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Women's Navigation of Maternal Health Services in Ghana's Upper West Region in the Context of the National Health Insurance Scheme

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Supervisor: Isaac Luginaah, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in Geography

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**Women's Navigation of Maternal Health Services in Ghana's Upper West Region in the
Context of the National Health Insurance Scheme**

(Thesis Format: Monograph)

by

Andrea Christine Rishworth

Graduate Program in Geography

A thesis submitted in partial fulfillment
of the Requirements for the Degree of
Master of Arts

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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Abstract

In 2008 the sub Saharan African country of Ghana implemented a Maternal Exemption Policy (MEP) within its National Health Insurance Scheme. This policy provides coverage for free antenatal, postnatal, and facility delivery to all pregnant women for a one year period. By removing the fees associated with maternal health services, the MEP was intended to reduce maternal mortality and provide equitable health care for pregnant women. While the MEP is generally regarded as beneficial to the women of Ghana, challenges remain, especially in the poor, marginalized and rural communities of the Upper West Region. Given that access to a skilled attendant for birth is widely recognized as the most important factor to prevent maternal deaths and achieve improved maternal health outcomes, this thesis explores barriers to access and utilization of maternal health services provided under the MEP. Using a multi-theoretical framework (political ecologies of health, feminist political ecology, behavioural access to healthcare model) and data from in-depth interviews (22), focus group discussions (10), and key informant interviews (12) collected in 2013 in the Upper West Region, this thesis examines factors which affect women's navigation of maternal health services, in the context of the maternal exemption policy. Findings suggest certain socioeconomic, geographic, and cultural characteristics, such as hidden costs, lack of available transportation, and the banning of traditional practitioner delivery, dramatically influence the access and use of maternal health care. Although the MEP is technically free, barriers to access exist at every stage of pregnancy, posing detrimental health risks. Results from this study inform policy recommendations.

Key Words: Maternal Health, Health Insurance, Ghana, Access to Care, Gender, Health Policy

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List of Abbreviations

ANC	Antenatal Care Service
CEDAW	Convention of the Elimination of All Forms of Discrimination Against Women
CHPS	Community Health Programme Service
FGD	Focus Group Discussion
FPE	Feminist Political Ecology
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HF	Health Facility
IAG	Safe Motherhood Inter-Agency Group
IDI	In-depth Interview
IMF	International Monetary Fund
KI	Key Informant
MEP	Maternal Exemption Policy
MDG	Millennium Development Goal
MHC	Maternal Health Care
MHS	Maternal Health Services
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
PEH	Political Ecology of Health
SSA	Sub-Sahara Africa
TBA	Traditional Birth Attendant
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities/ United Nations Population Fund
UWR	Upper West Region
WHO	World Health Organization

Chapter 1

1 INTRODUCTION AND CHAPTER OUTLINE

1.1 Research Background

Maternal mortality rates (MMR) represent the single largest health discrepancy between developed and developing populations, with nearly all – over 99% – maternal deaths worldwide occurring in developing countries (Canudas-Romo, Liu, Zimmerman, Ahmed, & Tsui, 2014). Over half of these deaths occur in sub-Saharan African (SSA) countries (Canudas-Romo, Liu, Zimmerman, Ahmed, & Tsui, 2014), and most are avoidable with preventable medical care (Lawn, Cousens, Zupan, 2005; Ronsmans, Graham, 2006; Stanton, Lawn, Rahman, Wilczynska-Ketende, Hill, 2006; WHO, UNICEF, UNFPA, 2004). Most of these deaths occur around the time of delivery and are unpredictable (there are no obvious clues ahead of time of what deliveries will lead to complications). Therefore, it is important that all pregnant women have access to a skilled attendant for birth (i.e. someone with midwifery skills), who are able to manage a normal delivery and can recognize and manage obstetric complications. Skilled attendance at delivery is advocated as the “single most important factor in preventing maternal deaths” (WHO, 1999; 16), and is argued as the most efficient strategy for low-income countries to reduce maternal mortality. Ideally skilled providers should be placed in health centers with referral capacity (Campbell, Graham, 2006). In practice, skilled attendance in most countries, such as Ghana, is synonymous with facility delivery.

Global discussions surrounding the reduction of maternal mortality, particularly in SSA have heightened in recent years, prominently due to increased attention directed towards Millennium Development Goal 5 (MDG5), which aims to reduce maternal mortality by three quarters by 2015, while providing access to universal reproductive health services (UN, 2012). Yet, this is one of the goals for which progress has been the slowest (Hogan et al., 2010; Paxton & Wardlaw, 2011). To reduce mortality rates, international health agencies (i.e. IAG, WHO, UN)

have begun to address factors inhibiting rate reduction, primarily focusing on costs associated with maternal health coverage. Given that SSA holds the highest, most disproportionate burden of maternal mortality (ranging from 400-750 per 100,000 live births) compared to global levels (260,000 per 100,000 live births) (WHO, 2012), economic costs associated with maternal health care have been given heightened attention, with user fees, (i.e. cash payments required to access services at health facilities) perceived as a key barrier to improving maternal health care and limiting the use of health services (Ansah et al. 2009; Borghi et al., 2006; Lagarde & Palmer 2008, 2011; Palmer et al., 2004; Parkhurst et al., 2006), particularly for the poorest households (Nabyonga et al., 2005; Xu et al., 2006).

1.2 Research Problem and Question

Multiple calls to abolish user fees for maternal health care have been repeatedly voiced (Ridde & Haddad 2009; Yates, 2009), triggering many countries in SSA to introduce fee exemption health service programs targeting pregnant women and children (e.g. Burundi, Ghana, Kenya, Niger and Senegal) (Ana, 2011; Richard et al., 2013). Ghana responded to its high maternal mortality rates and inequities in health provision for poor rural women by introducing a maternal exemption policy (MEP) in 2008, which effectively gave pregnant women free enrolment in the national-level health insurance system, and thus providing health coverage for pregnant women. Covered items include, antenatal care (ANC), delivery services, post-natal care of the mother and free neonate coverage on the mother's card for three months after delivery in all accredited health facilities (Dzakpasu et al., 2012). Women must prove their pregnancy and go through the process of policy registration before they can take advantage of this offer for free maternal health care (Witter et al., 2013).

Despite the MEP, Ghana's maternal mortality rates remain persistently high and outside the MDG 5 targets with rates between 378 (GSS, 2009) and 560 deaths per 100,000 live births (WHO, 2009). These figures likely mask regional disparities, where striking differences in

wellbeing and access to health care between rich urban centres and poor rural areas exists (MOH, 2011). Together, this means that women living in deprived rural areas face fundamentally different challenges related to access and utilization of health services than their urban counterparts.

Theoretically, cost barriers to deliver in a facility should be eliminated with the introduction of maternal premium exemption policies. However, there are concerns that cost at the health facility may only be part of the problem in enabling access and utilization for maternal care in rural SSA. Studies on Ghana's MEP and health insurance more broadly tend to privilege discussion of equity surrounding matters of wealth, improved access, and increase in facility utilization (Asante, Chkwama, Daniels, Armar Klemesu, 2007; Health Systems 20/20; Omane-Adjepong, Ababio, Aidoo, Boateng, Loius, Nsowah-Numah, 2012; Penfold, Harrison, Bell & Fitzmaurice, 2007). Nonetheless, such conjectural assumptions of health access rests on the notion that removing user fees will ultimately translate into increased utilization. Such narrow focus sequesters broader discussion of access, while neglecting the intricacies of ones lived environment and ability to utilize health services. This raises concerns that such policies, however well-meaning, may not be sufficiently nuanced and responsive to specific needs of women in Ghana's UWR.

Given this, my thesis seeks to answer the question: *How do women in Ghana's Upper West Region navigate access and utilization of maternal health services in the context of the National Health Insurance Scheme and its Maternal Exemption Policy?*, which is operationalized into the following five objectives:

- 1) To explore women's understanding of the MEP and provided maternal health services;
- 2) To explore the relationship between women's enrollment in the NHIS and enrollment in the MEP;
- 3) To explore the contextual factors which influence antenatal care, facility delivery, and postnatal care in in the Upper West Region;

- 4) To explore the influence of women's autonomy on women's access to maternal care under the MEP and the NHIS;
- 5) To explore how women's experiences with health care workers may influence their use of maternal health care services.

1.3 Contributions of this Research

This research will provide important contributions to understanding women's access and utilization of maternal health services and more broadly towards issues of maternal health policy implementation in Ghana and other SSA countries. Contributions of this research relate directly to three primary areas targeting: theory, methods, and policy.

Principally, this research will contribute to the discussion within health geography, enhancing understanding of gendered health access. The theoretical frameworks employed in the study will allow access to health care to be understood as a function of one's environment, while also recognizing how gender, underscored by structural factors influence ability to access and utilize health care services. These approaches further strengthen the central tenet of health geography which regards our health and our geographies as inextricably linked (Gatreel & Elliot, 2009), while more broadly adding to theorizations on women's health equity (Anderson, 1995).

Secondly, this thesis will demonstrate the importance of using multiple qualitative methods to gain a deeper understanding of factors that influence perceptions, access, and utilization of maternal services. It is hoped that by developing an in-depth understanding of the participants' lived environment, the researcher will suggest interventions that address both specific issues and seek to initiate fundamental changes in health and health care.

Lastly, this thesis will contribute towards the development of policy interventions which address issues of access to maternal health services in Ghana's UWR. Accordingly, the research will demonstrate how access of maternal health services is not exclusively the decision of individual women, but must be interpreted within the context of structural mechanisms, influences of socioeconomic factors, gender relations, and environmental characteristics which

shape, manifest, and determine women's access of maternal health care. Taken together, this thesis hopes to provide policymakers with information that can help in the development of interventions aimed at curtailing poor maternal health outcomes. Further, given the limited resources available to health professionals in the UWR, it is hoped that this thesis will provide an initial guide for further research in the region.

1.4 Chapter Outline

This thesis comprises six chapters. The following **Chapter 2** provides the theoretical framework employed in this research, beginning with a review of literature on women's access to maternal health care within Ghana. The chapter then progresses to an examination of barriers to maternal health care in Ghana. Chapter 2 positions this research within the wider field of health geography and feminist health geography, reviewing contemporary research emerging from the field, as well as discussing the contribution of health geography to the study of women's health within the developing context. This is followed by an explanation of the use of feminist theory, political ecology of health, and Anderson's Behavioural Access model to understand women's use of maternal health services. The three theoretical frameworks grant the ability to unearth various factors influencing maternal health care.

Chapter 3 provides a contextual synopsis of Ghana, focusing on the Upper West Region. The chapter begins by providing a brief history of the country. The chapter then details the social, economic, and demographic characteristics of the UWR. This is followed by a discussion of maternal health care in Ghana, specifically the UWR, outlining current status and challenges pertaining to this access as evident in the literature.

Chapter 4 reviews the study design and methods utilized for data collection and analysis. This chapter also emphasizes the usefulness of qualitative methods within health research, the strengths of in-depth interviews, focus group discussions, and key information interviews for the

outcome of this research. This chapter concludes with an outline of the data analysis techniques used, as well as a brief discussion pertaining to the use of qualitative data analysis software.

The study findings are presented in **Chapter 5**. The results were formulated from the research objectives, which are aimed at capturing the perceptions of research participants and their use of maternal health services. As such, the results seek to address the five objectives while formulating an understanding of maternal health in the context of the UWR. The chapter combines the results from in-depth interviews, focus group discussions, and key informant interviews

Chapter 6 concludes the thesis and situates the empirical findings within current research examining the removal of user fees and maternal health outcomes. Limitations are presented along with potential areas for further research. The chapter also outlines the theoretical and methodological contributions to both the field of health geography, as well as development of potential policy initiatives in the Upper West Region. The research appeals to a combination of policies that address both the immediate problem of mortality reduction, coupled with structural-environmental issues that shape the lived realities and behaviour of women.

Chapter 2

2 LITERATURE REVIEW AND THEORETICAL CONTEXT

2.1 Introduction

This research is situated within the field of health geography and employs an interpretive approach aimed to examine determinants of access regarding health care under Ghana's Maternal Exemption Policy under the National Health Insurance Scheme in the UWR. Through a case study design employing qualitative methods, the study addresses five main objectives:

- 1) To explore women's understanding of the MEP and provided maternal health services;
- 2) To explore the relationship between women's enrollment in the NHIS and enrollment in the MEP;
- 3) To explore the contextual factors which influence antenatal care, facility delivery, and postnatal care in in the Upper West Region;
- 4) To explore the influence of women's autonomy on women's access to maternal care under the MEP and the NHIS;
- 5) To explore how women's experiences with health care workers may influence their use of maternal health care services.

In examining barriers to maternal health care within the context of the MEP, this research draws on the theoretical frameworks of: feminist theory (particularly the gender equity approach), political ecologies of health, feminist political ecology, and Andersen's behavioural access model of health care. This theoretical combination provides a platform in which to understand the complexities of maternal health in the UWR.

Until recently, concepts of gender and sex have been a missing component within these theoretical frameworks (Caldwell, Orubuloye, Caldwell, 1994), consequently stagnating discussion of women's health issues. This absence created a dominant research environment that is unfavorable to examining the gendered components of health issues. However, heightened

awareness of women's health needs both in research and within the international area has led to a social model of health which locates women's health issues as central to analysis (Ruzek, 1993). This increased consideration to the diversity and intricacies of women's health issues, draws attention to the diversity of women's health throughout the life cycle (i.e. adolescence, maternity, postpartum) (Dyck, Lewis, McLafferty, 2001). Accordingly, maternal health care falls under the umbrella of reproductive health care services. Whereas the former corresponds to care received during pregnancy (i.e. antenatal, delivery, postnatal), the later refers to women's health needs throughout their life course (i.e. adolescence, puberty, adulthood, and menopause). By drawing on aspects from these theoretical frameworks, a rich environment is cultivated in which to gain insights regarding maternal health outcomes in the UWR.

The political ecology of health framework, originally proposed as political ecology of disease by Mayer (1996), and subsequently modified (Hunter, 2003; Kalipeni & Oponng, 1998; King, 2010; Richmond et al., 2005; Turshen, 1984), provide a means to interpret health and disease in a localized context while examining broader socioeconomic and environmental forces that support, constrain, and produce (ill) health. Additionally, the intricacies of feminist theory offer a way to decipher common binaries and dichotomies of life while understanding that individual worldviews are socially constructed within a particular context reflected in social order, while offering a way to empower women and other oppressed people (Sprague & Zimmerman, 2004).

The terms health care access and health care utilization have distinct definitions, though the two ideas are not mutually exclusive. Simply put, access can be understood as the "the opportunity or right to see or approach", while health care access is defined as the opportunity or ease that patients have in using the appropriate services, as according to their needs (Levesque, Harris, & Russell, 2013). Utilization is the actual use of the health care, or what Andersen has called "realized access" (Andersen, 1995).

In practice the two concepts are deeply intertwined. For instance, Levesque, Harris and Russell (2013) found that access is usually used to mean either approachability, acceptability;

availability and accommodation, affordability and/or appropriateness of the health care. Yet, in the abstract, all five of these dimensions can also influence a patient's utilization. On a similar note, Glick reflects that while a patient may see having no transportation or the burden of other responsibilities as preventing their access to health care, "to a health care provider, these concerns may be seen as underutilization of available resources. The providers are available; they're just not being used. That is not an access problem" (Glick, 2009: 398). Perhaps in part because of this confusion the two terms are frequently used interchangeably in the literature.

While the reader should be aware of the difference in these concepts, and the debate in the literature as to their proper use, for the purposes of this thesis I am not focused on measuring 'either-or'. The primary reason for this is the recognition that *both* access and utilization are important elements in trying to understand a women's navigation of the health care system (see objectives). Indeed, Andersen's Behavioural Model included both parts in a feedback loop of causation (see Andersen, 1995). In sum, the two parts (access and utilization) work together as part of the whole experience, so it is not necessary to try to separate the two apart.

This chapter situates Ghana's maternal health policy within the discussion of global maternal health care. This is followed by a description of Ghana's Maternal Exemption Policy (MEP), provided services and potential barriers to health access. The National Health Insurance Scheme, Maternal Exemption Policy, and women's utilization of maternal health care services is also discussed. The second section theoretically situates this research within the field of health geography and feminist health geography, examining the discourses and epistemologies which characterize the discipline. The third section concludes the chapter by providing the theoretical framework guiding this research. An examination of the intricacies of political ecologies of health, feminist theory, and Andersen's Access/Utilization of Health Care Model are presented establishing the convergence of the three theoretical perspectives.

2.2 Global Maternal Health

Global health leaders have put increased attention on the problems of maternal mortality over the past two decades while simultaneously intensifying initiatives to alleviate the number of maternal deaths, including the 1987 Safe Motherhood Initiative, the 1994 International Conference on Population and Development, and most notably the development of the fifth United Nations Millennium Development Goal (MDG 5) which aims to reduce the maternal mortality ratio (MMR) by three-quarters from 1990 to 2015 (International Conference on Population and Development, 1995; Obaid, 2009; Ronsmans & Graham, 2006; Starrs, 2006; United Nations General Assembly, 2000). Maternal health outcomes are a key indicator of societal development where low maternal mortality translates to better social services and higher rates of development (WHO, 2009). Nonetheless, there is a growing disparity among maternal health outcomes between developed and developing countries creating vast inequalities in health outcomes (WHO, 2009). Annually, 260,000 women die worldwide during pregnancy and childbirth; with 99% of these deaths occur in developing nations (WHO, 2012).

Despite global attention aimed to improve maternal health outcomes, maternal mortality especially within sub-Saharan Africa (SSA) remains a major public health concern. Estimates suggest SSA holds a disproportionate burden of the world's maternal deaths, ranging from 400-750 maternal deaths per 100 000 live births (WHO, 2012) representing globally the highest regional maternal mortality rate. Ghana has similar outcomes, with results placing the maternal death rate between 378 (GSS, 2009), 560 (WHO, 2009), and 819 deaths per 100,000 live births (Hogan et al., 2010).

Studies from World Health Organization (WHO) data and other international organization (i.e. UNFPA, IAG) indicate that most maternal deaths in SSA are related to direct obstetric complications that occur around the time of childbirth, such as haemorrhage, hypertension, or obstructed labour (Kahn et al., 2006). In order to mitigate these problems in low resource settings, particularly SSA, it is widely recognized that access to skilled delivery care at

health facilities is key to reducing maternal and perinatal mortality and morbidity (Meda et al, 2008; Ofori-Adjei, 2007; WHO, 2009). As such, strategies have focussed on getting women support before, during, and after childbirth to prevent avoidable maternal and infant mortality, stressing the importance of skilled care provision. Consequently, the provision of adequate maternal and reproductive health presents major challenges for female populations, since both women's resources and needs are inherently varied with diverse economic, geographical, cultural and religious factors constantly changing throughout the reproductive life span of the individual (WHO, 2009).

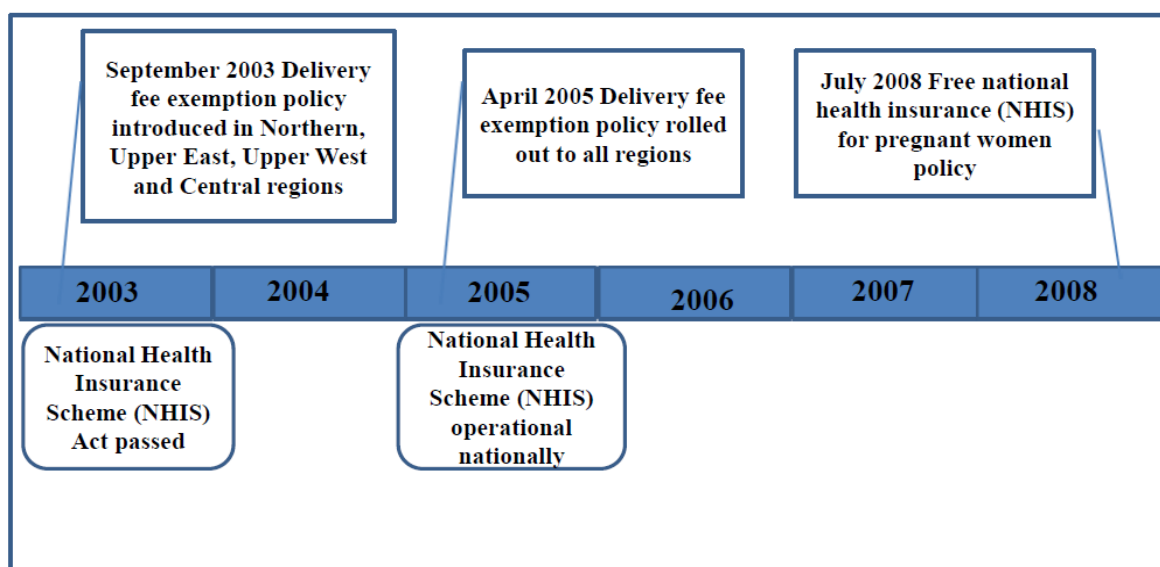
2.3 Health Care in the Upper West Region

One of Ghana's greatest challenges is that infrastructural development and economic prosperity are disproportionately shared amongst the population (GSS, GHS & ICF Macro, 2009; IMF, 2012), a problem embedded in Ghana's colonial legacy and continuously reinforced by government policy and harsh environmental conditions (Agyei-Mensah, 2006; Konadu-Agyemang, 2000; World Bank, 2011). Growing poverty levels have pervaded the northern half of the country (Coulombe & Wodon, 2007) creating striking differences in wellbeing and access to health care between rich urban centres and poor rural areas (MOH, 2011). Together, this means women living in the northern rural areas encounter fundamentally different lifestyles than their southern and/or urban counterparts. As Ghana strives to meet its MDG 5 commitment to reduce maternal deaths in the country, there must be a conscious effort to target rural women in the poorest areas of Ghana.

Ghana is a developing SSA country that has in many ways, dramatically improved national health care access within recent years. In 2003, Ghana established the National Health Insurance Scheme (NHIS) aimed to provide equitable, affordable health coverage (Agyepong & Adjei, 2008; Mensah, Oppong, Schimdt, 2012), mitigating problems associated with the previous "cash and carry" health system, where patients were required to pay for health care, inherently

restricting access for a large portion of the population (Waddington & Enyimay, 1989). Regarded as highly beneficial, the NHIS was created as a “pro-poor” health system, alleviating the need to pay out of pocket at the point of service delivery (Agyepong & Adjei, 2008). However, women who were not enrolled in the NHIS still had to pay for maternal health care services. Between 2005 and 2008, Ghana had in place a “free delivery” policy which functioned separately from the NHIS, and was found to increase maternal facility deliveries, though was plagued by problems of funding, budgeting and increased workloads as more women attended (Witter et al., 2007). Even with the “free delivery” policy, women continued to encounter challenges to health services due to communication and management failures (Witter et al., 2007). In order to rectify divergent policies and provide more comprehensive maternal health coverage, the government implemented a Maternal Exemption Policy (MEP) within the NHIS. See Figure 1 for a timeline of NHIS and Maternal Health policy implementations.

Figure 1: Timing of Ghana’s Health Insurance and Maternal Health Policies



Adapted from: Dzakpasu, S., Soremekun, S., Manu, A., ten Asbroek, G., Tawiah, C., Hurt, L. ... & Kirkwood, B. R. (Nov. 2012).

2.4 Maternal Exemption Policy and Women's Access of Maternal Health Care

The MEP allows all pregnant women to be exempt from paying health insurance premiums and yet receive coverage under the NHIS for a limited period following pregnancy with the incentive that they would join the NHIS (WHO, 2010). Maternal health coverage is extensive, including: a minimum of four antenatal care visits, free delivery (including more expensive procedures such as caesarean sections), management of emergency obstetric conditions, postnatal and neonate care, and applies to all NHIS accredited facilities, both public and private for a coverage period of a year (MOH, 2004; WHO, 2010:18).

Health services in the UWR, as in the rest of Ghana, are organized along a three-tier health system consisting of hospitals, health facilities (HFs) and Community Based Health and Planning Services (CHPS). Hospitals provide the most extensive care, and are commonly staffed with doctors, midwives, and nurses. However, due to shortages of health personnel in the UWR, health facilities receive sporadic visits from doctors, and are commonly staffed by nurses and few medical assistants, and seldom employ a midwife. CHPS act as lower tier health infrastructure, which are part of the Community Based Health and Planning Services (CHPS) initiative (Awoonor-Williams et al., 2004; Nyonator et al., 2005) started in 1999 by the Government of Ghana to increase access to primary health care across the country. CHPS provide basic preventive and curative services including services provided under the MEP, and are commonly staffed with nurses who facilitate health care to underserved and rural communities (Awoonor-Williams et al., 2004; Nyonator et al., 2005). Nonetheless, they too are often short staffed and managed with limited health personnel.

Despite recent progress, challenges remain in providing accessible maternal health care. Theoretically, the introduction of free maternal health services for women should reduce maternal mortality rates and alleviate costs associated with pregnancy. With such expansive national health services, together with the proliferation of global maternal health awareness surrounding the

importance of skilled delivery, it could be assumed that Ghana would experience significant reductions in maternal mortality rates. Nonetheless, Ghana faces challenges of meeting its MDG 5 target of 75% reduction in the mortality rate. Recent studies have estimated Ghana's maternal death rate between 378 (GSS, 2009), 560 deaths (WHO, 2009), and even possibly as high as 819 deaths per 100,000 live births (Hogan et al., 2010) based on study design.

The maternal exemption policy should, in theory, see improvements for women's health and maternal outcomes across the country as coverage and number of women delivering in health facilities has increased (e.g. the Brong Ahafo Region increased from 81.1% to 86.5%) (Dzakpasu et al., 2012). Despite some regional increases, the rate of skilled delivery in the UWR has remained low, with 22.3% of women delivering with a skilled attendant in 2010 (Nang-Beifua, 2010). Notwithstanding increases, the UWR has one of the lowest rates of skilled delivery compared to the national average of 52.2% (GSS, 2011). Furthermore, since the implementation of the MEP, reported regional mortality rates in the UWR have remained consistent (Nang-Beifua, 2010), suggesting underlying challenges for women seeking maternal health care (Ekman, 2004; MOH, 2004).

Evidence from successful maternal health programs in other countries teaches us that many deaths and complications can be avoided if all women had the assistance of skilled health workers during pregnancy and access to emergency care when complications arise (WHO, 2003). Yet, in these other examples, despite free health services, women continue to experience devastating maternal outcomes. Even though most women understand the underlying logic and safety imperative for seeking skilled assistance during childbirth, numerous other reasons inhibit access to skilled care, in turn creating detrimental health impacts for women and children (Aboagye, Agyemang, 2013). Previous studies examining the cost efficiency of the MEP found that the exemption was effective in significantly raising the utilization of health services in Ghana's Central Region (Penfold, Harrison, Fitzmaurice, 2007), while others found exemptions in Ghana increased access to healthcare in a timelier manner by removing out of pocket costs

(Apoya &Marriott, 2011; Blanchet, Fink, & Osei-Akoto, 2012; Sekyi & Domanban, 2012; Sulzbach, Garshong, & Owusu-Banahene 2005; GHS, 2009; Witter & Garshong, 2009). While some indicate the MEP has been an effective tool in increasing facility deliveries for women (Blanchet, Fink, & Osei-Akoto, 2012; Dzakpasu, Soremekun, Manu, ten Asbroek, Tawiah, Hurt, Kirkwood, 2012; Mensah, Oppong, & Schmidt, 2010; Sekyi, & Domanban, 2012; Witter & Garshong, 2009), others raise concerns about the overall effectiveness of this policy, as it may not uniformly remove financial barriers across social groups to accessing health facilities (GSS, 2012; Witter, Garshong, & Ridde, 2013).

Often the most vulnerable populations, such as poor, uneducated, rural women experience heightened difficulty obtaining access to health care. Previous literature reveal obstacles to health services which include but are not limited to, meagre finances, scarcity of available transportation, and socio-cultural influences (Asante, Chickwama, Daniels, Armar-Klemesu, 2007). The potential for exemption policies to translate into improved health outcomes for women and children depends on the effectiveness and implementation of the health policies and service provision.

Theoretically, poverty and cost barriers to delivery in a facility should be eliminated with the introduction of the maternal premium exemption policy. However, there are concerns that cost at the health facility may only be part of the problem in enabling access and utilization for maternal care in rural Ghana. (Adai, 2000; Gymiah, Takyi, & Addai, 2006; Gyimah, 2007; Mills, S., Williams, J., Adjuik, M., & Hodgson, A., 2008). Given the complexity of access and utilization and the multidimensional factors influencing maternal health access and utilization (Gabrych, 2009), this thesis adopts a qualitative approach to data collection and analysis, emphasizing theory development from multiple perspectives of reality to understand factors which contribute to uncovering access and utilization of health services. The concern that such policies, however well-meaning, may not be sufficiently nuanced and responsive to specific needs of particular groups of people forms the central focus of the present study.

2.5 Barriers to Maternal Health Care in Ghana

Maternal health care encompasses the spectrum of antenatal care, facility delivery, and postnatal coverage. While women navigate access and utilization of maternal health services in various regions of Ghana, research studies are building to indicate that questions of access and utilization are somewhat dependent on the phase of maternal health care. As such, the issues are first highlighted below in the separate phases of the spectrum of maternal health care. However, as all of these phases reveal similar challenges in access and utilization of maternal health services. Therefore, after discussing the timing specific findings (ANC, delivery, postnatal), the common barriers in the literature will be presented individually to allow the reader to fully appreciate their impact.

2.5.1 Antenatal Care

The National Ghana Reproductive Health policy recommends a minimum of four antenatal visits per client. However, 2010 data indicates that only 67% of MEP registrants visited ANC four or more times during pregnancy, revealing a decrease from 78% in 2008 (Nang-Beifua, 2010). Findings reveal that even though antenatal health services are rendered free of charge, wealth still has an influence on the use of ANC service, revealing that women in higher wealth quintiles more likely to make more ANC visits than those in the lowest wealth quintiles (Arthur, 2012). Further, a woman's type of employment had no association with the number of times women attended ANC, but was associated with the timing of ANC visits, indicating employed women were more likely to attend ANC in the first trimester of pregnancy than the unemployed (Dixon, 2013).

A study examining NHIS enrollment and use of antenatal care revealed that the NHIS did not have a significant influence on the timing of first ANC visit (Dixon, 2013). This may be for two reasons: first, NHIS can only impact the timing of ANC if women are aware they are pregnant, and some women in Ghana and the rest of SSA do not realize they are pregnant until

the second trimester, making early ANC impossible (Gross, Alba, Glass, Schellenber, Obrist, 2012; Myer & Harrison. 2003; Pell et al., 2013). Second, the poor are less likely to be enrolled in the NHIS (Dixon et al., 2011), and thus women of higher socioeconomic status are more likely to already be enrolled when they discover they are pregnant, making early ANC more practical.

Although Ghana's MEP exempts pregnant women from premium payments, there are multiple points in pregnancy where the "free" enrollment may be deterred or delayed by other obstacles (Pell et al., 2013). These include realization of pregnancy, cost of travel to a clinic, completing a pregnancy test, travel to the NHIS office to initiate and complete paper work with the agent, which may take multiple visits. The end result is the receipt of a temporary enrollment card. Thus, by the time a woman receives her MEP enrollment it may be well beyond her first trimester.

Further, additional factors such as education, where less educated women, especially in rural centers are less likely to utilize ANC to the full capacity. The age of the expectant mother, number of living children and health insurance status influence the use of ANC, whereby older women are more likely to use more ANC compared to younger women. Additionally a woman's religious affiliation was found to influence ANC use, indicating Christians compared to Traditionalists and women without any religious affiliation demonstrated increased antenatal visits (Dixon et al., 2013).

2.5.2 Facility Delivery with Skilled Attendant

Medical experts in the literature regard health facilities and hospitals as the most ideal, safest location for delivery (Starrs, 1997; WHO/UNFPA/UNICEF/World Bank, 1999; WHO, 1996). Nonetheless, due to geographic disparities in access to health facilities and limited number of health professionals, women in the UWR are most often unable to deliver with a skilled health professional. The GHS estimates that only one out of every five (22%) women of the UWR delivered in a facility (Nang-Beifua, 2010). Additionally, a study using nationwide data from the

Ghanaian Living Standards Survey found women who reside in urban areas are approximately 16% more likely to deliver in public facilities relative to home delivery (Nketiah-Armponsah & Arther, 2013). This geographical barrier relates to the distance between the service providers and recipients, which becomes more problematic for women farther away from a health facility. In some remote towns, the unavailability of transportation and the cost of transportation are severe all year round and thus lead to delivery outside of a facility (Aboagye, 2013).

Stark differences exist between women's income and delivery with a skilled birth attendant (Witter, Adjei, Armar-Klemesu, Graham, 2009), revealing a positive correlation between skilled delivery and wealth quintile (GDHS, 2009), with a 3.2 fold increase in utilization of skilled birth attendants between women in the poorest (24%) and richest (93%) socioeconomic groups (WHO, 2009; GDHS, 2009). Generally, women in the highest wealth quintile and those with a secondary education were the least likely to report having a serious problem accessing health facilities (GDHS, 2009). Educational attainments of the women was found to significantly affect delivering at a facility as women with primary, secondary education or above were more likely to deliver in a facility compared to their uneducated counterparts (De Allegri et al., 2011; Mrisho et al., 2007; Nketiah-Armponsah et al., 2013).

2.5.3 Postnatal Care

Postnatal care within the first two days (48 hours) of childbirth is of crucial importance for both the women and child's health as it ensures there are no complications or problems associated with delivery (GDHS, 2009). However, only 34.1% of women in the UWR receive postnatal care (Nang-Beifua, 2010). Women who deliver in a facility are more than twice as likely to have a postnatal check-up within the first two days of delivery compared to women who delivered outside of a facility (GDHS, 2009). This may be related to the level of awareness surrounding the importance of postnatal care, knowledge imparted from health personnel or close proximity to health facilities for postnatal care.

Even though Ghanaian women have the same specified care provisions during the postnatal period, women's ability to access services is varied due to geographic or socioeconomic limitations. In Ghana, 63% of mothers obtain postnatal care from a health professional, 12% from traditional birth attendants, and approximately one in four women (23%) do not receive any postnatal care within 41 days, which almost marks the end of the postnatal period (GDHS, 2009). This is detrimental to both the health of the woman and child marking vast health disparities.

Studies suggest that postnatal care is strongly associated with socioeconomic status as women in the highest wealth quintile more than twice as likely to have an early postnatal check-up and receive postnatal care from a health professional compared to women in the lowest wealth quintile (GDHS, 2009). A similar pattern is observed by level of education, where mothers with secondary or higher education are twice more likely to receive postnatal care from a health professional than those with no education. As well, geographic location plays a role in access to postnatal care; revealing women in northern regions are 45% less likely to access postnatal checkups from a health professional within the first two days of delivery than women in the south. This is most likely because facility based delivery is the lowest in the northern regions (GDHS, 2009).

2.5.4 Location of Health Care Provision

Some studies suggest that health insurance registration has increased significantly among pregnant women after adoption of the MEP. However, women received differential treatment at hospitals, health facilities, and CHPS, which has subsequently created other complications throughout pregnancy. Results in Ghana indicate coverage of clinical and diagnostic services for pregnant women was high, but during ANC clients received only partial counselling about safe motherhood (e.g. pregnancy-related danger signs). Findings also reveal the location of ANC influenced location of delivery, where women who sought ANC in hospitals or health facility

were more likely to deliver in a health facility compared to women who sought ANC at a CHPS (Frimpong, Helleringer, Awoonor-Williams, Aguilar, Phillips, & Yeji, 2013).

Higher quality maternal health services were found to be associated with seeking treatment at a hospital, compared to women who received treatment at CHPS, where women received fewer diagnostic tests, were less extensively counselled about safe motherhood and were less likely to be vaccinated against tetanus toxoid than non-registered clients. Thus, this locational variation in care provision is likely associated with the level of awareness and treatment a woman receives during pregnancy, ultimately affecting delivery location.

2.5.5 Wealth

Socioeconomic status has been found to play an important role both independently and as a mediating factor in determining access of MHC and delivery in a facility (Moyer, et al., 2013). Financial (in)security is found to influence a woman's ability to access maternal health services, where women in the highest wealth quintile experience fewer problems accessing health facilities than poor women (GDHS, 2009). Indirect consumer costs such as transportation, purchasing of drugs during pregnancy (both in hospital and clinic), food, and lodging for the mother and accompanying family members also affect use and access of maternal health care (Abel-Smith & Rawal, 1992; Kawnine et al. 1998; Nahur & Costello 1998; Witter, Garshong and Ridde, 2013). Indirect costs also encompass the opportunity costs lost from seeking care, which relate to reduced family wellbeing in the absence of a primary caregiver, or the income/ employment lost due to health seeking behaviour (Ensor et al., 2004; McIntyre et al., 2005).

2.5.6 Geographic Barriers: Urban-Rural, North-South Disparities

Disparities in health access exist both between the rural and urban areas in Ghana, and between the northern and southern half of the country. Studies indicate women in rural and urban areas experience vast inequalities in the location and attendance of birth, revealing urban women

are twice as likely to deliver with a health professional at a facility than a women in a rural area (GDHS, 2008; GDHS, 2009) with only 30% of rural births attended by a skilled professional (WHO, 2009; GDHS, 2009). As well, caesarean sections are more common in urban areas (11%) than rural areas (5%) (GDHS, 2009) likely associated with greater access to doctors in urban areas (GDHS, 2009). Contraceptive use also varies dramatically as 19% of women in urban areas utilize modern contraceptives compared to their rural counterparts (WHO, 2009).

Northern Ghana experiences significant shortages in health personnel and health facilities compared to significantly higher concentrations in the south, due to higher rates of industrialization and urbanization (Dovlo, 1998). Rates of skilled delivery are significantly lower in the northern regions, where only 14% of women receive care from a doctor compared to 47% in the south (GDHS, 2009). Utilization of skilled birth attendants span from 47% in the UWR to 85% in the Accra area, highlighting an almost twofold difference in utilization representative of great disparity within the country (WHO, 2009). Further, large knowledge gaps exist regarding complications of pregnancy. Studies indicate only 46% of women in the north receive knowledge surrounding pregnancy complications compared to 85% of women in the south (GDHS, 2009).

2.5.7 Education

There is a strong relation between a woman's education level and their utilization of doctors and nurse/midwives during pregnancy. Nationally, women with secondary education or above have higher rates of using health care services (46-50%) (GDHS, 2008). Conversely, women with no education have significantly lower rates of utilization of doctors and nurse/midwives (11.4% & 66%, respectively) (GDHS, 2009). Results also indicate the use of family planning services (i.e. contraceptive use, planning practices) is directly related to women's educational level (GDHS, 2009). Findings indicate the Ghana fertility rate is inversely related to education and wealth as fertility decreases with higher education and increased wealth (Solo, et al. 2005). Socioeconomic factors influence the rate of contraceptive use. Women in the highest

wealth quintile, who have a secondary education or higher, and live in an urban location have the highest use of contraceptive methods in Ghana (World Bank, 2011). Alternately, rural women experience a total fertility rate that is double urban women (Solo, et al).

2.5.8 Religion

Religion acts as a significant factor in maternal health care utilization. Even after controlling for socioeconomic variables, Muslim and Traditionalist women were less likely to use MHC compared with Christian women (Gyimah, Taki, Addai, 2006). Various studies indicate use of MHC services is influenced by religious background (Addai, 2000), as women affiliated with the Catholic denomination had a higher utilization rate of health services and were more likely to deliver in a hospital than home when compared to their Muslim and Traditional counterparts (Addai, 2000). Nonetheless, religion may mask other important characteristics associated with health related behaviour (Gyimah, 2007). Traditional views are intertwined with deprived socioeconomic settings, which influence women's perspectives on modern health practices and thus shape their decisions to seek facility delivery (Addai, 2000; Gyimah, Takyi, Addai, 2006; Gyimah, 2007; Tabi, Powell, & Hodnicki, 2006). Religious affiliation and socioeconomic status indicate women of lower socioeconomic position are linked to more Traditional healthcare practices, often due to lower costs of Traditional methods compared with professional health care (Gyimah, Takyi, Addai, 2006; Schouten, Meeuwesen, 2006). Traditional delivery practices, including TBAs have typically been less expensive than hospital based delivery care. As such, illiterate women with presumably fewer economic resources may opt for traditional care. Even with the MEP, the barriers erected by differences in SES are not entirely alleviated (Moyer et al, 2013).

Polygamous practices have been found to influence the rate of MHC utilization. Often rejected by Christians while acceptable in Islamic religions, polygamy is widespread among

certain populations in the UWR. Polygamous household environments place women in a competitive position in the family, where wives are considered rivals (Solo, et al., 2005). In this family structure, the natural way to gain precedence is to have as many children as possible, and as such ignore female family planning practices. Nonetheless, when women in polygamous families want to practice family planning, their husbands and in-laws often do not agree and often punish women with violence (Solo, et al., 2005). Fear of opposition deters women from using modern contraceptives, and when used, is often secretive (Solo, et al., 2005). Therefore, a woman's involvement in a polygamous family commonly associated with religious affiliation may hinder utilization of maternal health care services. Even after controlling for socio-economic and demographic factors, results indicate that religious denomination has a strong impact on the utilization of maternal health services (Gyimah, Takyi, Addai, 2006).

2.5.9 Relations with Health Personnel

Literature indicates relations between health providers and patients influence a woman's utilization of MHC. Studies examining the Ghanaian health system found some nurses degrade and intimidate patients, consequently dissuading them from returning to a health facility for further care (Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei, Adongo, 2008). Health providers routinely blame female patients for their ailments and describe their low education and social status as the main determinants in their 'non-compliance' of good health (Andersen, 1995). Women reported being berated and criticized for lack of knowledge surrounding pregnancy issues. Thus, if women experienced degrading behaviour, they consciously changed their place of delivery and recommendations (D'Ambruso, Abbey, Hussein, 2005). In a rural area such as Ghana's UWR, where patients are likely to be illiterate and of low socioeconomic status, maternal health treatment is likely to be worse. It is observed that due to the harsh and negative treatment women receive at health facilities; women are more likely to choose to deliver at home where they feel more comfortable and are less likely to experience degrading comments.

Additionally, women are less likely to access a facility if they are concerned no female care providers are present (World Bank, 2011).

2.5.10 Barriers to Maternal Health Care Summary in Ghana

Studies that have looked at maternal health care in Ghana reveal that the barriers to care are far-reaching and complex. Not only do these barriers differ by the different phases in the spectrum of maternal care (ANC, delivery, postnatal care), but they are also informed by health service factors (location of care, relations with health personnel), geography (rural-urban, north-south divides), cultural elements (religion, education) and economic elements (wealth). This research takes notes of these many complicating factors, and tries to understand how they interact both within the geographic context of the UWR and the political context of the introduction of the MEP.

2.6 Geography Sub-Disciplines

This work straddles two sub-disciplines within geography: health geography and feminist geographies of health.

2.6.1 Health Geography

The concept of health has come to the fore within the last two decades as it transitioned from the disease ecology model into the geography of health and health care (Elliot, 1999; Luginaah, 2009). Health geography emerged as a sub discipline of medical geography with the premise that our health and our geographies are intrinsically linked; this means an understanding of place is required to fully understand health (Gatrell & Elliott, 2009; Kearns & Moon, 2002; Kearns, 1993; Rosenberg, 1998; Dyck, 1999; Jones & Moon; 1993). Despite that the discipline of health geography has increased in breadth and scope, debate continues to surround the nature of health geography. Health geographers' query issues such as "how can we continue to identify, classify, and reduce the risks to health that result from environmental and social inequalities,

behavioural determinants (without victim blaming) and often location specific determinants?” (Luginaah, 2009: 94). Even though the discipline is rooted in spatial science, health geography is distinct from medical geography since it strives to investigate the complex relations between people, place and their health/health care (Dyck, 1999; Kearns & Moon, 2002).

Epistemologically, the discipline moved away from traditional positivist and biomedical approaches to examining health and health care to increasingly cultural approaches (Andrews & Evans, 2008; Curtis & Taket, 1996; Rosenberg, 1998; Dyck, 1999) utilizing feminists' concepts of attributing voice to the 'other' (Kearns & Moon, 2002). Kearns and Moon (2002) distinguish medical geography from health geography, arguing the latter is “indicative of a distancing from concerns with disease and the interests of the medical world in favour of an increased interest in well-being and broader social models of health and health care” (p. 606). As the discipline of health geography progresses and increasingly interacts with the policy field, questions and implications of research become increasingly complex and require interdisciplinary collaboration with researchers both within and outside of geography drawing on a pluralism of theoretical perspectives. This interdisciplinary approach grants the ability to simultaneously build upon principles of health geography while contributing alternate experiences and explanations offered by other disciplines, bestowing the capacity to bridge ideas and extend concepts as they relate to place based questions of health and health care (Luginaah, 2009).

Methodologically, the field of health geography has been characterized by its use of mixed methods, using both quantitative and qualitative approaches (Dyck 1999; Elliot, 1999; Baxter & Eyles 1999) to understand the richness and complexities of social contexts in which health is imbedded. Qualitative methods, such as interviews, focus groups, and participant observation provide the capacity to produce place sensitive, subjective accounts regarding geographic dimensions of health and health care (Hay, 2000; Dyck, 1999). These methods prove beneficial for human geographers as they uncover experience, perceptions, and meanings (Dyck, 1999) allowing subtle differences in health to be exposed. These methods offer a more “holistic

approach” (Dyck, 1999) to understand health and provide the capacity to deconstruct traditional medical conceptions of health.

The concept of place has become an important aspect to understanding the realities of health in geographies. Place has been reasserted in the geographies of health as being of special significance (Kearns, 1993; Tuan, 1974) as it relates to one’s experience and understanding of place (Eyles, 1985). This broader understanding of place not only considers the context of place but attributes value to the micro/ macro influences of structures and human responses within a locality (Dear & Wolch, 1989). Reconceptualising place provides the ability to understand the complex relations between the physical and social environments and how this impacts people’s health outcomes (Luginaah, 2009). These health outcomes are relational due to connections between individuals in their local environments which are produced and maintained by actors across geographic scales (Cummins, Curtis, Diez-Roux, & Macintyre, 2007).

The acknowledgement of the role of ‘place’ came alongside a cognitive shift in biomedicine. This brought about an increased understanding of women’s health issues which deepened the awareness of the complexities of women’s lives. The previous biological ways in which female health issues were conceptualized were challenged by incorporating the complexities of social, political, and economic relations and how they affect the ways in which women experience health and illness (Dyck, Lewis, McLafferty, 2001). Accordingly, gender emerged as a major axis of difference that affects health status, coupled with the concepts of class, “race” and nationality which are recognized as interrelated in the complexities of health inequalities (Dyck, et al., 2001).

2.6.2 Feminist Geographies of Health

Feminist health geographies emerged in the 1990’s as a fairly new sub discipline within the realm of health geography. The ‘cultural turn’ in geography signified a critical moment for the earliest feminist geography (McDowell, 1992). This represented a critical moment of staking

claim within a discipline that had either ignored women or constructed them as the “other”. Coming out, feminist geographers aimed to produce better understandings of human experiences through the inclusion of gender in geographical work and provide knowledge useful to the struggle for gender equity (Mattingly, 1995).

Increased interest and awareness regarding the gendered nature of health, health care, and caregiving necessitated the examination of geographic variations of gendered realities. The changing discipline of social science accordingly reinforced the need to conceptualize the relationships between society, place, gender, and health and how these relationships are all experienced and internalized differently in various localities. This disciplinary shift represented the changing atmosphere pertaining to health and women’s health issues, removing traditional boundaries of the biomedical approach, allowing knowledge to be understood spatially beyond the confines of the traditional domain.

Nonetheless, there is a scarcity of work noting these intersections (Dyck, 2003), as gender has not always been easily incorporated into existing frameworks. A growing number of studies within feminist health geography have begun to emerge examining geographic health disparities (McEwan, 2001; Rose, 2008), centering women’s experience within the wider social realms and political economies, while also prescribing methods appropriate for investigating gendered social relations and their impact on where and how women live (Dyck, et al., 2001). This increase in feminist geographies of health provides the capacity to target women’s health needs, focusing attention on the diversity of women’s health throughout the lifecycle (e.g. adolescence, pregnancy, elderly care).

While feminist health geography mirrors certain aspects of health geography, it emphasizes the structured inequalities based on gender, while also accounting for those pertaining to class, race, sexual orientations and age of women (Dyck et al., 2001). It must be understood that gender is socially constructed, influencing one’s health status and experience. Gender cannot be equated with “sex difference”, but rather referred as the socially and culturally constructed

meanings around biological sex which inform our conceptualizations/notions of femininity and masculinity and its associated norms of behavior (gendered norms) (Dyck, et al., 2001). The meanings and identities associated with these gendered constructs are not fixed but vary across time and space thus affecting the ways in which one's position is negotiated.

Women are most often the subordinated population within these gendered constructs of meaning. Gendered constructs of masculinity and femininity are subsequently translated into the development and formulation of politics and economies, which consecutively affect the social lives, health and wellbeing of the entire population. As noted by Doyal (1995), it is evident that women and men experience material and cultural discrimination and devaluation that respectfully affect their mental, physical, and emotional wellbeing (Doyal, 1995). It is necessary not to compartmentalize health as a separate issue in a woman's life but rather an integral aspect of everyday life with its absence or presence closely linked to the organization of social relations at different geographical scales and an individual's positioning in society (Dyck, et al., 2003).

Given the sparse contribution of geography to the investigation of women's health (Dyck et al., 2001) this research will unearth a wide range of issues concerning women's health and suggest ways geographic inquiry can deepen understandings of women's health. This involves, as previously noted, a refocusing of thought to broader conceptualizations of health and a more inclusive view locating itself within the political and economic processes of social change (Dyck, et al., 2003). Thus, it is imperative to consider the locality of women and how the social constructions of gender shape and manifest themselves in their daily lives, generating a distinct geography to women's health, health care, and illness, whether as consumers or providers. It is imperative that women are not viewed as "victims" but should be seen as women using strategies to manage health and illness, while accessing both formal and informal care (Dyck et al., 2001).

As previously indicated, issues of access and use of maternal health services in the UWR vary during phase of pregnancy, while also being affected by health service factors, geography, economics, and cultural elements. As such, this thesis requires the utility of a multidisciplinary

approach of analysis, utilizing and drawing on concepts based on the spectrum of health geography and the developing discipline of feminist health geography. It is hoped this research will be able to further the development of feminist health geography and merge theoretical approaches and designs pertaining to women's health access.

2.7 Theoretical Frameworks

This thesis employs a combination of theoretical frameworks: political ecology of health, feminist political ecology, and Andersen Behavioral Model. Utilizing these approaches posits a more nuanced way in which to understand women's navigation of maternal health services. By realizing women's maternal health seeking behavior cannot be isolated to individual decisions but concurrently shaped by the socioeconomic, political, and physical environments in which they live, brings to the fore issues of gender and power dynamics which shape health outcomes. The following three sections distinguish between these theoretical frameworks while drawing affinities among frameworks to provide greater understanding of MHC access and utilization.

2.7.1 Political Ecologies of Health

Political ecology of health (PEH) is a disciplinary perspective underpinned by theoretical conceptualizations of political ecology (Mayer, 1996), which examines the constantly shifting interaction between societies, land based resources, and classes within society (Blaikie & Brookfield, 1987). This framework effectively merges political ecology theories with population health discourses (originally termed political ecology of disease) (see Richmond et.al., 2005) focusing on how large scale economic, social, and environmental determinants shape contemporary patterns of health and wellbeing, with a specific focus on politicized environments (Grossman, 1993: 348; Kalipeni & Oppong, 1998; King, 2010; Mayer, 1996). This framework explores how these process influence and shape local contexts and in turn shape health outcomes (Mkandawire et al., 2013).

Political ecology of health encompasses themes crucial to understand connections between broad global social and economic contexts and the need to relate both health outcomes and its socioeconomic context to a variety of scales ranging from the local to the global. However, the specific site of political ecology examines local scale dynamics with connections and influences that transcend scalar boundaries (Mayer, 1996). Accordingly, my research will focus on women's experiences at the local level to examine how they manoeuvre their maternal health needs within the broader social and economic contexts of their lives.

This approach acknowledges the significance of historical, local dynamics (Mayer, 1996), including the effects of states policies and activities on the local scale and how the local changes in human environmental relations affect the structure of social relations (Bassett, 1988). Hence, this research will examine the political changes made to the NHIS including the maternal exemption policy, and how they have symbiotically affected the structure of social relations, particularly those of women's health outcomes. This framework is also strengthened by anthropological perspectives which draw out cultural meanings and practices through which people perceive, use, and live in their environments (Harper, 2004), hence providing the ability to understand how women attribute meaning to pregnancy, health, and wellbeing.

Since the transition from disease ecology to geography of health and health care (Elliott 1999; Luginaah, 2009) the dominant perceptions of health have experienced subsequent progressive transitions. Prior to Mayer's (1996) call for increased uptake of political ecology frameworks in medical geography, the conceptualization of health was one which prioritized biomedical and epidemiological frameworks to understand health and the environment (Harper, 2004). This shift in understanding health from one of spatial distribution of (ill)health, to one which includes much broader concepts focusing on how health is expressed through the interaction of an individual within ones physical and social environment is of particular importance to understand health inequality, given that public health models have often neglected socially marginalized groups (Farmer, 2001). This broader conceptualization also recognizes the

differing social responses to environmental practices that affect human health (i.e. maternal health care) (Harper, 2004).

Studies examining health from a political ecology perspective capitalize on the versatility of mixed methods approaches to research (Rocheleau, 2008), representing a strong affinity between the political ecologies of health framework and the field of health geography. Both frameworks are intricately connected and share a certain affiliation to address health equality, recognizing particular structures, agendas, or agents that shape environments and health risks for populations (Mayer, 1996).

The ways health and perceptions of illness are experienced is highly subjective and varies not only across geographic regions, but also among individuals within a region (Engel, 1977). In developing an understanding of situated meanings associated with health and illness, researchers strive to understand underlying factors affecting health/ disease distribution and target areas for preventative efforts. Yet the scalar approach of PEH has limitations as it focuses on the micro-individual and the highly localized. While the framework draws clear connections discerning the links between the physical environment and population health, less emphasis is typically placed on social environmental change at the very individual level (Mayer, 1996). The degree to which an individual has access to the social environment is determined by a number of individual characteristics, including one's gender, sex, income, and age. While PEH examines the influences of health at large (international) and small (regional) scales, this framework falls short in its exploration of various scales of individual health. While patterns of maternal mortality and positive maternal health outcomes may be viewed as reflections of the broader social circumstances of a society (Bryceson, 2002), understanding maternal health care utilization as an individual behaviour requires a more in-depth analysis of the factors which motivate access and utilization of health services at the individual level (Thind, Mohanj, Banerjee, Hagigi, 2008).

Further, this perspective neglects the aspect of gendered relations and how a particular individual's health is constructed by certain large-scale economic, social and environmental

realities. In pursuit of Peacock, Morrow and Gladwin's (1997) vision for a broad ecological and political approach and focus on interactions, it is necessary to consider the interactions among all social systems. In this manner, concerns of conflict, competition, and inequality are brought to the fore, rejecting the notion of a single autonomous social system, and instead conceptualizing community as an ecological network of interacting social systems (Peacock & Ragsdale, 1997). By drawing on a PEH framework which considers all social systems, these systems become no more gender neutral than they are race neutral (Enarson & Morrow, 1997; Morrow, 1997; Yelvington, 1997). Thus, it is necessary to draw on the framework of feminist political ecology in order to properly analyze women's ability to access maternal health care in Ghana.

2.7.2 Feminist Theory

Feminist theory shares a dynamic affiliation with political ecologies of health as many feminists argue the goals of both perspectives are mutually reinforcing and ultimately involve the development of worldviews and practices based not on domination but on uncovering equality and parity within society (Warren, 1996). Radford (1975) argues that there can be no liberation for women or no solution to the ecological crisis within a society that continues a fundamental model of domination. The demands of the women's movements must be united with those of the ecological movement to envision a radical reshaping of the basic socioeconomic relations and the underlying values of this [modern industrial] society (Ruether, 1975:204).

The theoretical basis for this work is rooted in the feminist movement which signifies a shift from a purely demographic/epidemiological approach to one based on gender equality (Wang, 2010). This focus on gender equality is used to understand variables of women's reproductive health and argues that women's reproductive rights are intrinsically important in and of themselves, exclusive from any demographic or population health goals (Wang, 2010). Women have the right to self-determination regarding reproductive health and the state is obliged to provide women with the social, economic, and political means of enabling women to achieve

their individual choices (Wang, 2010). Additionally, aligned with the PEH model, this approach recognizes that these decisions are not strictly medical, and cannot be removed from the social, political, and economic realities of women and their access and control to achieve reproductive self-determination (Wang, 2010).

Feminist theory, of which the Gender Equality Approach is rooted, challenges the prevailing expectations of women's reality, and strives to expose and challenge the flawed assumptions of women which are pervasive among disciplines (Cook, 1993). This has profoundly impacted the perception of women and positively challenged the assumed normative roles of females in society. In order to challenge these societal constructions of females in society, international human rights law must be accountable to provide effective, preventative, and curative measures to protect women's reproductive health and to provide women the capacity for reproductive self-determination (Cook, 1993).

The increased awareness surrounding women's rights and wellbeing has ignited much international development and partnerships which address a variety of human rights issues and concerns. In this sense, the "Gender Equality Approach" to maternal health issues is a part of a larger international trend towards "Rights Based" health care. The UN General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979 and has been commonly associated as the international bill of rights for women, "condemning discrimination (Article 2, CEDAW, United Nations Entity for Gender Equality and the Empowerment of Women). This increased attention towards a "Rights Based" health approach has provided greater attention towards measures to eliminate discrimination against women in the field of health care to ensure equality in access to health care services. The goal of CEDAW is to reduce maternal mortality and morbidity, enhance the dignity of women, their reproductive determination (Cook, 1993) and address the disadvantaged position of women.

Greater attention towards Rights Based health needs has generated international recognition towards equality for both women and men in access to civil and political civil

liberties, not only including the right to marry and found a family, but the economic, social, and cultural rights, such as the right to health care (Cook, 1993). The Convention recognizes that women are not only subject of specific inequalities but are also subject to pervasive, ubiquitous forms of oppression that are bound to economic, social and cultural rights. Avoidable death in pregnancy or childbirth is the most obvious violated human rights abuse which abuses a women's right to life itself. A woman's right to life entitles her access to basic reproductive health services, and laws impeding such access violate international human rights provisions. Women's right to life must include not only her medical condition, but the threat which comes from her membership in a group at high risk of maternal mortality or morbidity due to pregnancy (Cook, 1993).

2.7.3 Feminist Political Ecology

Feminist political ecology (FPE) extends analysis of political ecology and feminist theory, to analyze power relations, including gendered relations, and extend consideration of scales of analysis to include the household within the local and communal context which shape women's ability to access and secure resources (Rocheleau, 2008). FPE examines gender relations in specific environmental contexts with an emphasis on women's practical environmental knowledge and the nexus of gender inequalities, environmental degradation, and environmental vulnerability (Rochelau, Thomas-Slayter, & Wangari, 1996). This perspective draws heavily on gendered knowledge, and gendered environmental rights and responsibilities (Rocheleau, et al., 1996) to interpret local experiences in the context of global environmental and economic change. Women's roles as primary resource users and managers, their dependence on natural based livelihoods, and the responsibilities they have to household dependents and community members are of central concern (Enarson, Fothergill, Peek, 2007). Women are consequently viewed as especially sensitive to precarious conditions that put their families, homes, and communities at risk for environmental degradation (Cuter, 1995; Steady, 1993).

Feminist political ecology provides the ability to link gender relations to specific environmental conditions (Enarson et al., 2007).

Despite debates surrounding gender difference (see Doyal, 2000; Fraser, 1996; Walby, 2005) for the purpose of this thesis it is suggested that there are real, not imagined, differences in experiences of, responsibilities for men and women, and these differences are not rooted in gender per se. Rather, these differences derive from the social interpretations of biology and the social constructs of gender (Rocheleau, Thomas-Slayter, & Wangari, 1996), which vary by culture, class, race, and place, which are subjected to individual and social change. This view of gender informs the emerging conceptual framework of feminist political ecology in which this work is situated.

By drawing from the insights of feminist cultural ecology (Leach 1994; Fortmann 1988), political ecology (Blaiki & Brookfield, 1987; Schroeder, 1993), feminist geography (Pratt & Hanson, 1994; Townsend, 1995), and feminist political economy (Mackenzie, 1995; Stamp, 1989), this research is able to draw connections between women's roles within their socioeconomic and environmental realities with their maternal health utilization. Given such ideological breadth, this framework beneficially positions itself to treat gender as a critical variable in shaping resource access and control, while interacting with class, culture, and ethnicity to shape processes of ecological change, the struggle of men and women to sustain ecologically viable livelihoods, and the prospects of any community for "sustainable development" (Rocheleau et al., 1996). Feminist political ecologies and its subsequent positioning of gender draws explicitly on feminist theories. These two ideological frameworks share a theoretical affinity and should forge an even closer relationship as they use similar concepts (social power, privilege, domination, vulnerability, empowerment, and social change) and equally embrace global, interdisciplinary and practice oriented inquiry with a liberatory intent.

Given the increase in feminist concerns over the last twenty years, excitedly new and different voices have begun to emerge for the first time within the social science discipline. These new ideas not only engage with philosophy but speak distinctively from a feminist standpoint which critically acknowledges women's different positioning (Plumwood, 2002). The diversity in views has brought to the fore new issues and approaches which place the conceptual foundations of oppression at the very center of inquiry. Thus, through the synthesis and influence of theoretical approaches, founded on similar groundings of understanding with an aim to alleviate oppression, this thesis will attempt to clarify particular influences inhibiting women to access maternal care.

As a result, feminist theory, along with the wider social sciences incorporating PEH and FPE theorize the intersectionality and relations between different social categories including gender, culture, and sexuality. Nonetheless these conceptual frameworks neglect the personal attributes which influence and predetermine an individual's ability to access desired environments. Accordingly, this theory will draw on aspects of Andersen's Behavioral Model to understand women's predisposing, enabling/restricting factors, and needs factors (Andersen, 1995; 1996; German, 1973) which explain a women's ability to access maternal health care.

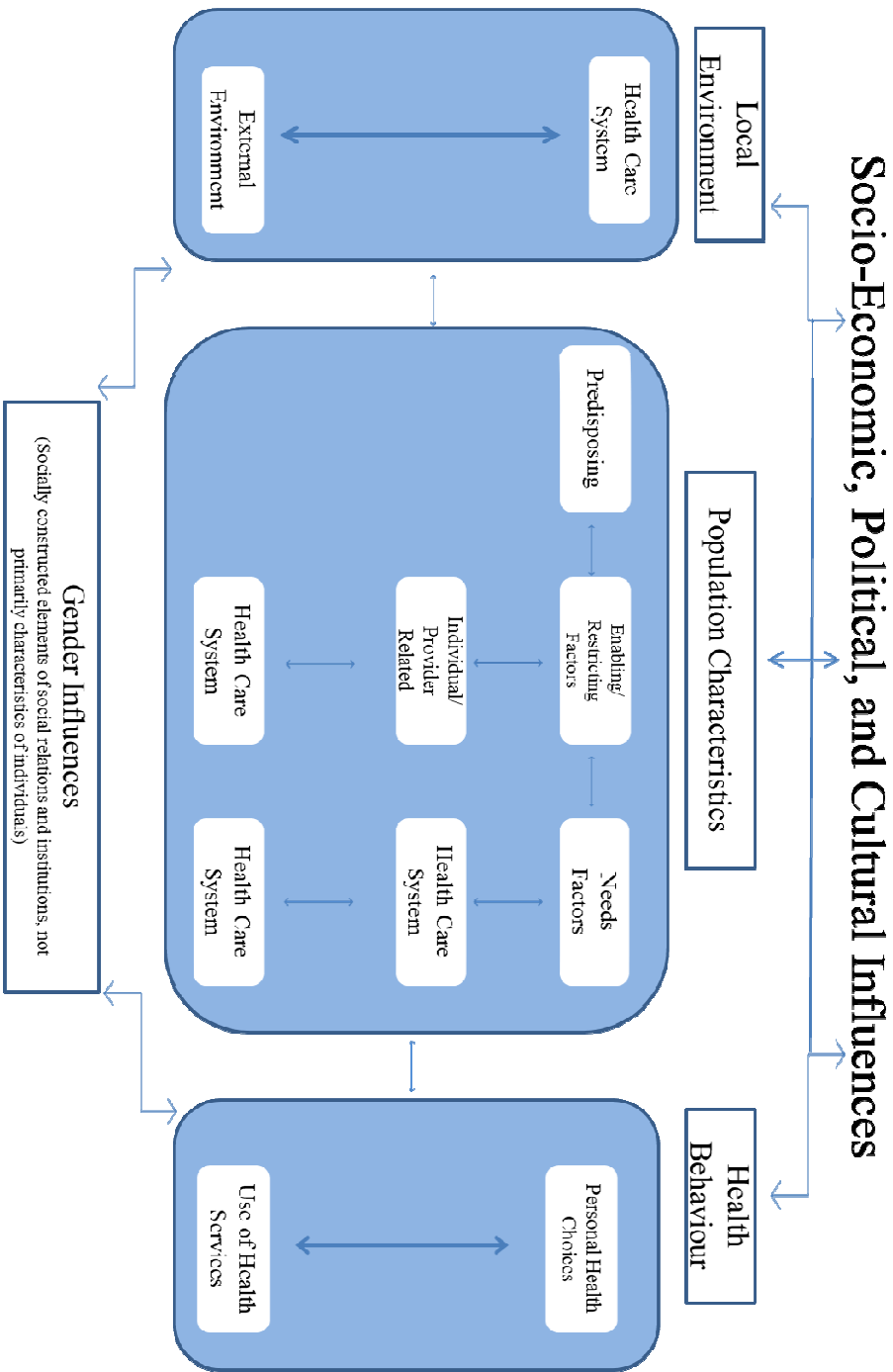
2.7.4 Andersen's Behavioral Model

In order to capture women's individual experiences seeking MHC, Andersen's Behavioral Model is used to situate women's MHC access among an array of characteristics which shape access and utilization. Originally developed to understand individuals health use (Andersen 1968; 1995), and subsequently modified to increase health seeking knowledge pertaining to vulnerable populations (Aday, 1993; 1994, Gelberg, 1996; Rew, 1996), this model assists in garnering an in depth analysis of the intricacies of women's health seeking behavior. Drawing on this framework, predisposing characteristics (i.e. age, sex) and enabling features, such as individual resources (i.e. household wealth, insurance, income, financial support), and

community resources (i.e. physician and hospital bed ration, residence) (Choi, 2010) are explored. Further, needs factors (i.e. perceived health status, self-rated desire to seek care), and restrictive factors (i.e. distance to the nearest health facility, young children making travel difficult) will be examined in the context of women's MHC utilization (Andersen, 1968).

Given this models affinity with PEH and FPE which critically examine structural influences on health outcomes, this model extends the discussion of health by providing the capacity to link an individual's health decisions to the broader social and political macro environments in which they are situated (Hausmann-Muela, Ribera, Nyamongo, 2003). Despite this frameworks ability to explore individual health seeking within context, it falls short of understanding how gendered constructs influence health seeking behaviour, which may obscure understanding health seeking (Green, Polen, Perrin, Leo, Lynch, Rush, 2004; Hausmann-Muela, Ribera, Nyamongo, 2003). Fittingly, by incorporating feminist concepts to understand how a woman's position in society is socially constructed, having impacts on their enabling and restrictive characteristics, this work will unearth realities of women's health seeking in an environment which cannot be isolated from the context in which they occur. Figure 2 illustrates the theoretical framework for which the research was conducted.

Figure 2: Theoretical Framework



Source: Created by Author

2.8 Chapter Summary

This chapter began by providing an overview of literature which addresses the development of the National Health Insurance Scheme and the implementation of the Maternal Exemption Policy. Potential barriers to access and utilization were examined, providing areas which need further investigation to garner a more comprehensive understanding of women's behavioural access. Limits to the current body of literature and conceptualization of women's health issues are cited, including the largely biomedical approach to understanding and comprehending women's reproductive health.

Situated within the domain of health geography, particularly the new subfield of feminist health geography, this research adds to discussion of women's health research within the context of Ghana's UWR. This discipline distinguishes itself from medical geography in its epistemological approach and emphasis on understanding health within context.

Methodologically, health geography increasingly employs mixed methods approaches, with an emphasis on qualitative methods. Given the nature and purpose of this research, a qualitative approach with supplementary methods set the foundation upon which this thesis was formed. These methods allow the researcher to gain an understanding of geographic patterns of health and provide a means to gain deeper meaning behind health outcomes. The characteristics of place and its relationship to health are examined before linking place to health behaviours.

The third section of this chapter presents the theoretical framework through which this research is conducted. Given such disciplinary breadth and span, this research is best understood as incorporating complementary yet vital theoretical components in which to understand women's health care utilization. Using the political ecologies of health framework provides the ability to understand how certain broad social and environmental influences shape health outcomes. However, this theory does not strictly consider the concept of gender within its framework. Thus by heavily drawing on aspects of feminist theory, the area of feminist political ecology becomes crucial to examine and analyze women's ability to access maternal care. In

order to examine other direct and indirect explanations influencing a women's choice, aspects of the Andersen's Behavioral Model are utilized. These approaches merge on understandings that recognize health decisions are not strictly medical, and cannot be removed from the social, political, and economic realities of women's lives, as they navigate maternal health care services to gain a thorough integration of theoretical and methodological intentions.

Chapter 3

3 STUDY SITE PROFILE: THE UPPER WEST REGION

3.1 Introduction

Understanding the research site is crucial as it provides a contextual background of the physical and socio-demographic regional characteristics, while generating an understanding of women's experiences seeking maternal health care. The chapter begins with an overview of the UWR including locational and historical features, followed by an examination of the current socio-demographic characteristics of the region, including a review of Ghana's health care system. Throughout this chapter, the UWR is compared to the rest of Ghana, providing a contrast between development in the UWR and rest of the country. The chapter concludes by presenting opportunities for improvements in health outcomes.

3.2 Study Location: The Upper West Region

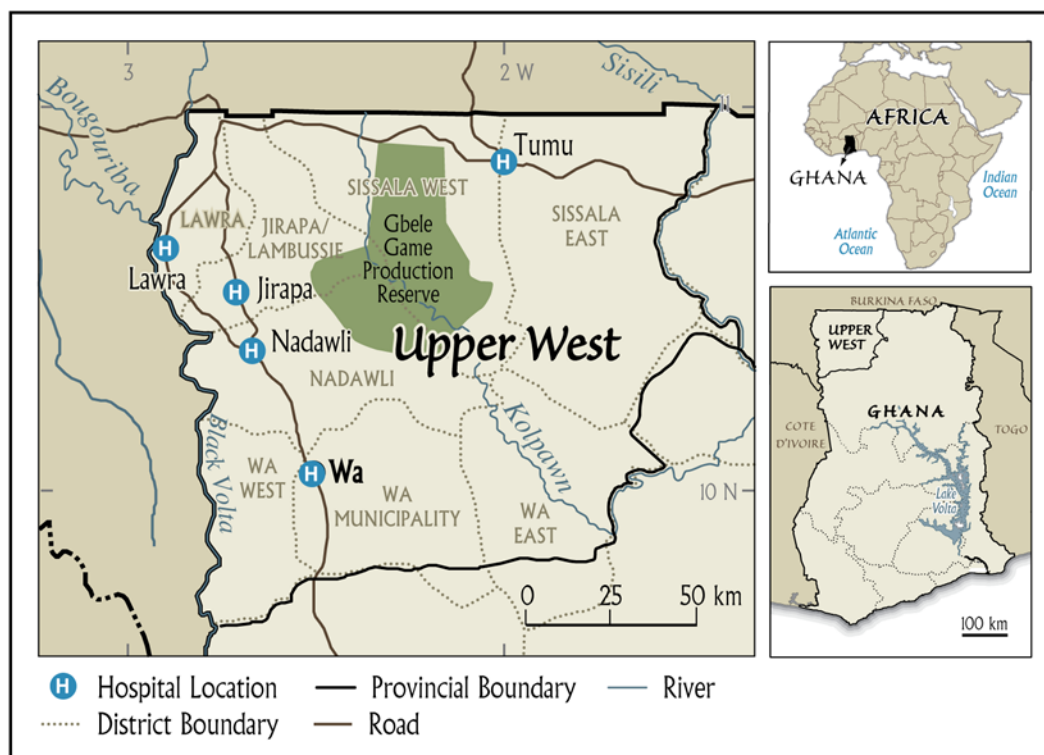
This section provides a description of the physical and social environment of the UWR enabling one to have a greater comprehension of the contextual features influencing access to maternal health facilities. This section begins by locating the study site (Figure 3) and describing the physical characteristics of the region. Proceeding is a description of the regional demographics and access to health care, highlighting the significant discrepancies between the Upper West Region and the rest of Ghana.

In 1957 Ghana became the first SSA country in colonial Africa to gain its independence. Until July 1960, the UWR was previously part of the Upper Region, which was itself part of the Northern Region. Pursuing a policy of decentralization, in 1983 the government of Ghana divided the Upper Region into the Upper West and Upper East region. The UWR spans 18,478 kilometers, and accounts for 7.7% of Ghana's total land area (GSS, 2012). Figure 3 illustrates the geographic location of the UWR, which is bordered on the North by the Republic of Burkina

Faso, on the East by the Upper East Region, on the South by the Northern Region, and on the West by Cote D'Ivoire.

The region is located in the guinea savannah vegetation belt, with low rainfall and dry soils limiting crop production, which consist primarily of yam, groundnuts, guinea, maize and beans. Major economic trees are mango, sawadawa, and sheanut. Nonetheless, cash crop production is generally poor, resulting in seasonal food insecurity. The single rainy season in the region restricts farmers to a single harvest, in contrast to the southern region, where two harvests generally occur. Further, bushfires are common in the region, despite efforts to stop them, typically caused by poor hunting practices and land preparation (Songsore & Denkabe, 1996).

Figure 3: Study Location



Produced by the Cartographic Section, Department of Geography, Western University, 2012

The regional climate consists of two seasons, the wet and dry seasons, with the dry beginning in early November and lasting until June, while the wet begins in July bringing warmer weather and rainfall. The wet season has begun to occur later in the year, near the beginning of July creating increasing problems of food insecurity and drought. This in turn has led to male residents to migrate to the south in search of more viable economic opportunities (Adjasi & Osei, 2007). Precipitation during the rainy season is usually in the form of sporadic and intense storms, with large amounts of rain falling in short periods of time, typically no longer than one or two hours, accumulating annually to 100-150 centimeters. The intensity of the storms leads to increased erosion and runoff in the area. The regional temperature ranges from 40°C during the day and 15°C at night (Songsore & Denkabe, 1995).

The Regional Co-ordination Council is the main political and administrative authority, located in the regional capital city of Wa. The region currently has nine political administrative regions which are: Jirapa, Lambusse, Lawra, Nadowli, Sissala East, Sissala West, Wa East, Wa Municipal, and Wa West (GHS, 2009).

Only 12.5 percent of UWR roads are tarred, with most in poor condition. Most roads are narrow, unpaved, and lack adequate drainage. In rural areas, roads become impassible in the rainy season, making certain areas vulnerable to erosion (ASIRT, 2014). There is a small airstrip in the regional capital but is rarely used, as there are no commercial flights servicing the area. The predominant means of transport used by residents is travelling by road using *tro-tros*¹, motorcycles or bicycles. The region currently has five FM radio stations and two television networks that broadcast in English and in local languages (Dagaare, Waale, and Sissali). Further, telephone and fax facilities exist in eight of the nine districts, with all the district capitals and

¹ A *tro-tro* is a commonly used form of public transportation throughout Ghana. It typically consists of a passenger van operated by a driver and an assistant. Fares are non-negotiable, based upon distance travelled, and are paid in cash. While departures are loosely scheduled, most *tro-tros* do not leave for their destination until the majority of seats have been sold.

most of the surrounding villages having limited cellular network coverage provided by the three companies operating in the area.

3.3 Demographic and Economic Characteristics of the Upper West Region

The Upper West Region is one of the poorest, least populated regions in Ghana (GSS, 2012), with only 17.5% of the total population characterized as urban compared to the national average of 51% (GSS, 2010). The region has a total population of 702,110 citizens (GSS, 2012), representing a significantly lower population density and one of the lowest growth rates when compared to other regions in the country. Further, females comprise 51.4% of the population, while 48.6% are males (GSS, 2012).

The UWR has a relatively young population corresponding to a large dependent population of 38% under the age of 15 years, combined with a small population of 6.5% over 65 years of age (GSS, 2012). The average regional household size is 7.2 persons, with dependents comprising the majority of those living within a household (GSS, 2005). Such a large dependent population impacts the availability of social services, health provision, and employment opportunities in the region, while concurrently increasing household expenditures and reducing savings, resulting in added livelihood stress (Luginaah, 2008).

Educational disparities stand in stark contrast to national levels, revealing only 5% of residents in the UWR have attained any form of post-secondary education, due to a combination of poverty, cultural practices, and the late introduction of higher education in the north (Adjasi & Osei, 2007). Estimates indicate that 69.8% of residents aged six years or older have never attended school, compared with the national average of 38.8%. Women in the UWR hold a disproportionately higher percentage of illiteracy as 53.3% have never attended school, with only 25.07% having received primary education, and a staggering 1.2% having attained a middle school education (GSS, 2012). Despite the high illiteracy rates in the UWR, most official

government publications are produced in English, with only 36.1% of the population is able to read the information (GSS, 2012).

Increasing regional drought and sporadic farming have induced increased male migration to the south in search of labor opportunities (Kuuire, et al. 2013). Prominent forms of subsistence rest on agricultural production, with peasant agriculture constituting the main economic activity of the region, employing over 72% of the region's economically active population. Besides agriculture, there are limited opportunities for employment in other sectors of the economy. Of the UWR's total population, over half of the female population is employed in the agricultural sector, with most self-employed in the private sector (GSS, 2012) forming the crux of their livelihoods. Such high levels of deprivation, ingrained in centuries of governmental neglect and abandonment explain such adverse educational and employment disparities experienced in the UWR (Anyinam, 1994; Konadu-Agyemang, 2000).

Religious affiliation in the UWR is centered on three dominant religions including Catholic, Islam, and Traditionalists representing 44.2 %, 38.1% and 13.9% respectively (GSS, 2012). The region also consists of four main ethnic groups, the Wala (16%), the Dagaaba (51%), Sissala (16%), and the Lobi (12%). Other indigenous ethnic groupings collectively constitute an additional 5.0% of the population in the region (GSS, 2011).

It is against this backdrop that women must navigate their reproductive needs. Thus access to health services in the context of the UWR must be seen in concord arise with other important environmental and social influences in order to properly understand how women use maternal health services.

3.4 Health Care in the Upper West Region

Spatially uneven development has translated into a neglected regional health care system, severely underserviced and short-staffed, impeding the ability to provide equitable services. Currently, the region has six hospitals and only 17 of the country's 881 physicians, representing

both the lowest number of doctors in total as well as per population, with a ratio of 1:140,144 (MOH, 2011). This is almost eight times worse than Greater Accra Region with one doctor per 5, 073 inhabitants (MOH, 2011). The UWR also has 758 of the 21, 861 nurses in the country, representing the lowest regional population of health personnel (GHS, 2011). Other crucial health personnel are significantly lacking, as there is only one midwife per 1,122 women (GHS, 2011), representing the second lowest region in Ghana. These numbers are expected to worsen with the retirement of aging midwives in the region (Nang- Beifua, 2010). Furthermore, the UWR has one of the lowest quantities of CHPS, with 87 facilities for the entire region (GHS, 2011), while three quarters of households in the UWR live outside the recommended 8 kilometer radius to a health facility, representing the severity of the challenge (e.g., walking long distances to the nearest facility) in accessing health services (GSS, 2008). See table 4 for number and placement of health facilities per district.

Of the top twenty causes of outpatient morbidity in Ghana, pregnancy related complications are the eighth leading cause of death (GHS, 2010). Only 45.3% of women in the UWR deliver in a health facility (the second lowest rate in the country) compared to well over 83% in the Greater Accra Region, the national capital (GSS, 2009; GHS, 2009). Despite pervasive levels of poverty, the UWR has the highest levels of enrolment in the NHIS with active membership placed at well over 50% (Dixon, 2011), although this does not ultimately translate into access and utilization of services.

Figure 4: Health Facilities Per District

District	Hospitals	Health Facilities	Clinics	RCH Centre	CHPs	Private Maternity Homes	Private Clinics	Private Hospitals	Total
Jirapa	1	7	0	0	8	0	0	0	16
Lambussie	0	6	0	0	9	1	1	0	17
Lawra	2	8	0	2	10	0	0	0	22
Nadowli	1	12	0	0	13	0	0	1	27
Sissala East	1	6	0	0	5	1	0	0	13
Sissala West	0	4	0	0	7	0	0	0	11

Wa East	0	6	1	0	9	0	0	0	16
Wa Municipal	1	6	3	0	13	1	3	2	29
Wa West	0	6	0	0	13	1	0	0	20
Regional Total	6	61	4	2	87	4	4	3	171

Source: Nang- Beifua, A. (2010).

In the UWR, there are two dominant health care systems in which residents frequent. The first system is akin to Western biomedical treatment and prevention, whereas the latter comprises the traditional medical system, including Traditional Birth Attendants (TBA), herbalists, faith healers, and fetish priests. Most Ghanaians regard the two services as complimentary and attend each as necessary. Historically, TBAs (who are commonly senior and highly regarded women in communities) have provided delivery services for women, and have been heavily depended upon in many developing countries (De Brouwere et al., 1998; UNFPA, 1997; WHO, 1978). These women have always been an integral part of their local communities, normally acquiring knowledge and skills from some form of apprenticeship training along older and more experienced women (Leedam, 1985; Lefeber, 1994; Paul & Rumsey, 2002; WHO, 1992).

Since the 1970s, many African countries, including Ghana have addressed sociocultural and geographic issues of access by training TBAs in health promotion, basics of safe delivery, and referral practices aimed at reducing maternal and child morbidity and mortality rates (De Brouwere et al., 1998; UNPFA, 1997; WHO, 1978). The Ghana Ministry of Health implemented TBA training programs in the early 1980's, as part of the maternal health policy with the intention of reducing maternal and infant mortality rates, revealing promising results including an increased ability of the TBA to assess gestational age, recognize potential infection, cross infection, and complications, and increased referral practices in high risk pregnancies (Ampofo, Nicholas, Amonoo-Acquah, Ofosu-Amaah, & Neumann, 1977; Eades, Brace, Osei, & LaGuardia, 1993; WHO 1978).

However, despite international support for TBA training programs, global maternal mortality rates remained high (WHO, 1996), which lead policy makers to question the

effectiveness of TBAs in supporting women's maternal health needs. These concerns led to the 1992 joint WHO/UNFPA/MCH agreement which declared TBA training and use to be considered only as an interim measure until "all women and children have access to accessible, professional, modern health services" (WHO, 1992:30). This was reinforced by a 1996 WHO directive that discouraged pregnant women from TBA delivery in favour of delivery by a skilled health provider at a health facility.

The WHO's policy change altered the language addressing safe motherhood practices from a 'trained attendant' to a 'skilled attendant', reinforcing that someone who has received training is not necessarily *skilled* (Starrs, 1997). Skilled attendants were classified as people with midwifery skills (doctors, midwives, nurses) trained proficiently to manage normal deliveries, diagnose, manage and refer complications to specialists (WHO, 1992). This stand affectively terminated global TBA training programs. Yet, even with limited skilled personnel in the rural areas of the north, the global guidelines on TBAs resulted in the Ghanaian government's decision to cease TBA promotion in lieu of skilled personnel, allowing TBAs to assist only in the transportation of pregnant women to a health facility (De Brouwere et al., 1998; Starrs, 1997). These policy changes have had lasting impacts on women's maternal health provision in Ghana's UWR.

3.5 Maternal Health Care in the UWR

Under the MEP, all women who register in the MEP are able to seek antenatal care, prenatal care, supervised delivery and postnatal care for a one year period. The following section presents information on women's utilization regarding the continuum of care provided by the health services in the UWR.

3.5.1 Antenatal Care

When measuring antenatal care four indicators are usually considered including: proportion of population accessing service, proportion making adequate number of visits (4), timing of initiation of antenatal care, and service received. In the UWR, antenatal coverage in 2010 remained similar to the previous year with the highest coverage per district placed at 58.4% and the lowest district placed at 34.6%. Given the recommended 4 visit antenatal minimum, only 67% of the female population in the UWR were able to make the requirement in 2010 (GHS, 2011). For effective antenatal care women are supposed to visit the ANC clinic in their first trimester for early identification of pregnancy related problems and management of complications. However, no noticeable change in enrollment time was observed from 2009-2010, indicating the same percentage of women registering pregnancy in their third trimester. This has serious implications regarding services received by pregnant women as they are not using the full services and receiving preventative treatment for malaria in pregnancy (IPT). See figure 5 for yearly antenatal registration. See Figure 6 for districts which indicated four more antenatal visits yearly.

Figure 5: Antenatal Registrants, 2008 – 2010

Percentage of Antenatal Registrants			
District	2008	2009	2010
Jirapa	41.1	51.5	49.4
Lambussie	34	38.6	40.2
Lawra	32.1	39.1	34.6
Nadowli	64.7	66.6	44.7
Sissala East	44.8	48.2	45
Sissala West	34.4	39.2	44.9
Wa East	39.1	48.9	54.5
Wa Municipal	54.3	54.2	58.4
Wa West	45.3	43.2	49.8
Regional Total	46.8	49	47.2

Source: Nang- Beifua. (2010).

Figure 6: Four Plus Antenatal Visits, 2008 – 2010

Percentage of Pregnant Women who Attended 4 or More Antenatal Checkups			
District	2008	2009	2010
Jirapa	49	89	84
Lambussie	41	75	69
Lawra	74	90	81
Nadowli	50	50	68
Sissala East	73	99	57
Sissala West	113	183	61
Wa East	42	47	49
Wa Municipal	32	69	70
Wa West	55	79	61
Regional Total	53	78	67

Source: Nang-Beifua. (2010).

3.5.2 Skilled Delivery

Significant variations are observed in relation to skilled delivery, with figures indicating only 22% of the female population in the UWR are attended by a skilled birth attendant and 11% attended by a TBA during delivery (GHS, 2010). In order to achieve the MDG 5, Ghana Health Services has stated it is essential to ensure that all births are managed by a skilled health professional (MOH, 2011). However, due to the geographical access to health facilities and limited number of midwives in facilities, women are sometimes not able to deliver with skilled attendants.

Women in Ghana are able to seek maternal health care typically from nurses, midwives, or doctors who are located in CHPS, health facilities, or hospitals. Nonetheless, placement of health facilities and shortages in health personnel cause women in the UWR to seek maternal care from TBAs. Conversely, as indicated above, TBAs are no longer directly associated with Ghana's formal health care system and are only allowed to assist women in the transportation process to a health facility; with the MOH strongly recommending women seek maternal care from a skilled professional during delivery and not that of a TBA (MOH, 2009). Yet, women encounter many barriers to access and utilization of skilled maternal care for delivery and may subsequently deliver with TBAs. See Figure 7 for skilled and TBA delivery.

Figure 7: Skilled and TBA Delivery

Percentage of population that delivered with either a skilled personnel or a TBA						
District	2008		2009		2010	
	Skilled	TBA	Skilled	TBA	Skilled	TBA
Jirapa	27.3	14.1	31.1	11.3	35	8
Lambussie	16.7	12.5	17.2	7.5	21.7	5
Lawra	20.3	10.2	20.9	5.1	28.1	2
Nadowli	19.1	10.4	20.5	7.7	21.3	6
Sissala East	11.3	23.0	17	25.8	15.9	20
Sissala West	8.2	28.4	11	23.6	11.6	22
Wa East	7.3	35.8	7	31.5	6.8	26
Wa Municipal	31.2	19.2	34.2	15.0	35.2	7
Wa West	7	19.6	7.5	17.2	10.2	16
Regional Total	11.3	11.6	17.9	13.2	22.3	11

Source: Nang-Beifua. (2010).

3.5.3 Caesarean Section Delivery Between 2008- 2010

GHS regard the number of births by caesarean section as an indicator of access to utilization of care during child birth, where higher rates of caesarean section indicate greater access to health care (GHS, 2011). In the UWR, it is estimated that between 5-15% of all births involve a complication that requires an intervention such as caesarean section. While caesarean sections may act as lifesaving procedures, only five of nine districts in the UWR have access to these health measures. Consequently, without this service, many pregnant women can experience complications, develop disabilities due to childbirth, or die (Nang-Beifua, 2010). Even though caesarean section delivery has increased, it has yet to reach a minimum of 5%, indicative of the unavailability of health providers in the region. See Figure 8 for percentages of yearly caesarean section delivery.

Figure 8: Caesarean Section Delivery 2008-2010

Percentage of Women that delivered by caesarean section, 2008 - 2010			
District	2008	2009	2010
Jirapa	8.9	6.6	7.7
Lambussie	0	0	0
Lawra	4.1	2.6	2.8
Nadowli	0.8	0	2.6
Sissala East	2.3	2.6	3
Sissala West	0	0	0
Wa East	0	0	0
Wa Municipal	10.4	7.4	8.9
Wa West	0	0	0
Regional Total	4.6	3.4	4.8

Source: Nang- Beifua. (2010).

3.5.4 Postnatal Care

Postnatal care is deemed necessary within 48 hours of delivery to ensure the health of the child and mother. The postnatal period spans 42 days after pregnancy and assists the health of the women and child. Consequently, only 34.1% of the population receive postnatal care within the 42 day period, with even fewer receiving care within the first 48 hours (GHS, 2010), which can jeopardize the health of the mother and child. Additionally, only 23% of the population accept family planning options, which can have long-term consequences (GHS, 2010). See Figure 9 for yearly postnatal delivery.

Figure 9: Postnatal Care, 2008 – 2010

Postnatal Care Utilization, 2008-2010						
District	2008		2009		2010	
	Number	Percent	Number	Percent	Number	Percent
Jirapa	820	32.8	1021	27.6	1463	56.6
Lambussie	622	32.2	598	30.4	584	29.2
Lawra	1,098	27.4	1197	29.4	1100	26.5
Nadowli	1305	34.5	1095	28.9	1191	30.4
Sissala East	564	27.2	724	34.4	609	28.4
Sissala West	668	36.3	641	34.3	614	32.3
Wa East	981	28.6	843	33.1	9963	37.2
Wa Municipal	2008	44.1	2060	44.2	1697	35.9
Wa West	1112	32.4	942	27	1087	33
Regional Total	9172	34.8	7972	28.3	9308	34.1

Source: Nang- Beifua. (2010).

3.5.5 Maternal Mortality

Recent studies have estimated Ghana's maternal mortality rates between 378 (GSS, 2009), 560 deaths (WHO, 2009), and even possibly as high as 819 deaths per 100,000 live births (Hogan et al., 2010) based on study design and data collection technique. It should be noted that these figures are often based on institutional mortality and do not account for the women who die silently in communities quietly buried without registration. Reasons underlying maternal mortality are varied in context (i.e. knowledge, transportation, cost, availability of health providers/facilities) but interventions aimed at increasing access to skilled delivery, emergency obstetrics, and neonatal care including safe blood is necessary to ensure safe deliveries (GHS, 2011). Thus, there is a dire need to investigate the underlying causes of maternal death in the UWR.

3.5.6 Anemia at Registration

Anemia during pregnancy poses a serious threat for the mother and child as it increases risk of pre-term delivery, low birth weight, and anemia in infancy (American Society of Hematology, 2013). Anemia also increases the risk of blood loss during labour, making it difficult to fight infections (American Society of Hematology, 2013). The percentage of pregnant women living with anemia at MEP registration in the UWR decreased slightly from 16% in 2009 to 13.7% in 2010. Nonetheless, district variation indicated some locations as high as 24% and as low as 5% (Nang- Beifua, 2010). It should be noted low recorded rates of anemia in the UWR are due to the lack of facilities to check hemoglobin levels coupled with low rates of ANC checkups (i.e. figures indicating only 8.9% of women are recorded anaemic during ANC visits) creating supplementary challenges of early indication (Nang- Beifua, 2010). Further, anemia during pregnancy causes problematic health issues, especially for pregnant women, and children.

Anemia is a condition that occurs when the red blood cells do not carry enough oxygen to the tissues of the body and can affect all population groups. However the most susceptible groups are pregnant women, women of childbearing age, low birth weight infants, and young children (WHO, 2000). In the milder form, anemia is “silent”, without symptoms, while in the more severe form anemia is associated with fatigue, weakness, dizziness and drowsiness (WHO, 2000). Without treatment, anemia can worsen and become underlying causes of chronic ill health, such as impaired fetal development during pregnancy, delayed cognitive development and increased risk of infection in young children, and reduced physical capacity in all people.

Among the nutrition factors contributing to anemia, the most common is iron deficiency, due to a diet that is monotonous, but rich in substances (phytates) inhibiting iron absorption so dietary iron cannot be utilized by the body. Iron deficiency may also be aggravated by poor nutritional status, especially when it is associated with deficiencies in folic acid, vitamin A or B12, as is often the case in populations living in developing countries (WHO, 2000). In the context of the UWR, with figures indicating 686,527 of the total population are moderately to severely food insecure (WFP, 2012), it is likely a large portion of pregnant women and children in the UWR experience consequential effects of anemia despite the low recorded percentages of pregnant anemic women.

3.6 Health Education

Health education in schools represents a significant aspect of health access in the UWR, exposing students to information about sanitation practices, reproductive health and infectious diseases. Schools are also used to prevent, reduce, treat, and monitor health problems and conditions in youth. Further, it is hoped health messages provided to children are conveyed to their families. In 2008, 26% of schools in the UWR had more than three education talks which is an increase from 8% in 2006 (GHS, 2008). However, access to primary education facilities is problematic as less than 40% of communities in all but one district have access to primary

schools within five kilometers. Long distance to school surely affects attendance and resulting enrolment motivation, especially at the primary school level. Additionally, class sizes have an average of 1:46 teacher to pupil ratio (GSS, 2005). Together, this influences the ability of schools to engage in information regarding reproductive health, sanitation practices, and infectious diseases.

3.7 Family Planning

The Ghana Health Services regards contraceptives as a means to reduce maternal mortality and improve women's health by preventing unwanted and high risk pregnancies, while also reducing the need for unsafe abortions (GHS, 2010). Some contraceptives also improve women's health by reducing the likelihood of transmissions of infections such as HIV (GHS, 2010). As a result of contraceptive use, theoretically child survival is improved through adequate birth spacing, prevention of births among very young women, and prevention of births among women with four or more children. Further, using contraception to impede childbearing after four births helps reduce infant and maternal mortality rates (GHS, 2010). However, family planning acceptance rates decreased from 27.7% in 2009 to 21.5% in 2010 (GHS, 2010) indicating substantial room for improvement. Such low rates of acceptance highlight the need for proper education to reduce the need for unsafe abortions, and improve health outcomes of both women and children.

Furthermore, additional structural barriers impede the promotion of maternal health in the UWR. Poor documentation of family planning, inadequate coordination of services at all levels; delays in submission of reports by the district, and delay in payments of funds by some districts create detrimental outcomes for both women and health institutions in the UWR. Coupled in these barriers, are additional low patronage of some devices (e.g. IUD and female condoms), lack of male involvement in family planning activities, and limited resources/support from the government (e.g. contraceptives not included in NHIS).

3.8 Conclusion

The health care system in the UWR is drastically underdeveloped creating substantial impediments for women's health. Given accessibility challenges to health services, coupled with a low health professional to population ratio, seeking maternal health care is a difficult task for many women in the region. Annual check-ups are rare amongst residents, with many avoiding trips to a health facility until they become very ill, which may contribute to low antenatal visits and low rates of skilled delivery.

As Ghana strives to meet its MDG 5 target, contemporary studies have suggested Ghana's newest MEP may be a key policy solution in encouraging women to deliver in a health facility and decrease maternal mortality (Witter et al., 2007). Nonetheless, it must be recognized that a substantial number of women experience deep-seated barriers to accessing care that go beyond health insurance payments, which are heightened in a geographic context of endemic maternal deprivation, poor health care infrastructure and rural livelihoods. Thus, the current thesis emerges to consider the geographic location and extraneous costs associated with pregnancy for Ghana to meet the MDG 5 and improve the wellbeing, livelihood, and prosperity of the country.

Chapter 4

4 STUDY DESIGN, METHODS, AND RATIONALE

4.1 Introduction

This chapter is a review of the methods, study design, and data analysis techniques employed throughout this thesis. The chapter begins with a discussion of qualitative methods and progresses to their suitability within the field of feminist health geography. The subsequent sections discuss the methods utilized in data collection including: in-depth interviews focus group discussions, and key information interviews. The chapter closes with a description of the techniques utilized in data analysis.

4.2 Research Design and Methodology

This thesis employs a combination of qualitative research methods in order to address the stated research objectives. This thesis broadly examines the maternal exemption policy within Ghana's UWR, and more specifically the relationship between policy awareness, health insurance and socioeconomic, cultural, and geographic influences on women's ability to access maternal health care. These relationships are bounded by time and space, creating an arena in which to study women's utilization of maternal health services. This thesis strives to generate an in-depth, comprehensive understanding of women's experiences aimed to unearth intricacies surrounding maternal health care. Since this research strives to uncover social processes relating to women's utilization, the application of qualitative methods was ideal to explore integral social relationships and the behavior of groups where little exploration of contextual factors affecting individuals lives have occurred (Crooks, 2001).

4.3 Qualitative Methods

Qualitative research methods are used as the tool for addressing the objectives of the study. The practice of qualitative research and the application of its diverse techniques do not privilege any particular methodological approach. This grants the ability to use multiple theoretical frameworks in the application of qualitative techniques. Given this, qualitative research is very interpretive in nature (Denzin & Lincoln, 2005; Hesse-Bieber & Leavy, 2004;), embracing and thriving on the interpretive diversity resulting from differing backgrounds and worldviews which researchers and social actors possess. Silverman (2005) suggests that qualitative methods are suitably placed to answer questions that require in-depth examinations and description, while discovering meaning concerned with human beliefs, values, and actions. This study adopts a qualitative approach since it seeks to provide a detailed description of women's experience and uncover how they navigate maternal reproductive needs in the UWR.

This thesis broadly concerns itself with the importance of maternal health care in relation to the NHIS and MEP in the UWR, while understanding women's utilization of maternal health care services, enrollment in the MEP and certain geographical, socioeconomic, and cultural characteristics influence health care behavior. According to Giacomini and Cook (2000), qualitative research is important in studies of health care as they offer insight into emotional and experiential phenomena in health care. Qualitative studies may pursue a variety of theory-generating aims, including the exploration and description of social phenomena, capturing diverse perspectives while giving voice to participants (Sofaer, 1999). This provides the ability to identify potentially important concepts, to recognize patterns and relationships, and to generate an understanding of the phenomena under investigation. By capturing narrative accounts and explanations, women's navigation of maternal health services is illuminated.

4.4 Qualitative Research in Health Geography

The shift from medical to health geography generated the desire for increased methodological approaches to understand space and place and its relation with health (Dyck, 1999). The use of qualitative methods proved beneficial to develop alternate forms of 'knowing' separate from the dominant paradigm of Western medical knowledge and positivist science (Dyck, 1999) which frequently focused on disease ecology. The emergence of health geography signaled a distancing from the concerns and interests of the medical world that commonly focused on quantitative techniques, to a broader interest in concerns for well-being and social interpretations of health and health care in "place" (Kearns & Moon, 2002). Mirrored in this transformation is the change from space and place as strictly a container for health outcomes, to one which perceives space and place as a significant factor necessary to understand factors effecting health (Kearns & Joseph, 1993; Moon, 1990). Accordingly, the use of qualitative methods, in its' ability to focus on the views, perceptions, and experiences of study participants (Dyck, 1999) proves beneficial to develop a thorough understanding of space, place and health outcomes.

This transition from medical to health geography resulted in the greater acceptance for qualitative methods, due to the methods strong link between the philosophical concerns of the discipline, and the methods in which it employs (Dyck 1999; Scarpaci, 1993). Qualitative methods have significantly increased in prevalence and utilization over the past two decades becoming an accepted strategy for producing place-sensitive and subject-centered analysis of the geographic dimensions of health (Dyck, 1999). Further, qualitative methods increase the voice of participants while allowing an examination of the nature of items that are socially constructed, promoting or inhibiting health. This allows concepts of health and health care to be linked with behavioural choices and health outcomes within a specific locality (Poland et al., 1989).

The move from medical to health geography is not only indicative of a theoretical and methodological change, but one that accounts for the appropriateness of theory and methods

while seriously accounting for space and place. This increased concern provides the capacity to challenge the status-quo assumptions and understandings regarding the intersections of social meaning, power distribution, and experience within space and place (Dyck, 1999). Given the recent cultural turn in geography, and increased recognition of feminist geography, health geographers are able to push the limits of medical geography to challenge and deconstruct the central categories and concepts that have guided directions in conventional medical geography.

4.5 Feminist Research Methodology and Epistemology

Theoretical shifts within feminism have allowed for connections regarding matters of power, scale and the production of knowledge to form the crux of feminist research (Dyck, 2003). These shifts generated a discussion about the nature of field research, challenging the traditional scientific ideals of neutrality and objectivism (Nast, 1994). Given the expansive transformative period within the social sciences, especially the cultural turn in geography, greater attention was granted to intersubjective and reflexive forms of qualitative analysis.

Feminists have argued against claims of neutral and objective forms of knowledge acquisition commonly associated with quantitative research, asserting claims of universal applicability have perpetually only been valid for men of a particular culture, class, or race (Haraway, 1991; Nicholson, 1990). As a result, feminist researchers challenge the dominant epistemological and methodological practices of research, bringing to the fore a discussion regarding the objective quantitative data versus the subjective qualitative methods used to yield “the truth” about the nature of the world (Gregory, 1979).

The transformatory environment in which feminist health geography emerged garnered increased attention to gendered health issues within space and place, and accordingly altered the ways in which feminist health research is conducted. The new epistemological tenant aimed to generate comprehensive, personal accounts of individuals lived realities, and increased interest surrounding political issues informed the methodological strategies and approaches employed by

feminist geographers (Mattingly & Falconer-Al-Hindi, 1995). No longer were medically-driven categories a primary focus, but rather attention was turned to issues of social construction of health “in place”, experiences of illness, consumer accounts of health care provision, and a variety of ‘landscapes of care’ (Gesler & Kerns, 2002; Kearns & Moon, 2002; Parr, 2002). In pursuit of these concerns, qualitative methods were heralded as allowing investigation of context and meaning, as well as understanding of individuals’ realities (Dyck, 2003).

When feminism emerged in the early 1970’s, its main focus was to put women on the map, making women’s issues important for geographers and other researchers alike. However, little focus was granted towards appropriate methods for feminist inquiry. Issues later arose, querying ‘male stream’ research approaches commonly aligned with quantitative approaches, which led to the rejection of quantitative methods by many feminist researchers and increased attention directed towards qualitative methods within feminist geography (Nast, 1994).

Nonetheless, there is a continued debate within feminism about whether there is, or should be, an accepted set of feminist research methods (Harding, 1987; Oakley, 1981; Stanley & Wise 1993). Generally, a broad understanding permeates feminist research within and outside geography, where the researcher seeks methods which are consistent with the values and aims of feminism and topics of inquiry (McDowell, 1992). However, it is argued (Stanley & Wise, 1993) there is nothing inherently feminist in either quantitative or qualitative methods, but what is considered “feminist” is the utilization and epistemological stance towards these methods. Accordingly, no single method provides access to the “truth” and as such, it becomes less important to associate certain methods with particular epistemologies. This has shifted the relevance of the method used to be dependent on the research question (Elliott, 1999; England, 2006). Thus imparted with this method-question relation, coupled with the aims of this research, multiple forms of qualitative methods were conducted.

Qualitative methods within feminist health geography are a critical way to include issues of gender, racialization, sexuality and disability in the broader domain of health geography

(Kearns, 1993; 1997). Methods which center in women's experience have increased understandings of women position in various life stages, with a greater focus on space (Dyck, 2003). These methods do not aim to make grand claims of universal applicability but limit and locate one's truth claims, relevant to qualitative research methods (Mattingly, 1995). Suitably, qualitative methods provide the most appropriate investigation of context and meaning while offering alternate ways of "knowing" (Dyck & Kearns, 1995; Parr, 1998). Feminists commonly advocate collaborative, non-exploitive relationships between research participants and researcher. To garner such relationships, variations of qualitative methodology, including in-depth interviews, participant observation, and ethnographic research (McDowell, 1992) and used to generate less exploitative, more egalitarian relations between the researcher and participants.

4.6 Choice of Case Study: Qualitative Methods

A case study approach was used to investigate women's utilization of MHC in the context of the MEP and the intricacies of utilization within the socioeconomic and geographical landscape. According to Hancock and Algozzine (2006), qualitative case studies are usually richly descriptive with illustrations of key aspects of the case. They may be exploratory rather than confirmatory thus allowing for the understanding of the subject under study from the perspective of the participant. As such, qualitative case study designs may contain a series of narratives, enriched with illustrative descriptions highlighting themes, without the intentions of generalizing study findings. The case study research method allows the ability to investigate a phenomenon within a specific context without attempting to manipulate the events within the context (Hancock & Algozzine, 2006). This *in situ* investigation process allows the complex interconnections between various issues associated with the phenomena under investigation to be identified without interfering with contextual features.

The choice of a qualitative case study proved beneficial for researching women's utilization of maternal health services as it allowed the use of multiple sources of data for

evidence to develop internal validity and reliability of the data (Guba & Lincoln, 1981). While providing descriptions of phenomena under study in a given context (Hancock & Algozzine, 2006), case studies have traditionally been misconceived as best suited for exploratory research. However, Yin (2003) indicates that case studies are just as appropriate for descriptive and explanatory investigations. As such, this research has descriptive characteristics with overlapping explanatory aspects to provide thorough context and insight regarding maternal health care.

The overarching intent of case study research is not to create generalizable findings and grand laws but rather to garner an intensive in-depth understanding of a specific case or issue, while drawing upon the accounts and personal experiences of those impacted (Eyles & Donovan, 1986). As such, it is not appropriate to study Ghanaian women's maternal health issues on a grand scale since individual women hold varying perceptions regarding maternal health care and experience differing lifestyles. It is inaccurate to understand women's maternal health issues as a homogeneous concept, but rather focus on in-depth examination of social and structural factors *in context* which influences women's maternal health outcomes.

Previous literature (Abel-Smith & Rawal, 1992; Borghi et al., 2003; Ensor et al., 2004; Gerein, Greean & Pearson, 2006; Kawnine et al., 1998; Oppong & Hodgson, 1994; Perkins et al., 2009; Nahur & Costello, 1998; Witter, Garshong & Ridde, 2013) indicates access to health care in Ghana is complex, influenced through an interaction of environmental and societal factors which serve as a basis for the selection of a case study approach for addressing the objectives of the study. The phenomenon under study was conducted through the use of interviews, and focus groups which grant the opportunity for triangulation (both investigation triangulation and methodological triangulation). Since it has been critiqued that no single method is adequate to solve the problem of competing explanation (Patton, 1999), multiple methods were used to capture contextual features and personal dynamics related to the inquiry. Thus, by employing multiple qualitative methods, the contextual significance was able to stay intact, as each method compensated for the weakness of the others.

4.7 Multiple Methods in Health Geography

This thesis implemented a multiple method approach to research, which focused on various forms qualitative data collection. Multiple methods differ from mixed methods as the former indicates the use of multiple forms of data collection within the same methodological domain, while the latter refers to the combination of both qualitative and quantitative approaches. Traditional definitions of mixed methods typically indicate the use of both qualitative and quantitative approaches as a means of increasing the quality of a study (Rank, 2004). Different in purpose, multiple methods offer similar strengths drawing on several methods within the same approach. Within this thesis, multiple mixed qualitative methods are used, employing focus group discussion (FDG), in-depth interviews (IDI), and in-depth key informant interviews (KI).

The use of multiple methods allows the researcher to capture the complexity and diversity of the study context, participants values, perceptions, and experiences (Hemming, 2008). Feminist researchers commonly develop strategies to explore issues using a combination of complementary methods to garner a comprehensive understanding of the 'field' (Rose, 1993). Nonetheless, while in the field, the researcher must be cognizant of shifting power relations between the participants and researcher within the research process and try to mitigate issues when they arise (Hemming, 2008).

4.8 Qualitative Rigor

Unlike quantitative researchers who seek causal determination, prediction, and generalization of findings, qualitative researchers seek instead to illuminate and understand the situation under investigation (Hoepfl, 1997). While quantitative researchers try to guard against threats to rigor through ensuring reliability and validity, rigor in qualitative work is more subtle and complicated. Though defined differently by different authors, it is largely understood by social geographers to consist of: credibility (authentic representations of the experience); transferability (the fit outside of the study context); dependability (consistency in interpretation,

minimizing idiosyncrasies); confirmability (the investigators biases, motivations, personal perspectives are recognized and strategies enacted to counter them) (Baxter & Eyles, 1997). The following sections describe how this study controlled for threats to rigor through data collection techniques, data triangulation, theoretical saturation, positionality and reflexivity and research assistant training.

4.8.1 Data Collection Techniques

Several steps were taken to mitigate threats to qualitative rigor. First, rigorous data collection was promoted by taking detailed accounts of the research interviews and focus groups, highlighting important issues and themes which emerged during the process. I also made comprehensive notes pertaining to the location, road characteristics, and availability of health infrastructure in the community, which as Creswell and Miller (2000) suggest assist in credible research.

4.8.2 Triangulation

Another important procedure I used to promote rigour was through the use of methodological triangulation. The multiple methods employed in this thesis are complementary and are aligned with the given theoretical perspectives. Baxter and Eyles (1997) argue the use of multiple methods increases the rigor of a study while concurrently strengthening credibility. The studies rigor is increased though the use of triangulated methods to attain a diversity of views regarding a specific topic, whereby the combination of methods assists the claims of validity of a study (Olsen, 2004; Mathison, 1988).

Further, during the data analysis process, investigator triangulation assisted in conducted a rigorous analysis. To improve analysis and understanding, I met with Dr. Luginaah after initial coding was complete, to review codes and provide an impartial set of eyes. This use of investigator triangulation is beneficial as it considers the ideas and explanations generated by

additional researchers studying the participants, increasing the validity of findings (Johnson, 1997). Though I recognized that inviting Dr. Luginaah would not eliminate all subjective factors in the coding process, investigator triangulation is said to promote an inter-coder dialogue and thus *assist* with the problems of having just one set of eyes. Despite its imperfections, this process helps make sure the two investigators agree about what occurred, and if so is less likely that outside reviewers of the research will question whether something occurred or not (Johnson, 1997). In this analysis, Dr. Luginaah and I shared very similar coding preferences which assisted in a rigorous analysis.

4.8.3 Theoretical Saturation

Rather than striving for generalizable results, qualitative methods seek to develop internal validity and rigorous data collection. In order to generate internal validity in the research process, it was important for data collection to reach a level of theoretical saturation. To reach a level of theoretical saturation, “no additional data are being found whereby the researcher can develop the properties of the category (Glaser & Strauss, 1967: 61). During the research process, certain themes such as women’s experiences seeking transportation or the troubles endured acquiring money for pregnancy testing were reappearing concepts. While certain themes were prevalent in many interviews, other themes occurred occasional such as women’s personal experiences with maternal mortality, or knowledge about the intricacies of the MEP policy. Thus, theoretical sampling, as Charmaz (1990) suggests, was best suited to accommodate the identification of newly discovered concepts. Since initial data collection was conducted with a fairly ‘random’ group of people, who had experienced the phenomenon under study, theoretical sampling was used to generate further data to confirm or refute original categories. Accordingly, theoretical saturation was deemed complete when themes were fully developed and no new data emerged which provided the ability to understand properties of the concept (Glaser & Strauss, 1967).

Themes which emerged from the data were consistent providing a level of trustworthiness, and credibility of the data reaching a level of theoretical saturation (Lincoln & Guba, 1985).

4.8.4 Researcher Positionality and Necessity of Being Reflexive

Concerns surrounding issues of power relations often convolute the research process. As such, it is necessary for the researcher to thoroughly reflect on the research goals in order to produce more inclusive methods sensitive to the power relations of fieldwork (England, 1994). However, it is impossible to remove all powered relations present within the research process since the position and biography of the researcher directly affects fieldwork (England, 1994). Thus, the researcher's position must be realized throughout the entire research process so the researcher is able to reflect on their situated and partial understandings of the "other". This reflexivity is not solely about the identification of one's ethnicity, gender, sexuality, or class, nor about some omniscient understanding and representation of ourselves or others. It must rather be conceived as a continuous process to understand some of the relational dynamics that can impact the co-creation of knowledge (England, 1994). These relational dynamics can include the social construction of gender, cultural milieu and social environment, and how these in turn shape and construct the way in which knowledge is attained. Given this, it was crucial to understand my positionality prior to conducting research and how this would ultimately affect the entirety of the research process.

As I am a white Canadian born woman, an obvious difference exists between myself and the citizens of Ghana's UWR. Significant sociocultural, racial and ethnic distinctions exist, which have the ability to influence the research process. As a result, I paid close attention to these discrepancies and how they potentially affected the research process. Having spent my entire life studying in Canada, I had no experience conducting research within a developing country, other than certain techniques I received in graduate courses.

Prior to commencing field work in May 2013, many challenging questions arose which were associated with my gender and ability to conduct research in the UWR. Given that I am a white female in a different cultural context, the construct of gender and what it means to be a female within the UWR is dramatically different than that within the Canadian context. Gender cannot be understood as fixed category but must instead be understood as socially constructed forms of classification, given meaning during socialization and reinforced by daily experiences (Hopkins, 2009). As a result, I had to be aware of the differences (subtle and obvious) my gender created while conducting research and living daily within the community.

It was speculated that I may have challenges associating with individuals living in the villages of UWR or acquiring suitable participants due to my “outsider” status. However, these speculations quickly diminished upon arrival as residents of the region were extremely welcoming and friendly. Women in the villages were eager to discuss their experiences with childbirth with someone from outside of their region in hopes that their story would “be heard” and have the potential to improve their current situation. Even if some participants were initially apprehensive, my research assistant ensured confidentiality and women’s perceptions shifted as they freely discussed their ideas and knowledge. Many participants expressed to me that they felt a significantly higher degree of comfort speaking to an “objective foreigner” rather than a member of the NHIS or Ghana Health Service. Further, women stated they found it easier to talk to me since I was there not to cast judgement, but to listen to their voices and help them achieve their goals of equal access and improvement of women’s health care.

A fundamental aspect of my research that helped to bridge the gap between myself and the people of the UWR, is that my supervisor is originally from the region. This dramatically increased the ability to build rapport and relations with people of the area. Prior to the commencement of fieldwork, Dr. Isaac Luginaah established contact between myself and his pre-existing relations in the area. By being introduced as a student of Dr. Luginaah, I was able to meet a variety of academics, health officials, and local residents and easily become associated

with these individuals. Additionally, one of Dr. Luginaah's PhD students had extensively worked in the UWR prior to my arrival, which provided the added benefit of being able to utilize her contacts. These contacts helped me become accustomed to the local culture while assisting in understanding the nuances within the health care system.

An associate of Dr. Luginaah's, Dr. Sylvester Galaa at the Wa campus of the University of Developmental Studies, provided the assistance necessary to hire a qualified research assistant. With the support of my research assistant, I was able to determine appropriate study sites and locations best suited to conduct research. A number of other factors contributed to the final decision of conducting research in villages and communities within the five of the seven districts within Ghana's UWR. Foremost, I wanted to gather enough information necessary to understand the various gradients of maternal health access in relation to distance and locality. Secondly, I wanted to collect enough information to investigate if women experienced different accessibility challenges between districts.

A number of considerations were made prior to conducting research. The issue of transportation was important to contemplate. Since I was able to access both a motorbike and trotto for transportation, I was able to cover a significant amount of area. I also had to consider that my research was being conducted during the rainy season, and access to some areas would be sporadically interrupted and impossible if roads were flooded. Furthermore, the areas had to be locations that my research assistant was able to speak the local dialect. If this was not possible, a university student in the community would assist in translating certain words and phrases. Knowledge of the regional dialect was necessary in order to facilitate interviews, focus group discussion, accurate translation and proper transcription.

During my time in the UWR, I worked with one research assistant who was a high school teacher at Wa Polytechnic, and a university graduate from the University of Development Studies. He played a pivotal role in the ability to conduct research as he guided the initial visits to the research sites, performed proper introductions and translated the interviews. Since the

research was conducted cross culturally, certain differences in dialect and meaning were expected (Valentine, 2005) as some English words were not easily translated into the local dialect. Thus, I ensured that my research assistant was aware of certain linguistically codes of behaviour and use the appropriate form during interviews (Evans et al., 1994), to ensure information was sufficiently collected.

4.8.5 Research Assistant Training

Fowler (1993) states that training research assistants should take more than one day in order to create good interviews. The training of my research assistant took approximately one week to develop a complete understanding of my research goals and aims. Given his extensive work on a previous and related project on Ghana's NHIS conducting interviews and focus groups, and previous research on maternal health issues, he had substantial knowledge regarding the proper format and aims of research. Given this, I felt greater comfort in his previous knowledge and skills.

Nonetheless, our training consisted of discussing the goals and theoretical approach to the research and the various aspects of maternal health care women utilize in the context of the UWR. These discussions occurred in an informal manner where the research assistant was free to express his own thoughts with regard to both the research design and feasibility of the research. This occurred within the first two days of training. The third and fourth day were devoted to practice interviews and focus group discussions and the manner in which they were to be conducted. This involved ensuring the assistant understood the questions that were to be asked, as well as the ability to properly translate these questions. Given that my research assistant was also a teacher at one of the town high schools, coupled with his extensive background in translating interviews from the local dialect to English, I was not concerned in his ability to attain proper information. I also discussed probing techniques and follow up questions during our discussions to attain appropriate information. In the following days, we designed a timeframe in which we

hoped to complete research in specific areas and regions we hoped to target. We also discussed proper greetings and forms of conduct while in the field. I learned the proper ways to address elders, the ways to address community members and appropriate responses to their questions. This ensured the research process would run smoothly and provided self-assuredness while in the field.

4.9 Data Collection Methods

Participants involved in the interviews and focus groups spanned a large age range, and possessed different individual characteristics. Women who were involved in the research included those with children, women with no children, women who had enrolled in the maternal exemption policy during pregnancy, women who did not enroll in the policy during pregnancy, elderly women (pre policy), pregnant women, Traditional Birth Attendants, nurses, midwives, and health officials. Given that this research examines various aspects of utilizing maternal health care services, many individuals openly discussed issues regarding family relations, cultural influences, and their socio-economic realities. These conversations were very personal and highlighted challenges, and their daily experiences encountered to seek care. As a result, the individuals participating in the research were ensured confidentiality and anonymity.

4.9.1 Semi Structured and In-Depth Interview

Interviews are an essential research method within qualitative research as this enables respondents' to recall information, expressions, and feelings in regards to a specific topic (Drew, 1993). They provide a way in which to deepen the inside knowledge of the community under study while obtaining a thorough grasp of the individual as a social actor (Fowler & Hardesty, 1994). Two dominant forms of interviews were employed during fieldwork which consisted of semi structured interviews and in-depth interviews. Semi structured interviews have a flexible

structure consisting of open ended questions that define the area of exploration while providing the ability to deviate from the original question in order to pursue an idea in more detail (Britten, 1995). In-depth interviews are less structured than the former, and may cover only a few issues, but in much greater detail (Britten, 1995).

These two interview methods provide the means of obtaining knowledge from individuals in an interactive manner (Miller & Crabtree, 2004). Feminist researchers stress the importance of interacting and sharing information with participants (Oakley, 1981), with underlying principles of good research as reciprocity, sharing experiences and ideas (Valentine, 2005). The interview process signifies the importance of human interactions and developing an understanding of how others create knowledge and exist within their daily lives. The questions served to facilitate discussion and allow women the ability to speak freely regarding their socioeconomic realities, geographic location, and the cultural factors that influence their health utilization.

Though usually considered as a weakness of the interview method of data collection, the homogenous nature of the gathered data from the sole perspective of the interviewee was one of the reasons for selecting this method. This way overlapping and concurrence of issues within the various interviews help give credence to the characteristics of the phenomena under investigation (Creswell, 2013). Moreover, the utilization of maternal health care varies among certain localities due to the effects of the socioeconomic and cultural realities of the women, and as such these differences need to be recognized. This method offers the opportunity to delve deep into the issues surrounding access to health services, effect of social situations, cultural characteristics of birth, geographic impediments and their significance in ensuring safe birthing practices.

The twenty two interviews for this study were conducted between May and July of 2011 in the five of the nine districts in the UWR: Wa East, Wa West, Nadowli East, Nadowli West, and Jirapa District. Figure 10 provides a description of the district, community, and number of women interviewed. Interviews were conducted with women capturing a diversity of life stages

including: pregnant women, women who had recently gave birth (1-4 days after), women with/out children, women who had/not registered for the maternal exemption policy and elderly women who had witnessed the introduction and implementation of the maternal exemption policy within the context of the UWR.

Given the nature of women's work (i.e. farm, market, labour activities), the interviews were conducted at various times during the day and in various locations. These predominantly occurred outside/inside an individual's home, outside/inside a health facility, or in another public atmosphere. The objectives and goals of the research were explained to the participants. The women were told that we wanted to hear their story as it relates to their maternal health, health of their children, perceptions of the overall health care system and how this affects their utilization of maternal care provided under the MEP. The interviews undertaken addressed all of the research objectives and strove to attain a thorough understanding of the mediating factors that affected women's use of maternal care.

Figure 10: In-Depth Interviews

District	Location	Date	Number of Women
Wa East	Goripie	May 7	3
Nadowli East	Dafiama	May 19	3
Jirapa District	Jirapa	May 21	3
Nadowli West	Nator	May 22	3
Nadowli West	Tapko	May 23	3
Wa East	Bulenga	June 11	3
Wa West	Nakor	June 20	4

4.9.2 Focus Group Discussions

The focus group discussion is characterized as “informal discussion among selected individuals about specific topics” (Beck, 1986:299), where issues for discussion receive contribution from all group members. Agar and MacDonald (1995: 80) characterize focus group discussion as “somewhere between a meeting and a conversation” which minimizes the production of homogenous discourse obtained from the individual interview method.

Focus groups are useful for gaining insight into various views and understandings of participants regarding a particular social issue and provide the ability for members to compare and challenge others ideas and experiences. These contested accounts are fundamental to this method as they influence the nature and context of responses (Kidd & Parshall, 2000), revealing the processes whereby social norms are shaped (Lunt & Livingstone, 1996). Evidence also indicates that focus group are valuable in the study of issues in socially marginalized groups (Kitzinger, 2000; Madiz, 1998), such as women and their children.

Focus groups are highly regarded for discussion of culturally sensitive topics (Kitzinger, 2000) as less reserved members of the group may ease conversation for other participants. This was highly applicable in the context of this research, given its relation to family relations, cultural characteristics of birth, and the experiences of miscarriage. Usually, when a sensitive topic was broached, one or two individuals would initiate discussion that encouraged other women to share their perspectives. Often once one woman began talking, others would chime in and discussion would flow easily. Women would often ask other participants to support their opinions or express their own thoughts, which led to intense conversation and exploration of topics unanticipated.

The participants in the study were of similar socio-economic background, most with no education or basic education, allowing for easy comparisons between group members. This also enabled group members to easily relate experiences among participants (Kidd & Parshall, 2000), developing a community image of the subjects under study.

Focus groups are commonly criticized that individual voices may become silenced when an individual's view runs contrary from the majority feeling embarrassed to share their thoughts. As well, within this context, individuals may feel self-conscious or awkward discussing certain issues among the elderly women. Only a few participants did express a small degree of embarrassment after being asked certain questions, but overall the serious nature of the discussion helped them overcome these feelings. Thus to prevent this, moderation of the FGDs were carefully done with a strong commitment to constantly seeking the personal perspective of all FGS members on issues, especially from quieter members of the group.

The 10 focus groups were conducted between May and July 2013 in five of the nine districts of the UWR: Wa East, Wa West, Nadowli East, Nadowli West, and Jirapa District. Figure 11 provides a description of both the number of participants in each group as well as the location. The objectives of the focus groups were to develop insight into the characteristics of maternal health care use and capture the women's local knowledge. The discussions lasted between 45 minutes to 1.5 hours in length and occurred in common village area. Groups consisted of between 8 – 23 participants, which have been argued as an appropriate size to render stimulating and pertinent conversation (McLafferty, 2004; Merton et al, 1990). The women ranged from 18 years of age to very elderly women, composing pregnant women, birthing women, women with/out children, women who had/not registered for the maternal exemption policy, elderly women and TBAs. As well a focus group entirely consisting of TBAs was conducted allowing further questioning of issues that arose during TBA interviews. These focus groups were conducted on various days of the week that best met with the women's schedules. Focus group discussions normally occurred a few days after interviews in order to flush out issues that were discussed during the interviews. This provided the ability to probe certain topics and issues that arose during the interviews to garner depth and clarity of certain issues.

Figure 11: Focus Group Discussions

District	Location	Date	Number of Women
Wa East	Goripie	May 9	10
Nadowli East	Dafiama	May 20	15
Jirapa District	Gbare	May 30	23
Nadowli West	Tapko	May 31	6
Jirapa District	Gbare	June 1	21
Wa East	Bulenga	June 8	14
Wa West	Glang	June 11	18
Wa West	Tabazu	June 13	15
Wa West	Nakor	June 23	9
Wa West	Polee	June 24	8

4.9.3 Key Informant Interviews

A key informant interview for the purpose of the thesis is defined as an individual who directly is either affiliated with Ghana's health institutions, is knowledgeable regarding maternal health issues, and is in direct contact with the population of the region. These key informants are residents within the region embedded in the study's social context. Given the knowledgeable areas these individuals hold, they can provide thorough understanding and analysis regarding factors which may facilitate or impede utilization (Lytle, Ward, Nader, Pedersen, Willston, 2003). These individuals are believed to provide a high degree of insight regarding structural processes underlying the problem being investigated due to their esteemed employment or social position.

According to prior health studies (Lytle, et al., 2003; Wig, Suleiman, Routledge, et al., 1980) key informant interviews provide many benefits to the research process. These individuals are thus able to provide insight regarding certain aspects of the community which may be

neglected in other forms of data collection. The information attained can be used in selecting priorities and designing interventions to promote community involvement and evaluate the effectiveness of new forms of health care (Wig, Suleiman, Routledge, et al., 1980). The WHO (2005) states there is no criterion regarding the number of key informants involved within a specific study as the number is determined by the number of different positions that can be identified in the relevant social environment. They argue it is not necessary to interview more than one individual from the same category, but to enrol as many different key informants as possible.

Given these aims, a series of semi-structured in-depth interviews were conducted in various localities (see Figure 12) between May to July 2013 to understand the development, implementation, and functioning of the maternal exemption policy. The interviews were conducted with the goals of understanding the process of health policymaking in the Upper West, to acquire deeper insight regarding the underpinnings of maternal health within the region and to further contextualize the issue of maternal mortality and its proliferation. A total of 12 key informant interviews were conducted between May and July 2013 in 4 districts with various key informants. This sample consisted of 2 males and 10 females spanning an array of professions. Although efforts were taken throughout the research process to ensure equitable gender representation, the nature of the topic positioned the research with an arbitrary capacity to gather equitable gendered representation, providing more information from the gendered perspective of females. The number of interviews was conducted on the basis of theoretical saturation (Sandelowski, 1995), whereby no new information regarding a given topic emerged after a certain number of interviews had been conducted.

Figure 12: Key Informant Interviews

District	Location	Date	Key Informant
Wa East	Goripie	May 7	TBA
Wa East	Goripie	May 7	Nurse
Nadowli West	Nator	May 22	TBA
Nadowli West	Nator	May 22	TBA
Nadowli West	Nator	June 4	TBAs (FGD)
Wa East	Bulenga	June 8	Nurse
Wa East	Bulenga	June 11	TBA
Nadowli East	Dafiama	June 20	Medical Assistant
Wa Municipality	Wa	June 22	District Coordinator of Maternal and Child Health
Wa West	Polee	June 24	TBA
Wa Municipality	Wa	June 30	Nurse
Wa Municipality	Wa	July 2	Nurse

4.10 Field Observations and Notes

Observations are an important source of primary research in community studies providing supplementary information and clarification of interviews (Poklinghorne, 2005). Observational data ranges from facial expressions, vocal tones, gestures of interviewees to general physical characteristics of the environment that would contribute to a clarification and understanding of issues related to the study. Observation and documentation of general living conditions, socioeconomic characteristics, religious affiliation, road conditions, and geographic context of respondents provided useful to further understand the third objective of the thesis. The observations assisted with the ease of comprehension and appreciation of the respondents living conditions as to develop a more thorough understanding of the situation under investigation.

Field notes provide meaning and an understanding of the culture, social situation, and particular event being studied (Mulhall, 2002). Field notes were taken after every interview and focus group to make note of particular responses, physical, social religious differences among areas, and indicate certain costs women deemed associated with pregnancy. For example, women provided an approximate monetary amount of associated with necessities to deliver in a health facility including rubbers, detol, and cloth. Women also noted the cost associated with pregnancy testing. By generating field notes regarding this information, I was able to make locational comparisons and draw further connections after research was conducted.

4.11 Data Analysis Techniques

All interviews and focus groups were translated by the research assistant during the interview, and recorded. After each interview I transcribed the data and read through the interview text to garner a thorough understanding of the emerging themes and concepts and uncover commonalities and distinctions in women's experiences. This allowed me to become fully immersed in the data before I started coding for themes. In accordance with grounded theory, research and initial analysis was conducted simultaneously. Though a rough sample of 20-30 was helpful for planning purposes, interviewing and analysis was conducted until the saturation of concepts was complete, where no new information about the core processes is forthcoming from ongoing data collection (Strauss & Corbin, 1998). Based on the literature it was probable that between 20 and 30 interviews would be needed to reach this point of saturation (Creswell, 2007).

Following, the interviews and focus groups transcripts were then printed into hard copies which were thoroughly read once again in order to get a general "feel" for the data. Once I felt comfortable with the material and questions, I began going through the interviews in a more formal manner, using the procedure of open coding. Open coding allowed the highlighting of particular words or chunks of responses that indicated concepts and categories that fit the data.

Using Strauss' (1990) conception of this procedure, this stage involved unrestricted coding of the data and the understanding that all concepts uncovered are tentative. At this stage, the interviews were reviewed independently and taken for their individual contributions. By the time I had reached the last of the interviews, it was clear that many of the questions generated similar responses, and moreover, overall themes were emerging across questions. At this stage of analysis, data saturation was evident. However, it was also important to note any of the unique answers, as these were never excluded from the analysis.

Upon the completion of open coding, I consulted with Dr. Luginaah about the generated codes. We compared and contrasted ideas, which was helpful as this was my first time conducting this kind of work. Viewing Dr. Luginaah's understanding of the codes affirmed that I was on the right track with the analysis. The occurrence of similar coding by two separate people, as was the case here, lends credibility and reliability to the study.

After our meeting, I created an axial coding model, which is a multileveled coding model. This step in the content analysis is used to organize the data and identify findings after open coding has been completed. I read through each transcript again and tried to group the open codes previously collected. This allowed for analysis of recurring themes and for quick reference when identifying commonalities and comparing answers between participants. This proved to be a very effective way to organize and analyze the data.

Often, qualitative researchers use computer programs for this type of work. However, I chose not to do this for three reasons. First, I was eager to complete the analysis in order to keep with the projected timeline outlined for my thesis. Using a computer program would have required a greater investment in learning a new program and thus would have delayed my work. Secondly, I did not have any access to the computer program while I was in the field, and had restricted temporal and locational access to the program once arriving in Canada. Lastly, the total number of interviews was small enough to make manual coding manageable. As well, when I consulted others, they agreed that this was reasonable.

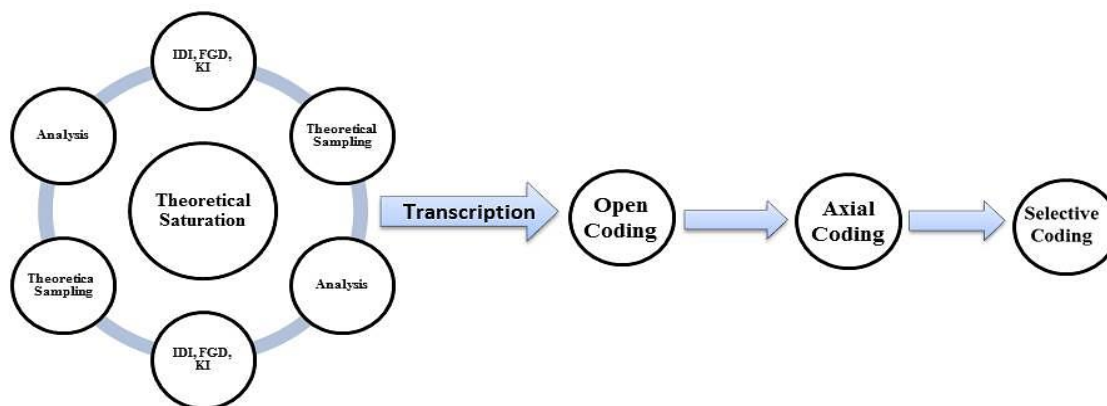
While all questions posed during the interview process could provide context and insight into my thesis, I was primarily interested in developing an understanding of the thesis' five objectives. The exercise in coding the entirety of the interview was not a fruitless effort. It was first and foremost, an excellent way for me to immerse myself into the interviews and get a feel of the information. If I had only analyzed my five questions I would have missed a great breadth of information and misunderstood responses given in the narrow context. The interviews were conducted as a whole entity and thus I felt that any analysis of the information needed to be performed in its entirety. It also gave me a greater understanding as to women's knowledge, access, and utilization of maternal health care within their socioeconomic, geographic and cultural context. Finally, it was a necessary step in conceiving overarching themes of the data and demonstrates connecting aspects of the research questions.

While it was important to analyze all of the interviews, it was also important to focus on the five key objectives for this study. As such, my final step in the analysis was to pick apart the responses for those particular responses related to my objectives. I did this by creating a chart, which indicated the location of the respondent, the age of the participant, their enrollment status, location of delivery, number of children, and role of the participant (mother, community nurse, general nurse, midwife, TBA, or health administrator). The chart contained all of the relevant information generated by respondents' responses to the objectives. This included both responses that fit well with the axial coding created earlier and unique answers that highlighted alternative viewpoints. Since the total number of participants in each district or category was limited, a unique response could potentially be quite telling. The data were entered into the chart in concise point form method, which gave myself detailed referencing so I could easily go back to the transcripts and understand the point in the proper context of the interview. Organizing the findings into the chart provided significant assistance when I shifted into the analysis stage. By using this "selective coding", the findings were organized in relation to other variables which were of interest. I could therefore interpret the results accordingly. For instance, the women's life

stage, policy status, and location of delivery were all laid out. While it can be a mistake to assume a variable has relevance (Strauss, 1990), this method of organization allowed the variable to prove its relevance in the larger picture of the research. For example, understanding the role of exemption status could explain the location of delivery or prove beneficial for locations otherwise different.

After the data was organized and analyzed, my consultation with Dr. Luginaah helped to focus and articulate the main ideas. Taken together, the use of open coding, axial coding, and point form notes for the five objectives provided a solid base for analysis and interpretation. See Figure 13 for data analysis diagram.

Figure 13: Data Analysis Techniques



Source: Created by Author

4.12 Chapter Summary

This chapter described the study design and methods utilized to obtain the results of the study. Specifically, this study adopted the qualitative case study methodology. This chapter outlined the logic of qualitative methods and qualitative case study design, as they work particularly well in addressing the research objectives. Following this description, the chapter

outlines the multiple methods utilized noting their strengths as well as the choice of qualitative methods for this particular study. The section discussed the details of participant selection and how the interviews, focus group discussions, key informant interviews, and field observation/notes assisted in the gather of data for the study. The chapter concludes by discussing data analysis techniques which were utilized to produce the themes presented in the results section.

Chapter 5

5 Results of the In-Depth Interviews, Focus Group Discussions, and Key Informant Interviews

5.1 Introduction

The interview questions explored participant's prior enrollment in NHIS, the number of children they have birthed and the location of child delivery (ies). Further discussion topics were derived from the theoretical framework of this thesis, incorporating concepts relating to political ecology of health, women's autonomy, and factors which influence access to health facilities. The results are presented around key themes examining women's knowledge of the MEP, the influence of the NHIS enrollment on use of the MEP, certain geographic, socioeconomic, and cultural influences on maternal health care utilization, confusion regarding appropriate care, and treatment women receive from health professionals. Additional concepts which emerged from the research is also presented covering concepts such as anemia, blood transfusions, complicated delivery, inadequate food supplies, coverage of drugs, MEP expiration, desire for ambulance services, and lack of male involvement. Under each theme, sub-themes are provided with quotations used to help contextualize the findings. Respondents' quotations were selected in order to ensure not only "representativeness" but also vividness in reporting of themes (Seale & Silverman, 1997). Each quotation is identified with a pseudonym, focus group discussion (FGD) or in-depth interview (IDI), their occupation when a key informant, and the age of the participant.

5.2 Knowledge and Understanding of MEP and Provision of Services

This section addresses the first objective of the study and is organized into three main sub-themes describing the nature of women's knowledge relating to the MEP. The first category includes women who had knowledge of the MEP prior to pregnancy. The second consists of

women with no knowledge of the MEP prior to pregnancy or during the initial stages of pregnancy (1-3 months), while the third captures misperceptions surrounding the MEP.

5.2.1 Women with Knowledge of MEP Prior to Pregnancy

Findings of both interviews and focus groups revealed women were somewhat aware of the MEP prior to pregnancy. This was attributed to policy knowledge dissemination from health personnel at facilities or education sessions in the village, with fewer women obtaining knowledge through the radio:

...the nurses normally gather women together to educate them. If you've missed your first period they tell you to go and get tested, and if you're pregnant you go and get registered, then you attend free antenatal care and everything else until you give birth (Abena, IDI, 26).

Once enrolled, some women were aware of the provided services through the MEP, most often noting the use of antenatal care and its benefits for child development:

Sometimes they do laboratory tests on us (urine, fecal). For me it's through the antenatals that you actually know if you can have a safe delivery, if you'll have complications, or if you need a caesarean section. I had two caesarean sections, and it was because of the care (FGD, 1).

Despite awareness surrounding antenatal care, fewer women were informed of the services covered during the postnatal period. This may suggest poor education of the coverage under MEP during the postnatal period, or may suggest district-to-district variations in the way knowledge is disseminated.

5.2.2 Women with No MEP Knowledge Prior to Pregnancy or During Initial Stages (1-3 months)

A second group, women with no knowledge of the MEP emerged during the analysis. Here it was revealed that MEP information was acquired only once these participants realized they were pregnant and sought care at a facility:

I wasn't aware of the maternal exemption and free registration for pregnant women. It was only when I went to the clinic for care when I recognized I was pregnant that I found out about the free service (Alice, IDI, 21).

Women expressed that free coverage under the MEP was only realized once accessing a health facility to enroll in NHIS. Given the delayed timing for procurement of the MEP, many women lacked proper health care during initial stages of pregnancy.

5.2.3 Misunderstandings of the MEP

A third group of women in both interviews and focus groups held a high level of misunderstanding regarding the MEP, with dominant sub-themes pertaining to the MEP's implementation, provision of services, and the benefits of MEP enrollment.

While some women agreed they could access services at health facilities unconditionally, others reported irregularities in treatment, expressing one antenatal care visit was allowed every three weeks. These women revealed if care was sought before the three week period, they were refused services:

I go every month but would like it to be more regular. You have to go in the third weeks' time after you had seen a nurse. If you go in the second week and you are sick they'll turn you away. It has to be in the third week. I'd want it to be more regular so anytime I could go if I had problems (Lydia, IDI, 22).

On the contrary, health personnel said women can access care unconditionally if they are sick, while normal antenatal assessments are to be done once a month:

They can come once a month, that is if you're ok, but if you're sick, you come every two weeks and it's free (Nurse, KI).

Conflicting responses by women and health personnel expose a high level of uncertainty surrounding proper functions and services provided under the MEP, which was experienced by many women.

Further problems relating to the availability of services provided at CHPS were discussed by many women, revealing a discrepancy in actual availability of services, compared to suggested

care provision. Despite clear signs outside CHPS compounds presenting the services to be provided at the clinic and statements from health personnel specifying 24-hour care provision, women revealed many irregularities surrounding available health services:

When you go to the CHPS, after 3pm no matter what's worrying you they will tell you they've closed and won't care for you. The nurse will be there and you're knocking, but they won't mind you....the nurse will say "Oh I'm tired, you go home, we can't treat you today" (Mary, IDI, 20).

Moreover, women specified all designated CHPS intended to provide maternal health care and delivery do not actually support and deliver women. Even though the Ghana Health Services implemented CHPS to facilitate community access to health care, including MHC, women spoke frequently about the scarcity of services provided at CHPS:

It's easier to get to the CHPS, but you can't deliver there... They'll refer you to Jirapa hospital, but you have to get there yourself and that's about seven miles (FGD, 7).

These shortcomings in health system management posed accessibility challenges for pregnant women in remote locations when seeking MHC, especially when labour occurs. Despite the government intentions of creating accessible health care, results from this study indicate accessibility difficulties endured by many women highly problematize maternal health outcomes. Additionally, participant's responses reveal various levels of understanding of the MEP and the provision of health services, which clearly portrays a disconnect between the national narrative of "free maternal health care for all" and the reality of women's knowledge of maternal health care availability in the UWR. As discussed below, misunderstanding surrounds MEP services, threaten access and utilization for further maternal health needs.

5.3 Enrollment in NHIS and the Subsequent Influence on Utilization of the Maternal Exemption Policy

Two themes emerged from this study relating to participants' enrollment status in the NHIS and subsequent utilization of MEP services. The first focused on women who were not enrolled in any form of health insurance (NHIS) at the time of pregnancy, predominantly due to

socioeconomic determinants hindering even heavily subsidized premium payments (see Dixon, Luginaah and Mkandawire, forthcoming). The second theme focused on women who were currently insured by the NHIS at the time of pregnancy and were thus provided free maternal services without any pregnancy testing. Additionally, two significant unforeseen themes emerged related to MEP enrollment. The first was associated with MEP misuse, since it acted as a free health care system for women, while the later related to the cost of pregnancy testing as a deterrent of MEP utilization.

5.3.1 No Enrollment in NHIS at the Time of Pregnancy

The majority of women, both in interviews and focus groups, had not enrolled in the NHIS prior to their first pregnancy, specifying maternal health care was obtained exclusively via the MEP. Several women said they had prior enrollment in the NHIS, but due to the requirement for annual premium payments, were unable to renew their coverage for health care. For these women the MEP provided a foundation to seek care, alleviating monetary burdens associated with health registration:

I heard about it and registered free. I had NHIS initially but it expired and I didn't renew it, so when I got pregnant again I did a different registration for free with the maternal exemption (Esther, IDI, 34).

As the above quotation suggests, the policy has alleviated out of pocket spending associated with enrolment or renewal for the NHIS, increasing a woman's ability to access health coverage. However, it has failed to account for hidden fees required for women to enrol in the policy, such as pregnancy testing, travel costs, and the cost of items necessary to delivery in a health facility. These hidden costs will be further explained in the following section.

5.3.2 Women who were Enrolled in NHIS at Time of Pregnancy and Reorganized into MEP

Although fewer, women who were enrolled in the NHIS at the time of pregnancy did not require a pregnancy test, and were merely streamlined into the MEP. After the three month postpartum coverage ended, they would re-enter into the NHIS unless their yearly health insurance had expired. One woman discussed her experiences with NHIS and MEP specifying that she did not have to prove pregnancy due to her prior enrollment in NHIS:

I had NHIS and it wasn't going to expire so I didn't have to prove that I was pregnant because I was already covered... Only those who are not already registered in NHIS have to prove pregnancy. I gave birth before my NHIS expired. (Porcia, IDI, 25)

On the contrary, those who were not registered in NHIS had to prove pregnancy to benefit from the MEP:

If you aren't registered, you have to prove you're pregnant but if you're already insured and pregnant you can just go and start enjoying the services (Dorita, IDI, 31).

5.3.3 Pregnancy Test Payment

Discussion with women revealed that pregnancy tests were necessary to procure the MEP. Pregnancy tests were conducted at health facilities or hospitals for a cost of 2-3 *cedis*², and if positive would allow a woman to access the MEP. Findings reveal slightly over half of the women interviewed paid for a pregnancy test at either a CHPS, health facility, or hospital:

Yes, they have to take your urine and your fecal samples to determine. Sometimes you pay either two *cedis* or three *cedis* for the testing (FGD, 9).

Many health professionals also indicated payment was required for pregnancy tests, which in turn was required before being granted the MEP: "Before women are given care they pay two *cedis*" (Nurse, KI). However, nurses in some facilities indicated no expense associated with pregnancy tests, describing the process below:

² Ghana *Cedis* equates to roughly 73 Canadian cents. The upper poverty line of 90 *Cedis* is equal to 66.28 Canadian dollars per year.

If they aren't insured it is still free...you ask them to go to the health insurance office where they will give them a note to come and it will be free (Nurse, KI).

Likewise, some women also indicated paying nothing for pregnancy tests claiming, "you have to prove pregnancy but we all paid nothing" (FGD, 5). This clear discrepancy and ambiguity surrounding practices of pregnancy tests and enrollment in the MEP caused great confusion for women in the UWR.

5.3.4 Pregnancy Testing and Abuse of the MEP

Many women and health providers discussed issues related to what they termed as abuse of the MEP and health system. This was said to occur when women would become pregnant and make use of MEP to acquire free health care for themselves and their child, yet once the MEP expired they would not enrol in the NHIS. Several women spoke of others giving birth, letting their MEP expire without enrolling in the NHIS, then soon after becoming pregnant all over again in order to retain the health care services provided under the MEP:

...some women take advantage of it, they register and when it expires they get pregnant again. They go and tell lies that they have never registered so they will re-register with a different card and will give birth again and keep doing that and throwing their old cards away without reregistering (Rebecca, IDI, 29)

Similarly, health providers also discussed the high degree of policy misuse by many women:

...some women are trying to misuse the policy. Someone may be pregnant today, come for insurance, and once she delivers she will not come back after she's delivered, until she's pregnant again, then she comes and takes a different card..... (Nurse, KI).

These women are capitalizing on the MEP to access health care, with most trying to avoid the NHIS fees they cannot afford. Moreover, given the annual NHIS renewal payments, abuse of the MEP becomes a feasible option in order to obtain health care.

5.3.5 Cost of Pregnancy Testing as a Deterrent in Health Care Utilization

Several women said they waited to access antenatal care until the mid-stage of their pregnancy, enrolling in the MEP during their fourth month, as a way of avoiding the pregnancy test payments:

Here you go and you register. Most of the time you go after 4 months so by that time it's noticeable and don't question pregnancy (Faustina, IDI, 26).

It was obvious that women who were visibly pregnant did not need the laboratory verification, and therefore they did not have to pay for pregnancy tests.

Although the Ghana MOH considers the MEP a fee health care policy for women, with no associated costs for health care utilization, the costs of pregnancy tests appeared to act as a deterrent of early health seeking behaviour, potentially delaying crucial health care provision. As revealed during interviews, all women encountered personal financial burdens in allocating the necessary money (two or three cedis) to prove pregnancy and enroll in the MEP:

I suffer a lot, a lot. Before I can come up with two cedis I have to brew pito, but the process is long. I need to carry things to get it done and I don't have anyone helping me. Sometimes, here people don't actually buy it. You brew pito but no one actually comes around (FGD, 4).

Financial burdens associated with funding the pregnancy tests were vocalized by many women, which caused a great burden on their lives:

I go look for firewood to sell. Sometimes you spend five, six, seven hours looking and sell it for two cedis. But from that I have to feed the family, take care of myself and pay for the children... it's not easy to come by (FGD, 8).

Given the deep-seated deprivation in the UWR a situation has emerged where women stay home to avoid payment of pregnancy tests until they become visibly pregnant and can access the MEP without paying for the test. These women may benefit from not paying for pregnancy tests but miss out on crucial health services, which are vital for proper child development (AbouZahr, 1997: UNICEF, 2006).

5.4 Utilization of Services under MEP

Generally, once registered in the policy women utilized all available antenatal services covered under the MEP, highlighting its importance for proper child development and coverage of drugs, with many women commenting their desire for increased services:

The antenatal care benefit us, but I wish we could go all of the time, instead of every three weeks for care (FGD, 9).

5.4.1 Importance of Facility Delivery

Most women understood the importance of delivering in a facility, discussing it as a safer option than home delivery. For instance, the woman below refers to the medication received for pain as one of the clear benefits:

It's good because they give you drugs for free...it also helps with complications. For instance, blood transfusions can't be done outside a hospital and they give you certain drips if they realize you are losing energy (FGD, 8).

Disease spread was also alleviated by delivering in a facility with mothers indicating:

...I think it's important to deliver in the hospital because they can prevent mother to child transmission or diseases that may affect children (FGD, 6).

Findings indicated that even though many women were enrolled in the MEP during pregnancy, the majority of women did not deliver in a facility despite knowledge of MEP coverage. Findings reveal that women who resided in locations with limited local access to a CHPS, health facilities, or hospital were more likely to deliver at home, despite enrollment in MEP. Further, women with access to only a CHPS frequently delivered at home, due to limited skill and services provided at CHPS.

Limited knowledge surrounding the signs and symptoms of labour was found to be a factor influencing home delivery. Inadequate provision of information during antenatal sessions left most women unaware of the symptoms related to labour, limiting the time necessary to seek a facility once labour begins. Women also discussed impersonal visits at health facilities during pregnancy commenting on the lack of proper care or attention:

When you go, they don't talk to you very much or ask how you're doing. They just ask if you need drugs for pain but don't tell you what to expect when you're going to deliver. They don't tell you the signs at all, that's why I might not make it to a hospital (Kusia, IDI, 23).

This created a deficit of knowledge for pregnant women generating additional problems during labour. Since women were ill informed regarding the signs and symptoms of birth, most sought a health facility too late during labour, causing many women to deliver at home despite being covered under health insurance through the MEP:

Labour was unexpected, it just came. I was on the way to the hospital but I delivered on the way there. It was midnight; I couldn't get to the hospital. I didn't know I was going to be in labour (Rebeka, IDI, 22).

Several women said it was only through personal knowledge and experience of birth that they learned the signs of labour, noting they hoped their proceeding deliveries would occur in a facility:

My first experience taught me, now I'll know when I'm in labour. The first time I didn't know what to expect. It's my personal experience that makes me know what to expect and go to a hospital (Ama, IDI, 28).

5.4.2 Knowledge of Coverage and Use of Postnatal Care

Results showed that more women were informed of the services provided during pregnancy (antenatal care), than those covered during the postnatal period. Participants suggested this gap in knowledge may be due to limited contact with health providers in the communities. Women in many communities did not discuss the benefits of postnatal care or utilizing the service. Lack of postnatal knowledge and limited access to health infrastructure is reinforced by certain geographic and economic barriers which will be addressed in the following sections.

5.4.3 Geographic Barriers to access Maternal Health Care

Most commonly, women reported walking long distances to seek antenatal care with one participant vocalizing, "We suffer a lot to get there; we have to walk long distances since there's no transport" (FGD, 7). Findings revealed that women used antenatal care more frequently than

other services, since there was no rush to access a health provider unless they are sick or in experiencing problematic health issues.

Women in rural communities without any form of health infrastructure (CHPS, health facility, hospital) experience significant burdens in acquiring money for travel fees or their own transportation, which was especially problematic during the acute onset of labour. Given the isolation of many villages, available transportation is infrequent and uncommon, resulting in arduous health seeking experiences:

There's a problem with transportation. There's no cars or vehicles in this community, so if a woman's in labour you have to go back to the main road, but they don't come often so we end up delivering at home (FGD, 2).

Women discussed the complexities of seeking a facility during labour, indicating they first had to acquire some form of transportation while also securing money for travel. However, due to monetary and transportation shortages, many women were forced to walk, consequently delivering on the roadside:

At the time that you're in labour a vehicle may not come and you might not have the money. You may not also have the money to buy fuel for a motor bike to get there so women have to walk there. I was walking and in labour and delivered on the way there. I couldn't get to the hospital (FGD, 8).

Inaccessible health care complicates health seeking behaviour and jeopardizes delivery outcomes:

A woman was in labour and a vehicle finally came but the vehicle also got damaged on the way. When they got to the hospital it became a complication and they had to give her a caesarean section immediately ...it's a big problem, getting there, getting the means, and women who have to walk that distance to deliver (FGD, 6).

Postponing delivery as a result of inadequate transportation, long travel distances, coupled with inability to acquire transportation enhance complications, and can lead to fatalities, as described below:

One woman was on the way to the health facility and delivered on the road side, she brought the child home and the child passed away two days later... it was cold outside and he couldn't breathe, we tried to revive him but he passed on (FGD, 10).

The commonality of delivering on the way to a facility, together with the increased risks of mortality caused several women to stay home during labour and delivery. Observations of women's traumatic experiences hindered subsequent utilization of health facilities, causing women to prefer delivering at home indicating, "We do fear so sometimes you just prefer to be at home" (FGD, 2). Challenges associated with a woman's remote location, combined with the cost of transportation increased the odds of delivering at home and not accessing a facility afterwards. Further complications of transportation and personal financial means, also inhibits utilization of postnatal care provided under the MEP.

5.4.4 Economic Barriers to Access Maternal Health Care

Results from both interviews and focus groups indicate the cost associated with facility delivery is paramount in a women's ability to deliver in a facility. The cost of facility delivery emerged in the analysis into equally important aspects: first, the cost of transportation to the health facility and second, the cost for required items necessary to deliver in a facility.

The further the distance a woman must travel for care increases her personal out of pocket cost for transportation. Insufficient personal finances, scarcity of public transportation, and poor roads, were discussed as a main deterrent to utilizing health care. Some of the participants recalled trying to seek care by walking to the health care facility during times of their labour, which then resulted in precarious delivery:

I didn't have the means to get there. I was walking there and the child was just coming so I delivered along the way and brought the child back to the house and didn't go to the hospital after that (FGD, 6).

Numerous women discussed how problems of low income and the cost of transportation became amplified during situations of health seeking behaviour, revealing how these factors jeopardized the lives of many women causing women to deliver on the roadside and not seek a health facility after birth.

Women participating in this study were also forthcoming when discussing additional costs of delivering in a health facility. Findings revealed that several supplementary fees were required to deliver in a facility, posing further burdens for pregnant women. Prior to reaching a facility, women are told to bring certain items necessary for facility delivery (such as detol, cloths, rubbers, etc.), which are not covered by the MEP. These hidden costs associated with pregnancy afflict women throughout the pregnancy process, with most women indicating awareness of items that are necessary for delivery. For instance, one woman in a focus group discussion voices her concern over this hidden cost:

The least you can send is about five items. You need to send rags, gauze, detol, soap, diapers. The nurses are always saying that you need to bring adult diapers so if you can't bring the diapers they sell them to you for one cedis there. You have to be using those always (FGD, 4).

The cost of items ranged between 30-60 cedis with many agreeing, "at least 60 cedis" (FGD, 5).

The high cost for these items strained participants during their pregnancy. Given the poor economic conditions in the UWR, many women encountered difficult tasks to allocate sufficient funds to purchase required items revealing:

It's difficult... the detol is about five cedis. So a pregnant woman has to cut down a tree, chop it into pieces to prepare charcoal that you sell for small cost, and go credit tomatoes for Wa market and sit under the hot sun, and maybe make five cedis. So basically, its expensive and difficult to get these things (FGD, 3).

Transportation costs, underscored by the cost of required purchases associated with facility delivery may impede a women's decision to seek a health facility during labour, instead choosing home birth.

5.4.5 Cultural Influences: Effect of Traditional Birth Attendants and Use of MEP

5.4.5.1 Mother's Perceptions and Impact of TBA Ban

Women in remote rural areas with no form of institutional health care regarded TBAs as highly important, playing a vital role in the maintenance of women and children's health. During

the discussion, several women indicated that TBAs are vital for pregnancy outcomes, satisfying women's need for care during labour. Since labour occurs unexpectedly, TBAs were able to provide immediate care in such remote locations:

I didn't know the time I was going to give birth and once it started the nearest person around was the TBA. They brought the TBA to my house and they assisted me to deliver and that was helpful (Rashita, IDI, 21 years old).

Even where there may be local nurses, women indicated that such nurses did not always provide around-the-clock care, hence, the need for TBAs. Overall, participants also agreed that transportation challenges due to poor road infrastructure and high transport cost means they have to rely on TBAs regularly:

In this remote place, nothing is accessible, we need the TBAs here because transportation is not always available, and the income to pay for transport is always a problem...worse still in the rainy season, sometimes cars cannot come here...If you are in labour, by the time someone will take a bicycle to go to the city to get a car to come and take you to the hospital, it will be too late. The baby may already be here. We have to rely on the TBAs... (FGD, 3).

5.4.5.1.1 Increased Risk of Pregnancy Complications

Women in the UWR expressed that since the implementation of the TBA ban they often walk or bike during labour with the assistance of a TBA. Several comments were made about instances where women have ended up delivering on the way to a health facility. In the comment below, a participant described her experience:

With my third child I was on the way to the hospital with my husband and a TBA, and then I realized the baby was coming so we stopped by the roadside. She [TBA] helped me deliver...I just had to deliver on the ground in the bush (Annolata, IDI, 25 years old).

Such predicaments were not uncommon in the focus groups and interviews, and women spoke passionately about the potential health consequences to both mother and child.

Nevertheless, there was a clear distinction between women located in a community with access to some form of government health care (i.e. hospital, health facility, CHPS) and a community with no available health care services regarding the perceived importance of TBAs in promoting maternal health care. While rural women called for the maintenance and continuation of TBA services, others in mostly urban areas thought otherwise. Women in urban communities with access to health care facilities unanimously agreed that TBAs were no longer important in the provision of maternal health since they were able to easily accessible health care provided by the government.

... Hospitals and clinics are now better. I don't think TBAs are relevant anymore because you get the best treatment at the clinics...it's just down the road (Matina, IDI, 34 years old).

Invariably, poor rural women in remote locations spoke highly of TBAs in their ability to provide easy accessible maternal health care:

Nothing's accessible here; there are no vehicles that come down these roads. When I was in labour the closest person was a TBA, and that helped me a lot. (Felicia, IDI, 23 years old).

5.4.5.2 Traditional Birth Attendants Perceptions of the Ban

TBAs suggested they had received no formal communication in the form of letters or statements from health professionals regarding the ban on TBA practice. They reported that health professionals simply stopped coming to check their records or provide them with the necessary items such as gloves, soap and razors. Some TBA participants indicated it was only through their inquiry that they were told to stop delivering women, and only assist in transporting women in labour to health facilities for delivery:

It was when I went and asked the nurses why they were not given us gloves and other basic things they told me TBAs were not deliver babies anymore... We were never told why; there has been no formal communication between us and even with the people who trained us (Angelina, TBA, KI).

The interviews revealed a high degree of confusion surrounding the policy change and what TBAs in remote locations could or could not do. Many TBAs expressed frustration over what

they argued has been a poorly thought out decision by “the powers that be”, given their traditionally acquired skills, relevance in their local communities and the subsequent training that was provided by the government. One TBA commented:

When people look at the records you see that I have been doing well. I cannot understand why they cannot allow us to still continue our services... since I've been delivering babies, no mother or child has died in my hands... (Wakila, TBA, KI).

It was unanimous in all discussions with TBAs that they regard their role within their communities as essential. TBAs expressed worry over the potential impact of the policy on local women and most agreed that diminishing support of TBAs would create imminent repercussions:

The essence of maintaining TBAs is still very important. Even if there was a way to train us better, if the government is afraid of the maternal mortality issues they should train us to facilitate our services instead of trying to fade us out just like that. We should work together instead of those in higher offices with no ideas about the difficulties women in these remote locations face, trying to get rid of us... (Samata, TBA, KI).

5.4.5.2.1 Challenges in Transporting Women in Labour to Health Facilities

Given that the new policy has directed that TBAs can only help in the transportation of women in labour to facilities, most TBAs agreed that this has been highly problematic in many cases:

Motor bikes aren't common here, only the rich have them. Even when a woman's in labour, she'll have to sit on the bicycle, sometimes it complicates things, a delivery that would've been normal get complicated when travelling during labour to the hospital (Edora, TBA, KI).

These complications have the ability to cause fatality for mother or child:

In many cases when we are sending women to facilities, they deliver on the way. Once we were going with a woman, but the car broke down, and we were stuck in the bush and delayed getting to the hospital and baby passed away... this new policy is leading to terrible experiences in our area (TBA, FGD, 1).

TBAs also reported that since the ban, relations with health providers have become tense. Some reported being treated poorly when they send women to health facilities. A TBA named Wakila

described how she sent a woman in labour to the hospital only to end up delivering the baby because of negligence on the part of the nurse on duty:

We went to the facility like we were supposed to. The nurse was there but she left to go to her house, and the baby was just coming so I attended to the woman and delivered the child. Then the nurse came back and started insulting me about why I didn't come to get her. The child was already coming and she left the woman in that state... That could've caused the death of the child. We should've delivered at home.... (Wakila, TBA, KI).

In remote locations, TBAs play vital roles in providing care for women. A TBA summed this up saying:

In remote locations it's not every woman who knows the exact time they'll give birth, so in cases where woman don't know, and there is sudden labour, we're able to birth her. Sometimes transporting a woman to the nearest clinic is a tedious task. If you can't move the woman she's forced to give birth where she is, and now the TBAs aren't allowed to attend to them, which may actually result in more babies dying... I use my own conscience, and I will help deliver any woman in labour, that is the right thing to do (Alice, TBA, KI).

The incongruence and tension between TBAs providing care to pregnant women while adhering to government policy was evident throughout the discussions.

5.4.5.3 Health Personnel: Perceptions and Impacts of the TBA Ban

Most acknowledge that TBAs are no longer able to practice but are only to assist in helping transport women in labour to the nearest health facility. A health provider indicated that this policy came as a result of the incompetence of some TBAs:

They were trained in the early 1990's, given boxes and the job description. But some were abusing the opportunity, doing things they shouldn't. Some didn't use the gloves, didn't clean them, or reused them after birth. There was malpractice so we stopped them. Some TBAs knew how to attend to women, especially women that delivered multiple times, but some were daring enough to do what they weren't supposed to and that was very risky. So now we don't want them to deliver; we just allow them to help women to the nearest health facility (Health Professional, KI).

Yet after further probing the health providers about the sometimes tragic experiences women in remote locations encounter, their views about the new policy began to shift from

enforcing the ban on TBAs to allowing those in remote locations to deliver women when in life or death situations. A nurse commented:

No no no no, you can't ban them absolutely, without them some women in rural areas will have complications and may die. When the baby is already coming, the TBA is the best person in the community, especially in our remote villages. The husband will normally send for the TBA and they deliver the baby and mother and then send to a health facility after birth (Nurse, KI).

Juxtaposed against the government's mandate prohibiting TBA delivery, another health professional acknowledged the continued use and importance of TBAs in emergency situations of unexpected labour.

In emergency they can still deliver because you can't allow the woman in labour to suffer or die....they still help such women deliver, because obviously some women can't get to the health facility. Some women have labour that comes immediately so in such cases a TBA can bring out the baby but then they should tell the women and baby to see a mid-wife for further examinations (Medical Assistant, KI).

The above comments allude to the inherent challenges in maternal health care provision in a context subsumed in historical and geographical inequalities in health care services. Taken together, these results demonstrate the multidimensional challenges accessing skilled maternal health care for delivery.

5.4.5.4 What do participants suggest can be done?

Overall, the women and TBAs agreed that in remote communities it is necessary to have at least some TBAs who can deliver women in emergency situations. They suggested a more realistic policy alternative is to retrain a targeted number of TBAs in isolated communities. Such a targeted group can then be monitored and also given frequent refresher courses to upgrade the skills and maintain quality control:

If TBAs in the villages are trained and given the basic items such as soap, they have all sorts of things they use to clean themselves before they deliver, just like the nurses so they should be allowed to continue, they can then be monitored frequently (FGD, 6).

These responses indicate the highly regarded importance of TBAs for women in the UWR despite the ban on their utilization.

TBAs stressed the importance of integrating their work within the current health care system, which would allow easy accessible care for women in remote locations thereby reducing the likelihood of complicated delivery:

So if TBAs are retrained and integrated back into the system, especially in areas where they can easily assist, it's better than always trying to bring women for the sake of hospital delivery (FGD, 1).

These responses conveyed the necessity of creating a cohesive health system where TBAs are able to promote safe and effective health coverage for women in rural localities.

5.5 Women's autonomy and access to the MEP

Given the large body of research directed to developing measures of women's autonomy (Agarwal & Lynch, 2006; Kishore, 2000), and exploring the links between these measures and women's reproductive health (Fikree, Khan, Kadir, Sajan, & Rahber, 2001; Ghuman, Lee, & Smith, 2006; Morgan & Niraula, 1995; Sathar & Kazi, 1997), this section examines concepts related to women's autonomy and their relationship to utilization of the MEP, both within the family/household structure, and more broadly within the UWR. Broadly defined as "control over their lives", women's autonomy is viewed as a set of multiple but inter-linked domains including, but not limited to, decision making authority, economic, social, emotional and physical autonomy (Jejeebhoy, 2000). The theme of household dynamics emerged as a main factor influencing a woman's ability to access maternal health care.

5.5.1 Economic and Familial Responsibilities

While discussing their daily life and work, many women indicated their main source of income was obtained from farming, while simultaneously providing care for their children.

Several conversations revealed women would farm from the early hours of the morning to late

into the day, followed by tending to children and managing the household. As Esther voices, this provided limited time to seek reproductive care from health providers due to unavailable transport, limited operating hours at health facilities and care for children at home:

Women have a lot of responsibilities. Women may be sick but you might have to go to the farm or out to get something so unless it's so severe you might not think it's a priority (Esther, IDI, 31 years old).

Additionally, women with many children often discussed how they were deterred from accessing maternal health care during pregnancy because of the obligations to feed their children and tend to other tasks. The women ranked their obligations at home as more of a priority than seeking individual care for themselves and their unborn child during pregnancy. These competing needs acted as a huge burden for women and inhibited care for their unborn child:

I have to leave all of my children at home when I go to the hospital. If they don't have food, it's hard... because I would be working instead of going to the facility (FGD, 8).

These problems were further aggravated by the seasonal nature of rural livelihoods. Women's responsibilities increased during the intensive farming seasons (during the rainy months) and made leaving to seek maternal care even more problematic, with participants commenting:

Around farming season (rainy), women need to be working a lot and it's harder to access health care (FGD, 2).

Economic responsibilities and seasonal rainfall exacerbate the pre-existing challenges women encounter seeking maternal health seeking.

5.6 Women's Experiences with Health Care Providers

This section explores how prior experiences in a health facility influence a women's use of maternal health care. The influence of past experiences on a participants' current utilization centered around three main concepts characterized as: negative experience and positive experiences, and confusion regarding standards of appropriate care.

5.6.1 Negative Experiences

Some participants described negative instances of the poor treatment received at health facilities when they sought care. Some women said that if they were loud during labour, nurses would not attend to them or provide necessary care. However, if women remained quiet, they would receive necessary services. Nonetheless, keeping quiet during labour is problematic since women are obviously in pain. A woman in one focus group discussion captured this tension:

Women who make noise, the nurses shout at you. Most of the time you can't keep quiet because you're in labour and it's painful, so you're loud... but when you are quiet they'll see you (FGD, 1).

Due to these negative experiences with health providers, women said they chose to deliver at home instead of the health facility, since it increased their comfort and ease during labour:

Sometimes the way the nurses treat you, they shout at you, they chase you around and yell, so most of us feel it's always better to deliver at home so then you're at ease with yourself (FGD, 2).

5.6.2 Positive Experience

Conversely, several women revealed receiving good quality care at health facilities during pregnancy and labour indicating:

The nurses are very friendly towards me. When you're going they welcome you, they ask you what's wrong and they treat you....Here the nurses are good, sometimes when there are problems they try to transfer you and I think their attitude is very good towards us (FGD, 4).

Some of the participants praised the local midwife in their community for her skills and ability to help women in labour:

Here they are very good and we pray that the midwife will not be transferred away because she's very good (Clementia, IDI, 41 years old).

These results reveal how women's experience with health providers shape subsequent utilization of maternal health services, either generating negative or positive health seeking behaviour. Accordingly, women's varying experiences with health providers were found to influence women's expectations of proper care during labour.

5.6.3 Confusion Regarding Medical ‘Care’ During Labour

Data analysis revealed differences in the way women understood “appropriate care” received at health facilities during labour and delivery. Many women discussed beatings received from health providers during labour in a negative tone, conversely, others spoke favourably of the beatings, saying they were meant to help induce labour, safely deliver the child and try to minimize surrounding complications. These contrasting narratives regarding the medical standards for appropriate care created confusion among women regarding expectations during labour. Many participants recalled beatings they received during labour:

If you’re lazy in labour they yell at you and beat you. Sometimes they yell at the women and give you small beatings... (Abena, IDI, 25 years old).

However, other women clarified beatings were necessary for the safety of the mother and child:

Sometimes if the woman’s not pushing the child can die! If you’re not fast enough to get the child out, it can get stuck and can die. So I think the nurses are doing it to help the mother and the child so you can get the child out quick. I think it helps the mother. (Dorita, IDI, 29 years old).

These responses highlight the need for proper education pertaining to the expectations during labour, and thorough consultation with health providers. If women are not fully aware of the expectations or proper practices during labour, they may be more inclined to deliver outside of a facility due to anxiety surrounding beatings.

5.6.4 Confusion Regarding the Availability of Services: Referral Practices

Some of the participants were of the view that referrals made by local nurses were a method of sending them away to other health facilities instead of attending to the women themselves:

One of the things they do to deter you away is they tell you to go to Wa. The nurses would rather refer you away; they don’t want to treat you themselves. So if you go there you suffer, so next time you just to stay at home (FGD, 5).

Limited care provided by health professionals was discussed by many women, indicating nurses would only provide services during certain times of the week. Given labour and sickness may

arise unexpectedly, women do not necessarily have the ability to choose the time in which they seek care. The limited availability in services jeopardizes women's health outcomes:

Weekend visits at the clinic aren't good, the nurses always complain about people coming on the weekend. If you go at night they complain about why are you bringing a child at that time, but it's not your fault (Mary, IDI, 36 years).

Confusion surrounding the availability of services was tied closely to the MEP enrollment status. Findings revealed that women who were currently enrolled in the MEP and sought health care without their MEP card were denied from accessing services. Often occurring in times of need, women indicated forgetting or misplacing their card during access. This deliberate refusal heightens complications during pregnancy inflicting increased problems:

When you're in desperation and sick you can forget your card, but they will tell you to go back for the card. Despite the fact you've registered and been there several times and they know you...they can easily treat you but they send you back (Esi, IDI, 33 years).

Refusal of care occurred at all health locations (i.e. CHPS, HF, Hospital), despite MEP coverage. This outright refusal of care influences health behaviour, shaping succeeding decisions of care utilization. Findings suggest that a lack of clear messaging surrounding the specific rules for use of the MEP in the UWR is subsequently harming the success of the program.

5.6.5 Differences Among Health Care Providers

Behavioural differences between young and elderly nurses were discussed by many women. Most women said young nurses were "wicked" and treated them horribly, while the older women were more respectful treating pregnant mothers with kindness.

Some of them they are very kind, but others they are wicked. The elderly nurses are kind. The young ones are more disrespectful because they think since we're from the village maybe we are useless or something, but the older ones are respectful and kind (FGD, 10).

Additionally, women indicated better care was usually provided by midwives, who were mostly older:

The midwives who are much older tend to be more kind and tender towards the pregnant women and they respect your feelings, but the younger ones don't

respect you ...you are there suffering but they don't respect us, especially the young ones (FGD, 7).

Women from mostly rural areas discussed in the focus groups that the nurses in urban centers frequently treated them badly and made them feel inferior to their urban counterparts. These differences in nurse attitudes were shown to affect the participant's perceptions of the health care facility. Uncertain care providers and ambiguity of treatment were shown to deter women from accessing skilled care.

5.6.6 Perceived Satisfaction: Out-of-Pocket Payment Vs. Insurance

Many participants said that since the implementation of the MEP, nurses no longer have any monetary incentive to care for patients, consequently leading to poor services for pregnant women:

It's true, everybody's seen it... the nurses are much more eager to treat those who pay the money because they will get something small out of it. So once you pay the cash they want to treat you, but with the health insurance, they never even get to see the money... So if you have the cash in your pocket those women will get better care (Emena, IDI, 47 years).

Many women shared stories of negligence and mistreatment at facilities despite their MEP insurance, expressing those without insurance were given priority compared to women with MEP insurance:

I went to Wa when I was sick. When it got to my turn, the nurses jumped me to treat people without insurance. So I asked why and they told me those people who are coming to pay so that's why they want to treat them first (Sakina, IDI, 34 years).

Women reasoned since the introduction of the MEP nurses no longer receive money directly for services provided, and are less likely to deliver proper care for women. Knowledge of maltreatment at facilities, consequently affects a woman's use of services provided by the MEP.

This negligent behaviour on the part of nurses was reported to have created devastating health impacts for many women in the UWR. Women revealed health personnel would bypass

enrolled women who were visibly suffering and in labour in order to care for other women who were willing to pay in cash. Participants said they thought the consequence of this was that it potentially jeopardized the health of the mother and child, and may have even caused fatalities. Below, Adua recalls an incident she witnessed where a different standard of treatment by the nurses resulted in a complicated delivery and the death of a child:

Two women were in labour, admitted to the clinic, and going to deliver, but one had insurance and the other one did not. They were both having complications, but one didn't have insurance and was willing to pay, so she was referred to Wa hospital quickly and given a caesarean section. The other one had to wait. Since the nurses knew she was insured and no money was involved, they delayed her for another day. The 48th hour they realized the woman was going to lose her life, they finally referred her to Wa. They finally did a caesarean section on the fourth day, but within less than an hour the child died. I think the child died because she didn't have the 200 cedis to pay cash for the caesarean section (Adua, IDI, 36 years).

These discrepancies in care providers led women to question the efficacy of the policy in its ability to provide equitable care for women. This influenced their perceived satisfaction with the MEP and ensuing utilization of its services.

5.7 Emerging Challenges with MEP

5.7.1 Problems of Anemia, Blood Transfusions, and Complicated Delivery

Many women discussed challenges with anemia in interviews and focus groups, specifically mentioning the problems of excessive blood loss during delivery. These responses seem appropriate given that 61% of pregnant women in the UWR are reported to be anemic (ORC Macro, GHS, 2007). Low rates of hemoglobin increase the risk of complications during delivery, commonly requiring assistance through blood transfusions to replenish a woman's blood supply during labour. Given this, participants were concerned that blood transfusions were not covered under the MEP, suggesting this heightened complications and decreased the likelihood of a safe delivery. Due to the shortages of blood within the UWR, and the cost of associated

transfusions, pregnant women experience a twofold burden associated with pregnancy in the UWR:

....But you know women giving birth lose a lot of blood and you may need a blood transfusion but that's not covered and the money's not easy to come by and sometimes you have to run around and run around and the blood bank too doesn't have it so what do you do (FGD, 4).

Limited availability of blood at health facilities and hospitals complicates deliveries and increases the likelihood of death. For those women lucky enough to reach a facility during times of excessive bleeding, they were more likely to deliver via caesarean section, with many women indicating increased rates of caesarean section delivery in the UWR. Indeed, Nang-Beifua (2010) supports this perception, finding that rates of caesarean section delivery in the UWR increased from 3.4% in 2009 to 4.8% in 2010. Though fortuitous in most often saving the lives of the mother and child, participants suggested there were detrimental health impacts resulting from the caesarean section delivery:

...the caesarean section affects the health of the woman. If you give birth normally within a day or two you can go back to your normal activities, go and fetch water, and be cooking but when you have a C-section those complications and things, you can't even work, then you have to rely on others (FDG, 3).

Women's work in the UWR involves strength and the ability to endure long hours, tending to both the farm and household. IDIs and FDGs vocalized that caesarean section jeopardized a women's ability to economically support and provide for her family, rendering her handicapped.

The caesarean section itself becomes a disease like a sickness for women because even when the sore heals there are certain things you can't do because you lose strength. It reduces the strength and economic activities that you can do (FGD, 5).

The negative impacts of caesarean section were expressed by many women, specifically their effects on a woman's ability to care for themselves and children. Caesarean sections further inflict problematic circumstances after birth, consequently shaping a women's function in her life:

...the work women do is very demanding and takes a lot of strength, so a caesarean section renders a woman weak and may take you up to a year to regain strength. Most of us here are alone, you don't have any other person to help you, you're the only one. For instance I go look for firewood, I have to go 5 – 6 kilometers, and carry it on my head and I have to take my child, you can't leave it at home so I can't do the work. I'd have to be at home and be rendered handicapped. I'd be handicapped and have no means of survival (FGD, 6).

Taken together, food insecurity increases the rates of anemia and complications during delivery increasing the commonality of caesarean section delivery. Inadequate availability of food jeopardizes the health of a woman and unborn child, increasing complicated delivery and possible fatality. Further, the incapacity of women to recover from caesarean section deliveries decreases their ability to generate income to sustain the larger family unit. In its entirety, these issues relate to many aspects of maternal health and affect both short-term and long-term outcomes for the women and child.

5.7.2 Food Supplements

Women in both focus groups and interviews revealed the government had previously given pregnant women food supplements during pregnancy to assist in maternal and foetal health, but this program was discontinued with the implementation of the MEP. These food supplements helped garner adequate iron stores in the female body, which was needed during pregnancy and labour. In addition to the outlined in the previous section, iron deficiency anemia creates a greater risk of preterm delivery and increases rates of mortality (Allen, 2000). Women recalled sitting through lectures from local health providers where they would discuss the food women should consume during pregnancy. Yet, as indicated below, women in the UWR do not necessarily have either the availability of such items, or the economic means to purchase them:

I can't even find 10 peswas to buy salt! If they add supplements to the maternal exemption it would help those who are poor and can't afford it, supplements should be part of it so it can reduce some of the problems we face (FGD, 2).

Accordingly, if the MOH reintroduced food supplements, potential benefits in the areas of anemia, blood transfusions, and caesarean section delivery may be reduced. This, in the long-

term, could reduce MOH costs associated with growing rates of caesarean section delivery in the region.

5.7.3 Coverage of Drugs within MEP

Similarly, drugs necessary during and post labour were not covered under the MEP, further increasing the cost of facility delivery. The drugs that were perceived by participants as most beneficial were excluded from the MEP. The additional costs of medication exacerbated the costs endured with facility delivery:

The coverage of drugs is not the best, especially with the health insurance. We don't pay the bed user fee and the fees for the most common (generic brand) drugs, but the effective drugs that cure diseases aren't covered. So you think you're insured but then you're told to go out and buy drugs (FGD, 7).

Shortages of medication were more pronounced in remote locations, as women with access to a CHPS said they experienced persistent shortages of drugs in comparison to the urban counterparts:

Looking at these small small clinics, most of the times they don't have the drugs. There's always a shortage of drugs, and you're forced to always buy drugs, so they should make the drugs in the bigger town available to smaller communities (FGD, 6).

5.7.4 MEP Expiration after Birth

The NHIS registration period after birth was a main concern for many women. Since the MEP only covers mothers and children for 3 months after delivery, women experienced difficulty generating sufficient money to register both themselves and their children as full members in the NHIS. Many voiced that “the MEP should last for 6 months” (FGD, 3), suggesting a longer period after birth would allow adequate time to generate enough income for enrolment. As Alice notes below, generating income is difficult in the post-partum period:

The biggest challenge is when it expires. It expires 3 months after delivery, before the 3 months you might not be able to work and get money to renew it. Because at the time you still can't be working so if they're able to extend it to maybe 6 months or a year it would be better for us (Alice, IDI, 26 years).

Those participants found the limited free enrollment period after birth to be particularly hard underscored the gendered nature of household and subsistence work. This made subsequent enrollment for both the mother and child highly complicated.

5.7.5 Need for Ambulance and Available Transport

Shortages of ambulance services in the region heightened the challenges of facility delivery. Participants vocalized that, due to inadequate ambulance services, they were often forced to find their own source of transportation:

Sometimes there's pressure on the ambulance so if you're not lucky, and the ambulance is elsewhere you will have to charter your own vehicle and go there (Pricilla, IDI, 28 years).

Accentuated by poor transportation networks, limited monetary funds, and inadequate transportation options, many women do not reach a facility for delivery.

Health providers conferred limited health infrastructure and few ambulances decreased the likelihood of facility delivery. Acknowledging systemic difficulties, providers discussed small benefits in maternal health coverage, but agreed the main impediments endured by women were access and transportation:

Women want to deliver in the health facility, but the problem is access. Its access because those communities are distant and most women delivered at home because they will be in labour and there's no available transport to carry them to the nearest health facility. Some even walk, far distance in order to deliver there, so there is improvement (Lydia, IDI, 44 years).

5.7.6 Need for Male and Communal Involvement during Pregnancy

A main theme throughout IDIs, KIs and FDGs was the desire and necessity for pregnancy to be conceived holistically. Pregnancy was discussed as an entity solely concerning and experienced by the woman, with men and other family members uninvolved and disenchanted from the process. Women spoke of the need for pregnancy to become a collective experience, as this would decrease challenges of negative outcomes:

The problem is communities still don't see the importance in supporting pregnant women, or families, it's an individual problem. It's only the women and the husband, or the women alone. So there's no immediate support for the woman, which may lead to maternal death. People are aware a woman's in labour and should get to a facility, but it's like they don't want to be involved (Dorita, IDI, 34 years).

Collectively, topics related to anemia, blood transfusions, food shortages, limited coverage of drugs, MEP expiration, the necessity for ambulance services, and desire for greater male and community involvement during pregnancy reveal unintended subjects of study but illuminate additional areas of improvement for the MEP and maternal health outcomes in the UWR.

5.8 Chapter Summary

This chapter presented the results of key informant interviews, in-depth interviews and focus group discussions as it related to the five objectives of the study. Understanding of the MEP was varied among the participants with some having a clear understanding, while others did not. Women with no knowledge of the policy prior to pregnancy were not using the policy to the full capacity, hence missing antenatal care in vital stages of pregnancy, while prior MEP knowledge promoted early health seeking behaviour. Many women were not enrolled in the NHIS at the time of pregnancy, indicating the MEP was beneficial in securing health care without enduring the associated fees of NHIS enrollment. There were no clear guidelines surrounding provision of pregnancy tests to enroll in the MEP. However, findings reveal that the costs of pregnancy tests may deter early maternal health care seeking behaviour.

Women's knowledge, geographic location, and economic situation were found to be main determinants of antenatal care, facility delivery, and postnatal care. Most women knew about the benefits of antenatal care and facility delivery, but many delivered at home. Reasons for home delivery related to the lack of knowledge surrounding the signs and symptoms of labour, alluding to the level of education and care granted by health providers. Further, postnatal care was less frequently mentioned, possibly due to women's lack of knowledge surrounding the postnatal

period, limited knowledge provision at health facilities or women's perceived importance of postnatal care.

Geographic proximity to health facilities greatly hindered women's use of antenatal, facility, and postnatal care with many women recounting walking long distances in search of care due to limited transportation and inaccessible roads. Women indicated that such geographic disparities in transportation and health facilities increased their chances of complications during labour, most often delivering on the way to the facility (i.e. road, bush, and farm). Counterintuitive to the aims of MEP, many women chose to stay at home during labour due to stories of 'deliveries on the way'. Yet this sometimes itself ended in fatality of the mother or child.

Financial (in) security was found to influence a women's utilization of maternal health services. The greater the distance a woman must travel to a facility, translates into increased costs associated with transportation. If finances are scarce, a woman may choose to walk for services, or decide to remain in her home. Additionally, hidden costs associated with facility delivery deter women from delivering in a facility.

The influence of traditional birth attendants played a significant role in women's health care and delivery location. Due to the remote location of many women, and the costs associated with travel, many women chose to deliver with TBAs. Significant variation was observed among women from rural and urban areas regarding the importance of TBAs in promoting and maintaining maternal health.

Household responsibilities, such as farming and childbearing hinder a woman's ability to seek health care. Further, given that many husbands do not pay for children's day-to-day expenses (i.e. food, care provision, education), women are forced to juggle their personal health needs and finances while simultaneously providing for their children and household. Such competing needs deter maternal health seeking behaviour.

Prior experiences with health professionals was also found to influence the use of maternal health care, where positive experiences promoted use of the health facility services and poor care deterred further use of services. Women expressed different understandings of what constituted appropriate care at health facilities. While some accepted beatings as a normal part of the treatment process beneficial to help induce labour, others perceived such treatment as cruelty. This confusion surrounding what was 'appropriate' care influenced maternal health seeking behaviour. Further, participants suggested that women who pay cash for services received better care than women enrolled in the MEP, influencing a woman's perceived satisfaction with the MEP and subsequent utilization.

Chapter 6

6 Discussion

6.1 Introduction

This chapter summarizes the major findings of this thesis, its theoretical and methodological contributions with regard to women's access and utilization of maternal health care services in the context of Ghana's MEP in the UWR. Access, and utilization as discussed in this thesis, consists of enrollment in the MEP, and the use of provided services: antenatal care, facility delivery, postnatal care, and overall health outcomes. This chapter also provides an indication of policy functions and outcomes, and concludes by highlighting relevant issues for further research.

Studies on Ghana's MEP and health insurance schemes more broadly have tended to focus on questions of equity surrounding matters of wealth, improved access, and increased facility delivery (Asante, Chkwama, Daniels, Armar Klemesu, 2007; *Health Systems* 20/20; Omane-Adjepong, Ababio, Aidoo, Boateng, Loius, Nsowah-Numah, 2012; Penfold, Harrison, Bell & Fitzmaurice, 2007). For instance, Onami-Adjepong et al.'s (2012) study in the Ashanti Region found the introduction of MEP had significantly increased maternal enrollment at hospitals due to the removal of paid enrollment. Asante et al.'s (2007) study in the Central and Volta Regions found the MEP significantly decreased out-of-pocket payments for caesarean sections and normal deliveries at health facilities, with a heightened positive impact on the extreme poor than on the poor. Despite the increase in utilization, findings revealed benefits were greatly skewed towards the rich (Asante et al., 2007, Dixon 2011, Hatt et al., 2013), raising questions about the MEPs functioning, and ability to deliver comprehensive equitable health services, suggesting the policy is failing in its target of providing accessible health care to all pregnant women.

With Ghana's MOH touting free health care for all pregnant women, the assumption was that by removing user fees, utilization of maternal services would increase, thereby also improving maternal health outcomes. With this simplistic causal understanding of a relation between removal of enrollment fees and increased maternal health outcomes, it seems policy makers have passed over a critical discussion on women's socio-cultural realities, livelihoods, geographic proximity to health provision, and knowledge surrounding the maternal exemption policy. Driving this thesis is the need to understand why even with the MEP, there remains a high maternal mortality rate and underutilization of services.

While wealth remains a critical factor influencing access to health services, there is a dearth in theoretical support for this focus. Except for few studies which focus on social norms surrounding women's perspectives on delivery location (Crissman, Engmann, Adanu, Nimako, Crespo, & Moyer, 2013), discussions are primarily a theoretical, resting heavily on the assumptions that removing user fees will ultimately translate into improved health outcomes. Given the complexity of access and utilization of maternal health care services, this research employed qualitative methods in order to examine the barriers to enrollment, access, and utilization of the MEP in Ghana's Upper West Region. The research objectives were as follows:

- 1) To explore women's understanding of the MEP and provided maternal health services;
- 2) To explore the relationship between women's enrollment in the NHIS and enrollment in the MEP;
- 3) To explore the contextual factors which influence antenatal care, facility delivery, and postnatal care in in the Upper West Region;
- 4) To explore the influence of women's autonomy on women's access to maternal care under the MEP and the NHIS;
- 5) To explore how women's experiences with health care workers may influence their use of maternal health care services.

6.2 Summary of Findings

6.2.1 Objectives one and two: Explore women's previous enrollment in NHIS in relations to their knowledge and use of MEP.

Qualitative methods were used to assess the relationship between women's enrollment in NHIS and association with women's knowledge and use of MEP services. The goal was to try to disentangle these two related but separate programs and whether the success of one necessarily translates to the success of the other. Findings reveal a connection between women's full NHIS enrollment status and subsequent use of the MEP and maternal health services. The findings of this study suggest that women with full NHIS enrollment (i.e. mostly those women who had been able to pay for the premium payments) were more inclined to use the available maternal services. In contrast, those with prior enrollment or no enrollment in NHIS seemed to be unaware of all maternal services provided by the MEP since they had only a few sporadic encounters with health personnel. An advantage was granted to women enrolled in NHIS at the time of pregnancy compared to those with no enrollment as they seemed to be more informed about the MEP services, and utilized services from initial stages of pregnancy (i.e. antenatal care) right into the postnatal period. Although the MEP was specifically designed to target poor women and enable them to make use of maternal health care services not otherwise available, and that in theory care is to be granted equitably for all women, those enrolled in NHIS at the time of pregnancy were the most likely to benefit from maternal health services throughout pregnancy. Women also accessed health facilities if they were in close geographic proximity to a health facility, had the financial resources, or had readily available transportation at their disposal.

6.2.2 Objective three and four: Examine the influence of women's autonomy on utilization of antenatal care, facility delivery, and postnatal care.

In order to properly understand the barriers to use antenatal, facility delivery, and postnatal care, it was essential to explore women's perceptions of the MEP in the context their daily lives. Given the intertwining of subsistence farming along with other livelihood activities, disentangling this from the need for maternal health care was impossible. By drawing on qualitative data, this relationship was explored through a political ecology of health framework, feminist political ecology framework, and Andersen's Behavioural Access Model.

The findings reveal that although the MEP is regarded as highly beneficial, especially with respects to improving health outcomes for women and children, accessing all necessary components of the maternal health care package remain problematic for a wide segment of women. Specifically, the more rural ones livelihood is, the more difficult it is to access the services available under the MEP. This occurs primarily due to the requirement for out-of-pocket cash payments for transportation to the health facility and for purchasing the necessary items required to deliver in a facility. Consequently, together this limits women who have subsistence lifestyles with little to no cash incomes.

Enabling factors such as wealth were found to influence maternal health seeking behaviour. However, the MEP has brought about changes in the way these factors shape women's health seeking behavior. Despite several challenges including lack of transportation, this study found that the use of a health facility for antenatal checkups was common and much improved with the introduction of the MEP. This situation is quite different with deliveries as labour can happen suddenly.

Since the onset of labour can occur swiftly and unexpectedly, anytime and anywhere, this was reported by participants as a limiting factor in a woman's ability to access health care in a

timely manner. The many challenges deterred the facility delivery and the subsequent use of postnatal care. Given the pre-existing challenges of seeking skilled health personnel (i.e. inadequate and unavailable transportation, limited financial resources, familial responsibilities), women in rural communities with limited available transportation often chose to deliver with TBAs. Furthermore, the costs of items required to deliver in a facility emerged as an obstacle for women accessing health facilities for delivery. Additionally, spending money and time accessing postnatal care competed with women's household responsibilities, financial insecurity, and responsibility of caring for children. Thus, access to maternal care is situated within an array of competing individual needs and structural factors such as stark regional disparities in welfare, high incidence of poverty, and underfunding of social services in Northern Ghana.

6.2.3 Objective five: Examine how previous experience with health care providers influence subsequent use of maternal health services.

In exploring how women's experiences with health personnel may have influenced their utilization of MHS, the findings were clear on the fact that most women tend to encounter negative attitudes and harassment from health personnel. It was in this light, many women indicated they prefer to stay away from the health facilities during the course of the pregnancy and not go and experience the many burdens related to health seeking while further receiving insult and degrading treatment from nurses.

The findings also revealed a high degree of confusion and ambiguity surrounding appropriate care a woman should receive during labour. For instance, some women said they thought that beatings by health staff during labour were detrimental to a woman's health while others thought such beatings were meant to help induce labour. Thus, there is a great need for programs aimed at education of health workers on the appropriate maternal health teachings.

6.3 Contributions of the Study

6.3.1 Theoretical Contributions

This study adds to the literature on maternal exemption policies and health insurance schemes in SSA, and more particularly to understanding enrollment and access in Ghana's MEP. While the scheme has generated greater discussion surrounding maternal health issues, with academics eager to assess the vitality of Ghana's Maternal Exemption Policy and National Health Insurance Scheme, the relative novelty of maternal exemption policies in SSA have left voids regarding theoretical and practical implications of such policies. Thorough understandings of exemption policies are negated in most of SSA. Thus, one of the goals of this thesis was to begin to draw attention to the theoretical and practical implications for maternal health care and broader health development within the SSA.

6.3.1.1 Enabling factors: The continued importance of Wealth (Or Deprivation and Health)

The socio-behavioural theoretical model pioneered by Anderson and subsequently updated (see Andersen, 1968; Andersen, 1995; Gelberg, Andersen & Leake, 2000) has been widely utilized in explaining access to health care, including Ghana (Bour, 2004). This study reveals the importance of enabling factors (such as wealth and education) to explain access and utilization of health care, in this case enrollment and use of the MEP. Given the impetus of this thesis is to understand why even with the MEP – a policy that provides 'free' access to maternal health care – services remain underutilized, questions regarding the role of wealth on the ability to access services remained important.

The findings also emphasize the multidimensional nature of the factors affecting the utilization of MHC, even when one is enrolled in MEP. Competing challenges including accessing antenatal care, facility delivery, and postnatal care compete against other household

needs (Koch & Alba, 2010), such as the cost of transportation, household duties, and available money. This places maternal health care even with the introduction of the MEP, in direct conflict with the other (immediate) needs of the family. Given most women's financial ability to access care often comes from fixed and tight household budgets, access to care can be problematic. Since enrollment in the 'free' MEP first requires a paid pregnancy test, together with women's twofold household and financial responsibilities, women's need to access MHC rival their necessary daily responsibilities, creating a situation where women must navigate their need for maternal health services amidst other financial obligations and meager incomes. Others researchers (Aboagye, Agyemang, 2013; Arhinful, Zakariah- Skoto, S, Madi B et al., 2006; Richard, Antony, Witter et al., 2013) have also observed medical barriers such as partial user fees and bottlenecks introduced by health personnel are used to supplement the capacity of the facility. Even though maternal health services are supposedly free under the MEP, this policy is occurring in a context where health care services are under resourced and therefore require women to bring items such as carbolic soaps, disinfectants and cloth to assist delivery. These auxiliary fees are, in a sense, the new user fees, replacing to old user fee model and increasing cost burden for women of low social status (see Aboagye & Agyemang, 2013). The additional requirement of women to bring items to a health institution at the time of pregnancy further inhibits a women's desire to access skilled care for delivery.

While recent studies have shown deprivation acts as an important factor in enrolment in the NHIS, there is little understanding of how the nexus of poverty, gender, and access to health care effect women's maternal health in the UWR. To date, studies evaluating enrollment in health insurance within the context of SSA pay marginal consideration to the role of gender in shaping access to resources required for healthcare. This study demonstrates that even when health insurance specifically targets women providing free maternal health care, women continue to encounter financial quandaries seeking care in the context of pervasive deprivation.

6.3.1.2 Gender Dynamics and Access To Maternal Health Care

Feminist approaches to reproductive health argue women's reproductive rights are intrinsically important, but extricably linked to the socioeconomic, political, and environmental realities of women and their access and control to achieve reproductive self-determination (Wang, 2010). Societal gender norms, constructed within context, often interact with socioeconomic circumstances, influencing exposure to health risks, access to health information, services, and health outcomes, often with women benefiting less from health services (Doyal, 1995; Ostlin et al., 2007). These gendered constructions are created, reinforced and constructed by families, communities and social institutions (Connel, 1987; Kimmel, 2000) in turn shaping women's maternal health outcomes

To understand access to maternal health care in the UWR, it is important to realize women's health needs are situated in deprived contexts with limited economic opportunities, primarily based on subsistence farming, fashioned to meet familial obligations and household responsibilities. This means that resources to (potentially) pay for maternal health needs must first be divided among household members and women's responsibility to provide food and care for their children. In the UWR, women's household income is generally less than their husbands and yet must also cover costs associated with children and attend to other household expenses (Koch & Alaba, 2010). Additionally, it is noted that women's heavy 'compulsory' workloads, financial insecurity, and considerable financial responsibility for their children create negative psychosocial and physical health effects (Avotri & Walters, 1999). In the non-waged context of subsistence agriculture, as in the majority of the UWR, this often translates to gendered norms around crop production, where incomes from "male crops" and "female crops" are put to different uses (Haddad & Hoddinott, 1994). As indicated in the findings, this financial division makes enrolling in health insurance and accessing health care in times of need (i.e. during the

onset of labour) extremely difficult as women may have to bargain with husbands to receive money for transportation and care.

Regardless of social norms that expect men to contribute to women and children's healthcare costs, in practice Ghanaian women often rely on their own meager financial resources to pay for maternal health care (see Tolhurst & Nyongator, 2006). Findings from this research indicate a disproportionate burden on women to provide economically for themselves and their children in the household, often discussing how they had to separate and hide their money from their husbands in order to purchase desired goods (i.e. health care). Additionally, findings reveal women's use of maternal health services were closely tied to their obligation of mothering and household duties, indicating they would rather stay home and work to feed their children than access personal maternal health care and let their children go hungry. These underlying challenges experienced by many women clearly indicate the gendered constraints around access to health care services.

Despite earnings procured by women, men are normally regarded as the household decision makers, and may frequently take custody of any income from farm proceeds. Even among women engaged in off-farm activities, the husband frequently has access to his wife's financial income (Buor 2004). This limited financial capacity pretenses a woman's ability to use services provided under the MEP. Due to these asymmetrical relations between men and women within the household, Ghanaian women are forced to secure their own finances often unknown from their husbands or expected to barter with their husbands to contribute to household health care payments. This gendered position of women in the UWR highlights the significance of recognizing impacts of gender when developing health policy.

The fact that women are often more marginalized by the social costs of seeking healthcare, coupled with their specific needs for reproductive health care, necessitate a more visible

recognition of the problems they face if they must pay out of pocket for health care. Even though exemptions have been implemented, this does not preclude other costs that women experience over and above waived insurance fees, which together can add up to be beyond their means. The trade-offs women may make in order to pay for health care can lead to debt, use of ineffectual treatments or neglect of their health and other needs (Nanda, 2002). Thus, it is vital to obtain women's own evaluation of the true barriers to health care, thereby helping to flesh out a more meaningful understanding of what constitutes access.

6.3.1.3 Discrepancies between MEP and local livelihoods

Government neglect of Ghana's UWR has become well known, embedded in centuries of unequal development and disregard for vital social services. Further, given the large geographical separation between Ghana's UWR and the capital Accra, the UWR remains off the national 'radar' and the national government remains less accountable for policy neglect. Due to the government's inability to adequately incorporate regional components in political development, a key finding from this work indicates a clear discrepancy and separation between the way the MEP was designed and intended to function and the local realities, practices, and contexts within which women live and work in the UWR.

While the government intention is to complete maternal health coverage, many notable examples revealed women's inability to use the breadth of provided services under the MEP. Common examples included: delayed enrollment due to lack of money, limited transportation, loss of farm days, fees required for pregnancy tests and facility delivery, and limited knowledge pertaining to signs, symptoms, and regarded benefits of postnatal care. These problems indicate how women's livelihoods converge with structural inequalities to prevent the most vulnerable women in the UWR from fully benefiting from the MEP.

Utilizing political ecologies of health framework, which situates health decision making options within the larger political, economic, cultural, and environmental systems, it becomes evident how the government's continuous neglect permeates the development and implementation of the MEP. Structural inadequacies and policy malfunction, drastically misaligned with the ecological realities of the UWR, decrease health knowledge and access in rural marginal areas. Although access to health care is generally included in PEH studies as a contributing factor to disease spread (e.g., Barnett & Blaikie, 1992; Kalipeni & Oppong, 1998; Mkandawire et al., 2013), geographers have yet to embrace PEH to study access in and of itself. In the case of MEP, this was evident in the requirements to pay for pregnancy tests and items for facility delivery, pregnancy knowledge gaps in health providers and women, inaccessible terrain, and limited transportation options during all stages of pregnancy. In this regard, this research highlights the relevance of the PEH framework for understanding the role of political ecology in access and enrollment to the MEP in Ghana's UWR.

Taking this one step further to include the influence of gender on access to health care, this research reveals how health care provided by the MEP shapes general community and familial perceptions of women's health in the UWR. As revealed in the findings, since health care is now "free" for women, there is a heightened sense of detachment regarding the process of pregnancy and decreased communal engagement surrounding pregnancy outcomes compared to the social environment prior to the exemption policy. Furthermore, women often experienced sole responsibility for the procurement of finances for transport, children, and delivery items. Hence, health personnel denoted the necessity for males to become more involved in maternal health and made suggestions for local communities to make arrangements for communal vehicles or gas reserves to assist in the transportation process to a health facility. In this manner, the perpetual national neglect of health services in the UWR, deep rooted in Ghana's colonial past, combined

with local challenges have manifested in detrimental health outcomes for women and their children.

6.3.1.4 Fragmented Policy Knowledge and Implementation

Addressing financial barriers constraining maternal health access is consistently claimed as a "quick win" for MDGs (Sachs & McArthur, 2005), increasing access and positive health outcomes. Nonetheless, findings indicate abolishing user fees have consequential effects on health systems related to the financial sustainability of programs and quality of care provision (Hatt, Makinen, 2013; McPake, Brikci, Cometto, Schmidt, Araujo, 2011; Ridde & Haddad, 2009).

A key finding from this research is the knowledge gap between health personnel and women surrounding the proper functioning of the MEP. This study shows there may be a policy misunderstanding, whereby some providers believed the exemption only covered deliveries, but not complications in post-partum, while others suggested the package does include pregnancy related complications and transportation costs (see also Witter et al., 2007). Several qualitative studies in Burkina Faso, one of Ghana's neighbouring countries, have demonstrated the process used to define maternal health policy was restricted, indicating women and health workers were not aware of the policy's components (Ridde et al., 2013). Vague policy implementation creates a situation where health providers are unaware of proper policy elements which affect care women receive, sequentially creating an ambiguous health system for women have to maneuver. Additionally, the high transferal rate of health providers between districts means appropriate knowledge of MEP may be sparse, impacting the care women receive.

A key example of this knowledge gap was the confusion surrounding payment for pregnancy tests among women enrolling in the MEP. This ambiguity in payment may be reflective of the health workers attitude towards the exemption policy. Due to sporadic funding and

reimbursement for the MEP, asking for payment for pregnancy tests may be a coping behaviour by frontline workers to raise funds – a modification of the policy to echo the previous cash and carry system. A study in Southern Ghana found parallel results when examining child exemptions, whereby health workers ignored the exemption policy and simply charged for services, justifying such actions with claims that it was to protect their institutions from paying creditors for medicine, consumables and recurring costs (Agyepong, 2011). The results of this study suggest a similar situation indicating that women who paid for services would receive better and quicker care than those enrolled in the MEP. As others have documented, Ghana has recently faced substantial problems in disbursing funds to health facilities (Witter, Arhinful & Kusi, 2007), inducing health workers to charge patients, raising the price on other services to recoup lost fee revenues (Richard, Antony, Witter et al., 2013).

Further, national guidelines make no mention of incentive payments to staff once the MEP was introduced (Witter et al, 2007, Ridde et al., 2013). Thus, staff may be reluctant to care for increased numbers of women when they are already functioning on restricted funds. This may act as rational to charge women auxiliary fees for maternal health care. Qualitative work with midwives and communities in Ghana suggest that comprehension of the policy was weak (Arhinful, Zakariah- Skoto, S, Madi B et al., 2006), indicating the need for clear, simple designs and better communication between policy directors and health workers

Another key finding of this study is that the Community Health Planning Services (CHPS) Programme in Ghana has not met its desired goals of improving the accessibility, efficacy and quality of health and family planning care (Binka et al., 1995). Despite the CHPS national health policy goal of reducing geographical barriers to access health care (Nyonator et al., 2005), findings from this research indicate that CHPS facilities only provide limited health care to women, with health providers demonstrating inadequate knowledge regarding the MEP and policy components. Despite CHPS focus of providing “outreach” mobile community care

(Nyonator, et al., 2005), results indicate CHPS are short staffed, operating for only minimal times during the day, and offering only partial care for pregnant women (i.e. antenatal). Although CHPS claimed to provide care during all stages of pregnancy, women were unable to deliver at these locations, heightening risks during the most critical point in pregnancy.

As theorized by King (2010), since the discrepancy between health policy and local practices and knowledge systems is problematic for health outcomes, it somewhat explains how maternal public health policy in Ghana's UWR is structurally inept to deal with the local realities and practicalities of the health system. Although this framework has commonly been used to understand the ways in which diseases are discursively understood through relations of political power, this work expands the PEH theoretical constructs to reveal how institutions develop policies and discourses that conflict with local understandings of health care provision. This study reveals how power inequalities embedded within the Ghanaian health infrastructure shape access to information, resources, and opportunities for maternal health care in Ghana's UWR.

6.3.1.5 Abandoning Traditional Birthing Practices

Overall, the findings suggest the ban on TBA delivery has detrimentally affected women in rural, isolated communities who now encounter immense challenges seeking care from a skilled provider during pregnancy and labour. There is no doubt that rural women recognize benefits associated with facility delivery with skilled attendants, however, geographical challenges simply mean some women are unable to access care in health facilities. Consistent with findings by others, even when professionals provide care for pregnant women, many continue to access services of TBAs, particularly those in rural areas due to cost of travel to facilities, convenience, local custom, and kindness (Paul et al., 2002; Starrs, 1997; SMIAG, 2003). Additionally, the experiences of women arriving at understaffed facilities only to find

there is no skilled provider, adds to calls to rethink the TBA ban entirely, even without consideration to context specific challenges.

The abandoning of traditional aspects in birthing is reflected in both international policies and clinical practices of many skilled health providers who consider Western-based knowledge and education as the only legitimate form of knowledge (Kruske & Barclay, 2004). Similarly, the sole concentration of pregnancy based on biomedical motives for facility delivery, discounts the socio-economic and cultural fabric of society. This discrepancy between health policy and local practices and knowledge systems (King, 2010) has the potential to create detrimental health outcomes for women seeking maternal health care. Exemplified in this case study, geographic disparities entwine with pervasive economic inequalities, restraining women's use of maternal health services throughout pregnancy. Thus, the decision-makers need to be cognizant of local level issues and modify policy appropriately in this regard, rather than simply transferring it and implementing it whole sale (see Walshe & Rundall, 2001).

The transformation of maternal health care in Ghana's UWR has positioned health professionals in a tension between adhering to international and national health policy mandates and local "on the ground" experiences. Reports by women in labour who had to walk or travel on a bicycle or motorcycle to a health facility, but ended up delivering in the bush, seems to defeat the notion of safe delivery for all mothers. Such precarious deliveries could potentially be mitigated if policy-makers acknowledged that geographical inequalities in specific contexts warranted the use of TBAs. Consequently, claiming adherence to the TBAs ban, health providers still recognized that many TBAs continue to practice in remote locations and that they are the only available help many women have access to.

This complicated sentiment is a product of the blatant 'rural versus urban' disparity in health provision in Ghana, which has resulted in systemic problems experienced by rural

populations throughout the country. As a consequence, there seems to be an obvious disconnect between the policy banning TBAs and the government's aim of achieving reduced maternal and child mortality at birth. This mismatch has occurred due to the Ghana government's adoption and implementation of an international health policy without a critical examination of local contextual realities that are persistent in parts of the country, especially in the northern regions. While recognizing the limitations of a global policy accommodating local realities, I call on the government to be forthcoming in recognizing the challenges of this policy in remote areas where there are no health facilities or personnel.

6.3.1.6 Does the MEP Go Far Enough For Maternal Health?

Even though gender equity is increasingly cited as a goal of health policy, policies which address the promotion of gender equity must align with the distribution of health related resources (Nanda, 2000). A key finding indicates that since the MEP only covers women's maternal health needs for a one-year period, the viability and maintenance of health for both the new mother and child post policy coverage remains uncertain. A key finding to emerge from this research is that a three-month coverage period after birth (one year total) is insufficient for women to acquire enough money to enroll herself and child in the NHIS. Since mothers are caring for their newborn, and likely additional children, they may be unable to take the child to the farm to conduct normal tasks necessary to gain finances, or they may be recovering from a caesarean section delivery. As demonstrated in this research, many women did not have NHIS coverage prior to pregnancy and thus encountered heightened difficulty enrolling themselves and newborn in the NHIS. Further, such political demarcations for health insurance, seems to suggest women's health is insignificant beyond childbirth. Such assumptions apparent in the design of the MEP are consequential for health outcomes, policy maintenance, and for inequitable health provision.

If exemption policies only cover certain procedures or temporal periods of pregnancy, concerns are raised regarding the marginalized incentives to both users and providers (El-Khoury, Hatt & Gandaho, 2012). If the ultimate goal is to reduce maternal mortality and morbidity, while only alleviating maternal fees for a one-year period, there is a risk that mortality due to non-delivery pregnancy and complications or postpartum issues would not change (Witter S, Arhinful DK, Kusi A, Zakariah-Akoto, 2007.) If policies such as the MEP are to promote gender equity regarding health access, they must be realistic in their goal of distributive health related resources. As such, gendered obstacles related to care provision, jobs related to household sustainability, and intra-household economics must be realized.

A dominant result indicates that maternal health care in the UWR is recognized as a problem of the individual women, with policy and community obtuse and insensitive to women's health needs. This theme permeated women's responses noting entire responsibility for personal and child health needs, and costs associated with care within the family structure. This aloof and disengaged atmosphere surrounding pregnancy reflects the creation of a policy that conceives maternal health as a separate entity, in turn ineffective in promoting health equity for women in the UWR. As evidence suggests, gender equitable relationships between men and women are more effective in producing behavioural change than narrowly focused interventions (Barker, Ricardo, Nascimento, Olukoya, Santos, & 2010), since they reach beyond the individual level to a societal context. As such, it is necessary to consider repercussions of designing and implementing a policy outright, without considering gendered norms and relations within society and the broader socioeconomic forces which constrict ability to access services.

6.4 Methodological Contributions

The benefit of utilizing qualitative methods was thoroughly illustrated in this research. In a study environment where very little is known about the subject, set against a backdrop of unfamiliar local contexts and customs, qualitative methods allow significant insight into the

subject to be gained. A comprehensive appreciation of maternal health care and problems associated with accessibility were able to develop through in-depth interactions. The use of qualitative methods allowed for the emergence of issues previously unexplored, such as the overemphasis of free services and traditional birthing practices, which became integral for a comprehensive understanding of the research issue. This uncovered interwoven factors that simultaneously impact access and health outcomes, which could not have been captured through quantitative methods. These methods also proved beneficial to uncover conflicting rhetoric's between women, trained health providers, and traditional medical services providers, which diverged from the objectives of the MEP. Furthermore, by immersing oneself within the study context, I was able to establish lasting relationships with several residents of the region and gain a true appreciation of the study context.

Through utilizing a feminist political ecology lens, it becomes obvious why women face restrictive and prohibitive barriers to access all necessary care during pregnancy or the inability to deliver in a facility. Given that current research commonly focuses on inequalities in women's access to health care, utilizing indirect measures to compare differences between groups of socioeconomic status (Allin, 2006; Asada, Kephart, 2011; Ortayli, Malarcher, 2010; Kongsri, Limwattananon, Sirilak, Prakongsai, Tangcharoensathien, 2011), this research highlights the greater need for in-depth approaches in evaluating women's health needs pertaining to maternal health care. This has several practical implications.

6.5 Practical Contributions

A number of practical considerations have emerged from the findings of this research. First, given previous understandings regarding health enrollment, where women face characteristically different experiences in the use of NHIS (Dixon, 2011), we find that despite the MEP providing free health care specifically for women, maternal health outcomes have been reported marginal, and associated costs of maternal health care continue to remain. Notwithstanding the

improvements in enrollment and antenatal utilization (Dixon et al., 2014; Omane-Adjepong, Ababio, Aidoo, et al., 2012; Aboagye & Agyemang, 2013), facility delivery and mortality outcomes have yet to improve. Apart from marginal equity effects in improving access for poor and less educated women (Penfold, Harrison, Bell, & Fitzmaurice, 2007), several studies highlight the fact that families still experience out of pocket spending even when maternal health user fees are nominally removed (Richard, Antony, Witter, Kelley, Sieleunou, Kafando, et al., 2013). A qualitative study by Witter et al. (Witter, Arhinful, Kusi, & Zakariah-Akoto, 2007) in Ghana's Central and Volta Region noted that the loss of user fee revenue at health facilities led to outages in stocks of drugs and other supplies, negatively affecting the quality of care provided, resulting in reinstating fees by some facilities. Instead of paying for health enrollment in the NHIS, health payments have been transformed into a system where women encounter hidden user fees, creating a new system of cash and carry, thereby affecting the base objective of the NHIS. Other barriers to service use must be addressed for the poorest segment of women to have equitable access to health care.

Extending this discussion of fee removal, one must ask if merely subsidizing service costs for women eliminates inequality in healthcare utilization. Although the effects of fee exemption policies on providers are not well measured, there is sufficient evidence to conclude that user fee exemption policies have important consequential effects on resources of health facilities which could negatively impact maternal health services (Hatt, & Makinen, 2013). Given that Ghanaian user fees obtained from pregnant women at NHIS enrollment were found to previously contribute between two thirds and four fifths of the non-salary operating budget of government health facilities (Hatt et al., 2013), the imposition of the MEP has created financial burdens, generating questions about the sustainability of Ghana's health care system. Since fee removal in 2008, government actions have been insufficient in replacing key revenue sources for health care, leading to drug shortages, unsustainable financial practices directed towards maternal care

provision, and reduced health personnel motivation which may result in poor quality care (negating health benefits of the policy) or facilities recouping costs from patients in alternate ways (negating the financial access benefits of the policy) (Hatt & Makinen, 2013; Witter et al., 2007). Findings from this study suggest insufficient funding and reimbursement for maternal health services have lead health providers to charge women for enrollment in the MEP (i.e. pregnancy test), or treat women who are willing to pay cash for services with more attentiveness compared to women enrolled in the MEP. Consequently, insufficient health service funding modalities have created a situation where women encounter economic charges, despite the MEP.

Theoretically, MEP claims should be reimbursed or replaced by the government, but in practice, reimbursement is delayed, insufficient or cumbersome to obtain (Witter, Arhinful, Kusi, & Zakariah-Akoto, 2007). This draws attention to the necessity to build strategies that provide diligent planning regarding implementation, broad communication strategies targeting different groups (i.e. health management, donors, health staff, community officials), commitment to the expected budgetary burden among government and international partners, and clear rules for transferring resources to health facilities to compensate for loss income or new costs.

By eliminating the costs associated with NHIS enrollment, intentions of gender equitable health care should be expected. However, evidence from this study and other studies (Aryeetey et al., 2010; 2012) points to the failure of MEP, and the ineffectiveness of NHIS in Ghana. One of the reasons for this failure is the lack of consideration of women's roles within the household structure, strained household resources needed to access care, and the impediments of seasonal farming. This positions health care access as not necessarily about MEP enrollment but deeply embedded within a particular socioeconomic context. This draws attention to the need for better servicing women of rural subsistence lifestyles. For instance, recognizing women's economic, familial responsibilities, coupled with sporadic and seasonal incomes need to be realized by developing alternate forms of care provision. While health insurance agents do travel out into the

villages for enrollment in MEP and outreach programs, their visits are intermittent and irregular. Additionally, even though nurses travel to rural communities to perform antenatal and postnatal services, visits persist to be sporadic and inconsistent. Visits from health personnel in underserved rural areas need to be increased to alleviate travel demands in rural locations. Recognition of the general levels of poverty in the UWR, and understanding women`s position as dual care providers would also assist in providing better tailored health services.

Most importantly, resolutions in care will not come solely from changes to health policy or insurance schemes. What is needed is empowering women with education, viable economic options, sustainable solutions, and equitable services. These solutions must come from government policies which deal with uneven development in Ghana taking a comprehensive approach to health care which situates health outcomes within the larger development of the region, incorporating education, economies, gender divisions, and transportation issues. Given the deprived economic situation of most women in the UWR, together with inaccessible transportation and farming responsibilities, it is not viable for women to access available services provided under the MEP. Thus, the Ghana Health Services should target grassroots options (i.e. increasing staff at facilities, improving CHPS systems with greater human resources and equipment, down shifting health provider roles, retraining and allowing TBAs to practice in the region), while concurrently targeting the broader health system (i.e. rallying the government for essential support to sustain the health of the UWR).

Secondly, evidence from this study points to the failure of the health system to properly manage the promotion, knowledge, and maintenance regarding proper functioning of the MEP. Similar to findings from others studies (Hatt, Makinen et al., 2013; Odame, Akweongo, Yankah, Asenso-Boadi & Agyepong, 2013), our findings reveal MEP has created unintended financial consequences rooted in the removal of user fees, which has directly affected maternal health care delivery in the UWR. Since MEP funding is sporadic and insufficient to cover maternal health

services, health providers in poor districts are unmotivated to provide covered services, referring women to other locations, or providing superior care to women willing to pay cash for services. Given the ambiguity surrounding payment of pregnancy tests and proper coverage of services, findings reveal health providers ask for payment from women or send women away to other health providers instead of providing hypothetically covered services under the policy. This calls attention to the equity effects of fee removal, noting the MEP has created an environment of decreased provider motivation, thus in turn affecting the most marginal women in the UWR. Ideally, the lessons from this study should inform NHIS to be more adaptable to local settings, and pay greater attention to the bureaucratic and structural difficulties of the health system, while increasing training of health providers and providing greater incentives for workers in remote locations.

Thirdly, findings from this research indicate continued challenges in health provision, whereby skilled health providers prefer to remain in urban areas (Gilson, 1995; Hart, 1971; Nyongator, Dovlo & Sagoe, 2005), leaving rural areas frequently under-staffed and without health services. Given the shortages of health personnel in UWR, the Ghana Health Service should adopt an approach which aims to improve health systems from a bottom up where implementation of policies takes into account local realities. For instance, the Government's decision to ban TBAs in maternal delivery, relegating them to only assist in helping women access a health facility questions the Ministry of Health's aims of improving maternal health outcomes. Given the rural and isolated communities of the UWR, it is problematic to assume women can easily reach a skilled attendant for delivery. In light of such extensive shortages in health personnel, the Ghana Health Service should adopt a dual and complementary system (Sibley et al., 1997), whereby trained TBAs are allowed to operate when they are the only resource available to women in life or death situations.

Despite aims for all deliveries to be attended by a “skilled health provider”, the government must first realize the geographic disparities and human resource shortages in the UWR. In the absence of such idealism, it makes sense to look critically into the role that TBAs can continue to play until the ideal scenario is accomplished. Evidence suggests that training programs targeting TBAs can result in improvements in knowledge and behaviour relating to intrapartum, antenatal and postnatal care practices (Allotey, 2000; Gill et al., 2011; Sibley et al., 2006). In Ghana’s UWR, where maternal mortality is high and the use of TBAs common, maternal health programs should collaborate with TBAs in order to promote reproductive health and hygiene, avoid complicated delivery, and ultimately reduce maternal mortality.

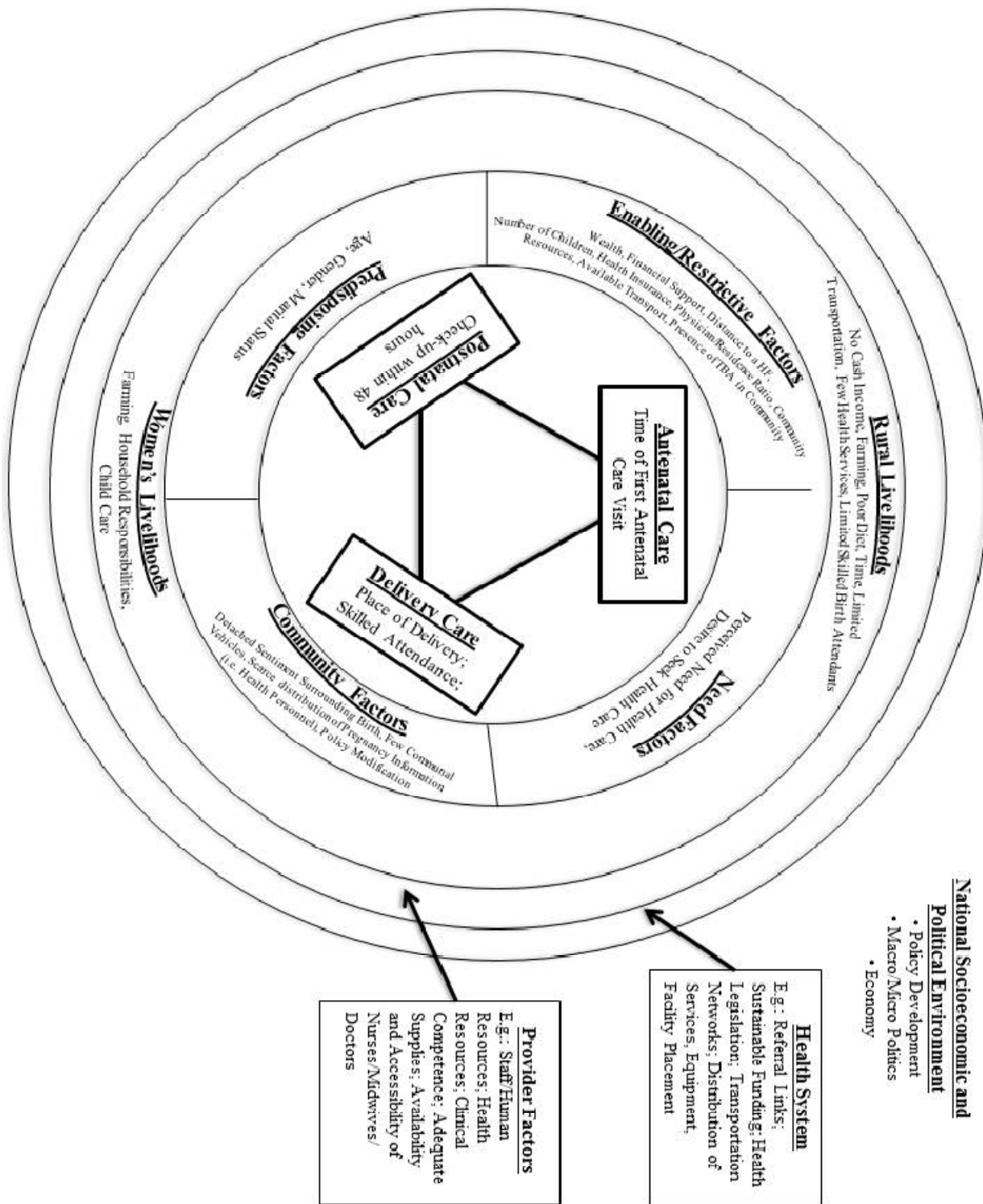
Given the prior collaboration between health providers and TBAs in Ghana’s UWR, it seems viable that training programs could be targeted to provide effective health care to women in rural localities. This collaborative approach could address issues related to shortages of human resources and health care management. For instance, by using existing and previously trained local TBAs and mobilizing community collective action in the promotion and generation of positive health outcomes, both women’s health needs and the quandary of limited skilled providers in the UWR could be remedied. One possibility may be to provide the TBAs with mobile devices (e.g., cell phones) so they can contact midwives who would give instructions during emergency deliveries. As some remote villages are beginning to organize their own health cooperative transport systems for emergencies, these can be supported by the government through integration into the health care system. This will greatly facilitate maternal and child health.

Finally, this thesis draws attention to the strong need to increase family planning and communal involvement surrounding the process of pregnancy. Given that gender norms are directly related to men’s and women’s health behaviours and impact the entire family (Kimmel & Messner, 1989, Campbell, 1995; Cohen & Burger 2000), the MOH should introduce programs which target education and awareness of maternal health and policy for both women and men.

Studies confirm that reasonably well designed programmes incorporating men and boys can produce changes in attitudes and behaviour surrounding health seeking behaviour. Such gender focused approaches are able to improve health outcomes, especially among men and boys (Barker et al., 2010), which would benefit the female population during pregnancy.

Even though health promotion and service based programs have included men and boys as a target population, they have not fully considered how gender norms and relationships affect the health related behaviours, attitudes, and vulnerabilities of women and men. As such, there is a need to incorporate males in maternal health programmes to fully consider how gender norms affect maternal health related behaviours and outcomes in Ghana. Seeking to identify ways to change gender inequality at a societal level requires policy change which addresses social issues such as women's greater participation in employment outside the home (Barker, et al., 2010). Interventions targeting gender specific programs also need to recognize that other factors, particularly socio-economic marginalization, can also lead to positive and necessary changes in women and men's vulnerabilities and health related behaviours. Where possible, multiple issues of economic and social exclusion should be addressed simultaneously to ensure the most significant and lasting impact. See figure 14 demonstrating women's navigation of maternal health services in the context of UWR's rural livelihoods.

Figure 14: Women’s Navigation of Maternal Health Services in the UWR



discussion of areas for future research. Foremost, a limitation of the study relates to the language

barriers between me and the research participants, specifically among focus group participants. Although efforts were made towards training and providing sufficient background information to the research assistant regarding key components of the research, time constraints limited the depth of understanding I could achieve regarding the many issues influencing maternal health access. As such, some items that might have been explored may have been lost in translation and time constraints. Also, as with translation, some of the intended emphasis behind participant's responses may have been lost or misinterpreted. Unfortunately, member checking was not an option for focus groups since it was difficult to reach many participants following interviews given the predominance of subsistence lifestyles and problematic transportation. Given the majority of farming activities in the UWR occurred during the time data for the thesis was collected, it was difficult to locate women after the interview process.

Reaching the target population in the UWR was a big challenge in this research. Potential research participants lived in far off villages, which were poorly serviced by commercial mini vans popularly called "tro tros". Motor bicycles were the primary mode of transport in order to reach respondents. In instances of heavy rainfall, respondents could not be reached either because footpaths leading to such locations were rendered dangerous to continue travel or water levels in streams had risen making it dangerous to cross on a motor bicycle. Given the remote location of such villages and time of the rainy season, phone service was sporadic making communication to arrange interviews and focus groups difficult.

Further, some women questioned the intentions of our research, indicating NGOs had previously come to their communities with discussion of change and positive health benefits for the population, but claims never materialized into tangible outcomes. This apprehension of some posed a hindrance to data collection.

6.7 Directions for future research

Maternal health care fee exemptions are a relatively new form of health care in many SSA countries, with much to be studied. Despite aims to enhance access to care and improve maternal and neonatal outcomes (De Brouwere, Richard, Witter, 2010; Ridde, 2011), the extent of coverage remains limited. While this thesis adds to the body of knowledge surrounding maternal exemption policies, it has also offered some directions for future research, which this section will explore. Firstly, one of the limits of this study was the use of qualitative interview data. Qualitative approaches lack the ability to capture statistical evidence regarding enrollment rates, antenatal utilization, facility delivery, and postnatal utilization. Thus the use of a longitudinal survey design would be helpful in making definitive causal connections between MEP enrollment, utilization of provided services, and the sustainability of the policy. Especially when interrogating the relationship between enrollment in MEP, use of services, and further ability for women and children to enrol in NHIS after birth, could provide more insight into the intricacies of factors related to utilization and sustainability of health insurance. For example, while the study showed women are utilizing MEP services, it was unknown to which extent women in the UWR are aware of the policy or the portfolio of services covered under the policy.

Secondly, while the study probed contradictions regarding free MHC and underutilization by focusing on the specific context of the UWR, the next step will be to contrast and compare these findings to other areas, both in Ghana and in SSA to gather a greater understanding of how these results compare with other locations. The neighbouring Upper East Region shares similar characteristics as the Upper West Region, and it would not be surprising to find similar results of underutilized services in this area. While this study cannot generalize, it provides potentials to query if problems of underutilized services are due to resource poor settings in the UWR compared to other parts of Ghana. Further, it would be useful to examine if there are similar gendered influences and delineations of gendered labour were found to impinge utilization in

other parts of the country. Since more countries are beginning to adopt maternal health exemption policies towards a social health approach, there is a need to be aware of the geographic differences in marginal areas.

Thirdly, gender is a significant construct to interpret barriers to enrollment and utilization of health services. Given that gender is important in shaping access and need for health care, it is important for others to apply gendered theoretical approaches to examine health utilization. This demonstrates how gendered barriers continue to pervade despite the MEP, and as a consequence raised a number of questions. For instance, has maternal health insurance impacted familial responsibilities surrounding birthing or altered relations between husband and wife? Does the MEP act as a sustainable approach to gender equitable health care? Deeper qualitative work exploring the implication of the gendered nature of health seeking behaviour, access, and health care systems will prove beneficial. Further, since gender frameworks have not been applied in other studies examining insurance exemption policies, it will be interesting to see how this study's results will compare across space.

Finally, this study was focused on detailed questions of how the MEP influences utilization of services in a particular context. While the findings provide crucial intricacies of access and utilization of maternal health services, they provided limited ability to gauge the extent to which the MEP is functioning on the large scale. Hence, a broader maternal investigation of MEP impacts would be relevant. Further, there is also a need to examine MEP utilization during all stages of pregnancy. It will be interesting to explore how women of the Upper West Region navigate the connection between MEP enrollment, rural subsistence lifestyles, and limited health infrastructure which theoretically would make accessing care more difficult during all stages of pregnancy, beginning from conception to postpartum outcomes. There is still much work to be done examining and understanding the dynamics of MEP enrollment and utilization of maternal health services in developing contexts.

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Appendices

Appendix A : Check List for In-depth Interviews

Women's Navigation of Reproductive Care in the Context of Ghana's National Health Insurance Scheme CHECKLIST FOR RESIDENTS' IN-DEPTH INTERVIEWS		
<p>Preamble:</p> <p>Hello my name is Andrea Rishworth, a MA student in the Department of Geography at Western University, Canada. This study seeks to evaluate gendered, social, and economic barrier to access and use free maternal health care under the maternal exemption policy of the National Health insurance Scheme (NHIS) in Ghana's Upper West Region.</p>		
TOPIC	QUESTION	PROBES

1. Perceptions of NHIS and Maternal Policy Exemption	<p>Why is maternal health care important?</p> <p>What services are offered by the government to pregnant women</p> <p>Do you think that most women in the UWR know about this?</p> <p>How did you hear about the maternal</p>	<p>What serviced under the NHIS are offered to pregnant women?</p> <p>Are you aware of the maternal exemption policy?</p>
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	<p>exemption policy?</p> <p>How does the exemption policy work?</p> <p>How long are you covered for free services under the policy?</p>	<p>- Family, market, radio, other?</p> <p>- What do you have to do to get free care? Proof? Where do you get proof?</p> <p>- Challenges in proving your pregnant?</p> <p>- Weeks? Months? Mother and children?</p>
<p><i>I just want to check to make sure I have this correct. In 2003/2004 the government provided free delivery at the health facilities. In 2008 they changed that so that all pregnant women get free NHIS coverage (the “maternal exemption”). Is that right?</i></p>		
	<p>Did you know about the policy before you had children?</p>	<p>If yes, did it affect your utilization of the service?</p> <p>If not, would it have affected your use of the service?</p>
	<p>What is your opinion of the maternal exemption policy?</p>	<p>- Advantages/ benefits of the</p>

	<p>Why do you think women don't use free care?</p>	<p>policy?</p> <ul style="list-style-type: none"> - Disadvantages? - Benefit some more than others? - Do you trust the policy? - Feel comfortable using it? <p>- Main reasons?</p> <p>Distance, work, children, cost?</p>
	<p>What do you think could fix this?</p>	<ul style="list-style-type: none"> - Easier access? - Transportation? - Reimbursements?

<p>2. Prior Enrollment in NHIS and use of Maternal Services</p>	<p>Have you given birth in the last ten years?</p> <p>If yes, did you use the exemption policy? (free services)</p> <p>Did you give birth in a health facility?</p>	<ul style="list-style-type: none"> - Free delivery? OR free NHIS coverage?
	<p>Are you enrolled in NHIS (full time)?</p> <p>Did you know about the policy prior to enrolling?</p> <p>Where you given information about the maternal exemption policy? How?</p>	<ul style="list-style-type: none"> - What are the benefits of NHIS? - What elements of the policy would discourage you from joining/maintaining membership? -

	<p>If you were enrolled in NHIS prior to giving birth would you be more likely to use the maternal health care?</p>	<p>- Why? How would this affect your use? (prior knowledge, knowledge of health facilities, difference in perceptions)</p>
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<p>3. Experiences with Health Facilities and Utilization of Maternal Health Care</p>	<p>How often do you go to the clinic or hospital?</p>	<p>When was the last time?-</p> <p>Why?</p>
	<p>Tell me about your treatment the last time you went to the health facility?</p>	<p>Experiences positive or negative?</p> <p>Reasons why?</p> <p>Will you continue to use or not?</p>
	<p>What do you /women do to try to prevent complications (problems) when you deliver your baby</p> <p>When women deliver their babies which place is considered the best? (Public, private at home?) Why?</p> <p>When women deliver their babies which care provider is considered the best (Dr, Nurse, TBA/midwives) ? Why?</p>	

<p>4. Reasons for Utilization and Barriers to Access</p>	<p>Would you go to a health facility numerous times prior to birth if care was free?</p> <p>When you were pregnant did you make use of the free maternal care?</p> <p>What are the challenges you face when accessing a health facility?</p>	<p>- Reasons?</p> <p>- Time, cost, travel, children, family, perceptions/stigma, more important obligations?</p>
	<p>Would you prefer using a traditional birth attendant than going to a health facility?</p> <p>What are your motivations to seek maternal health care?</p>	<p>- Why? Easier, perceptions, treatment, religion, culture, hidden costs?</p> <p>- Health, medical attention, safer?</p>
	<p>Who in the household makes decisions about when to seek maternal health care?</p> <p>Who in a household pays for health care/ maternal health care? (costs associated with health care)</p> <p>Do women have to seek permission to access maternal health care?</p> <p>Are these things related?</p>	<p>- Men/husband, female/wife, joint, extended family?</p> <p>- From who? Why?</p>
	<p>Do you feel comfortable in a health facility?</p>	<p>- Fair treatment?</p> <p>- Stigma, poor</p>

<p>5. Social, Economic, Cultural, Geographic Barriers to Access (Payment for Health Care and/or NHIS)</p>	<p>How do you feel the staff/nurses treat the patients?</p> <p>How does money influence your decision to seek care in a health facility?</p> <p>How does the cost of delivery affect use of health facilities?</p> <p>Does your religion affect your health care utilization?</p>	<p>treatment from nurses?</p> <p>How does it affect? Too expensive? Do you/ some people take out debts to access health facilities for delivery?</p> <p>How has this impacted these people?</p> <p>Time spent at work, health, family structure, stress?</p> <p>Hinder? Allow/prohibit utilization?</p>
	<p>Women have lots of responsibilities in daily life including at the home, on the farm, going to market, at work etc. Does all this work make it hard for women to deliver in a health facility?</p> <p>Certain times of the year when women are more likely to use a health facility? (seasonality of work) or when it's harder to get to the clinic?</p>	<p>Can't take time off? Too much work? Can't afford the loss of productive time?</p> <p>Rainy season/dry season?</p>
	<p>How do you access a health facility?</p> <p>Does accessing a health facility take too much time? Why?</p>	<p>Walk, transportation?</p> <p>Distance, walk, children?</p>

	<p>If facilities were closer are you more likely to use them? Why?</p>	<p>Easier access? Proximity? Treatment?</p>
	<p>Before the exemption policy, what did you do when you were pregnant?</p>	<p>Where did you deliver? Who delivered your child? How did you pay for maternal health/delivery? (personal, family, friends, loan)</p>
	<p>How have things changed in your village since the policy came into existence?</p> <p>Do you think women feel more comfortable? How/Why?</p> <p>Does having free care change the way women decide to deliver? How?</p>	<p>Better health, positive environment, nothing changed?</p> <p>More likely to deliver in a facility? Still prefer home or traditional birth attendants?</p> <p>Does it change the way maternal health is bargained for in the household?</p>

<p>5. OTHER CONCERNS</p>	<p>Do you have any other types of concerns related to the maternal exemption policy or NHIS in general? How would you rank these concerns? Have you always felt this way?</p>	
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	<p>How do you manage/deal with these concerns? How could these concerns be minimized?</p> <p>What direction do you want to see the government, health professionals and community take to improve the maternal exemption policy?</p>	<p>Coping strategies: talk to neighbours, do nothing</p> <p>Better services? Easier access? Improved treatment in health facilities?</p>
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6. CONCLUSIONS	Is there anything more you would like to add?	
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Appendix B: Check List for Focus Group Interviews

Women's Navigation of Reproductive Care in the Context of Ghana's National Health Insurance Scheme CHECKLIST FOR FOCUS GROUP INTERVIEWS		
<p>Preamble:</p> <p>Hello my name is Andrea Rishworth, a MA student in the Department of Geography at Western University, Canada. This study seeks to evaluate gendered, social, and economic barrier to access and use free maternal health care under the maternal exemption policy of the National Health insurance Scheme (NHIS) in Ghana's Upper West Region.</p>		
TOPIC	QUESTION	PROBES

1. Perceptions of NHIS and Maternal Policy Exemption	<p>Why is maternal health care important?</p> <p>What services are offered by the government to pregnant women</p> <p>Do you think that most women in the UWR know about this?</p> <p>How did you hear about the maternal exemption policy?</p> <p>How does the exemption policy work?</p>	<p>What serviced under the NHIS are offered to pregnant women?</p> <p>Are you aware of the maternal exemption policy?</p> <p>- Family, market, radio, other?</p> <p>- What do you have to do to get free care? Proof?</p> <p>Where do you get proof?</p>
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	How long are you covered for free services under the policy?	<ul style="list-style-type: none"> - Challenges in proving your pregnant? - Weeks? Months? Mother and children?
<p><i>I just want to check to make sure I have this correct. In 2003/2004 the government provided free delivery at the health facilities. In 2008 they changed that so that all pregnant women get free NHIS coverage (the “maternal exemption”). Is that right?</i></p>		
	Did you know about the policy before you had children?	<p>If yes, did it affect your utilization of the service?</p> <p>If not, would it have affected your use of the service?</p>
	<p>What is your opinion of the maternal exemption policy?</p> <p>Why do you think women don't use free care?</p>	<ul style="list-style-type: none"> - Advantages/ benefits of the policy? - Disadvantages? - Benefit some more than others? - Do you trust the policy? - Feel comfortable using it? - Main reasons? Distance, work, children, cost?
	What do you think could fix this?	<ul style="list-style-type: none"> - Easier access?

		<ul style="list-style-type: none"> - Transportation? - Reimbursements?
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<p>2. Prior Enrollment in NHIS and use of Maternal Services</p>	<p>Have you given birth in the last ten years?</p> <p>If yes, did you use the exemption policy? (free services)</p> <p>Did you give birth in a health facility?</p>	<ul style="list-style-type: none"> - Free delivery? OR free NHIS coverage?
	<p>Are you enrolled in NHIS (full time)?</p> <p>Did you know about the policy prior to enrolling?</p> <p>Where you given information about the maternal exemption policy? How?</p>	<ul style="list-style-type: none"> - What are the benefits of NHIS? - What elements of the policy would discourage you from joining/maintaining membership? <p>- Why? How would this affect your use? (prior knowledge, knowledge of health facilities, difference in perceptions)</p>
	<p>If you were enrolled in NHIS prior to giving birth would you be more likely to use the maternal health care?</p>	

3. Experiences with Health Facilities and Utilization of Maternal Health Care	How often do you go to the clinic or hospital?	When was the last time? - Why?
	Tell me about your treatment the last time you went to the health facility?	Experiences positive or negative? Reasons why? Will you continue to use or not?
	<p>What do you /women do to try to prevent complications (problems) when you deliver your baby</p> <p>When women deliver their babies which place is considered the best? (Public, private at home?) Why?</p> <p>When women deliver their babies which care provider is considered the best (Dr, Nurse, TBA/midwives) ? Why?</p>	

4. Reasons for Utilization and Barriers to Access	<p>Would you go to a health facility numerous times prior to birth if care was free?</p> <p>When you were pregnant did you make use of the free maternal care?</p>	<p>- Reasons?</p> <p>- Time, cost, travel, children, family,</p>
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	What are the challenges you face when accessing a health facility?	perceptions/stigma, more important obligations?
	Would you prefer using a traditional birth attendant than going to a health facility? What are your motivations to seek maternal health care?	-Why? Easier, perceptions, treatment, religion, culture, hidden costs? - Health, medical attention, safer?
	Who in the household makes decisions about when to seek maternal health care? Who in a household pays for health care/ maternal health care? (costs associated with health care) Do women have to seek permission to access maternal health care? Are these things related?	- Men/husband, female/wife, joint, extended family? - From who? Why?

5. Social, Economic, Cultural, Geographic Barriers to Access (Payment for Health Care and/or NHIS)	Do you feel comfortable in a health facility? How do you feel the staff/nurses treat the patients? How does money influence your decision to seek care in a health facility?	Fair treatment, Stigma, poor treatment from nurses? How does it affect? Too expensive? Do you/ some people take out debts to access
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	<p>How does the cost of delivery affect use of health facilities?</p> <p>Does your religion affect your health care utilization?</p>	<p>health facilities for delivery?</p> <p>How has this impacted these people?</p> <p>Time spent at work, health, family structure, stress?</p> <p>Hinder? Allow/prohibit utilization?</p>
	<p>Women have lots of responsibilities in daily life including at the home, on the farm, going to market, at work etc. Does all this work make it hard for women to deliver in a health facility?</p> <p>Certain times of the year when women are more likely to use a health facility? (seasonality of work) or when it's harder to get to the clinic?</p>	<p>Can't take time off? Too much work? Can't afford the loss of productive time?</p> <p>Rainy season/dry season?</p>
	<p>How do you access a health facility?</p> <p>Does accessing a health facility take too</p>	<p>Walk, transportation?</p> <p>Distance, walk,</p>

	<p>much time? Why?</p> <p>If facilities were closer are you more likely to use them? Why?</p>	<p>children?</p> <p>Easier access?</p> <p>Proximity?</p> <p>Treatment?</p>
	<p>Before the exemption policy, what did you do when you were pregnant?</p>	<p>Where did you deliver?</p> <p>Who delivered your child?</p> <p>How did you pay for maternal health/ delivery? (personal, family, friends, loan)</p>
	<p>How have things changed in your village since the policy came into existence?</p> <p>Do you think women feel more comfortable? How/Why?</p> <p>Does having free care change the way women decide to deliver? How?</p>	<p>Better health, positive environment, nothing changed?</p> <p>More likely to deliver in a facility? Still prefer home or traditional birth attendants?</p> <p>Does it change the way maternal health is bargained for in the household?</p>

<p>5. OTHER CONCERNS</p>	<p>Do you have any other types of concerns related to the maternal exemption policy or NHIS in general? How would you rank these concerns? Have you always felt this way?</p>	
	<p>How do you manage/deal with these concerns? How could these concerns be minimized?</p> <p>What direction do you want to see the government, health professionals and community take to improve the maternal exemption policy?</p>	<p>Coping strategies: talk to neighbours, do nothing</p> <p>Better services? Easier access? Improved treatment in health facilities?</p>
<p>6. CONCLUSIONS</p>	<p>Is there anything more you would like to add?</p>	

Key Informant In-depth Interview Checklist

A) Key Informant Interview with Government/NHIS officials

Perception of NHIS and Maternal Exemption Policy

- Overall, what is your impression about the NHIS?
- In particular, what is your perception of the maternal exemption policy?
 - (Probe: effective? Not effective? Why?)
- What strategies have you/the government/officials used to get information out about the free maternal health care?
- How effective have these been?
- What obstacles have you/others faced getting information out about the maternal exemption policy?
- How has the maternal exemption policy been received in your area?

- How beneficial/unbeneficial do you think the policy is for the people in your area?
- What obstacles have you/others faced in proving women are pregnant?
 - (Probe: How do women have to prove their pregnancy? Is this harder for some?)
- How does this effect/influence women's ability to use the maternal exemption policy?
- What do you think are the largest obstacles for women to successfully use the exemption policy?
- Do you think certain people are more likely to take advantage of the policy than others?
 - (Probe: poor/rich, educated/uneducated, distance)
- If yes:
 - Why is this so?
 - What strategies have you/others adopted to attend to this?

Economic Factors

- To what degree do you think finances/payment determines women's utilization of the maternal exemption policy?
- Do you think that this has created inequities in who is using maternal services?
- What changes have occurred in your area after the implementation of free maternal health care?
- What changes have you noticed regarding how often/for what reasons most women seek health care?
- How would you describe the quality of medical care in the area? Maternal health care?
- Has this changed with the implementation of the maternal exemption policy?
- To your knowledge, are women satisfied with the maternal exemption policy?
- How do you think the policy has impacted family relations? With others in the village? TBA's?
- How do you think women differ in their desire for free maternal health care?
- Do you think some women prefer to use a Traditional Birth Attendant/Midwife than going to a health facility?
- If yes:
 - Why is this so?
 - Specific women? Locations? (Probe: Farm women? Rural vs. Urban; Religion? Income?)
- How has the NHIS changed relationships between men and women?
- What obstacles do you expect for reaching women who are currently still not using the maternal exemption policy?
- What obstacles do you see for the future of the maternal exemption policy?

B) Key Informant Interview with Health Care Providers

Perception of NHIS and Maternal Exemption Policy

- Overall, what is your impression about the NHIS?

- In particular, what is your perception of the maternal exemption policy?
- What strategies have you/health providers used to get information out about the free maternal health care?
- How effective have these been?
- What obstacles have you/others faced getting information out about the maternal exemption policy?
- How has the maternal exemption policy been received in your area?
- How beneficial/unbeneficial do you think the policy is for the people in your area?
- Do you feel adequately equipped to manage prenatal, antenatal, postnatal care?
 - Why or why not?
- What are the challenges you face providing maternal health care?
- What do you think government officials can do to help this problem?
- What do you think are the largest obstacles for women to successfully use the exemption policy?
- Do you think certain people are more likely to take advantage of the policy than others?
 - (Probe: poor/rich, educated/uneducated, distance)
 - Why or why not?

C) Key Informant Interview with Traditional Birth Attendants

Perception of NHIS and Maternal Exemption Policy

- Overall, what is your impression about the NHIS?
- In particular, what is your perception of the maternal exemption policy?
- Do you feel women feel more comfortable going to a Traditional Birth Attendant than a health facility for maternal health care?
 - Why or why not? Explain
- What do you think are the benefits of using a Traditional Birth Attendant?
- Do you feel confident in your medical knowledge?
- What services do you provide pregnant women that a health facility does not?
- Do you know about the maternal exemption policy?
 - If yes: How do you feel about the services it provides?

Appendix C: Research Ethics Approval



Research Ethics

Use of Human Participants - Ethics Approval Notice

Principal Investigator: Dr. Isaac Luginaah
File Number: 103499
Review Level: Full Board
Approved Local Adult Participants: 0
Approved Local Minor Participants: 0
Protocol Title: Women's navigation of reproductive care in the context of Ghana's National Health
Department & Institution: Social Science\Geography, Western University
Sponsor:
Ethics Approval Date: April 11, 2013 **Expiry Date:** May 31, 2014

Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Instruments		
Western University Protocol		2013/02/02
Board Recommendations	Response to REB recommendations	2013/04/04
Letter of Information & Consent	Letter of Information - Interviews	2013/04/04
Letter of Information & Consent	Letter of Information - Focus Groups	2013/04/04
Other	RA Confidentiality Agreement	2013/04/04

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above named research study on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussions related to, nor vote on, such studies when they are presented to the NMREB.

NMREB is registered with the U.S. Department of Health & Human Services

Ethics Officer to Contact for Further Information

Grace Kelly
 (grace.kelly@uwo.ca)

Janice Sutherland
 (jsutherl@uwo.ca)

This is an official document. Please retain the original in your files.

Appendix D: Curriculum Vitae

Curriculum Vitae

Name:	Andrea Rishworth
Post-secondary Education and Degrees:	Western University Department of Geography London, Ontario, Canada 2012-2014 M.A.
	Western University London, Ontario, Canada 2008-2012 B.A.
Honours and Awards:	E.G. Pleva Teaching Award, 2013 University of Western Ontario Excellence in Teaching Assistantship in Geography
	Global Opportunities Award, 2013 University of Western Ontario Commitment to International Learning Opportunities
	Certificate of Merit for Academic Excellence, 2013
Related Work Experience	Teaching Assistant, Geography of Health and Health Care Winter 2014 University of Western Ontario, Department of Geography
	Teaching Assistant, Health Geography Fall 2013 University of Western Ontario, Department of Geography
	Teaching Assistant, Geography of Health and Health Care Winter 2013 University of Western Ontario, Department of Geography
	Teaching Assistant, Geography of Canada Fall 2012 University of Western Ontario, Department of Geography

Publications

Rishworth, A., Dixon, J., Luginaah, I. Tampah, C. "I was on the way to the hospital but delivered in the bush": Maternal Health in Ghana's Upper West Region in the Context of a Traditional Birth Attendants' Ban. (Under Review) *Social Science & Medicine*.

Conference Presentations

Qualitatives, Brescia, Western University, Ontario **June, 2014**
 “Do exemption programs remove barriers to health care? Underutilization of Ghana’s Maternal Exemption Policy in the Upper West Region”

Session Chair, Qualitatives, Brescia, Western University, Ontario **June, 2014**
 Session: “Managing Health and Illness”

CAG Annual Meeting, Brock University, Ontario **May, 2014**
 “Free Maternal Health Insurance in Ghana’s Upper West Region: Is it Really Free? Exploring determinants related to underutilization”

AAG Annual Meeting, Tampa, Florida **April, 2014**
 "I was on the way to the hospital but delivered on the way... I couldn't get to the hospital": Challenging policy modifications and the necessity of retraining TBA in Ghana's UWR rural remote areas

AAG Annual Meeting, Tampa, Florida **April, 2014**
 “Maternal exemption policy within the National Health Insurance Scheme in Ghana’s Upper West Region: Exploring the hidden determinants of lack of utilization”

AAG Annual Meeting, Los Angeles, California **April 2013**
 “Does Wealth Influence Enrolment Status? A Study of the National Health Insurance Scheme in Ghana's Upper West Region”

CAGONT Annual Meeting, Toronto, Ontario **October 2012**
 “Do Maternal Exemption Programs within Ghana’s NHIS Remove Barriers to Health Care for Rural Poor?”

Invited Lectures

Guest Lecture, Africa South of the Sahara **Fall 2013**
 Western University, Department of Geography
 “Women's Navigation of Ghana’s Maternal Exemption Policy”