

Access to Maternal Health Care Services in the Cape Coast Metropolitan Area, Ghana

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Abstract: Maternal mortality can be prevented if mothers had routine obstetric care and access to emergency obstetric services. However, in accessing healthcare most expecting mothers will have to struggle with distance and financial problems. The study sought to; assess the barriers that discourage women from accessing antenatal, delivery and postnatal services in the Cape coast Metropolis and give recommendations to inform policy. Questionnaire was administered to 150 pregnant women and nursing mothers with babies less than one year from ten communities in the Cape Coast Metropolis. An institutional questionnaire was administered at the University of Cape Coast Hospital which provides health care services to the communities. The study revealed that challenges such as money (16.7%), distance (15.4%), and the behaviour of health personnel (20%) were the dominant barriers to accessing antenatal, delivery and post natal services in the Cape Cost Metropolis. These barriers lead to the inability of 14% of pregnant women and nursing mothers with babies less than one year to adhere to the minimum antenatal visitation number of 5 recommended by the Royal College of Obstetricians and Gynaecologists. Again 15.3% of these respondents were delivered by Traditional Birth Attendants and family members, while 5.8% were unable to adhere to the minimum postnatal visitation of two times. NGO's and government organizations for women should organize training programmes aimed at improving the livelihood or employment for women in these communities.

Key words: Antenatal care, community, delivery care, post-partum care, services

INTRODUCTION

Worldwide, over 500,000 women and girls die from complications related to pregnancy and childbirth each year and over 99% of those deaths occur in developing countries (UNICEF, 2004). Hattar-Pollara (2009) in a presentation on Health for Economic Development, affirmed that there was a linear positive relationship between improved health and economic growth; lower infant mortality rate and economic growth; and lower maternal mortality rate and economic growth. Thus improving maternal health is a way of promoting human capital development and wealth creation. Significantly, maternal mortality issues have gained wider attention and priority in development discussions and this has been influenced by the Safe Motherhood Initiative which was launched in Nairobi, Kenya, in 1987. The Millennium Development Goals and other development frameworks recognize safe motherhood as an essential part of development and call for a 75% reduction of maternal mortality ratios by 2015, and for 90% of all births to be assisted by a skilled attendant within the same time frame

(UNFPA, 2004). Recent data on maternal mortality among developing countries indicates that 336 deaths per 100,000 live births occurs in Asia and the Pacific regions, 992 deaths in Sub-Saharan Africa, 220 deaths in Middle East and North Africa and 136 deaths per 100,000 births in Latin America and the Caribbean (World Bank, 2010).

In Ghana the percentage of women who received antenatal services decreased marginally from 88.7% in 2005 to 88.4% in 2006; while 44.5% of the women had supervised delivery (NDPC, 2007). Though maternal health care has improved over the past 20 years, the pace has been slow and extra effort is required for Ghana to achieve the MDG 5 target of reducing maternal mortality rate by three quarters by 2015 (NDPC, 2010). The 2007 Maternal Health Survey revealed that maternal mortality rate has declined from 740 per 100,000 live births to 503 per 100,000 live births between 1990 and 2005 and as at 2008 it has been estimated that maternal mortality in Ghana was at 451 deaths per 100,000 live births (MOH, 2008). Nevertheless, these achievements in the rate of decline of maternal mortality rate are not enough. NDPC (2010) concludes that if the current trends continue

maternal mortality will be reduced to only 340 per 100,000 live births by 2015 instead of the MDG target of 185 per 100,000 live births by 2015, and it is unlikely Ghana will meet the target.

In order to reduce pregnancy and delivery complications in Ghana, the Government has introduced a number of interventions which include: free maternal health care under the National Health Insurance Scheme, Safe-Motherhood Initiative; Intermittent Preventive Treatment (IPT) and Prevention of Mother to child Transmission (PMTCT).

Ghana introduced a policy of free medical care for pregnant women under the National Health Insurance Scheme (NHIS) from July 1, 2008, to ensure financial accessibility for maternal health care. Under the programme pregnant women would benefit from the antenatal period to three months after delivery, emergencies during delivery and all other medical problems within this period are also covered (Adoma-Yeboah and Appiah-Adjei, 2008).

The Safe Motherhood Initiative is a national reproductive health service delivery and it's delivered through the Primary Health Care (PHC) programme. With this initiative, services are taken closer to the communities and it also includes community participation. By this, the aim of the government is to ensure the well being of a woman during pregnancy, labor and delivery and the period thereafter at the grass root level through the various district hospitals, clinics, health centers and posts. The Safe Motherhood Initiative purportedly represents comprehensive policies, strategies, programmes and projects aimed at improving the quality of health care received by expectant and nursing mothers as well as making an effort to removing the obstacles faced by these women in accessing health services. Some of these policies brought forth by UN ECOSOC (2007) are:

- **Making Pregnancy Safer (MPS) initiative:** The main objective of this programme is to reduce complications (and death) in pregnancy. It is delivered through the Primary Health Care Programme. The interventions are in four parts:
- **Care during pregnancy:** I.e., Antenatal Care, Treatment of Severe Anaemia, Treatment of Syphilis, Treatment of other STDs such as gonorrhoea, Chlamydia, and Treatment of malaria.
- **Care during and after delivery:** This aims at ensuring delivery by skilled birth attendant as well as routine newborn care, Management of eclampsia, postpartum haemorrhage, obstructed labour/Caesarean delivery sepsis, basic of newborn complications, Postpartum care, abortion complication, and post surgical care.
- **Postpartum family planning:** This has to do with the use of Condom, Depo-Provera, and IUD, Norplant, Oral Contraception, and Sterilization.

Community component: This consists of Community Based Health Planning Services (CHPS), Traditional Birth Attendants (TBA), Community Empowerment Programme for MPS, and Prevention and Management of Safe Abortion Programme.

The purpose of Intermittent Preventive Treatment (IPT) programme is to control pregnancy associated malaria. It is assumed that every pregnant woman living in areas of high malaria transmission, with or without malaria symptoms, has malaria parasites in her blood or placenta. Iron and folate supplementation, deworming, case management and Insecticide Treated Nets (ITN) have been integrated into the IPT package within the safe motherhood programme (GHS/NMCP/JHPIEGO/MSH/Global Fund, 2005).

Mother-to-child transmission also known as vertical transmission, occurs when an HIV-positive woman passes the virus to her baby during pregnancy, labour, delivery or breastfeeding. Increasing the level of general knowledge of transmission of HIV from mother to child and reducing the risk of transmission using antiretroviral drugs is critical to the Prevention of Mother to Child Transmission (PMTCT) of HIV. Pregnant women attending antenatal clinics at health centers/hospitals are counselled and tested for HIV/AIDS and those who are sero positive are provided with ART.

Several studies indicate some barriers to women utilizing health care in developing countries. These barriers were identified to be distance (Forster *et al.*, 2009), money (Family Care International, 1998; Gage, 2007; Celik and Hotchkiss, 2000) and customs and traditions (Arhin, 2001; Addai, 2000; Navaneetham and Dharmalingam, 2002). In all their observations, they concluded that women will opt for medical care during pregnancy and childbirth provided that barriers of distance, cost, and cultural acceptability are overcome and if staff in the health care facilities provides the necessary interpersonal skills to support them.

Consequently the study sought to; assess the barriers that discourage women from accessing antenatal and postnatal services in Cape coast Metropolitan area; analyse the factors influencing the choice of place of delivery and give recommendations to inform policies. Cape Coast Metropolitan area was chosen for the study because two of the researchers had lived in the District for several years and had observed that women in some deprived communities did not access maternal health services.

RESEARCH METHODOLOGY

The Cape Coast Metropolitan area in Ghana was selected in a case study with focus on some selected women of the University of Cape Coast (UCC) sub-district because of their high poverty levels. The research was carried out from September 2009 to May, 2010. Data

for the study was collected from both primary and secondary sources. Secondary data was obtained from journals, articles and relevant research papers on maternal health issues. Whiles primary data was obtained through observation, semi-structured interviews and individually administered questionnaire. The study began with reconnaissance visits to the Metropolis especially within the UCC Hospital catchment area to consult and interact with various agencies, groups and individuals involved in the provision of health services. Primary data were obtained from pregnant women and nursing mothers with babies less than one year between the ages of 15-49 from ten communities in the Cape Coast Metropolis and the maternity unit at UCC Hospital that provides antenatal, delivery and postnatal services through interviews and questionnaires administration.

A combination of purposive and disproportionate stratification sampling techniques was used for the study. Using the Slovin's Sampling Formula (Guilford and Fruchter, 1973) $n = N/[1+N (\alpha)^2]$ (where n = sample size; N = sample frame (6209); α = margin of error (0.08)) 150 pregnant women and nursing mothers with babies less than one year were purposively selected from a population of 6209 women of child bearing age (CCMA, 2006) in ten (University of Cape Coast, Ola, Kokoado, Apewosika, Amamoma, Kwaprow, Akotokyir, Duakor, Ahenboboe and Abakam) randomly selected communities within the catchment area of the UCC Hospital. The sample size was disproportionately distributed among the ten communities.

Households with pregnant women and nursing mothers with babies less than one year between the ages of 15-49 were selected for the study. In order to determine the validity of the respondents' answers and knowledge

concerning the health services provided, an institutional questionnaire was administered at the UCC Hospital.

The nature of the research necessitated a combination of both qualitative and quantitative techniques to analyse the data. In analyzing the data, statistical association was used to establish relationships and tables and charts were used for the quantitative data. Descriptive analysis was used for the interview conducted.

RESULTS AND DISCUSSION

Background of pregnant women and nursing mothers:

From the field survey, 40% of the women were between the ages of 26-35 years and 25% were between the age group of 15-25 years (Table 1). This means that a majority of the mothers are in their youth and are likely to give birth to children thus making them more likely to access health facilities during their pregnancy, delivery and postnatal stages.

The marital status of the mothers helped to know if they received any form of support, be it moral or financial

Table 1: Socio-demographic characteristics of pregnant women and nursing mothers

Socio demographic	Frequency n = 150	%
Age		
15-25 years	38	25.30
26-35 years	60	40
36-45 years	35	23.30
Above 45 years	17	11.30
Marital status		
Married	110	73.3
Divorced	7	4.7
Separated	10	6.7
Widowed	2	1.3
Consensual union	21	14
Educational background		
No formal education	20	13.3
Basic	56	37.4
Secondary	38	25.3
Tertiary	36	24
Employment status		
Employed	96	64
Unemployed	54	36

from their partners or spouses. Majority (73%) of the women interviewed, were married (Table 1). These married women have a high probability of giving birth and are therefore more likely to access health facilities.

About 37.3% of the mothers have basic education; 25.3%, secondary education; and 24%, tertiary education. However 13.3% have not received formal education. Generally, majority (62.6 %) of all respondents had basic and secondary education and 24% had tertiary education. According to Elo (1992) more education might lead to more decision-making power for the mother within her household and it might also increase her knowledge of modern health care.

Sixty four percent of the pregnant women and nursing mothers were employed while 36% were unemployed. Out of the 64% who are employed, 40% are in the informal sector, while 15% are in the commerce sub sector with their main occupation being petty trading. These women receive an average monthly income of GH¢120 and are responsible for the up-keep of the home, provision of food for the household, clothing for the children and other basic needs. The men do however assist them in the payment of school fees, rent and medical bills of the children. The fact that, most of the women are working is in line with Obaid (2006) saying that, with increased status, independence, income and negotiating power, women are better able to exercise their right to sexual and reproductive health.

The level of education received has a positive link with one's employment status. As high as 51.8% (Table 2) of pregnant women and nursing mothers who had received basic education were unemployed, and without the capital and skills needed to start a trade. This case was peculiar to the women from Abakam, where 80% of the respondents never attended school, 20% had basic education and all the women were unemployed.

Table 2: The relationship between level of education attainment and employment status

Educational level	Employment status					
	Employed		Unemployed		Total	
	Frequency	%	Frequency	%	Frequency	%
Basic	27	48.2	29	51.8	56	100
Secondary	26	68.4	12	31.6	38	100
Tertiary	36	100	0	0	36	100
No formal education	7	35	13	65	54	100

Table 3: Visit of women to the hospital for antenatal health care services

Communities	No. of visits					
	Visits hospital		Do not visit hospital		Total	
	Frequency	%	Frequency	%	Frequency	%
Kwaprow	15	100	0	0	15	100
Akotokyir	14	93.3	1	6.7	15	100
Kokoado	14	93.3	1	6.7	15	100
Apewosika	13	86.7	2	13.3	15	100
Amamoma	13	86.7	2	13.3	15	100
Duakor	9	90	1	10	10	100
Ahenboboe	5	100	0	0	5	100
Abakam	4	80	1	20	5	100
Ola	25	100	0	0	25	100
UCC	30	100	0	0	30	100
Total	142	94.7	8	5.3	150	100

However, respondents who had tertiary education were all employed. For this reason, improving women’s educational level does not only enhances their employment and income status but has positive ramifications for increase access to maternal health care services.

Access to maternal health care services: Three types of health care services are eminent for promoting maternal health care namely; antenatal, delivery and postnatal health care services.

Access to antenatal health care services: The first step of assessing women’s access to maternal health care services is to inquire about their access to antenatal care; which refers to the comprehensive healthcare that a woman receives and provides for themselves throughout their pregnancy (Baker, 2006). The study revealed that 5.3% (Table 3) of the women had no knowledge of antenatal services and do not visit the hospital whereas as high as 94.7% were aware of antenatal services and do visit the hospital to access this service. This figure is comparable with that of the country (95%) in 2008 (GSS *et al.*, 2009). All these respondents had a maternal health record booklet to prove that they attend/attended antenatal care. According to the midwife in charge of maternal health services clients who access antenatal care receive the following services: History taking, Physical and laboratory examinations (Measurement of blood pressure, temperature, height and weight, abdominal examination and checking of foetal heart beat, Urine test, Blood tests; for malaria, hepatitis B, HIV, Syphilis, Sickle-cell, full

blood count, blood group), administration of Tetanus Toxioid, Intermittent Preventive Treatment with Sulfadoxine Pyrimethamine, distribution of Insecticides Treated Nets, deworming, iron and folate supplementation, Pelvic Ultrasound, Counselling on health problems and complications of pregnancy.

Reasons behind the decision to access these antenatal services included the need for good medical care (83%) and fear of complications during pregnancy (10%). In addition, 4.3% of women were asked by their spouses to attend the antenatal care while 1.4 % of the pregnant women and nursing mothers did so because of the free antenatal care policy under the National Health Insurance Scheme.

According to an UCC Hospital official, the number of visits recommended for antenatal services are once every month for the first six months, fortnightly (once every two weeks) from the seventh to ninth month and weekly till delivery. This means that a pregnant woman should attend antenatal care 15 times before delivery. About 14.1% of the women adhered to the recommended visits given by the UCC Hospital. 60% of the women of Ahenboboe accessed antenatal care a maximum of four times (Table 4) which meets the WHO’s minimum visits care. According to the midwife in charge of maternal health services clients who access antenatal care receive the following services: History taking, Physical and laboratory examinations (Measurement of blood pressure, temperature, height and weight, abdominal examination and checking of foetal heart beat, Urine test, Blood tests; for malaria, hepatitis B, HIV, Syphilis, Sickle-cell, full blood count, blood group), administration

Table 4: Frequency of visits to health facilities for antenatal services

Communities	No. of visit											
	1-4		5-9		10-14		15+		Still attending		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Kwaprow	2	13.0	3	20.0	8	53.3	1	6.7	1	6.7	15	100
Akotokyir	1	7.1	3	21.4	7	50.0	3	21.40	0	0	14	100
Kokoado	2	14.3	2	14.3	8	57.1	2	14.3	0	0	14	100
Apewosika	4	30.8	1	7.7	7	53.8	1	7.7	0	0	13	100
Amamoma	2	15.4	1	7.7	9	69.2	1	7.7	0	0	13	100
Duakor	1	11.1	1	11.1	6	66.7	0	0	1	11.1	9	100
Ahenboboe	3	60.0	1	20.0	1	20.0	0	0	0	0	5	100
Abakam	1	25.0	2	50.0	1	25.0	0	0	0	0	4	100
Ola	4	16.0	4	16.0	13	52.0	4	16.0	0	0	25	100
UCC	0	9.0	0	0.0	18	60.0	8	26.7	4	13.3	30	100
Total	20	14.1	18	12.7	78	54.9	20	14.1	6	4.2	142	100

Table. 5: Place of delivery and complications faced

Place of delivery	Complications faced			
	Yes		No	
	Frequency	%	Frequency	No %
Hospital	22	18	100	82
Home	12	57.1	9	42.9
Total	34	23.8	109	76.2

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Inaccessibility to the hospital was attributed by women to factors relating to observations made by Family Care International (1998) and Forster *et al.* (2009). Fifty two percent of pregnant and nursing mothers faced some form of challenges in accessing antenatal care; money 16.7%, distance 15.4%, behaviour of health personnel

20.5%, long waiting period at the hospital 7.7% and a combination of these challenges. About 25% of natives of Abakam cited distance as a reason for not accessing antenatal care. Money and distance which accounted for 37.5% were cited by natives of Duakor who were unemployed and had to depend on their partners for survival. Natives of Amamoma and Apewosika cited ignorance.

Access to delivery health care services: Health care services related to delivery refers to the services that enable pregnant women in labour to bear forth their babies. This occurs mostly after nine months of conceiving. According to GSS *et al.*, (2009) 57% of deliveries in Ghana occur in health facilities while 42% of births were assisted by traditional Birth attendant, relations or friends at home. The survey revealed that as high as 84.7% of women who had delivered gave birth in the hospital while 15.3% were delivered by Traditional Birth Attendant (TBAs) (4.2%) and family members at home (11.1%). The numbers of TBAs in the communities are as follows: Kwaprow 3, Kokoado 1, Amamoma 2, Apewosika 4, Akotokyir 3, Duakor 1, Ola 3, Ahenboboe and Abakam share 2. For the women who were delivered by the TBAs and family members, numerous reasons were given which varied across the ten communities. Firstly, 23.8% (Fig. 1) of the women did not recognize the labour signs early while 9.5% of the women felt that they were healthy and did not need medical care. Again, 28.6% of the women cited money as a reason explaining further that the hospital admission fees was expensive, coupled with the fact that they were unemployed. This situation was peculiar in Abakam (16.7%), Ahenboboe (16.7%) and Duakor (33.3%). According to Celik and Hotchkiss (2000) household wealth is positively and significantly associated with choosing health facility for delivery. Distance accounted for a total of 4.8% (Fig. 1) of the respondents. The respondents claimed the hospital was quite far. This problem is peculiar to the women of Abakam.

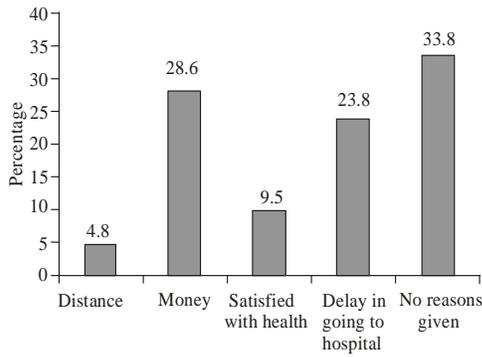


Fig. 1: Reasons for not accessing health care services related to delivery

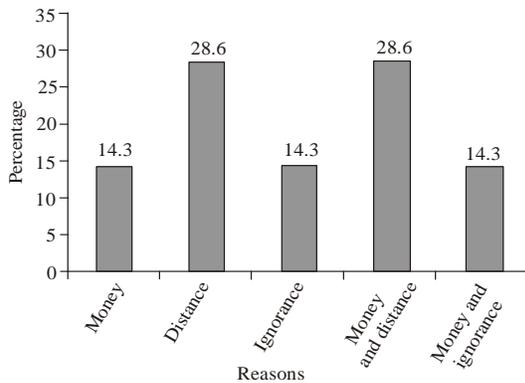


Fig. 2: Reasons for not accessing postnatal health care services

However, 33.3% of the respondents who had delivered could not offer any reason for delivering at home and this could be attributed to the conservativeness of residents in the Metropolis who would prefer unorthodox ways to conventional health care services. The reasons identified for not accessing antenatal health care services are similar to those relating to access to delivery services.

The survey revealed that 81.5% of the women delivered their babies the natural way, 2.0% had induced deliveries, 7.6% had assisted deliveries and 9% had caesarean sections. After birth 28% of the respondents who had delivered faced complications such as postpartum haemorrhage (loss of more than 500 mL of blood after delivery) postpartum fever; and retained placenta (when the placenta remains undelivered after 30 min, this can lead to an increased risk of infection or bleeding). About 18% of the women who delivered in the hospital and 57.1% of those who delivered at home faced these complications during delivery (Table 5).

Accessibility to postnatal health care services for mothers: NCCPC (2006) states that the time frame for

postnatal check-up is in three parts. The first time-frame is within the first 24 h after delivery, the second is between two and seven days (24-168 h) while the third is between the second and eight week or from the eight day onward. UCC Hospital recommends two visits for postnatal check-up: once in the first week and another one in the sixth week. According to the GSS *et al.* (2009) more than two thirds of women in Ghana receive post natal checkups within two days of delivery while 23% of women did not receive any postnatal care within 41 days after delivery. The survey however showed that even though as high as 95.1% of women who had delivered went for postnatal checkups within six weeks after delivery only 23.5% attended postnatal check up within the first two days. Akotokyir, Amamoma and Duakor each had 14.3% of the women attending postnatal care once while Abakam and Duakor each had 28.6% of their women also attending postnatal care once.

Analyses of the challenges of accessing postnatal services in the Cape Coast Metropolis as against the challenges of accessing delivery and antenatal services in the Cape Coast Metropolis were found to be the same. For instance 40% of the mothers in Duakor who cited money as a challenge in accessing antenatal care cited money again as a challenge in accessing postnatal care. Money was also a challenge faced by the women of Kokoado (6.7%). More so, 50% of the mothers in the UCC community who cited 'behaviour of personnel' as a challenge in accessing antenatal services cited 'behavior of personnel' as a challenge in accessing postnatal services. Distance was a challenge faced by the women of Abakam in accessing antenatal services as well as accessing postnatal services. The other reasons for not accessing postnatal healthcare can be seen in Fig. 2.

Barriers to accessing maternal health care services: In all, the study has revealed a certain trend. The challenges facing women in accessing antenatal care are the same as the challenges faced in accessing delivery and postnatal health care. Money, distance, and the behaviour of health personnel were the dominant barriers to accessing maternal health care services in the Cape Cost Metropolis. It must however be noted that some of the women faced two or more challenges simultaneously. For instance 17.9% of pregnant women and nursing mothers faced the challenges of money and distance; 5.1%, distance and behaviour of personnel; 3.8%, money and behaviour of personnel; 6.4%, behaviour of personnel and long hours; 5.1% distance, behaviour of personnel and long hours; and 5.1%, money, distance and behaviour of personnel. All these have implication for Ghana's effort of achieving the MDG target of 185 deaths per 100,000 live births by 2015. These barriers have been discussed

comprehensively in the subsequent paragraphs and how they affect access to maternal health care services in the Metropolis.

Challenges associated with finance: About 16.7% of the pregnant women and nursing mothers faced the challenge of money in accessing healthcare, 36% of them were unemployed and therefore had no source of income. However, those who were employed received an average of GH¢120 a month. Regardless of the inception of the free maternal health care under the National Health Insurance Scheme (NHIS) in July 2008, 30% of the women had not registered. When asked why they were unable to register, 14% explained that they were in consensual unions and did not receive any financial support from their partners and were left to fend for themselves. Consequently, they were able to visit the hospital on days that they had money to pay the GH¢1.2 transportation and between GH¢7-GH¢10 health care charges. Further questioning revealed that although the women had heard about free maternal health care under the NHIS scheme, they did not know what it entailed.

Some expectant women who had registered under the scheme said they were often restricted by insufficient funds to cater for transportation, uncovered medications and food. Thus financial challenges discouraged these expectant and new mothers from seeking antenatal, assisted delivery in the hospitals, and postnatal health care services which they all agreed was the preferred choice. This affirms the study by Babalola and Fatusi (2009) that household wealth in Nigeria, had positive effects on the use of maternal health care services.

Challenges associated with distance: About 15.4% of the pregnant women and nursing mothers faced the challenge of distance in accessing healthcare. The issue of distance did not only have to do with how far the community was to the hospital but also the ease of obtaining transportation to the hospital. Communities like Kokoado and Apewosika were closer to the hospital and so had 93 and 87%, respectively of their pregnant women and nursing mothers citing money, and not distance as a hindrance to accessing the health facility. The women acknowledged that, distance to the health facility was indeed a walking distance of an average of 20 minutes and thus was not an obstacle to them. This was in contrast to communities like Abakam and Ahenboboe which is far from the hospital and therefore pregnant women and nursing mothers needed transportation to get to the hospital. There is no direct public vehicle from these communities to the hospital. As such in order for these women to be able to get to the health facility, they must pick a taxi that is moving from Elmina to Cape Coast, a light at the UCC west gate and pick another taxi moving

from Cape Coast (Kingsway or Ola) to UCC. The average waiting time at the two places is between 40-45 minutes. The hustle involved in obtaining transport resulted in 20% of the pregnant women and nursing mothers in Abakam refusing to seek maternal health care and 60% of the women of Ahenboboe visiting the hospital a maximum of 4 times for antenatal care. A study conducted by Bour (2003) in Ahafo South in Ghana found distance to be the most important factor that influences the utilization of health services. According to Stock (1983) physical proximity of health care services plays an important role in utilization of these services in developing countries.

Analysis from the data collected also showed that regardless of the existence of a number of traditional birth attendants in all the communities and a clinic in Kwaprow, members of the community, despite their income levels, preferred to have assistance from the hospital. A significant number (94.7%) of expectant mothers in communities visited the UCC Hospital for antenatal services, 84.7% visited the hospital for delivery services and 95.1% visited the hospital for postnatal services. Due to the geographical location of the hospital to their place of abode, almost all of the respondents in Abakam and Ahenboboe (80 and 100%, respectively) said that distance from their homes to the hospital affected accessibility and influenced their ability to obtain maximum maternal health assistance.

Challenges associated with the behaviour of health care personnel: Another challenge which faced 20% of the women was the behaviour of personnel. They cited situations where they had been made to feel embarrassed because they could not attend an antenatal appointment or afford some of the things required for delivery. They further cited situations where the nurses had been rude and arrogant towards them probably because of their poor background. This discouraged the respondents from continuing with antenatal care and checking in for assisted delivery. The women interviewed also expressed their dissatisfaction about the time spent at the antenatal clinic. They had to wait for several minutes before maternal health services began and spent long hours at the hospital (on average 3 h). To them time is money and so any time spent outside business could lead to the loss of a customer which in effect means loss of income.

Awareness of maternal health programmes: The study showed that though mothers did not have an in-depth knowledge about the Making Pregnancy Safe policy, they were familiar with the NHIS and its objective to reduce the financial burden faced by mothers in accessing healthcare. Data collected showed 0.8% of the mothers had heard about the MPS Initiative, 70.3% of the mother

knew about the NHIS, 28.9% knew about both the MPS and NHIS policies. This fact was further demonstrated when the survey revealed that 70% of the mothers had been registered under the NHIS. About 86% of respondents received Intermittent Preventive Treatment (with Sulfadoxine Pyrimethamine), during their pregnancy and 76% sleep under Insecticide Treated Nets with their children. All respondents who attended antenatal care at UCC hospital had been tested for HIV and according to the head of maternal health services women who are tested positive are given Anti Retroviral Therapy.

CONCLUSION AND RECOMMENDATIONS

The drive to achieve the fifth MDG of reducing maternal mortality rate by 75% by 2015 in Ghana is eminent. This is particularly important when research continues to identify cost and distance as a constraint to accessing maternal health care services pointing to the fact that interventions have not been comprehensive. The study revealed that women within the ages of 15-49 years; are confronted with challenges such as distance, money and the behaviour of health personnel as hindering access to maternal health services.

In order to assist women financially to be able to access maternal health services, NGO's and government organizations for women should make female education a priority in their activities. They can also organize training programmes on crafts and skills such as batik, tie-and-dye and beads making as a source of livelihood for unemployed women in these communities. This will go a long way to supplement their income. The District Mutual Health Insurance Scheme should embark on a door-to-door education on the free maternal health care and the benefits and importance of NHIS.

The District Health Management Team (DHMT) should adopt focused antenatal care services, and train their midwives to acquire the appropriate skills to manage its implementation. They should organize yearly workshops to upgrade the work efficiency and communication skills of health personnel who handle maternal health services. The Private sector and the District Assembly should provide funding scholarships for indigenes to midwifery training to improve availability of skilled attendants at delivery.

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