



Female Health and Development

A case study regarding a maternal Health Scheme in Ghana

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Supervisor

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This Master's Thesis is carried out as a part of the education at the University of Agder and is therefore approved as a part of this education. However, this does not imply that the University answers for the methods that are used or the conclusions that are drawn.

University of Agder, [2010]

Faculty of [Economics and Social Science]

Department of [Development Studies]

Abstract

A study of female health and development regarding maternal health scheme was carried out in Kumasi, Ghana from 2009 to 2010. The study conducted at Komfo Anokye Teaching Hospital (KATH) in Kumasi, Bantama revealed an unstable situation regarding maternal deaths even though pregnant women have free access to antenatal care. The study aimed at finding out whether the free antenatal and delivery care provided by the Ghanaian government is encouraging pregnant women to access the facility in order to improve maternal health and also, whether it is aiding in the reduction in maternal deaths.

A total of three health personnel's and fifty-five pregnant women participated in the study. Some of the pregnant women are residents of Bantama while others have been referred from nearby towns. Semi structured interviews and observation were the main tools employed for data collection.

The MDGs if attained as anticipated would make the world a better place. Women and children who happen to be the most vulnerable too would be relieved of various diseases. As part of the MDGs, Maternal deaths and child mortality are also considered. Out of the eight MDGs, the goal 5 and 4 happens to be those that may not meet the anticipated dead line. Sub-Saharan Africa seems to be greatly affected as compared to developed countries.

Even though, countries are working hard to reduce the maternal mortality rate and infant mortality rate by 2014, most countries in sub-Saharan Africa including Ghana are presently behind and needs to accelerate in order to reach the set target. Maternal deaths occur as a result of numerous complications which are claiming the lives of many pregnant women and those who go into labour. Although efforts are made to reduce maternal mortality, the present situation calls for more attention. The curbing of maternal deaths depends on several factors. A few are availability of health personnel, cost, good hospitals and health care centers, accessibility to these facilities and education. Can maternal deaths be reduced by 75% by the year 2014? The reduction in maternal deaths serves as a positive influence on the attainment of the MDG 5 and 4 which are to improve maternal health and to reduce child mortality respectively. The study indicated that the presence of skilled birth attendants at delivery as per pregnant woman ratio is quite poor. The ratio is one doctor is to 17,733; 839 and the Nurse-Population ratio is 1: 1,510 with disparities between urban and rural settings and dwellers. In Kumasi for instance, the Ratio of Midwives to Women of Reproductive Age is 1:427. Other factors affecting maternal mortality rate are the Contraceptive prevalence rate and accessibility to health facility.

Dedication

This work is dedicated to my loving husband and dear children. May the favour of the Lord rest with you always

ACKNOWLEDEMENT

Words are not enough to express my gratitude to the highest God for his bountiful mercies and grace throughout my studies. I am deeply grateful to my supervisor, Sven Åke Bjørke for his exceptional support, advice, suggestions guidance, and encouragement. Professor Arne Olav Øyhus and all the other professors, Jeanett Wilberg Schibbye, my coordinator and co-coordinators from member universities, lecturers, tutors and the entire staff deserve appreciation for their support in divers ways. I acknowledge Professor Maung Kyaw Sein and Jannik Timenes too for their support in the course of my studies.

Special thanks to Abdul-Basit Tampuli and Jones Opoku Ware my course mates from Ghana. My appreciation to all other course mates from, Tanzania, Ethiopia, Sri Lanka, Bolivia, Norway and Uganda especially, to my roommate Diana Nampijja (Uganda). To all those who were sources of inspiration and encouragement to me, I say a very big thank you.

I am indebted to my family, especially my dear husband, Dr. Dr. Samuel Aikins for his valuable contribution as well as selflessness and love throughout my study. It has not been easy but my children Samuel Aikins Jr., Kenneth Aikins and Lloyd Aikins have managed to cope. Indeed you deserve special thanks. All my siblings and their spouses are not left out, especially, Mrs. Jocelyn Boamah, Ebenezer Asante and Mrs. Perpetual Asare-Darkwah who sacrificed so much to take care of my kids whiles I was away for the face to face sections. My mum is so special and has always been there for me, Thank you mum!

My immense gratitude to all friends for their prayer support. Special thanks to Ms Grace Adjei, Ms. Mercy Opare-Adu, and Ms. Mercy Ofori for their assistance during my data collection. I would like to thank all the pregnant women I interviewed. Thanks also to KATH Research and Ethics department, the head and department of Obstetrics and Gynaecology KATH and staff of Consulting Room 8. Mr. William Gariba Akanwariwiak and Ms Anita Boateng of Theoretical and Applied Biology, College of Science, KNUST and my immediate head Mrs. Theodora Agate Nsiah KNUST. There are many whose names are not mentioned but deserve to be appreciated. To these, I say may the one who sees in secrete reward you openly. Once again my appreciations to all, God richly bless you!

Declaration

I hereby declare that the thesis

Female Health and Development:

A case study regarding a maternal Health Scheme in Ghana

Has not been submitted to any other universities than the University of Agder for any type of academic degree.



Lydia Aikins

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ABBREVIATIONS

CSW	Commercial Sex Workers
DMHIS	District Mutual Health Insurance Scheme
FCUBE	Free Compulsory Universal Basic Education
GES	Ghana Education Service
JHS	Junior High School
JSS	Junior Secondary School
KATH	Komfo Anokye Teaching Hospital
KNUST	Kwame Nkrumah University of Science and Technology
MMR	Maternal Mortality Ratio
MDG	Millennium Development Goals
NHIS	National Health Insurance Scheme
NABPTEX	National Board for professional and Technician Examination
TBAs	Traditional Birth Attendants
SHS	Senior High School
SSS	Senior Secondary School
OPD	Out Patients Department
STI	Sexually Transmitted Diseases
SMS	School of Medical Sciences
TB	Tuberculosis
TBAs	Traditional Birth Attendants

VCT

Voluntary Counseling Testing

WAEC

West African Examination Council

CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION

Women all over the world become prone to death once they become pregnant and enter child birth. However, the situation is more prevalent in developing countries as compared to developed countries.

Although pregnant women worldwide are losing their lives, unborn or newly born babies at a rate which is quite alarming, those in sub-Saharan African are comparatively at a greater risk. The high maternal mortality rate in Africa could be attributed to the quality of health care services that is provided among others. The present situation calls for attention in order to assist third world countries to minimize the death tow and protect both mothers and babies.

According to WHO (2005), the estimated deaths per pregnant women or complications resulting from childbirth is 1,500 each day. In the same year, 536 000 maternal deaths were estimated worldwide. However, it was developing countries that saw the occurrence of most of these deaths partly because the number of pregnancies in women from developing countries is more as compared to that of developed countries. Whiles 450 maternal deaths per 100,000 live births occur in developing countries, a relatively low number of 9 maternal deaths per 100,000 live births occur in developed countries. For instance, the risk of losing one's life through pregnancy in advance countries is 1: 7,300 as against 1: 75 in developing countries.

Death related to pregnancy may be due to a number of factors and complications during pregnancy labour and post labour period. Complications arising from severe bleeding, infections, poor health during conception as well as obstructed labour may result in the death of a pregnant woman. These conditions are known to be the major killers and account for about 80% of maternal deaths. Some of the commonly known diseases and illnesses that result in the death of pregnant women include malaria, hypertension, anemia and HIV. Women who go through unsafe abortion also stand the risk of dying due to the complications associated with it.

Since complications are not predictable but avoidable, it is advisable for pregnant women to seek

help during pregnancy. Most mothers can be saved if they seek health care from professionals since there is the existence of preventive measures to various conditions. Conditions that cannot be prevented however can be managed. It is also, of immense importance that women are able to access family planning and safe abortion to reduce pregnancies that are not wanted and abortions that are not safe.



Figure 1.1: A section of pregnant women waiting to be attended to in a hospital

Ghana is a West African country located in between Côte d'Ivoire and Togo. Ghana's population is above 20 million with an annual population growth rate higher than the global rate. Ghana is one of the countries that have experienced a relatively high rate of maternal deaths as a result of many factors of which poor antenatal care is paramount. Population growth, early marriages, teenage pregnancies and poverty are some of the factors that have contributed to the increase in maternal deaths. Pregnant women in Ghana stand a higher risk of dying as compared to pregnant women in developed countries.

Ghana also lack important resources like good water, electricity as well as the needed clean environment (sanitation) in many villages. Stabilisation procedures are therefore needed to improve the standard of health services in Ghana in order to curb the death toll of pregnant women. Like other African countries many pregnancies take place in remote villages. Existing barriers that are socially and culturally oriented, does not make room for pregnant women to get the proper health care they need and families as well as communities are not able to support with adequate assistance (Hill, 2009).

Sierra Leone is one of the countries with high mortality rate. For instance, one woman out of seven loses her life as compared to one out of 10,000 in the UK. Complications in pregnancy and child birth easily lead to the death of expectant mothers if there is delay in addressing it. Most of the pregnant women in Sierra Leone give birth at home due to many factors including the costly nature of hospital bills. Traditional birth attendants (TBAs) are those who usually save the situation by offering services in the traditional way (The Kambia Appeal, 2005).

Most TBAs assist in deliveries for free. Those who are remitted usually get it in kind. In Ghana, TBAs can be found in the rural areas. They assist pregnant women who do not have access to health centers or have to travel long distances. Prior to the introduction of the free maternal health care in Ghana, the cost of antenatal care as well as delivery was a matter of concern too especially for the poor rural folks who are mostly engaged in subsistence farming. TBAs in Ghana like other West African countries are mostly old illiterates who attend to pregnant women in their own houses. Sometimes, TBAs have a room designated for deliveries in their homes too. They make use of herbs in the course of delivery processes amidst incantations. This is in contrast with the application of orthodox medicine, sophisticated machines and other medical equipment used in the hospital for delivery purposes.

In Ghana, most women in sub-Saharan Africa are characterized with high fertility. This makes them prone to death with every pregnancy. To help reduce possible deaths, and most importantly to contribute toward achieving the millennium development goal 4 which concerns the improvement of maternal health, the government of Ghana on the 1st day of July, 2008 introduced free medical care policy for all pregnant women to enable them enjoy medical attention during ante-natal, delivery and post delivery. This medical care for pregnant women was provided under the Country's National Health Insurance scheme (NHIS) which makes it possible for pregnant women to enjoy free medical care during pregnancy until three months after delivery (Public Agenda, 2008). The NHIS came into being under Act 650 of 2003 by the Ghanaian government to make available to all residence of Ghana basic health care services, (NHIS, 2009)

This work will look at increased patronage of pregnant women on antenatal facilities as a result of free antenatal and delivery care instituted by the government of Ghana through the National

Health Insurance Scheme (NHIS) in support of the fifth Millennium Development Goal (MDG 5) to help reduce maternal deaths.

1.2 STATEMENT OF THE PROBLEM

The growth in Ghana's population coupled with recent rise in various diseases puts a lot of pressure on available medical facilities. Since the growth rate is also geared towards females, the implementation of policies like the NHIS would increase the pressure on the hospital as more women marry and teenage pregnancy rise.

1.3 PURPOSE OF THE STUDY

This topic was selected to find out whether the free antenatal and delivery care provided by the government is encouraging pregnant women to access the facility and secondly whether it is aiding the reduction in maternal deaths. Data for this research would be collected through interviews as well as observation at the sampling sites including Komfo Anokye Teaching Hospital and surrounding communities.

1.4 RESEARCH OBJECTIVE AND RESEARCH QUESTIONS

1.4.1 RESEARCH OBJECTIVE

To find out to what extent the free Antenatal and Delivery care scheme has improved the life of pregnant women and its contribution to the achievement of the MDG 5 and 4. The MDG 5 aims at improving maternal health while MDG 4 deals with the reduction of child mortality.

1.4.2 RESEARCH QUESTIONS

- How has the free antenatal health affected maternal deaths and infant mortality rates?
- How has the free Antenatal and delivery care affected medical personnel and health facilities at the Komfo Anokye Teaching hospital? (Is there any pressure on health personnel and facilities; is existing infrastructure adequate for expectant women)?
- Who makes use of the free maternal health care in the Bantama area? (Is it the poor or the rich, literates or illiterates?)

- What is the economic impact of the health policy on the pregnant women in the Bantama locality? (How has the free antenatal care affected the living conditions of the pregnant women of Bantama)?
- What is the rate of accessibility with the introduction of the free Antenatal and Delivery care?

1.5 LIMITATIONS OF THE STUDY

A few of the challenges I encountered includes the willingness of respondents to answer interview questions. Most of the pregnant women were reluctant and would prefer staying away instead of participating. They appeared to be mostly tired and uncomfortable in the state and condition in which I met them. Also, there was tight bureaucracy involved in the process of getting permission to collect data from KATH. The research and ethics department of KATH took me through an extensive and hectic procedure before granting permit for me to gather information. This situation caused frustration and delliance. Financial and time constraints cannot be left unmentioned.

1.6 ORGANISATION OF THE STUDY

Chapter one of this work gives the introduction and thus the background of the thesis. Among others, it has also given the research objective and stated research questions. The remaining work is outlined in the following way: The second chapter gives a presentation of the study area, , chapter three is based on the review of literature, chapter four focuses on the methodology of this study, findings are presented and analysed in the fifth chapter and chapter six concludes the research.

CHAPTER TWO: GHANA'S PROFILE

2.1 HISTORY OF GHANA

Ghana was formally known as Gold Coast. It was a British colony until the 6th of March, 1957 when independence was gained through the brave sons of the land like Dr. Kwame Nkrumah. During the colonial era, the capital was Cape Coast in the central region of Ghana. The Portuguese were Ghana's first colonial masters. They engaged in trading activities at the Elmina Castle. The Portuguese, English, Danes, Dutch and Germans monitored events until the British took over in 1821. Ghana has since experienced coup de tarts which resulted in political instability (Bureau of African Affairs, 2010). But now it is widely recognised as one of the peaceful countries with a stable democratic rule.

2.2 GEOGRAPHY AND TOPOGRAPHY OF GHANA

Ghana is a West African country who first attained independence among those in sub-Saharan Africa. The country is surrounded by francophone countries like Burkina Faso located to the northern part. Cote D'Ivoire can be found to the western part and Togo lies on the eastern part. Ghana also shares boundaries with Gulf of Guinea to the south. Ghana's land coverage is 239,540 square kilometers with water coverage of 8,520 square kilometers (Mukungu, 2010).



Figure 2.1: Map showing Ghana and neighboring countries

Ghana's highest point is 883 meters. The country's 152 kilometer coastline is characterised by a low sandy shore. The land is blessed with many rivers, streams and lakes and the Volta Lake is the biggest man-made lake in Ghana and in the world (Bureau of African Affairs, 2010).

Ghanaian's have over the years benefited from the electricity that the lake generates and the inland transportation that it offers among others. It is generally hot and humid in most parts of the country. Ghana is a tropical country with two main seasons which are the wet and dry. The southern part of the country experiences much rain in May, June and July and also August to September. Ghana also experiences the Harmattan which is a dry northeasterly wind which blows between December and February (Bureau of African Affairs, 2010). The colours of the Ghanaian flag below are of great significance. The red signifies the blood of our ancestors (leaders) shed in their fight for independence. The yellow represents Ghana's mineral wealth and rich resources. In fact the yellow is referred to as gold instead, because of Ghana's minerals like gold and diamond among others. The green stands for the rich agricultural wealth thus Ghana's vegetation. In the middle of the flag is a black star identifying Ghanaians as Africans and importantly the hope of Africa.



Figure 2.2: The Flag of Ghana

2.3 THE PEOPLE OF GHANA

The nation is divided into ten regions with Accra as her capital found in the Greater Accra region. The other regions are Northern, Upper West, Upper East, Volta, Ashanti, Western, Eastern, Central and Brong-Ahafo. Ghanaians are made up of different ethnic groups and the various tribes have their own unique languages. Akan is the most widely spoken language. However, the official language is English.

2.4 THE GHANAIAN ECONOMY

Ghana is an agriculturally predominated economy. Cocoa, gold and lumber are some of the country's exports. While food items, capital equipment and petroleum products make up the countries import (Mukungu, 2010). The discovery of oil three years ago has attracted numerous investors. About 11.1 million people constitute the workforce. Agricultural and fishing are made up of 47.9%; industry and transport constitute 16.2%; sales and clerical form 19.3%; services take 5.9%; professional form 8.9% and other sectors form 8% (Bureau of African Affairs, 2010).

2.5 EDUCATION

The implementation of the Free Compulsory and Universal Basic Education (FCUBE) policy compels every child to have nine years of education. The Ghana Education Service (GES), National Board for Professional and Technician Examinations (NABPTEX) and The West

African Examinations Council (WAEC) are all units of the Ministry of Education (Bureau of African Affairs, 2010). Ghana's educational system has undergone a lot of changes. Previously, there was the six years primary education, four years middle school leaving certificate and from there one could proceed to a training college or secondary school for five years. Those who successfully complete the five years secondary education may take two years sixth form course to enter university. This system of education became six years of primary education, three years of junior secondary education (JSS) and three years of senior secondary education (SSS).

Currently, with the new educational reform, children who attain age four begin their basic education from kindergarten. The SSS too has been increased to four years from three. The interesting aspect of Ghana's educational reform is characterised by the names given to it. Over the years political leaders have influenced the structure at the secondary level making it three years at a point and four years at another point. They have also used names like JSS for Junior Secondary School and JHS for Junior High School. Senior Secondary School (SSS) has given way to Senior High Secondary (SHS). Presently, a lot of private universities are competing with the three main government Universities in Accra, Kumasi and Cape Coast. Additionally, recent times have seen many private institutions including colleges springing up (Mukungu, 2010).

2.6 HEALTH

During the period of 1995 and 2001 the Health World Bank estimated life expectancy at birth to be 57 years. Infant mortality rate stood at 58 per 1,000 live births. The same period showed that children below age five who lacked enough healthy food amounted to 25 percent. Hospital beds were approximated to be 1.5 per 1,000 people (Ghana Web 1994). During the period, there were about six hospitals in Accra (the capital) which included Police Hospital, Korle-Bu Teaching Hospital, 37 Military Hospital, The Trust Hospital, Nyaho Medical Centre and The Lister Hospital. Ashanti Region could boast of Komfo Anokye Teaching Hospital, Radiant Medical and Dental Centre, University of science and Technology Hospital, Agogo Hospital and West End Hospital. For the other regions, Western Region had one, Central had five, Volta Region had four, Eastern Region three, Northern Region one, Brong Ahafo Region one and Upper West Region two (Ghana Web, 1994). Presently, numerous hospitals and clinics have sprung up nationwide including herbal centers.

2.7 THE ASHANTI REGION

The Ashanti Region is one of the famous regions in Ghana. It shares boundaries with Brong-Ahafo to the northern part, the Western region to the south west, Eastern and Central regions to the east and south respectively (Ghana Web, 2002). The region grows a lot of crops. Cocoa, oil palm, tobacco, cotton and cashew are some of the industrial crops grown there. Additionally, minerals like gold, bauxite, manganese and iron are in high deposits, hence the name “Resource Basket of Ghana”. The region also stands tall in chieftaincy affairs. The Asantehene is the head of the Asanteman Council to whom all the paramount chiefs owe allegiance to (Ghana Web, 2002).



Figure 2.3: Map of Ashanti Region showing Kumasi the capital

2.7.1 PROFILE OF KUMASI

Kumasi which is the capital of the Ashanti Region could be found at the central part of the nation. According to United Nations Population Division 2005, the population stood at 1,517,000. The city is made up of different ethnic groups of which the Ashanti's, are the majority. Lake Bosumtwi which is the largest natural lake in Ghana is in Kumasi (Ghana net, 2007).

In the 1980s the city was established by King Osei Tutu I. As afore mentioned, royalty and chieftaincy was of significance and still is today. Among the reasons why Kumasi is held in high esteem by the Ashanti's is the claim that Okomfo Anokye got the golden stool from the sky in that city (Ghana net, 2007).

Economically, Kumasi contributes immensely to the state with hardwood and cocoa as the

leading exports. One of Ghana's oldest brewery (Guinness Ghana Breweries) is also located there (KMA 2006) The Suame Magazine which is efficiently known for the building and repairs of vehicles in all sub-Sahara Africa cannot be left out (Ghana net, 2007). Comparatively, Kumasi experiences a relatively low temperature than Accra. It usually rains in Kumasi from March to July and also from September to November. The remaining months make up the dry season (KMA, 2006).

2.8 HEALTH CARE

The Kumasi metropolis falls under five main sub health metro. Among the lot are the Komfo Anokye Teaching Hospital, some quasi health institutions as well as hospitals and clinics owned by churches (KMA, 2006). The Kumasi area has one teaching hospital (Komfo Anokye Teaching Hospital, 736 beds), five public clinics and 57 private clinics. The health sector provides both public and clinical assistance. OPD, In-Patient and obstetrics and gynecology are a few of the clinical services.

Health Information Management, Programme on Immunisation, Disease control and Reproductive and child Health are all public health services. Adolescent Reproductive Health Services including the prevention of teenage pregnancies, STIs and HIV//AIDS are also services offered to the adolescent. Commercial sex workers (CSW) in the metropolis are also offered various form of assistance. These include, mobilising them, giving them health education, offering Voluntary Counseling and Testing (VCT) and engaging in the treatment of sexually transmitted diseases (STIs) like gonorrhoea and syphilis. Treatment of STIs goes on at Kumasi South Hospital and KATH among others.

Programmes such as the screening of newly born babies for sickle cell gene and rehabilitating malnourished children are on the way. The rehabilitating programme is aimed at reducing the frequency of hospital attendance (KMA, 2006). Due to the good roads in the city, both public and private health sectors are accessible to inhabitants of Kumasi and beyond. Financial constrain which served as primary deterrent to health seekers has become an issue of the past with the introduction of the NHIS. There are four District Mutual Health Insurance Schemes (DMHIS) constituting Subin, Bantama, Manhyia and Asokwa in Kumasi (KMA, 2006). The

Kumasi metro would be better off in health care if there were adequate skilled workers to commensurate the wide spread the health facilities.

Health personnel in the metropolis are comparatively lower than health seekers (KMA, 2006). Although various diseases ran across the country, malaria, tuberculosis (TB), hypertension, septic abortion and diabetes are some of the prominent diseases in Kumasi. Even with the introduction of free maternal health care, the yearly records of infant mortality are on the ascending order. For instance, 2003, 2004 and 2005 recorded increases (KMA, 2006).

The problems faced by the health sector in the Kumasi metropolis are no different from that of the Nation as a whole. Among them are insufficient skilled workers, insufficient “budgetary allocation” and unavailable good commutable vehicles. In addition to these problems are the following challenges:

- The increasing cost of health care especially for conditions that the NHIS do not cover.
- Skilled health practitioners migrate to seek greener pastures abroad as a result of inadequate motivation.
- The doctor patient ratio is high leading to fatigue and stress for available skilled workers. This could partly be attributed to inadequate health training institutions.
- Most hospitals lack modern equipments in addition to operating in fast deteriorating facilities.
- High prevalence rate of diseases like Cholera, malaria, HIV/AIDS and Hypertension.
- Rise in population growth.
- Sanitation (KMA, 2006).

According to the Kumasi Metropolitan Health Director, maternal deaths are on the increase. The Kumasi metropolis had a record of a rise of 222 maternal deaths in 2008 from 2007. In 2007 too there was a record of 179 deaths, an increase from the year 2006 which stood at 175. He attributed the deaths to “unsafe abortion, lack of personnel and inadequate facilities” (Ghana News Agency, 2009).

CHAPTER THREE: LITERATURE REVIEW

Over the years most mothers in an attempt to procreate have lost their lives and sometimes their babies too. A large percentage of motherless babies usually are not really able to stay alive. In this chapter, literature is reviewed in line with the topic under discussion.

3.1 BRIEF PRESENTATION OF THE STUDY SITE

The Komfo Anokye Teaching Hospital (KATH) is one of the most important Medical Centres located in the West African sub-region. The "Teaching Hospital" in its name is because KATH also serves as the Teaching Hospital of the School of Medical Sciences (SMS), Kwame Nkrumah University of Science and Technology (KNUST), Kumasi. The public present to the hospital various ailments for treatment. In addition, KATH receives expectant women and, therefore, provide both ante-natal and post-natal care.



Figure 3.1: Main entrance of KATH from the hospital round about.

Source: Researcher, (2010)

In addition, emergency medical cases are received at the hospital. The vision of KATH is to excel in delivering best quality services both clinically and non-clinically. They wish to obtain within a period of five years, a standard that can be compared internationally. KATH has a mission of providing quality service to satisfy their clients by embarking on innovative and best

procedures through their reliable staff. There is a Board made up of 11 members who are in charge of policy for the hospital. And a six-member Executive Management team in charge of the day to day administration of the Komfo Anokye Teaching Hospital (KATH, 2008).

The Komfo Anokye Teaching Hospital (KATH) is located in Kumasi, the second largest city after the capital of Ghana, Accra. Kumasi can be found in the Ashanti Region in Ghana which happens to be the region with the largest population. The Komfo Anokye Teaching Hospital is situated in an area that can be easily accessed by people from almost all the regions in Ghana. Hence, not only does it accommodate most referral cases from within the country, but also from neighbouring countries of which La Cote D'Ivoire and Burkina Faso are among. KATH is estimated to cover a population of 10 million people (KATH, 2008). The hospital is also accredited for postgraduate training by the West African College of Surgeons in surgery, obstetrics and gynaecology, otorhinolaryngology, ophthalmology and radiology (KATH, 2008).



Figure 3.2: A section of patients at the overcrowded O. P. D. Photo by: Researcher, (August, 2010)



Figure 3.3: Labour wards of KATH. Photo by: Researcher, (August, 2010)

3.2 BRIEF HISTORY OF KATH

During the 1940's that is before Ghana had her independence, a hospital was located in Bantama, one of the popular suburbs of Kumasi. In those days the hospital had two main sections, as one treated Africans the other section was meant for Europeans. Although, some high- ranking officials had the opportunity to be treated at the European part of the hospital, it was not a common situation. History has it that, about twelve years into its establishment, rapid demographic increase, resulted in the hospital's inability to take care of the populates. This called for another hospital which could accommodate them. Following this, the European part was sent to Kwadaso, a Military Quarters in Kumasi and an amount of 2.5 million pounds sterling was voted by the United Kingdom for the construction of a new hospital with the strength of 510 beds for the region. The then population stood at five hundred thousand. By the year 1954/55, three natives (Messrs Gee, Walker and Slater) of the United Kingdom had finished the project. The hospital complex which was called Kumasi Central Hospital has since been referred to by different names. Kumasi Central hospital was later changed to Komfo Anokye Hospital. Komfo Anokye was a powerful fetish priest who did wonders in the Ashanti land. He was the spiritual advisor of the founder of the Ashanti Kingdom Nana Osei Tutu I. However, in

recent times the hospital bears the name GEE in reference to the company which constructed it.



Figure 3.4: The famous Komfo Anokye statue in front of KATH. Photo by: Reseacher, (August, 2010)

The Komfo Anokye Hospital apart from treating cases serves as a teaching hospital because it has been training medical students and nurses. The 510 bed capacity hospital has about a doubled capacity now with an annual admission of forty-three thousand and four hundred (43,400) and fifty thousand (50,000) out patients (KATH, 2008).

As part of the efforts of the government of Ghana to meet the health needs of Ghanaians and meet the Millennium Development Goals by 2015. The government established a National Health Insurance Scheme in order to provide free medicals to the citizens. The Komfo Anokye Teaching Hospital also operates with the NHIS whose unit was set up in the year 2005 under the Finance Department of the Hospital to handle Health Insurance issues. The unit started with only three staffs namely: the Head, Accountant and the secretary who dealt with only the Ashanti Region Civil Servants Medical Care Scheme and KATH Non-Insured Medical Care Scheme. Initially, a 7-member committee (the Head of the Unit, the Accountant of the Unit, the Head of Drug Information Centre, a Doctor, a Nurse, a Business Manager and a Secretary) was appointed to oversee the activities of the Unit.



Figure 3.5: A pregnant woman arriving at KATH to deliver. Photo by: Researcher, (August, 2010)

Some women make a journey of no return as soon as they become pregnant. According to WHO (2005) an estimated number of 1,500 women worldwide lose their precious lives each day as a result of complications in pregnancy. Sub-Sahara Africa records high rates of maternal deaths. For instance, a pregnant woman's risk of dying is 1:7,300 in advance countries as against 1:75 in developing countries. In Niger, one out of 7 pregnant women has the risk of dying as compared to 1 out of 48,000 in Ireland (WHO, 2005). The situation is worse in countries like Afghanistan, Angola, Burundi, Cameroon, Chad, the Democratic Republic of the Congo, Guinea-Bissau, Liberia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone and Somalia: where the maternal death rate is 1000 per 100 000 live births (WHO, 2005)

Maternal Mortality Ratio (MMR) indicates that the pregnant woman risks dying in the course of the pregnancy, during delivery and forty-two days after the woman has delivered (Public Agenda, 2009). The Millennium Development Goal (MDG) 5 aims to improve maternal care and has targeted to reduce MMR by three-quarters between 1990 and 2015. The second target is to access reproductive health universally by the year 2015. MMR, therefore, indicates the progress of the set target of reducing by three quarters maternal mortality (WHO, 2005). The reduction in maternal deaths would have a positive effect on MDG 4, which aims at the reduction of child

mortality. Its target is to reduce by two-thirds the mortality rate among children less than five years. The MDG 4 and 5 are part of the eight Millennium Development Goals which was translated from the United Nations Millennium Declaration. It was adopted and endorsed by 189 countries in year 2000 by heads of state. The eight Millennium Development Goals are:

- MDG 1: To eradicate extreme poverty and hunger
- MDG 2: To achieve universal primary education
- MDG 3: To promote gender equality and empower women
- MDG 4: To reduce child mortality
- MDG 5: To improve maternal health
- MDG 6: To combat HIV/AIDS, malaria, and other diseases
- MDG 7: To ensure environmental sustainability
- MDG 8: To develop a global partnership for development

Source: (WHO, 2005).

3.3 FREE MATERNAL HEALTH SCHEME IN GHANA

In an attempt to ensure that both mother and baby live, the Ghanaian government through the assistance of the UK government in the form of grant of US\$90 million introduced a free antenatal care in 2008. Every pregnant woman has the chance of accessing it throughout pregnancy until three months after delivery. Since its insertion, more and more women have registered (IRIN, 2008).

The British Government who is Ghana's biggest bilateral donor, signed a Memorandum of Understanding with Ghana, committing 42.5 million pounds to support the government's efforts at providing affordable and accessible health care for Ghanaians throughout the country. The grant facility, which would support the country's budget, would be disbursed in tranches of eight million pounds annually over the next five years from 2008 to 2012, to implement the Health Sector Programme of Ghana's Ministry of Health that aims to ensure a healthy and productive population in order to meet the challenges of the Millennium Development Goals (MDGs) by 2015 (Ghana News Agency, 2008). Various programmes are in place for the promotion of good

health among pregnant woman. A Nutritional and vitamin supplement for expectant mothers is also essential. Basic hygiene practices like hand washing after using the toilet and before food preparation which could go a long way to improve the health situation are ignored and needs to be encouraged to curb neo-natal deaths which could result from unhygienic practices.

Prior to the introduction of the free antenatal care, most expectant women (especially in the rural areas) did not frequent the hospital. For instance, in the Gomoa District, (one of the districts in Ghana in the Central region), statistics have it that, from January to June 2008, out of nine thousand, two hundred and one (9,201) expectant number of pregnancies, only four thousand, seven hundred and six (4,706) were registered pregnancies, representing 51 %, out of which two thousand, three hundred and two (2,332), representing 25.3 % of registered pregnancies, was the total skilled delivery of registered pregnancies (Botchway, 2008)

The Gomoa Scheme Manager of the NHIS, upon the introduction of the scheme commented on how that less than a month of the President inaugurating the Policy, over six hundred pregnant women had registered, and wondered what would have been their fate if the government had not intervened. He encouraged expectant mothers to take the opportunity to go to the hospitals and ensure the health of both mother and child.

Dr. Akoto Osei, (the then Ghana's Minister of State at the Ministry of Finance and Economic Planning under Kuffour Government), said, that Government was doing everything to make real progress towards achieving the Millennium Development Goals of reducing by three-quarters the maternal mortality ratio and reducing by two-thirds the mortality rate among children under five. Also, the then Deputy Health Minister, Hon. Abraham Odoom, noted that in the countdown to 2015, Ghana remained behind schedule to attain the goal to reduce child mortality and to improve maternal health. He added that, the assistance would enable the Ministry to implement its priority programmes, one of which was the free maternity health care for all pregnant women, to meet the health-related MDGs (Ghana News Agency, 2008).

According to Hill, (2009) pregnant women may suffer from diseases that may arise as a result of pregnancy. But regular visits to antenatal clinics could aid in the treatment of such diseases or even the prevention. Frequent visits, regular checks and observations carried out may facilitate

the report of strange symptoms promptly.

However, many countries are still behind the attainment of a 70 percent reduction of maternal mortality by 2015 and about 50 percent of the world's women do not have professional assistance during delivery. Although in the urban areas most women have professional attention during delivery, the rural folks lack professional attention. If fertility rates are not reduced through family planning measures, unsafe abortion would continue to claim the lives of many mothers as they try to get rid of unwanted pregnancies. Skilled care is necessary at delivery to curb complications. Although Ghana has made efforts to reduce her maternal mortality rate, the nation lacks behind attaining the national set target of reducing by 3/4 the maternal mortality rate of 214 per 100,000 live births to 54 per 100,000 live births by 2015 (Ministry of Health, 2008)

Hypertension, bleeding, infections, anaemia and unsafe abortion ran through the records of major hospitals throughout the country as the main causes of maternal deaths in the country. Family planning is an inevitable aspect towards the reduction of maternal deaths. But in Ghana, contraceptives (one of the family planning methods) are scantily used in the rural areas. Apart from the fear of side effects, most women are concerned about the high cost. Even though, producers and advertisers continue to make the public aware of having the natural feeling during sexual activity, most people are not yet convinced. There are also issues of breastfeeding problems and some people are simply not interested in using contraceptives. Apart from the lack of interest, the availability of contraceptives to consumers is an issue health professionals have to address. Since contraceptives are not part of the free maternal health scheme, interested persons are expected to pay for it. However, the rural folks who need it the more are those who cannot afford it. Besides, the contraceptives are not even available in some remote communities.

Although, there is free maternal care for all Ghanaian pregnant women, those in the rural areas and the Northern regions lack access to professional care during delivery. Expectant mothers in the Northern region of Ghana have as low as 30 percent skilled birth attendant's whiles 71 to 80 percent account for those in the Greater Accra region with the rich placed in the best position (Ministry of health, 2008).

3.4 SKILLED CARE AT DELIVERY

The importance of facilities and professional staff during delivery cannot be over emphasized. However, the number of pregnant women accessing skilled care varies in relation to public, private and regional distributions. A greater percentage of women made up of 53 percent give birth at home, followed by 36 percent who access public facilities and 09 percent have access to private facility (Ministry of health, 2008)

PROFESSIONALS	Percentage
Doctors	10
Nurses and midwives	41
TBAs	41
Relations and Acquaintances	17

Table 3.1: Access to skilled birth attendants

Source: (Ministry of health, 2008)

Ghana's medical staff comprises of 1,190 registered and practicing doctors, 11, 511 nurses and 2400 midwives. Hence the ratio is one doctor to 17,733; 839 and the Nurse-Population ratio is 1: 1,510. However, disparities remain between urban and rural settings as well as dwellers. Other medical staff like the laboratory assistant and pharmacist may not be found in certain health facilities (Ministry of health, 2008).

Regions	Percentages
Greater Accra	71 - 80
Ashanti Accra	51 - 60
Brong Ahafo	51 - 60
Central	31 - 50
Eastern	31 - 50
Western	31 - 50
Volta	31 - 50
Northern	0 - 30
Upper East	0 - 30
Upper West	0 - 30

Table 3.2: Regional differences of access to Skilled Care at Delivery

Source: (Ministry of Health, 2008)

Most midwives offer their services in government facilities as against private facilities. In Kumasi, located in the Ashanti region, 71 percent of midwives are in government facilities while 20 percent are in private facilities. Kumasi has a population of about 1,170,270 with 287,887 in reproductive age. About 67 registered nurses are in the region and the Ratio of Midwives to Women of Reproductive Age is 1:427. There are 67 registered midwives to render services to all these people so the ratio of midwives to women of reproductive age is 1:4297 (USAID, 2006). The table below shows a district distribution of midwives in government and private facilities.

DISTRICT	GOVERNMENT FACILITY	PRIVATE FACILITY
Ahanta west	90%	18%
Shama Ahanta East	79%	31%
Gomoa	56%	11%
Awutu Afutu Senya	68%	35%
Kumasi	71%	20%
Ejisu Juabeng	87%	13%

Table 3.3: Midwives Providing Services at Government and Private Facilities, by District

The role of midwives in Ghana cannot be over emphasized regarding their support to pregnant women during delivery. Unlike doctors, most midwives are found in the remote places. And since most pregnancies take place in the villages where doctors are missing, the midwives assistance to expectant mothers is on the higher side. Twenty-one percent of pregnant women receive antenatal care from doctors, and doctors in turn assist about seven percent during child birth. 71 percent of pregnant women receive antenatal care from midwives and the midwives also assist 41 of them during delivery. In addition to these direct services, midwives refer cases that need doctors' attention to be addressed by them. They give post abortion care and organise counseling sections on nutrition and breastfeeding among others (GSS, 2003).

3.5 FERTILITY RATE OF GHANA

Ghana's fertility rate has been on the decline over the period. This downward trend could be associated with the desire of many urban couples to have lesser children than before. The reduction in the number of children is associated with low fertility rates.

Rate of Fertility	Year
1988	6.4
1993	5.2
1998	4.4
2003	4.4

Table 3.4: Ghana's Fertility Rate

Source: Ministry of health (2008)

In 1988 Ghana had a fertility rate of 6.4 children per women. Ten years down the line it was reduced to 4.4. The estimated maternal mortality rate for Ghana in 1990 was 740 per 100,000 live births and between 214 to 540 deaths per 100,000 live births. (WHO/UNICEF, 1996; MOH/GHS, 2003; PRB, 2005). Although, regional variations exist which portrays unequal rates, Ghana's maternal mortality rate as compared to her African neighbors like Côte d'Ivoire with

maternal mortality of 810, Burkina Faso 700, and Senegal 980 is low (WHO/UNICEF/UNFPA, 2007).

Asia, Latin America and Africa have also made some progress in reducing the maternal mortality rate. For instance, between 1980 and 1982 Sri Lanka had 250 deaths per 1,000,000 live births which reduced to about 200 deaths per 1,000,000 live births in 1988. Egypt's maternal death rate in 1994 was about 250 per 1,000,000 live births and below 200 per 1,000,000 live births in the year 2002. Honduras had a maternal mortality rate of 300 deaths per 1,000,000 live births in 1990 and below 200 deaths per 1,000,000 live births in 1998 (Ministry of health, 2008).

Even though, Ghana has seen a decline in maternal mortality rate, her set targets has not yet been reached. There are several health indicators like contraceptive prevalence rate, deliveries that take place in hospitals and health facilities, the number of deliveries assisted by skilled health workers. These show why the national target and for that matter the global target needs acceleration in order to meet set goals.

3.6 TRADITIONAL BIRTH ATTENDANTS (TBAs)

Ghanaians have the orthodox system as well as the traditional way of meeting their health needs. The acceptance of either an orthodox way or traditional way depends largely on an individual or the customs and traditional believes of communities and families. Some Ghanaians believe certain diseases are best treated traditionally.

The health needs of Ghanaians are therefore supplied by professionals who use orthodox means of treatment in government facilities, the private section which is mainly a profit making venture who also provides services through orthodox means. These comprise of hospitals established by churches, clinics, pharmacies and chemical shops and maternity homes. Herbalists, traditional healers, bone-setters, spiritual healers and traditional birth attendants are all part of the traditional set up Martey et.al (1998) as in Imogie (2009). Although, traditional treatment could be found in urban centers, it is prevalent in remote areas.

The Ashanti region gets 60 percent of health service from the public sector which is made up of

government hospitals and 30 percent from the private sector comprising of hospitals and clinics which belong to individual persons rather than the state. The remaining 10 percent is provided by Traditional Birth Attendants (TBAs) as well as other bodies within the traditional set up such as pastors, herbalist and fetish priests (Imogie, 2009).

Traditional birth attendants are mostly grown up females without professional skill who assist other women during pregnancy and delivery. TBAs are usually found in rural communities where difficulty in accessing health facilities is a common phenomenon. Although, non-professionals, TBAs contribution to the reduction of maternal births is highly commendable. To curtail further problems, TBAs are allowed to assist women with normal deliveries and refer those with complications to skilled health workers.

Since some proportion of pregnant women would depend on TBAs for reasons like payment for some services at health facilities though maternal care is free, inaccessible roads and long distances to health centers, lack of good rapport between them and health personnel and difficulty in getting transport to health facility, there is the need to train and equip TBAs to assist expectant mothers and help curb maternal mortality (Imogie, 2009).

TBAs generally do not use standard healthy equipments during delivery. In fact, they lack most delivery equipment and their hygienic status is very questionable. Although not very popular, some TBAs identified in the Northern part of Ghana are said to be performing well to aid the reduction of maternal deaths despite the challenges they face (Nonor, 2009). They could therefore be trained and assisted with the right materials for the job. This is necessary because, not only are they praised for contributing towards the reduction of maternal deaths but also blamed for causing maternal deaths by not referring complicated issues early enough to be dealt with by skilled health personnel.

When TBAs are trained, they turned to understand the work better. For instance, they would quickly refer complicated cases to skilled health practitioners and with timely and appropriate support pregnant mothers could be safe. TBAs are advised to encourage expectant mothers who are teenagers and those above thirty-five years to deliver at health facilities since they need the support of health professionals (Myjoyonline, 2008). Trained TBAs contributed to increase in

antenatal attendance. The visits rose from 20,000 to 180,000 in 1990 through to 1993. During the same period, Deliveries by TBAs also saw an increase of about 40,000 (UNFPA, 1996).

3.7 HEALTH INDICATORS FROM GHANA

Indicator	Value
Total fertility rate**	4.4
Contraceptive prevalence rate (among married women 15–49), any method*	25%
Contraceptive prevalence rate (among married women 15–49 Modern methods	19%
Unmet need for contraception**	34%
Deliveries in health facilities**	47%
Deliveries at home	53%
Skilled assistance (doctor, nurse, midwife) at birth*	47%
Live births annually	645,000
Maternal deaths per 100,000 live births	540 - 214
Neonatal mortality rate (per 1,000 live births	43
Infant mortality rate (per 1,000 live births)*	64

Table 3.5: Health Indicators from Ghana

Sources: * GSS, 2003; PRB, 2005; WHO, 2000 and **MOH/GHS official figure

3.8 REGIONAL AND ECONOMIC DISPARITIES OF HEALTH INDICATORS

Table 6 shows lower fertility rate in urban centers than rural areas, thus 3.1 as compared to 5.6. Antenatal care provided by professionals in urban centers is higher than the rural and again, 79.7 deliveries are assisted by skilled attendant in urban centers as against 30.9 in rural areas.

The fertility rate of Ashanti region (the region where this research is conducted) is 4.1, antenatal care by skilled attendant is 94.2 and 59.9 deliveries are assisted by skilled health workers.

	Total Fertility Rate	Use Of Modern Methods Like contraceptives	Antenatal Care Provided By Skilled Attendant	Delivery By Skilled Attendant
RESIDEENCE				
URBAN	3.1	24.2	97.9	79.7
RURAL	5.6	14.9	88.6	30.9
REGION				
WESTERN	4.5	17.7	94.9	38.6
CENTRAL	5.0	13.2	94.6	38.4
GREATER ACCRA	2.9	26.0	96.3	72.6
VOLTA	4.4	19.3	89.5	81.4
EASTERN	4.3	21.5	91.7	46.5
ASHANTI	4.1	21.0	94.2	59.9
BRONG AHAFO	4.8	24.8	95.7	58.4
NORTHERN	7.0	7.7	82.7	18.3
UPPER EAST	4.7	9.7	85.4	27.8
UPPER WEST	5.5	19.5	90.9	33.3
WEALTH QUINTILE				
LOWEST	6.4	8.6	83.3	20.6
SECOND	5.9	19.1	91.3	31.9
MIDDLE	4.9	18.6	94.7	43.3
FOURTH	3.3	21.3	95.3	73.1
HIGHEST	2.5	26.3	98.2	90.4
TOTAL	4.4	18.7	91.9	47.1

Table 3.6: Regional and Economic Disparities in Demographic and Health Indicators

Source: GSS, 1993 and 2003

3.9 CAUSES OF MATERNAL DEATH

Although the causes of maternal death vary from one country to another, the prevalence is higher in the developing nations than in developed ones. There has been much progress in countries in the middle-income group with regards to pregnancy related deaths, but less progress in reducing maternal deaths in low-income countries, particularly in sub-Saharan Africa. In West and Central Africa, the risk that a woman will die in childbirth is 1 in 17, compared with 1 in 8,000 in developed countries on the average.

The estimation is that, one in four pregnant women currently receives no antenatal care, and that more than 40 percent give birth without the assistance of a skilled attendant (Public Agenda, 2008). Hence, it is important that antenatal care be improved and as expectant mothers gain access to it, it would increase their chances of survival during labour. According to Veneman, "Access to pre- and antenatal care must be improved, as part of integrated efforts to establish stronger national health systems," and "investing in maternal health care is crucial for achieving the Millennium Development Goals (Public Agenda, 2008). Besides maternal death, the impact of the absence of adequate pre- and neo-natal care is compounded by other issues women and girls face, such as rape, violence and child marriage.

Even though, Ghana's maternal mortality rate is low as compared to Sub-Saharan Africa which has nine hundred (900) deaths for hundred thousand (100,000) live births it behoves on the nation to reduce it further. A further reduction may put attention on the northern part of the country. Generally, more pregnant women die in labour in rural areas than urban centres. The director-general of the Ghana Health Service said, Ghana will be in the position to meet the MDG 5, if she could reduce maternal mortality by three quarters to 54 deaths per 100,000 births (IRIN, 2008). The high mortality rate could be associated with the high cost of caesarean sections too if not for the free maternal health care in Ghana. Like any other country, the cost of delivery through caesarean is much higher in Ghana than normal birth. While a caesarean section is estimated to be around US\$229, normal birth or delivery is US\$43. In comparison with neighbouring countries like Burkina Faso who take US\$124 for caesarean and US\$ 39 for

normal birth. Ghana's rates rather rest on the higher side (IRIN, 2008).

Severe bleeding accounts for about 25% of maternal deaths. But if medical staff addresses it in time, complications that arise from severe bleeding could be managed by oxytocin, a reliable drug which is good in lowering the chances of bleeding in mothers just after delivery (WHO, 2005). In Ghana, bleeding is the second leading cause of maternal mortality. Most women bleed to death even before they reach the hospital to deliver. In addition to no money to settle hospital bills or for transportation, expectant mothers in rural areas could suffer the loss of their babies (that is, if they themselves live) due to bad and inaccessible roads leading to the health centres (IRIN, 2008)

Mothers who become infected in the course of pregnancy stand the risk of losing their lives since infections claim the lives of 15% of pregnant women. An infection like sepsis can be treated if the signs and symptoms are seen early. Hypertension is one of the common diseases that can result in the death of a pregnant woman. It accounts for 12% of maternal deaths. Convulsions (eclampsia) in pregnant women could be fatal. Eclampsia is a hypertensive disorder which could be managed with magnesium sulfate, a drug capable of reducing convulsions in pregnant women. An abnormally positioned baby in the womb could cause obstructed labour which claims the life of 8% pregnant women. Sometimes, a baby's head too could be larger than the mother's pelvis which is a common case with bride children and teenagers who usually have undeveloped bodies to carry babies. In order to reduce maternal deaths, unsafe abortions which accounts for 13% of maternal deaths should be made safe. Family planning procedures too would help women to avoid the pregnancies they do not want. These conditions are known to be the major killers and account for about 80% of maternal deaths worldwide (WHO, 2005).

According to public agenda (2008), one pregnant woman out of 2,800 expectant mothers risk dying in an advanced country. For Africa as a developing continent, it is one out of sixteen, while Ghana who is ranked the 143 of countries identified to have high maternal mortality have one pregnant woman dying out of thirty-five. For Ghana, 19 percent for hypertension, 17 percent accounts for bleeding, 12 percent for anaemia, 11 percent for unsafe abortion, 10 percent for infections, 7 percent for obstructed labour and 24 percent are other causes of maternal deaths.

Causes of Maternal Deaths	Percentages
Hypertension	19
Bleeding	17
Anemia	12
Unsafe abortion	11
Infections	10
Obstructed labour	07
Other causes	24

Table 3.7: The causes of maternal deaths in Ghana

Source: Ministry of Health (2008)

Four major hospitals in the capital of Ghana recorded cases of haemorrhage, hypertension and unsafe abortion. These were in addition to sepsis, ruptured uterus and diseases related to sickle cell as the causes of maternal deaths that occurred at the hospitals cases (Ghana News Agency, 2010)

Korle Bu Teaching Hospital, the biggest and main referral facility in the country in 2008 had the following records. Out of the 10,673 maternal cases handled, there were 86 deaths out of which 18 were due to haemorrhage and 15 were induced abortion. 15 deaths were Hypertensive-related, five for Sepsis, another five for ruptured uterus and 10 for sickle cell related cases (Ghana News Agency, 2010)

It has been observed that one out of every five women who die is due to pregnancy related complications. ICF Macro and an anonymous donor had these findings on maternal mortality and abortion in Ghana.

3.9.1 ABORTION

Abortion also claims the lives of quite a number of women. In Ghana, abortion claims the life of one out of nine women. More than one in seven women have had abortion before and one in three out of the seven women have had more than one abortion. This situation could be found among women between the ages of 12 and 49. About one-third of abortions occur in the home of

the woman. They may be performed by friends and relatives, traditional practitioner or a pharmacist. Some reasons why women abort their babies are insufficient financial support to take care of the baby, having had many same sex children previously, having the desire to study or achieve a goal before bearing children and husbands refusal of an additional child. Even though family planning methods could reduce and prevent unwanted pregnancies, only 14 percent between the ages of 15 and 49 practice modern family planning methods (DHS, 2009).

3.9.2 LACK OF ACCESS

Women lack access to maternal care due to how health facilities and services are distributed. Ghana has 11 regional hospitals, 204 district hospitals and 1,798 health centers (Canagara and Ye, 2001 as cited in USAID, 2006). Some pregnant women, especially, those in the rural places usually have to travel long distances to get to health facilities. Transportation is another issue of concern since most roads are bad and the few available drivers either refuse to ply it or charge exorbitantly. Also, pregnant women are expected to pay for some medicines and transport cost even though, there is free antenatal care. In addition, traditional believes and practices that engulf communities are a few of the factors that hinder access to maternal care. Even in these modern times, some pregnant women still go to fetish priest soothsayers and herbalist before they seek medical attention (USAID, 2006).

The Millennium Development Goal 5 is linked with the goal 4 so much so that a progress in the goal 5 which is maternal health will positively affect the goal 4 which is child survival. The World Health Organization has confirmed that a motherless child is more likely to die before the age of two than an infant whose mother survives. It is therefore of a necessity to improve the health of pregnant women and new mothers to ensure that children survive their first years. Also, better access to maternal health care will result in a reduction in the estimated half a million pregnancy related deaths that occur yearly and also help decrease child mortality rates (Public Agenda, 2008)

3.9.3 DELAYS

Delays on part of health professionals have been identified as one of the causes of maternal

deaths. Any delay in attending to expectant mothers with some sort of complications also contributes to maternal deaths. Several pregnant women could be saved by professionals if they timely intervene. A 20 percent reduction in maternal and infant mortality ratios has been recorded in Ridge Hospital, one of the hospitals in Accra, the capital city of Ghana as a result of immediate assistance offered to expectant mothers by skilled hospital staff (Ghana News, 2009).

The second part of MDG 5 target of accessing reproductive health universally by the year 2015 is monitored by the proportion of births attended by skilled health personnel.

Regular antenatal attendance reduces the effects of pregnancy related complications and its associated problems. Ridge hospital reported a reduction in maternal deaths in 2007, 2008 and 2009. The records are as follows: 30 deaths out of 6,049 deliveries in 2007, 29 deaths out of 7,465 deliveries in 2008 and 26 deaths out of 2,825 deliveries in 2009 (Ghana News Agency, 2010).

A study conducted by Dzadeyson (2007), indicated that a neonatal mortality rate of 50% in infants was recorded in African sub-region. There is the need for government to strengthen all health systems for them to give their support in order to reduce maternal death. In fact, not only should the mother be saved but the child's health is also important. Most teenagers engage in unsafe abortion which is about the fourth highest cause of maternal mortality. A greater percentage of this category of people engages in pre-marital sex for financial support as a result of poverty (IRIN, 2008)

3.9.4 TEENAGE PREGNANCY

Most girls become pregnant between the ages of 15-19. Some of the possible factors which cause teenage pregnancy are peer pressure, economic hardship and or family financial problems, weak parental control and supervision, low self esteem and social customs, long-term dating relationships and exposure to nudeness on television. Teenagers who find themselves pregnant may be in one of such situations.

According to BBC world news report (March, 2010), there has been a considerable rise of teenage pregnancy issues between the ages of 10 and 14, thus those who constitute the young

adolescent group. The older group of adolescent's between the ages of 15 and 19 however, experienced a decline in the number of pregnancies. Whiles in 2008, younger adolescent recorded cases stood at 2,269 that of 2007 were 1,616 a difference of about 653 more cases. On the contrary, 111,021 older adolescent cases were recorded in 2008 as against 101,527 in 2007, an indication of a reduction.

A national health facility recorded an increase of 653 in pre adolescent teenage pregnancy in 2008 as against 2007. The preceding years, 2003 to 2006 equally indicated an increase of 0.14 percent to 0.2 percent of cases recorded for younger adolescents. Whiles a decrease of 13.0 percent from 14 .0 percent was recorded for older adolescent within the same period (Daily Graphic, 2009).

In Ghana adults enrolled in schools risk being assaulted by teachers and or school mates. There are few cases involving fathers who abuse their girl adolescent, some housemaids are forced into sex by the husbands of their mistresses. Also, street girls are exposed to criminals of various calibers who put them in the family way thereby resulting in pregnancies that are against their desires and wishes. Adolescent girls are therefore impregnated beside other causes because they do not have knowledge on safe sex. Added to all these is the issue of rape. Most mothers have lost their lives in an attempt to abort the unwanted babies (APSWU, 2009).

3.9.5 CHILD MARRIAGE

Globally, countries have their own civil, religious, cultural and traditional systems under which they operate pertaining to issues of child marriage. In South Asia for instance, 48 percent of women between the ages of 15 and 24 marry before they turn 18 years. Africa is next with a percentage of 42 and the lowest in this group which happens to be Latin America and the Caribbean follows with 29 percent (UNICEF, 2005).

Whereas poverty or economic constrain seems to be a justification for child marriage, education on the other hand serves as an opposing agent. In Ghana for instance, females in poor families stand the chance of being married off earlier than those from wealthy homes. The probability that

women with a little education would marry late as compared to those without any education at all is very high.

Moreover, most of those from wealthy backgrounds usually have access to higher education and their prolong years of schooling delays their marriages and help them to mature. Since every pregnancy is associated with the risk of death for women, more pregnancies would mean a higher rate of risk. Child bearing is therefore a problem associated with early marriages which has the tendency of increasing maternal mortality. Although, a woman may enter a monogamous marriage early which could contribute to her having many children, polygamous marriages also facilitates this situation through competition among the women.

In developing countries where poverty hangs on numerous families, child bride is seen as a means of taking care of the household. Irrespective of their ages, poor parents consider the wealth they gain by marrying their daughters off at the expense of their health and other implications.

In Niger and Bangladesh for instance, three girls out of every four girls are given out for marriage below age 18. This situation of child marriage is associated with lots of risks which includes, early child bearing, increased risk of contracting HIV/AIDS, lack of access to formal education since they are compelled to drop out of school and all sorts of abuse of which force sex and beating are inevitable (Global Action for Children, 2009).

Child marriage contributes to maternal mortality in that the girls are expected to bear children even when their bodies are not fully developed. Girls younger than 15 are five times more likely to die in childbirth than women in their 20s, and pregnancy is the leading cause of death worldwide for girls ages 15 to 19. Early childbearing can cause obstetric fistula (when a young mother's vagina, bladder and/or rectum tear during childbirth) a condition that causes urine and feces leakage, often resulting in ostracis (Global Action for Children, 2009).

In addition, older women with experience and matured knowledge are likely to take proper care of their young ones which could bring about a reduction in infant mortality than children born to child mothers. Lack of proper care from child mothers as a result of child marriage can therefore

increase infant mortality.

3.9.6 POVERTY

Ghana, unexceptionally, has her share of the world's poverty. Factors that contribute to poverty in Ghana are numerous. It is however, almost amazing how Ghanaians manage their meager salaries with crude oil always on the increase. Whenever, prices of crude oil go up, not only do fares shoot high, but prices of everything, whether commodities or services also rises. The unemployment situation also contributes to young ladies engaging in prostitution which results in teenage pregnancy and abortion leading to maternal mortality (Ghanaian Chronicle, 2009). For instance, it was estimated that, 26.9 percent men were gainfully employed as compared to 8.6 percent of women in 2005 and 2006. The percentage of unpaid female workers went up to 28.5 percent from 24.5 percent (Ghana News Agency, 2010)

Girls are usually given off for marriage as boys are sponsored to study. Due to poverty, Ghanaian parents and guardians in their scale of preference, forgo the education of the girl child. The girl child who may not be physically and mentally matured, but becomes a source of income for livelihood when married off would have to bear the cost of educating the boy child. Poverty stands out as one of the elements of maternal mortality. But for the intervention of the government of Ghana, the introduction of the free antenatal care is expected to reduce maternal mortality and infant mortality (Ghanaian Chronicle, 2009).

Ghana poverty reduction strategy (GPRS, 2003-2005), defines poverty as unacceptable physiological and social deprivation as a result of lack of macro-economic stability that erodes the resources of the poor through inflation and other variables. Also, the inability of the national economy to optimise benefits within the global system as well as low capacities through lack of education, vocational skills, entrepreneurial abilities and poor health and poor quality of life among others.

From the year 2003 and 2005, there were 4.2 million households with about 4.3 persons; rural population was 56 percent and proportion of female 50.5 percent. The percentage of males who never attended school is lower than females, male's 21 and females 41. This implies a higher literacy rate among males thus, 62 percent as compared to 36 percent for females. Urban

dwellers have advantage over rural dwellers regarding nearness to education and health facilities. Also, more health workers including doctors, nurses and midwives are located in the urban areas to supervise and handle delivery cases as compared to rural areas. Delivery assistance from health professionals in urban centers is 79 percent and 33 percent for rural centers (GPRS, 2003-2005).

It would be observed that females dominate in the regions with high poverty levels. Lower rate of accessibility to human and social capital like education, health, legal rights and startup capital holds women up in poverty.

3.9.7 HIGH POPULATION RATE

Population growth has been identified as a contributing element of maternal mortality. A growing population without appropriate infrastructural support would be adversely affected. Hunger, poor health, joblessness, and crime among others would militate against the nation. The growing Ghanaian population needs adequate resources in line with education, health care, employment and others in order to cope. Annually, the population is estimated to increase by 3.0 percent. And the fertility rate stands at 5.5 percent. While infant mortality rate stands at 66 deaths out of every 1,000 live births, maternal mortality rate is 214 per 100,000 live births (Ghana News Agency, 2006). The percentages of males who receive formal education are more than females, hence leaving the majority with less control over their sexual lives. When more females engage in sex (are sexually active) there is the tendency of a rise in population.

With more females unemployed, early marriages, polygamy and prostitution become substitutes for livelihood. A woman who marries early is likely to have more children than a woman who marries late. And many pregnancies mean more risk. A man who has more than one wife is expected to have children with all his wives. Where there is child marriage, the pregnant child risks losing her life since her body is not matured enough to carry a baby. Prostitutes often end up with unwanted pregnancies and abortions lead to a lot of complications (Ghana News Agency, 2006).

3.10 REDUCING MATERNAL MOTALITY

Family planning has been identified as one of the means to improve maternal health and curb maternal mortality. But contraceptives use as one of family planning measures has not seen a rising patronage throughout 1998 and 2006. In 1988 the use of contraceptives was low in almost all the ten regions in Ghana. It however increased in 2003 and fell again in 2006 with Northern, Upper East and central Regions reaming high (Ministry of health, 2008). The use of contraceptives among married women would enable them have control over the pregnancies they want to keep and those they do not. This will reduce unsafe abortion and curb maternal deaths; however, is contraceptive prevalence rate adequate to reduce maternal mortality?

CHAPTER FOUR: METHODOLOGY

The main method used for this work was the qualitative method. There are several options available for every research work, the researcher may use quantitative method, qualitative method or combine the two which is mixed methods. The choice of a research method depends on factors such as the researchers objective, thus what the conductor of the research aims to achieve. For a social research like this, some factors to consider include values, practical consideration, theory, epistemology and ontology.

4.1 QUANTITATIVE AND QUALITATIVE RESEARCH

Apart from the general distinctive factors of numbers and words between quantitative and qualitative research which is widely spoken of, quantitative research strategy relates theory and research deductively. Quantitative research takes a natural science stance and it is objective (Bryman 2008: 140). On the other hand, qualitative research relates theory to research in an inductive manner. It takes a social science stance being concerned about what society deems important and how society interprets the world around them (Bryman 2008: 366). Although, a number of differences could be outlined between quantitative research and qualitative research, there also exist a range of similarities and researchers may combine the quantitative and qualitative research strategy in a project known as a mixed method research. Mixed method research is a research that “integrates quantitative and qualitative research within a single project” (Bryman 2008: 603).

4.2 VALUES

“Values reflect either the personal beliefs or the feelings of a researcher” (Bryman 2008: 24). However, since values cannot be left out on the grounds that researchers have to be objective and not subjective, they would have to make efforts to control and manage their impressions so as to leave the research work as credible as possible.

4.3 PRACTICAL CONSIDERATION

Practical considerations are very important because the “nature” of the researchers topic, those the research would be conducted on as well as researchers “constraints” among others, would have a significant impact on how the researcher would carry out the research (Bryman 2008: 27). For instance, a topic that seeks the views of people on an issue would consider qualitative research strategy because the researcher would get to know how subjects interpret their social world (Bryman 2008: 26).

4.4 THEORY

Theoretical considerations are essential for the researcher because research has a linkage with theory. “Theory is something that guides and influences the collection and analysis of data” (Bryman 2008: 9). Theory could be deductive or inductive. Theory is deductive when the researcher “deduces a hypothesis” from theory and builds research questions factoring data collection process to arrive at the hypothesis. Inductive theory is the other way round. The researcher conducts the research without a hypothesis from theory but formulates one at the end of the project based on the outcome of the research.

4.5 EPISTEMOLOGICAL AND ONTOLOGICAL CONSIDERATION

Epistemological considerations are based on “what is and should be” accepted as knowledge in a said discipline (Bryman, 2008: 13). Epistemology is associated with a positivism position which advocates that, “the social world can and should be studied according to the same principles and procedures as the natural sciences” (Bryman, 2008: 13). Yet, the contrasting view of epistemology positivism which is interpretivism has it that there should be a different approach to the study of social sciences because it deals with people and institutions which are different from natural sciences (Bryman, 2008: 15). Thus, fundamentally, the subject matter of natural and social science differ. Whereas the former is associated with molecules, atoms and electrons the latter is related to how human beings act based on the meanings and interpretations they associate with what they do (Bryman, 2008: 16). Hence, for the researcher to understand

how people behave, it should be gathered from the peoples opinion and the interpretations they give to the social world around them. Then the researcher would interpret what others have already interpreted based on the meaning they have accorded social reality (Bryman, 2008: 17).

Ontological consideration on the other hand, is based on “whether social entities can and should be considered objective entities that have a reality external to social actors, or whether they can and should be considered social constructions built up from the perceptions and actions of social actors” (Bryman, 2008: 18). As epistemological considerations are influenced by positivism and interpretivism, so is ontological consideration influenced by objectivism and constructionism. Objectivism as an onthological consideration has the stance that we as human beings are confronted by phenomena which we are expected to succumb to (Bryman, 2008: 18).

Objectivism could be expanciated through organization and culture. It is obvious for employees of an organization to conform to the requirements of the organizations in order to remain working in the organization else the tendency of employees losing their job cannot be over emphasised. As for natives of any given traditional area, they are born to observe existing cultural practices. For any of these two, the employer or the native does not determine which rules he should be governed by. The regulating procedure already exists in the organization to which he must adhere, so are people born into cultures to practice them. Thus, objectivism “is an ontological position that asserts that social phenomena and their meanings have an existence that is independent of social actors” (Bryman, 2008: 19). Thus, the actors are set apart from the social phenomena which are already in existence.

Whereas the objectivist approach asserts society is independent of social phenomena, constructionism looks at the society constructing their own social meanings (Bryman, 2008: 19). Society constructs meaning based on the occurrences within their environment as well as the period of time within which events take place. The constructions of society are mainly to bring a reform to their current situation.

4.6 RESEARCH STRATEGY

Qualitative research approach to a large extent, deals with words as compared to quantitative research which deals with numbers. Qualitative research is inductive as theories emerge from

research. Also it takes an epistemological position in the light of interpretivist view by examining and interpreting the meaning people give to the social world (Bryman 2008: 366). Ontologically as constructionist, implying that interactions between people serve as social outcomes. This strategy emphasises how individuals interpret things in their environment and how they progressively influence their world with the construction of new ideas. Qualitative research engage in purposive sampling that dwells basically on units such as people, organizations and departments. In addition, qualitative researchers who find it expedient to make a generalisation on a wider population may also engage in probability sampling.

This work is highly influenced by qualitative research strategy by looking at the in-depth interpretation that people accord to the social world. The work is more focused on units such as pregnant women from Komfo Anokye Teaching Hospital (KATH) as well as information from staff of the maternal health department thereby sampling purposively. In order to embark on in-depth analysis of this study, the focus was on qualitative method which enabled me to get respondents point of view in a natural setting by interacting with them through interviews. The qualitative method gave room for participants to express their views and comments on the free antenatal health scheme by the Ghanaian government.

4.7 RESEARCH DESIGN

The research design was based on the selection of the Komfo Anokye Teaching Hospital (KATH) in the Kumasi Metropolis. KATH was selected because it is the second biggest hospital in Ghana located in the second largest city after the capital of Ghana, Accra. KATH happens to be in an area that can be easily accessed by people from almost every corner in Ghana. The geographical position also makes it the gate way to many referral cases from within and without the country. Among the countries that enjoy the services of KATH are La Cote d'Ivoire and Burkina Faso, they also share boundaries with Ghana. KATH is estimated to cover a population of 10 million people (KATH, 2008). I embarked on a case study to find out particularly, how the free antenatal care offered to pregnant women has affected those at KATH hospital, the facility and staff.

This research employed a qualitative approach in the collection of data so as to understand the

interpretation that the pregnant women attach to the changes in government policies concerning the free maternal health care as against the cash and carry. The free antenatal care introduced by the Ghanaian government is - a social policy, which aims at minimizing maternal and infant mortality in Ghana. The research approach made it possible for the respondents to establish their views, opinions as well as personal experiences with KATH. The main data collection method included interviews and observation which was carried out at KATH.

4.8 SEMI-STRUCTURED INTERVIEWS

Data collection started with establishing contacts with KATH administrators, research and ethics department for approval. A letter was written through the local co-ordinator to the head of department for an introductory letter to the concerned KATH authorities. The letter was sent to KATH research for forms to be completed for a certificate. The certificate was an inevitable part of the many forms I completed and submitted to KATH ethics for approval to enable me gather information for this work. After a hectic time with ethics, the approval was given.

Data collection was carried out at KATH labour ward and consulting room 8 where pregnant women reported for delivery and antenatal checks respectively. As already indicated, semi-structured interviews were employed. Semi-structured interviews are a list of flexible questions known as interview guide (Bryman, 2008: 438).

The guide made it possible for interviewees to share their views freely without any form of rigidity in their responses. I could also make further enquiries to obtain detailed information since it was not obligatory for me to follow any strict order. Questions bothered around the frequency of maternal checks and its effect on the hospital staff and facility. Among the (31) interview questions used were basic statistics on respondents age, marital status and number of children. Most of the rest were mainly open-ended questions which allowed in-depth conversation. However, the researcher was guided by a checklist which kept conversations in focus for relevant information.

Participants of the study included pregnant women and other hospital staff. Although, the questions were printed in English, I had to translate it to Akan (the widely spoken local language in Ghana) to enable respondents to freely err their views and to contribute without difficulty

since the study site was dominated by Akans. However, for the literates, interacting in English, our official language was comfortable. I had no need for translators because I understand and speak both languages very well.

4.9 PARTICIPANT OBSERVATION

As a qualitative data collection method, I gathered information by observing participants. Ethnography and participant observation as indicated in (Bryman, 2008: 402), are not easily separated by their meaning. This is seen in the activities the participant observer and the ethnographer carry out. They are both involved with a group for a certain duration acquainting themselves with the behavior of the people being studied through observation. As a participant observer, I engaged in conversations and listened to respondents too. I interacted with pregnant women and staff from early morning till late over a period of three months. I observed how medical staff interacted with pregnant women and vice versa. I listened to their conversations and asked questions thereby placing me in a better position to marry what the subjects told me and what I saw “through their eyes”.

4.10 DATA ANALYSIS

4.10.1 SOURCES OF DATA

The study used both primary and secondary data sources. The secondary data was accumulated from existing literature, precisely the internet, mass media, KATH statistical department, which gave me insight into the trend of events from previous years. Primary data was gathered through interviews and observations. Through the use of semi structured interview guide, observation and in-depth conversation information was accumulated for this work.

4.10.2 POPULATION AND SAMPLING

The population for this study consisted of pregnant women and hospital staff. The study employed purposive sampling technique which has the merit of selecting the targeted unit.

Purposive sampling is the method of choosing respondents who have the opinion of the research which is relevant to the research topic. This method is also relatively simple, cost effective as well as easy to apply. Interviews and observations were the instruments used. The semi structured interviews were directed towards pregnant women and hospital staff. Even though, I had planned to include focus group discussion and interview for NHIS personnel the situation on the ground made it impossible.

4.10.3 PILOT STUDY

I embarked on a pre-test study which gave me some insight into the prevailing situation at KATH. This helped me to make changes to my semi-structured interview guide. During the pre-test, I observed that I needed to do follow up for further information. This, I did when I was collecting the actual data. I went to the workplaces of some pregnant women for in-depth discussion. Another important observation I made was the timing. I realised that, the pregnant women were their best during the early hours of the day. And easily got tired and irritated around noon so it was best to engage them early enough to elicit information.

4.11 ETHICAL ISSUES

The research and ethics department of KATH is very particular about ethical issues whenever researchers engage in the gathering of data. They did everything in their power to protect the respondent's image and privacy. Documented agreement between the researcher and the respondent were put in place before the researcher proceeds with the interview. It was mandatory for the researcher to read and explain the agreement to the respondents who could not read for them to thumbprint as a confirmation of their consent to the interview or data collection. KATH ethics mandated that the study be explained to each participant and assure them of confidentiality. Ethics issues were thereby highly considered in the course of data collection.

CHAPTER FIVE: PRESENTATION OF EMPIRICAL FINDINGS AND ANALYSIS

This chapter presents the results of the study and how data collected for this work has been analysed. The study made use of interviews and participant observation to put together respondents view. Data was also gathered from documented information by Komfo Anokye Teaching Hospital (KATH). For this study, information on participants age, marital status, educational background, occupation and source of livelihood were all considered in order to give readers a fair view of the background of those who participated in this study. In all, fifty-five 55 pregnant women participated in the study and three 3 midwives who are KATH staff.

Although, the initial plan was to interview some doctors and National Health Insurance Scheme (NHIS) personnel too, the situation on the ground did not make it possible. My respondents seem to be gender biased because of the topic under discussion, also in Ghana the nursing and midwife profession is largely dominated by females. Below is the personal information of respondents. Table eight shows the percentage distribution of participants of the study.

Gender	Number	Percentage (%)
Male	0	0
Female	58	100
Total	58	100

Table 5.1: Percentage distribution of number of Respondents

Source: Researcher, 2010

It can be observed for the table all the respondents were female

Status	Number	Percentage (%)
Single	3	5.45
Married	51	92.73
Separated	0	0
Divorced	1	1.82
Total	55	100

Table 5.2: Marital Status of pregnant women

Source: Researcher, 2010

Table 9 shows that the majority of the pregnant women interviewed are married. They represent 92%, the singles comprised of 5.45% and 1.82% represented divorced women interviewed.

5.1 EDUCATIONAL BACKGROUND OF RESPONDENTS

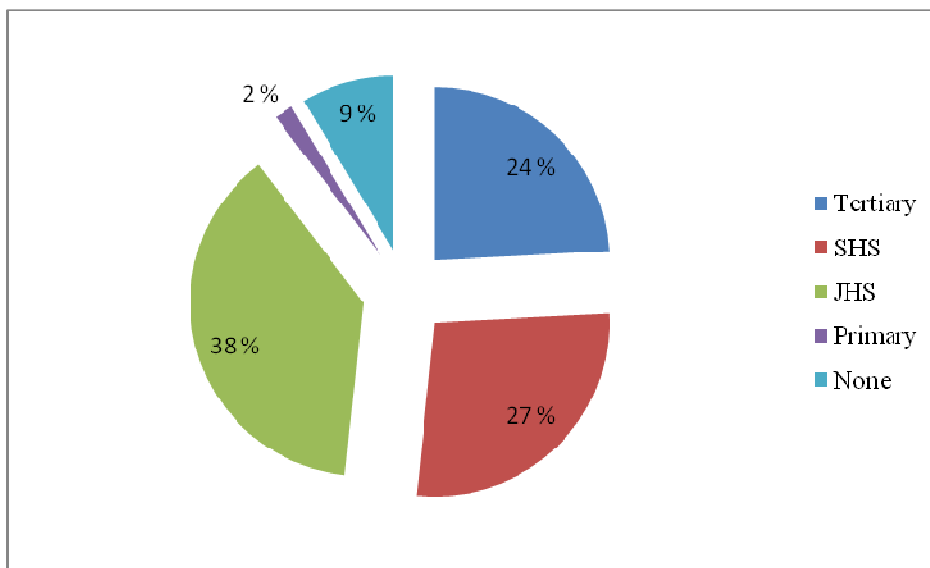


Figure 5.1: Level of education of pregnant women

Source: Researcher

Figure 5.1 shows that among the pregnant women interviewed, five of them representing 9% had no education. One person representing 2% have primary education and 24% have acquired tertiary education. Those who have gained education up to senior high school level represented 27% while the largest representation were Junior high school graduates representing 38%.

5.2 OCCUPATIONAL BACKGROUND OF PARTICIPANTS (STAFF EXCLUDED)

The occupation of respondents may give some indications of their purchasing power. This

background gives enlightenment on how respondents can afford their health needs especially in the critical moments of pregnancy.

Responses from subjects revealed that most of the people engaged in small scale business with a larger proportion into trading. The other group of people is civil servants earning little incomes. The third group is those who have no jobs (housewives). Traders constitute 36.4 percent, beauticians 12.7 percent, fashion designers 14.5 percent, Teachers 12.7 percent, secretaries 5.5 percent, housewives 16.4 percent and one farmer representing 1.8 percent.

On the whole, those who are engaged in minor businesses account for over 65 percent while public servants account for 18.18 percent and those without jobs account for 16.4 percent. The occupational background of respondents indicated the need for government support and intervention as a motivational factor to encourage pregnant women to go for antenatal checks and thus reduce any occurrences of maternal deaths in an attempt to achieving the millennium development goal five.

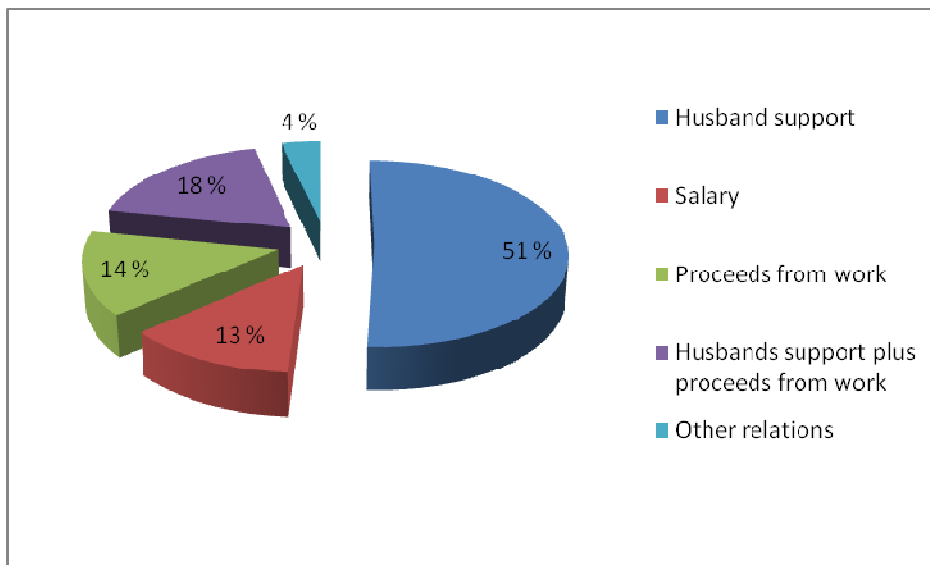


Figure 5.2: Source of Livelihood for pregnant women

From the responses illustrated in figure 5, as much as 51 percent of the pregnant women depended on their husbands for support. The second highest group depended partially on their

husbands too. This is an indication of a strong financial burden on husbands. No wonder, misunderstandings erupt between couples when funds are demanded by women for antenatal care. Further discussions revealed that until the introduction of the free antenatal care policy, most married people quarrelled for financial constraints. Hence, the introduction of the free maternal health care is a great relief and an encouragement to pregnant women to make use of health facilities which has a positive effect of controlling diseases if not curing to curb maternal deaths.

Time of commencement	Number	Percentage (%)
Up to 2 months	29	52.7
3 months	11	20
Above 4 months	15	27.3
Total	55	100

Table 5.3: Date on which antenatal checks begun

Source: Researcher, 2010

Table 10 above shows that out of the 55 pregnant women interviewed, 29 reported at the hospital in the early months of pregnancy. This they attributed to the free maternal care. This is what one woman said, “I used to come for antenatal checks during the later part of pregnancy because I could not afford the bills prior to the introduction of free maternal health care. But for this pregnancy I started early because it is free and I can see I am in good condition as compared to the previous one. I have less health challenges”.

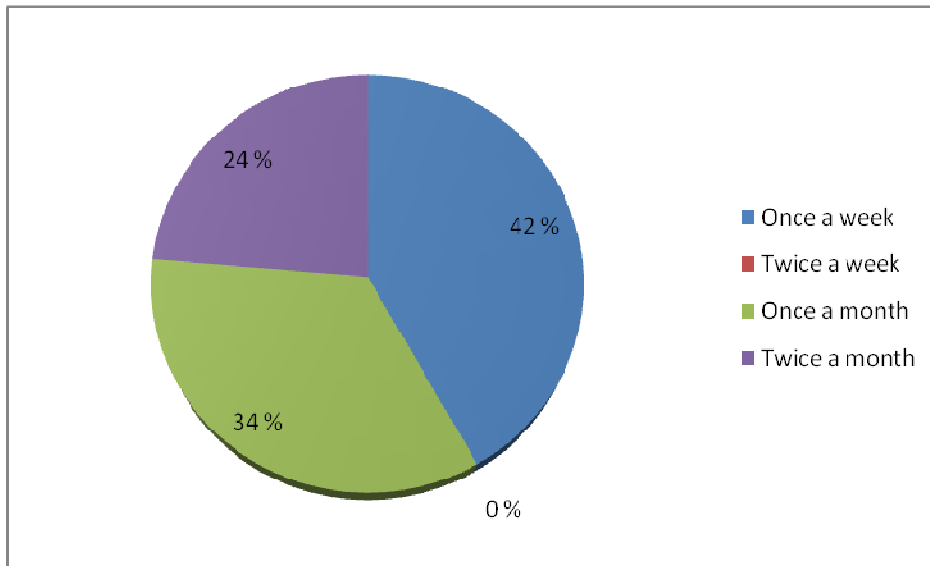


Figure 5.3: Periodic Checks of pregnant women

Source: Researcher, 2010

The periodic checks are actually determined by the doctor. And it may depend on the number of weeks or months of the pregnancy as well as the health of the expectant mother among others. However the pregnant women can go for a check in the event of sickness or strange feeling even when the time is not ripe for her visit. Figure 6 shows that the majority of the pregnant women had periodic checks once a week, representing the highest percentage of 42.

Category or Grouping	Number	Percentage (%)
First child	23	42
One child	6	11
Two –four children	26	47
Above five children	0	0
Total	55	100

Figure 5.4: Number of children of Respondents

Source: Researcher, 2010

Table 11 indicates that most of the women interviewed already had children. 26 women

representing 47 percent already had between two and four children and yet were still pregnant. An indication that Ghanaian women and for that matter women in the third world countries give birth to many children, a confirmation of WHO, (2005) report. The next group are those who are about to have their first child, they represent 42 percent. The smallest group of participants representing 11 percent have a child each.

5.3 EFFECTS OF FREE MATERNAL HEALTH ON PREGNANT WOMEN

Almost all the pregnant women interviewed attested to the fact that they have benefited from attending antenatal checks. Out of the 55 respondents, 14 people said they have received advice on personal hygiene, eating habits and good medical care from health personnel. One person said, she has been educated on helpful exercises. Three women were excited to have their Aids status checked. They said although, they were interested in knowing their Aids status they did not have the courage to go for the test. But it was easy to have it as a part of maternal checks.

Two women confessed that the free antenatal care has reduced their financial burden. Another two said, by coming to the hospital for antenatal checks has enabled them to acquire vital information from other pregnant women through interaction. One pregnant woman was happy to get free drugs under the scheme. Thirty-two pregnant women said they have benefited through free good medical care and malaria treatment. Malaria claims the life of many pregnant women so preventive measures have been factored into the proceedings of caring for women during pregnancy.

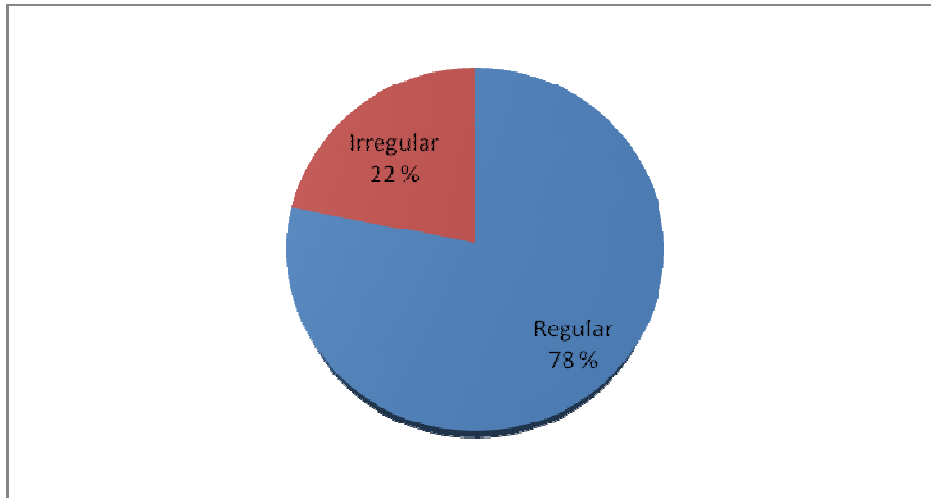


Figure 5.4: Maternal check-ups (regular and irregular) of the pregnant women

Figure 7 shows that 78 percent of those interviewed used to go for maternal checks before the introduction of free maternal health care by Ghana government. However, they confessed that it was a heavy burden on them financially. Therefore, in order to reduce the financial burden, they usually reported during the later part of the pregnancy. They added that they might not have sought medical attention if it were in these Modern times of economic crisis and credit crunch. They attributed their presence at the hospital to the free maternal health scheme. Out of the 22 percent who said maternal checks were irregular, the majority explained that the pregnancies they were carrying were their first. A few of them said they had no reason.

Some of the respondents said they have lost one or two children in the course of pregnancy, delivery and birth before. Even some of those who were carrying their first babies have had miscarriages before. The figure below indicates that, out of the 55 respondents, 36 have not lost any baby before and 19 have lost their children before.

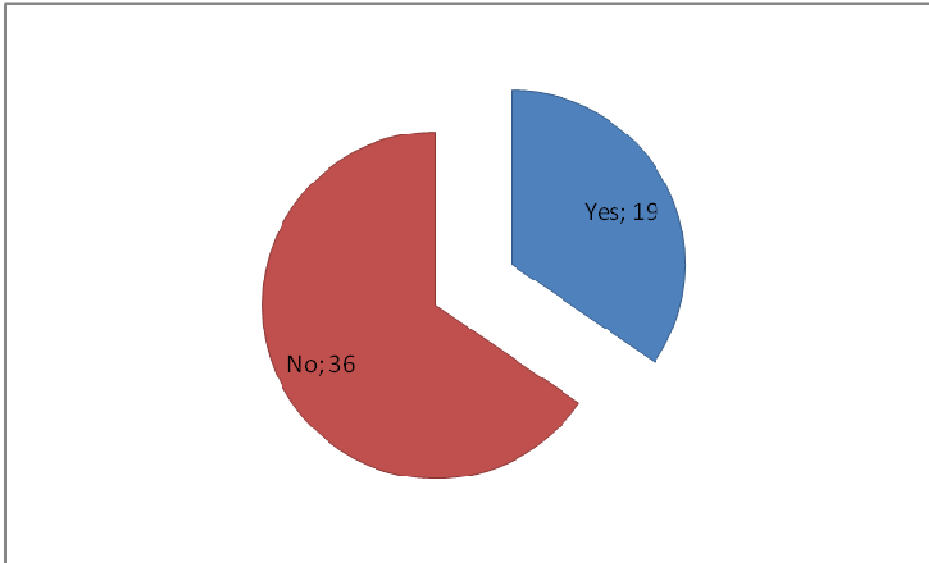


Figure 5.5: Mothers who have or have not lost their babies during pregnancy and delivery.

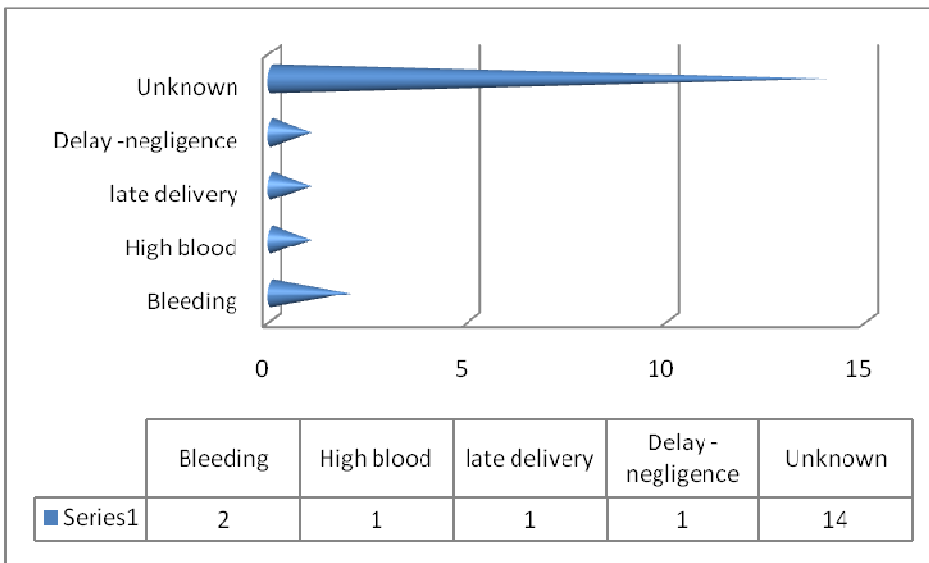


Figure 5.6: Causes of baby death during pregnancy

Figure 9 shows that out of the 19 women who have lost their babies in the course of pregnancy, 14 of them do not know the cause of death. Out of the remaining five, two occurred as a result of bleeding, one was high blood pressure, one attributed it to late delivery and one said it was unnecessary delay and negligence.

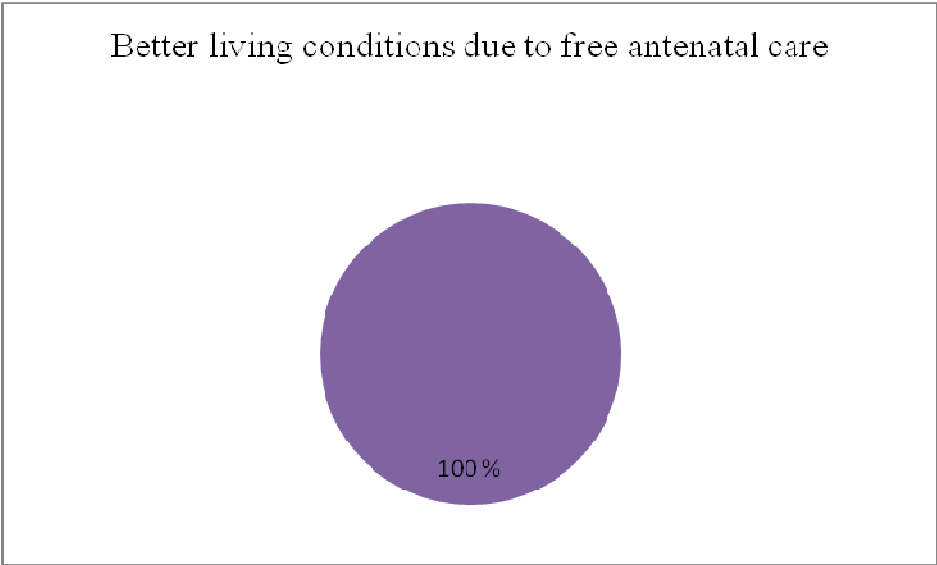


Figure 5.7: Living conditions of respondents

Figure 10 shows participants response to changes in living conditions. All 55 pregnant women interviewed responded that the free maternal health has positively affected their health and finances in general.

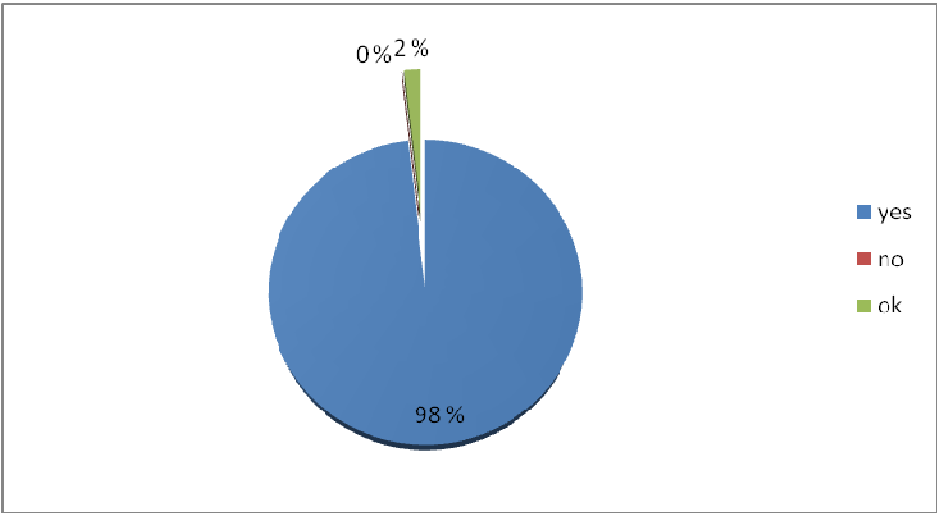


Figure 5.8: Level of attendance for antenatal checks

Due to the introduction of free maternal health scheme by the Ghanaian government, the number of pregnant women who go for antenatal checks at Komfo Anokye Teaching Hospital was confirmed by medical staff to be on the increase. Ninety-eight percent of the pregnant women interviewed were in agreement and only 2 percent said the influx was ok and normal (figure 11). Once again, the 54 women who said there has been a rise by way of numbers attributed free maternal care and as one woman “individuals do not have to worry about antenatal bills”.

As much as it is good for women to attend antenatal care in order to curb unforeseen complications and reduce maternal deaths and for that matter, infant mortality, infrastructure is an important element. Out of the 55 respondents, 27 confirmed an expansion work at KATH. One person said there were no changes and the remaining 27 said they had no idea about the changes. Their reason was that they did not know the previous state of KATH and that they were at KATH because they were referred. With regards to conditions at KATH, 16 percent said they were satisfied and 6 percent said they were ok. But 36 percent were dissatisfied claiming, there were not enough furniture (chairs) and the out patients department (OPD) for the pregnant women was so crowded. I also observed that the OPD was crowded may be partly because it was shared with the eye clinic. In addition to this situation, most of them said they had to spend long hours at KATH before they are attended to. Figure 12 gives a detailed account.

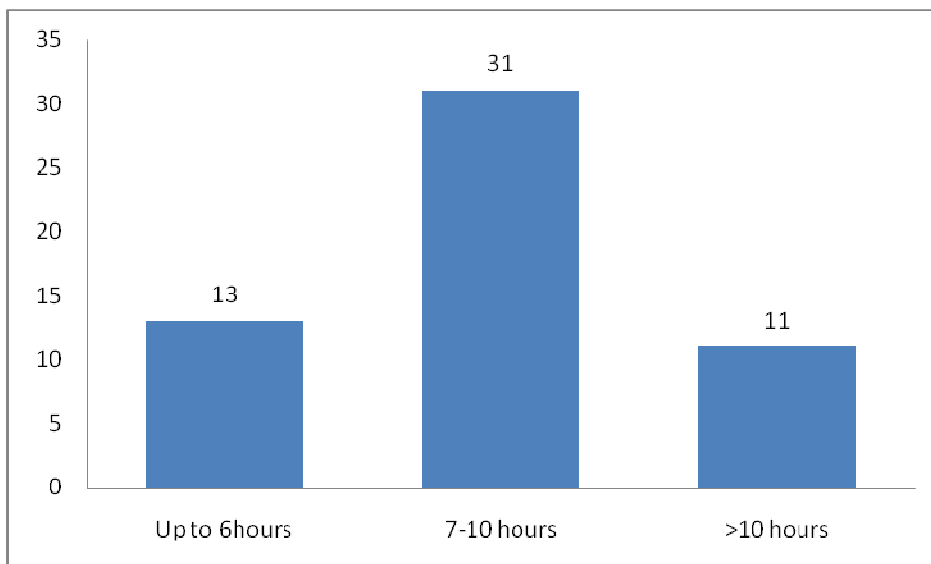


Figure 5.9: Number of hours spent at the hospital.

The minimum time that pregnant women spent at the hospital was six hours. This was advocated by thirteen people. Thirty-one said they spent between seven to ten hours and eleven stayed at the hospital for more than ten hours to go through health checks by skilled personnel. Some of the respondents held the view that the long hours spent at the hospitals could also be attributed to inadequate health personnel.

In all, 6 people representing 11 percent said they were ok with the number of health workers who attended to them. Twenty-one women representing 38 percent said the health workers were enough and twenty-eight respondents, representing 41 percent said the health workers were inadequate. The variation in participant's responses depends to a large extent on the days allocated to them to go for checks.

At KATH, the pregnant women had been grouped and days allotted to them. It was observed that, Mondays and Tuesdays were much crowded as compared to the other days. So those who reported on Monday and Tuesday had the opinion of large crowd, limited space, inadequate chairs and health personnel among others. Respondents were almost divided on the issue of cordiality between them and medical staff. Twenty-eight people said there was good rapport while 27 said there were hitches.

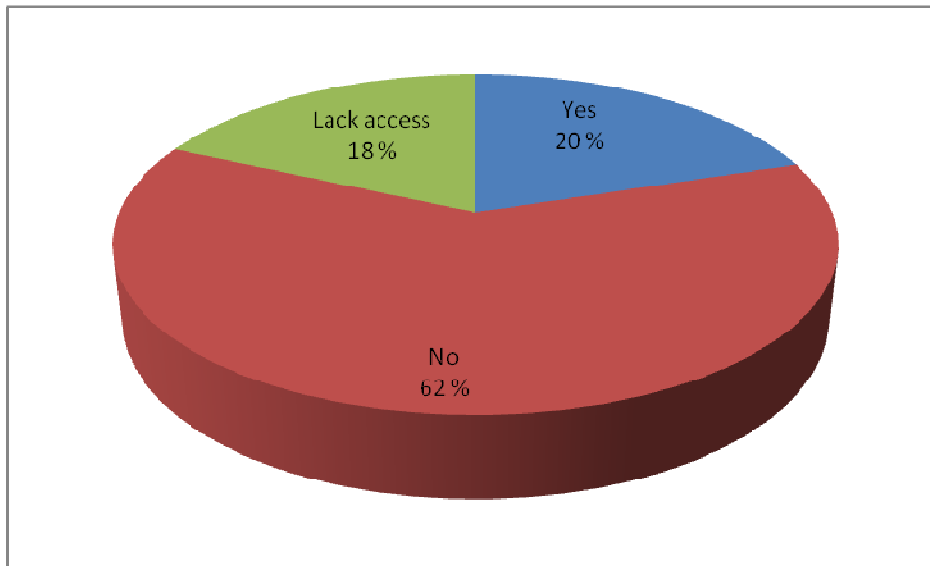


Figure 5.10: Accessibility of drugs for pregnant women at KATH

Another important element for the well being of expectant mothers is the role of medicine. Under the scheme, pregnant women are to be given free medicine according to their health needs. But the situation on the field revealed that although, 20% of the respondents got all needed medicines the rest did not. Among those who had problems accessing drugs, 18% attributed it to long queues. They said even though the drugs were available, accessing it was not easy due to the long queues they had to join.

The respondents added that the drugs they received from the hospitals were those they could afford. Hence purchasing these drugs from a pharmacy shop gives time saving reward. They mentioned drugs like folic acid and vitamin B complex. Therefore, to avoid waiting longer, they preferred skipping the queue to buy from the drug stores. They claimed this did not put any financial stress on them since the cost was almost insignificant. Besides, their consultation bills and others are born by the government so it was a matter of diverting finances. Further probing revealed that the entire hospital had one drug collection point which ran relatively slow. In the same vane 62% indicated that they bought most of the drugs since they did not receive all needed drugs from the hospital.

However, they explained that the drugs prescribed for them were not available and quite expensive; hence buying it often was a financial burden. It was elicited that some of the pregnant

women and their unborn babies needed special care and attention for survival. Hence they were uncomfortable purchasing drugs like pre-care.

By all indications, the free antenatal care by the Ghana government is a step in the right direction to curb maternal deaths. Notwithstanding, like any project, improvement is key to its success and progress. Table 12 below show the view of respondents on how the scheme could be improved.

Respondents Views	Number
Train more medical staff	21
Improve infrastructure including expansion of KATH labour ward.	12
Provide needed drugs	14
Measures that allow staff to work well and hard should apply	5
Government should increase insurance premium	1
Scan babies free	1
No idea	1
Total	55

Table 5.5: How government can improve the maternal health scheme

Source: Researcher, 2010

For the free maternal health programme to run well, 21 women said there was the need to train more skilled workers. Twelve were concerned about infrastructural development, while 14 participants advocated for all needed drugs to be free and available. Five of the participants were of the view that if skilled workers worked effectively, there would be progress.

Therefore there should be measures to check the workers to perform well. One woman said the NHI premium should be increased for sustainability. A woman wanted free scans besides the doctor's request. Another woman who was satisfied with the way things are did not see the need for any improvement. She had no idea what could be done to improve the scheme.

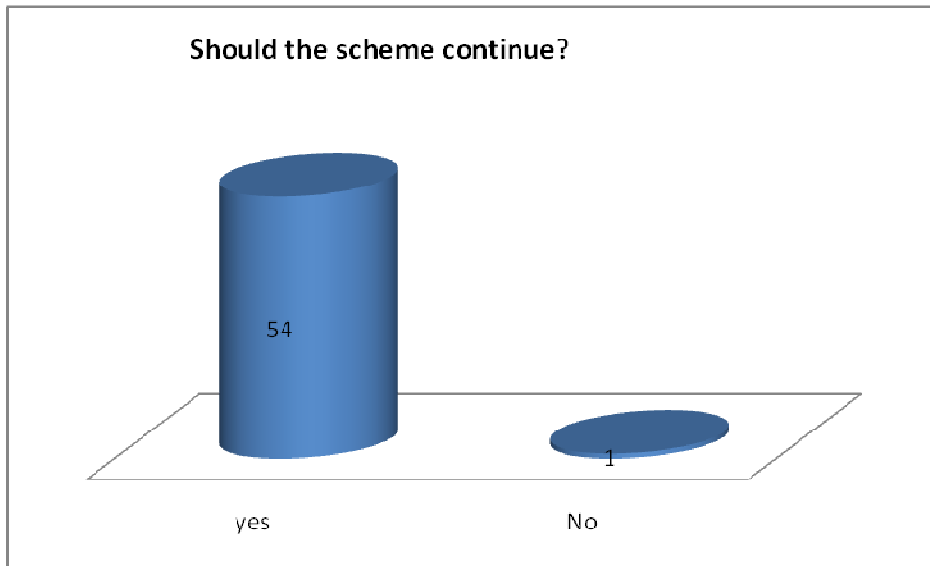


Figure 5.11: Response to whether Free Antenatal Care should continue.

The following are some of the responses received.

“It should continue because I no longer have to worry about maternal check bills”.

Another woman

“It should continue so the poor can access and money for antenatal could be used for other things”.

The only woman who disagreed with the rest said,

“It should discontinue because teenage pregnancy is on the increase”.

5.4 HOSPITAL STAFF (midwives, nurses, doctors, statisticians and other paramedical staff)

The KATH midwives said there has been a rise in the number that comes for antenatal checks. They attributed this to the free maternal health scheme. One of them reported:

“We report early to work and work for longer hours than before because the pregnant women are

too many. The workload has increased so we get very tired”.

The midwives added that there was the need for further expansion to accommodate the growing crowds. They added that the labour ward needed to be expanded too. Currently, the delivery area has only 8 beds. That is where mothers and their babies are observed for at least an hour before they are sent to the main ward. The insufficient furniture there has necessitated the preference accorded to those who have delivered. Even at the main wards, the story is not different since newly born babies and their mothers have to join the floor patients. Those who do not get access to beds at the delivery area had to wait on a bench as they go through labour pains especially during the initial stages. Under very tight conditions, some women are assisted on stretchers during delivery.

As many as 40 deliveries could be made in a day. The other wards which are A2 to A5 also deal with obstetrics and Gynaecological issues. Apart from space and furniture, the midwives also complained about staffing. They said more hands were needed because of the workload. They however, expressed the hope that with the training of more midwives which started 2001, the burden would be lessened. Also, the completion of the new labour ward for KATH would minimize the infrastructural problem.

“As for equipment, there is enough. Although, we do not have sophisticated monitors, we are able to make do with what we have to assist the women to have safe delivery”. (Comment of a midwife)



Figure 5.12: New nursing and midwifery training block.



Figure 5.13: New labour ward complex under construction

5.6 THE RATE OF MATERNAL DEATHS AT KATH

YEAR	MATERNAL MORTALITY RATE
2005	1088 PER 100,000 LIVE BIRTHS
2006	941 PER 100,000 LIVE BIRTHS
2007	804 PER 100,000 LIVE BIRTHS
2008	1073 PER 100,000 LIVE BIRTHS
2009	932 PER 100,000 LIVE BIRTHS

Table 5.6: Maternal Mortality Rate

Source: Department of Obstetrics and Gynaecology (KATH)

Table 13 shows an unstable trend in the maternal mortality rate (MMR) from 2005 to 2009. In 2006 the MMR experienced a reduction of 147 from the previous year. In 2007 too there was a reduction of 284 from 2005 and 137 from 2006. But in 2008, MMR rose again to record an increase of 269 from 2007. However, in 2009 MMR recorded a reduction of 141 from 2008.

Months	Year-2005	Year-2006	Year-2007	Year-2008	Year-2009
JANUARY	17	9	9	9	13
FEBRUARY	10	4	7	11	8
MARCH	7	9	9	6	6
APRIL	12	4	15	12	9
MAY	13	9	13	12	11
JUNE	11	5	5	9	14
JULY	9	4	7	16	4
AUGUST	9	9	7	17	14
SEPTEMBER	6	11	8	9	7
OCTOBER	7	8	5	8	7
NOVEMBER	6	10	8	8	10
DECEMBER	8	12	6	21	11
TOTAL	115	94	99	138	114

Table 5.7: Maternal Deaths 2005-2009, the case of KATH

Source: Department Of Obstetrics and Gynaecology (KATH)

Table 14 gives monthly detailed account of maternal deaths at KATH from the year 2005 to 2009. In all, 560 mothers have lost their lives through child birth from 2005 to 2009 at KATH. There was an encouraging decline of 21 maternal deaths in 2006 from 2005. In 2007 maternal deaths increased by 5, rising from 94 to 99. The year 2008 experienced a notable increase of 39 maternal deaths from 2007. But in 2009, maternal deaths reduced again by 24. Throughout the five years MMR has not been stable, it rises and declines.

5.7 POSSIBLE CAUSES OF THE MATERNAL DEATHS IN KATH

The causes of maternal deaths as recorded by KATH, depicts a wide range of diseases and conditions.

Some of them are, Eclampsia, Severe Anaemia, Hemorrhagic Shock, Irreversible Shock, Meningitis, Septicaemia, Cardiac Failure in Cyesis, Tetra Plegia in Pregnancy, HIV Infection, Cardiac Failure, Hyperemesis Gravidarium, Viral Hepatitis, Pneumonia, Ureamia, Sickle Cell Disease, P.I.H, Hepatitis, Ruptured Uterus, Hypertensive Coma, Hypovolaemia Shock, Severe Malaria, Bleeding Oesophanal, Peritonitis, Perforated Uterus, Endotoxic Shock with Multiple Organ Failure, Dilated Cardinomyopathy, Renal Failure, Septic Shock Haemolytic Crisis and abortion. However, the common ones which resulted in maternal deaths between 2005 and 2009 included Eclampsia which claimed the lives of about 88 pregnant women, Septicaemia 64 lives, PPH 44, Renal Failure 22, Anaemia over 20, Pneumonia more than 19, Meningitis above 17 and P.I.H 13 lives. Over the same period, bleeding had claimed only one life thereby making it comparatively low as far as causes of maternal deaths at KATH are concerned. One midwife attributed it to the support of KATHs blood bank.

5.8 THE ROLE OF FAMILY PLANNING IN CURBING MATERNAL DEATHS

As discussed earlier, family planning is one of the ways through which MMR could be reduced. Family planning enables married people to control birth while they enjoy their sex life. With family planning, people are empowered to decide when they want to make babies so the issues of unwanted pregnancies do not arise. Women may engage in all forms of abortion when they do not want to have the baby. Over the year's unsafe abortion have claimed the lives of many women. Spacing in child bearing also keeps the woman strong and healthy. Family planning helps women to space their children for strength and good health to be regained. This reduces complications in subsequent pregnancies. Contraceptive prevalence rate at KATH from 2004 to 2007 revealed the following.

Year	Total
2004	7092
2005	4475
2006	3971
2007	4842

Table 5.8: Family Planning Statistics, KATH

Source: Department Of Obstetrics and Gynaecology (KATH)

Table15 shows the statistics of family planning measures. This comprises of a variety of family planning procedures including male and female condoms, vasectomy, female sterilisation, laparoscopy and natural family planning. In 2004 family planning patronage was high but it reduced in 2005 and 2006 by 2617 and 504 respectively from its previous year. However, the year 2007 saw a higher patronage of 871 from 2006.

5.9: EFFECTS OF FREE MATERNAL HEALTH ON PREGNANT WOMEN

Almost all the pregnant women interviewed attested to the fact that they have benefited from attending antenatal checks. Out of the 55 respondents, 14 people said they have received advice

on personal hygiene, eating habits and good medical care from health personnel. One person said, she has been educated on helpful exercises. Three women were happy to have their AIDS status checked. They said although, they were interested in knowing their Aids status they did not have the courage to go for the test. But it was easy to have it as a part of maternal checks.

Two women confessed that the free antenatal care has reduced their financial burden. Another two said, by coming to the hospital for antenatal checks has enabled them to acquire vital information from other pregnant women through interaction. One pregnant woman was happy to get free drugs under the scheme. Thirty-two pregnant women said they have benefited through free good medical care and malaria treatment.

5.10: SOCIO-ECONOMIC IMPACT OF FMHC

Respondents noted that the Free Maternal Health Care (FMHC) has lessened their financial burden. The days when couples used to quarrel over hospital bills or borrow for antenatal checks were gone. They hailed the Ghanaian government for the free antenatal care initiative.

Most of the expectant mothers did not comment on having received direct increment on their wages and salaries or stipend as the case may be. However, they attested to the fact that they are able to manage with what they receive because the government have relieved them of the burden of medical bills. Monies they would have used to pay for medical bills could be put to other uses including subsidizing the purchase of goods (food stuffs) and payment for services.

Most pregnant women confirmed the peace they enjoy in their homes due to the free antenatal care. They affirmed that they no longer have to battle over hospital bills with their husbands. With the introduction of the FMHC system, the most their partners give them is money to pay for their transportation and what they would spend during their visit to the antenatal.

5.11 HEALTH IMPLICATIONS OF FMHC

A healthy people definitely would promote economic progress and help in development, if a larger proportion of a nations people are unhealthy, it would be a setback to nation building. Despite the introduction of NHIS for all Ghanaian habit of frequenting the hospitals to check

their fitness. For one reason or the other, most people are simply reluctant to check their status on the killer or deadly disease AIDS. However, the pregnant women have the AIDS status among others checked as part of their routine checks. Hence, hospitals would have records on mothers and babies who are infected unlike if they were attend to by Traditional Birth Attendants (TBAs).

The TBA may not be interested in the Aids Status of the expectant mothers. And where they are, they may not have the equipment to work on it. In addition, improper hygienic practices could further compound the problem where manhandling of HIV victims could cause a spread. But with proper care and attention, health facilities are able to manage and handle victims and their babies.

With more pregnant women patronizing and delivery, proper records could be kept. Maternal mortality rate as well as infant mortality rate could be accessed through hospitals as compared to when one delivers at home and dies. Even the cause of the death may not be known for medical experts to find solutions.

5.12: MEASURES TO CURB MATERNAL MORTALITY

Despite the efforts of the Ghana government to curb maternal deaths in Ghana to meet MDG 5 and 4, maternal deaths continue to rise in the Ashanti region. The minister responsible for the region attributed this to the presence of inadequate midwives as compared to patients (GNA, 2010). Since the situation needs attention, the Regional Coordinating Council is establishing Maternal Health Committees in the districts to assist in maternal health issues. Also efforts are made to resource the existing facilities with equipments (GNA, 2010).

CHAPTER SIX: CONCLUSION AND RECOMENDATION

6.1: CONCLUSION

The study revealed that the introduction of the free maternal health care for pregnant women has positively affected pregnant women who may not have frequented health facilities. Even though, most women have attended antenatal in time past, they affirmed they had financial difficulty which either affected their regularity or the date of first attendance. To report early and regularly meant more financial burden. Although, they agreed the practice of irregular and late attendance of antenatal had a tendency of resulting in pregnancy related complications, they attested to have no other options.

In as much as pregnant women are frequenting health facilities, the outcome of the study has it that, the introduction of the free maternal health care has not completely eradicated maternal deaths and infant mortality neither has it brought the death tow to the desired national set target of reducing by 3/4 the maternal mortality rate of 214 per 100.000 live births to 54 per 100,000 live births by 2015 (Ministry of Health, 2008).

As reviewed by literature, the free maternal health is aimed at reducing maternal deaths. Although, pregnant women are frequenting the health facilities, the study revealed problems such as insufficient health personnel, unavailability of needed drugs, and congestion at the facilities among others. The link between health facilities and health personnel are inseparable. Many facilities without personnel is incomplete and vice versa. Again, the review of literature has it that in the 2008 ministry of health's report, as much as 53 percent women gave birth at home. This means they did not receive the attention of skilled personnel, no records of maternal nor child mortality exists for future reference.

Once again, the various diseases like hypertension, bleeding, anemia and unsafe abortion just to mention a few that causes maternal deaths are said to be managed and controlled if brought to the attention of health personnel early enough. Additionally, other factors such as lack of access to health facilities, teenage pregnancy, child marriage, poverty and population if addressed

would aid in the reduction of maternal deaths and child mortality.

6.2 RECOMMENDATION

As indicated in the literature review, poverty is one of the causes of maternal mortality in Ghana. For the Ghanaian government to assist in eradicating poverty, MDG1, concrete steps like effective elimination of poverty at the district level will impact the entire nation. The government can contribute to reducing poverty by the effective use of aids and donations from donor countries. Also, the government should encourage trade fairs to create a platform for local industries and business people to exhibit and promote their products. Additionally, the government should avoid succumbing to any unfair deals and conditions of development partners' among others.

Child marriage, another contributor to maternal mortality could be discouraged by creating opportunities for the girl child to access education to the highest level. The longer the girl child is in school, the longer the chances of getting married early. Also, gaining opportunities in economic ventures discourages girls from entering into marriage early.

The use of contraceptives helps in avoiding unwanted pregnancies. Hence its inclusion in the NHI scheme would aid in the reduction of maternal deaths that may occur from unsafe abortion. Although, family planning counseling services are offered to women and especially mothers who have newly given birth, they have to pay for any family planning method they decide to use against unwanted pregnancies.

Pre-service as well as in-service training programs for midwives would go a long way to improve the services they offer and reduce any variations in their services which can lead to limited access. In addition, expectant mothers could also be given briefing on the services they can gain from skilled workers when they go to the hospitals for antenatal checks.

Another important element is the doctor patient ratio. More health workers should be trained to cater for the increasing number of pregnant women. The need for adequate infrastructure to commensurate the influx of pregnant women cannot be over emphasised. I observed that KATHs

maternal care unit was over crowded and congested. Most of the pregnant women got tired from standing for long periods. It would therefore, be of immense help if the pregnant women are assisted with enough chairs while they wait to be attended to. The present situation at the labour wards call for immediate attention especially the issue of floor patients. Also, the available free medicine under the insurance scheme should comprise of the needed ones in accordance to the health needs of the pregnant women and not only common and cheap ones. Those who had to buy expensive drugs for the survival of both mother and child fail to enjoy the free maternal care to its fullest. Financial constraints deter some from getting the prescribed drugs which could result in complications. In addition to providing needed drugs, the drugs should be easily accessible from their point without going to queue again with all other patients considering the large crowd.

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APPENDIX

Interview guide for pregnant women and staff of KATH

1. Age (a) 20 (b)20-30 (c) 30-40 (d) >40
2. Marital status (a) married (b) single (c) separated (d) divorced
3. Educational background. (a) JHS (b) SHS (c) Tertiary
4. Number of children (a) one (b) two –four (c) five and above
5. What work do you do?
 - trader
 - housewife
 - other - specify
6. Source of livelihood
7. When did you start antenatal checks?
(a)< 2 months (b)> 3 months (c) 4 months and above
8. What benefits have you derived from the free antenatal care?
9. How often do you go for antenatal checks?
 - A .Once a week
 - B.2 times a week
 - C. Other (specify)
- 10 .If you have older children, have maternal checks been a routine or regular?
If no, why are you taking it regularly now?
- 11 .Antenatal attendance for previous pregnancy- Reasons
 - A. lack of funds
 - B. no reasons for irregular attendance
12. Have you lost a child before during birth or pregnancy? What coursed it?
- 13 .Any changes in living conditions, what factors contributed to the changes? e.g.
 - better living conditions
 - Is it due to free antenatal care?
 - Other (specify)

14. Any changes in infrastructure? i.e. Has there been an enlargement or expansion?

A. Yes

B. No

C. I don't know

15. Are pregnant women comfortable in terms of (space) when they visit the hospital? Is it always crowded? What factors contribute to the crowding?

16. Do you have a good rapport with medical staff when you go for antenatal?

17. Do you think there has been an increase in the crowd (attendance)?

18. Are there adequate health personnel to attend to you when you visit the antenatal centre?

19. How long does a pregnant woman have to wait in line to be attended to? Is it different from when antenatal care was not free?

20. Do pregnant women get all the medicine prescribed by the doctor from the hospital? Do they have to buy a larger quantity which the scheme does not cover?

21. How can the government improve the maternal health scheme?

22. Should the scheme continue? Why or why not?

e.g. teenage pregnancy is on the increase so free maternal care must stop.

It should continue because I no longer have to worry about maternal check bills.

HOSPITAL STAFF

23. Any rise in antenatal attendance?

24. If yes, what is its impact (effect) on hospital staff and equipment?

25. Any expansion in hospital facility?

26. What is the rate of maternal deaths at Kath? What are the possible causes of the maternal deaths?

27. Is there an upward or downward trend of maternal deaths?

28. Has free antenatal health care reduced maternal deaths and mortality rate? If yes how? If no, why?

29. Records of NHIS in KATH

30. Are pregnant women treated in privacy with confidentiality?

31. How about family planning issues, does the hospital organise counselling sections, are

contraceptives free? How is KATH staff assisting in this direction to curb unwanted pregnancies and maternal death?

Approval Letter from Ethics-KATH



**KWAME NKURUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES**

**SCHOOL OF MEDICAL SCIENCES
COMMITTEE ON HUMAN RESEARCH PUBLICATION AND ETHICS**

Our Ref: CHRPE/Student/65/10

May 24, 2010

Mrs. Lydia Atkins
KNUST Basic School
P.O. Box 598, Kumasi

Dear Madam,

LETTER OF APPROVAL

Protocol Title: *"Female Health and Development: A Case Study Regarding a Maternal Health Scheme in Komfo Anokye Teaching Hospital, Kumasi"*

Sponsor: Principal Investigator

Your submission to the Committee on Human Research Publication and Ethics on the above named protocol refers.

The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year. The committee may however, suspend or withdraw ethical approval at anytime if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the committee if any amendment to the protocol or use, other than submitted, is made of your research data.

Please note that photo taking is deemed irrelevant to this protocol; the Committee does not approve it as part of your study protocol.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Thank you Madam, for your application.

Yours faithfully,

Rev. Prof. Alan Appian Poko
Honorary Secretary
For: CHAIRMAN

Introductory Letter from KNUST

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University Post Office
Kumasi, Ghana

TAB.7

February 11, 2010

Our Ref:

Your Ref:

Date:

THE ADMINISTRATOR
KNUST HOSPITAL
KUMASI

Dear Sir/Madam,

REQUEST FOR ASSISTANCE

This is to introduce to you Mr./Miss/ Mrs. Lydia Aikins, a second year/third year/fourth year undergraduate/postgraduate student of Department of Environmental Science at Kwame Nkrumah University of Science and Technology, Kumasi.

They are/He is/She is currently working on a project entitled: "Female Health and Development: A Case Study Regarding a Maternal Health Scheme in Kumasi" and requires the understated assistance from your outfit.

- | | |
|--|---|
| To use facilities in your laboratory [] | To obtain information [] |
| To obtain chemical(s) [] | To collect data [<input checked="" type="checkbox"/>] |
| To test sample(s) [] | To collect samples(s) [] |

The Department will be most grateful if she can receive all the assistance she needs to achieve this goal.

Sincerely yours,

W. G. Akanwariwak
W. G. AKANWARIWAK
HEAD OF DEPARTMENT

*D.H.S.
To see JSA
16-02-10*

*This research is designed to be carried out at KNUST, but not here
17/2/10*

DES is in the Faculty of Biosciences, College of Science

Certificate of Registration for Research in KATH



**KOMFO ANOKYE TEACHING HOSPITAL
RESEARCH AND DEVELOPMENT UNIT (R & D)
CERTIFICATE OF REGISTRATION**

REG. NO. RD/CR/089

This is to certify that

Prof/Dr/Mrs/Mr/Ms. Lydia Aikens
has registered his/her proposed study titled Female health and development
a case study regarding a maternal health scheme in Ghana, Kumasi
with the Research and Development Unit.

Date 15th April, 2010

Name of issuing officer
Bernard Arhin

Signature
Arhin

*Must tally with registration number on the registration form

Permission Letter to KATH-Obstetrics and Gynecology department

KNUST Primary School

P. O. Box 598

Kumasi

28-4-2010

The Head

Department of Obstetrics & Gynaecology

KATH, Kumasi

Dear Sir/Madam,

PERMISSION TO COLLECT DATA FOR MY RESEARCH WORK

I am a student of Agder University which is affiliated to KNUST. In partial fulfillment of the requirement for the degree of MASTER OF SCIENCE IN DEVELOPMENT MANAGEMENT, I am researching on the topic: **Female Health and Development: A case study regarding a maternal Health Scheme in KATH, Kumasi Ghana.**

My objective is to find out to what extent the free Antenatal and Delivery care scheme has improved the life of pregnant women and its contribution to the achievement of the MDG 5 and 4. This is to improve maternal health and reduce child mortality. In order to achieve this objective, I am by this letter seeking permission to enable me gather information from staff and pregnant women for this work.

Thank you for your usual co-operation and consideration.

Yours faithfully,



Lydia Aikins (Mrs.)