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Gender Relations and Maternal Health Services:
On Prenatal Care Utilization in Rural Northern Ghana

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List of Acronyms

CHPS	Community-based Health and Planning Services
DHS	Demographic and Health Survey
FCI	Family Care International
GDHS	Ghana Demographic Health Survey
GHS	Ghana Health Service
GMHS	Ghana Maternal Health Survey
GP	General Practitioner
GSS	Ghana Statistical Service
IBRD	International Bank for Reconstruction & Development
IMF	International Monetary Fund
MCH	Maternal and Child Health Care
MDG	Millennium Development Goal
MMR	Maternal Mortality Rates
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
OECD	Organisation for Economic Cooperation & Development
PNC	Prenatal Care
SMI	Safe Motherhood Initiative
SMP	Safe Motherhood Programme
UN	United Nations
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation

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Abstract

Gender issues have come into the international limelight and have been debated on their adverse effects on maternal health care utilization. As long as artificial social cultural barriers prevent the full and equitable involvement of both sexes in creating and enjoying the benefits that society offers, individuals will not be able to realise their potential for health and well-being.

This study attempts to unravel how women in rural northern Ghana straddle the gap between patriarchy and health necessity; and how that has ripple impacts on the health of women. Data from the GDHS 2008 are examined in this research and highlight the constraints of education, religion and place of residence on the use of prenatal care.

The measures taken to curtail these adverse consequences on women's access and use of prenatal care services are discussed.

Relevance to Development Studies

Women need attention before, during and after pregnancy. This is to enable the early detection of any potentially life threatening complications that may ensue during the course of pregnancy. However, more often than not, target-driven health policies often fail to take into account the perspectives of women's experiences and their perception of their health needs. While it is true to say that significant progress has been made in Ghana to reduce maternal mortality over the years, more still needs to be done if Ghana is to meet the targets set for reducing by two thirds its maternal mortality rate by the year 2015 under the Millennium Development Goals (4&5). Therefore, politically, it is urgent to assess the determinants of access and utilization from a bottom-up approach and not the reverse.

Keywords

Gender relations, rural women, patriarchy, gate keeping, prenatal care, access, and utilization, household

Chapter 1
Introduction

During the appraisal of the implementation of the Cairo Programme of Action, the need to reduce maternal mortality was re-emphasized urging countries to see it as a high priority (AbouZahr and Wardlaw 2001:561). The reduction in maternal mortality was adopted as an International Development Goal by the United Nations (UN), The Organization for Economic Cooperation and Development (OECD), The International Monetary Fund (IMF) and The World Bank (WB)[1]. In furtherance to this declaration, 149 heads of state agreed to strengthen information systems on regular monitoring of Maternal Mortality (MM) at the millennium summit in 2000[2].

Globally, there are many factors accounting for maternal deaths before, during and after pregnancy. These range from the need to provide emergency obstetric and neonatal care systems, skilled attendance at delivery and eliminating socio cultural barriers to care and improved financial access to care (Issah et al. 2011:208-209). These factors apply validly to both developing and developed countries. According to existing data from the World Health Organization (WHO) and the United Nations Children's Emergency Fund (UNICEF) about eight million neonates die during delivery or a few weeks after they are born. Similarly, for women, annual deaths stand at almost 600,000 (i.e. 585,000) during pregnancy and childbirth (WHO 1999; UNICEF 2003 as cited in Appiah-Kubi 2004:388). The enormity of the problem is the fact that perinatal conditions account for about 2.4 million deaths annually in developing countries (Appiah-Kubi 2004:388).

By comparison, in sub- Sahara Africa, it is estimated that one in every 13 women dies of pregnancy related causes as compared to one in 4,085 women in developed countries(Ransom and Yinger 2002 as cited in Appiah-Kubi 2004:389).

Apparently, this picture is not far from what pertains in Ghana. Consequently, there have been national and regional surveys to determine the situation of mothers and children in the country. In 2007, the Ghana Maternal Health Survey (GMHS) reported that the Maternal Mortality Ratio (MMR) was 451 per 100,000 live births (Issah et al. 2011:208-209).

These deaths could be avoided in developing countries if utilization of these services were not hampered by either of the factors listed above namely

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[1] This was the realization that there was a case for sustained international and local efforts to increase development assistance and bridge the gap between rich and poor countries. This was at the conference entitled *'shaping the 21st Century: the contribution of development cooperation. Paris.*

[2] This was resolutions adopted by the General Assembly at UN. *The Millennium Declarations; Resolution A/RES/55/2*. New York, United Nations, 2000

structural barriers and their lack of timely accessibility. Issues like these need to be identified if success rate of reduction of pregnancy related deaths is to be achieved. A solution to reducing maternal deaths thus is to pay attention to expectant women when they need to seek prompt medical care. Belabouring on these could also give a false impression that nothing is known about this phenomenon.

1.1 Background

While the world has reduced gender gaps in health, it is not the same condition for women in low –income countries (WB and IBRD 2011:73). Although arguably one can say things have changed for the better for women since the inception at the international policy level, a watershed for the realization and achievement of women's health and rights[3] progress has been slow. Translating this policy into practice has not reflected in the domain of gender equality and thus remains a 'chasm between theory and practice' (*ibid*: 76).

Women in Ghana still remain disadvantaged in the control of assets and decision making both at the household and community level. This is compounded by other means of social exclusion such as patriarchy and belief systems. Whilst it is safe to say there have been improvements in some aspects of policy in gender equality in access to health care, effective implementation remains bound by deep structural constraints that do not go away with economic growth and development. Gender disparities thus keeps widening despite the large gains in women's civil and economic rights in the past century (WB and IBRD 2011:73). Rural women in northern Ghana face a significant access (structural) disadvantage, a disadvantage that is the opposite observed elsewhere in the Southern part of the country. As in health, household wealth; education; religion and ethnicity as well as geography are important for understanding and addressing gender inequality in health care. Other factors may also have a predisposition to disadvantage women in ways that affect their health outcomes (*ibid*).

Whilst in several literature, access factors have been seen to be the distance between the individual's home and the location of the health facility, or the health service costs in relation to ability to pay for the cost (see Asenso-Okyere et al.1998 and McIntyre 2007), others have alluded to the individual, household and socio-cultural factors as imperative catalyst influencing access (see Elo 1992; Goldman and Pebley 1994; Magadi et al. 2000; Ngom et al. 2003). This paper prefers to use the term 'access' to denote the gender disparities or unbalanced power relationship between women and men at the

[3] The ICPD in 1994 identified MM as a 'core component of women's sexual and reproductive health' while the Millennium Summit in 2000 situated MM within the 'broader context of poverty reduction efforts and overall development efforts'

household level (micro) and how that influences prenatal health utilization (macro) in particular. The term is preferred for two main reasons: one is to capture the ambiguous and often confusing usage of access by medical researchers, and secondly, an attempt to bring out evidence of the experiences of rural women in northern Ghana which is complex and not always understood by medical researchers and policy interventionists. It also serves to better the understanding of the link between unequal gender relations and prenatal care use in the study setting.

1.2 Outlining the Research Problem

It is true to say that whilst the last twenty years have seen an improvement in health care access and utilization of sexual and reproductive health services, the same is not the case with developing countries as progress has been slow in spite of huge investment (Malarcher 2010:1). Advancing gender equality, equity and empowering women among other concerns are the cornerstones of the programme of Action (principle 4) adopted at the International Conference on Population and Development (ICPD) in 1994.

As health is a cornerstone to development for many developing and developed countries, maternal health care among rural women has been identified as a social problem since in most cases, it leads to maternal mortality. It is estimated that around 600,000 women die yearly resulting from reproductive health problems such as pregnancy complications and child birth (ICPD 1994; Doyal 2002: 5).

In addition to maternal deaths, globally, it is reported that annually over fifteen million women experience severe pregnancy complications which results in life impairments or terminal illness (Panos 2001: 3).

In sub-Saharan Africa, women stand a stronger risk of dying as mothers than in other parts of the developing world such as in Peru (*ibid*). Estimated mortality rates sub of the Sahara is said to be 1000 per 100,000 live births (Gyimah et al. 2006: 2931) which is atypical of all maternal deaths globally.

In Ghana, most of the causes of maternal deaths are due to factors that are preventable but is accounting for increase in the MMR in the country as stated above.

Given the existing trend in maternal and child morbidity in sub-Saharan Africa, it is imperative that the underlying causes for this should be unravelled. It is for this reason, that the key public health worry presently in Ghana is Maternal and Child Health care (MCH). In line with this worry is the prime concern of public health programmes in the country about the disproportion in access and utilization of reproductive health services such as antenatal and post natal services between women in the urban and the rural areas of the country. Subsequently, many governments in Africa like Ghana have instituted different policies and programmes aimed at improving MCH outcomes. The reproductive health service and policy standards for instance, was set up in 1996 and revised in June 2003 to make reproductive health affordable and

accessible to the majority of the target population. Pursuant to this, the Ghana Health Service (GHS) under the Ministry of Health (MoH) introduced a free maternal health care programme across the country. It also introduced a new category of health care providers (Community health nurses) within the health care delivery system to reach out to rural communities as well. Despite this policy, which offers door step access to health services, it is agreed that very few women do have access to reproductive health services (see Ngom et al.1997; Adongo et al. 1998; Bawah et al. 1999 and Gyimah 2002, 2006).

The government through its health policies[4] attempts to achieve the targets set for halving by three quarters MMR by 2015. Maternal health services such as antenatal, delivery and post-natal care are available in all the ten regions and almost in all the 166 districts of Ghana encouraging women to obtain adequate health care during and after pregnancy. Adequate access alone to health services is not sufficient to address the problem of the seemingly high rates of maternal mortality in the study area. Most probably, other factors on the demand side do play a role. One of such factors is the system of gate keeping, a process of decision making in the household or compound dwelling unit that is upheld by patriarchs- husbands, community elders and older women.

In the African framework which is not different from what pertains in the Ghanaian situation, increasing attention has been drawn to patriarchy as a factor that may enable or constraint the use of reproductive health services for women for example. Followers of this social structural perspective (for a review see Kishor 2000 and Ngom et al. 2003) point to the overriding influence of male dominance and cultural processes on the entire reproductive health seeking behaviour of women. The savannah belt of Ghana of which the study is located prescribes to patriarchy and privileges assigned to adult males to the disadvantage of women and children.

In this regard, the researcher argues that, unequal gender relations in rural settings of the study area represent a social structural element that may influence patterns of PNC utilization. A body of literature, for example on epidemiological studies tend to reveal that mothers who attend or receive prenatal services reduce their maternal and neonatal deaths significantly (see Debpuur et al. 1999, Beegle et al. 2001). In Ghana, the MoH through the requirements of the WHO obliges all pregnant women to make a total of four prenatal visits, with visits at least once in each trimester of pregnancy (GSS et al.2009: 44). Considering that the timing and content of prenatal care is important, it is agreed that more women in the urban areas will be able to make up for all the four prenatal visits than the rural woman. Presumably then, Kirby (1997) in his study of infant mortality in northern Ghana contends that the problem with under utilization of health services has nothing to do with the distance of travel to neither a health facility nor that of their perceived

[4] These were the setting up of two 5-Year Programme of Work (5-YPW): 1992-1997 and 2007-2011 which were aimed at contributing to the reduction of maternal and child mortality but these did not meet their set targets.

inefficiency. Instead, his finding leads him to belief it has to do with the "culture of illness management" (Kirby 1997:1).

Following Kirby's ideas about illness management and Bawah et al's (1999) thoughts about gender tensions that arise in spousal relationships in an attempt to use contraceptives by rural women in the rural north of Ghana; this research examines gender relations within the household in analysing maternal health implications focusing especially on use of prenatal care services.

Existing literature that examines the challenges of women to utilize health care services in Ghana especially that of maternal or reproductive health services, tend to focus on four broad areas: religion (Fosu 1994; Takyi 2003; Gyimah et al. 2006), costs of health care (see Asenso-Okyere et al. 2000), spiritual/cultural beliefs (Kirby 1997, Adongo et al. 1997), and gender relations (Bawah et al.1999; Addai 2000; Ngom et al. 2003). Moreover, there is extant literature that is replete with studies that show that gender relations shape and influence attitudes towards reproduction, contraceptive usage (fertility control), and utilization of health services among others. Thus far, these findings are important but have not provided much information on the reasons for low utilization of prenatal services in the study area. The study purports to compensate for the lack of information in this perspective and to add to the additional literature on maternal health utilization.

Understanding the linkage between gender power relations in the household and utilization of prenatal care in the study area is important given the overriding influence of patriarchy in the social fabric of Africans in general and Ghanaians in particular. These factors have to be identified and understood by policy makers and programme managers if health for all including the rural woman is to be realized.

This research will therefore look into the set of factors at the household level and establish how gender relations within the household level inhibits or enables women to use maternal health services (prenatal care services).

1.3 Relevance and Justification

> "Humanity is male and man defines women not in herself but as relative to him; she is not regarded as an autonomous being" (Simone de Beauvoir 1949 as quoted in Wang 2010:21).

Issues of gender and health care have come under the eagle eyes of international bodies in recent decades. This is because most international organizations try to enhance the well being of humans through an equity approach which they justify can only bring about the realization of development to a country for both men and women (Doyal 2005:3-4). The equity approach requires that both men and women have the 'same opportunity' as citizens; 'participate equally' and above all, have 'equal access to its benefits' (*ibid*).

It is this gender equity approach to women's health care that is the premise for this study. It must be borne in mind that not all women encounter the same challenges when accessing and utilizing prenatal health care. Similarly, the discussion of the status of women relative to that of men is considered a

sensitive issue especially in cross-cultural studies (Wang 2010:29). This therefore, calls for the identification of sub groups of women who in one way or the other are not able to use such services. This is important for health planning purposes.

The complex realities of rural women to access prenatal care cuts across patriarchal tradition and decision making at the household level making it necessary to analyse the power dynamics and gender relations that determine their access to these services. This research thus purports to unveil some of these issues.

Given that in many Ghanaian cultures it is the head of the household who is the breadwinner and makes most of the decisions with or without consultation with the sexual partner as the case may be, may provide the environment for propagation and influence of decision making on prenatal care uptake and reproductive health services in general.

The trajectory of the problem highlighted above paradoxically, is underlined by the fact that Ghana's health policies have focused on increasing access to and use of MCH services targeting women especially.

Thus, increasing access to health care services alone as evidenced under Ghana's health policy is not sufficient for addressing the problem of utilization of prenatal services as Donabedian 1972 (cited by Appiah-Kubi 2006:389) contends that 'availability of health facilities…must be measured by the level of use in relation to need'. Utilization is therefore, a function of access that justifies its level of achievement. It thus follows that access is the ingredient for utilization. Since maternal health is dependent on a working health system, it calls on the government to see Safe Motherhood Initiatives (SMI) as a barometer for measuring the overall health system in the country as well as aiming to reduce the burden of maternal morbidity and mortality. A time series chronology of incidents on maternal health and rights is attached in the appendices section (Annex I).

Although a plethora of literature exists on gender and maternal health, very few have provided information on gender relation and the experiences of women to use prenatal care services in Northern Ghana. Where studies have been done on maternal health and gender, the focus has been on contraceptive and fertility control; religion among others aimed at providing insight for the development of intervention packages. Since the passage of the free maternal health care policy in Ghana in 2008, there has been growing efforts to ensure that there is maternal health coverage especially those relating to pre and post natal care. This research seeks to complement and contribute towards the existing body of literature on health seeking behaviour by engaging with the latest GDHS data whilst at the same attempting to influence policy on improving coverage in the provisioning of PNC services.

The preference for this topic revolves around two impetuses. My personal interest in the area of maternal and reproductive health care draws heavily from past working experiences in the health care front in deprived rural communities where ingrained traditions, customs, taboos (beliefs) and poverty pose a challenge to medical research interventions. Secondly, it is instigated by the fact that, very little studies have focused their research on prenatal care use

an aspect of maternal health in the three northern regions of Ghana. This research is therefore an attempt to unveil experiences of rural women and understand the factors or challenges that surrounds their health seeking behaviour.

1.4 Research Objectives and Questions

This research aims to make a contribution to the existing literature on gender relations and MCH utilization, precisely on the effects of gendered social relations at the household and community level on PNC use. It does this by positioning certain social agents within the household and community as gate keepers of the health care system. This research also aims to inform policy and practice about strategies to adopt in their design of health intervention programmes in the midst of the challenges that women face in using PNC services.

In order to achieve this, a main research question was posed alongside three other sub questions:

1.5 Main Research Question

How do gender relations at the household and community level play a role in determining prenatal care utilization amongst rural married women?

Sub- Questions

1. How do rural women's experiences at the household interact to affect the process of seeking prenatal care services?
2. How do rural women make their own health seeking decisions without asking permission from the gate keepers?
3. What has been the effect of this on the health needs of rural women?

1.6 Methodology

This study was situated within a social structural perspective which looked at gender relations within the household organisation so as to analyse rural women's patterns of use of PNC.

Data Sources

The data for this study came from the GDHS 2008 [GDHS08]. The data source is the fifth and latest version of series of nationwide household surveys conducted by the Ghana Statistical Service (GSS) and the GHS through the support of the MEASUREDHS programme and other donors as part of the global demographic surveys. This was undertaken between September and November 2008. All interviews were conducted by trained and monitored staff using detailed questionnaire (GDHS 2008). From this data source, it is possible to get information on all the relevant aspects of maternal care before,

during and after delivery for a nationally representative sample of women aged between 15-49 years. In addition, socio-demographic attributes (age, education, place of residence etc) of women was obtained. The survey employed a two-stage sample based on the 2000 Population and Housing Census (GDHS 2008). Analyzing the GDHS08 data thus provided an opportunity to understand MCH coverage and utilization from an objective view point.

Secondary data was also helpful in throwing more detailed information into different theoretical perspectives on gender and maternal health care utilization. The following data sources were consulted: peer reviewed journals ;(*Reproductive health, The Lancet, Women in Culture and Society, Social Science and Medicine, Policy and Politics, Anthropology, Family Planning and Population*); Books; and other online resources that proofed useful for the study such as International Organizations (e.g. *United Nations Population Fund* (UNFPA), *United Nations Development Programme* (UNDP), *World Health Organization* (WHO) and Panos Institute).

Statistical Methods

Descriptive analysis was carried out taking into consideration the sampling frame. The difference in utilization was examined across regions. Since data from the GDHS08 was collected from all the ten regions (selected households) in Ghana, the researcher had to recode this into two ecological zones namely the Northern (study area) and the Southern (non study area) for ease of analyses before any comparisons could be drawn. To categorise these into two, a recode command (variable 0) was assigned to the three (Upper East, Upper West and Northern regions) out of the ten regions to be known as "Northern Ghana" and a recode command (variable 1) for the remaining regions (Greater Accra, Ashanti, Western, Central, Eastern, Volta and Brong-Ahafo). Furthermore, religion was categorized into three affiliations namely Christians, Muslims and Traditionalist/spiritualist although the standard GDHS08 recode file data categorizes it into nine different religions. Data was analyzed using STATA software package version 11.2 (StataCorp 2009) for all calculations using 'survey commands' based on a bivariate analysis between two variables. Simple descriptive statistics were then made in the form of percentages and tables where relevant.

1.7 The Study Setting

The Northern region, Upper East and Upper West regions together constitute what is popularly known as "Northern Ghana". These were selected for the study for the following reasons: In the first place, the three regions have generally the same socio-demographic characteristics. The main source of livelihood is subsistence agriculture which includes crop and animal production on a small scale. Additionally, these regions are deprived in terms of education, health care facilities and other infrastructure such as good road network, sanitation and the like in comparison to the southern halve of the country.

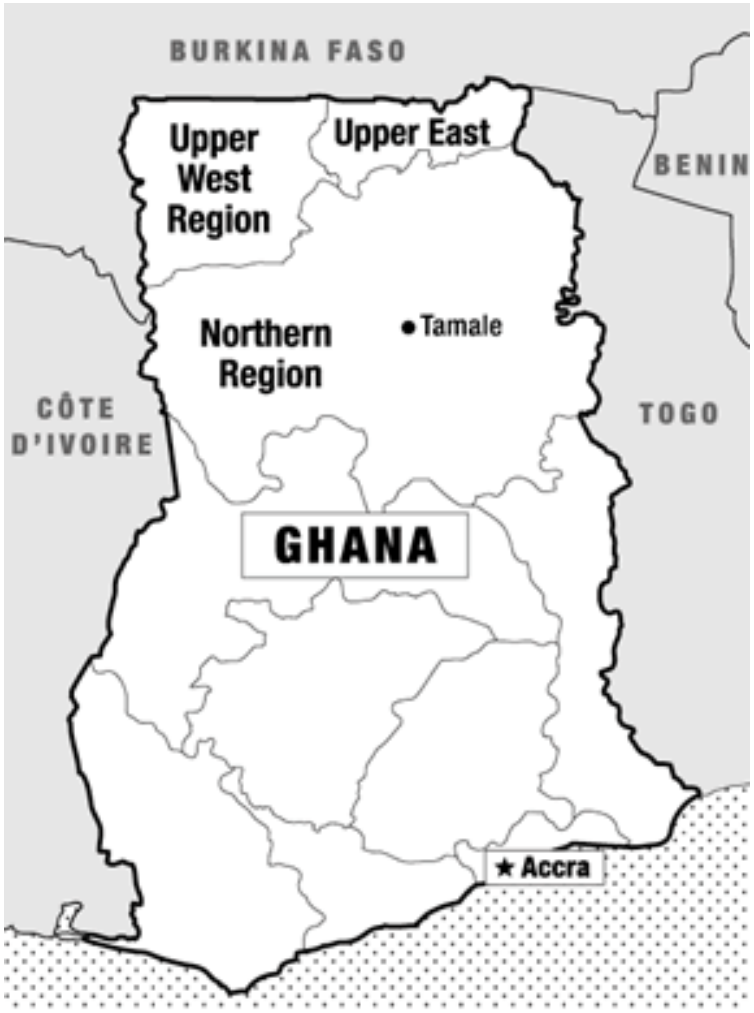
Northern Ghana is located in the Savannah Grassland belt. Features of this vegetative belt are characterized by low grasslands, dispersed trees and shrubs. Rainfall pattern is very unpredictable usually resulting in drought and famine. Incidence of poverty here are as high as almost ninety percent in comparison to just seven percent for instance for the Greater Accra region to the south of the country. Most of the communities in the study setting live in housing structures made out from mud-bricks. The annual population growth rate is estimated at 6.8 percent. Land is held by families and is continuously under cultivation. Furthermore, access to land by women is limited. The combined effects of this have resulted in inadequate food which causes malnutrition of pregnant women and children. Distinct gender roles are prescribed through social norms. The way of life here is prescribed by patriarchal traditions.

The belief system of the study area focuses majorly around ancestral or cult worship notwithstanding the recent introductions of the people to the Catholic, Pentecostal and Muslim faiths. Thus in this mixed belief system, followers of Christianity and Muslim faith have not abandoned aspects of ancestral worship especially in times of need of "higher order discourses" (Haverkort et al. 2003: 156).

In the below, the geographical location of the study setting under this research paper is illustrated by the map of Ghana.

Map 1.1

Map showing regions of Northern Ghana (Study area)



Source: UN Africa Renewal, 2008

1.8 Challenges

Being able to detect gender power relations in household decisions concerning PNC utilization from DHS data is problematic. This is because DHS data are collected in a hierarchical manner - use or non use. It will therefore proof difficult to ascertain the level of household decision-making process at which men or the social structure plays a vital role in determining over all PNC use. Additionally, it is equally difficult to proof whether or not gender affects all decision making processes relating to health care use.

To overcome this challenge, data from other secondary sources that have focused their research on gender relations and its impact on women's health seeking behaviours were used judiciously in this paper with reference to the

theoretical framework outlined in this research to understand the link between the intersectionality of gender relations and prenatal health utilization.

Furthermore, this research could not contain a large number of variables in the descriptive analysis. A number of predictors would allow for a logistic regression model to be employed in finding out utilization patterns, but that was not the case for this research study.

It could therefore, not employ multivariate analysis as other studies on health care utilization does to find out why certain individuals do not seek health care or otherwise because the household decision making process could be determined at different levels. In its place however, bivariate analysis using percentages and tables was adopted which is advantageous as it allows for the determination of the empirical relationship between two variables. It also helped in identifying an association or causality between the two variables.

Notwithstanding these drawbacks, DHS data is of a high quality that has widely been commended for providing accurate information based on analyses on maternal health utilization patterns.

1.9 Organization of the paper

This paper is divided into five main chapters. The first chapter discusses in a bird's eye view the research topic of gender relations and health care utilization among rural women. In the second chapter, conceiving the framework of the research is done through the critical lens of exploring the intersectionality or power dynamics among gender at the individual, household and community level.

In chapter three, the mitigating factors surrounding utilization of PNC services by women is unravelled which then provides a back bone for analyses in the next section. In chapter four a presentation and analysis of the GDHS findings on MCH use is reported. The concluding chapter brings together all the facets of the research study and the implication for policy intervention strategies on utilization of PNC service by rural women.

Chapter 2
Conceptualising the Research Problem and Framing the Data Collection and Analysis

This section seeks to provide pointers to conceptualize gender relations; extend understanding of how gender relations are created within and outside the household. In order to realize this, a conceptual framework was mapped out that served as a conduit through which analyses could be made. The following concepts deemed important to this research are also discussed later in this section of the paper: gender relations; household/compound; gate-keeping; agency and discourses surrounding women's utilization of health care. These facets of gender relations hence serve as a back bone for analyses subsequently in chapters three and four.

2.1 Conceptual framework

In rural communities of the study setting, it is usually the case that the influence of culture on decision making in terms of seeking treatment for health care is a common practice. In most instances, permission has to be sought by women to leave their own households. Furthermore, a decision by an individual (say females) to use a particular type of health care service may only be reached after what Warren (cited by Addai 2000:3-4) would term as an exhaustion of 'their own folk remedies and family resources'.

It is in this perspective that, the researcher constructs a conceptual framework drawing extensively from the quantitative approach of Kroeger's (1983) determinants model of health seeking behaviour. In this model, he categorized health care utilization into two ways namely the pathway and the determinants model. The pathway employs a qualitative method that involves direct observation to describe the different steps in decision making and illness behaviour while the determinants model which is the seminal concern of this research employs a quantitative approach to explain variables or determinants that are associated with the use of health care (Sauerborn and Pokhrel 2004:218). Furthermore, under the determinants model Kroeger argues that these can be put under three main themes namely 'predisposing factors' (age, sex, household composition and size, ethnic group affiliation and education); 'characteristics of illness' (expected benefits from treatment and beliefs about disease causation) and lastly 'characteristics of the health care system' (cost and service provider attributes). This he claims is mostly common practice in developing countries (Kroeger 1983 cited in Elo 1992:5).

The determinants model is chosen over the pathway model because the former allows the researcher to ascertain the effect of one explanatory variable (e.g. gender relations) on another (say maternal health utilization) 'holding all other factors constant' (Sauerborn 2004:219). In the light of this statement, the quantitative approach in which the determinants model of Kroeger (1983) is situated, to a large extent seems to reflect clearly in this study.

In this research study, the researcher creates a conceptual schema that hinges on the first of the themes outlined (that is the predisposing factors) by mapping out the process of decision making at the household level that determine PNC utilization which is helpful in analyzing it quantitatively. In most rural patriarchal societies such as the study area for example, decisions regarding maternal and child health care are household decisions. That is to mean that the decision to seek health is solely influenced by other members of the household (e.g. husbands, compound heads etc) and as detailed by Pillai et al. (2003) by their 'educational and occupational exposures' (Pillai et al. 2003 cited in Sauerborn and Pokhrel 2004: 219) and house hold income among others.

Sex, household composition, ethnic affiliation and beliefs about the causes of ill health according to Kroeger's framework can be identified as influencing decisions and in the context of this research, concerning the utilization of PNC services in particular. It is a fact that, sex or gender may be linked with some of the factors enumerated above. The sex of an individual, in this context, females, is likely to be related to access constraints of health care services and the ability to meet financial commitments of modern health services. Additionally, the sex of a woman from the study area for example, depends on her place of residence as well as her ethnic grouping or descent. In the context of the study area, ethnic groupings are informed by lineages and descent is patrilineal[5].

It is important to acknowledge the limitations of using this model in the sense that whilst it is easy to make predictions in this manner, the outcome might be biased because 'household decision making on health care is usually complex' and it is a 'process that involves several steps' (Sauerborn and Pokhrel 2004:219). Furthermore, it is important to note that in analyzing utilization of maternal health care, Ward et al. (1997) suggests that a triangulation of methods involving both qualitative and quantitative data is required 'to better understand health seeking behaviour' (Ward et al. 1997 cited in Sauerborn and Pokhrel 2004:219). However, due to resource constraints and available data, the researcher decided to settle on the quantitative over the qualitative model.

Despite these shortcomings of the model, it is still relevant for understanding how households go about making decisions to seek health care which will contribute to influencing Ghana's health care policy which largely suffers from low utilization notwithstanding the government's commitment on increasing access and availability of health facilities. In the decision making process, there may be other factors that might act to determine how maternal

[5] This involves the inheritance of property, titles or names through the male line. Men's autonomy is advanced in patriarchal societies of northern Ghana in contrast with southern Ghana cultures which is matriarchal whereby women exhibit a great deal of autonomy. As Mason (2005) notes in his study of women in Kumasi, Ghana that women's autonomy is limited at the domestic level and has little impact, when it comes to fertility regulation.

health care is used. Sauerborn and Pokhrel (2004) thus, put forth that the 'husband's education' and whether 'or not one or both parents live in the household' may be instrumental in determining whether a woman seeks regular visits during pregnancy (Sauerborn and Pokhrel 2004:221). It could also be determined by a 'mother's status within the household level' (Levin et al. 2003 cited in Sauerborn and Pokhrel 2004:221). All these delineated explanations on determinants of use maternal health care are relevant in the context of the study area.

2.2 Gender relations

Gender is an integral part of culture and social relations which is created through sexual differences as well as social and cultural constructs (Lamas 1996 cited in AVSC and IPPF/WHR 1998a:3). These socio-cultural constructs in turn shape the gendered system which includes 'norms, practices, social values and the meaning that society gives to the reproduction of the human species' (AVSC and IPPF/WHR 1998a: *ibid*). This is linked to how power relations between individuals are structurally shaped and expressed. This framework of social relations determines what Rubin (1996) and De Barbieri (1992) term as 'sexed persons' (cited in AVSC and IPPF/WHR 1998b: 6) which implies that (re)production and sexual relations are strictly governed. Gendered systems as mentioned by Lagarde (cited in AVSC and IPPF/WHR, 1998a:3) further 'define hierarchies, ways of relating, the privileges and sanctions accorded to different social gender and spaces in which individuals are organized according to their gender'.

Research studies in the field of gender relations (for a review see Binka et al. 1995; Adongo et al. 1997; Debpuur et al. 1999 and Bawah et al. 1999) in Ghana point to the fact that the gender system that exists in these societies are characterized by male dominance of women. This is the situation where the system is structured to give hegemonic authority to men in a gender-based composition (AVSC and IPPF/WHR 1998a:3). Gender based power relationship is ordained through patriarchy which considers women as inferior to men. It further delineates a relationship that is characterized by dominance and submissiveness between genders. This implies different opportunities for men and women both in the public and domestic arena.

Taking this further, relationships here are based on inequity and segmented between men and women in decision making, control over and distribution of resources. The private domain is home to the women whereas the men exercise their masculinity in the public arena.

Additionally, this gendered system defines and differentiates roles for men and women and sets boundaries for the construction of gender identities. At the household level, gender identities are translated into division of labour and characterize males as providers of food and controllers of resources including decisions to seek modern health care.

2.3 The household/compound

Typically, households in developing countries are composed of the elderly, adults and children; each having duties, responsibilities and obligations that are in one way or the other socio-culturally determined. From the socio-cultural perspective, obligations and rights of adults (fe/male) and children are cut out from the social norms that determine who gets what and what type of work needs to be done by who (Agarwal 1997:15).

In the past, the household was theorized as a unitary model (see Becker 1965, 1981). In this model, the family or household is assumed as a single unit in terms of production and consumption, thus resources are pooled together where a benevolent dictator [usually male head] distributes these resources to members of the household equally by maximizing utility. Recent growing interests on intra household dynamics however, do not support this assumption. Instead, a variety of household models tend to use the game-theory model to unpack the complexities of decision making at the household level that allows for "individual differences and preferences, and [in] control over resource use" (Agarwal 1997:2). The basis of this constitutes intra-household allocation and distribution of resources. It further conceptualizes the household as an arena of varied competing interest accounting for what Ellis (2000) refers to as "interdependency" between household members for social and economic existence (Ellis 2000:18).

The household is a natural setting where the gendered division of labour is manifested and sustained. Women and men do different tasks at home so that this sexual division of labour appears to conform to "natural laws" (WHO 2006:4) so that women do jobs that are suitable to their bodies and recognized by social roles. Equally, this characterizes a form of a "vertical" division of labour in many countries, since women in many households do work in the household that is both unpaid and at the same time assigned a low social status. This can be stressful as it is combined with the triple burden of family responsibilities of child bearing and caring; and as a mother. Increasingly, in rural northern Ghana, women are concentrated in the agriculture labour force as farm hands producing cash crops such as rice and vegetables. Their exposure to harmful agricultural chemicals such as pesticides is inevitable in most instances. The adverse effect of exposure to agricultural chemicals includes spontaneous abortions, premature births and malformed babies. As reported by WHO (2006), this exposure has the tendency to be 'invisible to health care personnel' in developing countries (WHO 2006:16). Subsequently, the differences between males and females in households and the manner of their upbringing and socialization in the community, may lead to differences in the way they manage illness, "perceive risks" (Gustafson 1998 as cited in WHO 2006:10) or even "seek treatment"(Alexanderson et al.1994, 1996 cited in *ibid*). Thus gender differences combined with sex differences (biological) interplay within the household and become embedded within the community to produce specific patterns of health seeking and utilization behaviour for both genders.

In patriarchal societies such as in parts of Africa (Ghana, Tanzania, Nigeria) and Asia (Pakistan, India, Bangladesh), it is common to find that in

some communities and households, there is little attention paid to daughters health and education. This is contrasted with the value attached to the education and health care of males or sons who are seen as the ones to build and maintain the family lineage. The household is therefore an important model for this study as it offers a channel for unequal power base relationship where men are typically heads of the family and household which then informs the practice of 'gate-keeping'. The rippling effect of this being access constraints by rural women to use PNC services.

2.4 Gate Keeping

Keeping the gates to the health care system is a social desirable role ascribed to certain individuals to restrict direct access to health care. For instance, in the United Kingdom and the Scandinavian countries, the General Practitioners (GP) has a gate keeping role in the health care system (Brekke et al. 2003:2). In this system, patients require a referral from their GPs to have access to a hospital or a specialist. Similarly, in many African traditional settings such as Northern Ghana, the hierarchical arrangement of the social structure gives a gate keeping role to compound heads, husbands, older women and extended family members (in-laws) who also in a way give 'referrals' to its members to access health care services. In this case, permission or approval is required from either of the above mentioned gate keepers.

Building on Ngom et al.'s (2003) definition of gate keeping in their study of women's health seeking in northern Ghana, this study also refers to it as individuals whose authorization is required before women [*within the compound arrangement*] can attend a modern health facility (Ngom et al.2003: 19, emphasis mine).

In the study area, settlement patterns are characterized by extended families living in dispersed compounds. A group of nuclear families due to the dispersed settlement pattern prefer to come together to form a compound settlement or unit. The hierarchical arrangement within this society and within the compound structure places men at the top and women at the bottom. Women have no autonomy when it comes to decision making that affects their reproductive health or that of their sick children. However, older women are given some authority when they uphold tradition by being the repository of knowledge on fertility and childbirth for younger women. The gate keeping mechanism is a function of the balance of power relations between husbands and their wives, younger wives versus extended family members (e.g. mother-in-laws)/older women and compound heads versus wives. This triad of power relations depicts the challenges that women have to encounter in attempting to use maternal health services.

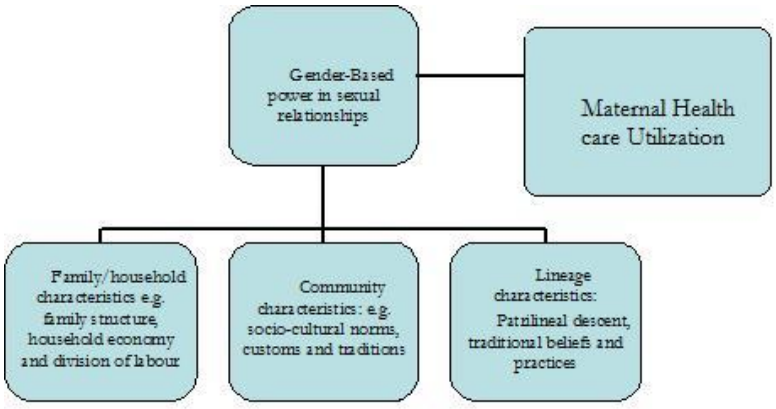
In general, there are two main reasons for the system of gate keeping in the health care system at the compound level of the study area. First, it is usually claimed that compound gate keepers guard the 'gates' between the spiritual and physical realm by serving as a mediator between the two worlds (Ngom et al.2003:20-21). As pointed out in a study article by Ngom et al. (2003), uncertainty and beliefs about causes of certain illnesses and their treatment legitimizes the role of the compound head and makes him the 'pillar

of the compound hierarchy' (Ngom et al.2003:21). This uncertainty coupled with traditional beliefs and customs surrounding pregnancy and maternal care could result in keeping pregnant women away from public health facilities by the 'gate-keepers'.

Secondly, it is argued that the gate keeping mechanism is performed for economic reasons (*ibid*). This has its basis from the material and consumer goods that have to be given out to the bride's family as a marriage seal. Consequently, in marriage the domestic and sexual rights of women are presided over by men. Economically, women's autonomy in the household or compound in terms of household spending income, money to attend a medical facility for themselves and their children or money to buy household accessories is seen as the husband's sole responsibility. In making a decision to attend a modern health service thus, husbands' and compound heads approval or permission must be sought; a situation that should not be disobeyed by women. Hence, the household or compound is conceptualized as an avenue of restricted gate keeping that constraint the timely quest and use of health services by women. It also underscores a situation where there is absolutely little or no room for women to manoeuvre their way out without having to ask for authorisation in the household hierarchy or what Agarwal would term as "bargaining" (Agarwal 1997:2).

In figure 2.1 below, the structural relationship at the household and community level is schematised to bring out its impact on MCH utilization.

Fig. 2.1 Structural determinants of MCH utilization



Source: Author's own elaboration based on Blanc, 2001

2.5 Women's Agency

Instrumentally, agency in women serves a positive outcome not only in terms of their health or wellbeing but also developmentally.

In Sen's framework (cited in Samman and Santos 2009:4), agency is a process of freedom and capabilities which defines every aspect of human

development in society. Agency thus according to Sen, is 'what a person is free to do in pursuit of whatever goals or values he or she regards as important'. Apart from this, agency can be seen as the capacity to realize one's own interest against the weight of custom, tradition, transcendental will or other obstacles whether as an individual or collectively (Mahood 2001:206).

Approaching women from the agency perspective thus, rural women in northern Ghana can be considered as social actors who can bring about change in their lives collectively or individually by either challenging or secretively changing the system that subjugates them (see Fuchs and Moch 1990; Carter 1995; Bawah et al.1999). In this section, I will examine agency from two perspectives namely the passive and active approaches. I will however dwell on the former in this section and in chapter 3 I discuss the other perspective (active) in an attempt to show how rural women actively attempt to exercise their agency against social norms.

The passive perspective of agency, culturally, relates people as 'mindless adherent to cultural rules' (Akinyoade 2010:44). In the context of this research study then, women are conceptualised as 'mindless adherents' to social norms in their society. Male dominance is certified in patriarchical societies as the case pertains in the study area. Consequently, marriage serves as a good conduit for the exercise of this supremacy of males over females. The major reason attributed to this being what I will term as the 'commoditisation' of women's reproductive capabilities through the institution of bride wealth[6]. This is paid out by the groom to the family of the would-be bride. In patrilineal communities of the study area, this payment is a seal of rights of children to the husband's family and not the would-be wife's family. Hence, in marriage Lloyd and Gage-Brandon (1993), assert that the perception usually held about women, is that of an asset for the 'corporate patrilineage' than as an individual with 'autonomous rights' (Lloyd and Gage as cited in Adongo et al.1997: 1791). In the household setting thus, power relationships are unbalanced favouring men in terms of access, distribution and ownership of assets as well as in health seeking decision making (*ibid*). These social constructs thus seemingly compares women to "mindless adherents" who must kowtow to the social mores of their society without any resistance or questioning. An exhibition of agency in marriage by a woman in making autonomous decisions without consultation with her husband is ridiculed as out of character for a good wife. However, women's agency is often met by physical violence from husbands or males.

2.6 Agency begets Resistance

Alsop et al. 2006 aver that it is the 'opportunity structure' in society that allows people, in the case of this research, women to translate their asset base into

[6] The institution of bride wealth stipulates that a prospective husband with the help of his family relatives must provide a sum of money or goods of high value to the bride's family as a form of compensation for their daughter.

effective agency. They argue further that this can only come about if there are 'more equitable rules and expanded opportunities' (Alsop et al. 2006 as cited in Santos and Samman 2009: 3-4).

A central question in this scholarship is how women can use their asset base to contribute advertently to resist or subvert tradition as a way of achieving their reproductive wellbeing. It is for this reason that Mason (1986) points out that even though women may be powerless in one area they may not necessarily be powerless in another perspective (Mason 1986 as cited in Wang 2010:60). Thus, Carter (1995) (cited in Akinyoade 2007:48) alludes to the studies in North India that reveals how women use their agency to successfully resist their husbands and in-laws [mother-in-laws] who stand in their way in matters relating to contraception and reproduction issues for that matter.

Similarly, in Ghana Bawah et al. (1999) report that women who are given self autonomy to practice contraceptive usage under the community-based family planning programme upsets the prevailing power relationship between men and women (Bawah et al. 1999:55) and shakes up the status qou of the social 'expectations of women's reproductive obligations' (Adongo et al. 1997: *ibid*).

Women's agency thus causes a stir of resistance by men which relates to the concern that some women may seek sexual satisfaction outside the marriage or by granting autonomy to the woman to take her own decisions and move freely about may threaten the 'strong, deeply anchored patriarchal traditions' of these communities (Bawah et al. 1999: 60).

Furthermore, societal norms set limits to women's agency as it outlines what can or cannot be contested over. This gives a reigning authority to the husband to preside over and control the affairs of women. Consequently, the agency and the bargaining power of women are weakened since they are regarded as properties of their husbands and his family members. In a gendered society such as the study setting, a woman who opposes the husband's decision is most often beaten up for 'correctional purposes' or threatened with divorce.

Cultural beliefs also may contribute in weakening the agency or bargaining power within women. For instance, older women may be less comfortable with modern health care facilities and may be reluctant to have their daughters or daughter-in laws attend an antenatal session during pregnancy. This behaviour has an influence on the use of PNC services. Added to that, a husband's attitude towards the health/belief system for example may further influence the wife's decision of whether to seek modern health care services (Elo 1992:8).

2.7 Discourses around pregnancy, childbearing and use of maternal health care services

The twin problem of gender which relates to the relationship between men and women and health care utilization further draws pregnancy and hence women's sexual and reproductive health into the eye of the storm.

The following discussions are an important attempt to locate in theory why women do not have autonomy and absolute control over the decision making efforts in reproductive health access and utilization at the household level. The aforementioned, is a predicament of women, which relates to their low utilization of MCH services for themselves and their children.

Women face several obstacles in accessing health care. For instance, Nash et al. 1992 in their study (as cited in Hausmann-Muela et al. 2003:20) systematized these obstacles into four different types. These are the institutional barriers which relates to the unequal treatment by health care providers; economic barriers which includes differences in access to resources between males and females; cultural barriers that relates to the low social status of women and male health providers who must attend to the health needs of women with critical health conditions; and educational barriers as evidenced by the low illiteracy rate of women.

As discussed by Gill et al. (2007) in their conference paper *'women deliver for development'* affirm that where women have access to resources and other economic advantages they are better able to use services during pregnancy or childbirth or even maintain a general maternal health (Gill et al.2007:23) Conversely, where women have a low status, and are disempowered their access to health care is poor. Linking this assertion to the context of women in the study area, resource acquisition such as farm lands, animals or houses is a limitation if not a challenge to women to enable them to be independent financially providing for themselves and the needs of their children without having to be dependent on their husbands for such needs.

Applying the unitary model of the household, Becker (1985) assumes that the family or household is a single unit in terms of production and consumption so much so that resources are pooled together where a benevolent dictator distributes these resources to members of the household equally by maximising utility (Becker, 1985:40). Indeed, if this assumption is true then the various households under study will be living in a cooperative pattern rather than in conflict through household interactions and its members will be better off in terms of utilizing health services within their reach.

Given this, Agarwal (1997) posits that interactions within the household are characterised by both "cooperation and conflict" (Agarwal 1997:4). Benefits only accrue to both parties under 'local theories of entitlement' arrangement designed as to who does what, who gets what goods and services, and how each member is treated (*ibid*). However, if such a maximisation of utility in the unitary model as put forth by Becker (1965,1985) is anything to go by, then in such situations "one person's gain is another's loss" as Agarwal (1997:4) would have us believe hence bringing about conflicts even in cooperative households. This is exactly the scenario portrayed in the study area, where a win-lose situation is created between males and females.

In a study of northern Ghana, Bawah et al. (1999) found out that, women faced a big barrier to use contraceptives because they have to ask for money from their husbands coupled with the enshrined male dominance in their society (Bawah et al.1999:54). This is tied by the fact that, the control of household income and resources is controlled by their husbands. This is typically the case where women do not have autonomy in the decision making

process at the household level making them highly dependent on their husbands.

In Uganda, the anxiety of women to ask permission from husbands for fear of being beaten up or divorced for using contraceptives or adopting a family planning method discourages women to use certain health services that are required for their health needs (Blanc 1996 cited in Bawah et al.1999:55). Similarly in Kenya and Zambia, women fear to use a family planning method without their husbands consent (*ibid*).

Bonilla and Rodriquez (1993) assert that the reason why women in one way or the other are prevented from accessing and using health care services is through the gendered 'division of labour' whereby women's work is in the private domain and that of the men in the public realm (cited in Hausmann-Muela et al. 2003:19). This private sphere limits women's access to resources such as money to attend to their health needs when they do need to since their work is unpaid. Consequently, this makes them heavily dependent on their husbands who are the decision makers of the household (*ibid*). Linking this to the research study, the head of the household is typically male who makes economic, social, and political and health decisions alone without taking the needs of women into consideration. Instances like this only increase women's dependence on men to seek approval when they want to use health care services for their sexual and reproductive needs and their children when they fall ill.

Arguably, the nature of women's work according to Hausmann-Muela et al. (2003) could be a militating factor in their access and utilization of healthcare. This is because women have a triple (re) productive role to play in the house such as child bearing and care, day-to-day household chores and working on their husband's fields (Hausmann-Muela et al. 2003: 19). This assertion they debate further, limits the travel to and waiting times at the health care facility, thus discouraging many women from going to a health facility. This assertion is however, debatable in the context of this study setting. In the first place, if husbands do not give their approval to their wives to go attend a medical facility, the triple burden of women as outlined by Hausmann-Muela et al. 2003 would be out of context in relation to travel time. Instead, it would be prudent to view the travel and waiting time as an opportunity cost forgone for other more productive activities such as fetching water, fuel wood, cooking, trading or farming. Secondly, since women in this study area are not independent economically and have to depend on their husbands for money, whatever decision the household head or husband has to say is final. So if the household head for instance, says there is no money to attend hospital, the mobility of the woman would be limited in that regard.

Similarly, various studies by Vlassoff et al.1995; UNICEF 1990; Mwenisi 1993 identified that even though it is women who identify the first symptoms of illness in their children or themselves, their lack of financial capability coupled with their overly dependence on men for funds inhibits on their ability to take any action when illness sets in (Cited in Hausmann-Muela et al. 2003: 19). Again, this can be contextualised in the present research paper as a lack of economic opportunities for women in the study area to be self reliant and independent of their husband's earnings.

In several studies by authors (see LeVine et al.1991; Obermeyer and Potter 1991; Elo 1992; Bhatia and Cleland 1995; Govindasamy 2000; Frankenberg et al. 2001; Wypij et al. 2001) they found that educated women are more likely to utilize ante-natal care services than the uneducated ones, to use it early and frequently, and to use trained providers and medical institutions. However, other scholars (for a review see Govindasamy 2000 and Wypij et al. 2001 point out that where there is low use of maternal care services, social norms prohibiting the easy movement of both educated and uneducated women to access health care services where they are available play a major part. As a result of social norms, the bargaining powers of women in the three northern regions of Ghana are curtailed to a large extent. All in all, it is the uneducated woman who most often accepts without contesting these social norms as a given thereby compromising on their health.

Pointing out to health technologies, Ojanuga and Gilbert (1992) argue that such technologies serve as barriers to access of services in some developing countries. This is because as they argue further, that such technologies in themselves only go to benefit the few urban rich woman while the poor rural woman has no access or lacks information about the availability of such resources or services (Ojanuga and Gilbert 1992: 2). It will not be out of place to aver that, in the study setting many households and communities are illiterate and exposure to the media (print and electronic) is limited and hence possesses a challenge to knowledge acquisition on regular attendance of PNC sessions during pregnancy. Most often, information sources concerning maternal or reproductive health is obtained from peers or friends who themselves may not be well informed about such issues.

Raju and Leonard's study in India (as cited in Blanc 2001:198) underscores the importance that service providers 'officially or unofficially' demand the approval of husbands or a close family member before services can be rendered to women in need of such services. This finding by Raju and Leonard is relevant and indicative of a barrier in using health services, which is also appropriate in the context of this research, in which case approval of husbands is needed by women before they can be able to use such services.

In Islamic settings, women's participation in health care service is generally a challenge and low. This, Youssef (1977) attributes to the "combined effects of traditional seclusion and exclusion (prohibitions and limitations imposed by males)" (Youssef 1977 cited in Ojanuga and Gilbert 1992: 614-615). A caveat must be said here that there are variations of this practice from many Islamic countries or communities for that matter. The practice of purdah for instance, excludes women from men in public interface. This greatly impacts on women as to whether or not they get consent from their partners for medical care or routine checkups for their health. Additionally, as instigated by Ojanuga and Gilbert (1992), in Islamic practice, there is no "concept of matrimonial property" (Ojanuga and Gilbert 1992:615). A husband's property is his and vice versa for the wife or wives. Paradoxically, this is not entirely true as husbands still control the movement of their wives to earn their own income.

Using the pathway model of Good (1987), the "significant others" (cited in Hausmann-Muela 2003:15) is said to be a key decider in health treatment and can be used to accurately explain women's inability to use health services

in rural northern Ghana. The "significant others" plays a fundamental role in this paper, of patriarchs, compound heads, older women and husbands in decision making at all levels including health. That is to say these significant others have to investigate the pathway to treat diseases and ill health that afflict members of the household.

Chapter 3
Mitigating Factors in Access and Utilization of PNC Services

Chapter three seeks to provide the challenges women are faced with in their household and community as far as the participation of PNC is concerned. These factors are reassessed against how they impact on women's health. This will serve as a backbone for analyses later in chapter four. The chapter draws to a close by looking at whether women's agency matters in a male dominated society.

3.1 What men don't know can hurt women's health: Problems of traditional norms and PNC use

The factors affecting maternal deaths are diverse and many across the world. Essentially, many point to the fact that there is need to have effective emergency and neonatal care systems in place, improve financial access to care and improve skilled attendance at delivery (Issah et al. 2011:208). Equally important then is the need to reduce socio-cultural barriers that affect prenatal health care utilization. The consequences of which are deaths that are preventable and avoidable. Considering this, Helzner (1996) argues that men's ignorance of women's health concerns may lead them to make wrong assumptions about women and thus make uninformed decisions about them (Helzner 1996 as cited in Blanc 2001:197). Maternal deaths in the study community are commonplace and usually occur before, during, and on arrival at the health facility or even in some cases 72 hours after delivery according to maternal death audits[7].

3.1.1 Kinship System

Descent among the study area of Ghana is patrilineal or patrilocal unlike the southern part of Ghana where the practice is matrilineal or matrilocal. Descendants thus trace their origin through lineages. A lineage is a corporate group in which members trace their origin through males to a known common ancestor or founding member of the patrilineage (Adongo et al. 1997:1798). The lineage therefore consists both the living and the dead and recruits new members at birth (*ibid*). Maintaining the lineage is very much important as it

[7] Recently, it has become mandatory for health facilities to conduct maternal death audits across the country. In some instances, Verbal autopsy or the Sisterhood method is preferred and used to identify causes of deaths.

underscores the essence of having sons. Here, sons or male children inherit movable and immovable properties of their fathers such as land, farms, cattle, sacred grooves, trees and houses. In contrast, females (wives and daughters) cannot inherit any property since they are regarded as properties to be inherited when they are married. Marriage is exogamous and women in a patrilineage are considered as sisters. This means that relations within the same lineage or clan cannot inter marry.

Male dominance in gender relations is maintained primarily through marriage as well as the lineage and followed by the family in that order. Health seeking decisions for women and children; control over and use of family assets is under the prerogative of males. Maternal health could thus be impacted through this way.

3.1.2 Religious beliefs and practices regarding childbearing

The African according to Mbiti (1969) is 'a deeply religious being living in a religious universe' (Mbiti 1969 as cited in Haverkort et al. 2003:141). Decisions about health, nature management and farming are sought through world views of African traditional religion even though many converts adhere to Christianity and other religious values. There is a belief that a vital force runs through the universe which is "unseen".[8] For this reason, selected male elders who are believed to have the knowledge and skill to tap, 'manipulate and use these forces' are relied upon to unravel the underlying causes of ill health (*ibid*). Thus on many occasions, rituals are performed in marriages to bring about fertility and child births in women. Even though pregnancy is not an illness, symptoms of pregnancy complications may set the tone for the quest to some answers to these complications. Veneration of ancestors is embedded in religious practices as they are believed to cause misfortunes such as deaths and terminal illness of members of the household or lineage if their consent is not sought in all matters concerning marriage and health seeking. It is appropriate therefore, to view women at the centre of a religious belief system that involves how decisions are taken and problems solved in relation to the health concerns of women.

In his study of religion and contraception usage in Ghana, Addai (1999) found that religious beliefs had a profound influence on contraceptive utilization by women (Addai 1999 cited in Takyi 2003: 1222). Similarly, Kirby (1997) acknowledges the strong role of 'medico-ritual' beliefs among the Anufo in Northern Ghana (Kirby 1997:216). These findings are synchronous with the ethos among rural dwellers of the study area where reproductive motives are deeply influenced by religious beliefs and practices. The motives behind reproductive health behaviours by and large are reinforced through

[8] Witchcraft and evil spirits are attributed to these unseen forces that can cause misfortunes in women especially during pregnancy or child birth.

community elders, compound heads, husbands, and sometimes by older women[9]. This constraints the mobility of women to respond promptly without delay when pregnancy complications sets in most especially but generally to issues affecting their health and well-being.

3.1.3 Decision making regarding Prenatal Health Care (PNC)

Complications during pregnancy are one major cause of maternal and neonatal morbidity and mortality (GDHS 2008: 150). For numerous reasons, many women in Ghana especially in the rural areas do not seek maternal health care even when they do understand the benefits and safety reasons for doing so (*ibid*). Applying the "Three Delays Model" of Thaddeus and Maine (1994); delays in seeking, reaching and receiving care are said to be factors contributing to maternal deaths (Thaddeus and Maine 1994:1092). In the present paper, the first of the three delays (seeking early health care) is of seminal concern which relates to the socio-cultural barriers that holds back women from receiving timely prenatal care from health facilities. Consequently, a decision is only reached when there arises a complication caused by 'difficult labour' (Harrison 1997: 8) or advanced complications during the last trimester of pregnancy. Arguably, the reason attributed to the ignorance of men can be linked to the socialisation process that they get from their fathers, older men and their peers (AVSC International and IPPF/WHR 1998b).

The consequences of prenatal care neglect results into complications such as anaemia, malaria prophylaxis and high blood pressure when women do not make regular visits to the doctor, midwife or nurse. In most situations, deaths are inevitable as a result of this absolute neglect or delay. In the study area, deaths resulting from pregnancies and child birth are not uncommon. Using maternal death audits, Issah et al. (2011) report that in 2009 a total of forty nine maternal deaths were recorded in the Upper West region which were attributed to a delay in seeking appropriate and timely care (Issah et al. 2011:209).

Apparently, the reasons that can be deduced for the above maternal health implications again are attributed to the interplay of household dynamics that is presided over by the head of the family. In conclusion, decision making regarding maternal health is often complex as to the best facility care to use. Late choices for modern facilities are made only when complications in pregnancy sets in which often than not results in deaths.

3.2 Having Children: Men's concern, Women's fears

Traditionally, marriage serves as a means to bear children. Men's concern about being in control and powerful over women in the household can put off

[9] Older women are known to derive substantial authority under the patriarchal hierarchy if they uphold tradition by discouraging younger women from delivering in health facilities. It therefore serves as a way of entrenching their gatekeeper position.

the discussion of health concerns relating to maternal wellbeing with specific regard to participating in prenatal care sessions. Among cultures in the study area, reproductive decisions are not made unitarily by either the husband or wife but are a function of the broader extended family and lineage system. Fundamentally, the preference for many children especially sons makes matters of fertility regulation come under the control of men since these societies depend on larger lineages to command male respect and influence. In these circumstances, it is impracticable to assume that 'couple[s] operate as a decision making unit' (Bankole 1995:317-318). It therefore becomes a source for concern for men if a woman is infertile or her children keep dying.

The responsibility of women, mothers/wives here in the study area as it is elsewhere is that of a home maker; bearing and caring for children and other sick members of the household. Increasingly, women's fears are awakened by the importance of making sure that the health of their offspring and they themselves is in constant check.

What is more, women's fears are heightened as the demand for more children by their husbands and kin members increases putting their reproductive health at greater risks. In addition, fears are heightened as mobility (e.g. seeking permission to travel to a health facility or visit family) is limited because of the autonomous decision making powers of their husband's.

Furthermore, fear of conflict over prenatal service utilization with other extended family members such as mother-in-laws who may not be in agreement with the idea of their daughter-in law utilizing prenatal services may exacerbate these worries. Even the anxiety of reprisals from ancestors may deter women from going to prenatal sessions. In relating prenatal utilization with contraceptive practice then, Bawah et al. (1999) report in their study of the impact of gender relations on family planning in Northern Ghana that, it is a common belief among women that such practices may result in their untimely deaths or them not receiving blessings from the ancestors (Bawah et al. 1999:59). Since these two beliefs (reproduction and religious customs) go hand in hand, and are inseparable, it is not out of place to assume that ignorance coupled with illiteracy might cause those who wield authority over women to be concerned that the foetus in the womb might be compromised during such visits to the hospital. Studies elsewhere have also revealed that beliefs in traditional birth practices may hinder utilization of prenatal care services. For instance, in an ethnographic study of the Bariba's of Benin, Sargent (1947) found out that modern medical care often comes in conflict with traditional beliefs of infanticide practice (Sargent 1947:26). This is not too different from the "chichuru" or spirit child phenomenon that is characteristic and practiced by some communities in the study locale thus encouraging home deliveries to that of facility care deliveries; as the perception is that facility deliveries might provide an alternative to obstruct the practice of infanticide soon after delivery. In this context, that having children sparks off anxiety in men and fears in women is not surprising.

3.3 Do women have a say in maternal health care issues: Does it matter in a gendered society?

Initiating agency within women is neither an easy tasks nor decision to make due to the structural opportunities that are available for women which by and large seem to be limited in this study area.

In this regard, women attempt to straddle the gap between traditions of male supremacy, and economic and health necessity when dealing with issues of prenatal care. While accommodating gender norms and the belief system, as discussed by Osakue and Martin-Hilber (1998) (cited in Petchesky and Judd 1998: 180-216) articulated their views that, some women attempt to 'secure certain areas of control for themselves' while putting across messages of 'a desire for change on such issues' (*ibid*: 180-216). It is in this perspective that Mahmood's (2001) concept of positive freedom an aspect of agency applies here. In this concept, agency takes on a positive form when others are able to realize an autonomous will created against the 'self-interest or universal reason' (Mahmood 2001:207).

The pathways that women have to navigate to exercise their agency or empowerment in terms of prenatal health access and utilization in the study locale is largely determined by a host of factors such as income (savings), ownership of assets, education, freedom from domestic violence, the level of pressure to conform to social norms, husbands support and permission to go out of the house freely. Each of these is necessary but not sufficient in itself to bring about agency in women to have an exclusive say in issues surrounding prenatal care or maternal health in general; than if there is a combination of these factors.

For instance, it might be sufficient to explain the gains in freedom of mobility for a woman to take her sick child to the hospital if her husband supports her but might not act as a necessary condition for her to exercise her agency in a culture that is regulated by male dominance and power. Therefore, if a husband is educated and supportive of her wife at the same time would serve both a necessary and sufficient condition for a woman to have a say when it comes to issues of maternal and child health care. Again, the effect of asset ownership (e.g. goats, sheep or poultry) by a woman will depend on the structural opportunities that allows for freedom of mobility in the society.

Saddled by these determinants and coupled with the increasing burden of responsibilities and financial constraints, rural women are determined to circumvent their husbands and in-laws even if it amounts to breaking social norms as evidenced by this quote:

> If I do not have any money and my husband does not also give his consent, I am prepared to go to the bush and gather firewood and take it to the market to sell. Whatever I get out of that, I will use to adopt a method to prevent any pregnancy [A young woman from Kologo, quoted in Bawah et al. (1999:59)].

These combinations of factors therefore, shape the different pathways of initiating agency in women to handle matters relating to prenatal care solely and may vary from one woman in a household to another. How this is carried

out in practice, however, depends by and large on the conditions beyond the control of most rural women. This therefore makes it impossible for women to circumscribe to prenatal health behaviours in a male dominated society.

Chapter 4
Findings, Analysis and Discussion: PNC Utilization in the study region

Information on PNC is important to identify sub groups of women who do not use such services. This chapter is relevant to the research question following the trends presented in chapters 2 and 3 on unequal gender relations and health care access and utilization by rural women. It presents in details findings of PNC utilization during pregnancy specifically on four indicators. These findings are essential for health planning purposes to improve service delivery. The chapter concludes with a discussion and policy implications.

4.1 Descriptive Statistics

Analysis was drawn from four PNC health indicators namely number of PNC visits; place of delivery; PNC assistance from a health professional and Tetanus immunization of pregnant women. This was done through the use of STATA software employing a bivariate analysis. Geographically, Ghana is divided into ten administrative regions.

Based on the information collected by the survey data, the researcher realizing the challenges and avoiding the pitfall of analysing this nationally, recoded these ten regions into two based on their different ecological zones. These were Northern Ghana and Southern Ghana. This allowed among other things to consider Northern Ghana as rural since most of its populations are not densely populated, deprived in some essential health care facilities such as Emergency and Obstetric care as well as skilled health professionals. Most skilled health professionals such as doctors refuse postings to Northern Ghana. The opposite is observed for Southern Ghana which is densely populated and hence more urbanised. To separate these two, a recode command (variable 0) was assigned to the three (Upper East, Upper West and Northern regions) out of the ten regions to be known as "Northern Ghana" and a recode command (variable 1) for the remaining regions (Greater Accra, Ashanti, Western, Central, Eastern, Volta and Brong-Ahafo) to be called "Southern Ghana'. The terms Northern Ghana or North and Southern Ghana or South, and study and non study area hence would be used interchangeably throughout this section of the chapter.

The GDHS08 data was used because it represented nationally, household samples that were interviewed. Furthermore, data of this sort has also been used in several studies by different scholars to test theories and hypothesis on certain health care indicators therefore, making it more reliable and accurate in drawing conclusions.

In addition, there were other variables that had to be identified that may have an influence on the use of PNC services. These three determinants were education, place and region of residence and religion. These are discussed below in detail which will offer trends for analysis later in this section.

4.2 Determinants (predictors)

The determinants or predictors of use of MCH services have been chosen based on a theoretical reason most of all and secondly, from hindsight other studies purport to use it for analysis of this nature. Using the determinants model or concept of Kroeger (1983) as stated elsewhere in chapter two, the researcher identified three socioeconomic variables: education, region of residence and religion. These would serve as explanatory or predisposing variables (these would be used interchangeably henceforth) that might have a confounding effect with gender relations and how that affects the utilization of each of the four indicators of PNC outlined above holding gender power relations as a constant. These predictors were considered separately because they may have different effects on use. This was necessary as the researcher wanted to find out whether gender relations have an independent effect irrespective of these control variables. In order to do this, a cross tabulation was made for at least one of the components of prenatal care indicators against each of the predisposing variables to see if differences existed in patterns of utilization.

4.2.1 Education

From a total of 11,888 observations for educational attainment 5,112 respondents did not have any form of formal education in Northern Ghana representing about sixty percent of the population (59.5 percent) in comparison with 40.5 percent in Southern Ghana. The break down for the area of reference is as follows: Northern region registered a high of (26.02 percent), Upper West (17.9 percent) and Upper East (15.3 percent).

For primary education out of a total of 2,664 observations, twenty percent (20.4 percent) of the population in the study area had attained some primary education in comparison with approximately eighty percent (79.65 percent) in the South. Similarly, the same was the trend for respondents who had some secondary education. Six percent (6.25 percent) had secondary level education in the North in comparison with 93.75 percent for the South from a total of 3,907 observations.

The South again was competitively higher in terms of higher level education than the North. Out of a total of 195 respondents from both North and South, the South recorded a high of seventy five percent (75.4 percent) of higher level education and the North a low of about twenty five percent (24.6 percent) of higher education. It was found out that by comparison; the study area (Northern Ghana) was disadvantaged in terms of overall educational attainment than the Southern part (Table 4.2). This is not surprising in a way because education was espoused to the then Northern Territories (referring to Northern Ghana) later than in the Southern part of the country through colonial policies.

Table 4.2 Educational attainment by Region

Region	No Education	Primary	Secondary	Higher Educ.
0	59.5%	20.3%	6.2%	24.6%
1	40.5%	79.7%	93.8%	75.4%
Total	100%	100%	100%	100%

Source: Author's construction based on GDHS, 2008 dataset

4.2.2 Urban-Rural (North/South) Residence

Whereas Northern Ghana can be described as rural (40.1 percent) and partly urban (17.5 percent), Southern Ghana is more urbanised (82.5 percent). Distribution of health care facilities and other social amenities favour the South than the North of the country. Similarly, problems of access and use of health facilities seemingly favour the Southern part of the country than the North.

Given all these challenges, urban-rural place of residence was assumed to have a predicting effect on certain aspects of PNC use. It is thus, hypothesized in several studies that the place and area of residence impacts on the health care needs and utilization of people especially that of women (see Ellaway and Mackintyre (1996); Shouls et al. (1996); Wang (2010)). In the case of this study however, urban-rural place of residence did not seem to be a significant determinant of PNC use as indications from the supply side reveal that health care facilities such as the presence of CHPS compounds (within 10km of walking distance) in the North did not change the variable patterns of seeking modern care during pregnancy or delivery. This finding can be said to be due more importantly to cultural beliefs and practices of gate keeping inhibiting modern health care use, and the lack of information or misinformation by rural women. The analysis thus shows sharp differences existing between the North and the South or urban and rural women for that matter in their PNC seeking behaviour in the four components of PNC outlined above.

4.2.3 Religion

It is the case in Ghana and elsewhere that religious belief plays an important role in predicting utilization of MCH services (Appiah-Kubi 2004:400). Under customary laws, not only do traditional religious fanatics adhere strictly to laws regulating taboos, but also their Muslim and Christian counterparts remain steadfast to laws regulating the surgical delivery of a baby.

Thus, aspects of religious beliefs stand tall and serve as a proxy for unequal gender relations by community elders, traditional/faith healers and in-laws in keeping the gates closed to PNC especially on place of delivery thereby denouncing modern medical procedures involved during delivery. This further presents a constraint barrier of women to utilize such services. As mentioned by Gyimah et al. (2006) in their study that the differences in religious dogma may permit or restrict its members from using or not using certain maternal

health services may also serve as a highlighter to this study. As a result, an estimated 200 women in Northern Ghana alone die from complications during child birth yearly, directly attributable to customary laws and the influence of gate keeping.

Mirroring the aforementioned influence of religion on the uptake of some components of PNC use then, the DHS data shows that there are more Christians in the Southern part of the country than the Northern part accounting for about fifty six percent (55.5 percent) and about twelve percent (11.95 percent) respectively. The Catholic and Pentecostal/charismatic women were more likely (37.9 and 46.9 percent respectively) to be protected against neonatal tetanus by going for more than two doses of TT injections during pregnancy compared to women from a traditional religious background representing about 31 percent. Across different religious denominations, observations reveal that there are more Catholics in the South (55 percent) than it is for the North (45 percent). Furthermore, observations show that Pentecostals are also in the least in the North (11.5 percent) than in the South (88.7 percent). In stark contrast, Islamic religion also dominated for the North than in the South. The figures show 68 percent and 32 percent for the North and South respectively. Conspicuously, Traditional/spiritual religion was also more pronounced for the study area (74 percent) than it is the case for the South (26 percent). Variations across different religious denominations could be explained by different periods of the introduction of Christianity to the South and the North of the country respectively through colonialism.

This finding on religion and TT immunisation hence supports similar assertions by Gyimah et al. (2006) on religion and immunisation against measles and Addai (2000) on the influence of spiritual healing on cost recovery of health care.

In the below table a cross tabulation of North/South place of residence and religion is outlined.

Table 4.3 Place of residence and Religious affiliation

Region	Christians	Muslims	Traditionalists
0	**17.7%**	**68.0%**	**73.5%**
1	**82.3%**	**32.0%**	**26.5%**
Total	**100%**	**100%**	**100%**

Source: Authors own, based on GDHS, 2008 data sets

4.3 Findings: Bivariate analysis of use of PNC Services

Table 4.4 shows the relative effects of the selected variables (determinants) on the four components of PNC use. As the data suggests, the most significant determinants of use of PNC are education, religion and place of residence.

4.3.1 Place of delivery

It is important to state here that culture (unequal gender relations) and rituals surrounding pregnancy and child birth influence women on the decision and choice of place of delivery. Under patriarchal traditions in Northern Ghana decision making regarding issues such as a place to deliver is communal; the husband, community elders, in-laws and the woman herself all have a say, but the weight of the final decision rests on the husband after seeking views from his parents and that of his in-laws. Following on this trend, the analysis of the GDHS data portrayed considerable variations in the pattern of place of delivery.

A difference of 6.18 percent existed between the North and the South in terms of home deliveries. At the extreme end are Northern women (53.1percent) who prefer to deliver at home as against 46.9 percent Southern women who chose home deliveries. The proportion of women in the North who went to deliver in a hospital or government health facility (e.g. hospital, health centre or health post) was considerably lower in comparison to the South of the country that recorded high proportions of deliveries in a hospital. It was however, the case that there was increased access to professional care through the use of Community Health Planning Services (CHPS) as birthing place for women in the North than women in the South. In percentage terms, this represented 71.4 percent and 28.6 percent respectively. This can be attributed to a policy influence of the introduction of the CHPS programme into the GHS policy and services in rural settings of the country.

Women with education (at least secondary) have a much higher propensity (62.7 percent) to deliver in a hospital compared with their counterparts with primary/junior secondary education (43.2 percent) and no education (27.9 percent). Rural-urban variations in level of education and place of delivery are also evident. On religion and place of delivery, it was noticed that religion influences the choice of place of delivery (Table 4.4). Even though religion was categorized into three, it was easy to distinguish which religion was higher in percentage terms in terms of preferred place for delivery. For instance, it was observed that, a higher percentage of Catholic (50.8 percent) and Pentecostal women (49.8 percent) deliver at a hospital or government facility compared to a lower percentage observed among Muslim (43.2 percent) and Traditional women (16.4 percent).

In conclusion, although rituals and customs surrounding pregnancy and child birth spelt out by the 'gatekeepers' may have an influence on the place of delivery, economic and social factors should not be ruled out.

4.3.2 Number of PNC Visits

In the study locale, the movement of pregnant women is shrouded in customs and belief systems of the people. It is a belief for example that a pregnant woman should not walk alone and must be accompanied by another female at all times. This belief is essentially meant to protect the unborn from being 'possessed' or 'devoured' by malicious spirits.

To call attention to this view, the researcher wanted to find out if patriarchal traditions influenced the number of times pregnant women attended PNC sessions. The findings showed that, the level of attendance at PNC visits or checkups varied by region of residence (North/South), education and religion (Table 4.4). The proportion of women from the study area seeking four or more PNC visits is about half (36.5 percent) less than that reported by women from the South of the country (63.5 percent). Also, women with no education in the study area show almost the same high tendency not to solicit up to four PNC visits as their educated counterparts with secondary and primary education.

The percentage of Christian women (69.6 percent) who went for up to four PNC checkups is higher than that for other religions such as Muslims (18.4 percent) and Traditional women (6 percent). Catholic and Pentecostal/charismatic women were largely predominant in going for up to four PNC visits than any other religious group. Although the statistics are descriptive, it draws attention to a significant difference between women from different religious backgrounds. As the findings suggest, women who are Christians (various) are more educated, reside in urban areas and have fewer children in most cases than women from other religions who reside in rural areas, are uneducated and have more children. For this reason, rural women for example, are less likely to go for all the four PNC visits. Consequently, these differences will seem to have a bearing on PNC uptake.

4.3.3 PNC from a Health Professional (once during pregnancy)

Since customary restrictions prevail on the movement of pregnant women in the study area, women who need to see a health professional must seek permission from their husbands to obtain PNC checkups from a health professional. The researcher thus wanted to find out if pregnant women used a health professional at least once during pregnancy before birth.

Once the household decided to seek care for their pregnant women the preference for a doctor to attend to them during pregnancy was as low as almost twenty percent (19.9 percent) in the North in comparison to 80 percent in the South of the country. This variable usage of the doctor (presumably male) could be attributable to the unacceptability of a male doctor treating their wives, or their level of wealth to pay for the services of a doctor and educational attainment. Given this backdrop, it was found that preference of use of a health professional during PNC in the North revolved around the community health officer/nurse. This recorded a percentage point of 69 against 30 percent or 30.8 percent in the South. Again, this propensity to go to the community health officer could be alluded to the fact that most personnel are females and are trained in midwifery skills to handle deliveries and refer pregnancy related complications to a doctor when necessary.

Midwives and other auxiliary level health professionals were also a preferred choice by women during pregnancy. Whereas the South recorded a significant percentage of 70 points, the North recorded an almost 30 percent use of midwives or auxiliary midwife during pregnancy. There was almost a

negligible observation for mothers who use traditional midwifes (both trained and untrained) for PNC during pregnancy in both the North and the South.

In terms of education, more mothers with secondary education for example received PNC from a health professional (doctor) compared with mothers with at least primary education or no education. Similarly, women in the highest wealth quintile in both North and South were more than likely to receive care from a health professional (doctor) than women ranked lowest in the wealth quintile in both North and South.

It is gratifying to say that at least all pregnant women have access to a health care professional during pregnancy at least once before they give birth.

4.3.4 Tetanus Immunisation

Tetanus Toxoid (TT) immunisation is important for pregnant women to prevent them from losing their babies during delivery. According to GDHS the leading cause of neonatal deaths in developing countries is neonatal tetanus where a good number of deliveries are at home and may be susceptible to unhygienic conditions (GDHS 2008:152).

Guided by the fact that the belief system and traditions of patriarchy looms large on rural women's mobility and PNC seeking behaviour the researcher wanted to test if this impacted on tetanus immunisation.

Essentially two doses of TT are required if a woman has never received a previous immunisation for 'full protection' (GDHS 2008:152). Also, if the woman received an immunisation before becoming pregnant then a single or no dose of TT will be required. A life time protection requires five doses. However, for this research I wanted to find out whether women received at least two doses of TT injection and whether the pregnancy in the last five years preceding the survey was protected against neonatal tetanus.

On a national level the percentage women receiving the two TT doses before birth was 41.9 percent. Low proportions of two doses of TT coverage were recorded for the South than the North of the country which showed higher percentages of TT immunisation during pregnancy (Table 4.4). This could be attributed to the fact that urban women do not perceive themselves of exposure to unhygienic conditions during pregnancy or child birth as most live in modern facilities and deliver in hospitals that observe strict hygienic rules.

Education of the mother is also related to TT coverage across the country. Mothers who had some secondary education in the South of the country were able to receive the two doses of TT which was slightly higher than for the North of the country. For example, 29.5 percent of births from mothers with secondary education in one of the study regions (Upper West) are protected against neonatal tetanus, compared to 46 percent in the Ashanti region to the South.

Similarly, women from the Catholic and Pentecostal/Charismatic religious denomination were more likely to have received two or more of the TT doses during pregnancy than women from other religious denominations. By

deduction, use of PNC services may not be determined by the same factors and in the same way as use of other reproductive health services including family planning or STI (including HIV) prevention and treatment in the household. This of course, has implications for reproductive health policy creation and service provisioning.

Table 4.4 Percentage Distribution of women by use of PNC services and selected characteristics in Ghana, 2008

Characteristics	Place of Delivery (Home)	Number of PNC Visits (Four times)	PNC from a Health Professional (Doctor)	Tetanus Immunization (Two doses)
Education				
No education	**62.7**	**15.5**	**18.0**	**36.6**
Secondary/higher	**27.9**	**11.8**	**53.9**	**46.5**
Region				
North (Rural)	**53.1**	**36.5**	**19.9**	**58.4**
South (Urban)	**46.9**	**63.5**	**80.1**	**41.6**
Religion				
Catholic	**13.3**	**14.8**	**13.7**	**13.1**
Protestants	**23.8**	**12.2**	**38.2**	**35.8**
Muslims	**23.9**	**18.4**	**18.5**	**18.3**
Traditionalists	**17.5**	**6.0**	**2.1**	**5.7**

Source: Author's own 2011 based on GDHS 2008 data sets

4.4 Discussion and Policy Implication

Focusing on the trends and analysis in the preceding chapters that highlighted unequal gender relations as more of a greater concern; and drawing insight from the GDHS data illustrates in this part of the discussion how better analysis from the framework in chapter two can help in policy implementation.

This research therefore calls to attention that in choosing and designing policies, the determining factors should be of prime concern. For this reason, the effect of gender seemingly was not an overriding influence on PNC use. This could be explained in threefold. First, there could be an under reporting of male dominance conducted at the household level when it comes to decision making on issues of access and utilization of PNC services. Secondly, biases could result in respondents trying to please the interviewers thus avoiding a perceived sanction for not using PNC services especially when these are made free by the government which urges them at the same time to do so.

Lastly, although respondents may indicate use of PNC services, this may not reflect in their care seeking behaviour.

In practice, therefore, policy makers need to understand whether a 'single constraint' is at work for a particular problem or 'multiple constraints' (WB and IBRD 2012: 288) interplay with each other so as to determine the best solution for addressing it.

No variable that had been identified in the determinants model were found to lose their significance. The significant socioeconomic variables were education of mothers, religion and region of residence which had a bearing on PNC use.

The effect of mother's with education is noteworthy on prenatal care decisions. It is important for policy to reduce gender disparities in decision making in households and societies through education. Examining trends in the data on female education, we can infer however, that customs and traditions of a patriarchal world view may have contributed in the variable patterns of education between men and women in the North than in the South. This can be traced to the value attached to male education than women's in a patriarchal tradition. It is not surprising therefore, to find variable patterns of PNC seeking behaviour from women who are not educated to those who are educated. Women's/mother's education should therefore become a central policy lever in increasing women's chances of using PNC services. In the long term, mother's education may increase her income level and reduce any access barriers when it comes to funding health costs for example. Women's education may also effect population and health changes in rural settings to a greater extent.

Additionally, policies need to be created to expand economic opportunities for women by putting in check measures that can influence societal norms. In dealing with each of these policy measures stated above will thus require better service provisioning and holding accountable institutions that provide these services taking into consideration that it remains accessible to the poor.

With respect to religion, the picture portrayed is mixed in terms of its major role in the propensity of women from the North and the South of the country to go for TT immunisations during pregnancy as a case in point. It is for this reason that Kirby (1993) asserts that much effort needs to be taken into considering 'peoples religious orientations and beliefs' in the provision and delivery of better health care (Kirby 1993 as cited in Gyimah et al. 2006: 2933). Furthermore, Addai (2000) cautions that where allopathic medicine exists alongside 'herbalists, diviners and spiritualist' women are often compelled to make decisions as to which facility is appropriate for their needs (Addai 2000:3). This therefore has policy implications in the planning and provisioning of health services across the country.

Conclusions

Traditional beliefs and practices in which form exist unequal gender relations have complex influences on pregnant women; often times undermining their health and agency. Although the findings from the GDHS

data did not reveal clearly the influence of one social gender (men) over another (women) when it comes to utilizing PNC services, it is still relevant that if women's reproductive health is to be achieved, then the political and socio-economic grounds should be well organized for women's voice to be actively heard; to be able to challenge social norms that prevail in their communities and societies. This finding lays bare the need to strengthen the link between gender equality and reproductive health not only at the local level, but also nationally so as to improve women's reproductive health. This therefore brings to the fore an indication for re-designing health policy interventions. The introduction of the free maternal health care programme and the National Health Insurance Scheme (NHIS) are good examples in this direction aimed at bridging the rural- urban divide in terms of health care access. However, as the NHIS requires a payment of a premium before an individual from a household can access free health care, rural women are more likely to find it difficult to raise this amount thereby pushing them to utilize other unorthodox means instead of modern methods. Much needs to be done therefore, in identifying particular determinant factors at the household level that brings about low utilization of PNC services.

Chapter 5
Gender Relations and the use of PNC services

The aim of this study was to establish how gender relations in patriarchal environments of the study area influence the use of prenatal services by rural women. To establish the nature of interaction between gender relations and the use of PNC services, data from the GDHS08 was reviewed. The study also explored how household factors interacted with institutions such as health to influence the use of PNC services. This concluding chapter synthesises the issues in the study into a conclusion from the point of view of the research questions that were posed in chapter one. The chapter also reassesses the implications of the study findings in as far as realising the right to health of women is concerned.

5.1 Gender relations and opposing views at the household

The connection between gender relations and how women strive to maintain a balance between their triple roles in the household and social roles expected of women at the community level was alluded to. These roles often came into conflict with the gate keepers in the household or community when women attempted to challenge discourses surrounding the social norms. The findings of the study even though not explicitly captured through this data could allude to patriarchy as interacting with the predisposing factors outlined to affect rural women's chances of using such services. The policy implication of these, calls for the operationalisation and advancement of the course of women's reproductive health through the lens of gender equality. This is crucial if theoretical goals of reducing MM are to be achieved.

5.2 Gender relations and the education of women

The findings of this study point to the current policies on equity in access to health care in Ghana. At the same time, it specifically brings out the gendered discourse of (re)production, child bearing and nurturance that has been placed on women. This responsibility of women has been to the neglect of their education. The implication of this being the lack of negotiating powers of women at the household for utilizing PNC services when they do need them. A call to attention for a rights discourse approach in the educational policy making arena should be embraced.

5.3 Gender relations and health implications for rural women

The findings delineated above are indicative of the implications that it has on the health of pregnant rural women. As indicated elsewhere couples do not always act as a single unit and might have different preferences and choices influencing health seeking behaviours. Consequently, maternal mortality is high

in Ghana which is as a result of the factors outlined and discussed in this paper namely stoic traditional belief systems and interplay of the link between the intersectionality between genders in the household and community in influencing health seeking behaviour of women. Many of these deaths result from pregnancy related complications, the impact being borne most especially by rural poor, uneducated women. A needed solution in this regard, is to provide timely and adequate attention to expectant mothers. Following this, women health activists need to be stepped up to educate young women to break the cycle of older women being the bearers of tradition surrounding sex, re(production) and maternal and child health care.

In conclusion, this study has provided the yardstick for determining the experiences of rural women in their prenatal seeking behaviour at the household level. Whilst rural women attempt to subvert these gender norms and traditional beliefs, it also comes with punitive measures for these women when they are caught in the process. The findings of the research further brings to the fore, that despite the existence for two decades in Ghana of the "health for all' policy, not all Ghanaians especially rural women are truly covered under the umbrella of this health policy which only remains a chasm. For a transformative health policy thus, attention has to be paid to the socio-demographic and the discursive circumstances of women.

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Appendices

Annex I

Chronology of International Conferences on Gender Equality, Women's Rights and Women's Reproductive Health

1948: UN approved the Universal Declaration of Human rights. This declaration spelt out for the first time that every man, woman or child has a right on the bases of the fact that they are human beings. No exceptions for gender, skin, colour, ethnicity, religious or political views or nationality.

1968: First Conference on Human rights, Tehran. This conference acknowledged the fact that 'parents have a basic human right to decide freely and responsibly the number and spacing of their children and a right to adequate education and information to do so'.

1969: The United Nations Fund for Population Activities (UNFPA) was founded

1974: First World Population Conference, Bucharest. This conference put population issues on the international agenda.

1975: First World Conference on Women, Mexico City. This conference declared the right to family which is important for men, women and children

1976: United Nations Development Fund for Women (UNIFEM) founded

1976-85: UN International Decade for Women

1979: The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) came into being. This involved among other things the removal of discrimination and the decision by women to decide freely and responsibly the number and spacing of their children.

1980: Second Conference on Women, Copenhagen. This outlined equality in access to education, employment opportunities and health care

1984: International Conference on Population, Mexico City. The conference spelt out and documented the dangers of unsafe abortion and recognized a global unmet need for contraceptive services.

1987: Safe Motherhood Conference, Nairobi. The Safe Motherhood Initiative was launched

1989: UN approves the Convention on the Rights of the Child

1992: UN Conference of Environment and Development, Rio de Janeiro. This conference recognized the insurmountable role of women in contributing to sustainable development

1993: World Conference on Human Rights, Vienna. It was declared that Women's rights are human rights.

1994: International Conference on Population and Development (ICPD), Cairo. It reiterated the need to meet individuals for a universal education and sexual and reproductive health care and rights.

1995: Fourth World Conference on Women, Beijing

1995: World Summit on Social Development, Copenhagen

1998: Vienna+5, Rome. Recognition by the Rome statute states that rape and sexual violence are among the most serious war crimes.

1999: ICPD+5, The Hague

2000: Beijing+5, New York. It called for more male involvement in promoting women's rights and sexual and reproductive health

2000: Millennium Development Summit, Declaration and Millennium Development Goals (MDGS)

2001: UN General Assembly Special Session (UNGASS) on HIV/AIDS, New York. This stressed the urgent need for adolescents globally, especially girls and women to be educated on SRH services.

2002: World Children's Summit, New York. This was a call for emergency obstetric care before, during and after pregnancy and delivery to be available as a life saving mechanism for mothers and children.

2004: ICPD+10, London. Reflections of ICPD Programme of Action, 1994

2005: Beijing+10

2006: The UN General Assembly, New York. Targets for MDG 5 was earmarked- Improve maternal health among others

2006: African Union Meeting, Mozambique. The Maputo plan of action committed world leaders towards universal access to comprehensive SRH by the year 2015.

2007: Women Deliver Conference, London. Investing in women to improve maternal health

2009: ICPD@15, Addis Ababa: 4th International Conference on ICPD implementation.

2010: UN, New York: MDG+10. Summit on global progress of MDGs

2015: Deadline to achieve the ICPD Programme of Action and the MDGs

Source: UN, 2009(cited in Wang 2010:133)