally called Asante Akim North Municipal Assembly (AANMA) until July, 2012 which saw the creation of Asante Akim North District Assembly (AANDA) from the municipality. The name of the municipality therefore changed from AANMA to AACMA.

The land size of AACM is 400 square kilometers (km^2). The municipality is located at the eastern part of Ashanti Region and shares borders with AANDA, Ejisu-Juaben Municipality, Sekyere East and Asante Akim South District Assembly (AASDA). Both the eastern and southern borders of the municipality are shared with AASDA, the northern border is shared with AANDA whereas the west is shared by Ejisu-Juaben and Sekyere East. The major settlements within AACM aside the twin capital include Dwease, Patreansa, Obenimase, Kyekyebiase, Nyaboo and Praso (Asante Akim Central Municipal Assembly 2014; Ghana Statistical Service 2013a). The Municipality is made up of about 140,694 populations according to the 2010 Population and Housing Census (Ghana Statistical Service 2013a).

1.7.2 Population size and distribution

The 2010 population and Housing census in Ghana revealed the population of the municipality. The municipality was made up of 71,508 population in the year 2010 and out of this, 33,942 were males signifying 45.5% and 37,566 females representing 52.5%. The sex ratio for the municipality is 90.4 which implies that there are about 90 males to every 100 females in the municipality. The population increased from 71,508 in 2010 to 73,438 in 2011, 75,421 in 2012 and 77,457 in 2013. As at 2013, the municipality was made up of 36,766 males and 40,691 females (Asante Akim Central Municipal Assembly 2014).

The increase in population from 71,508 in 2010 to 77,457 in 2013 has put significant pressure on available resources including health facilities and equipment. Most residents within the municipality are situated in the urban areas making the municipality predominantly urban.

The urban population is 48,511 representing 67.8% and the rural population remains 22,997 representing 32.2% (Asante Akim Central Municipal Assembly 2014).

1.7.3 Health

The MHD works to ensure the prevention of diseases and deaths that can be averted. It is the responsibility of the directorate to check that residents of AACM get access to quality driven, results oriented, close to client as well as affordable health service by a well-motivated workforce (Asante Akim Central Municipal Assembly 2014). However, the municipality has only one public hospital at Konongo which serves residents within and beyond the municipality. Two other privately owned hospitals are located in Konongo to help provide health services. In addition, there are two health centres in Dwease and Praso which also provide health care services. These health centres provide out-patient, antenatal, in-patient and dispensary services to the inhabitants. AACM has constructed one CHPS compound at Obenimase for dwellers (Asante Akim Central Municipal Assembly 2014).

The municipality continues to fight malaria which negatively affects its health care. Malaria remains the highest diseases recorded in the municipality than any other disease including rheumatism and joint pains, anemia, diarrhea, acute respiratory tract infection, skin diseases and hypertension among others. In the year 2013 alone, the municipality recorded 59,535 cases of malaria which was above any other diseases recorded in the municipality (Asante Akim Central Municipal Assembly 2014). The prevalence of malaria in the municipality has contributed to the high maternal mortality cases.

Though government has implemented several programmes to address the issue of maternal mortality, the municipality still battles with high maternal mortality cases. Some of the causes of maternal mortality in the municipality include severe post-partum haemorrhage, cardiac failure, eclampsia with failure and chemical poisoning from herbal concoction (attempted abortion) (Asante Akim Central Municipal Assembly 2014).

1.8 Research questions

Ghana is far from attaining the goals of the MDG 5 by 2015. The reason is complex. In order to understand why maternal health is not keeping pace with the MDGs, the study seeks to divide the research questions into two main sections to better understand what is preventing Ghana from meeting the goals of MDG 5 by 2015. It does this by targeting a rural community as an example.

1. To understand how women respond to issues of maternal health in AACM.

a) How do women approach maternal health in AACM?
b) What available education is there for pregnant women and how do they respond to the education?
c) What are the outcomes?

2. To explore how government is improving maternal health at AACM in Ghana.

a. How is the government putting structures to improve maternal health?
b. In what way does the AACM create an enabling environment to address the issue of maternal mortality?
c. Are the introduced policies and practices effective?

1.9 Thesis structure

The thesis is organized in six (6) main chapters. The structure and organization of the thesis is examined below.

Chapter one includes the introduction of the study. This section deals with the introduction of the thesis topic and its importance, sufficient background information on maternal mortality which provides an understanding of the issue right from the global to the national level. This is followed by a problem statement, significance of the study and delimitation. The objective and research questions come after the aforementioned within the same chapter.

Chapter two provides the theoretical background and conceptual framework of the thesis and the introduction and definitions of key concepts related to the study. It introduces the three delays model and discussions on power relations, gender and patriarchy which are the theories employed in the study.

Chapter three explains the methodology used in the research to achieve the objective of the study. This includes the study design, methods for data collection, sampling method, validity and ethical issues. Moreover, the sources of data, analysis of data and limitations of the study are all considered in this chapter.

Chapter four deals with the presentation of findings in the form of cases. These are presented from data obtained from key informants in the in-depth interviews, focus group discussions and personal observation.

Chapter five presents the analysis of the data collected according to themes which are geared toward answering the research questions.

Chapter six concludes the study by summarizing the major points and findings from the study. Recommendations are also made in chapter six.

CHAPTER TWO

2.1Theoretical background and conceptual framework

This section introduces theory and key concepts that are relevant to this study. It introduces the definition of key concepts including maternal mortality, maternal mortality ratio (MMR), obstructed labour, gender, power and patriarchy. It also delves into the causes of maternal mortality and specifically explains the direct and indirect causes of maternal mortality. The three delays model by Thaddeus and Maine (1994) is also applied in the study. The theory concerns power relations and gender. The gender and power theory by Connell (1987) and the gender of power by Davis et al. (1991) will form the foundation. Connell maintained that gender is needed for a comprehension of personal life, politics and society. This will be used to explain maternal mortality which can be related to personal life, politics and society. The unequal power relations and gender-based inequities go a long way to affect women's health and further contribute to the high prevalence of maternal mortality (Wingood & DiClemente 2000). The gender and power theory will be applied to explain the government's structures (policies and institutions) and pregnant women's health issues and other social and economic exposures causing the high prevalence of maternal mortality in AACM.

2.2 Definition of key concepts

Maternal mortality: It has been defined in several different ways by different scholars and international organizations, however, a definition by WHO in their International statistical classification of diseases health problems, 10th revision (ICD-10), is used in this study to provide common understanding of this concept. Maternal mortality is "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" (WHO 2014, p. 4).

Maternal mortality occurs in several different ways which are all relevant. From the medical perspective, the deaths of women occur due to complications which manifest during pregnancy and delivery. Most of the causes of maternal mortality are pregnancy related complications; however, others are as a result of existing health conditions which become worse during pregnancy. There are major complications which cause 75% of all maternal deaths in the world. Among these are severe bleeding which occurs mostly after birth, high blood pressure which often occurs during pregnancy and child birth, infections which usually occur after birth, obstructed labour which is also a condition where the baby fails to find its way through the birth canal and dangerous abortion. The rest of the deaths occur from

indirect causes (Sybley 2014; Thaddeus & Maine 1994). Two causes of maternal mortality are recognized from the medical perspective namely the direct and indirect causes:

Direct maternal mortality: This results "from obstetric complications of the pregnant state" which include pregnancy, delivery and postpartum. Other direct causes include interventions, omissions, incorrect treatment and series of events that resulted from any of these causes. For example, death resulting from obstetric haemorrhage or hypertensive disorders in pregnancy is considered a direct cause of maternal mortality. Others include complications of anesthesia or caesarean section (WHO 2014, p. 4), severe bleeding, obstructed labour, infections, high blood pressure and unsafe abortion among others (Sybley 2014).

Indirect maternal mortality: It occurs as a result of "previously existing diseases, or from diseases that developed during pregnancy and that were not due to direct obstetric causes but aggravated by physiological effects of pregnancy" (WHO 2014, p. 4). For instance a death caused by the aggravation effects of existing malaria is considered as indirect death (Sybley 2014)[6]. Others include malnutrition, severe anemia from other causes including hookworm infection, vitamin A deficiency and blood loss from earlier pregnancies, hepatitis and diabetes among others (Nieburg 2012).

Maternal mortality ratio (MMR) is defined as the "number of maternal deaths during a given time period per 100 000 live births during the same time period" (WHO 2014, p. 6).

Obstructed labour is a situation where the baby cannot find its way through the birth canal (Sybley 2014).

Emergency obstetric care (EmOC) is "the care given to pregnant women and their new born by skilled attendants equipped to perform functions like administration of emergency drugs to induce contractions and removal of entire retained placenta manually without caesarean section to avoid death" (Adu 2013, p. 6).

Moreover, several non-medical factors also account for maternal mortality in the globe. Thaddeus and Main (1994) developed a model describing the non-medical causes of maternal mortality which has been very useful especially in resource poor settings. This model is presented in Figure 2.1 below.

[6]Detailed information concerning indirect maternal mortality by Lynn Sibley (2014) can be found at https://class.coursera.org/pregnancychildbirth-001/lecture/9

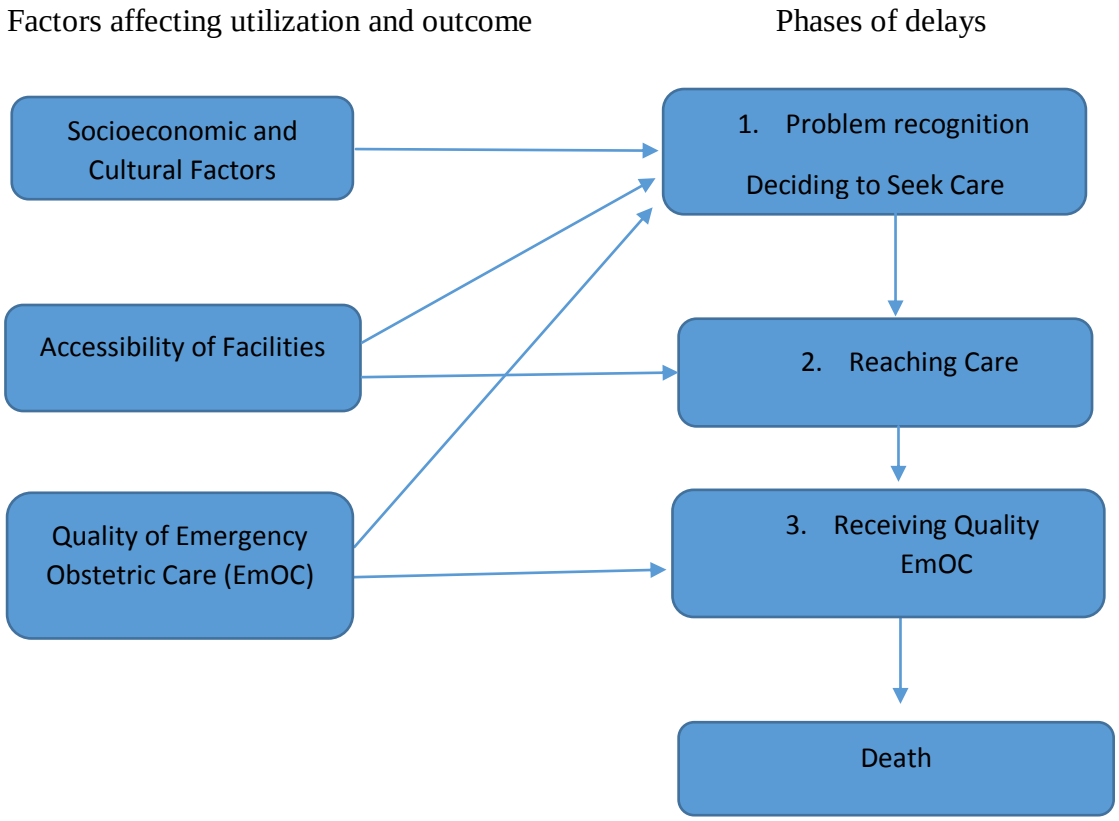

Figure 2.1: The three delays model

Source: Adapted from Thaddeus and Maine (1994)

The three delays according to the model are the delay in deciding to seek care, delay in reaching care in time and delay in receiving adequate care treatment in the health facility (Sybley 2014; Thaddeus & Maine 1994).

Delay in deciding to seek care may occur due to failure on the part of a woman or her family or her birth attendant to recognize or seek care for life threatening complication. Most births usually occur at homes in resource poor setting with unskilled birth attendants who are mostly family members or traditional birth attendants. Medical knowledge and skills are needed to diagnose life threatening complication in order to treat it and a TBA may not possess the needed knowledge and skills or she may consider the problem as not life threatening or may even rely on non-medical causes like evil spirit or fate. The situation becomes complex if the TBA is not able to do much to prevent the bad outcome. Again, some social norms and dynamics which function within the family or community may also prevent the woman from seeking health care and it often becomes too late for the birth attendant or family to realize the need to seek for a higher level of care than what is provided at home (Sybley 2014; Thaddeus & Maine 1994).

Delay in reaching care facility in time may occur as a result of distance, road conditions and lack of money for transportation. Distance is seen as a major barrier in most rural areas which prevents patients from utilizing health care. Long distance hinders patients from reaching health facility and it also demotivates them to even try seeking health care. Lack of transportation and poor roads combined with distance intensify the difficulties in accessing health facility and seeking health care. Many communities do not have access to good roads and many families also lack access to vehicles. The main types of available transportation may be public transport or travelling on animals which implies that it may take hours or days to get to the health care facility. Even though the woman and the family or the birth attendant decided to seek care after detecting a life threatening complication, they may not reach the health facility in time to save the woman's life as compared to patients who can use good vehicles on good roads (Sybley 2014; Thaddeus & Maine 1994).

Delay in receiving quality EmOC may occur when a woman who has visited a health care facility is not given adequate care. This may be that the health care providers do not have the required knowledge, skills and equipment needed to offer the critical emergency obstetric care for the woman suffering from severe bleeding, obstructed labour and infections. Women's death may result from wrong or delayed treatment (Sybley 2014; Thaddeus & Maine 1994).

Other factors that cause delay in receiving care is financial cost which includes physician and facility fees, transportation costs, medication cost and other supplies and opportunity costs (Thaddeus & Maine 1994). The figure above provides a better understanding of the various causes of maternal deaths. This in turn helps and especially better guides the policy, programming and safe motherhood research at the local, national and international levels (Sybley 2014).

Gender unlike sex is the social construction of differences between being a feminine and a masculine (Holmes 2007). According to Davis et al (1991, p. 5), "gender is central for understanding sexual dichotomies, behavioural differences between the sexes, sexual identity, sexual divisions in social activities and the symbolic representation of masculinity and femininity." There are various definitions given to the concept of gender. However, for the sake of the study, gender will be defined as the "primary way of signifying relationships of power" (Scott 1999, p. 1068).

The three levels of gender

There are three levels of gender. The first level views gender in terms of the individual which looks into the behaviour of men and women, their beliefs and attitudes and gender identity. The second level considers gender in terms of social structure which includes gendered divisions in the social activities or labour of men and women whereas the third level looks at gender in terms of symbolic orders including gender symbolism and our perception on masculinity and femininity (Davis et al. 1991). These levels do not consider gender as an issue of difference between individuals, social organizations or human thought respectively but gender is regarded as a power asymmetry. This means that gender is seen as asymmetrical power relations between men and women which is relations of domination and subordination (Davis et al. 1991).

Generally, gender is understood as a central feature of patriarchy. This is a social system that makes men to dominate in relation to women (Holmes 2007). For instance, we talk of a patriarchal structure of gender relations if political, religious and conversational practices all place men in authority over women. A strong patriarchal gender order may deny women access to education and personal freedoms whereas men may be exempted from having an emotional relationship with children (Connell 2009).

Patriarchy has two main forms namely domestic and public patriarchy. These two forms of patriarchal system are manifesting and operating in the Ghanaian society. The domestic patriarchy has been a system where women's lives are controlled and constrained by men within their immediate family and these women solely depend on fathers and then husbands. The public patriarchy on the other hand is seen in the world of work and politics where collective decisions affecting women's lives are usually made by men in the work place and in government (Walby 1997).

According to Davis et al (1991), power is also inclined to take asymmetrical relations. These relations are produced, reproduced and transformed as its objects. As a result, exercising power appears to be inherently asymmetrical. Weber (1978, p. 926), states that power is "the chance of a man or of a number of men to realize their own will in a communal action even against the resistance of others." This implies that power is activated based on a person's will even in opposition to someone else's (Sadan 2004).

According to Davis (1988b), power is exercised if B can do something based on A's influence which under other circumstance, B would not do when left on his own devices

(Davis et al. 1991). This, referred to as the overt dimension of power is investigated through observing the behaviour: "who participates, who profits, who loses, and who expresses himself in the decision-making process" (Sadan 2004, p. 40). This implies that power is linked to the purposive action of individuals (Davis et al. 1991).

However, Sadan (2004), came out with the two faces of power which delved into finding the connection between the overt face of power and the covert face of power. The overt face of power concerns the manner in which decisions are made whereas the covert face of power is concerned with the power to prevent decision-making. In covert face of power, it is emphasised that power is activated by prevailing over other participants in decision-making process, preventing and excluding certain participants from the process (Sadan 2004).

On the contrary power is viewed as a "structural feature of society. This power is the medium by which collective interests may be realized, including class interests" (Davis et al. 1991, p. 8). People therefore act under circumstances which are not of their own choosing and which they only partly oversee (Davis 1988b).

2.3 Power theories and gender

According to Meyer (1991), a theory of power for the less-powerful groups must include mechanisms for change. There have been various meanings attached to change by different groups of less-powerlessness. The young white, male radical can use his minority status to criticise existing doctrine and structure to become prominent. It has been explained that by contributing and yearning for innovation, he can find himself as part of the leaders of the new generation and become part of the establishment when the time comes. In line with this, to strive for individual or group power is not enough for the categories of people including women and ethnic minorities within society who are referred to as powerless because of their immediate recognizable physical attributes. The powerless cannot become integrated and they will eventually become invisible in the powerful group. Besides that, their actions will still be interpreted and valued differently from actions of the same kind by members of the powerful group. They will continue to experience the impact of inequality unless they succeed in changing the power relations itself (Davis et al. 1991).

Meyer (1991), on one hand postulated that concepts should be included in a theory of power and should be relevant for women in order to define the relative power position of women and the features used to define the values tied to women as a social category. On the other hand, she asserted that such theory must be process oriented. In imbalance power relations,

the view point of the less powerful are usually overlooked by the more-powerful party. This is true both at the macro social level and on interpersonal basis especially in male-female relationships. Besides, the more powerful party finds it attractive and easily assume that their preferences will always be accepted by the less powerful. This has therefore led to the justification of certain actions that damage women's interests (Meyer 1991).

Moreover, the less powerful group's rights to their own wishes, preferences and goals have been denied and refused due to the projection of the preferences of the more powerful party (Davis et al. 1991). For instance in AACM, poor pregnant women with no or low educational level who reside in the remote areas are mostly allowed to deliver at home under the care of TBAs. Moreover, husbands who are the heads of the household in their own will fail to take their wives and newborns to the hospital for treatment unless they detect some physical abnormalities on them.

2.4 Problems in theorizing power

It is asserted that power as a social concept has attracted various definitions. There seems to be little agreement regarding how power should be defined despite the massive theorizing concerning the concept (Davis 1991). Davis et al (1991, p. 68) in their reference to Lukes (1979), a leading theorist definition of power states that "when it comes to power, one is left with the unavoidable impression that anything goes." Besides that, several attempts are made towards resolving the dilemmas that have emerged from theorizing power and three basic bones of contention have emerged about the discussions of power (Davis et al. 1991).

2.4.1 Agency versus structural determinism

There are instances where power is linked to human agency or structural determinism. This is related to the extent to which a person is entitled to some freedom of choice even in asymmetrical power relations or whether the socially structured system can determine the individual's activity (Davis et al. 1991).

2.4.2 The nature of power

Even though many people seem to accept that power involves A exercising some control over B's activities, there have been debates on the exact nature of power. There have been instances where power involves an overt or observable manifestation or covert and even latent. Again, there are also instances where power may not necessarily have to be against B's interest or any interest. This means that power can be a straight forward exercise of control and more likely to be elusive, ambiguous, complex and subtle (Davis et al. 1991).

2.4.3 Consensus versus coercion

Furthermore, power as consensus or coercion has been the basis on which the theories of power focus. To some extent, power is viewed as an essential and desirable component of highly organized societies and is also regarded primarily in terms of domination and authority. It is relevant to know the kind of approach that is necessary for understanding contemporary society. Moreover, if problems may arise as a result of discussing power, then there is a need to find theories in order to resolve the situation (Davis et al. 1991).

2.5 Giddens' conception of power

Giddens (1984), also came out with his conception of power. Power is seen as one of the several basic concepts which is necessary for the analysis of social life. It is also seen as a kind of "mysterious phenomenon that hovers everywhere and underlies everything" (Davis et al. 1991; Giddens 1984, p. 226). Power has been conceptualized in a manner that is dynamic, processual and highly complex. Giddens' conception of power follows five dimensions which include power is integral to social interaction, power is intrinsic to human agency, power is relational involving relations of dependence and autonomy, power is enabling as well as constraining and power is processual (Davis et al. 1991; Giddens 1976; Giddens 1984).

2.5.1 Power as integral to social interaction

Giddens (1976), affirmed that every aspect of social life involves power. This is expressed right from the global cultures and ideologies to everyday interactions. The analysis of power goes beyond social institution and political collectivities. The social interaction consists mainly of three components namely its constitution as meaningful, its constitution as moral or normative order and its constitution as the operation of elements of relations of power (Davis et al. 1991).

These distinct but interconnected elements of power make it possible to deal with one taking into consideration the others (Davis 1991; Giddens 1979). Moreover, power affects the mobilization of members' skills and resources in the production of interaction which influences its course. It also ensures compliance to moral claims and members exercise it by enacting or resisting sanctions. The production of meaning, constitution and maintenance of order reveal how power works. This takes into consideration the definition of the situation as well as the respective social position of the participants (Davis 1991).

2.5.2 Power is intrinsic to human agency

It has been emphasised by Giddens (1976) that every study of power takes agency into consideration. Power is generalized as agency. The desired outcomes in the daily social practices of social actors mediated by what Giddens termed the "can" and "could have done otherwise" is also entailed in every circumstance including even the most restrictive and oppressive situation (Davis 1991; Giddens 1976). There is a possibility of rejecting the assertion that social actors are ever completely governed by social forces when power is linked to agency. There can be no justified conclusion that social actors are driven by mechanical pressures beyond their control even when they comply with the oppressive contingencies of their situations (Giddens 1984). Compliance does not necessarily imply agreement but rather the "result of a decidedly rational assessment of the situation and the viable alternatives" (Davis 1991, p. 72).

Giddens (1976) rejected the assertion that individuals can ever be completely powerless, however, he refrained from arguing extremely that society is made under circumstances of their own choosing and unacknowledged conditions and unintended consequences always limit the social actions (Giddens 1984). The power analysis involves uncovering the elusive flux of what actors do and do not, what they achieve and fail to achieve as well as what they might have done but did not do (Davis 1991).

2.5.3 Power is relational, involving relations of dependence and autonomy

Giddens (1984), identified power in the relationship between actors. In this view, actors mobilize resources towards achieving their respective goals or influencing the course of events towards a specific direction. Members are unable to effect the outcome of the interaction because they do not have equal access to resources. This is due to asymmetrical distribution of resources according to the structure of domination.

However, he postulated that power relations is always reciprocal. It involves some measure of autonomy and dependence in both directions. This means that power is not just a matter of "haves" or "have nots" since such a conception can only lead to the overestimation of power of the powerful. It also involves how even the less powerful manage resources in order to exercise control over the more powerful in established power relationships.

2.5.4 Power is enabling as well as constraining

Power goes hand-in-hand with structured forms of domination in many of the context of everyday life. Actors in this case attempt to exert control over each other aside intervening in

the course of events and this is done through sanctions which are structurally available. Some actors can use the sanctioning process to restrict the activities of other actors or cause them to do certain things which they might not have done under other circumstances. This sanction does not involve the use of force, threat or violence but uses disapproval, criticism and absence of response to achieve intended goals (Davis 1991).

Sanction but not restriction is also enabling which cause actors to participate in specific activities. Social interactions are considered as orderly and normal through the means of sanctions. This means that regardless of the inherent social association, power cannot be equated with forms of domination and neither is it an inherently noxious phenomenon. A person always holds the ability to say no. This means that the very constitution of social life involves power which makes it productive, enabling and even positive (Davis 1991).

2.5.5 Power is processual

This dimension of Giddens' power perceives power as a process which becomes part and parcel of the perpetual flux of situated practices of social actors. These practices produce and reproduce the structural relations of power which involves domination and subordination. This conception of power, however focuses on how actors always construct, maintain, change and transform their relations of power rather than on the outcome of power (Davis 1991).

2.6 Theorizing power and gender

According to Davis (1991), a conception of power is needed to link agency to structured relations involving domination and subordination. Women need to be reinstated to the position of agency without being blamed for social inequities. Davis (1991), further asserted that in order to uncover the subtle and multifaceted complexities of how power works in everyday encounters between the sexes, they had to come to terms with the janus face of power. They emphasised that Giddens's theory of structuration which deals with such issues is relevant in helping to come to terms with power in interaction between the sexes. Though Giddens' theory of structuration is useful, he has been criticised for failing to address the subject of gender, gender relations or power relations between the sexes (Davis et al. 1991).

Moreover, Giddens' theory of structuration and conception of power failed to create a connection with concrete context or the situated practices of social actors. He used general and extremely abstract theory to serve as heuristic framework for investigation. This implies that, power which is very contextual serves as a relationship between particular actors or groups. It also draws on specific rules and resources and is organized in specifically

structured ways. Power is analysed in relation to sex, class, religion and historical period among others (Davis et al. 1991).

Though Giddens has been criticised for his theory of structuration and his conception of power, they are very useful for both empirical and theoretical grounding. It is therefore possible to reveal how power works without losing women as subjects when using both structural and individual approaches to power. It becomes possible to reveal women's contribution towards undermining and transforming relations requiring domination and subordination without being blamed for structured inequities as well as their contribution in production and sustenance (Davis et al. 1991).

Power can be seen as very complex and subtle enough to explain most routine interaction between the sexes where the order of the day ceases to be straight forward forms of repression (Davis et al. 1991). They concluded that the attempt made shows that it is possible for a theory of power to be used to apply the analysis of gender relations in a specific context (Davis et al. 1991).

2.7 Theory of gender and power

Connell (1987), came out with a theory of gender and power: a social structural theory which explains sexual inequity, gender and power imbalance. It has been emphasised that sexual division of power, sexual division of labour and structure of cathexis are the three main distinct but overlapping social structures. These are working together and characterizing the gendered relationships between men and women which have influence on women's health (Wingood & DiClemente 2000). Societal and institutional levels have been the two different levels on which the three structures exist. However, it has been noted that the societal level has been the highest level on which the three major structures exist. There have been various abstract, historical and socio-political forces that have caused the three structures to gain roots in the society therefore consistently segregating power and assigning social norms on the basis of gender determined roles.

2.8 Theory of gender and power structure

The theory of gender and power emphasises three different structures. These structures including the sexual division of power, the sexual division of labour and the structure of the cathexis are elaborated below (Connell 1987).

2.8.1 Sexual division of labour

The sexual division of labour is a social structure which involves the distribution of specific types of work to some group of people. The allocation of this group of people becomes restraint on further practice which makes sexual division of labour a social structure. The prior division of work among people based on their gender in the first place becomes a social rule that allocates people to work. This happens when for instance an employee entering a specific company is given job X if a woman and job Y if a man (Connell 1987).

Moreover, he opined that one of the mechanisms through which the sexual division of labour is made a powerful system of social constraint is skilling and training and it becomes powerful when a conscious effort is made to change it. Though the antidiscrimination and affirmative action programme have made slow progress, they are still relevant for change. There have been evidence even though not much recognized but equally important to change the sexual division of labour in unpaid work such as housework and childcare (Connell 1987).

Under the sexual division of labour structure, Connell (1987) further mentioned that women are assigned to unequal, lower paying positions at the societal level. Moreover, at the institutional level, they are frequently assigned to do what is usually termed as women's work where they are largely responsible for raising children, performing household chores, caring for the sick and elderly which are often uncompensated for and are assigned less values because they are not income generating.

This economic divide that favours men over women has a heavy implication on women's health and well-being as a result of the uncompensated nature of the so called women's work. In addition, sexual division of labour causes women especially those who are economically disadvantaged, have lower level of education, living in poverty and have no health insurance to be at a higher risk for experiencing poorer health outcomes than women who do not experience such risk factors (Wingood & DiClemente 2000).

Women in AACM who happen to fall within the selected sample for the study are largely affected by the gender division of labour. These women are mostly involved in domestic activities including reproduction, raising children and household chores which are largely uncompensated for, less valued with no income generation. While most are largely illiterates, some are having less than high school education. These women solely depend on their husbands for money in order to access medical care.

2.8.2 Sexual division of power

The inequality of power between men and women forms the basis of the sexual division of power at the societal level. This same structure at the institutional level is maintained by the abuse of power, authority and control (Wingood & DiClemente 2000). In view of this, the general connection of authority with masculinity is the main axis of the power structure of gender. The balance of advantage or an inequality of resources which may be power are usually in a workplace, a household or a larger institution. Generally, it has become very difficult for women to gain access to top positions because men who mostly control the corporations, universities and government departments arrange things to make it so. The assertion of a hegemony which includes the availability of imposing a definition of the situation, setting the terms in which events are understood and issues discussed as well as the formulation of ideas and the definition of morality is an essential part of social power (Connell 1987).

2.8.3 Structure of cathexis

The structure of cathexis has been framed by Connell (1987) to refer to the structure that organizes a person's emotional attachment to another. Under this structure, Connell makes it clear that it is important to see sexuality as social in order to recognize social structure in sexuality. This implies that sexuality is socially constructed. Sexuality as asserted by Connell is a social structure because its bodily dimensions are already embedded in social practices within which relationships between people are created and carried on.

The theoretical discussions above portray how broad power relations and gender are, however, not every element of this theory and concepts will be used in the study but those that will be used for the study include the three delays model, power, gender, patriarchy, sexual division of labour, power as enabling as well as constraining and power as relational, involving relations of dependence and autonomy.

CHAPTER THREE

3.1 Research methodology

The nature of exploring how and why maternal health as MDG 5 in Ghana is affected by policies and is not keeping pace with the MDGs requires the use of qualitative research for the study. Qualitative research is the main research strategy used in the study. It usually involves the use of words in data collection and analysis (Bryman 2012). By employing a qualitative research in the study, a wide range of information including the subjects' views, experiences and attitudes were gathered (Denzin & Lincoln 1994).

When a researcher is interested in finding answers to the question "why" or "how", when the behavior of the subjects in the study cannot be manipulated and finally, when the researcher wants to cover contextual conditions because it is relevant to the phenomenon under study, a case study becomes very relevant (Yin 2003). This section introduces the study design, reliability, data collection instruments, preparation for the field work, the sampling method, focus group discussions, key informants, sources of data, ethical consideration and data analysis and limitations in the study.

3.2 Research design

A research design provides the framework for data collection and analysis. It has been emphasized that "having a clear plan for conducting your research provides a means for an effective systematic inquiry" (Berg & Lune 2012, p. 261). Moreover, the research design is relevant in every thesis because it helps in expressing the causal connections between variables and understanding behavior and the meaning of that behavior in its specific social context. However, it is useful for generalizing to larger groups of the individuals than those forming part of the investigation and for having a temporal appreciation of social phenomena and their interconnections. It is asserted that "choice of research design reflects decisions about priority given to a range of dimensions of the research process" (Bryman 2012, p. 46).

In this study, I seek for the reasons that account for the slow improvement of maternal health. The research conducted was a case study because it involved a detailed and intensive analysis of maternal mortality in AACM in Ashanti Region, Ghana. In addition, a case study is usually conducted intensively in a location such as community or organization and also done in a specific point in time.

Employing a qualitative research strategy allows a researcher to interact directly with respondents in order to research the problem understudy. Moreover, it also enables

respondents to tell their stories and to understand the context under which the stories are told (Creswell 2007). This in qualitative research will help respondents to voice their stories based on their experience and for the researcher as well to position himself in the worldview of informants in order to make meaning from their subjective experiences (Lambert et al. 2010). In line with that, to obtain in-depth information, questions were framed with why and how with follow up questions in the interview guide.

3.3 Validity

Considering validity in any research produces quality results. It is asserted that validity remains the most important criterion for research which is "concerned with the integrity of the conclusions that are generated from a piece of research" (Bryman 2012, p. 47). A research can be affected by different extraneous factors which can harm the validity of the outcome. It is therefore the responsibility of every researcher to control all factors that can threaten the validity of any research[7]. In relation to the study, one of the factors that could have affected the validity of the study is my personal bias. Having an idea about maternal mortality based on my experience as a field officer with an NGO in AACM, I went to the field with my own personal preconceptions which I had to deal with in order to present valid results and conclusions. I tried as much as possible to remain objective as possible by collecting data from different sources (triangulation) in order to reach a meaningful conclusion. I conducted interviews with pregnant women, health personnel, municipal health directorate, municipal development planning committee and representatives of NGOs working on maternal health in the municipality which helped me to compare the responses where necessary.

3.4 Data collection instruments

According to Bryman (2012, p. 68), a case study becomes helpful in qualitative research whenever a researcher makes use of participant observation and unstructured interview as means of data collection which helps the researcher to conduct "detailed examination of a case." In relation to this, the study employed qualitative techniques including interviews, observation and secondary data as means of data collection. Interviews are useful for the study because they allow researchers to generate in-depth information about respondents' experience and viewpoints of a specific topic. Such information obtained from interview transcripts and field notes among others are empirical materials collected from first-hand

[7] Detailed information on validity can be found at http://linguistics.byu.edu/faculty/henrichsenl/ResearchMethods/RM_2_18.html

experience (Moen 2006). Moreover, interviews coupled with other means of data collection help the researcher to obtain a wide range of information for analyses (Turner III 2010).

Even though different types of interviews are used in qualitative research to obtain data as asserted by May (2011) which includes unstructured interview, semi-structured interview, structured interview and focus group discussion, a semi-structured and focus group discussions were deemed appropriate for the study. The semi-structured interview allows both the researcher and the interviewee to engage in a detailed dialogue due to its open ended nature. With a semi-structured interview, "the researcher asks the interviewee questions in a systematic and consistent order but the interviewee is allowed freedom to digress" (Berg & Lune 2012, p. 112).

In addition, I aimed to avoid rigidity and promote flexibility by giving respondents the opportunity to further exhibit their point of views. According to Bryman (2008, p. 456), "flexibility is important in such areas varying the order of questions, following up leads, and clearing up inconsistencies in answers." Moreover, an interview guide was used during the interview in order to ensure that respondents remain within the objective of the study. The individual interviews as well as the focus group discussions that were conducted allowed pregnant women and other key informants to share their experiences on maternal health both currently and over time encouraging them to share their experiences and ideas about the changes over time.

3.5 Preparation for the field work and during field work

I have a personal experience on maternal health. I worked as a field officer with an NGO that aimed at promoting and improving maternal health in AACM. We often visited the rural areas and educated the women on their reproductive health and the need to seek early health care. Throughout my stay in the municipality, I saw that most pregnant women fail to attend ANC after detecting they are pregnant and therefore resort to the use of traditional medicines. Others also attend late ANC after several months of pregnancy. Those women in the rural areas mostly deliver at home with the help of TBAs and sometimes their husbands. After delivery, their husbands fail to take them and their newborns to the hospital for treatment except when the women feel some pains or discover some physical abnormalities. Besides that, some cultural beliefs and practices restrict women from delivering at health facilities because some families rely on TBAs, herbs and even spiritual ways of assisting pregnant women to deliver and most women who deliver at homes feel reluctant to visit the health

centres afterwards because they may receive verbal abuse for not attending ANC earlier or immediately after delivery.

These experiences intrigued me to conduct a study on maternal health in Ghana, specifically within AACM. I came up with a general research topic, maternal mortality in Ghana: prospects of meeting the Millennium Development Goals and I developed various research questions based on the research topic. My motivation for the research topic was basically because I am coming from Ghana, a sub-Saharan country where maternal mortality is prevalent especially in the rural areas. I therefore found it relevant to research on why Ghana is moving at a slower pace towards achieving the MDG 5. I took a letter from the department's coordinator introducing me to my country, Ghana. Upon my arrival in Ghana, I contacted the Municipal Chief Executive (MCE) of AACM who served as a 'gatekeeper' to contact potential informants (Seidman 2012). He therefore directed me to the Municipal Development Planning Coordinator (MDPC) and the planning coordinator also gave me the authority to conduct the research within the municipality.

I visited the sampled areas within the municipality where the research was to be conducted. This included Konongo, Praso, Dwease, Adumkrom, Kramokrom and Boatengkrom. At these places, I met the MHD, midwife and the Physician Assistant (PA) who also requested for my letter upon arrival. I was therefore granted the permission to conduct the research after introducing myself, showing the letter and explaining briefly the reasons for the study.

3.6 Sampling methods and interview setting

Sampling is basically taking a small part of a larger population to represent the whole. Since the study was a qualitative research, a non-probability sampling was suitable for the study. Even though there are several types of non-probability sampling in qualitative research which include convenience sample, quota sample, purposive sample and snowball sample (Berg & Lune 2012), purposive sample was deemed fit for the study. This is because I targeted subjects who have knowledge, experiences and information about the study. Participants were therefore selected purposively based on their knowledge and information about the research questions being asked (Bryman 2012). In view of this, the key informants and the pregnant women were selected for the study based on their knowledge and experiences related to maternal health.

A sample of fifty-six (56) participants were selected for the study in AACM using a purposive sampling approach. Out of the fifty-six (56) participants were ten (10) key

informants and eighteen (18) pregnant women who participated in the in-depth interviews and in addition to other twenty-eight (28) pregnant women who were involved in the focus group discussions. I chose the categories of the people based on my personal experience as a field officer during my work with the NGO in the municipality. I had already established credibility in the area with the staff and some of the local people.

Before interviewing the ten (10) key informants, I called the MDPC and the MHD concerning the interviews for the study. They responded positively to participate in the research. They then invited me to their offices to book appointment for the interviews. The MHD gave me a form to fill in the office which involves the reason for the study as well as reasons for deriving information and report from them. I was given a second assurance for the interview. It is asserted that the nature of an interview setting affects the outcome of a research. It is therefore necessary to have a better setting for an interview in order to have a valid outcome. They agreed to be interviewed in their offices. All the ten (10) named key informants were successfully interviewed so I turned to focus on interviewing pregnant women.

In relation to the interview of six pregnant women at each health centre, I informed the Physician Assistant and the midwives in charge about the interviews for the pregnant women. They agreed and gave me the permission to go ahead with the interview. At Konongo-Odumase health centre, I was asked to go into a separate room within the maternity ward so after they visited the health personnel, the pregnant women were directed to come to me for the interview. At Praso health centre, they arranged some chairs and a table in the corridor within the facility which was very conducive for the interview and at Dwease health centre, they prepared the veranda which was also very convenient for the interview. Recordings were made throughout the in-depth interview sessions and important points were written down.

Moreover, I understand the language used locally so there was no need for an interpreter. The medium of communication for the group discussions was Asante Twi. Asante Twi is one of the dominant languages in Ghana which almost all the people from other tribes can use as a medium of expression. Based on this, all participants expressed themselves best in that language without any barrier. Recordings were also made throughout the discussions for later transcription and points relevant to the study were also written down. Each focus group discussion lasted for an hour.

3.7 Focus group discussion

As stated earlier, focus group discussion was one of the main research methods for collecting primary data for the study. Focus group discussion was deemed appropriate for the study because it paves way for the different views and experiences on issues about maternal health. This, Cloke et al (2004, p. 160) confirm that "as an interview technique, group discussions allow researchers to draw out interaction between participants and make direct comparisons between the experiences and opinions narrated in the group."

Focus group discussion was used because I wanted to generate further discussions in order to get in-depth understanding of participants' experiences on issues of maternal health. Moreover, I wanted to get different perspectives about the issue which brings diversity in terms of discussions.

I therefore organized three focus group discussions for pregnant women at Konongo-Odumase Hospital, Praso health centre and Dwease health centre. I targeted eight to twelve participants for each focus group interview (May 2011). However, at Konongo-Odumase, participants were made up of nine members, eleven members formed the focus group at Praso health centre and eight participants formed the group at Dwease health centre.

The focus group discussion was scheduled on the same day for ANC with the aim of getting a large number of pregnant women who will show up for the ANC. Through the help of the Physician Assistant at Praso health centre, the midwife at the Dwease health centre as well as the midwife at the Konongo-Odumase hospital who served as gate keepers, I recruited participants for the focus group discussions in the aforementioned places. Pregnant women who attended the ANC clinic were asked to wait after being attended to by the health personnel.

Before, the commencement of the group discussions, I briefed participants about the study, the reasons for choosing them for the study and the harmful aspects of the interview. However, participants still expressed their interest to participate in the study. The focus group discussion unlike the key informant interviews were organized for only pregnant women. This was because I wanted pregnant women to share their views and experiences on maternal issues covering their health, livelihood and education on their reproductive health among others. Besides, I realized that women can express themselves better when they are separated from men. Majority of the pregnant women for the focus group discussions both at Praso and Dwease health centre were in their ninth month of pregnancy. Moreover, most of the pregnant women for both the focus group discussion and the one on one interview resided in

the rural areas of the municipality. Some of them had basic education whereas others had no education.

In order to familiarize myself with participants, I began the interview with throwaway questions. "Throwaway questions may be essential demographic questions or general questions used to develop rapport between interviewers and subjects" (Berg & Lune 2012, p. 121). However, these questions became relevant and formed the basis for presentation of the data. This was done by asking demographic question like hometown, occupation, months of pregnancy, educational level, age and marital status among others. Essential questions were then asked after rapport was established and these questions were directly related to the topic of study. Questions were therefore opened for participants to engage in discussions with each other, however, I directed the discussions in order to ensure the group did not deviate from the objective of the study. In view of this, participants freely expressed themselves concerning the questions that were raised which opened way and gave chance for different views from different perspectives.

3.8 Key Informants

Another method for data collection for the study involved interviewing key informants. In-depth interviews were conducted for pregnant women who were the main target for the study. Six pregnant women were selected and interviewed at each of the three main health centres including Konongo-Odumase Hospital, Praso health centre and Dwease health centre. Aside the pregnant women, in-depth interviews were also conducted for ten other key informants who also possessed valuable information that were relevant for the study. These key informants included the MDPC, MHD, a worker of ABAK Foundation (an NGO operating on maternal health within the municipality), PA, midwife, a representative from MAMAYE, Ghana and four additional health personnel. In order to avoid gender disparity, I interviewed five males and five females.

3.9 Sources of data

The sources of data relevant for meeting the objectives of the study included primary data, secondary data and personal observation. The primary data were obtained from conducting key informant interviews and focus group discussions. A sample of twenty-eight (28) participants were engaged in the key informant interviews. Out of the twenty-eight (28) key informants were eighteen (18) pregnant women and ten (10) key informants from various backgrounds. Moreover, twenty-eight (28) pregnant women participated in the focus group discussions which also generated additional primary data for the study.

3.9.1 Secondary data

I started the secondary data collection by reviewing reports and taking documents from various departments. I collected a report from the Ghana Statistical Department on Ghana's population and housing census and on the MDGs. From the municipality, I collected the Asante Akim Central Municipal profile which included health, population size and distribution as well as report from the MHD. I also consulted books, Ghana's UNDP, WHO, NGOs reports and publications and policy documents. Moreover, I looked at the various researches conducted relating to my study.

3.10 Observation

When I was in the field, I realized that some information could be obtained based on observation. As a result, observations were done in different sections. I visited women in their various homes at Adumkrom, Kramokrom and Boatengkrom. Because I already have some personal experiences about maternal health in the municipality, I aimed at using personal observation to generate more in-depth information on my personal experiences with respect to traditional practices and use of traditional medicines among others. All these observations made, confirm the information I obtained from the focus group discussions and the key informants interviews.

3.11 Ethical issues

Ethical issues are very necessary to consider when conducting a research. Diener and Crandall (1978) present four ethical principles that researchers should consider when conducting research which include harm to participants, invasion of privacy, lack of informed consent and deception. Moreover, Bryman (2012) asserted that most people perceive research that is likely to harm participants as unacceptable. Harm in this case concerns physical harm, harm to participants' development which includes loss of self- esteem and stress among others. Two ethical principles were pertinent to the study namely informed consent and confidentiality. In order to ensure informed consent, participants were given a detailed explanation of what the research is about, the reasons for conducting the research and the reasons for their participation. I therefore asked permission from participants before recording the interviews and participants were made aware of the confidentiality of the records taken. Besides, I also avoided the use of names in all interviews to ensure confidentiality and participants to remain anonymous.

3.12 Data analysis

The data collected in the field from both key informant interviews and the focus group discussions were obtained through audio recordings. Transcriptions were made immediately after the data collection especially for the ten (10) other key informants from diverse background where the language used during the interview was English. However, I translated before transcribing the data obtained from both individual interviews and focus group discussions involving pregnant women since the language used was Asante Twi. The data collected were analyzed to meet the objectives of the study through the support of information from literature. Data obtained from field are grouped and discussed under various themes in association with structures, accessibility and health education.

3.13 Limitation of the study

The study encountered some limitations which include the study approach and time constraints. The study employed qualitative approach which gave information that cannot be obtained from quantitative approach. However, the quantitative approach with its probability sampling technique could have led to a meaningful generalisation. Although maternal mortality is prevalent in the whole of Ghana, but time was not available to conduct the study to cover all districts in Ghana. Hence the study was limited to only AACM. An in depth study was conducted in the municipality and even within the municipality, it covered Konongo, Dwease and Praso. The in depth study conducted in the few communities within the municipality does not allow for generalization.

CHAPTER FOUR

4.1 Presentation of findings (cases)

This section presents the findings in the form of cases. The presentation of cases in this qualitative study will help in exploring the reasons that account for the slow improvement of maternal health in AACM. The cases are presented from data obtained from key informants in the in-depth interviews, from discussions with pregnant women, results from focus group discussions as well as personal observation.

4.2 Informants' demography

This section explains the demographic features of the key informants for both the in-depth interviews and the focus group discussions. The demographic features of all the women engaged in the study including both key informants and focus group discussions are presented in (Tables 4.1, 4.2, and 4.3). There are three health centres in AACM: Konongo-Odumase, Dwease and Praso health centres. Each of these centres provides services for a number of villages. The Konongo centre includes: Konongo, Odumase, Ohenenkwanta, Kyekyebiase, Anuruso, Agyareago and Bomiriso. The Dwease centre includes Boatengkrom, Shell, Nyamebekyere, Adumkrom and Kramokrom and Praso centre includes Anawuokrom, Nsiakrom, Tutukrom, Nyamebekyere as well as Praso town.

The study focused on a total of forty-six (46) pregnant women. Out of the forty-six (46), eighteen (18) participated in the in-depth interviews and the remaining twenty-eight (28) in the focus group discussions. Six (6) of the eighteen (18) women were chosen from each of the three health centres in the area. The focus group discussions engaged twenty-eight (28) women with varying numbers at each health centre. At Konongo- Odumase, nine (9) women formed the focus group, eleven (11) formed the focus group at Praso and the remaining eight (8) formed the focus group at Dwease. None of the eighteen (18) women who participated in the key informant interviews partook in the focus group discussions.

The age of the women involved in the study ranged between twenty-one (21) and forty-five (45) years old. Among the forty-six (46) women, forty (40) women were below the age of forty (40). The remaining six (6) women were above forty (40) years. Thirty-nine (39) women were married whereas the remaining seven (7) were unmarried. Of the forty-six (46) pregnant women, thirty-three (33) had no education, ten (10) had basic education and the remaining three (3) had high education. The income status of the pregnant women was assessed on three factors: educational status, occupation as well as the occupation of their

husbands. The income status of four (4) women was high but the remaining forty-two (42) had low income. The months of pregnancy ranged between three (3) and nine (9) months. Of the forty-six (46), fifteen (15) were three months pregnant, twelve (12) were between four and seven months pregnant and nineteen (19) were nine months pregnant. In relation to previous experience, there were ten (10) women among the forty-six (46) who were pregnant for the first time and the remaining thirty-six (36) had one or more previous experience. Thirty-six (36) of the women were full-time housewives, five (5) were engaged in petty trading and three (3) had occupations: as a teacher, a civil servant and a bank teller respectively.

Most of the women engaged in the interviews resided at the outskirts of where the facilities are located. Out of the fifteen (15) women interviewed at Konongo- Odumase Hospital, three (3) resided at Konongo, two (2) at Odumase, three (3) at Ohenenkwanta, four (4) at Kyekyebiase, one (1) at Anuruso, one (1) at Agyareago and one (1) at Bomiriso. There are five (5) suburbs that fall under Dwease health centre namely Boatengkrom, Shell, Nyamebekyere, Adumkrom and Kramokrom. Out of the fourteen (14) women, one (1) resided at Boatengkrom, four (4) from Shell, four (4) from Nyamebekyere, three (3) from Adumkrom and two (2) from Kramokrom. The Praso health centre also had five (5) communities namely Anawuokrom, Nsiakrom, Tutukrom, Nyamebekyere and the Praso town. Out of the seventeen (17) women, eight (8) resided at Praso, one (1) from Anawuokrom, three (3) from Nyamebekyere, two (2) from Nsiakrom and three (3) from Tutukrom.

Most of the women at the Konongo- Odumase Hospital started attending ANC in their third month of pregnancy whereas only few started in their second month. Women at Dwease and Praso on the average started attending ANC in their fifth month even though there have been instances where women attended ANC in their seventh month. The tables below (Tables 4.1, 4.2 and 4.3) show the demographic features of pregnant women at the Konongo- Odumase, Dwease and Praso health centres respectively.

Table 4.1: Demographic features of pregnant women at the Konongo- Odumase centre

Village	Respondent	Age	Marital status	Occupation	Previous experience	Education	Financial status	Month of attending ANC
Konongo	1	44	married	Bank teller	1	High education	High income	2
	2	38	married	Civil servant	3	High education	High income	2
	3	21	Not married	Petty trader	0	No education	Low income	3
Odumase	1	35	Not married	housewife	1	basic education	Low income	3
	2	28	married	Petty trader	0	No education	Low income	3
Ohenenkwanta	1	37	married	housewife	2	basic education	Low income	3
	2	25	married	housewife	0	No education	Low income	3
Kyekyebiase	1	43	married	teacher	3	High education	High income	2
	2	30	married	housewife	1	basic education	Low income	3
	3	24	Not married	Petty trader	0	basic education	Low income	3
	4	39	married	housewife	2	No education	Low income	3
Anuruso	1	36	married	housewife	2	No education	Low income	3
Agyareago	1	28	married	housewife	5	No education	Low income	3
Bomiriso	1	35	married	housewife	2	no education	Low income	3

Source: Data from pregnant women on 15.01.2015

Table 4.2: Demographic features of pregnant women at the Dwease centre

Village	Respondent	Age	Marital status	Occupation	Previous experience	Education	Financial status	Month of attending ANC
Boatengkrom	1	40	married	housewife	2	No education	Low income	3
Shell	1	30	married	housewife	3	basic education	Low income	5
	2	25	married	housewife	0	No education	Low income	7
	3	44	married	housewife	4	No education	Low income	5
	4	31	married	housewife	2	No education	Low income	5
Nyamebekyere	1	29	married	housewife	3	No education	Low income	5
	2	42	married	housewife	4	No education	Low income	5
	3	27	married	housewife	2	No education	Low income	7
	4	38	married	housewife	3	No education		5
Adumkrom	1	21	Not married	Petty trader	0	No education	Low income	7
	2	23	married	housewife	2	Basic education	Low income	5
	3	27	married	housewife	0	No education	Low income	7
Kramokrom	1	32	married	housewife	2	No education	Low income	7
	2	34	married	housewife	3	No education	Low income	5

Source: Data from pregnant women on 22.01.2015

Table 4.3: Demographic features of pregnant women at the Praso centre

Village	Respondent	Age	Marital status	Occupation	Previous experience	Education	Financial status	Month of attending ANC
Anawuokrom	1	32	married	housewife	3	basic education	Low income	5
Nsiakrom	1	38	married	housewife	2	No education	Low income	5
	2	31	married	housewife	2	No education	Low income	7
Tutukrom	1	30	married	housewife	1	No education	Low income	5
	2	28	married	housewife	0	No education	Low income	7
	3	26	married	housewife	1	basic education	Low income	5
Nyamebekyere	1	31	married	housewife	3	No education	Low income	5
	2	25	Not married	Petty trader	1	No education	Low income	7
	3	34	married	housewife	2	No education	Low income	5
Praso town	1	43	married	housewife	3	No education	Low income	5
	2	30	married	housewife	3	basic education	Low income	7
	3	24	Not married	housewife	0	No education	Low income	5
	4	35	married	Petty trader	3	basic education	High income	5
	5	40	married	housewife	2	No education	Low income	5
	6	37	Not married	housewife	0	No education	Low income	7
	7	28	married	housewife	2	basic education	Low income	5
	8	42	married	housewife	1	No education	Low income	5

Source: Data from pregnant women on 07.01.2015

The remaining ten (10) key informants consisted of five (5) males and five (5) females. These included a member of the MDPC, a member of the MHD, a worker of ABAK Foundation, a PA, a midwife, a representative from MAMAYE, Ghana and four additional community health personnel in the study area. The age of these key informants ranged between twenty-five (25) and fifty (50) years old. Of the ten (10), three (3) were between the ages of forty-five (45) and fifty (50), three (3) were between the ages of thirty (30) and forty (40) years and the rest were between the ages of twenty-five (25) and twenty-nine (29) years.

4.3 Cases

This section presents the data collected from the field including primary data and observation in form of cases. Seven (7) cases are presented in this section with each case revealing factors that affect maternal health in AACM. The figure below (figure 4.4) shows the administrative map of AACM where the villages for the study are located.

Figure 4.4: The Administrative Map of Asante Akim Central Municipality

Source: Ghana statistical Service (2014)

4.3.1 Case one

At Kramokrom, I observed a thirty-two (32) year old married woman with no education and low income. She was a housewife to a man who was not employed but engaged in a petty trade. She was pregnant for the third time in her second trimester but she attended only one ANC at the Dwease health facility. She developed complications prior to the time of delivery. I observed she was facing financial constraints and she was also living far from the Dwease health facility. Moreover, there was no CHPS compound to provide first aid and no ambulance to convey her to the Dwease health facility. She was later picked up by a taxi which delayed on the way before reaching the health facility due to poor conditions of the road. This worsened her condition so the health personnel at Dwease could not handle the case. They found that she had not enrolled in the NHIS and there were not enough equipment at the Dwease health centre to provide health care for the woman. She was then referred to the municipal hospital, Konongo where she went through a caesarian section but she lost her life.

In the focus group discussion at Praso, it was discussed that:

"Most women in the remote areas have limited access to health facilities based on financial constraints, distance and poor roads." Moreover, the lack of CHPS in Boatengkrom, Anawuokrom, Adumkrom, Kramokrom and other deprived areas in AACM has contributed to the less significant effort towards improving maternal health. We are not able to utilize health care at our doorsteps due to the lack of CHPS in our areas. We are not also able to detect pregnancy related complications since we hardly access health care and the dalliance in detecting such complications mostly result to the loss of life"

Again, the stress we go through in order to subscribe and renew our NHIS card often deter most pregnant women especially those of us from the remote areas from signing up. We have to travel to the municipal capital every time considering this bad road network before we can register and even after the registration, we have to wait for several months before we receive the card (FGD, Praso).

Moreover, a key informant also indicated that:

"Some women in the rural areas have not enrolled in the NHIS. Some never renew their cards when they expire and others also fail to subscribe. Due to this, they face multiple challenges when they visit the health facilities. When they come to the facilities, these are some of the problems they face, when they are asked of their hospital card, they say they don't have and when they are asked of their HNIS card, it has either expired or they have not enrolled. This makes it difficult for us to address it especially when they come with emergency problems" (Health personnel, 06.01.2015).

List of factors affecting maternal health under case one:

1. Distance to the health facility
2. Availability of CHPS compounds
3. Accessibility of ambulance in the rural communities
4. Accessibility of private commercial vehicles (taxi)
5. Failure on the part of pregnant women to enrol in the NHIS or renew their expired cards
6. Dalliance in processing NHIS card for subscribers
7. Inadequate health equipment

4.3.2 Case two

A twenty-one (21) year old woman was also observed at Adumkrom. She was pregnant without a husband. She was not educated and was engaged in petty trading with low income. She attended only two ANC and never visited the health centre for checkup due to financial problems. She had no experience with pregnancy related complications because that was her first pregnancy and she relied much on traditional medicine. She developed complications during the 6^{th} month of her pregnancy. She had a severe bleeding and she was rushed to a TBA who could not handle the case. Later, they decided to rush her to the hospital but there was no ambulance to convey her so they had to rely on a motor bike to convey her from Adumkrom to the Dwease health centre. At the Dwease health centre, they could not handle the case so she was later rushed to the Konongo- Odumase Hospital where she was treated but she lost the pregnancy (still birth).

A key informant stressed that:

"Pregnancy is perceived as a health issue right from conception to delivery and beyond. The pregnancy related problems are not associated to only married women and this causes the number of maternal mortality to increase. It is also related to those involved in unwanted

pregnancy as well as those who get pregnant without a husband. They do not come for regular checkup because some of them try to hide the pregnancy at the initial stage. Some have not even enrolled in the NHIS to enjoy affordable health care.

At a point where they get the complications and they come to the hospital, we have to trace when she got pregnant and how she has been handling the pregnancy which is not known. It is therefore the responsibility of pregnant women to come to the health facility to seek for health care because we cannot be chasing them.

At the end, they are rushed to the hospital. When they come with complications, they become stranded and some complications are not easy to handle especially when they have been delayed. They bring complications that have been delayed such that addressing them become very complicated. The consequences become so great that at times they lose their pregnancy, their lives or even both" (Health personnel, 05.01.2015)

Moreover, in the focus group discussion at Dwease, the women discussed that:

"Some of the girls do not protect themselves when having sex and they become pregnant. They fail to seek health care until the pregnancy becomes obvious so they fail to detect all the complications that developed at the initial stages of the pregnancy. Moreover, some of the herbs they rely on are not effective so the situation becomes worse (FGD, Dwease).

In relation to this, a key informant emphasised that:

"There is always apathy towards health programmes in the municipality and Ghana as a whole. When the municipality organizes health programmes for women, you always see children and few women around so the actual impact cannot be achieved. In this case, it is only when they come to the facility for ANC that most of these education on reproductive health are given, however, most pregnant women do not show up during ANC in order to receive education concerning their reproductive health" (Health Directorate, 06.01.2015).

List of factors affecting maternal health under case two:

1. Irregular attendance to ANC
2. The use of traditional medicines
3. Limited skills of TBAs
4. Limited accessibility of ambulance
5. Late referral system

6. Poor attitudes of pregnant women towards health programmes and education

4.3.3 Case three

In the field, I interviewed a forty (40) year old pregnant woman from Boatengkrom, who already had two children. She had no education with low income and she was married to a farmer as a house wife. However, she had experience in pregnancy related complications due to her previous experience and the education she receives from the health personnel whenever she attended ANC. She was very committed to attending ANC but she was not an active subscriber of the NHIS which will allow her to access free ANC regularly.

The woman developed complications and she was asked to renew her expired NHIS card which took her about two (2) months to renew due to financial constraint and the long bureaucratic process involved. At the first attendant with the expired card, the health personnel neglected her despite the complications. After acquiring the renewed card, she was not given immediate attention because they assumed she normally came with expired card and after she was attended to, she was asked to buy some medicines that were not covered by the NHIS which she could not buy. The delay in the payment and the processing of the NHIS, the attitudes of the health personnel towards the woman as well as her failure to purchase the medicine worsened her condition which finally resulted in a miscarriage.

A pregnant woman as a key informant revealed that:

"Some of the SBAs do not handle pregnant women with care. I once forgot my hospital card when attending ANC and I received a lot of insults from them. In the worst case, I was denied being given medical attention without the card so I had to rush all the way home for the card with my condition before I was given the necessary medical care" (Pregnant woman, 06.01.2015).

According to a key informant:

"The NHIS is not improving maternal health as expected. There are limited funds for reimbursing it. There are not enough drugs in the medical stores because they are not having money to buy drugs for the health centres. From January to December, 2014, the government had only reimbursed up to May. The government owes a lot of hospitals and the private hospitals are collapsing because they rely on insurance to pay their workers. Even though the insurance is providing about 85% of health care cost, the dalliance in the insurance means clients have to buy their own drugs at relatively higher prices.

The implementation of the health insurance which has been the priority of the government is not being utilized due to dalliance in the provision of the health insurance for pregnant women as well as the long process of obtaining an insurance cards from the appropriate authority" (Key informant, 12.01.2015).

In relation to this, women in the focus group discussion at Konongo asserted that:

"Most women who visit the hospital with health insurance are not likely to receive immediate medical attention from the health personnel because the health personnel think of the number of people bringing money for the utilization of health services first before those with the insurance cards. It is therefore not working as expected" (FGI, Konongo).

List of factors affecting maternal health under case three:

1. Failure on the part of pregnant women to renew their expired NHIS cards
2. Dalliance in the process of renewing NHIS cards
3. Different attitudes of health personnel towards different groups (poor, uneducated, rural,) of pregnant women
4. Inability of the NHIS to cover expensive drugs

4.3.4 Case four

A key informant was interviewed concerning the attitude of health personnel towards pregnant women of different status. Specifically, there was a woman at the age of forty-four (44), very influential, well educated, having a high income status and working at the bank and was living at Konongo, the municipal capital. She was married to an educated man, they had two children. This woman got pregnant and at the early stages of the pregnancy, she developed a complication. However, she renews her NHIS card regularly, attends ANC regularly, has education on pregnancy related complications and she was very careful of her pregnancy.

Each time she goes to the health facility, the health personnel handle the woman very well by checking the temperature and the health of the baby in her womb. The informant indicated that she was given the necessary attention to have a safe delivery. All these conditions facilitated the safe delivery of the woman. However, he emphasised that this is not the case with women with no or low education and low income in the rural areas.

In the focus group discussion at Praso, it was also revealed that:

"Women with high financial status or high educational attainment are favoured at the health facilities. Pregnant women with this status have easy access to the ANC because the health personnel devote much attention on them" (FGD, Praso).

List of factors affecting maternal health in case four:

1. Different attitudes of health personnel towards (highly educated, high income, residing in the urban centres) of pregnant women
2. Regular attendance to ANC
3. Good roads linking the urban centres
4. Enrolment in NHIS

4.3.5 Case five

At the Dwease health facility, a key informant indicated that there was a 25 year old woman at Nyamebekyere who had no education and was engaged in petty trading with low income. She was not married; however, she had one child and got pregnant for the second time. She attended ANC only once due to the distance, poor road conditions as well as financial constraints so she did not have much education on pregnancy related complication. However, she had experience in pregnancy related complication due to her previous pregnancy. She used traditional medicine whenever she felt any abnormalities in her system.

During the last trimester of her pregnancy, she developed complications and prior to her delivery, she was put in a taxi to the Dwease health facility for delivery and she delivered successfully. However, she started bleeding severely after the delivery and there was no oxytocin[8] available at the Dwease health centre to stop the bleeding. Moreover, there was no office telephone at the Dwease health centre to reach the Praso health centre for assistance with respect to the medicine. One health personnel used her mobile telephone to contact the Praso health facility administrator and she was told the Praso health facility also did not have oxytocin.

This worsened the case since there was no medicine to stop the bleeding. They finally decided to convey her to the municipal hospital at Konongo for treatment but it was too late. Though the baby survived, the woman lost her life due to severe bleeding.

According to a pregnant woman (key informant):

[8] Oxytocin is very effective for treating and preventing excessive bleeding which remains one of the leading causes of maternal deaths (Kade & Moore 2012).

"The health personnel always educate us to desist from using concoctions or traditional medicines or even combining them with the drugs received from the health facilities since they are likely to cause complications. They also advise us to seek early health care. However, some pregnant women think they have experience in pregnancy related complications because they have been pregnant and given birth several times so they take this education for granted and use their own discretion when they face pregnancy related challenges" (Pregnant woman, 06.01.2015).

A key informant (MHD) stated that:

"Some of the deaths recorded were handled by the TBAs so we don't want to encourage them. Initially, we trained those who were active and provided them with equipment and medicines but because we are not encouraging them, we only visit them for data. However, there are some areas where there are no trained health personnel which is quite far from the hospital or health centres so we rely on TBAs in those areas" (15.01.2015).

In the focus group discussion at Dwease, a woman asserted that:

"I do not see any difference between delivering at a health facility and at home. If I should come all the way from Kramokrom to Dwease health facility to deliver and after delivery there is no medicine available to treat me from severe bleeding and infections, then it is better I remain in my village and seek assistance from a TBA who can also help me deliver just like a health personnel" (FGD, Dwease)

Another woman in the focus group discussion at Dwease also stressed that:

"The health facilities in the rural communities do not have many equipment and medicines so we think they perform their activities like the TBAs which makes less difference. Most of the medicines are not available, especially the most expensive ones so we have to buy them from the pharmacies and other chemical shops. Since we are not engaged in income generation activities, we don't have the cash to buy those medicines" (FGD, Dwease).

In relation to this, a key informant (health personnel) noted that:

"The health facilities do not get access to medicines from the medical store because the health insurance is not paying and we do not have internally generated funds to purchase the drugs. We are even lacking drugs like oxytocin and magnesium sulphate which should be found in every health facility" (health personnel, 12.01.2015).

Moreover, another key informant (a worker of ABAK) indicated that:

"The strategic plans of the government have always been toward winning elections and therefore neglecting very important issues like reimbursing the medical stores in order to provide medicines for the various health facilities as well as equipping the health facilities at the rural communities with equipment to serve the residents" (a worker of ABAK, 12.01.2015).

List of factors affecting maternal health under case five:

1. The use of traditional medicines and concoctions without consulting health personnel
2. Irregular attendance to antenatal care (ANC)
3. Distance to health facility
4. Financial constraints
5. Accessibility of private commercial vehicles
6. Inadequate number of medicines at the health centres
7. Inadequate number of equipment at the health centres
8. Late referral system

4.3.6 Case six

In the field, a worker in one of the NGOs operating in AACM informed me that there is a thirty-five (35) year old pregnant woman living at the Praso town. She has a basic education, engages in petty trading with a high income and is married to an assembly man. She has four kids and was pregnant for the fifth time. She had renewed her NHIS card and attended ANC regularly. She has experience in pregnancy related complications due to the education she received from the health personnel, her experience from previous pregnancy as well as her regular attendance to ANC. She did not use traditional medicine during the pregnancy.

However, she developed complications prior to delivery and she was rushed to the Praso health facility where she was given medical care which reduced the severity of the complications. She finally delivered at the Praso health facility but she started bleeding after the delivery. Just like Dwease health facility, the Praso health facility also lacked several medicines including oxytocin. The midwife also had to attend to another client who was also rushed in due to complications. They then decided to call the ambulance to convey the woman to the Konongo-Odumase Hospital, the municipal capital. However, the ambulance was also providing similar service to another client at different community so they could not get access to it.

The husband, being an assembly man got one of the assembly's vehicles to convey the wife to the Konongo- Odumase Hospital. On arrival, she was given the necessary medical care. They also gave her oxytocin which stopped the bleeding so she was discharged in few days.

A pregnant woman as a key informant indicated that:

"The inadequate number of midwives in the rural health facilities is not helping to improve maternal health. When we visit the health facility, we have to wait for a very long time before we access health care because there is only one midwife attending to all" (Pregnant woman, 06.01.2015).

In the focus group interview at Praso, some women revealed that:

"The inadequate number of midwives in our health facilities encourages us to seek the services of TBAs in order to avoid delay and untimely deaths. These TBAs in our communities are at our doorsteps, always willing and available to assist us to deliver" (FGD, Praso).

A key informant (MHD) revealed that:

"AACM is encountering problem in their referral services because all the health facilities especially those in the rural communities do not have quick ambulance services. When there are referral issues in those facilities, they have to call the ambulance all the way from the municipal capital before transporting the patient to the required health facility. The delay in the referral system leads to complications which may result in maternal mortality or morbidity. The delay in transporting patients to the other health facilities led to the death of a pregnant woman in the municipality" (municipal health directorate, 16.01.2015).

Another key informant (Midwife) stated that:

"Though AACM has increased the number of health personnel in the municipality, we are still lacking more health personnel. The area that is lacking is the midwives who take care of the pregnant women. When you go to some facilities aside the municipal capital, we have only one midwife taking care of pregnant women from about six different communities." (Health Director, 06.01.2014). Another said *"The number of health personnel in the municipality is inadequate. Here for instance, I am the only midwife with only one assistant who is an enrolled nurse."(Midwife, 05.01.2014).*

List of factors affecting maternal health under case six:

1. Regular renewal of NHIS cards

2. Regular attendance to ANC
3. Inadequate number of medicines
4. Accessibility of ambulance
5. Inadequate number of midwives in the rural health facilities
6. Late referral system
7. Positive attitudes of pregnant women towards TBAs
8. Differences between resources that can be accessed by different categories of women

4.3.7 Case seven

Another key informant (health personnel) indicated that there was a twenty-eight (28) year old woman with no education and she was married to a small holder farmer at Agyareago. They had five (5) children and she was pregnant with the sixth child. She was a housewife with low income. She could not attend ANC because she had not enrolled in the NHIS. She was advised by the husband and the mother-in-law to use traditional medicine throughout her pregnancy. They also advised her to seek health care and advice from TBAs since there was no CHPS at Agyareago and the distance to the Konongo- Odumase Hospital too was far, so TBAs are the closest people they can reach for help.

In her ninth month prior to delivery, she used a traditional medicine through an enema syringe which caused a complication. She was rushed to a TBA who could not detect such complication as life threatening and therefore decided to assist the woman to deliver instead of referring her to the Konongo-Odumase Hospital. The TBA assisted the woman to deliver successfully, however, the key informant indicated that it was a still birth with severe bleeding. They picked her up with a taxi and rushed her to the Konongo- Odumase Hospital for treatment. The health personnel became very furious concerning the delay on the part of the woman and her family in deciding to seek health care and felt reluctant to help. However, they gave her the necessary medical attention.

A key informant (pregnant woman) in an interview at Konongo indicated that:

"Most women in the rural areas feel reluctant to visit the health facility after they have delivered at home because they think the health personnel will insult them and will not give them the necessary medical attention" (Pregnant woman, 16.01.2015).

"In the focus group discussion at Praso, the women revealed that most health personnel have poor attitudes toward women who deliver at home and they feel reluctant helping them when

they visit the health facility. In view of this most women do not like visiting the health centre after delivering at home" (FGD, Praso)

A woman in the Praso focus group discussion shared her experience:

"I once delivered at home and my husband did not take me to the health facility after the delivery because I was not bleeding and moreover, I did not have severe pains so he thought I was healthy. In few days later, I started bleeding so my husband rushed me and my baby to the Praso health centre. Because I did not deliver at the health facility, it was not on their records so the midwife asked my husband when I delivered and he said few days ago at home. Then the midwife became very furious and asked my husband the reason for seeking health care now. She told him that he should never repeat such mistake since it could have caused my life" (FGD, Praso).

On the contrary, some women in a focus group interview at Konongo stressed that:

"Some of the health personnel are very kind, respectful and always willing to help us whenever we visit the health facility. They speak gently to us even when we deviate from doing what are expected of us. They spend much of their time educating us on our reproductive health and always advise us to seek early health care" (FGD, Konongo).

A key informant (Health personnel) also postulated that:

"We always inform pregnant women not to use the traditional medicines or concoctions and neither should they combine them with the drugs from the health facilities without the knowledge of the health personnel. Some of the local drugs are not good for their health but they take them just because of their pregnancy. Sometimes they lack even knowledge about the local drugs they take which might have a lot side effects and complications. Some of the drugs cause anaemia. We always educate them on the need to attend ANC and seek early medical care in order to detect and treat pregnancy related complications but they tend to be influenced by the advice from their husbands, family members and TBAs who have not been trained as health workers which at times even causes their lives" (Midwife, 05.01.2015).

Another key informant (health personnel) stressed that:

"Most women especially those with low education and those from the rural or remote areas fail to attend ANC and therefore exempt themselves from the education. Such people mostly deliver at home with the help of TBAs" (Health personnel, 15.01.2015).

List of factors affecting maternal health under case seven:

1. Distance from Agyareago to the Konongo- Odumase Hospital
2. Access to ANC
3. Access to NHIS
4. Influence from husbands, family members and TBAs
5. Access to CHPS
6. Limited knowledge and skills of TBAs to detect life threatening complications
7. Late referral system
8. Attitudes of health personnel

CHAPTER FIVE

5.1 Discussion

This chapter presents the discussion of results of maternal health in AACM. It will begin by exploring government structures introduced to improve maternal health. Next, it reviews the various ways AACM is creating an enabling environment to address the issue of maternal mortality. This is followed by a review of the existing policies, their practices and effects. The chapter begins by looking into the nature of maternal health and continues with the structures put in place to improve maternal health. The thesis uses three approaches to analyze the findings: the three delays model, gendered power relations and patriarchy.

5.2 The nature of maternal health in Ghana

The quest to improve maternal health in Ghana, and eventually meet the goals of MDG 5 by 2015, led to the adoption and implementation of several policies, initiatives and interventions in Ghana. These policies and interventions include the implementation of NHIS to provide quality and affordable health services to all residents in Ghana (Dietrich-O'Connor (2010). Others include the Safe Motherhood Initiative, MPS, PMMP (United Nations Development Programme 2012), free maternal health care and free delivery, implementation of NAS to transport women with obstetric emergencies to health facilities (Ministry of Health 2008), as well as the implementation of the CHPS (School of Public Health 2009). Despite the many programs and initiatives, the implementation of these interventions and policies have made less significant impact in improving maternal health in Ghana than anticipated.

5.2.1 Clients' attitude towards maternal health

It has been noted that every pregnant woman is supposed to have the opportunity to enjoy free ANC and free delivery as part of government intervention to help improve maternal health in Ghana. This specifically includes vulnerable women, who are also supposed to get access to free health care as a result of government's policy of taking out all financial barriers to the utilization of maternal health service (Asamoah et al: 2014). It was revealed by key informants (health personnel) at Konongo, Dwease and Praso that some pregnant women, especially those with no or low education and those from the rural or remote areas fail to attend ANC and exempt themselves from the education. These women mostly deliver at home with the help of TBAs.

A key informant, MHD emphasised that some pregnant women in the rural and remote areas have confidence in the TBAs because they are found in the remote areas and pregnant women

need not to travel far to seek health care. The MHD explained that these women at the point of delivery rely on TBAs and after delivery, some bleed excessively which becomes a medical emergency before the women are conveyed to the health facilities. Some of these cases eventually lead to death. It was further stressed that some of the deaths recorded in the municipality were handled by the TBAs so the municipality does not want to encourage the TBAs. However, there are some areas which are quite far from the hospital or health centres where there are no trained health personnel so the municipality relies on the TBAs in those areas.

According to the MHD, the municipality initially trained the TBAs who were active and provided them with equipment and medicines in order to assist pregnant women in the remote areas to deliver but because the municipality is not encouraging the TBAs anymore, the directorate only visits them for data. TBAs who are not equipped to address pregnancy related complications therefore rely solely on their own knowledge and skills which sometimes fail. In the focus group discussion at Praso, women revealed that some pregnant women in the remote areas have limited access to health facilities based on financial constraints, distance and poor roads. They stressed that lack of CHPS compounds in Boatengkrom, Anawuokrom, Adumkrom, Kramokrom and other deprived areas in AACM has contributed to the less significant effort towards improving maternal health because they are not able to utilize health care at their doorsteps.

Furthermore, pregnant women in the rural areas are not also able to detect pregnancy related complications since they hardly access health care and the dalliance in detecting such complications could result to the loss of life. Throughout my stay in the municipality, I saw that most pregnant women fail to attend ANC after detecting they are pregnant and therefore resort to the use of traditional medicines. Others also attend late ANC clinic after several months of pregnancy. According to the three delays model of Thaddeus and Maine (1994), socioeconomic factors such as education, income status and occupation affect pregnant women's decision to seek for health care in the rural communities. For instance, a woman with low level of education or no education may not make urgent decision to seek for medical services. An educated pregnant woman is likely to detect early pregnancy related complications based on reading, attending regular ANC because she knows the importance of it and always seeking advice from health personnel. Besides that, high income status is a clear indicator that gives people the urge to seek for medical care. This also goes in line with

occupation because a person who is employed and has a regular salary is likely to seek for medical care when necessary. (ibid.)

Besides, socioeconomic factors can help in recognizing a problem. The high financial status of a pregnant woman can influence her to attend ANC because she may be having money for transportation and she can cover part of medical cost, whereas pregnant women with low income may face challenges. According to Thaddeus and Maine (1994) in their three delays model, all these factors can contribute to delay of pregnant women in seeking medical care. This situation was illustrated in case one (1) of the findings where a thirty-two (32) year old pregnant woman residing in Kramokrom with no education and low income could access ANC only once. She lacked the education on how to detect pregnancy related complications and how to seek early medical care which led to death.

The information gathered from the key informant interviews, focus group discussions and the individual cases indicate that lack of education for pregnant women of AACM is a contributing factor since the rate of improvement of maternal health is lower than the goals that have been set. Most of the pregnant women in the remote areas are not educated and only few have basic education[9] but they are able to recognize that they are not getting access to relevant information about their health and that of their babies. Moreover, they are aware that pregnancy has certain risks; however, they may not be aware that it is possible to avoid or treat them. There is lack of knowledge on the part of these women concerning how to detect pregnancy related complications during prenatal and postnatal periods. It was revealed by a key informant (health personnel) that the means of acquiring such knowledge is through regular attendance to ANC where the health personnel use the opportunity to educate them.

In addition, the focus group discussions in the villages revealed that women in the remote areas do not access antenatal care regularly[10] due to financial constraint resulting from low income. It was emphasised that only few women were engaged in petty trading with low income. The rest of them were full time housewives who solely depend on their husbands for cash in order to travel from the rural communities to the health facilities in towns. Poor, rural women in rural areas may say no to not being able to access pre-natal care as their position gives them very little power to do so. In comparison, rich, educated women have more of all kinds of resources and can access both quantity and quality of care. This is the enabling as

[9] Refer to pregnant women's educational status on tables 4.1, 4.2 and 4.3 above.
[10] Refer to month of attending ANC on tables 4.1, 4.2 and 4.3 above.

well as constraining aspects of power which gives a person the ability to say no according to Giddens (1984).

With reference to Thaddeus and Maine (1994) in their three delays model, accessibility to a facility is a factor of reaching care in the sense that in a rural poor community, a pregnant woman or her family or her birth attendant may decide when she will seek medical care for a life threatening complication. For instance the family member or the husband may tell the wife to wait for some time before seeking for medical care because of financial issues or power relations. The pregnant woman herself may delay in seeking medical care and her traditional birth attendant could also tell her to wait because she is capable of handling any complication. All these cause delay in reaching health care services. It also points to the fact that in most cases the pregnant woman, the family members and the TBA may not have the knowledge to detect early pregnancy related complications.

However, it was identified that there was a power struggle between men and women with regard to when to seek for medical care. It was revealed in the focus group discussions that husbands have the power to determine when their wives seek health care and even the kind of health care they seek (skilled care or care from TBAs) since they provide the means for their wives to access the health care. This is in line with gender and power explained by Davis et al. (1991). They see gender as an asymmetric power relations between men and women which is relations of domination and subordination respectively (Davis et al. 1991). The issue of domination and subordination reflects in women expressions in the group discussions because the women said that some of the husbands cause their wives to use the services of the available TBAs who charge considerable lower prices compared to the cost involved in travelling far to seek skilled health care.

According to Holmes (2007), this is referred to as patriarchy. A patriarchal structure of gender relations occur if religious, political and conversational practices all place men in authority over women. According to Walby (1997), patriarchy is in two forms: domestic patriarchy and public patriarchy. The domestic patriarchy has been a system where women's lives are controlled and constrained by men within their immediate family. Women solely depend on fathers and then husbands whereas public patriarchy is considered to be in the world of work and politics where collective decisions affecting women's lives are usually made by men in the work place and in government.

The domestic patriarchy will be emphasised. In AACM men are dominating in decision-making in the family setting which has been handed down from generation to generation. Women resistance is very weak because of traditional norms. In Ghanaian setting, the traditional norm is such that women are subordinates and they are obliged to allow their husbands to take decisions for the family. They must also respect the decisions of their husbands. Some may be good, others may be bad. In relation to the study, when women are having complications and they mention it to their husbands (the head of the household), it is the husbands who decide when (the day and time) the women should visit the health facilities and where (skilled care or from TBAs) because they dominate in decision-making. In this kind of situation, it becomes very difficult for the women to ask why or object the decisions of their husbands. In the rural areas, a woman who asks why is seen as arrogant. Sometimes, the objection is very relevant and good for the women's health because it leads to early intervention in pregnancy related complications.

This is in line with Davis et al. (1991), explanation of power which shows asymmetrical relations. These relations are produced, reproduced and transformed as its objects. During 'bragoro'[11] in Ghanaian society, women are prepared for their future traditional marriages. In the traditional marriage institutions, women are trained to respect the decisions of their husbands who are the heads of the household and this has been handed down from generation to generation. However, this has changed as a result of education and modernization. Educated women also play part in decision-making and they know when to object decisions made by their husbands and when to take their own initiatives. They earn their own income so they do not depend on their husbands for money to seek for health care and they know their rights as well. However, in the local setting, most women have no or basic education and they are not in paid jobs so they solely rely on their husbands for cash in order to seek for health care. Hence, the patriarchal system and power in the hands of men at the domestic level have gone a long way to promote gender-based inequities in AACM affecting women's health. This study has found that most pregnant women in AACM especially those in the rural communities, delay in reporting pregnancy related complications because they do not access ANC.

During my work as a field officer with the NGO in AACM, we often interacted with pregnant women and their husbands in the rural areas and through those interactions, I realised that

[11] Bragoro is a puberty ritual that transforms a female from childhood to adulthood. During such rite, the woman is groomed about her future role in marriage.

pregnant women in the rural areas of AACM mostly deliver at home with the help of TBAs and sometimes their husbands. After delivery, their husbands fail to take them and their newborns to the hospital for treatment except when the women feel some pains or discover some physical abnormalities. Besides that, some cultural beliefs and practices restrict women from delivering at health facilities because some families rely on TBAs, herbs and even spiritual ways of assisting pregnant women to deliver and most women who deliver at homes feel reluctant to visit health centres afterwards because they may receive verbal abuse for not attending ANC earlier or immediately after delivery.

A woman in the Praso focus group discussion shared her experience that she once delivered at home and the husband failed to take her and the newborn to the health facility after the delivery because she did not bleed and she did not have severe pains. In few days later, she started bleeding so the husband rushed her and the newborn to the Praso health centre. Because she did not deliver at the health facility, it was not on their records so the midwife asked the husband about the time the woman delivered and the husband replied few days ago at home. The midwife became very furious and asked the husband the reasons for the delay in seeking health care. She told the husband never to repeat such a mistake since it could have led to death.

According to key informants (the health personnel), pregnancy is perceived as a health issue right from conception to delivery and beyond so they always advise pregnant women to attend ANC regularly in order to detect early and treat pregnancy related complications to ensure safe delivery. On the contrary to the claims of health personnel, my personal observation at the time of work as a field officer in AACM revealed that husbands who have the power to make decisions concerning when their wives seek health care define pregnancy as a health issue only during delivery and when their wives complain of pains and abnormalities which should not be the case. Those husbands should therefore be encouraged to use their power to promote and support their wives to seek regular health care right after conception.

5.2.2. Client's attitude towards maternal health education

According to key informants (health personnel), the municipality through health personnel and NGOs provide health education for all pregnant women. They educate the pregnant women during prenatal and postnatal periods. At the back of every antenatal card given to pregnant women contains health topics which the health personnel discuss with them when

they visit ANC before they deliver. It was further stressed that they provide pregnant women with health talk on every visit which is done twice a week. Besides that, the health personnel sometimes go on visits to educate the pregnant women on the need to seek early medical care.

A key informant (Municipal health directorate) emphasised that there is always apathy towards health programmes in the municipality and Ghana as a whole. When the municipality organizes health programmes for pregnant women, only few women show up so they are not able to achieve the desired impact. It is only when pregnant women visit the facility for ANC that most of the education on reproductive health are given. It was however stressed that most pregnant women do not show up during ANC in order to receive education concerning their health.

Another key informant (health personnel) emphasised that women especially those in the remote areas show up once for ANC when they become pregnant and they even come around the seventh month. These women only come for ANC when they observe that their bellies are protruding. It could be that there is a hidden disease or a condition which needs to be addressed; however they feel reluctant to attend ANC. The key informant (health personnel) further asserted that pregnant women living in hamlets and villages do not attend ANC and if there are no chip zones or compounds in such areas, the health personnel do not go there to provide ANC and education.

Education for pregnant women is available in the municipality and that pregnant women receive education on their health when they attend ANC. However, refusing to attend ANC implies failure to receive education on their health. It was found that most pregnant women who refuse to attend ANC regularly lack much education on pregnancy related complications and some rely on their previous experience. With reference to case one (1), the thirty-two (32) year old pregnant woman from Kramokrom could not detect that she had developed pregnancy related complication because she failed to attend regular ANC where she could receive education on her health. In addition, it was discovered in cases two (2), four (4) and seven (7), that a twenty-one (21) year old pregnant woman from Adumkrom, twenty-five (25) year old pregnant woman from Nyamebekyere and twenty-eight (28) year old pregnant woman from Agyareago respectively all relied on using traditional medicines because they did not attend ANC frequently to receive information on the dangers involved in using

concoctions. The study found that pregnant women's response to education in the municipality has been very poor.

5.2.3 Health personnel

There is a huge challenge in the equal distribution of health personnel across the country. Aside the shortage of the health personnel in the country, the few available ones have been distributed in favour of the urban areas at the expense of the rural hospitals (Salel 2012) .The government of Ghana aimed at increasing the number of health personnel and motivating them in order to distribute them equitably across the country (Ministry of Health 2007). This was done through the establishment of CHNTS in at least each region to train CHNs to provide health services in the various communities (School of Public Health 2009). In addition, the government increased the support of midwives through increased midwifery training programmes (Ghana Health Service 2014).

Moreover, the government aimed at improving productivity by increasing the salary of health workers (Salel 2012) which was done by replacing the additional ADHA with the HSS to improve the performance of health personnel (Ministry of Health 2007). According to a key informant (a member of the MDPC), though the number of health personnel has increased in Ghana, they are still not enough at AACM. The municipality needs more health personnel in order to distribute them equitably to all communities which will enable clients to access skilled health care irrespective of their residing areas. The reason for the less number of health personnel in AACM according to a key informant (health personnel) has been that they are not motivated enough to stay and work in the municipality. A key informant (a member of the MDPC) explained that the assembly aims at motivating the health personnel who are posted to the municipality by providing accommodation for them. This will reduce or eliminate the stress they have to go through in search for accommodation when they are posted to the municipality. The provision of accommodation as well as other incentives by the assembly to the health personnel posted to the municipality would motivate them to stay and provide health care services to the people.

5.3 Policies

5.3.1 National Health Insurance Scheme (NHIS)

The NHIS was introduced as a governmental policy to provide quality and affordable health services to all the residents in Ghana. Salel (2012), points that the government through the implementation of the NHIS has established a better accountability through the assurance of

significant public funding for the needy groups as well as the separation of providers from payers. In the quest of ensuring affordable health care service, there has been a subsidy for the vulnerable groups through the NHIS. Moreover, ensuring an improvement in quality standards has also been factored into the NHIS.

However, in the field it was observed that the NHIS was not functioning as expected to achieve the desired goals in AACM. At the health facilities, most pregnant women who visited the health centres with the NHIS card were asked to buy the medicines which were not available at the health facilities even though they are covered in the NHIS. This implies that the medical store through the NHIS does not always provide medicine to the various health facilities so the health facilities do not also get the medicines for the patients when they visit the health centres except to buy on their own.

All the respondents asserted that, the NHIS is not functioning to achieve the desired results in AACM based on cost. According to a key informant (MHD), the NHIS is working but partially because there is limited funds for reimbursing it. In 2014, the government only reimbursed up to May. The government owes a lot of hospitals and the private hospitals are also collapsing because they rely on the insurance to pay their workers. The bigger facilities are also indebted to suppliers and even some have threatened to go on strike by not providing free services to the patients. **A**nother key informant (health personnel) emphasised that they don't get the medicines when they go to the medical store because the health insurance is not paying. In 2014, the government had only paid up to the middle of the year so getting to the latter part of the year, they were not having medicines from the medical store and health facilities didn't have money to buy the medicines.

Moreover, the implementation of health insurance which has been the priority of the government according to a key informant (a worker at ABAK), is not being utilized due to dalliance in the provision of the health insurance for pregnant women as well as the long process of obtaining an insurance card from the appropriate authority. The insurance is providing about 85% of health care cost, however, the dalliance in the insurance means clients have to buy their own medicines at relatively higher prices. Moreover, clients who visit the hospital with health insurance are not likely to receive immediate medical attention from the health personnel because the health personnel think of the number of people bringing money for the utilization of health services first before those with the insurance cards. It is therefore not working as expected.

The power to reimburse the NHIS in order for it function effectively lies in the hands of the central government. It was asserted by a key informant that the central government decides when to reimburse the scheme and how to distribute the funds to the various medical stores at the national and regional levels. Furthermore, there is provision of medicines for the health facilities at the local levels. The information received from key informants and focus group discussions revealed that the central government is not capable of reimbursing the NHIS. This has brought limited supply of medicines in the system which also makes the medical stores to provide only limited number of medicines especially the cheap ones to the health facilities leaving the expensive ones for the patients to buy from private pharmacies.

This is in line with (Thaddeus & Maine 1994) in their three delays model which states that financial cost has been one of the factors that causes delay in receiving care which includes the cost of medications and other supplies, transportation costs, physician and facility fees and opportunity costs. This could be one of the reasons that patients especially those residing in rural areas with low incomes find it difficult to enrol in the NHIS as a result of high cost associated with the system and the bureaucratic process involved. This was emphasised in the focus group discussions in the villages that the situation deters most pregnant women in the rural areas from accessing skilled care which hampers the progress of improving maternal health in the municipality. In case three (3), it was discovered that the bureaucratic process involved in renewing the NHIS card as well as the unavailability of medicines especially the expensive ones in the health facilities caused the forty (40) year old pregnant woman from Boatengkrom with low income to lose her pregnancy even though she was committed to attending ANC. The NHIS needs urgent attention since its sustenance is at risk (Salel 2012).

5.3.2 Equity in accessing the NHIS

The NHIS aims to promote equity in providing access to the benefits associated with the scheme by reaching out to the poor. The scheme is designed to exempt the poor from paying premium. This includes pregnant women with respect to accessing free antenatal care, delivery and postnatal health care services (Witter & Garshong 2009). However, key informants (MHD and a worker at ABAK) stressed that there has been inequity in the utilization of the NHIS because most of the targeted group which is the vulnerable are not enrolled in it. It was observed that at the health facilities most of the non-poor pregnant women residing in the urban part of the municipality with high education and high income have dominated in the enrolment of the NHIS and make use of the skilled care services. Most of the poor pregnant women residing in the rural areas with no or basic education and low

income[12] in the municipality were not enrolled and were not accessing the available skilled care services.

This was illustrated in cases three (3) and four (4) respectively which revealed that the forty (40) year old pregnant woman from Boatengkrom with no education and low income could not access ANC because she delayed in enrolling and renewing her expired NHIS card which led to miscarriage, whereas the pregnant woman from Konongo with high education and high income accessed ANC because she had enrolled in the NHIS which led to a safe delivery. This is in line with sexual division of labour which falls under the theory of gender and power (Connell 1987). The sexual division of labour causes women especially those who are economically disadvantaged, have lower level of education, living in poverty and have no health insurance to be at a higher risk for experiencing poorer health outcomes than women who do not experience such risk factors (Wingood & DiClemente 2000).

This means the NHIS is not able to reach the targeted group which is the poor. Furthermore, Asamoah et al (2014) stated that the average and high income women utilize the health care services through the NHIS at the expense of the poor women despite the scheme's target of reaching the poor. The challenges in the implementation of the NHIS have hampered the smooth running of the scheme towards attaining its goals.

5.3.3 Strategic plans

Ghana has since independence implemented various medium term policies and programmes to improve the economy and raise the living standards of Ghanaians with different levels of success. This included Ghana Vision 2020, the First Medium –Term Plan, Ghana Poverty Reduction Strategy (GPRS 1) and the Growth and Poverty Reduction Strategy (GPRS 2) (Government of Ghana 2010). These medium-term strategies are supposed to be achieved within the duration of three to four years.

According to a key informant (a member of MDPC), Ghana's medium term strategies and programmes are mostly inspired by two major factors: external and internal factors. External factors include international declarations by the global and regional entities to achieve some desired outcomes. For instance the UN adoption of the eight (8) MDGs to be achieved by 2015. Internal factors for setting up strategic plans are mostly inspired by the manifesto of the party in power which could affect the relevance attached to issues like maternal health. Every

[12] Refer to educational status, income status and month of attending antenatal care (ANC) on tables 4.1, 4.2, 4.3 above

government prepares a medium term policy for the state based on its manifesto which compels every district to prepare a medium term plan based on that. In this case, the plans at the district level are geared towards meeting the goals of the central government.

This is in line with the constraining aspect of power where some actors use the sanctioning process to restrict the activities of other actors or cause them to do certain things which they might not have done under other circumstances (Davis 1991; Giddens 1984). In relation to the study, the central government being dominant comes out with strategic plans based on the party's manifesto and the local government being subordinate, accountable and responsible to the central government is expected to adopt and implement the plans at the local level. Such plans might not necessarily meet the prioritised needs of the people at the local level, however, the constraining aspect of power leaves the local government with no option than to implement them. The local government's priority according to a key informant (a worker at ABAK) has always been incorporating projects into policies and the municipal's composite budget which eventually increases the party's chances of winning elections. The attention remains on serving and meeting the interest of the party in power at the expense of that of the residents of AACM.

Every party that comes into power has its own visions and strategies which direct its priority so every government is driven by its own political agenda. It was revealed by a key informant (a member of MDPC) that in Ghana, the interest of the districts is largely influenced by that of the central government. If the central government devotes itself towards improving maternal health, so will the districts' priority be and vice versa. The priority of AACM for improving the health of the people in their medium term plan has been towards fighting malaria and HIV which has been the central government's priority at the expense of improving maternal health.

5.3.4 Budget allocation

The government of Ghana spends 13.4% out of the total expenditure on health (Mamaye 2014b). Local governments have their own District Assembly Common Funds (DACFs), however, the resources allocated to health from the DACFs are low and vary from one district to the other (Salel 2012). A key informant (a member of MDPC) stated that the major sources of funds for AACM have been the DACFs, District Development Fund (DDFs), Urban Development Grants (UDGs) and Internally Generated Funds (IGFs). Education, agriculture

and health have been the major departments which consume substantial amount of the limited funds.

AACM's priority even within the health sector has been fighting malaria, supporting immunization programme and supporting the fight against HIV/AIDS (Asante Akim Central District Assembly 2013). Improving maternal health is a lower priority to the municipality. The key informant (a member of MDPC) further emphasised that AACMA does not single out maternal health in the composite budget due to limited resources. It is not also able to create a specified budget to maternal health. The municipality considers and works on most pressing issues affecting the people because of the limited resources. Though maternal mortality is a pressing issue in the municipality, the limited resources does not allow AACMA to deal with it completely. The locally generated funds are used for recurring expenditure whereas the DACFs from the central government are used for physical projects which include the construction of roads, schools and provision of accommodation among others. Even though the 2015 composite budget has captured the construction of two CHPS compounds at Adumkrom and Boatengkrom (Asante Akim Central District Assembly 2015), the major priority has been on fighting malaria and HIV/AIDS (Asante Akim Central District Assembly 2013).

This implies that the inadequate funds from DACFs and the internally generated funds available to the municipality are not enough to capture all the health needs including focusing specifically on maternal health into the composite budget. Moreover, another key informant (a worker at ABAK) emphasized that the assembly always relies on other funds like DDFs and the UDG which come with their own objectives. This becomes difficult for the assembly to release some of these funds to support maternal health issue. This means that the funds come with their own set of objectives to be achieved and the resources available are not enough to implement all policies including maternal health, hence the delay in making significant improvement in maternal health at AACM.

5.4 Staff

5.4.1 Training and availability of health personnel

According to Salel (2012), there has been an improvement in the effort towards increasing the total number of health workers and distributing them across the country to provide health care services. NTS have also been distributed across the country to train nurses. However, the distribution of health workers is done in favour of urban areas at the expense of the rural

areas as well as hospitals instead of clinics. This leads to uneven accessibility as a result of the implementation process. For instance, the government being autonomous and dominant decides when and how to distribute health personnel across the country to provide medical services to the people. According to key informants (health personnel) in Dwease and Praso, more health personnel are distributed to the urban facilities at the expense of the rural facilities which leads to an unequal access to resources. They further emphasised that whereas Konongo- Odumase Hospital has more midwives taking care of pregnant women, the Dwease and Praso health facilities have one each.

Information from key informants (MHD, MDPC, PA, midwives, other health workers as well as pregnant women) revealed that though AACM has increased the number of health personnel, they are still lacking more especially midwives. A key informant (Municipal health directorate) stated that AACM has health personnel now which is better than before but the area that is lacking is the midwives who take care of the pregnant women. There is only one midwife in the facilities outside the municipal capital who takes care of pregnant women from about five different communities. Another key informant (health personnel) emphasised that the number of health personnel in the municipality is inadequate and that she was the only midwife with only one assistant who was an enrolled nurse. Moreover, a pregnant woman as a key informant indicated that the inadequate number of midwives in the rural health facilities is not helping to improve maternal health. When pregnant women in the rural areas visit the health facility, they have to wait for a very long time before they access health care because there is only one midwife attending to all.

It was discovered from key informants that the inadequate number of midwives in the rural health facilities of AACM affects the improvement of maternal health in the municipality. This indicates that the inadequate number of midwives in the rural areas contributes to the delay in provision of health care services to pregnant women especially during emergencies. According to the three delays model of Thaddeus and Maine (1994), the quality of care also affects pregnant women's decision to seek health care. A health facility that is understaffed, underequipped or both is unable to provide quality health care. It was found that there is only one midwife assigned to the Dwease health facility as well as the Praso health facility to provide medical care for all pregnant women from five (5) different communities which fall under the Dwease and Praso health centres respectively. Case six (6) illustrates that the inadequate number of midwives at the Praso health facility almost led to the death of a pregnant woman who was rushed to the Praso health facility due to a pregnancy related

complication. There was only one midwife so at a point in time, she had to stop attending to her and attend to another pregnant woman who was also rushed in due to an acute pregnancy related complication. This implies that the midwives were not able to attend to all the pregnant women who accessed skilled care.

5.4.2 Posting of health personnel

The quest of the government to improve maternal health in the country has led to the provision of incentive package for health personnel in order to retain them in the rural and remote areas to provide health care services to the people (Salel 2012). A key informant (Municipal health directorate) stated that most midwives who are posted to the rural communities are not willing to come. They prefer to be in the cities with their families so this has increased the midwife pregnant women ratio above the national level. They perceive the posting of health personnel into remote communities by the government as a discriminative policy. This is because accepting postings to the remote areas is a deprivation of access to many things including their families, electricity, good means of transport system and good drinking water and good sanitation among others. Whilst their colleagues in the urban centres have easy access to them, they rather lack them. The incentives provided by the government to the health personnel to ensure they remain in the remote areas and provide health care services to the people include housing, additional allowances and career opportunities. However, there is still a shortage of health personnel in the rural and remote areas despite the incentive package offered to them (Salel 2012).

For instance, health personnel who are married to influential people and are posted to the remote areas have the power to say no to being posted to remote areas. They find their way of changing their postings to the urban areas leaving the rural areas based on the power of the influential people. Giddens (1984), identifies this as the enabling aspect of power that allows a person to say no. However, refusing postings to the rural and remote communities has been a challenge to meeting the needs of the pregnant women in the deprived areas of AACM.

5.5 Facilities

5.5.1 Health centres

In Ghana, capital investment in hospitals is not based on need-based standard but rather on administrative levels which include regions and districts. Moreover, there is poor correlation with the non-public sector concerning the planning for the allocation of these hospitals. Whereas some districts possess several hospitals, others have none (Salel 2012). It was found

that AACM has only one public hospital located at Konongo, the municipal capital. It was revealed in the focus group discussions that even though there are two other public health facilities in Dwease and Praso to provide minor health services, most pregnant women prefer using the Konongo Hospital to the others. This is because of unequal distribution of health personnel and infrastructure among others which mostly favour the urban facilities at the expense of the rural.

The Konongo- Odumase Hospital has been equipped both in infrastructure and health personnel better than the health centres in Dwease and Praso in the provision of health care services. Most public facilities in the sub-district levels lack health workers, laboratory services and medicines among others which are needed in the provision of health care. This compels patients to seek health care from district or regional hospitals which are relatively expensive (Salel 2012). In the focus group discussions in Dwease and Praso, most women stressed that they visit the Konongo Hospital because of the adequate availability of health personnel, equipment, medicines and laboratory centre among others unlike those in Dwease and Praso. When they visit the health facilities at Dwease and Praso and there is the need for laboratory test, they still have to go to the Konongo-Odumase Hospital for the test because Dwease and Praso health centres lack the facility. In order to avoid delay and high transportation cost, they go directly to the Konongo-Odumase Hospital. Another key informant (MHD) emphasized that in 2013, the expected number of pregnant women to attend ANC at Konongo Hospital was 1842. However, 2040 pregnant women attended antenatal care ANC. On the contrary, 384 pregnant women were expected to attend ANC at Dwease and Praso, however, 301 women showed up.

This implies that most pregnant women prefer attending ANC at Konongo-Odumase Hospital, the municipal capital to the Dwease and Praso health facilities. This may also contribute to the pressure on Konongo-Odumase Hospital which will eventually delay the provision of health services to pregnant women. This according to a key informant is one of the reasons that pregnant women who visit the Konongo-Odumase Hospital are not likely to receive immediate medical attention due to the pressure on the health personnel, facility and equipment.

5.5.2 Community-based Health Planning and Services (CHPS)

CHPS compounds were strategically implemented by the Ministry of Health as part of its national programme to close the gap that exist in health care access. The ministry identifies

CHPS through the GPRS as a key element in pro-poor health services. CHPS were therefore implemented to enable the GHS to diminish health inequalities and promote equity of health outcomes through the removal of geographic barriers to health care (School of Public Health 2009). According to (Salel 2012), there has been an increase in capital investment, however, such investment is not based on need or equity-based principles. Whilst there is an increase in the construction of hospitals recently, such investment has not been pushed towards the construction of CHPS to ensure the equal accessibility of health service.

In the focus group interview at Dwease, women emphasised that the lack of CHPS in Boatengkrom, Anawuokrom, Adumkrom, Kramokrom and other deprived areas in AACM has contributed to the less significant effort towards improving maternal health. Pregnant women are not able to utilize health care at their doorsteps due to the lack of CHPS in the rural areas. They are not also able to detect pregnancy related complications since they hardly access health care and the dalliance in detecting such complications mostly result to the loss of life. The CHPS compounds according to a key informant (health personnel), tend to be located in the remote and deprived communities where accessibility to health facility is difficult. This is intended to reduce maternal mortality and give the residents in the remote areas access to health care.

However, it was observed through the visit to Kramokrom, Adumkrom and Boatengkrom among others that the municipality has not been able to implement comprehensively the chips concept which implies they are still beyond achieving the desired goals of constructing CHPS compounds in the remote areas. According to a key informant (a member of MDPC), there is only one CHPS compound in AACM because the government is not providing the resources for these CHPS and the municipality is not having enough funds to construct them in the remote areas. It was further emphasised that the CHNs who have been trained and motivated to stay within the deprived communities and provide health services to the pregnant women through the CHPS compounds rather stay in the urban centres and visit the deprived communities once a while. This is due to poor supervision of health personnel as well as the confidence entrusted in them in the provision of their service.

This situation could negatively affect the health of the pregnant women in the rural communities since there are no CHPS compounds and community health personnel are not always available to monitor their health conditions. With reference to cases one (1) and seven (7), it was found that the lack of CHPS compounds both at Kramokrom and Agyareago to

provide first aid for pregnant women before conveying them to the bigger facilities led to the death and still birth of the pregnant women in Kramokrom and Agyareago respectively.

5.6 Efficient allocation of resources at AACM to help improve maternal health

According to (Thaddeus & Maine 1994) in their three delays model, factors affecting reaching an adequate health care facility include the distribution of facilities, the travel time from residing area to facility, availability and cost of transportation and condition of roads. The distribution of resources both at the urban and rural areas play a significant role in improving maternal health in AACM. Resources including hospital ambulances, equipment, medications at the health centres and roads linking the various health centres are all geared towards improving maternal health in AACM and meeting the goals of MDG 5 by 2015.

5.6.1 Hospital ambulances at the health facilities

The Ministry of Health has increased access to emergency health care services by providing transport through the establishment of the NAS. The NAS has been mandated to prevent delays in accessing emergency health care by transporting women with obstetric emergencies to the health facilities and providing pre hospital care for the sick and the injured. NAS also aimed at providing efficient and timely pre hospital care services to improve the outcome of accidents and emergencies. This has led to the distribution of a number of ambulances to provide emergency services linking various communities within the sub-districts, districts, municipality and the metropolitan (Ministry of Health 2008).

Despite the increased number of ambulance to aid the provision of health services, a key informant, a member of MDPC explained that AACM has only one ambulance working in the entire municipality which is always situated at the municipal assembly. Even though the ambulance service at AACM is working, its impacts have been very minimal due to the inadequate number of ambulances in the municipality. Another key informant (MHD) stated that AACM is encountering problem in their referral services because all the health facilities especially those in the rural communities do not have quick ambulance services. When there are referral issues in those facilities, they have to call the ambulance all the way from the municipal capital before transporting the patient to the required health facility. The delay in the referral system leads to complications which may result in maternal mortality. The delay in transporting patients to the other health facilities led to the death of a pregnant woman in the municipality.

This means that residents in the municipal capital get quick access to the ambulance service than residents in the remote communities which also contributes to the wide gap existing between urban and rural in access to health care. Case six (6) illustrates that the pregnant woman who was rushed to the Praso health facility could not get access to the municipal ambulance to convey her to the Konongo- Odumase Hospital because the ambulance was providing similar service to another client at a different area within municipality. However, the position of the husband as an assemblyman saved the woman's life when the husband got the assembly's vehicle to transport the wife to the Konongo-Odumase Hospital.

5.6.2 Access to good roads linking the various communities

The availability of good roads go a long way to improve maternal health in AACM. In the field, four (4) main types of roads were identified in the municipality: first class road, second class road, third class road and fourth class road. The first class road as the name implies remains the best form of road linking the two major cities: Kumasi-Accra. The second class road links Konongo to Agogo which are the two capitals of AACM and AANDA respectively. The third class road links Dwease and Praso where the other two health facilities are located and the fourth class road links the various remote areas (Asante Akim Central Municipal Assembly 2014). It was observed through my visits to the areas within AACM that whereas the first and second class roads are better constructed because they link the major cities and towns, the third and fourth class roads are poorly constructed and are mostly untarred.

A key informant (pregnant woman) emphasised that the assembly has placed less priority on the roads linking the various remote communities. Poor roads in the remote areas make transportation very difficult when accessing skilled care. In the focus group discussions in the villages, women stressed that they mostly encounter transportation problems when seeking health care services. The bad conditions of the roads deter most drivers of commercial vehicles from coming to the deprived and remote areas where they reside. The bad road surfaces also hamper the effective running of the ambulance service in the municipality since the drivers have to slow down especially when driving on such roads during emergencies. Another key informant (health personnel) indicated that access to transportation in Boatengkrom and other remote areas is very difficult especially if it rains. Pregnant women have to wait till every Tuesday, the market day at Konongo before they get access to vehicles to convey them.

This means that the poor road network according to respondents is also a major contributing factor to the slow improvement of maternal health in AACM. The poor road surfaces make it very difficult for pregnant women in the remote areas to seek skilled care as compared to pregnant women in the urban centres. With reference to case one (1), it was found that the pregnant woman from Kramokrom lost her life because the taxi that picked her up to the Konongo-Odumase Hospital delayed on the way before reaching the facility due to the bad road conditions. According to (Thaddeus & Maine 1994) in their three delays models, factors affecting reaching an adequate health care facility include the distribution of facilities, the travel time from residing area to facility, availability and cost of transportation and condition of roads.

5.6.3 Access to equipment at the health facilities

It has been noted that availability and access to health equipment at AACM plays a major role in the effort towards improving maternal health. Even though individuals, NGOs and religious groups among others sometimes donate health equipment to the health centres, the government has been the major provider of health equipment in AACM. However, AACM lacks essential equipment needed in the provision of health care service (MamaYe 2014a).

5.6.3.1 Konongo- Odumase Hospital

Konongo-Odumase Hospital according to respondents is expected to possess most of the essential equipment needed in the provision of health care services because it is the municipal hospital situated at the municipal capital. A key informant emphasised that the Konongo-Odumase Hospital lacks sterilizer and waiting seats for pregnant women. This was confirmed in the MamaYe[13] Scorecard Round 1 Results. It was found that the facility does not have sterilizer, incubator for newborn, autoclave and adult ventilation bag and mask. Moreover, it does not have enough waiting seats for maternity and ANC clients (MamaYe 2014a).

The lack of sterilizer in the facility can contribute to the spread of communicable diseases including HIV/AIDS which is also indirect causes of maternal deaths. Moreover, the inadequate waiting seats for pregnant women at the hospital could affect their health since they have to stressfully linger around for longer periods waiting to be attended to. The study found that the Konongo- Odumase Hospital lacks some basic essential equipment needed in the provision of health services.

[13] MamaYe is an NGO into health that is helping improve maternal health in Ghana and other African countries in order to meet the goals of the MDGs by 2015. It conducted a survey on facility infrastructure and equipment assessment in many districts in Ghana including AACM.

5.6.3.2 Dwease and Praso health facilities

A key informant (health personnel) stated that the Dwease health facility which serves five different communities does not have an office telephone to make calls during emergencies and there is no adequate source of light in the maternity ward at the Praso health facility. In the focus group discussions in the villages, women stressed that the government's priority has been helping improve the health of pregnant women in the urban centres by equipping the urban hospitals at the expense of that of the rural. The government priority of equipping the urban hospitals at the expense of the rural according to the respondents has been one of the reasons for the continuous widening of the urban-rural gap existing with regard to the accessibility of equipment. The Dwease and Praso facilities lack clinical thermometer, regular stethoscope, autoclave, blood pressure meter, functional delivery table, lamp for surgery, manual vacuum and oxygen cylinder among others. Moreover, both facilities lack waiting seats for ANC and maternity clients (MamaYe 2014a).

It was found that both Dwease and Praso health facilities lack many equipment than Konongo Hospital. In this case, pregnant women visiting the Konongo Hospital may receive adequate health care services due to the availability of most of the essential equipment as compared to the pregnant women at both Dwease and Praso communities. It was discovered in case five (5) that the unavailability of office telephone at the Dwease health centre contributed to the death of a twenty-five (25) year old woman who was rushed in from Nyamebekyere. They delayed in reaching the Praso health centre for assistance with respect to the medicine to treat the woman.

5.6.4 Medication

It was found that the facilities receive medicines from the medical stores through the NHIS. A key informant (health personnel) revealed that the health facilities do not get access to medicines from the medical store because the health insurance is not paying and they do not have internally generated funds to purchase the medicines. They lacked oxytocin and magnesium sulphate which should be found in every health facility. In the focus group discussions in the villages, pregnant women stressed that most of the medicines are not available at the health facilities so they have to buy them from the pharmacies and other chemical shops. Since most of the pregnant women are not engaged in any income generation activities, they do not have the cash to buy those medicines.

It was observed at the health facilities that the absence of medication at the rural health facilities hindered the health personnel from treating and preventing complications that arose from the pregnancy. With reference to case five, the unavailability of oxytocin and magnesium sulphate at the Dwease and Praso health centres resulted in the death of the twenty-five (25) year old pregnant woman from Nyamebekyere who suffered from severe bleeding which was a direct cause of maternal mortality.

The evidence above clearly shows that the various structures which include policies, staff and facilities as well as resources that are put in place to help improve maternal health in AACM are lower than the goals that have been set. There is less significant improvement in maternal health in the municipality.

CHAPTER SIX

6.1 Conclusion and recommendations

The continuous death of pregnant women across the globe has received attention at the global, national and the local levels over decades. Various international organizations, governments and local organizations are putting much effort to help address maternal mortality. In the year 2000, members of UN including Ghana adopted eight (8) MDGs to enhance the overall development of people. The goal for the fifth MDG which is improving maternal health is to reduce maternal mortality ratio by 75% and universal access to reproductive health services both by 2015.

Policy makers and stakeholders in Ghana have introduced various policy interventions to reduce maternal mortality. These interventions include the NHIS, Safe Motherhood Initiative, MPS and PMMP. Others include the introduction of free maternal health care and free delivery, implementation of NAS to transport women with obstetric emergencies to health facilities and implementation of the CHPS. Despite the many programs and initiatives, the implementation of these interventions and policies have made less significant impact in improving maternal health in the country than anticipated.

In Ghana, some key MDG targets such as poverty eradication and food security, education and access to safe water have made significant progress, however, the overall pace of progress in maternal health is not encouraging and may likely not meet the MDG 5. Maternal mortality is prevalent in Ghana because every woman in Ghana has a 1 in 68 lifetime risk of dying from maternal causes and effort for improving maternal health has not been very successful. It has been noted that several developing countries including Maldives, Bhutan, Cambodia, Romania, Lao People's Democratic Republic, Equatorial Guinea, Timor-Leste, Cape Verde Eritrea, Nepal and Rwanda have made significant improvement in maternal health and are therefore considered as "on track", however, Ghana is still far from reaching the goals of the fifth MDG.

The objective of the study was to explore the reasons that account for the slow improvement of maternal health in AACM in Ghana towards achieving the goal of MDG 5. As a result, the study is to answer the following questions: How do women approach maternal health in AACM? What available education is there for pregnant women and how do they respond to the education? What are the outcomes? How is the government putting structures to improve

maternal health? In what way does the AACM create an enabling environment to address the issue of maternal mortality? Are the introduced policies and practices effective?

The study employed qualitative research approach with a case study design, conducted in AACM. A purposive sample technique was used which involved 56 participants in both key informant interviews and focus group discussions. The key informants included the pregnant women, MDPC, the MHD, a worker of ABAK, the PA and midwife, a representative from MAMAYE, Ghana as well as four additional health personnel. Moreover, focus group discussions were conducted for twenty-eight (28) pregnant women.Secondary data included research conducted, policy documents and articles related to the research interest area.

The gender and power theory by Connell (1987) and the gender of power by Davis et al. (1991) formed the basis of this study. Moreover, the three delays model by Thaddeus and Maine (1994) was also a supporting information used. These were applied to explain the government's structures (policies and institutions) and pregnant women's health issues and other social and economic exposures causing the high prevalence of maternal mortality in AACM. There were key concepts which were relevant to the study and these included maternal mortality, maternal morbidity, maternal mortality ratio, obstructed labour, gender, power and patriarchy. The theory and concepts were used to further explain the direct and indirect causes of maternal mortality in the study.

In relation to how women approach maternal health in AACM, it was found that most pregnant women residing in the rural areas of AACM have difficulty in accessing skilled health care. These women have limited access to health facilities based on financial constraints, distance and poor roads. Again, pregnant women with no or low education fail to attend ANC after conception and therefore use the services of TBAs. Others also attend late ANC clinic after several months of pregnancy. Moreover, most pregnant women in the rural areas of AACM mostly deliver at home with the help of TBAs and sometimes their husbands. It was found that some husbands in the rural areas fail to take their wives and their newborns to the hospital for treatment except when the women feel some pains or discover some physical abnormalities. Besides that, some cultural beliefs and practices restrict women from delivering at health facilities because some families rely on TBAs, herbs and even spiritual ways of assisting pregnant women to deliver and most women who deliver at homes feel reluctant to visit health centres afterwards because they may receive verbal abuse for not attending ANC earlier or immediately after delivery.

In addition, it was discovered that, AACM provides health education for all pregnant women through health personnel and NGOs. They educate the pregnant women during prenatal and postnatal periods. They also provide pregnant women with health talks on every visit which is done twice a week and the health personnel sometimes go on visits to educate the pregnant women on the need to seek early medical care especially in areas with CHPS compounds. However, most women show apathy towards health programmes in the municipality. Only few pregnant women show up for health programmes organized by the municipality which does not help to achieve the desired impact. It is only when pregnant women visit the health facility for ANC that most of the education on reproductive health are given. However, it was found that most pregnant women do not show up for ANC in order to receive education about their health and the lack of CHPS compounds in the rural areas hinder health personnel from going on visits to provide ANC and education.

In relation to the outcomes, the study found that most pregnant women in the rural areas of AACM lack knowledge concerning how to detect pregnancy related complications during prenatal and postnatal periods. The women delay in reporting pregnancy related complications because they do not access ANC which will provide them with education on their health. Moreover, most of the pregnant women in the rural areas at the point of delivery rely on traditional birth attendants TBAs and after delivery, some bleed excessively which becomes a medical emergency before they are conveyed to the health facilities and some of these cases eventually lead to death.

It was found that the government is putting structures to improve maternal health through the implementation of the Ghana National Health Insurance Scheme. However, the NHIS is not functioning as expected to achieve the desired goals in AACM. There are limited funds to reimburse the scheme and most medicines covered in the scheme package are not available at the health facilities so pregnant women have to buy them when they visit the health facilities with NHIS cards. Moreover, the health insurance is not being utilized due the long process of obtaining cards from the appropriate authority. There has been inequity in the utilization of the NHIS because most of the targeted group which is the vulnerable are not enrolled. It was found that most of the non-poor pregnant women residing in the urban part of the municipality with high education and high income have dominated the NHIS and were making use of the skilled care services whereas most of the poor pregnant women residing in the rural areas with no or basic education and low income were not enrolled and accessing the available skilled care services.

It was also found that the priority of AACM for improving the health of the people in their medium term plan has been towards fighting malaria and HIV at the expense of improving maternal health. The municipality is not able to single out and create a specified budget for maternal health in the composite budget due to limited resources. There is inadequate number of midwives especially in the rural areas of AACM and some health personnel also refuse postings to the rural areas of the municipality. Moreover, the Konongo- Odumase Hospital has been equipped both in infrastructure and health personnel better than the health centres in Dwease and Praso in the provision of health care services and there is lack of CHPS compounds in the deprived areas to give the residents access to health care.

In line with theways AACM creates an enabling environment to address the issue of maternal mortality, it was found that the municipality has only one ambulance working in the entire area which is always located at the municipal capital. The residents in the capital get quick access to the ambulance service than those in the remote communities and poor roads in the remote areas make transportation very difficult when accessing skilled care. The health facilities in AACM including Konongo- Odumase Hospital, Dwease and Praso health centres lack essential equipment and medication needed in the provision of health care services.

Lastly, the policies and practices introduced to improve maternal health are not functioning well. For instance, the NHIS is not functioning as expected to achieve the desired goals due to challenges in the implementation processes and limited funds for reimbursing the scheme. There is also an existing urban-rural gap in the utilization of the NHIS which is not helping to improve maternal health in the rural areas. Furthermore, inadequate number of midwives in AACM delays pregnant women's access to health care and changing the posting of health personnel from rural areas to urban centres hinders the progress of maternal health in the municipality. Besides that, lack of adequate funds to construct CHPS compounds in many deprived areas is contributing to the increasing gap existing between the urban and the rural areas in relation to accessing health facility. In addition, AACM encounters problems in its referral system due to the availability of only one ambulance in the municipality. The lack of ambulances in the rural health facilities is also contributing to the slow improvement of maternal health in AACM. The findings are revealing that there is the need for the government to join effort with other agencies to improve maternal health.

6.2 Recommendations

In relation to financial constraints, distance and poor roads, the Ghana financial sector which includes banks and money lenders should extend their services to the rural poor through microfinance to enable the poor have access to productive resources which financial service is a key resource for the rural poor women to improve their conditions of life. This will help reduce the financial burden and enable women to attend ANC regularly when pregnant. In addition, the local government should concentrate in the improvement of the rural road network to allow easy accessibility and connection to health centres.

The pregnant women especially those in the rural areas should be encouraged by health personnel and NGOs in AACM to attend regular ANC right after conception. This will enable them to receive education on their reproductive health to be able to detect and treat pregnancy related complications. Some men were observed to be obstacles with regard to encouraging their wives to attend ANC regularly. As a result, men who are the heads of the family and have the power to decide when women seek health care should be educated and encouraged to support their wives with the needed resources to seek regular skilled health care right after conception and also to deliver at the health facilities.

Moreover, the reimbursement of funds into the NHIS by the government should be faster to enable medical administrators to plan in advance by purchasing medicines, equipment and improve infrastructure to absorb the clients including the pregnant women. In addition, the municipality should concentrate on women's needs rather than concentrating only on fighting malaria and HIV AIDS which are assumed to be the deadly diseases. Besides that, the MHD should ensure that the health facilities in AACM have the needed health personnel, equipment and medication in the provision of health services to the residents by requesting from the national level. Furthermore, the local government should ensure the construction of CHPS compounds in most of the deprived areas to ensure easy accessibility of health care in the rural areas. This will help reduce the existing urban rural gap in access to health facility. The local government should provide incentives which include accommodation for health personnel who are posted to the municipality to motivate them to stay.

The study used qualitative approaches to obtain the information which involved small sample size of respondents and in depth information. As a result, it is difficult to generalize. I recommend future researchers to consider quantitative approaches to be able to give a meaningful generalization to issues related to maternal mortality in the study area.

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APPENDIX I: INTERVIEW GUIDE

INTERVIEW GUIDE FOR THE MUNICIPAL HEALTH DIRECTORATE, THE MUNICIPAL DEVELOPMENT PLANNING COORDINATOR (MDPC), THE PHYSICIAN ASSISTANT, WORKER OF ABAK FOUNDATION AND THE REPRESENTATIVE OF MAMAYE IN ASANTE AKIM CENTRAL MUNICIPALITY (AACM).

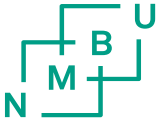
1. Why is maternal mortality prevalence in AACM despite the progress made towards attaining MDG 5 by 2015?
2. To what extent has government focused of maternal health in the municipality?
3. What structures are available to improve maternal health in AACM?
4. In what ways is the National Health Insurance Scheme (NHIS) working to improve maternal health in AACM?
5. What facilities are available in AACM?
6. What facilities is AACM lacking?
7. Are the health facilities provided with enough medications?
8. Does AACM have enough health equipment to provide health services?
9. What equipment is AACM lacking in the various health facilities?
10. How is AACM responding to the services of traditional birth attendance (TBAs)?
11. Are there strategic plans in AACM to improve maternal health?
12. To what extent are these strategies put in place effective for improving maternal health in AACMA?
13. Are there adequate number of health personnel and skilled birth attendants (SBAs) working to improve maternal health in AACM?
14. Are there efficient allocation of resources in AACM to improve maternal health?
15. How is budget allocated to help improve maternal health?
16. What are the main causes of maternal mortality in AACM?
17. Are there enough CHPS compounds in AACM?
18. In what ways are the CHPS compounds working to improve maternal health in AACM?
19. What are the conditions of roads linking the various communities within AACM?
20. How is the ambulance service operating at AACM?
21. In your personal opinion, what can be done to improve maternal health in AACM?

INTERVIEW GUIDE FOR HEALTH PERSONNEL AND MIDWIVES IN AACM

1. What are the attitudes of health personnel towards pregnant women in ACCM?
2. Are there enough education for pregnant women in AACM?
3. How often are pregnant women educated on their health?
4. How effective are such education?
5. Is such education provided only by the government through the health personnel?
6. How do the communities respond to health education?
7. Why the high rate of maternal mortality in rural areas compared to the urban centres within AACM?
8. Does AACM have enough health personnel in the remote areas?
9. To what extent are health personnel helping to improve maternal health in AACM?
10. How are health personnel collaborating with municipal health director and other officials to improve maternal health in AACM?
11. In your own personal view, what can be done to improve maternal health in AACM?

INTERVIEW GUIDE FOR PREGNANT WOMEN IN AACM

1. How often do pregnant women access the health facilities in ACCM?
2. What hinders women from accessing quality health care in AACM?
3. How often do pregnant women attend ANC and postnatal care?
4. How often do they follow instructions from ANC clinic?
5. What are the attitudes of pregnant women towards health personnel?
6. What practices affect pregnant women's response to accessing health care?
7. Does the status of pregnant women affect their response to maternal health issues?
8. How do they respond to such education?
9. To what extent do pregnant women practise what they are being taught?
10. What traditional practices do pregnant women engage themselves in?
11. To what extent do pregnant women make use of the services provided by the traditional birth attendants (TBAs)?
12. Why do pregnant women engage themselves in traditional practices?
13. In your own personal view, what can be done to improve maternal health in AACM?



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