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Obstacles to Primary Health Care:

A Three Village Study of the Maternal Child Health (MCH) Program in Ghana

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ABSTRACT

This thesis has explored the implementation of the primary health care strategy in Ghana, focusing on the Maternal Child Health program, one of main components of the strategy and the program that seems to have been most widely implemented in the country.

The analysis has been concerned primarily with identifying the obstacles to the implementation of this strategy in rural areas of the country, where levels of utilization and participation have been found to be lower than what was hoped for by the government. It does this by using data collected through in-depth interviews and participant observation in three rural villages of the country.

The findings reveal that a complex range of interrelated factors influence or deter women from utilizing and participating in the MCH program.

PRÉCIS

Ce projet de thèse s'addresse à explorer les dispositions qui servent à l'implantation des programmes de santé communautaire au Ghana, en visant le programme de santé maternelle et infantine, un des composant qui semble le plus répandu au pays.

L'analyse vise premièrement l'indentification des obstacles qui empêche l'instauration du programme au Ghana, où les taux d'utilisation et de participation n'ont pas atteint une échelle acceptable selon les attentes du gouvernment.

L'analyse se poursuit par des entrevues à fond et par l'observation des activités villageoises dans le secteur rural du pays. De cela, les données receuillies indiquent qu'une variété assez complexe de facteurs influence l'accès aux services de santé et nuit à la pleine participation des villageois, les femmes en particulier.

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Glossary of Terms

ANC	Antenatal Care
CWC	Child Welfare Clinic
DEL	Supervised Delivery Services
DHMT	District Health Management Team
ERP	Economic Recovery Program
FP	Family Planning
GDHS	Ghana Demographic and Health Survey
GDP	Gross Domestic Product
GLSS	Ghana Living Standards Survey
ICMMS	Infant, Child and Maternal Mortality Study
IMF	International Monetary Fund
MCH	Maternal Child Health
MOH	Ministry of Health
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PNC	Postnatal Care
PNDC	Provisional National Defense Council
NDC	National Democratic Congress
SAP	Structural Adjustment Program
TBA	Traditional Birth Attendant
TDC	Town Development Committee
UNICEF	United Nations Children's Fund
VHC	Village Health Committee
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organization

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CHAPTER 1

Introduction

1.1 An Overview

This is a study of obstacles to the implementation of the Primary Health Care (PHC) strategy, a strategy that was designed to make health services more accessible and available to rural populations in the developing world and to promote the participation of local people in the development and implementation of health programs. Since the signing of the Declaration on Primary Health Care at Alma-Ata in 1975, programs have been adopted widely in the developing world. At the local level, programs have consisted of a mix of strategies designed to address the multiple causes of poor health, including programs to provide immunization, health education, and maternal child health services, to control the spread of common diseases, improve environmental sanitation and the provision of water supplies, etc.

The analysis examines primary health care through an intensive study of three villages in Ghana, focusing on the Maternal Child Health (MCH) program, one of the main components of PHC and the program that seems to have been applied most successfully in the country. Through in-depth interviews and participant observation it determines the level of participation in primary health care in these villages and the degree of utilization of public health services, both of which were found to be lower than what was hoped for by the government. The study then uses data to offer explanations for this lower than expected trend in participation and utilization. On the basis of these findings, it offers some recommendations for policy and research.

1.2 The Concept of Participation

In recent years, we have seen increasing attention focused in the literature and at the level of policy-making on the need to involve local people in the design and implementation of development programs. This arose partly out of a recognition that the traditional 'top-

down' and centralized approach to service delivery, which left people with little role to play other than as beneficiaries, was often inappropriate and ineffective in addressing the needs of local communities (Rifkin, 1990; Finsterbush and Van Wicklin, 1987; Oakley, 1989). It has now been widely accepted that increasing community involvement is essential to develop programs that will be adaptable, responsive to people's needs, and sustainable in the long run - a conclusion backed by numerous examples in the field and by recent research findings (Johnson et al., 1989; Rifkin, 1990). Esman and Uphoff (1984) for example, in a cross-national study of 150 local organizations, found that the degree of 'participatory approach' was strongly correlated with good performance and with an organization's ability to raise the incomes and the accessibility of services to the poor. The principle of participation is also advocated on the grounds that it represents a basic right of people to be involved in decisions that affect their lives and to participate in the wider political process. In its broadest sense, participation is part of the larger process of empowerment: helping communities to gain more control over their lives and to become more self-reliant.

1.3 The Primary Health Care Strategy

The concept of 'participation' is one of the founding principles of the Primary Health are (PHC) strategy formulated by the World Health Organization (WHO), UNICEF and participating governments at the Alma-Ata conference in 1978. The main goal of PHC is to make essential health services more affordable and accessible for the poor and underserved populations in rural areas of developing countries. Programs are designed to integrate both curative care and preventive services as well as to promote local participation in the planning and delivery of services.

The Primary Health Care (PHC) concept emerged as governments and international institutions recognized that conventional health care services in developing countries were inadequate to meet the needs of the majority of the population residing in rural areas. All across Africa, and in most parts of the developing world, resources have traditionally been allocated primarily to 'modern' curative care. Governments followed what has been called a

'bricks and mortar' approach; the emphasis was on constructing large and costly 'modern' hospitals in urban areas providing mainly 'western' curative care and utilizing advanced technology and equipment. As a consequence of this, severe inequalities emerged between rural and urban areas in the distribution of resources, personnel and health facilities (Phillips, 1990). In Ghana, for example, it was found that over the 1974-75 financial year, over a third of the health budget went to the Korle-Bu teaching hospital in Accra and to other services in the region alone (Senah, 1992). Resources were, therefore, directed in inverse proportion to the needs of the population; a mere 15% of the Ghanaian health care budget went to primary health care for 90% of the population, while 85% of the health care budget went to serve 15% of the population with secondary or tertiary health care (Morrow, 1983). At the conference at Alma-Ata in 1978, governments declared these inequalities unacceptable and called for an approach that would promote equity in health care and reverse the rural-urban imbalance in the provision of services.

The background leading up to the formulation of the PHC strategy was also characterized by a growing disenchantment with 'modern' health care and its capacity to cure the problems of the poor in developing countries. It gradually became clear that health problems could be tackled more effectively with preventive strategies that treat the environmental and social causes of ill health such as poverty and its related problems: malnutrition, lack of potable water, poor hygiene and sanitation. PHC was therefore envisioned as a strategy that would not just involve the extension of health services and the delivery of preventive and curative care, but focus on improving standards of living and socio-economic conditions. As indicated in the report of the Alma-Ata conference, "primary health care is an integral part of the process of socio-economic development" and has to be coordinated with other activities aimed at combating poverty and improving people's access to resources. Thus, PHC is not only seen as the responsibility of the health sector alone, but of other departments concerned with water, agriculture, employment, housing, and education.

Another basic principle of PHC is the notion that lasting improvements in health can only be achieved once people have been encouraged to assume more responsibility for their health and to become 'agents' of the development process, rather than passive beneficiaries

of development aid (Muhondwa, 1986). The active participation of people is also essential to ensure that programs are not only appropriate, but have the support and commitment of local communities. In addition, it is expected that by involving local communities, resources of labor, materials and funds can be mobilized to support programs that would otherwise be difficult for governments to finance on their own (Oakley, 1989). In an age of dwindling resources and stricter budgetary constraints, the capacity of governments to respond to the needs of their growing populations has become severely limited.

In summary, the PHC strategy is an attempt to correct for the deficiencies in the health care system and to make health services more accessible to rural people by integrating both curative and preventive strategies and involving local communities in the design and implementation of programs. According to the Declaration defined at Alma-Ata, primary health care is:

> "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work"

Since the WHO Declaration at Alma-Ata, PHC has been integrated into the health care policies of governments in most countries in Africa. Different schemes, focusing on immunization, family planning, health education, water supply, and sanitation have been implemented in a number of countries, often with the assistance of donors or international agencies such as UNICEF and WHO (Economist, 1986). Although some success has been achieved in making health services more available and in improving how government's respond to and address the needs of rural communities, recent research has shown that significant obstacles remain to the effective operation of PHC (Bossert and Parker, 1984).

According to Good (1988), the evidence so far indicates that community-based PHC

in Africa generally suffers from weak popular support. Recent research findings from Ghana also indicate that levels of participation and utilization in the country remain low. In one district of the country, Pappoe (1993) found that participation generally amounted to 'contributions of labor or materials to specific projects', and people were rarely involved in decision-making and planning. Data from the Ministry of Health (MOH) also reveals the degree to which Maternal Child Health (MCH) services in the country remain underutilized. So while some gains have been made in increasing health care coverage in Ghana, success in promoting utilization and participation seems to have been far more limited.

An increasing amount of literature has been devoted to PHC, but we still find few examples of studies that analyze in detail how programs are working on the ground. As a result, we still lack an adequate understanding of the difficulties involved in implementing PHC and the factors that determine or shape the performance of programs. We need to explore more documented examples of how PHC is working in concrete situations, in order to understand the complexities involved.

The purpose of the present research is to examine how PHC is working in three rural villages in Ghana, the barriers to women's utilization of health services and their involvement in PHC. As the principal providers of health care both within the family and in communities, women's involvement is central to PHC. Yet, as we have learned from recent research findings, many women remain outside the scope of the program. The purpose of the present study was to try to identify the various socio-cultural, economic, and political factors that motivate or deter women from utilizing MCH services and participating in PHC, including the Traditional Birth Attendant (TBA) program. The Traditional Birth Attendant program serves as an interesting example of how some of the principles of PHC have been put into practice, and it allows us to view some of the dynamics involved in implementing the more participatory aspects of PHC. The findings of this study will therefore hopefully assist us in finding ways to remove the barriers to utilization and participation, and in clarifying the concept and application of PHC.

1.4 Organization of the Thesis

The first part of the thesis, Chapter 2, provides an overview of the economy, polity and social structure of Ghana. The discussion begins by giving a brief profile of the country and an overview of its recent economic and political history. It then turns to a more detailed description of rural Ghana, including the organization of the rural economy, gender relations and the status of women, educational stratification, religious groups, and health problems in the country. This information is necessary to provide the reader with the context needed to interpret the findings and to understand the circumstances in which the PHC program is being implemented. Too often studies do not provide adequate information about the setting and the nature of the society in which the study was carried out, denying the reader the opportunity to make at least partially independent interpretations of the data presented, and to compare the results with studies done in other contexts. For readers who are familiar with African societies and with Ghana, this chapter can be skipped. Chapter Three provides a description of the PHC program as it has been implemented in Ghana, including the Maternal Child Health and Family Planning Program.

The next two chapters describe the research itself: the methodology, and the setting in which the study was carried out, with a detailed description of socio-economic conditions in the villages; the provision of services; the composition of households; and a profile of the women who were interviewed. Chapter Six begins the presentation of the results of the research. It starts with an analysis of the patterns of delivery, utilization and participation in each of the three communities, then presents findings from other surveys conducted recently in Ghana and reports from the Ministry of Health to compare with the results of the present study. This leads us into Chapter Seven, the heart of the thesis, where our attention turns to a discussion of the various economic, social, organizational, and political factors identified in the study as barriers to women's utilization of services and participation in the MCH program. In the conclusion, the findings are summarized and recommendations are made for future research and for program planners and practitioners in this field who may be concerned with finding ways of improving the accessibility and utilization of MCH services in Ghana.

CHAPTER 2

Background on Ghana

2.1 Profile of the Country

Ghana, formerly known as the Gold Coast until independence from British rule in 1957, lies on the Atlantic coast of West Africa and shares a border with the Ivory Coast to the west, Burkina Faso to the north and Togo to the east. Total land area is 239 square miles. Total population was estimated to be 16.8 million for 1994, based on projections from the 1984 Census. Of this, approximately 68% of people live in rural areas and 32% in urban or semi-urban areas. The country is currently ruled by a popularly elected government under the leadership of the National Democratic Congress (NDC) headed by Flt. Lieutenant Jerry Rawlings. The country is divided administratively into 10 regions and 110 districts.

Ghana is a country that is still predominantly rural and agricultural based. Agriculture accounts for the bulk of GDP (as much as 47.3% for 1994) and employs the majority of the population. Data indicates that about 60% of men and women in Ghana are employed in agriculture, including hunting, forestry and fishing. The economy has traditionally been dominated by the export of raw materials - mainly cocoa, gold and timber - which today still account for about 2/3 of export earnings. Cocoa alone accounts for about 40% of export earnings, which is actually a decline from previous years. Other sectors, such as industry and non-traditional exports, have gradually become more important. The country is well-endowed with a range of other resources such as mineral deposits including diamonds, manganese, and bauxite, and it generates its own hydroelectric power which it sells to a few neighbouring countries.

Table 1: Key Indicators

Population: 16.8 million (1994)
GDP: (1994) $450
Share of GDP: agriculture 47.3% industry 16.0% manufacturing 8.8% services 36.7%
Currency: Cedi (average exchange rate for 1993 = 683/US $)
Average Life Expectancy: 56 years
Literacy rate: Male - 75% (urban) 53.5% (rural) Female - 57% (urban) 28.3% (rural)
Infant Mortality Rate: 81 (per 1000 live births) Under-five Mortality Rate: 170 (per 1000 live births) Maternal Mortality Rate: 500-1000 (per 100,000 live births)

2.2 Economy and Polity from Independence to the Present

When Ghana achieved independence from Britain in 1957, it was the first country on the African continent to be freed from colonial rule. At the time, the country was viewed as one of the most promising developing countries. It was the largest producer of cocoa, boasted a healthy mining and timber sector, and, by regional standards, had a relatively well-developed manufacturing sector. Per capita GDP during this period was actually higher than in either Nigeria, Egypt, or India (Huq, 1989). Today however, Ghana no longer holds such an enviable position. After experiencing a brief period of stable growth immediately after independence, the economy began a slow and gradual decline that only intensified over the years and nearly drove the economy to collapse by the early 1980s.

The country's rate of growth went from 6% during the immediate post-independence

continued to fall, averaging at 0.4%, with four years actually showing negative growth rates (Huq, 1989:2). Beginning in the 1970s, inflation rose steadily on and real wages began to decline. Exports also fared poorly: production of cocoa, the country's major export, fell from a level of 557,000 tons in 1964/65 to 185,000 in 1980/81. During this period Ghana's share of cocoa exports also fell significantly from 33% in 1970 to 17% in 1980 (Rothchild, 1991). Production of minerals also fell: gold production went down 47%, diamonds 67%, manganese 43% and bauxite 47% (Kraus, 1991:125). The decline was also visible in the marked deterioration of infrastructure, such as highways, communications, and electricity (Huq, 1989).

By the beginning of the 1980's the country had fallen into a deep economic malaise. According to several authors (Chazan and Pellow, 1986; Ray, 1986;Toye, 1990) the causes of the downfall were both external and internal; involving mainly inappropriate or 'mistaken' domestic policies, economic mismanagement and an unfavourable economic environment. The rise in petroleum prices which occurred during 1979-80 further exacerbated the decline.

This brief period in Ghana's history was also marked by political turmoil and instability. The country was plagued by coups, counter coups, and went through repeated stages of military and authoritarian rule, which were only briefly interrupted by three phases of civilian democratic government. Throughout the 80's the government continued to be a military dictatorship, under the leadership of the then Provisional National Defense Council (PNDC) of Flt. Lieut. Jerry Rawlings. It was only recently, in 1992, that the government finally accepted to hold popular elections and made the transition to civilian rule.

When the PNDC first came to power through a military coup in 1979, it handed over the government to a civilian leader, Dr. Hilla Limann, only to take it back one year later, over dissatisfaction with Limann's performance and his inability to relieve the country of its economic troubles. By the time the PNDC assumed power in 1982 it confronted an economy that had suffered from years of steady decline (Kraus, 1991b). In the beginning, the PNDC government stood on a platform of populist left-wing policies, but a series of crises that occurred in the early 1980s demanded that drastic action be taken and forced the government to make a radical reversal in policy. These included: the forced expulsion and repatriation of one million Ghanaians from Nigeria; severe drought; and bush fires which affected timber and

one million Ghanaians from Nigeria; severe drought; and bush fires which affected timber and cocoa exports (Toye, 1990:47). As the crisis mounted, the government realized that it would be incapable of halting the decline without some financial assistance from donors and international institutions. The only option it had at the time, after being turned down by the Soviet Union, was to turn to the International Monetary Fund (IMF) and the World Bank (WB) for assistance. But as a condition for obtaining loans, the government had to adopt a set of strict monetary policies, now popularly known as Structural Adjustment Programs (SAP), which embrace the liberal market-oriented ideology of the IMF and WB.

Before concluding an agreement with the IMF/WB, the government had apparently already begun to formulate its own plans for economic recovery which contained some of the essential IMF measures such as devaluation (Ray, 1986:130). Although it claims that the program represented its own views on what was needed to save the economy from further collapse, it is questionable whether it had much say in determining the overall framework of the program. There does not appear to have been much room for negotiation. All over Africa, SAPs have resembled a fairly uniform set of policies. The standard package consists of: liberalization of trade; promotion of exports; removal of price controls and marketing boards; devaluation of the currency; reduction in size of government and public spending; and privatization of state enterprises.

The government formally launched the Economic Recovery Program (ERP) in April 1983. In Ghana, the program would be implemented in two phases: the first phase, known as ERP I (1983-86) concentrated on stabilization and halting the decline in industrial production and commodity exports; the second phase (1987-89) focused on economic development. The main goals of the program were to: realign the price and incentive system to increase levels of productivity, particularly in the export sector; reduce the balance of payments deficit; and promote savings and investment.

According to World Bank and IMF criteria, Ghana's adjustment program has been a success. They point to Ghana's rate of growth, which has shown steady improvements; GDP has been increasing at a rate of over 5% per annum and per capita income has also shown a steady increase of 2% (World Bank, 1994). In addition, Ghana's primary exports, from cocoa

growth is also evident in the rehabilitation and construction of roads and highways, improved infrastructure (such as communications), a greater availability of imports and in higher domestic food production. Government revenues have also increased, from 6% of GDP in 1983 to 16% in 1991, and have permitted the government to reduce the fiscal deficit and increase public investment in infrastructure, which had collapsed by 1983 (World Bank, 1995).

Table 2: Selected Economic Indicators

	1985	1986	1987	1988	1989	1990	1991	1992
% Growth								
Real GDP	5.2	5.1	4.6	5.5	5.0	3.1	5.2	3.6
GDP per capita	1.5	1.7	1.3	2.2	1.6	-0.1	2.1	2.9
Real agriculture GDP				3.6	3.6	-2.0	4.7	-0.6
Real Industry GDP				7.2	2.6	6.9	3.7	5.8
Real Services GDP				7.8	6.7	7.9	6.3	7.7
Million US $								
Merchandise Exports	634.4	773	826.8	881.0	807.2	890.6	997.6	986.4
Merchandise Imports	668.7	712.5	951.5	993.4	1,002.2	1,198.9	1,318.7	1,456.7
Current Acc Balance (before official transfers)	-243.7.	-165.5	-220.1	-261.9	-318.8	-442.3	-454.1	-591.6

Source: Economic Intelligence Unit, International Financial Statistics, Institute for Statistical Social and Economic Research (1993).

Table 3: Production of Key Exports

	1986	1987	1988	1989	1990	1991	1992
cocoa '000 tons	-----	188	301	295	293	243	-----
timber exports '000 cubic metres	295	485	636	376	425	396	304
gold '000 fine oz	287	327	372	430	539	843	1004
manganese '000 tons	259	245	245	284	247	320	279
bauxite '000 tons	204	196	284	381	381	334	310
diamonds '000 carats	559	442	216	171	636	688	694

Source: Economic Intelligence Unit

While there are signs that the ERP has brought some economic gains, there are several weaknesses in the program that threaten the long-term growth of the economy. First of all, the program's overreliance on exports crops maintains the economy's dependence on a few traditional products that are vulnerable to international commodity price fluctuations. Since 1984, the world price for cocoa has declined; just between 1992 and 1993 the price fell by 22% in real terms (ISSER, 1993:54). So in spite of the higher volume of production achieved in 1993, export earnings were lower in 1993 than in 1992 as a result of the lower world price for beans. Starting in 1988 and continuing into 1993, the prices received by cocoa farmers have also fallen in real terms (ISSER, 1993). World prices for some of Ghana's other major exports, such as gold, have also shown a cyclical decline (World Bank, 1994).

The primary focus on export crops has also caused the government to neglect domestic food production, on which the majority of farmers depend. The main beneficiaries of the new price incentives have been large cocoa farmers, who represent a small proportion of the total farming population (Rothchild, 1991:133). For the majority of farming households that do not

produce cocoa, incomes have either declined or stagnated since 1984 (Weissman, 1990). A recent study by Sarris and Shams (1988) concluded that devaluation and liberalization have shifted the terms of trade against domestic food producers and brought a decline in real smallholder farm incomes. The authors also claim, however, that the decline has been occurring for several years and may not be entirely attributable to the ERP/SAP. Nevertheless, the evidence seems to indicate that small holders have most likely not benefitted from the ERP in the short term (Sarris and Shams, 1988). Not only have price changes shifted in favour of cocoa farming, but so have resources and services for agriculture, in the form of subsidies, credit, etc. The World Bank admits that a major flaw in the program was its failure to recognize domestic food production as a powerful engine of growth; yet, the ERP still lacks any coherent program for small-scale food production (Kraus, 1991).

There is evidence that local manufacturers have also been hard hit by the liberalization of trade and increased competition from imported goods. Local manufacturers have in addition, expressed concern that the strict credit policies pushed by the IMF and World Bank to combat inflation, have prevented companies from gaining access to badly needed foreign exchange (Harsch, 1989:26).

Moreover, one of the key goals of the ERP/SAP, which is to establish a current account balance, has not been met. The current account deficit remains high and has actually widened since 1986 (see Table 3). From 1991 to 1992 it increased from US $454.1 to $591.6 million. The ERP has also been accompanied by a growing debt burden. "In its 1993 report on Trends in Developing Countries, the World Bank even classified Ghana's level of indebtedness as severe" (ISSER, 1993:12). The external debt has increased from $3487.02 million at the end of 1990 to $4679.97 million at the end of 1993. As a proportion of GDP, it increased from 56% in 1990 to 79% at the end of 1993 (Ibid).

Until now Ghana has been able to maintain an overall balance and make debt repayments because it could count on external aid flows. Without these aid transfers, the trade deficit and debt would be difficult for the country to sustain. "Aid flows have been quite significant, rising from US $270 million in 1984, to US $385 million in 1986 and to US $480 million in 1990" (Kraus, 1991:25). But, as current trends indicate, the same levels of aid are

unlikely to continue into the future. Ghana's debt and current account deficit may therefore act as important constraints to economic growth in the long run. The future growth of the economy will have to be powered by greater foreign and domestic private investment, but, until now, levels of investment have been disappointingly low. According to the IMF's own assessment, levels of savings and investment in the country have been insufficient to maintain a satisfactory rate of economic growth (Kapur et al., 1991:10; World Bank, 1994:172).

SAPs have also been very controversial in Africa because of their inherent social costs. Some of the major aspects of SAP, such as devaluation and cuts in government spending, have direct and adverse consequences for the population, especially the poor. Devaluation has increased the prices of essential goods and the overall cost of living. Yet most people still lack an adequate income to satisfy their basic needs as wages have declined or stagnated in real terms. The shops may be glowing with a new and greater assortment of products, but to the average Ghanaian citizen most of these goods remain unaffordable. Structural adjustment has also entailed a reduction in government spending and the removal of subsidies for social services such as education, health, and water. As a result, user fees have been imposed in order to recover some of the cost of providing services. Yet with these fees, basic services, such as health have become even more inaccessible to the poor. Recent research has shown, for example, that after the government raised user fees for health services, levels of utilization dropped significantly, particularly in rural areas of the country (Waddington and Enyimayew, 1991;1990).

As part of the government's drive to reduce the 'wage bill', tens of thousands of workers in the civil service have been laid-off, and no adequate program has been organized to help workers with 'training' or skills to find other employment (Weissman, 1990). In a study among female civil servants in Accra who were 'redeployed', many claimed they had been forced into informal sector or agriculture work as a result of losing their jobs and had found their standard of living had lowered (Manuh, 1991).

The government and the donor community recognized that SAP was having an adverse impact on the poor and in response to this, initiated a scheme known as the Program of Action to Mitigate the Social Costs of Adjustment (PAMSCAD) in 1988. The PAMSCAD scheme

has undertaken a number of social projects aimed at meeting the needs of the most vulnerable groups, such as women, children, and the unemployed, but it appears that little progress has been made so far (World Bank, 1994).

Despite the success achieved during the last decade of the ERP/SAP, there are a number of trends which cast doubt on the future growth of Ghana's economy. While conditions have visibly improved, and the program has certainly reversed the decline of previous years, the analysis has shown that Ghana's economy remains in a very precarious state. It remains uncertain therefore, whether the present rate of growth can or will be sustained. The impact of the program has also been mixed. While the World Bank (1994; 1995) contends that "the benefits of adjustment have been large, visible and widely shared" and that policies have even lead to a decline in the level of poverty, critics of the strategy charge that SAP has done little to improve the living standards of the majority. In their view, the benefits of adjustment have been inequitable and restricted to a few (Kraus, 1991; Weissman, 1990). It has also been said that rural women have been among the worst affected by adjustment because the growing demand for cash has forced them to spend more time in productive activities, while they still remain either primarily or solely responsible for shouldering the burden of household work (Sparr, 1995; Kanji et al., 1991).

While the evidence suggests that structural adjustment in Ghana has had mixed results, it is clear that the economic strategies currently being pursued have critical implications for the success of PHC and community participation. In Ghana, PHC must operate in an environment of: economic austerity; tighter budgetary constraints; reduced spending on social programs and declining real incomes of the population. Ghana's experience with PHC can therefore offer us valuable lessons on how one country undergoing adjustment, has met the challenge of turning the promise of PHC, into a reality.

2.3 Rural Society

2.3.1 Ethnic Groups

A multitude of diverse ethnic groups are known to exist in Ghana, but among them we can distinguish five main groupings which share a linguistic affinity and common cultural attributes. These are: the Akan, the Ga-Adangme, the Ewe, the Guan and the Gur-speaking peoples (Foster, 1965:16). The southern part and coastal regions of the country are inhabited by the Akan, Ga-Adagme, Ewe, and some Guan-speaking communities. In the north live predominantly the Gur-speaking people who can be further subdivided into the Mole-Dagbani, Grusi, Gurma, and Senufo. A fairly extensive historical and anthropological literature is available on different societies in the north and south of Ghana, but for the purpose of this paper it is only necessary to give a brief outline of the Akan cultural system, which covers the area in which the present research was conducted. The population in the communities studied was mainly Fante, which is one of the sub-groups of the Akan. The Fante mainly inhabit the coastal regions west of the capital Accra. Most of what has been written on the Akan covers the Ashanti, and although they may in some ways be distinct from the Fante they still do exhibit a high degree of cultural similarity. The Akan are the predominant ethnic group in the south of Ghana and constitute as much as 44% of the total population in the country (Okali, 1983:12)

2.3.2 The Kinship System

The first step to an understanding of Akan society is the kinship system. Kinship relations in Akan society are based on a system of clans. Among the Fante, each person belongs to one of seven clans which traces its descent from one common putative ancestor or ancestress. In almost every rural community in the Akan region of Ghana one can find at least several clans represented. This has been attributed to dispersion due to wars, migration, etc. (Fortes, 1950). The Akan kinship system also functions along the rule of matrilineal descent,

which means that descent is traced through the female line. "Inheritance and succession also pass in the female line" (Nukunya, 1992:30).

The most localized form of the kinship system is the 'lineage' or 'descent group'(Fortes,1970). The lineage is comprised of members of the same clan who reside in the same community and can trace their descendance from one single ancestress back four or five generations (Okali, 1983:11). It is with the lineage, rather than the large dispersed clan, that people identify and associate themselves more closely. Members of the same lineage often live in the same area of a community in sections or in 'wards' and may have more frequent interaction (Fortes, 1950). Traditionally, the lineage was the centre of much communal activity (Busia, 1951:7). Still today, important social and cultural events, such as funerals, are organized around the lineage. "The lineage is also a corporate entity in the sense that it has a recognized head, owns property, such as land, and holds legal and economic obligations" (Nukunya, 1992).

The kinship system also defines the principles regarding marriage, residence and household organization. Marriages between two members of the same clan or descent group and certain categories of kin are not permitted. The marriage contract therefore brings two families of different lineages together (Nukunya, 1992:38). When couples marry they are expected to move into the husband's family residence or establish their own home apart from family and kin. But in reality, a husband and wife will often be living in separate households. Studies of domestic organization in rural Akan communities reveal that many women live in households with their own maternal kin rather than with their husbands, "which is evidently due to the greater weight given to matrilineal kinship ties in Akan society" (Nukunya, 1992:30). According to Fortes (1970), young women will often choose to stay in their mothers' home during the early years of marriage, but in later years, after they have given birth to two or three children, they may prefer to stay with husbands so that children can be under their fathers' care. Yet, when a woman reaches the end of her childbearing years she may decide to establish her own home, especially if she is widowed or divorced (Fortes, 1970:25). In a typical Akan community, one therefore finds households in which maternal ties are

emphasized and those which are based on the husband-wife relationship.[1] But in spite of the prominence given to maternal ties in Akan society, children still maintain a close relationship with their fathers. They play important roles in rearing and educating children and protecting their welfare. Christensen (1954) claims that one of the distinguishing characteristics of Fante social organization is the closer association children maintain with their fathers' lineage, which he suggests may classify the Fante as a 'double descent' group.

Another important role of the kinship system in Akan society is in the ownership and administration of land. Land in Ghana has traditionally been vested in lineages, families or in chiefs; chiefs controlled and administered what is known as 'stool' land on behalf of their people. Land was never viewed as something that was an object of sale. It belonged to the ancestors and could only be entrusted to the living to use. It had to be kept in the hands of the lineage for future generations (Nukunya, 1992). In gaining rights to land, individuals only gained the right of 'usufruct'; they could work on the land throughout their lifetime and even pass it on to an inheritor, but it stayed under the control of the lineage. Although the sale of land to private individuals has become more common with the establishment of cocoa farming in the country (Manoukian, 1950:15), most of the land in Ghana remains under communal ownership. In rural communities, people continue to have access to land through their chief or lineage. This is with the exception of strangers or individuals who are not original citizens of a village and who do not have lineage ties within a community; they must either rent or lease land from the chief or other landowners.

2.3.3 Local Political Leadership

The institution of chieftancy in Akan society also remains very important, especially to an understanding of life in rural villages. Each community in the Akan region is lead by a chief who governs along with a 'council of elders', which is usually made up of the respective

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1 Fortes (1970:16) contends there are three possible types of domestic groups: those built around a husband and wife; those built around a segment of a matrilineage or combinations of the two. But the dwelling group is usually a single kin group (Manoukian, 1950:26).

heads of the lineages resident in the community. The local council is linked to a Regional House of Chiefs and National House of Chiefs. Traditionally, the chief exercised considerable religious and moral authority and represented the link between the people and their ancestors. Although his powers have diminished through the years he still plays a very important role in maintaining order, regulating disputes, organizing communities for important social and cultural events such as funerals, mobilizing people for communal projects and in some cases he may be responsible for guarding and assigning 'stool' land. In some communities there will also be an elected Queenmother, who is not the real 'mother' of the chief, but actually a sister or female relative. She plays a particularly important role in the election of chiefs, and acts as a representative of women in the community (Busia, 1951:19). But her powers remain limited, and aside from the position of Queenmother, women do not have access to political office: "they may have the right to express their views freely in lineage affairs; but they can not be elected to the headship of a lineage" (Fortes, 1970:15).

2.3.4 The Status and Role of Rural Women

Within Ghanaian society, structures of authority and status are based on age and gender. Age is associated with wisdom and experience, and the more advanced one is in age, the more wisdom one is expected to hold (Pappoe, 1993). Men are also perceived as the primary producers and decision-makers of the household. Women are viewed as the 'dependents' of men and are mainly expected to serve their role as wives and mothers in the reproductive sphere. In the typical rural household, the head will either be the husband or father, or the senior person in the household by age, generation, or status, which can be either a man or a woman (Manoukian, 1950:26).

In rural communities, we also find significant numbers of households headed by females, which may be the result of a number of different factors including: migration; divorce and widowhood; or, as mentioned earlier, the influence of maternal kinship ties. It appears however that over the years the proportion of women who are becoming the de facto or dejure household heads has been increasing, which means that more and more women are held either

primarily or solely responsible for maintaining households. It has been estimated that in Ghana as much as 30 to 50% of women are the primary household heads, with variations between regions and rural and urban areas (Ghana Statistical Service, 1995b; Ardayfio-Schandorf, 1994).

Although women in Ghana have traditionally been associated with the domestic sphere, they have always been very involved in productive activities outside the home. According to Sai (in Robertson, 1984), women in Ghana have always had to work on the farm, in craftwork, dressmaking, or trading in order to provide additional income for the family. According to census data for 1984, women constituted as much as 51.3% of the labour force (Manuh, 1990). There are probably very few women in Ghana today who are not economically active, especially in the present economic circumstances which have imposed greater demands on families to earn cash to satisfy their basic needs. But in spite of their important economic role, women remain in a subordinate position relative to men in the political and economic realm, and this has important implications for their ability to exercise control over their own health and that of their children (UNICEF, 1990).

Studies have also shown that a gender division of labour exists in farming. According to Boserup (1970) and others (Bukh, 1979; Mikell, 1981), the policies of the colonial administration and the 'development' programs of subsequent decades are responsible for creating a more unequal division of labour between men and women by giving men opportunities to work in the modern sector and in cash crops, while restricting women's role to the domestic sphere. In Ghana for example, it was common in the past for husbands and wives to work together on farms to produce food for the family; but, with the introduction of cocoa into the country, men were encouraged to take up cash crop farming and withdrew their involvement from subsistence farming, leaving women with the responsibility of producing basic food for the family (Bukh, 1979; Roncoli, 1985). But even as men moved into cash crops, they would still need to draw on the labour of their wives and families to assist them. As a result, it is most typical today to find rural women in Ghana, and in many parts of Africa, working either as 'unpaid' family labourers on their husbands' farms and/or working on their own small farms to produce food for the family (Whitehead, 1990). Only a small proportion

of women in the total farming population operate as independent farmers, but most are probably cultivating for sale as well as for home consumption.

In addition to farming, rural women are responsible for daily household chores such as fetching water and firewood, processing and preparing food, and taking care of children. Many women also combine farming with other productive activities such as trading, food processing, or artisan work to supplement the household income (UNICEF, 1990). The majority of rural women therefore carry a very heavy economic burden and workload; yet, they continue to have less access than men to critical resources such as credit, agricultural extension, and education, that would help to improve their standards of living (Sarris and Shams, 1991).

2.3.5 Economic Organization

Agriculture in Ghana remains the mainstay of the economy. Over 60-70% of the population is employed in agriculture, which includes animal husbandry, forestry and fishing (Ghana Statistical Service, 1995a). The majority of farmers are smallholders involved in food production, either for subsistence and/or for the local market[2]. The predominant practice is shifting agriculture, where farmers move from one plot to another to allow a period for the soil to regenerate. Cocoa farmers, however, also tend to do 'mixed farming'; growing foodstuffs, such as plantains, bananas, etc., along with tree crops.

There is apparently little detailed information on the distribution of cocoa farms, but findings from a survey conducted in the 70's indicated that 32% of male and 25% of female members of the agricultural labour force were spending part of their time on cocoa production (Okali, 1983:9). The range in the size of cocoa farms tends to vary greatly. There are some very large cocoa farms, above 20 acres, but apparently most farms operate on a small-scale,

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2 Research by Sarris and Shams (1991) concluded that smallholders constitute about 76% of all holders in Ghana, the cut-off point being 1.6 hectares or 4 acres. Of total farms in Ghana, 26.4% were run only for subsistence, while 54% for subsistence and for sale, and the rest, strictly for sale.

on plots of 1-5 acres (Boateng, 1966)[3]. A recent study by Commander et al. (1989) reveals that the large cocoa farmers, with farm sizes above 30 hectares, control more than 60% of the income earned from cocoa sales. Although smaller cocoa growers control less than 10% of total income, they still earn significantly more than non-cocoa farmers. In terms of per capita income, small food farmers are in the lowest category (Commander, 1989:123).

The types of crops farmers grow vary across different parts of the country, depending on the soil and climate. As Boateng (1966:66) describes, there are three main agricultural zones: a) the forest zone, b) the coastal savannah zone, and c) the northern savanna zone.

a) The forest zone: this zone covers the greater part of the Eastern, Central and Western regions, the southern part of the Ashanti and Brong-Ahafo regions, and parts of the Volta region. The main crop grown in this area is cocoa, because of the rich soil and humid climate which is most suitable for cocoa. Other crops grown include: yams, plantains, bananas, cocoyams, cassava, maize, rice, and peppers, in addition to various vegetables and fruits.

b) The coastal savanna zone: this region comprises the area along the coast and further inland. The main occupations are fishing, farming, and stock raising. The most widespread crop is cassava. Further inland farmers may also grow maize, as well as, some vegetables and fruits.

c) The northern savanna zone: cocoa and most of the typical food crops found in the south can not be grown in the north, the main activity here is the rearing of livestock and cultivation of grains and other foodstuffs. Cotton, guinea corn, millet, groundnuts, and bambarra beans are some crops which are unique to this area. There is also widespread cultivation of yams and cassava, produced mainly for local consumption.

The next most important employer, especially for women, is wholesale and retail trade. For men, it is community, social, and personal services. Census data also show that the majority of people are self-employed. Wage employment is still only available to about 15%

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3 According to Sarris and Shams (1991), average size of cocoa holdings is 10.3 acres or 4.02 hectures.

of all workers, both men and women.

2.3.6 Religious Groups

Evidence from the Ghana Livings Standards Survey (1993) indicates that nearly two-thirds (64%) of the heads of households are Christian; a further 14% are Muslim, and 18% hold traditional or animists beliefs. The south of the country is mainly Christian, while the north is predominantly Muslim. Alongside these dominant orthodox churches there have emerged new syncretic churches which merge Christian with traditional African beliefs and rituals. They were formed largely as a result of the dissatisfaction people felt towards worship in orthodox churches, which tried to suppress traditional African expressions of dance, drumming and ritual and ignored the power of religion to heal (Appiah-Kubi, 1981; Nukunya, 1992). The new churches, whose leaders combine their roles as priests and 'faith healers', have become increasingly popular and appear to be luring more and more converts away from the orthodox churches. "A few of these movements originated in Ghana, such as; Mozama Disco Christo Church, Apostle's Revelation and African Faith Church, while others are branches of churches from North America and Europe such as Apostolic and Pentecostal" (Nukunya, 1992:131).

2.3.6 Education

In Ghana, education has always been considered by the government as a very high priority (Ghana Statistical Service,1995a). Over the 1960-84 period, the proportion of the population currently enrolled in school or ever having received an education, has steadily increased. According to census data, the proportion of the population 6yrs that has ever been to school increased from 29% in 1960, to 43% in 1970 and 56.5 % in 1984 (Ghana Statistical Service, 1995a). However, recent studies have also shown that educational attainment remains low; only a small proportion of young men and women reach beyond the primary or middle school level, and even fewer graduate from secondary school.

There are also significant differences between men and women, and across rural and urban areas in enrollment rates. Women constitute a smaller percentage of the student population at each level of the educational ladder. As results from the Ghana Demographic and Health Survey (Ghana Statistical Service, 1993) reveal (see Table below), educational attainment is particularly low among rural women; only an estimated 9.1% of rural women interviewed completed secondary school, in comparison to 12.9 of urban women.

Table 4: Educational Level of the Male and Female Household Population

		Highest Level of Education Attained			
		None	Primary	Middle/JSS	Secondary or Higher
Males	Urban	12.2	31.3	35.0	21.4
	Rural	32.9	34.3	27.0	5.8
	Total	26.2	33.3	29.6	10.9
Females	Urban	22.3	30.3	34.5	12.9
	Rural	46.8	30.8	20.4	1.9
	Total	38.3	30.7	25.3	5.7

2.4 Health Problems in Ghana

The pattern of health problems in Ghana is characteristic of most countries in Africa. Communicable and parasitic diseases such as malaria, measles, diarrhoea, tuberculosis, gastorenteritis, schistosomiasis and tetanus are some of the major causes of morbidity and mortality (Morrow, 1983; Feachem, 1991). Most health problems that people suffer from are connected with endemic environmental conditions such as lack of sanitation and hygiene, inadequate or contaminated water supplies, and poor housing and environmental conditions. Malnutrition and anemia, which are most common among women and children in Ghana, have

have also been identified as major indirect causes of morbidity and mortality (UNICEF, 1990). Other diseases which have become increasingly common over the years include: respiratory tract infections, hypertension and sexually transmitted diseases.

The rate of infant and maternal mortality in Ghana is also high. In the 1970s, the rate of infant mortality was estimated to be about 130 per 1000 live births, with wide variations between regions (Morrow, 1983). Maternal mortality was estimated to be around 500 to 1000 deaths per 100,000 live births. More recent studies put the ratio at 250 to 390 per 100,000 live births (Ghana Statistical Service, 1994). It has been estimated that in Sub-Saharan Africa as a whole, 640 women die for every 100,000 live births. "The leading direct causes of maternal death in the developing world include haemorrhage, infection, toxaemia, obstructed labour, and complications of abortion" (Eades et al., 1993). Women in Africa are also known to have the highest risk of suffering from long-term disabilities related to complications of pregnancy and childbirth (Paul, 1993). Yet, research has shown that some of the main indirect causes of maternal morbidity and mortality are preventable. They include the following: socio-economic status, nutrition, access to services and inadequate medical care (Paul, 1993; Kwast, 1989). Age, parity and birth interval are other well-known factors associated with the risk of maternal morbidity and mortality.

CHAPTER 3

The PHC Program in Ghana

It was in 1977 that the Ghanaian government formally adopted a proposal to develop a Primary Health Care (PHC) program in the country. In the statement of the strategy the government outlined two main objectives: 1) to achieve basic primary health care for 80% of the population in the country; and 2) to attack the disease problems that contribute to the 80% of unecessary deaths and disability in Ghana, doing so by 1990. Since then, primary health care services have been gradually expanded over the years and now reach most areas of the country.

The primary health care system in Ghana is structured on three levels: the community level or level 'A'; the health institution level or level 'B'; and the district level. The district level administration is responsible for overseeing the operation of the PHC system in the entire district and managing the district hospital, which serves a population of approximately 150,000 to 200,000. It is lead by a District Health Management Team (DHMT) made up of a district medical officer, a public health nurse, a district health administrator and a health inspector. The DHMT is the first level for planning, supervision, budgeting and financial control of the PHC program.

The health centre or healthpost is the first referral point for health services in the village. It is run by a medical assistant, with community health nurse midwives and community environment development workers, who are responsible for, among other things; the supervision of community health workers, including traditional birth attendants (TBAs), for holding monthly outreach clinics in villages and for providing immunizations and basic curative care to villagers in the catchment are (it has been planned that there should be at least one level 'B' institution within an 8 kilometre radius).

The organization at the community level consists of a village health worker (VHW), traditional birth attendant (TBA) and a village health committee (VHC). The VHW and TBA are local residents who have been selected by the community to receive special training from the Ministry of Health in basic curative care and obstetrical services. The VHW's duties are

to provide health education as well as other preventive and curative services. The TBA is primarily responsible for providing antenatal and postnatal care and for assisting women during childbirth. The community is expected to provide compensation in money or in kind to the VHW and TBA for their services to the community. The VHW, TBA and VHW are, therefore, the concrete expression of a community's commitment to, and participation, in PHC.

The PHC program in Ghana has eight essential components:

1) Maternal and Child Care Services including Family Planning
2) Health Education
3) Promotion of Proper Nutrition
4) Environmental Health Promotion
5) Prevention and Control of Locally Endemic Diseases
6) Expanded Program of Immunization
7) Treatment of Common Diseases
8) Supply of Essential Drugs

3.1. The Maternal Child Health and Family Planning Program

This study concentrates on the Maternal Child Health component of the primary health care program because this is the one component of the program that seems to be functioning most effectively at the local level. Family Planning programs, which are carried out in conjunction with maternal child health programs, were not included as part of the study. The Maternal Child Health and Family Planning (MCH/FP) program incorporates strategies for safe motherhood, child survival and family planning. The emphasis in the MCH component is on the provision of antenatal care, obstetrical or delivery assistance, postnatal and child health care services.

Antenatal services are designed to provide women with physical and laboratory examinations to monitor feotal growth and to detect pregnancies that may be at 'risk'. Risk factors include: age, parity, hemoglobin, height and other potential health complications. Antenatal clinics are also intended to provide women with tetanus toxoid immunizations,

malaria prophylaxis and iron supplementation for those suffering from anemia (MOH, 1992). The MOH expects women to attend an antenatal clinic (ANC) at least four times during a single pregnancy. Supervised deliveries (DEL) are conducted by trained midwives at the health centre or healthpost, or by 'trained' TBAs in the community. Postnatal services (PNC) are to promote the health of the newborn and newly-delivered mother. Child health services, which concentrate on child welfare clinics (CWC), are for children aged 0-5 yrs. By the eleventh month, a child is expected to have attended a clinic at least 9 times, mainly for growth monitoring and risk detection. During PNC and CWC clinics, women are also expected to receive health education on topics such as breastfeeding, good weaning diets, nutrition and family planning.

The Traditional Birth Attendants (TBA), who have been recruited and trained by the MOH, are a major focal point of the MCH program. They serve an important role in extending and improving the delivery of maternity services to women in rural communities. The idea to train traditional midwives[4] emerged as governments and international institutions recognized that modern maternity services could not be expanded throughout the rural areas and that traditional midwives, who were already key providers of maternal and child health in their communities, could serve as an important resource for PHC. It has been estimated that all over the world, over 2/3 of births are delivered by traditional midwives or birth attendants who have been trained in the 'traditional' medical system (Cominsky, 1983). In Ghana, these midwives are usually older women and sometimes men, who have acquired their skill in an informal setting, as an apprentice to another traditional midwife, a member of their family, kin group or community. There are also TBAs who claim they have never been given any special training, but have acquired their skills through visions and revelations.

The aim of the TBA program is essentially to upgrade the skills of traditional midwives and enhance the quality of care they provide to women during pregnancy and

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4 The terms 'traditional midwife' and 'traditional birth attendant' will be used interchangeably in the text. To some however, the term 'birth attendant' may be too restrictive because it implies that a midwife's role is confined to childbirth when, in fact, she may play a much broader role. Local midwives in the present study, for example, were sometimes consulted to provide assistance during the prenatal and postnatal stages.

childbirth. Under the program, TBAs have been trained to know how to: 1) take a basic history of a pregnant woman and do simple examinations; 2) give advice on nutrition, hygiene and tetanus immunization; 3) give routine drugs to women; 4) detect and refer high risk pregnancies and all women to a level B institution for tetanus toxoid immunization; 5) advise women on child care, immunization, family planning (FP) and to explain the benefits of 'good' health practices to women such as ORT (Oral Rehydration Therapy), and finally, 6) conduct normal and uncomplicated births using safer and more hygienic methods (e.g. to cut and dress the cord). By promoting healthier practices among pregnant women, referring high risk pregnancies, providing family planning services and safer obstetrical care, TBAs can make a significant contribution to lowering the high maternal and infant mortality rates in the country.

CHAPTER 4

Methodology

The research consists of an in-depth study of the MCH program in three villages in the Gomoa District of Ghana, which were served by a healthpost located in the town of Oguua. In determining the area of the country in which to implement the study, the MCH report for 1992 of the Ministry of Health was examined. Only regions in the south of the country were considered because of the researcher's greater familiarity with the area. It was found that among all the regions in the southern part of the country, the Central region had some of the lowest recorded rates of coverage and utilization, but in comparison to national averages, the rates of utilization were not neccessarily atypical. Health services in the region also appeared to rely heavily on community-based services such as outreach clinics and 'trained' TBAs. It was felt therefore that a study to examine the causes of the low utilization of services would be valuable in this area. Consultations were then held with Ministry of Health (MOH) personnel, including at the Health Research Unit. It was recommended that the study be directed from the operations research station in the region, where support and resources would be available if needed. After meeting with the head of operations research in Apam, the capital of the Gomoa District, the decision was finally made to focus the study on three villages surrounding the healthpost in Oguua. The healthpost in Oguua was chosen because it covered a wide area and served villages that were more remotely located and not connected to the nearest highway and/or paved road.

Two villages were first selected based on their size, distance from the healthpost and infrastructure. It was also necessary to select villages that were located in different directions from the healthpost. Gomoa-Achiasi and Gomoa-Tarkwa were chosen as the two villages in which to focus the study. It was later decided, however, that a third village, Gomoa-Mampong, would be added to the study once it was discovered that the community had been very successful in implementing PHC activities and was even awarded by the Ministry of Health (MOH) for its accomplishments. Since 1985, with the assistance of World Vision, an international development organization, the community in Mampong has worked on a number

of different projects, including: the construction of a day care centre and market, three KVIPs and a shed for a commill. The community has also been involved in other activities such as beekeeping and poultry-raising. Although Mampong was considerably smaller than the majority of villages in the area, it was felt that the community's experience with PHC would serve to make an interesting comparison and possibly offer some ideas as to what makes a program work or succeed. In total, six months were spent carrying out the fieldwork; approximately 8 (or total of 16) weeks were spent in Tarkwa and Achiasi, followed by 6 weeks in Mampong.

The research methodology was a combination of participant observation and semi-structured interviews. It was felt that a qualitative study should be done to follow-up on the findings of previous surveys and to examine the issues in greater depth. In-depth interviews were conducted with a sample of fifty women: 20 were selected in Tarkwa and Achiasi, and 10 in Mampong. Purposive sampling was used to draw up a list of women belonging to the four following target groups: 1) pregnant women with one or two children; 2) pregnant women having their first child; 3) women who have given birth in the last year; and 4) women with children between the ages of 2 and 5 years. A questionnaire, composed of both open-ended and close-ended questions, was designed to guide the interviews (See Appendix C). The focus was primarily on studying women's utilization of antenatal (ANC), delivery (including 'trained' TBAs), and child health services, such as postnatal (PNC) and child welfare clinics (CWC); but, questions were also directed more generally at beliefs and practices, management of health problems within the household, decision-making processes, knowledge and perception of health services, activities within the community and women's participation in the organization of health programs or other health-related projects, such as the TBA program. Women were also encouraged to articulate their views about development problems and processes in the community and to propose changes to the delivery of services and to PHC.

Since the majority of villagers spoke only Fante, a translator had to be hired to help in conducting the interviews. After one month however, the first person unexpectedly dropped-out of the project and someone else had to be found. Although a few women in the sample were able to express themselves in English, a translator was present for all of the 50

interviews. Each interview was recorded on tape. The text in English was then transcribed and typed.

The data used in the analysis is based on the responses as described by the translator. So as to cross-check the accuracy of this translation, another person was also hired to transcribe a second time the taped responses of women in approximately 15 interviews. The quotes included in the text are the actual statements made by the translator. In a few cases, however, it may be indicated that it is either the woman herself speaking or the interpretation given by the second translator.

In addition to the in-depth interviews, a number of formal and informal interviews were held with different members of the community: village leaders, chiefs, elders, traditional medical practitioners, priests, priestesses, church leaders, traditional midwives, community health workers, staff at the healthpost in Oguua, the district hospital, and representatives of World Vision. This information was further complemented with observations of activities in the community, a review of program documents, and records from the healthpost.

CHAPTER 5

The Setting

The Gomoa District covers an area that falls along the coast and further inland, several kilometres west of the capital Accra. The capital of the district and the centre for district level planning and administration is Apam, a large fishing town. The district hospital, run by the Catholic diocese is located in Apam. Other health facilities in the district include: three healthposts, one in Gomoa-Oguua, Gomoa-Buduatta, and Gomoa-Onyadze; a 'community clinic' in Ojobi, which provides a limited range of basic services, given by a 'community clinic attendant' (CCA) trained by the MOH. The community clinic attendant is essentially the equivalent of a VHW but is part of a new program started in 1990 to involve local communities in the construction of community clinics, maintained by a clinic attendant who manages a revolving fund of drugs. There are no consultation fees but people have to cover the full cost of drugs. There also exists a private clinic nearby in Mozano, recently opened by the Mozama Disco Christo Church (MDCC), one of the local African Christian churches. The total population in the district was estimated to be 146,749 for 1993, based on projections from the 1984 Census.

5.1 Health Infrastructure and PHC Services in the Area

The healthpost in Gomoa-Oguua was built in 1973 through funds raised entirely by the local community. It was later incorporated into the Ministry of Health and converted into a healthpost. The catchment area of the healthpost includes 48 villages and an estimated population of 54,135. The centre offers mainly preventive services, including MCH/FP, and basic curative care through static and outreach or 'mobile' clinics. Conditions brought to the healthpost that require more specialized care or are beyond the capabilities of healthpost staff are referred to the hospital in Apam.

According to Ministry of Health guidelines, each level 'B' institution (healthpost or health centre) is expected to have a minimum of twelve outreach sites. The healthpost in

Oguua held between 11-12 outreach clinics each month in different locations throughout the catchment area. During outreach clinics nurses conduct immunizations and growth monitoring for children under five, provide basic curative care as well as information on various health matters such as nutrition and family planning. ANC services are only available at static facilities. A day of the week was set aside specifically for this purpose (although the same services should be available every other day). Obstetrical care was provided by a midwife at the healthpost or by 'trained' TBAs in the community.

In addition to these services, the healthpost is expected to organize school health visits and health education activities in the villages. Nurses may also conduct home visits to follow-up on individual cases or to provide health education to women in their homes. The healthpost was staffed by: 1 medical assistant, 1 senior staff midwife, 1 community health nurse/midwife, 2 enrolled nurses, 3 community health nurses, 1 dispensary attendant, 1 clinic attendant and 2 health inspection assistants. Twelve TBAs were trained to work in different villages throughout the area. Finally, several VHWs had been trained to dispense basic curative care and promote preventive health measures.

5.2 The Villages

5.2.1 Socio-Economic Conditions

The villages selected were within an 8km radius of the healthpost in Oguua and about 20 km from the district hospital in Apam. The roads linking the villages were at the time in satisfactory condition, except during the rainy season when the passage became very difficult, especially to Achiasi, where roads were barely motorable. Transportation in the area was supplied by private taxis and buses ('trotros') which run on an irregular basis and are generally quite scarce. Transportation to and from Mampong and Achiasi was in particular very scarce and available perhaps a few times a day, if one was lucky!. In Tarkwa on the other and, transportation was available usually every 1 or 2 hrs, except in the evening when everything slowed down.

Living conditions in the communities were generally poor. In the research by Pappoe (1993) it was estimated that for villages in the same area, 61% of the population lived in relative poverty, a figure which seems consistent with the findings of Sarris and Shams (1991), who estimated that for the country as a whole, 66.8% of smallholders, or 50.6% of farmholders, had household incomes below the poverty line[5]. We also find there is relatively little socio-economic differentiation in these communities. The majority of people are small-scale farmers who produce food for the local market and for subsistence; few opportunities exist for people to earn money outside farming.

The infrastructure in the villages was poorly developed and/or in disrepair. As in most rural areas of the country, they were without electricity and communication facilities. Certain basic amenities were also lacking in one or two of the villages, except Mampong which benefitted from the financial and material support of World Vision and was well-equipped with, among other things, a day care centre, two KVIPs (Kumasi Ventilated Improved Pit Latrine), and a recently constructed shelter for a market. Public sanitation facilities were lacking in both Tarkwa and Achiasi. Each community did at least have piped-borne water which was supplied through a set of standpipes. It was found, however, that the pumps in Achiasi and Mampong would occasionally breakdown, sometimes for several days at a time; forcing villagers to rely on natural sources or wells for water. In terms of educational facilities, the villages did not appear to be as disadvantaged. Although schools were generally poor in resources, they were quite a prominent feature of life in the villages. In each location, one could find a primary and secondary school located right in the village or nearby and within walking distance.

In spite of the generally low standards of living in the area, there were some noticeable differences in wealth and access to resources between the three communities. The level of deprivation seemed particularly acute in Achiasi, visible in the deteriorating infrastructure, poor quality of housing and scarcity of goods. The largest of the three villages, Tarkwa, was

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5 Absolute poverty is defined as "income below which a minimal nutritionally adequate diet plus essential non-food requirements is not affordable" (Sarris and Shams, 1988).

fortunate to have better access to transportation and a more abundant supply of goods available in the village, such as food and other basic necessities. Foods, such as vegetables, fish, meat, and eggs, were generally not available in the two other villages, while in Tarkwa there was a small market which sold all of these goods on a daily basis. Villagers in Tarkwa could also buy drugs from the local drugstore, while in the other two communities, they relied on itinerant traders who visited on a weekly or monthly basis or they travelled to neighbouring towns.

5.2.2 Local Health Services and Resources

The majority of people in the communities travelled outside to obtain medical care, although in Tarkwa there was a 'homeopathic' clinic stationed on the outskirts of town, which offered treatment to villagers for various problems, such as: malaria, fever, aches and pains, and minor injuries. It became apparent however that the clinic was 'homeopathic' only in name; the attendant at the clinic was found prescribing various pharmaceutical drugs and administering injections to patients. There was actually some concern among health officials in the district that the attendant was providing services he was unqualified to give. But given that the clinic was privately-owned, health officials claimed they lacked the authority to enforce any kind of action.

A health environmental inspector, employed by the Ministry of Health, was stationed in Tarkwa and responsible for several surrounding villages including Mampong. His duties were to: monitor sanitation; inspect premises such as drinking bars and local 'chop bars'; record births and deaths; conduct health education; and inform the healthpost of any outbreak of a disease. The health inspector assigned to Achiasi operated from the healthpost in Oguua.

'Modern' medical services are, however, not the only source of health care within the communities. One could describe the medical system in Ghana as 'pluralistic'. It includes the government sector, a private sector, including mission clinics, offering western-based biomedical services, and an 'indigenous' or 'traditional' sector. The 'traditional' sector is comprised of a variety of different practitioners, from pure herbalists who employ or apply herbal preparations from selected leaves, roots, barks and other plants to priests and priestesses

of deities and gods who employ divination and ritual manipulation in their healing (Pappoe, 1993; Twumasi, 1975). "Although healing is often done using magico-religious acts and concepts, traditional healers also have a stock of remedies with which to treat ills that have an empirical basis" (Twumasi, 1975).

It has been said that as much as 80 to 90% of the world's population relies on the 'traditional' medical sector as their main source of health care (Phillips, 1990). In the communities in the study there were different types of healers. Some were herbalists who specialized in providing care for a limited range of diseases, while others offered treatment for a broad range of illnesses. There were a number of different 'faith healers' and spiritualists, some of whom were associated with the local African Christian churches. There was some suggestion that 'faith healers' helped not only with prayers and spiritual healing, but also provided herbal or other types of treatments.

Furthermore, in each village there were between 2-4 known or recognized traditional midwives, a few were also practising 'faith healers', referred to sometimes as 'spiritualists' or 'priestesses', tied to one of the local African Christian churches. All of the seven midwives interviewed indicated their main role was to assist women during childbirth, but they could also be called upon to assist during pregnancy. Each midwife was able to name a variety of treatments she administered as preventive or curative therapy. A few claimed however that their knowledge of treatments was only available through visions or revelations.

5.2.3 Social Structure

Accurate information on the population in the villages was difficult to obtain; estimates were around 3000 to 5000 for Achiasi and Tarkwa, and 500 for Mampong. But these figures do not reflect the actual size of the population year round. Many villagers apparently leave to farm in the 'forest areas' where the soil is believed to be more fertile and where they can establish cash crop farms. Within the study area, farming is limited to two main crops, maize and cassava, which farmers often complained had low economic returns. Other villagers have moved to urban centres for wage paying jobs. But those who migrate still maintain close ties

to the village, often returning for annual festivals and other important social events, such as funerals. It was also found that even though villagers may leave to work or live elsewhere, they are still expected to pay annual levies and to make contributions to community projects. This is an interesting, though not uncommon characteristic of communities in the Akan region according to Busia (1951) and Fortes (1950). Among the matrilineal Akan, people always regard their 'true' home, as the place where their mother or matrilineage resides.

The size of the population seems to increase considerably during August and September when many villagers return to take part in the Annual Akwambo festival, and in December, during the christmas celebrations. According to leaders in these communities, December and August are the two most important times of the year to hold community meetings and fundraising activities. There was some evidence that decisions would sometimes be set aside until these meetings were held, a practice which obviously slowed-down decision-making. It was also mentioned that some of the key decision-makers or influential members of the community reside outside and their presence is expected at these meetings. As indicated earlier, the population in the area is mainly Fante, which is one of the sub-groups of the Akan of Ghana. But it was discovered that even among the Fante, further sub-divisions can be made. Most of the people in these communities identified themselves as 'Gomoa'.

Akan customs and traditional social structures, which were described briefly in an earlier part of this paper, are mirrored in the life of these communities. Each village was governed by a council of chiefs and elders. The head chief was known as the Odikro, a position assigned to a particular clan or lineage in the community. Each clan in the community was assured representation on the council through an elected 'sub-chief' or elder. Tarkwa was the only village with an acting Queenmother. She had also selected different female leaders to represent certain sections of the community, and their role was mainly to mobilize women for communal activities.

It was apparent that chiefs and elders held considerable authority and influence in the community. Chiefs were still responsible for giving land, settling disputes, punishing offenders, raising levies, and mobilizing villagers for community projects. The authority of chiefs was also exercised through decision-making processes. Their approval for example, had

to be sought before any program or activity could be initiated within the community. They also remained responsible for handling most affairs that concerned the community. Other leaders of the community, including professionals and those with more formal education, might exercise some influence in decision-making (eg. TDC and assembly person), but the majority of men and women were excluded from these processes. If any other member of the community wanted to express his/her views they would first have to raise it with their elder or section head, who then decided whether to present it to the council. In Tarkwa it was not permitted for people to contact the chief directly. Individuals who are not original inhabitants or citizens of the village appear to have even less power to influence decision-making.

Although women recognized their role was limited, most seemed content to resign themselves to 'tradition'. They did not expect to play a greater role in decision-making and entrusted their leaders with the responsibility of defining what was best for the communtiy. In Achiasi on the other hand, women expressed their dissatisfaction with existing structures and felt their concerns were being ignored. The traditional structures of leadership and the Town Development Committee were virtually dominated by males. Leaders claimed they would consult women on any issue that concerns them, but women clearly wanted the opportunity to play a more active role. They were in fact hoping to find an educated and able young woman to assume the position of Queenmother on the council.

5.2.4 Characteristics of Households

Although the ideal in Ghana is now the 'Western' model of the nuclear family, the evidence from the present study shows that this remains far from being the norm. Only about a third of the households in this study represented this model. It was more common to find couples or individual women staying with their children in the same dwelling or household with family and/or other kin relations.

The results also reveal that a significant proportion of women, 44%, were living alone with their children in households or dwellings with other family members and/or kin. Sixty percent of these women were either single, divorced or seperated, while 40% were married but

their husbands were working in other towns, either in farming or wage work. The majority of these women indicated they were living with their own mothers and in their 'natal home' or 'hometown'. In the rest of the sample, 26% of women were living alone with their husbands and children, and another 26% with husbands and dependants, in addition to family or kin relatives. Couples living in households with other relatives were usually with family from the husband's side. It was often mentioned however, that family and kin relatives who resided in the same compound had migrated elsewhere to work, which reduced membership of the dwelling or household. Yet women's ties to kin were not only restricted to the household. Relatives and family were also resident in other areas of the village.

Although from the results of the present study we are unable to provide a very detailed outline of the composition and organization of households, the results do exhibit some similarity with the findings of Fortes' (1970) which were presented earlier. The high proportion of women living in their natal home and with their mothers is probably to some degree a reflection of the importance attached to maternal kinship ties in the society. A number of other factors, however, may also be involved. The level of migration and mobility in the villages, for example, affects a great number of households. Almost half of the women who were living with relatives had husbands or partners who were working elsewhere. The sample also included an unusually high number of 'pregnant' women or women who had recently given birth, and according to traditional Akan custom, a woman is expected to return to her natal home to be under the care of her mother and other kin relatives until she gives birth (Fortes, 1950). Within Achiasi and Tarkwa there were at least four women who claimed they had recently moved from other villages to be with mothers or parents during the pregnancy.

The pattern may also represent other structural changes that have taken place in the household. Nukunya (1969), in his study of the Anlo Ewe of Ghana, argues that women may return to join their parents in their household after their marriage fails or when they become divorced or widowed. Four women in Tarkwa and two in Achiasi indicated they had recently returned to stay with their mother or family as a result of marital difficulties or separation. To this we should add the group of women who fall pregnant or have children while single or

unmarried. In the present study, there were at least five or six women who fell in this category. At the time when Fortes (1970) and Nukunya (1969) carried out their investigations, this phenomenon was probably less common. Perhaps we can conclude that the pattern in the composition of households represents, on one hand, the persistence of kinship in determining patterns of residence and household organization, and on the other, the changing character and/or structure of families and households in response to migration and other socio-economic forces.

5.2.4 Profile of the Women in the Sample

The ages of the women in the sample ranged from 17 to 40. The level of education was low. Out of the forty-eight women for whom information is available, 52% had never attended school. Among those who had been to school, most dropped out at the primary level. Very few women went beyond to the secondary level. There were, however, some noticeable differences between the villages. While in Mampong only 2 out of 9 women (or 22%) interviewed had never been to school, in Achiasi, the result was 68%, or 13 out of 19 women. Tarkwa fell somewhere in between with 50% of women having no education.

The predominant occupation for women was farming. The main crops cultivated were cassava and corn. Women generally worked on small farms, averaging 1-1.5 acres, mainly for subsistence, and sometimes for sale. In addition to farming, some women were engaged in petty trading, either selling processed foods and/or goods in the village. None of the women interviewed was engaged in a professional occupation, the other occupations they held were: trader, kindergarten, teacher, seamstress, hairdresser and shop-owner. Only three women could be classified as 'wage earners', the rest were self-employed.

There was however a noticeable degree of religious diversity within the community. The women in the sample belonged to a number of different religious groups (in descending order of importance); Methodist, Roman Catholic, local African Christian churches (Mozama Disco Christo Church (MDCC), United Faith, African Faith, True Salvation Church), Muslim and Pentecostal. In each village a number of religious groups existed. In Tarkwa for example,

there were at least six different churches in addition to a mosque.

The results from the interviews suggest that women begin childbearing early. The women interviewed who were having their first child were all between the ages of 17-19 yrs (the GDHS indicates that the median age at first birth is 20). Fertility levels were also high. Women who were aged between 35-40 had on average given birth to 5-6 children. According to findings from the GDHS (Ghana Statistical Service, 1993), rural women have the highest rate of fertility - 6.4 children per woman in comparison to 4 children per woman in urban areas.

The rate of mortality among children and infants appeared quite high. A significant number of women in the study had lost children during childbirth or before the age of 5yrs. There were marked differences, however, between the three villages in the rate of mortality among infants and children. The most alarming report comes from Achiasi where over half (11) of the mothers interviewed had lost children during childbirth or before the age of 5yrs. In most cases they had lost one child, but three women had lost as many as 2 to 4 children. In Tarkwa, five mothers had lost between 1 and 2 children during infancy or childhood. In Mampong, on the other hand, none of the women interviewed had suffered such a loss.

According to records from the healthpost, the main health problems in the area are: malaria, measles, diarrhoeal diseases, intestinal worms, nutritional problems, hypertension, joint pains, anemia, upper respiratory tract infections, gyneacological disorders, skin diseases, accidents and bites, and minor trauma. According to records from the district, water-borne diseases such as schistosomiasis, diarrhoea and guinea worm represent other acute health problems in the area.

CHAPTER 6

Patterns of Delivery, Participation and Utilization

6.1 The Healthpost: Community-Based Activities

The PHC program envisioned a health care system that would not just be engaged in delivering curative care to people, but would involve health workers at the local level in vigorous efforts to educate the population in health matters and to motivate communities to participate in preventive activities and/or other health-related projects. Primary health care was essentially intended as a strategy that would move health services from the facility to the community and to use one popular expression, 'bring services closer to the doorstep of the people'.

One of the central tasks of the healthpost is to carry out health education activities in villages, including visits to schools to talk to children and adolescents. Ideally, nurses from the healthpost should also conduct visits to homes in the catchment area to follow-up on individual cases or to help those in need. It was found, however, that little activity was actually occurring at the local level, and apart from the outreach clinics held in the village, the only contact people seem to have with health workers is at health facilities. Healthpost records indicate that only 16 health education activities in 1993 and 8 in 1994 were carried out, for a total of 48 villages. Nurses also indicated they are only able to carry out home visits to villages within the vicinity of the healthpost.

6.2 Patterns of Participation

Primary health care was also envisioned as a strategy that would promote the active participation of people in solving their own health problems and in designing and implementing government-supported health programs. The findings of this study reveal, however, that participation was in reality low. As Pappoe (1993) has found before, there appears to be little evidence of participation in most of the villages spread throughout the area.

6.2.1 VHCs and VHWs

Only a few (3-4) village health committees (VHCs) were known to be scattered throughout the area. The healthpost was planning to start another program to form new VHCs and revive old ones. A date had been set for the formation of a VHC in Tarkwa and Achiasi, but by the end of the study, there was still no active health committee in either one of the villages. Mampong was the only village in which a health committee had been involved in carrying out health activities. The 'trained' TBA and former VHW admitted however that activities had died down over the years as villagers had become more and more aware of the importance of environmental hygiene and other preventive measures.

Of the original Village Health Workers (VHW), only two remained, but it was later discovered that they too had become inactive. When active they used to provide basic curative care and health education. Both claimed the main reasons why they had stopped working was 'lack of financial support' and 'lack of drug supplies'. Apparently, the drugs supplied in the beginning of the program were never replenished. Both indicated they had tried to maintain a role as VHW even without external support, by using their own funds to buy and sell drugs to members of the community, but in the end, they found this difficult to sustain. It was interesting to find, however, that at one of the outreach clinics in Mampong, the former VHW was volunteering his time to assist the nurse. In an interview a few days later, he mentioned that he would like to continue working as a VHW but not without the support of the healthpost or some other external agency.

6.2.2 The TBA Program

The 'trained' TBA program is the only program that was actually still functioning at the local level. There were 'trained' TBAs active in all three of the villages in the study. It should be noted however that in both Achiasi and Tarkwa two TBAs were 'trained' in the beginning, but eventually one of them dropped-out or left the village. In Tarkwa, one of the two 'trained' TBAs (a male birth attendant) apparently left the village to work elsewhere, and

in Achiasi, the other TBA was a fairly elderly woman who was forced to stop working due to health reasons. But the data show that the level of support for, and utilization of 'trained' TBAs was rather low in both communities. Most of the women in Achiasi and Tarkwa who had chosen to deliver at home, had called on the assistance of relatives or local midwives, instead of the 'trained' TBA[6]. In Mampong on the other hand, the 'trained' TBA had gained almost the full acceptance of women in the community. Of the nine women who had given birth before, seven had called on the 'trained' TBA for assistance during their last delivery.

Though we should not deny the efforts 'trained' TBAs were making in the other villages, the program has clearly worked more successfully in Mampong. The 'trained' TBA in Mampong indicated that she usually tries to make contact with all the women in the village who are pregnant or in need of help. She also regularly visits homes to check on their health status and that of their children, and is always recommending that people attend the healthpost for consultations or for medical attention. In the other two villages, the proportion of women receiving care from 'trained' TBAs was considerably lower. This essentially means that fewer women than expected in Tarkwa and Achiasi, were being reached by the program.

'Trained' TBAs in all three villages complained of a lack of community support. They were hoping that either the community, or the government would help with logistical and financial support to carry out their work, by providing a clinic or room in which to receive patients, and some compensation or funds to replenish and maintain their kits. Not one of the communities had managed however to provide any kind of support. In order to maintain their practice as 'trained' TBAs, all of the participants were requesting some compensation from clients, a sum of 1000 to 2000 cedis, in addition to a bar of soap.

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In Achiasi it appears the 'trained' TBA claimed that she and the other TBA (who has stopped working) used to assist the majority of women in the village, but that number had declined significantly in recent years. Apparently, more women were now turning to a priestess in the village, who had arrived a couple of years ago to serve in one of the spiritual churches.

6.2.3 Other Health-Related Activities

With the exception of Mampong, few health activities were carried out in the villages, aside from the outreach services provided by the healthpost. There appeared to be little mobilization at the level of communities, whether around sanitation, education, prevention etc. There was a Town Development Committee (TDC) in each village, which shares many overlapping functions with typical VHCs, such as a concern with promoting sanitation and environmental cleanliness, but during the period of the research, little activity was observed. There is however a tradition of 'communal labor' in these communities, where men and women get together to do a particular job such as: sweeping streets, clearing gutters and fixing roads. People claimed this was supposed to occur once a week or at least a few times a month, but it clearly did not happen that frequently. It was also argued however that communal labor was difficult to organize and people were often not motivated to participate.

In both communities, there were plans to develop various projects, but people claimed that projects were difficult to implement without substantial inputs and funds from outside. In Tarkwa, a project to build a fishpond was started with a donation from a former citizen of the village currently residing in Europe, but certain difficulties were encountered which brought construction to a halt, and by the end of the study, the project remained at a standstill. There was also a daycare centre which was started with an external donation, but after these funds ran out construction also stopped and never resumed. Achiasi was the only community which did not have an 'active' project, nor was it fortunate to have the resources of an external agency or individual.

The community in Mampong was, on the other hand, actively involved in a number of projects. Every day of the week a group was involved in communal labor. The community had been divided into four groups and each was assigned a particular day of the week. At the time of the study, the community was focusing its attention on the construction of a vocational school, financed almost entirely by World Vision. Activities were organized and lead mainly by the TDC which met on a regular basis to discuss projects and make plans. As mentioned already, there was also a health committee in the village, lead mainly by the 'trained' TBA and

the former VHW. Though it was admitted that activities had died down over the years, members still monitored environmental and sanitation conditions in the village, e.g. waste disposal.

Participation in communal labor activities in Mampong was monitored very closely. Attendance was taken each day and anyone found absent was given a warning. If a person failed to attend a second time without a valid reason they were forced to pay a fine. In the other two communities this was also a rule, but, as mentioned already, communal labor was less effectively carried out.

6.3 Patterns of Utilization

Since the healthpost was engaged mostly in providing routine services to communities, and the level of participation in the villages was low, what remains is the utilization of services by the population. Even here, the levels seem to fall far short of what is desired.

At the level of the healthpost and community the main services provided are those included in the maternal child health program, a program that involved, as mentioned earlier, the provision of antenatal, delivery, postnatal and child welfare services. Below are the findings about the level of utilization of these services.

All of the women in the sample were aware of the services provided at healthpost in Oguua and at outreach clinics held in the village, although knowledge about specific services, eg. immunization, antenatal care, may still be inadequate. Women used the services at Oguua, but also turned to the 'Wisdom' clinic in Tarkwa, the private clinic in Mozano established by a local church (MDCC), the healthpost in Baa, another nearby village, and, in very exceptional circumstances, the hospital in Apam. Achiasi was the only village for whom Oguua was the nearest location. For villagers in Mampong and Achiasi, health facilities in Mozano and Baa were also accessible and sometimes preferred.

6.3.1 Antenatal Care

Among the women interviewed who were pregnant, which was 23, more than 40% said they had not attended an antenatal at the healthpost in Oguua or another health facility during the present pregnancy. The number of visits ranged from 1 to 3, with most responses falling somewhere between 1 or 2 visits, short of the 4 times expected by the MCH program[7]. The only exception is one woman in Tarkwa, who was deemed 'at risk' and who, by the third trimester, had made a total of nine visits. The breakdown for the villages is given in the following table:

Table 5: Use of Antenatal Services

	Achiasi (8 women)	Tarkwa (11 women)	Mampong (4 women)	Total (23 women)	%
Yes	3	8	2	13	57%
No	5	3	2	10	43%

Among the women who had attended an ANC clinic, seven (or 54%) claimed they had decided to report to health facilities when they began experiencing various complications, such as 'abdominal pains' or other difficulties (eg. loss of appetite, headaches, vomiting, etc). The remaining six women (or 46%) indicated they had chosen to attend mainly to receive a routine 'check-up'. When asked why they did not attend more often, the main reasons women gave were; services were unaffordable or further treatment was unnecessary. In two separate cases, respondents also complained about the distance and said they lacked the energy or felt too weak to return for a follow-up visit. Similar reasons were given by the ten women who had not made a single visit. Seven claimed that it was due to 'lack of money'. The other three

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7 It should be noted that women were at varying stages of their pregnancy. Five of the women indicated they were 5 months pregnant and below, while the rest were 6 months and over. It is possible therefore that some would have returned for an antenatal examination after the data was collected.

indicated there was no clear reason or no strong 'felt-need' for a consultation.

When other women in the sample were asked about health care practices during previous pregnancies the same type of responses tended to emerge. Women would generally say they had reported to a clinic during their pregnancy but that often the decision to attend was prompted by the need for medical care. It was less common for them to report simply for routine purposes. The only exception may be Mampong, where women claimed they tried to attend clinics regularly and in most cases felt it was necessary to go for a 'check-up'.

In addition to 'modern' antenatal services, women relied to a significant degree on local herbal medicines during the pregnancy. All twenty-three of the pregnant women indicated they had or were currently using various herbal remedies during the pregnancy for curative and/or preventive and promotive reasons. Certain types of herbs appeared to be particularly well-known and commonly used. Most of the women mentioned they were using herbal treatments to protect and promote the health of the fetus and to facilitate childbirth, in their own words, *'to make the child grow well in the stomach and make it strong'* and *'to make the delivery easy'*. Various other uses included: 'to remove dirt from the womb', 'to improve one's appetite', 'to prevent complications such as miscarriage', and 'to make the child turn well in the stomach'. Herbal treatments were also used for curative purposes, e.g. to treat headaches or abdominal pains during pregnancy. These treatments were either prepared or procured by women themselves, by a family member, local midwife, including 'trained' TBAs, or local herbalist. There were three women in the sample who were also receiving treatment for chronic problems from either a local midwife, herbalist and/or spiritualist. All three had attended an ANC clinic in the early stages of the pregnancy but had not returned.

In addition to ANC clinics and herbal treatments, several women in the sample, mainly those who belonged to one of the local African Christian churches, were consulting priests of their local church to receive prayers. Women said these prayers were to protect them during their pregnancy and to ensure a safe delivery. This kind of religious intervention was not however, provided only within the new syncretic churches. A local Methodist church was, according to one woman, also providing prayer services for pregnant women.

6.3.2 Supervised Delivery Services

In the interviews women were asked with whom or where they had delivered all of their children, but for this analysis we will only refer to the 'last delivery'. As found elsewhere, the majority of deliveries took place at home or in the community. As part of the PHC program women are also expected to deliver with 'trained' TBAs[8] in their community, except for pregnancies deemed 'at risk' which are to be referred to the healthpost. But the data show that utilization of 'trained' TBAs was lower than expected in two of the villages.

Table 6: Use of Supervised Delivery Services

	Achiasi (16)		Tarkwa (18)		Mampong (9)	
'Modern' health facility	6	37%	3	17%	1	11%
'Trained' TBA	5	31%	2	11%	7	78%
other local midwife (includ. priests or priestesses)	2	13%	3	17%	1	11%
Alone at home or with relative	3	19%	10	55%	0	0%

*Seven cases have been omitted from the table. These include; four women who were having their first pregnancy and three women in Achiasi who were living outside the area during their last pregnancy and staying in various urban towns where they had access to 'modern' medical facilities.

The results reveal a very distinct pattern of utilization in each village. In Mampong for example we find the majority of women relied on the services of the 'trained' TBAs. In Tarkwa and Achiasi, the proportion of women who were assisted by 'trained' TBA during their last pregnancy was much lower - only 11% in the former and 31% of women in the latter case. We also find in Tarkwa a strikingly high number of deliveries, 55%, were conducted at

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8 Because of their inclusion into PHC, 'trained' TBAs will be referred to as being part of the 'modern' sector.

home with relatives or alone, while in Achiasi and Mampong, this was relatively rare. Only 19% of women in Achiasi delivered with relatives or alone, and none of the women in Mampong. In Achiasi, we also find the highest proportion of women who used the services of the healthpost during their last pregnancy. It is known however, that at least two of these women had to be admitted for complications.

The following lists the reasons women gave for selecting the service they used. There may be other underlying factors influencing women's choices but these were the explicit reasons given:

Healthpost in Oguua or other 'modern' medical facility

- The main reason was: 'modern' services are better and safer. We should note that out of the ten women in this group, at least five indicated it was either their first time giving birth and/or they had experienced complications during the pregnancy or during labour.

'Trained' TBA

- Most of the women who chose to deliver with the 'trained' TBA in their village indicated she was the one assigned to assist women in the community.

- A few claimed they would have preferred to deliver at the healthpost but chose instead the 'trained' TBA because she was available right in the community. The healthpost was inaccessible due to time, distance and/or cost.

Local midwife

- Two women who delivered with a priest or priestess of their local church indicated that as members of the congregation, they were expected to deliver in the church.

- The other women indicated they had chosen a local midwife for reasons of convenience and/or because she was the only person whom they knew could assist them.

At home with a family member, relative or alone

- Those who chose to deliver at home viewed their relatives as skilled and qualified to assist them. They were assisted by mothers, aunts or elders whom they claim had years of experience in delivering babies.

- There were seven women in this last category who delivered alone. Three of these

women claimed they had not planned to deliver alone and had called someone to assist them as soon as they fell into labour, but the person failed to arrive in time. For the other four women, the choice to deliver alone was more deliberate. They argued that since deliveries had always been conducted safely at home, they felt confident enough to deliver alone and only required someone to cut the cord and bath the baby.

6.3.3 Postnatal and Child Welfare Services (PNC and CWCs)

The information obtained on women's utilization of PNC and child welfare services is unfortunately, not as conclusive. It was generally more difficult for mothers to recall exactly when they had brought their children to outreach clinics. In the future it might be useful to refer to the 'road to health' cards which should specify clearly which vaccinations children have received. It appears, however, that women depended quite heavily on mobile or 'outreach' clinics for immunizations and child care, especially in Mampong, where the lack of transportation and distance made access to the healthpost even more critical. The healthpost seems to serve mainly as a source of medical care, e.g. when a child falls ill, less for routine services such as immunizations. Nevertheless, the majority of women interviewed claimed they took their children for outreach clinics when they were held. Out of the whole sample, only a couple of women indicated they were unable to attend clinics in the village because they 'lacked money'. In the sample of fourteen women who had given birth in the last 12 months, only three had not yet reported to a postnatal clinic since giving birth. Their children were between 2 and 19 weeks.

Although the results from this study remain inconclusive, it may be safe to say that few women report for PNC clinics, which should, ideally, be within the first 14 weeks of birth, but the majority eventually do send their children for immunizations. It still remains uncertain however, whether children are brought to clinics on a regular basis and receive the full coverage of immunizations. Again, the exception to this rule may be Mampong, where women were more likely to indicate they attended CWCs on a regular basis. It was also apparent that attendance at clinics was actively encouraged by World Vision and other members of the community.

Records obtained from the healthpost which are presented in Table 4, may help to provide a clearer indication of the overall patterns of utilization in the communities. Figures from the healthpost seem to suggest that levels of utilization are considerably lower than what was shown by the data from the villages. But if we compare the records for 1994 alone, the period during which the study was conducted, the results are a lot more similar. Unfortunately however, we do not have quantitative data from the villages to compare PNC coverage. (Please note: data for child welfare clinics have been excluded because of possible errors and inconsistencies).

Table 7: Records from the Healthpost in Oguua

	Total Coverage (as a percentage of expected pregnancies)		
Year	Total ANC registrants	Total Supervised Deliveries	Total PNC registrants
1993	30.3%	11.6%	7.6%
1994	42.5%	26.3%	16.8%

It may be important to note however that these estimates may not be fully precise. First of all, it is known that women who reside in the catchment area often attend health facilities in other towns, not only Oguua. Secondly, the figures are based on population projections from the 1984 census, which may also not be fully accurate. The records may therefore underestimate the real extent of use. In spite of these limitations, the data do help to provide a better overall indication of the existing levels of coverage.

6.3.4 Results from other Studies

Data from the MCH national reports for 1992 and 1993, and findings from survey studies conducted in Ghana are presented on the following page to provide us with information on which to compare and assess the generalizability of the research results.

Table 8: Figures from the MCH National Reports for 1992-1993

		Percent coverage of services				
		ANC	DEL	PNC	CWC (ages)	
1992	Country	83%	37%	24.3%	47.4% (0-2 y	
	Central Region	88%	27.2%	21.9%	34.2% (0-2 yrs)	
1993	Country	87%	40.6%	28.7%	64.7% (0-11 mo.)	23% (12-23 mo.)
	Central Region	93%	37%	25.5%	63.9% (0-11 mo.)	14.6% (12-23 mo.)

Findings from the Ghana Living Standards Survey (GLSS), the Ghana Demographic and Health Survey (GDHS), and the the Infant, Child and Maternal Mortality Study (ICMMS), are provided below.

Antenatal Clinics

- According to the GLSS, among women who were aged 15-49 yrs, and currently pregnant or pregnant during the previous 12 months, 69.6% in rural areas and 83.3% in urban areas had received prenatal care (Ghana Statistical Service, 1995).

PNC and Child Welfare Services

- The GLSS reported that 43.6% of all children below 12 months and 52.5% of those below 2yrs in rural areas had received postnatal care in the last twelve months (and 38.1 below 5yrs) (Ghana Statistical Service, 1995).

- On immunization coverage, the GLSS indicates that of all children aged less than 2yrs, 20% had never been vaccinated. The GDHS obtained a similar result and concluded that 19.2% of children in rural areas aged between 12-23 months had never been vaccinated (Ghana Statistical Service, 1993).

Supervised Deliveries

- According to the GDHS, 70.9% of births in the last three years were conducted at home, with only 28.0% in health facilities (Ghana Statistical Service, 1993). The

results from another study, the Infant, Child and Maternal Mortality Study (ICMMS), are fairly similar. They indicate that 30.9 percent of women delivered with midwives, 19% with 'trained' TBAs, and 48% with local midwives, relatives or alone (Ghana Statistical Service, 1994).

An analysis of the data from different surveys reveals that the results of the present study are fairly similar to the averages found elsewhere. We can probably assume, therefore, that the levels of utilization found in the villages are representative of other rural areas in the country. The comparison also reveals, however, that major discrepancies do exist between the estimates of antenatal coverage shown in the MCH national reports and the results of the study. According to government data, as much as 90% of women in the Central Region, the region in which the villages were located, had received antenatal care in 1993[9]. While in the present study, the result was less than 60% and approximately 40% according to records from the healthpost. It is particularly surprising to find that healthpost records should differ so sharply from government data. Could it be that national data represent an overestimation of coverage?. There is much greater similarity between data from the surveys and the results of the study. As indicated earlier, the Ghana Demographic Health Survey, for example, reported a rate of 70% coverage for antenatal care across the country.

Yet, if we look at the other estimates provided in the MCH national reports on supervised deliveries, postnatal care and child welfare services the differences tend to diminish. Government data for 1993 also indicate that the average number of ANC visits during a single pregnancy was 2.6 for the country as a whole - a finding that also appears more consistent with the results of the study. As indicated earlier, the rate of attendance among women in the villages fell somewhere between 1 and 3 visits, with the average being close to 1 or 2 visits. It is also interesting to note that one of the surveys, the ICMMS (Ghana Statistical Service, 1994), found that even where 'trained' TBAs were available, women still

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The report also states that its figures for ANC attendance may not be completely accurate for two reasons; 1) data from non-Ministry of Health institutions (especially the private sector and 'untrained' TBAs) are incomplete, and 2) data from almost all regions show some degree of double registration because pregnant women frequently register at more than one institution during a single pregnancy.

chose to deliver either with relatives, other local midwives or alone. Another finding that was revealed in the village study.

Although the data show that rates of utilization continue to be low, records from the healthpost also show that the rates for all of the different MCH services have been increasing over the years, as revealed in the table below.

Table 9: Levels of Utilization from 1990-1994

	Total number of registrants per year				
	1990	1991	1992	1993	1994
ANC	454	523	477	656	930
DEL	182	207	172	251	575
PNC	164	138	123	164	367
CWC	NA	517	346	406	2025

CHAPTER 7

Underlying Causes of the Low Levels of Utilization and Participation

7.1 Affordibility and Accessibility of Services

7.1.1 Cost

The findings of this study indicate that for many rural women, MCH services remain unaffordable and inaccessible. The principal reason women gave for not attending MCH clinics more frequently or not at all, was, as they stated, 'lack of money'. It is not only the cost of fees which women find unaffordable, but the combined cost of drugs and transportation, and perhaps the opportunity cost of spending time away from work, in addition to fees. The cost of transportation alone would consume between 300 and 400 cedis, which, at the time of the study, was about half the national minimum daily wage. For delivery services in particular, women mentioned the cost may be especially prohibitive. Taxi drivers will apparently charge as much as 3000 to 4000 cedis to take someone to a facility during an emergency or when a woman is in labor. Although the cost of preventive care remains relatively low, people have to pay for the full cost of drugs. There were some complaints that drugs were becoming expensive and that due to a lack of supplies at the healthpost, patients were sometimes forced to travel further away to fill their prescriptions, which not only added time but travel expenses.

Financial constraints and 'cost' have been identified before as significant barriers to utilization. In a study by Sylvester (1994) in the Upper West Region of Ghana, 'lack of money' was also cited as the principal reason for not using services at the local health facility. In other recent surveys, cost was again cited by many rural women as the main reason why they failed to use available antenatal services (Ghana Statistical Service, 1994; 1995b).

The findings of two other recent studies conducted in Ghana by Waddington and Enyimayew (1989; 1990) highlight the differential impact that price may have on different income groups, and in particular on the rural poor. The findings showed that immediately after the government raised user fees for health services in 1985, there was a substantial drop in

rates of utilization in both rural and urban areas. But while the rates in urban areas slowly recovered to their previous levels, the rates in rural areas recovered only slightly and remained well below their previous levels. The authors concluded that this was a clear indication that rural people were disproportionately affected by the rise in fees. In a study conducted in Swaziland (Yoder, 1989) it was also found that user fees had lead to a greater decline in demand among the poor, or those who usually paid the least for health care. Although it is recognized that some form of cost-sharing is needed in order to increase revenue for the health sector, we must also consider carefully that existing policies may serve to further disadvantage the poor and vulnerable groups, including women, most of whom live in rural areas.

The effect of cost on the utilization of services must also be viewed in light of the other changes brought about by the ERP/SAP. While the available evidence suggests that the program has had mixed results, on quality of life and standards of living, the view was, among most people in these communities, that economic difficulties had worsened over the years. People spoke repeatedly about the effects of inflation, low wages, the rising cost of living and the higher prices they were required to pay for everything from food, school fees, water and transportation. The hardest hit seem to have been small food crop farmers who claimed that real prices for their goods, mainly cassava and maize, had fallen significantly over the years. Though we still lack adequate data on the impact of ERP/SAP, the earlier conclusions drawn from the investigations by Sarris and Shams (1994) mentioned earlier, seem to find some resonance in the experiences of farmers in the communities. Discussions with farmers often centered on the poor terms of trade and what some considered to be unfair prices paid by middlemen or buyers on the local market. But again, not all of the problems can be attributed to falling real prices; farmers also complained about the lack of rainfall and the constraints on productivity from using low technology.

Nevertheless, the overwhelming evidence from these communities points to growing economic constraints for many families. It may be important to note as well, that in spite of their involvement in farming, rural households have been found to spend as much as 58% to 69% of their income on food (Ghana Statistical Service, 1995b; World Bank, 1993). It is reasonable to expect therefore, that in a context where women have to struggle to pay for food

and other basic necessities, the need for 'modern' health care will become secondary. For many rural women, the choice may actually be between feeding your family and attending the healthpost.

But, when the need arises people may go to considerable lengths to find resources to attend a health facility. One young woman who was interviewed in Mampong for example, and who was pregnant at the time of the study, claimed she could not afford to attend ANC clinics. Later on in the study however it was discovered that she did report to a local clinic several weeks after the interview to seek treatment for an illness, which she referred to as 'swollen leg', but in order to do so her mother was forced to borrow money from a relative or neighbor. The cost was 2100 cedis for the first visit, and 2200 cedis for the follow-up. This example illustrates, on one hand, the effort a family has made to obtain access to health services, but, also, the heavy social cost that may be associated with seeking care. In paying for medical services, people may find themselves with even less ability to satisfy other household needs.

7.1.2 Distance and Transportation

The accessibility of services was also a measure of distance and the availability of transportation. These were the two other main factors women cited as obstacles to the utilization of services at the healthpost. As indicated earlier, each one of the villages was about 5-8 km from the healthpost, and transportation, especially to and from Mampong and Achiasi, was in general quite scarce. A walk to the healthpost was also well over an 1hr from Tarkwa and Mampong, and just under 1hr from Achiasi. It is remarkable that women in Mampong were actually able to make it to the healthpost, given the distance and transportation difficulties. But this was indeed one of the reasons why women in the village chose to use services in Swedru or Mozano, two neighbouring towns, rather than Oguua, because health facilities there were easier to reach, either by taxi, bus or on foot. The problems associated with distance and transportation may also include an element of time or 'time of day' (Akin et al., 1985). Women mentioned for example that in some cases labor may start unexpectedly

or late at night when there is no transportation available, the only alternative then is to deliver at home or in the community.

Distance has been identified before as an important determinant of utilization. It has frequently been argued that the further away people live from health facilities the less likely they are to make use of those services; a phenomenon described before as 'distance decay' (Stock, 1983; Pappoe, 1993; Zwart and Voorhoeve, 1990; Voorhoeve et al., 1990). Stock (1983) for example, in a study conducted in rural Nigeria, found evidence of an exponential rate of decline in per capita utilization as distance increased. Other studies have further revealed that residence, distance, and lack of transportation may discourage women from using maternity services at static health facilities (Brieger et al., 1994:107; Voorhoeve et al., 1984:320; Akin et al., 1985:46). In rural areas of the Phillipines, 'travel time', measured as ability to walk to a facility, was also found to have a significant effect on the utilization of prenatal services (Wong et al., 1987).

There is however, additional evidence that the effect of distance may depend on other factors, such as the 'perceived need' for health care, the type or severity of the condition, and the perceived quality of care. It has been argued that people may often be willing to be pay for health care if they believe the services are reasonably good (Waddington and Enyimayew, 1989; Litvock and Bodart, 1993), and where they view a need, for example if a problem is viewed as severe, distance does not appear to affect utilization (Stock, 1983; Pappoe, 1993:161). Although we do not have a comparative basis from this study to assess the relative impact of cost and distance on patterns of utilization, it is reasonable to expect, and clear from women's responses, that these factors serve as major obstacles to utilization.

On the other hand, we should not expect cost and distance to limit demand for postnatal and child health services, given that services are provided at outreach or mobile clinics, which are scheduled to be held once a month in each community. The cost of child health services is also kept low; immunizations, for example, are provided free of charge. But, as one woman observed, nurses would often prescribe drugs at these clinics which meant some cost would almost inevitably be imposed. It might be therefore that the 'perceived costs' of attending outreach clinics served to discourage some women. In one interview, a woman did claim she

chose not to attend because she had 'heard' that nurses were collecting money. But this is probably not applicable to every situation, other factors must also be involved; possibly, a lack of information about clinics or inadequacies in service coverage, which are discussed later in this paper.

7.2 Perception of Need

It has been frequently argued in the literature that before people decide to use health services they must first recognize or perceive a 'need' for health care (Stock, 1987; Thaddeus, 1994; Poole and Carlton, 1986). The findings of the present study also lend some support to this conclusion. When women did attend ANC clinics, it was often purposely to seek treatment for a particular problem or complication, such as:'abdominal pains', vomiting, loss of appetite, headaches, etc. The data has further revealed that although many women do attend an antenatal clinic at least once during their pregnancy, the total number of visits remains low. Women reported going to the healthpost between 1 and 3 times, although the average was closer to one or two visits. When women were asked why they did not attend more often, it was indicated that aside from the cost or distance, there was no clear or apparent need to go. The following are the translator's description of women's responses.

> Interview A:
> *She explained that because of her stomach, that she had been vomiting. Anytime the pregnancy comes she starts vomiting. So that's why she goes for a check-up, so that they* (the health workers) *can advise her of the type of medicine to take. There's nothing aside from that, because she doesn't feel anything again that she has to go.*

> Interview B:
> (She said) *That this time the second pregnancy doesn't worry her as the first* (she had problems during the previous pregnancy). *But* (the) *first it worried her - that's why she usually visit the hospital, but this one she didn't feel anything. She doesn't feel anything. The mother didn't tell her anything* (that she had any problems), *so she, too, she doesn't feel anything* (any need to go to the healthpost).

It seems reasonable to argue, therefore, that women will be more inclined to attend

ANC clinics when they experience a health problem or feel they need medical attention. They may also be less likely to report if they feel healthy and find the pregnancy is developing normally. We could also argue that for those women who reported to the healthpost simply for a check-up, the motivation to attend was also a recognition of 'need'; it is only their conception of what constitutes a 'need' that differed. My field notes on one woman, for instance say, *"when she was pregnant and all her children she used to go. That at times when she's pregnant she feels she's not fine, but normally any pregnant woman should always go for check-up so though if she didn't feel anything she has to go for check-up"*. It is interesting to note that the GLSS (Ghana Statistical Service, 1995) and the ICMMS (Ghana Statistical Service, 1994), both reported that aside from the cost, the second major reason women gave for not seeking consultation during pregnancy was that a consultation was unecessary or 'everything was going well'[10]. Similar findings have been reported in other countries by Okafor and Rizzuto (1994) and Leslie and Rao Gupta (1989), where many women stated the need to attend antenatal clinic only if they did not feel well or if problems arose.

Similar reasons seem to apply in the decision to use delivery services at the healthpost. It was often said that if a pregnancy or birth was perceived as carrying any risks or dangers - if for example, a woman was giving birth for the first time, or if complications arose - the choice would be to deliver at a 'modern' medical facility. But if there were no apparent risks, a woman could give birth at home. As revealed in the data presented earlier, a number of the women who used 'modern' delivery services during their last pregnancy had complications or were delivering for the first time. Research by Peterson (1982:291) in the Brong Ahafo region of Ghana has also revealed that when births are viewed as 'natural' or 'uncomplicated', "anyone related to the parturient can be called in", but when labor starts to take on 'unatural' aspects, a specialist had to be called in usually a herbalist or priest-healer, or increasingly, women are turning to maternity centres.

To understand how women conceptualize 'need' we may need to look at the way in

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10 Although, the proportion of women in both surveys that did not receive antenatal care was relatively small - less than one-third of the sample.

which the society views pregnancy and childbirth. As several authors have noted (Thaddeus, 1994; Cominsky, 1983) pregnancy and childbirth in most non-western cultures is viewed as a 'normal' and 'natural' event, an experience that every woman undergoes during her lifetime. As a consequence, childbirth is not generally regarded as a condition that requires 'modern' medical care or that justifies the expenses associated with seeking care (Auerbach, 1982). In Tunisia and among the Yucatan of Mexico for example, women report to the hospital only as a last resort and as a source primarily of medical care, for complications or abnormal pregnancies (Jordan, 1978; Auerbach, 1982). 'Modern' medical treatment is, in other words, not viewed as necessary for a normal birth. This is, as Jordan (1978:35) notes, in stark contrast to the 'medicalized' view of childbirth dominant in Western medical systems where, with a few exceptions, the whole birth process is treated as a clinical event requiring the supervision and care of expert medical personnel.

It is also true however, that in many cultures, as in Ghana, pregnancy and childbirth are viewed as very vulnerable periods for a woman and her baby, and as dangerous and even potentially life-threatening events (Thaddeus, 1994; Kumekpor and Richardson, 1993; Cominsky, 1983). For this reason, special precautions have to be taken to protect the health of the expectant mother and the baby; which may include dietary restrictions, herbal remedies, and other rules about what she should and should not do. So during this period women may also be very concerned to protect their health. As quoted by Agyepong (1992) from a woman in Ghana who was asked what she would do if she had fever during her pregnancy, at first she claimed she would delay seeking care to see if the problem persisted but would then report to a hospital because, in her own words, *"when we are pregnant, we don't play with it. If we feel we are not well, we act. We don't tamper with pregnancy here"*.

There is a danger however that women may not always recognize the right symptoms as signs of ill health or fail to notice or take action in time (Okafor and Rizzuto, 1994; Thaddeus, 1994). As reported elsewhere, cultural interpretations of symptoms or illnesses may also lead women away from seeking the appropriate type of care or prevent them from receiving timely medical attention, as when 'obstructed' labour is viewed as a sign of woman's infidelity (PMMN, 1992:283; Okafor and Rizzuto, 1994). Women, therefore, may have to be

helped to recognize the danger signs or to know what appropriate action to take when problems arise.

7.3 Availability of Alternative Services

The findings of this study further reveal that women relied to a significant degree on 'alternative' medical resources which were available to them in the home or community. As indicated earlier, there were diverse health care services offered in the community by traditional practitioners including: traditional midwives, 'trained' and so-called 'untrained' TBAs, herbalists, faith healers such as priests, priestesses and spiritualists. There were local or itinerant traders and drugsellers from whom women could purchase patent or western drugs and, until recently, VHWs, who provided basic curative care. Within many households, women were also able to rely on members of the family or relatives who had skills in herbal medicine and/or traditional maternity care. The majority of women could therefore choose from a range of different resources, and, as one would expect, they tended to resort to a variety of methods in taking care of their own and their children's health; using different alternatives either in preference to, or as a substitute for, services at the healthpost or other 'modern' facilities. There were also many cases in this study where women indicated they had switched from one sector, or one treatment, to another, usually after the first treatment failed to provide a cure.

This pattern of 'dual' or 'multiple' use of distinct medical options, either 'indigenous' or 'western', seems to be a basic feature of societies in which a state of medical pluralism exists; a pattern we find in many parts of the world, and not only in developing countries (Phillips, 1990:69; Good, 1987:7). Findings from different studies show that wherever people have a range of services or resources to choose from, they tend to make use of the different options available, using them either in preference to one another, sequentially, or even concurrently (Yoder, 1982; Chen, 1975; Subedi, 1989), "making patterns of utilization appear very complex" (Phillips, 1990:186). It also seems common to find that traditional medicine remains a popular alternative in both rural and urban areas, and this in spite of the

establishment of 'modern' medicine (Anyiman, 1987). Some would even say that traditional medicine has not only survived but thrived under the circumstances (Phillips, 1990; Good, 1987:10).

One of the most striking features of women's practices in this study is the basic pragmatism they often exhibited in their search for treatments or in opting for 'modern' or 'traditional' medicine - a pattern which obviously challenges many of the stereotypes that still plague traditional medicine, as dealing mainly with the domain of the 'supernatural', as 'irrational' or 'unscientific'. The common tendency among anthropologists in the past has also been to lay much greater emphasis on the cultural basis or content of therapeutic choices (Kleinman, 1980; Young and Garro, 1982), but as the results from this study revealed, in selecting treatments, women are often most concerned about the practical benefits of the different options, such as the cost, convenience and effectiveness.

It was also apparent that women did not always feel necessarily loyal to one system or the other. They often seemed very willing to try different types of therapies in order to find something that would help them, or provide a cure for an illness. It has also been noted elsewhere that during episodes of chronic illnesses, people will usually switch back and forth between sectors, consulting different healers and practitioners, until a successful treatment is found (Heggenbougen, 1986; Janzen, 1978; Feierman, 1985). Women in this study often seemed quite capable of utilizing different types of therapies, or moving from one sector to another, without confronting any conflict, even though, as Press (1980) has remarked before, they may be fully aware of the paradigmatic differences between them. It seems therefore that women view both 'modern' and 'traditional' as useful and valuable approaches to health care, and as complementary, rather than contradictory.

This kind of 'pragmatic' decision-making is increasingly being recognized as typical of health-seeking patterns in pluralistic health care systems (Janzen, 1978; Cominsky and Crimshaw, 1980; Young, 1980). Other authors have referred to this as: 'rational' or 'utilitarian' (Spring, 1980); as characterized by 'trial and error' (Bierlich, 1995); or as symbolizing a kind of 'rustic pragmatism' (Gould, 1965). This does not of course, eliminate the role of cultural variables. All practices, even 'modern' medical practices, are embedded

in cultural systems that embody specific ideas and assumptions about reality and shape people's experience of health, illness and healing (Good, 1987). But an exclusive focus on therapeutic choices as 'cultural phenomena' may obscure the way in which beliefs and practices are also very dynamic and adaptable. It must also be remembered that the setting is one in which diverse healing traditions have been integrated and co-exist. 'Modern' medicine has, in other words, been absorbed into the culture (Twumasi, 1975).

It is also important to recognize however, that the nature of the medical system in Ghana is not only based on a dichotomy between 'traditional' and 'modern'. As alluded to earlier, it includes a popular sector which is based in the home and is "centered on self-treatment by the individual or family" (Good, 1987:23). A 'non-professional' sector exists which relies on the knowledge and skills of 'lay' people. It has been suggested that all over the world, the greatest proportion of health problems may be managed exclusively within this sphere. There are many illnesses that never reach a physician or medical professional (Kleinman, 1978; Scott, 1983). But in spite of its importance, the popular sector of the medical system remains the least studied and most poorly understood (Kleinman et al., 1978; Van der Geest, 1987).

In studying health care practices, Good (1987), following ideas developed by Kleinman (1978), has proposed that we view the totality of medical resources available to a community as constituting one 'ethnomedical' system, which includes three overlapping spheres: a 'popular' sector, a 'biomedical' sector and a 'folk' or 'traditional' sector (see Good (1987) for a fuller discussion). This classification is important for two reasons. First of all, it allows us to view 'self-care' or 'self-treatment' as a separate strategy that people use, and to recognize that it represents an autonomous sphere of health care that operates beyond the sphere of the professional health care system. At the popular level, people also resort to diverse therapies that fall within both spheres. It would be inappropriate therefore to label them as being either strictly 'modern' or 'traditional'.

7.3.1 Lay Practices and the Popular Sector

It has been said before that home treatment, home-based care and/or self-treatment, is usually the first strategy that people resort to (Pappoe, 1993; Agyepong and Menderson, 1994; Kleinman, 1978). Women in this study indicated they used home remedies, either herbal or pharmaceutical drugs, to treat a variety of problems including: 'fever', measles, diarrhoea, headaches, stomachaches. Herbal remedies in particular seemed fairly common knowledge. Even children were able to identify the roots and plants used in certain medicines. Women would therefore prepare these remedies themselves or turn to others around them in the household or community. Pharmaceutical drugs were purchased from the local drugstore, shop or itinerant traders. Until recently, the VHW in Mampong was also supplying people with curative drugs, such as paracetimol and chloroquine.

The evidence from previous studies conducted in Ghana and elsewhere seems to suggest that the level of self-medication in rural communities is typically high[11] (Pappoe, 1993; Agyepong and Menderson, 1994; Sussman, 1988; Ghana Statistical Service, 1995b), which suggests that the pattern of self-care found in these communities may be quite common. Some concerns have been raised however about the dangers associated with the rise in self-medication and the proliferation of 'western' pharmaceuticals in rural areas (Wolf-Gould, 1991; Abosede, 1984; Van der Geest, 1987). According to Agyepong (1992), one of the first strategies may also be to delay treatment. It may be valuable to note that staff at the healthpost indicated sick patients often report to the healthpost only after several days or once their condition has deteriorated.

In coping with pregnancy and childbirth women also relied on the resources that were available within the household or family. They turned to their own mother or their husband's mother, and/or to other elders in the family, such as aunts or grandparents, for medication,

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11 Findings from the GLSS of 1991/92, for example, indicated that only half of those who reported being ill and indisposed had consulted someone. The other half did not consult anyone, although some did purchase medicines or medical supplies (Ghana Statistical Service, 1993). The GLSS conducted for 1987/88 also noted a high degree of self-medication (Ghana Statistical Service, 1995).

advice or assistance. As revealed earlier, all of the pregnant women in the study were relying on herbal treatments during the pregnancy, and in the majority of cases, these were prepared by their mother or mother-in-law. A significant proportion of women in the sample were also found to have delivered their last child at home with relatives or on their own, and this, in spite of the availability of 'trained' TBAs. The role of home treatment or home-based care is illustrated in the responses below.

> Interview A:
> (She said) *That at times not all the main sickness problems that they* (have) *to send to the hospital. They get herbs for headaches or they get paracetamol and other drugs to treat* (themselves). *So at times through that they don't go.*

> Interview B:
> *She said that at times she feels that maybe if it is a headache or stomach ache and she knows some of the herbs she* (will) *usually take it. And if she has seen that the sister or the fellow is also suffering she will also advise them to take that herb. But if she has seen that there is no improvement, she will advise that person to go to Oguua. That at times she also seeks* (out) *these people going through town selling these medicines, so she will also buy from them.*

The findings of this study suggest therefore that women and/or their families will often choose to handle various conditions on their own, by relying on their own knowledge and skills or the resources of other individuals around them, and only if problems persist, or fall beyond their capabilities, do they seek help outside, from more 'trained' practitioners.

As Pappoe (1993:83) has indicated before, the household will be the primary sphere in which health care decisions are made; whether the choice is to use home treatment, to take something to a traditional healer, either midwife, herbalist or spiritualist or to report to a 'modern' medical facility. As the quotes below from the translator further illustrate.

> Interview A:
> *She visited the healthpost at Oguua but uhm, I was asking her* (about) *the first child and she said that because the grandmother is there, the one who is a TBA, she* (the grandmother) *has been attending to her. But because of the 'twins'* (the grandmother recognized she would deliver twins) *she has seen that she can not help so she* (the grandmother) *asked her to go to the hospital to 'feel her'.*

Ok even the woman herself (the grandmother) *took her because she* (the granddaughther) *was feeing lower abdominal pains and they can't detect what is really worrying the child* (what the problem is) *so she took her there for the nurses to 'feel her'.*

Interview B:
(Question: When do you find it necessary to go to the healthpost?)
Maybe that the medicine that they will give to the child maybe it won't work, it won't do. Meaning that the malaria will be too much on the child and he'll be too warm so they have to rush the child to the hospital.

It is important to note however that not every woman in the sample was able to rely on individuals or relatives in the home for treatment during their pregnancy or obstetrical assistance. In such cases they turned to traditional midwives, either 'trained' or 'untrained', herbalists, neighbors or friends, or to the healthpost. As mentioned earlier, several women in the study had also consulted priestesses and spiritualists in their community, either for treatment or to seek prayers and spiritual protection.

7.3.1 Accessibility and Affordibility

It appears one of the primary reasons why women choose to use traditional or home-based care was its greater accessibility, in terms of time, distance and cost. As indicated earlier these were some of the main barriers to the utilization of government services. Herbal remedies for example, could be easily procured from a nearby garden or local herbalist, in some conversations it was implied that herbs were the 'cheaper' alternative. Modern or patent drugs could also be obtained relatively easily, particularly in Tarkwa, where the local drugstore and 'homeopathic' clinic were open daily.

Interview A:
(She said) *You know this native medicine, some lorries, some cars have been going selling* (around) *some of the medicine, and at times they say it's good for the children. When the child is hot, if he's warm, and feeling feverish, they may not manage to go to the hospital* (so) *you apply those medicines for the child. So she feels this type of medicine they* (can) *usually* (use it to) *attend to the child in*

case they don't have money to go to the hospital.

As Kumekpor and Richardson (1994) argue, traditional maternity care may be preferred for its convenience and relative ease of access. In the home setting, "it is the health care providers who converge on the mother for care" (Kumekpor and Richardson, 1994:16). A mother does not have to be removed from her home nor worry about the difficulties of obtaining and paying for transportation. There may be situations where women have no other choice but to deliver at home, particularly at night when transportation is either difficult to find or simply not available. It may also be important to consider whether distance or location does not interract with other variables to render services inaccessible to women. Leslie and Rao Gupta (1989), for example, highlight the importance of women's workload and the competing demands on women's time in limiting their access to health services. In other studies, women indicated home birth was more convenient because it allowed them to maintain supervision of their children and household chores. Delivering at health facilities would mean being removed from these responsibilities and having to arrange for someone else to take over (Auerbach, 1982; Voorhoeve et al., 1990).

A few studies have shown that distance does in fact increase the likelyhood that people will resort to alternative services. According to Stock (1983:569) people living further away from health facilities are more likely to "to delay using its services, usually preferring to use some alternate form of treatment such as self-treatment with traditional or patent medicine". In a study on health care seeking patterns in the Phillipines, Akin et al. (1985), found that as distance from a private 'modern' health care facility increased, communities were more likely to resort to: no treatment, traditional medicine, or to 'modern' public facilities. Some researchers have even claimed that distance and/or accessibility may be the most critical determinants of therapeutic choice, more important than any characteristic associated with the patient (Lasker, 1981) or with beliefs and attitudes (Young and Young-Garro, 1982; Glik et al., 1989).

However, as Anyiman (1987) argues, we also have to be careful not to assume that the traditional sector will always be a more affordable or accessible alternative. There were two

cases recorded in the present study for example where a woman was forced to turn down the services of a traditional practitioner - one a priestess, the other a herbalist - because the treatment was unaffordable. In both cases, they fell on the assistance of kin. In one other case in the study, a woman chose to switch from one midwife to another - her grandmother who lived in another town - because she found the first treatment was too expensive. So traditional medicine can also be quite expensive or unaffordable for some people (Asenso-Okyere, 1995:86). Yet, traditional healers have also been known to accept more flexible payment schemes and are less likely to deny treatment to those who can not afford to pay (Anyiman, 1987; Asenso-Okyere, 1995:89).

7.3.2 Perceived or Observed Effectiveness of Treatment

Decisions about therapeutic choices also appear to be influenced by the perceived or observed effectiveness of a particular treatment. One very illustrative example of this is the case of a young woman, about 24 years old and six months pregnant, who claimed in the interview that she did not normally depend on herbal treatments. But for this pregnancy, she was relying on medication provided by a local midwife to treat abdominal pains she was having. When she first began having abdominal pains she sought medical attention at a healthpost in a neighbouring town, but found that even after using the medication prescribed, the pains persisted. She mentioned the problem to the wife of her landlord who then recommended she visit a traditional midwife in the village. After taking the herbal medicine provided by this midwife she found the pains began to diminish, so she decided to continue using the same treatment. She was not giving up on 'modern' medicine, but for this particular illness she found the herbal treatment effective. In other similar cases where women would switch from one type of treatment to another, the overriding concern also appears to have been to find something that would 'work' or produce the desired results. As one woman said, *'if one doesn't work, they try another'*. The following quotes by the translator provide further illustrations of this.

Interview A:
(She said) *At times when she takes the hospital medicine, for instance, her stomach will be worrying her* (she experiences discomfort) - *when she takes it it won't stop the pains. But when the man gives her the herbs and she syringe* (she takes the medicine in the form of enema) *then it relieves the pain.*

Interview B:
(She said) *Her mother attended to her during the pregnancy. She knows some of the herbs.* (She says) *That if at times she's not feeling fine for example, her stomach will be worrying her - and if her mother give her the medicine to syringe* (as enema) *she uses it and after that she doesn't feel anything.*

Interview C:
(She said) *That they've got a herbalist, so at times, he does help them. So* (except) *when maybe the sickness is so difficult that they can't treat them then, they refer them to Oguua. She can't tell much* (she doesn't know very much) *about the medicine that the herbalist gives them because they* (the herbalist) *prepare it before giving it to them to use for the child, so in fact she really doesn't know. At times she uses the medicine for fever, so when they give them medicine like this and she uses it they've seen that the child's temperature will fall and will be normal. So that's why she uses it.*

The various herbal drugs used by pregnant women in these communities appeared to be quite popular and were often described as beneficial and useful. Their utility served even to preclude the need for regular prenatal care or for 'modern' obstetrical assistance. It was said on several different occasions that certain herbs were effective in facilitating a smooth delivery, and this, women argued, made it safe for them deliver at home, a point which is illustrated in the quotes below from the translator.

Interview A:
(She said) *She purposely uses the herbs because at times when she wanted to deliver she delivered freely and at times the child may not turn well. Because of the herbs it helps the child to turn well, and, when it's time to deliver, she do it easily, without any difficulty, and this placenta too, everything comes out easily. She also uses a leaf that they will put it in the mouth to chew because sometimes the placenta will fail to come out, so with this herb it will just come out without any difficulty.*

Interview B:
(She said) *Ok, she says the medicine is to make the child fine in the stomach and*

to lie well and so if it is time for you to deliver you can deliver alone without anybody. So it's true that she alone delivered the child.

Women also held confidence in traditional midwives because of their perceived competence and skills in conducting deliveries. It may be reasonable to assume that, at the local level, people regard traditional maternity care as a practice or field of expertise equipped to handle many aspects of the birth process. Most of the TBAs interviewed in this study, for example, seemed to possess a wide body of knowledge and experience and demonstrated considerable familiarity with herbs or other techniques used for, among other things: relieving discomfort, facilitating childbirth, preventing and treating complications, and stimulating expulsion of the placenta. As other authors (Itavyar, 1984; Laderman, 1983) have suggested, it may be that in the eyes of women, local midwives are perceived as 'experts' or as fully competent to deal with childbirth. It has also been noted in other settings that the role of midwives lies not only in their capacity to assist birth, but in the performance of ritual functions; functions which may be important in meeting the emotional needs of women, as well as for their social and ritual significance (McClain, 1981; Cominsky, 1977).

The practice of traditional midwifery does not, however, appear to be limited to known village midwives. The knowledge may be shared by other women, particularly senior women within the household. In one interview, for example, as transcribed by the second translator, a woman said, *"it was my mother who took care of me. She gave me about five drugs to be taken, each had its time. One for strength, the other when it is about six months, the next to make the baby strong and the others to make you eat very well. There also was this one which looked not unlike okro slime. It made the baby come out smoothly".*

But just as women may be motivated to use traditional medicine because of its perceived efficacy, they turn to the 'modern' sector for the same reasons or with the same expectations. It is also important to note that not everyone may share the same 'affinity' or confidence in traditional medicine. There were many situations in which women expressed a preference for 'modern' health services based on their view that 'modern' medicine was 'more superior' and 'advanced' than 'traditional' medicine - an attitude which is evidently a reflection of the dominant cultural bias towards western biomedicine. It was often said for

example, that 'modern' medicine was more effective in detecting the causes of illness and, therefore, of providing a cure. As one woman said, *'only they can know what is really bothering you'*. The following are other comments made as given by the translator.

Interview A:
(She said) *At the hospital they can detect if the child lies well before the time you deliver. But if she's in the house they wouldn't know, and* (if) *there is a problem, she would be suffering, but she wouldn't know the cause. So she feels in the hospital it is safer. When you reach the hospital it is safer because they can know the problems. They can feel you and know what the condition is.*

Interview B:
(She said) *She would prefer to go to the clinic - that in the clinic when you deliver they will give you some treatment, such as an injection. Sometimes you will be feeling some pains within you, but by getting this injection you will be ok. So she feels if you deliver there and they give you that kind of treatment she will be better.*

So in spite of its continuing popularity, traditional medicine still does not enjoy as much 'respectability' as 'modern' medicine in the society. In some conversations, women were even a little reluctant or embarrassed to admit they used herbal medicine. We can conclude, therefore, that while some women may regard traditional medicine as an equally valuable and effective alternative, others may only use it as a substitute to 'modern' medicine, or where no other alternatives exist. But, as other researchers have pointed out, even among groups or individuals who profess to be more 'modern' in their ways, traditional medicine or herbs are still common practice (Warren, 1987; Anyiman, 1987).

Few other studies have pointed to the role of 'efficacy' in influencing people's therapeutic choices. Most researchers have tended to emphasize the importance of peoples' diagnoses and their interpretations of diseases as the primary determinants of therapeutic choice. Yet this argument also implicitly assumes that people view some treatments as more effective than others for certain conditions, but the question of 'efficacy' is rarely ever examined. One study by Ho et al. (1984), did report that 'effectiveness' was the principal reason people gave for choosing to consult a Chinese practitioner, or for switching between Western and Chinese medicine. It was also concluded from two other studies on therapeutic

choices in Mexico and India, that "faith in the effectiveness of folk treatment" or "the expectancy of a cure" were the key determinants of choice (Young, 1981; Bhardwaj, 1975). But still, we lack an understanding of the criteria people use or the process that leads them to conclude that a particular treatment is efficacious (Etkin, 1988:300). In the present study, the analysis is also limited to women's subjective interpretations or statements about the therapeutic efficacy of herbs.

Unfortunately, there is only limited information available in the literature on the effects of traditional medicines. Hence, the value of many of the drugs women remains in doubt. But this should not rule out the possibility that some drugs may have their intended effects. Etkin (1979), for example, has investigated the herbal pharmacopoeia of the Hausa in Nigeria and demonstrated the potential efficacy of plants in treating symptoms of malaria. In Ghana, Ampofo (1977) also found evidence that certain plants, known by local healers, were efficacious in treating bronchial asthma, guinea worm and diabetes (see also Etkin (1986)). Among anthropologists however, there has been some debate over the validity and/or accuracy of using biomedical methods to test the efficacy of traditional medicines. Critics argue that biomedical research is inherently flawed because it can not take into account the social and cultural context, which is central to the healing process and to perceptions of efficacy[12].

Until recently however, the question of 'efficacy' has largely been ignored in the anthropological literature (Anderson, 1992). The few attempts made by anthropologists to assess the efficacy of traditional medicine have focused mostly on ritual healing or the psychological dimensions of traditional healing (Kleinman, 1980; Young, 1977), less attention has been paid to the effect of specific medicinal herbs. Some recent attempts have been made to construct a methodology that bridges the gap between biomedicine and anthropology and utilizes the tools of both disciplines (Anderson, 1992; Etkin, 1986; 1990). But discussions on the subject remain controversial (Browner et al., 1988).

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The efficacy of a particular treatment might be assessed by its effect on social relations (Feierman, 1985); by giving meaning to the illness for the sufferer within the broader cultural context (Kleinman, 1980); and by reordering reality for the patient and giving him/her direction for future action (Young, 1977). According to Cominsky (1977), the emotional context may also contribute to patient satisfaction and the healing process.

A compelling case can nevertheless be made in favour of this research. As has been argued before, research into plant medicines could help to reduce the costs of providing medical care and the reliance on expensive imported drugs (Etkin, 1986); increase the benefits of local medicines (Veliromic and Veliromic, 1980); and make local drugs safer for women to use.

It is also important to recognize however, the shortcomings of traditional medicine. The unhygienic application of herbs or other substances on the umbilical cord for example has been identified as one of the common causes of tetanus toxoid (WHO, 1979; Mangay-Manglacas and Simons, 1986). Other common problems associated with traditional medicine include: imperfect techniques for preparation and dosage, lack of standardized training, and the increasing commercialism of herbal practitioners ((Veliromic and Veliromic, 1980; Good et al., 1979).

In spite of the problems associated with traditional medicine, it still seems generally agreed that local midwives can assist normal uncomplicated births safely, provided they are given further training and equipment to improve their practices[13]. But there will probably always remain conditions or illnesses that fall beyond the capabilities of midwives and require more specialized care (Sargent, 1982:151; Jordan, 1978:78). It is probably fair to say that each system, both 'modern' and 'traditional' has its limitations, and neither is sufficient or adequate on its own (Pappoe, 1993). In order to improve the provision of community-based health care services, programs need to build on the strengths of both systems[14].

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Van Ginneken and Kok (in Voorheove et al., 1984:339) for example, found, in a study conducted in Kenya, that mortality rates did not differ significantly between home births and uncomplicated hospital deliveries, and that rates of neonatal tetanus were in general low in the area. The authors attributed these findings in part to the performance and hygienic practices of local midwives, and the fact that midwives were able to refer complications to hospitals when needed.

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The Ministry of Health has extended official recognition to the association of traditional healers and established a unit in charge of herbal medicine (Osenso-Okyere (1995:90); MOH (1995)). Official policy is "to promote research into common herbal remedies with a view to introducing them into the formal health care delivery system" (MOH, 1995). Some of the pioneering efforts to integrate traditional healers into the orthodox health care system have been tried in Ghana, in the Brong-Ahafo region for example, which showed that cooperation was both feasible and beneficial, but unfortunetly, the program was never expanded to other areas (Good, 1988).

7.3.3 Characteristics of the Condition or Illness

Another way we might try to sort out or make sense of women's therapeutic choices is by linking the typology of disease with specific patterns of resort. Much of the attention in the literature has been focused on the association between 'folk' concepts and beliefs and attitudes about health and illness and patterns of use (De Zoysa et al., 1984; Colson, 1971). As Colson (1971: 235-236) argued, based on findings from a study in Malaysia, "features of the disorder were the crucial factor in accounting for the differential use of medical resources". More recently, Mwabu (1978), in a study conducted in Kenya, found people stated a clear preference for one type of treatment over others, depending on the illness: clinics were preferred for wounds and physical pains; drugstores for headeaches and fever, and traditional healers for problems like asthma, joint and body pains. Interpretations and concepts of illnesses or diseases have also been based on the common folk classification of 'natural' and 'supernatural' causes. Fosu (1981) for example, in a study conducted in Ghana, found individuals were more likely to take what they defined as 'supernaturally-caused' diseases to a traditional healer, while 'naturally-caused' diseases were treated with self-medication or taken to a clinic.

In the present study, we do not have sufficient data to state clearly whether such classifications are made. There was some evidence that people regarded certain diseases as caused by spiritual or supernatural forces, but few examples of these cases could be explored. There did appear, however, to be a clear distinction between diseases that could be treated at home, and those which required more professional help. As indicated earlier, many common illnesses, such as 'fever'[15], diarrhoea, and headaches, were treated at home; but if an illness persisted, or if the treatment or cause was unknown, people appeared more likely to report to a health facility. The following quotes provide illustrations of this.

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15 'Fever' is generally understood to be a symptom of malaria.

Interview A:
(She said) *That she didn't know of any medicines she could use to treat herself. That is why she went* (to the healthpost). (She says) *That there are some diseases that she knows some herbs can treat. She uses them.* (She says) *That usually when she has headache or waist pains she uses some herbs as enema and becomes ok.*

Interview B:
Ok, she feels that there are some diseases that you can't cure in the house - let's say this diarrhoea with blood. They will make all the effort, (but) *it won't go* (away), *so for that now they have to go to the hospital for medicine. So she thinks that at times too, even* (for a) *stomachache. At times they may ask people to come in to help and it won't go so you have to go to the hospital.*

Interview C:
Ok what she means is that they will go, something will press them to go, but here, normally, they don't have any serious cases. So they have minor cases. So because of that, they have the man Atta (the VHW). So people have been going to him for help and to give some medicine. Sometimes when they go to him, he will inject and give them medicine and discharge them. So with his work, they don't feel to go to Oguua. But since hiswork fell (he stopped working) - *you know the money wasn't there and the community are no more giving him money to do his work,* (so) *they couldn't get money to buy his things as he was doing at first, so now when the nurses come here, they go to him and he also helps them.* (He would volunteer to help nurses conduct outreach clinics).

It also appears, however, that a certain ambiguity or uncertainty remained in the categorizations women made. In some interviews for example, the same health problems which could be treated at home, were also classified as problems to report to a healthpost. Perhaps this illustrates a point made earlier by Warren (1978) that the classifications people make and their therapeutic choices may not always be so clear-cut. In a study conducted in the Brong-Ahafo region of Ghana, Warren (1978) found that people often referred the same problems to the hospital, herbalist and priest-healer: 'malarial fever', 'pregnancy cases' and 'stomach ailments' were among the top five reasons respondents gave for visiting the hospital as well as (emphasis mine) for seeing herbalists. Findings from research by Durkin-Longley (1984) in urban Nepal also raises interesting questions about the accuracy of concepts and

expressed attitudes as a guide to health care behavior[16].

Some researchers have gone as far as to suggest that it is not so much the type of illness, but rather its perceived severity, that determines the course of action (Sussman, 1988; Thaddeus and Maine, 1994). People will usually try to treat 'mild' or familiar conditions at home, but if an illness persists or is viewed as severe, more professional help is sought (Young, 1981; Lasker, 1981; Phillips, 1990). Perhaps this is the critical question; how amenable is an illness to home treatment, or how well an illness responds to a particular form of treatment, a point which was somewhat illustrated in the quotes provided earlier.

There may still remain however, certain problems or illnesses that people would prefer to take to one practitioner or health service over another. In the research by Pappoe (1993) for example, it was found that although familiar illnesses were treated at home, most people would choose to take a child afflicted with 'kwashiokor' directly to a 'modern' medical facility. In the present study, it was also reported that people would visit 'faith healers' to receive treatment for psychological or social problems, such as anxiety, stress, marital difficulties, financial problems, etc.

Most of the studies in this area have taken rather 'broad' categories of illnesses, 'folk' illnesses or more endemic health problems to analyze health care patterns. The findings may therefore be of limited relevance to a discussion of women's practices during pregnancy and childbirth. The nature of illnesses and the difficulties and symptoms women experience as a result of pregnancy andchildbirth may be interpreted and acted upon in very different ways.

The impression we have from the findings of the present study is that women do not generally view regular prenatal care as necessary if a pregnancy is developing normally, although they often did demonstrate a concern to protect and maintain their health during pregnancy and childbirth. It also appears from the findings of this study that in most cases women would report complications or abnormalities to the healthpost. Yet there were a few instances where a pregnant woman mentioned she had used a herbal remedy to treat abdominal

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Patients in her study indicated a preference for one type of treatment in the beginning, but in the end the majority consulted more than one practitioner during the course of the illness. The author also found that patients often modified their views about disease causation to suit different encounters with practitioners.

instances where a pregnant woman mentioned she had used a herbal remedy to treat abdominal pains and/or another health problem, such as 'fever'. Whether this was due to the lack of access to services or any other factor, we can not know, but it clearly suggests that not every pregnancy-related health problem will reach a health professional or health facility.

Unfortunately however, we do not have sufficient data from this study to establish any clear or definitive linkages. In the literature, there is also surprisingly little attention given to maternal health issues or reproductive health practices. There are a few descriptive or ethnographic accounts (Kay, 1982; Field, 1961; Otoo, 1973; Peterson, 1982), but little detailed information on the health-seeking patterns of women during pregnancy and childbirth in Africa, with the exception of Sargent's (1982) study of birthing practices among the Bariba of Benin. The information we have, also, remains largely anecdotal. More in-depth and systematic research is needed. Nevertheless, a few studies have indicated that certain signs and/or symptoms related to pregnancy and childbirth may elicit different reactions among women in different groups and cultures (Stock, 1987). There is evidence that certain complications or symptoms may not even arouse concern or be recognized as danger signals (Thaddeus, 1994; PMMN, 1992). For example, swelling of the feet, which is a symptom of the disease eclampsia, is apparently interpreted to be a sign that the baby will be a boy in one part of Nigeria, and twins in Accra, Ghana (PMMN, 1992:282). "The way in which women interpret 'edema', another common complication, as caused by 'bad blood', 'bad water' or 'bad baby', also leads them to seek out traditional treatments, rather than 'modern' health care" (Okafor and Rizzuto, 1994:356). But with more serious complications, such as heavy bleeding and convulsions, women do identify the need for prompt medical attention (PMMN, 1992:282).

The information gathered so far seems to point in different directions. While in some cases cultural concepts and beliefs appear to play an important role, other examples illustrate that interpretations and attitudes will sometimes vary; indicating perhaps that the association between characteristics of an illness and health-seeking behaviour is much more complex than we might assume. Nevertheless, there still seems to be some agreement among researchers that whatever the interpretation may be, the "assessment of the illness or its initial diagnosis is still

a crucial factor in the decision to seek treatment and the therapeutic choice" (Stock, 1987). People still remain guided by their beliefs, and by their perceptions and interpretations of the problem or condition (Staiano, 1981:324). Thus, a clear understanding of local attitudes and beliefs may still be essential to design programs that will be adapted and responsive to local communities (Bierlich, 1995; De Zoysa et al., 1984; Olango and Aboud, 1990; Belcher, 1975). This may be particularly important in the area of maternal child health, about which we still know so little. Further research is therefore needed to specify more clearly: how women interpret and respond to some of the complications and symptoms of pregnancy and childbirth; and the various strategies they use, both 'modern' and 'traditional', to protect and promote their own and their baby's health.

7.4 Knowledge and Attitudes about MCH Services

Women's knowledge and attitudes toward MCH services may also tell us why services continue to be underutilized. As mentioned already, women in this study did not always recognize or perceive a need to attend ANC clinics or use 'modern' obstetrical services. Although this, in part, seems to reflect their view that 'modern' medical care is not essential for a normal pregnancy and birth, it may also be due to their lack of awareness of the benefits and/or purpose of attending ANC clinics (Kumekpor and Richardson, 1993). This factor also seems to be what differentiates the 47% of women who attended simply for a check-up from those who reported primarily for medical treatment. The former were perhaps more convinced of the intrinsic value and/or the benefits of antenatal services.

Previous authors have argued that knowledge and attitudes serve as predisposing factors in the decision to use health services. "They do not serve as direct reasons why people use services, but affect people by making them more inclined towards using services" (Poole and Carlton, 1986:212). Marshall (1985) for example, in a study of antenatal clinic attendance in Port Moresby, Papua New Guinea, interprets the high level of attendance at clinics as largely a reflection of the 'western' attitudes women had adopted towards pregnancy and childbirth - that attending the clinic was either 'the right thing to do', as necessary to check their health,

and/or to avoid or prevent any complications that might develop.

The most obvious, though by no means the most important, factor which seems to explain why women in Mampong were more likely to use MCH services, is their attitude towards services. Women in the village were more likely to express views that suggested a higher level of awareness and/or acceptance of the goals of MCH services. In giving their reasons for attending clinics, they would often cite the advice given by health workers and World Vision - that attending clinics for example, was important for preventive reasons, and not merely for curative care. Yet, from talking with women and other members of the community one also got a sense that villagers felt some pressure to meet certain expectations - that failing to obey the advice of health workers or World Vision, was somehow disapproved of. As one women said, *"you have to abide by the regulations"*. Although this might indicate a hint of social pressure, one could also argue that it reveals the degree to which the ideas promoted by World Vision have been accepted by the community.

Education has also been frequently associated with higher rates of utilization. Evidence from the Ghana Demographic Health Survey (Ghana Statistical Service, 1993) and the ICMMS (Ghana Statistical Service, 1994) indicates that women with higher levels of education are more likely to utilize ANC and delivery services at health facilities. But the nature of the relationship between them remains unclear - whether education reflects attitudinal differences (Odebiyi and Ekong, 1982; Belcher et al., 1975) or is more a function of socio-economic status (Thaddeus and Maine, 1994; Kroeger, 1983). The role of education in influencing health-seeking patterns, also, tends to vary, depending on the study. While some have identified a clear effect of maternal education (Fosu, 1986; Abbas and Walker, 1986), others have found little or no association (Kutty, 1989; Olango and Aboud, 1990; Glik et al., 1989). In the present study, there was not enough differentiation in levels of education to be able to make a comparison, but it may be safe to assume that low education will not necessarily serve as a barrier. What rural women need is more information to be able to know what options are available to them and what they can do to better protect and promote their own and their family's health.

7.5 Perceived Quality of Care

Another factor that seems to affect the choice of health service is the perceived quality of care. This appeared to take on particular importance in the selection of obstetrical assistance and traditional birth attendants. In several different interviews with women and TBAs the remark was made that in one community the abilities of midwives will usually vary. Each midwife provides a different kind of care and has unique skills and talents, which means that women will also have their different preferences. As taken from my field notes, one woman said, *"ok that it's everybody's work (traditional midwifery), you will choose yourself because there are many, the one who is your favourite, the one whom you like, you will go to her"*. Some TBAs for example pride themselves on being able to know precisely when a baby is ready to come out when birth is imminent. In a few interviews with women the complaint was also made that during labour, some birth attendants will force a mother to push too early, or according to one woman, *'before the time is right'*.

Some of the qualities women praised in TBAs were; patience, kindness, and a caring attitude. It was mentioned that some TBAs will devote considerable time to the care of patients, helping them through recovery after birth, assisting in the preparation of meals and the care of the newborn. There are some TBAs however, who can, apparently, be quite harsh and impatient. As one woman was reported saying by the translator, *"she likes the TBA, that some people when you are delivering they do shout at people, they don't have the patience for the pregnant women, but for her (the TBA who was an aunt) she doesn't do anything like that"*.

A similar comparison was also drawn between local midwives and government midwives. A few women claimed they had been very poorly treated by government midwives in the past. They may have been referring to a former midwife at the healthpost who was known to have been unpleasant with patients, or to nurses at other health facilities. In general, few complaints were made about staff at the healthpost or about the service provided by nurses. Nevertheless, problems with staff behaviour and attitudes towards patients have been reported in other settings and appear to be quite prevalent (Kumekpor and Richardson, 1993; Waddington and Enyimayew, 1989) a phenomenon which may unfortunately, be a symptom

of their own poor and stressful working conditions (PMMN, 1992:290).

It was also mentioned in the present study that women did not always wish to deliver with 'trained' TBAs because they were known to 'gossip' about clients, and, according to one woman, would say things that could prove embarrassing to women. It may be important to note that women from different communities had communicated the same concerns to nurses at the healthpost, which may suggest that it was not such a trivial matter.

All of these findings point to one main conclusion: that the performance of midwives and the nature of the relationship or contact they have with patients may be crucial (Leslie and Rao Gupta, 1989). Previous studies have also noted that the professional competence of midwives, the attention they give to patients, and the kindness they demonstrate are key criteria women use in determining which service to use or which health care provider to choose (Parker et al., 1990; Mangay-Maglacas and Simons, 1986; Okafor and Rizzuto, 1994). It is perhaps unrealistic therefore to expect all women to agree to deliver with a particular 'trained' TBA unless she is recognized as capable and exceptionally good with patients. If we expect women to switch from one service to another, obviously women would have to view that change as acceptable. This may in part be what distinguishes the popularity of the 'trained' TBA in Mampong from the other two villages. All of the women in Mampong viewed the 'trained' TBA as someone both very capable and dedicated to her work. Among the ten women interviewed there was almost unanimous support for the TBA selected. In Achiasi on the other hand, the 'trained' TBA had lost support over the years. More women were now turning to a priestess in the village. This might have had something to do with her age. She was considerably older than the priestess, but it was also said that she liked to 'gossip'. In Tarkwa, the perceived type of care may have also been a factor deterring some women from consulting the 'trained' TBA.

People also appear to make judgements about the quality of care provided at health facilities. Although women in this study generally held a favourable view of the services provided at the healthpost, there were some complaints about the shortage and rising prices of drugs. Women claimed they felt some frustration at being given a prescription and told they would have to purchase the drugs in Swedru, a town approximately 30-45 minutes away by

taxi, which not only added time but travel expenses. It was indicated in a few interviews that shortages and the high cost of drugs can discourage people from using services in the future, or encourage them to switch to other facilities. As the quotes from the translator below reveal.

> Interview A:
> (She says) *That she has been going to Oguua. At times she couldn't get proper treatment so she prefer going to Apam* (to the district hospital). *It is there that she usually goes. She prefers going to Apam because they* (the healthpost) *don't give the same kind of treatment she needs, or the medicine they give, she didn't like it. Because here they will charge, but they don't give you the* (same) *amount or quantity of medicine. But you pay more,*(and) *they will only give you less medicine. So she prefer*(s) *going to Apam because at Apam, if they charge you 1500 cedis they will give you plenty medicine* (a large quantity) *to come and take.*
>
> Interview B:
> (Question: what might stop some people from going to the healthpost?)
> (The father of the woman given his comments about the services) *What he means is that the treatment that was given to them wasn't sufficient, because at first they were saying* (that) *before, after when you go to these hospitals, they give a lot of medicine, you will come, and even it will take one year before you go to the hospital again, but this time they will just give you a little of it* (the drugs) *and when you come too it won't even reach three days and it will start again, and unfortunetly maybe you don't have the money to visit the person* (the healthpost), (so) *you may have to stay back because of money.*

Deficiencies in services and shortages of drugs have been identified before as factors that deter utilization (Okafor and Rizzuto, 1994:357; Leslie and Rao Gupta, 1989). The only other complaint women made was concerning the condition of facilities and the lack of equipment. To improve services at the healthpost they recommended: more equipment, resources, both material and financial, and electricity.

7.6 Social Relations, Family and Kin

An important feature of health care patterns and behavior in these communities is the role of family and kin. Up to now the discussion has focused mostly on what 'women' do, as separate and individual actors, but through this study it became apparent that a woman rarely

acts on her own. She is often surrounded by other people, either in the same household, dwelling or in the community, who will be involved, either directly or indirectly, in the choices she makes: by offering advice, providing herbal remedies, financial assistance or lending their support in other ways, such as with childcare and household chores.

Husbands and/or mothers were the two key figures in a woman's life, but between them, the mother seems to have been the most constant presence. As the findings indicate, a significant number of women were staying with mothers in their natal home. But even when they lived apart or in separate dwellings, women often maintained a close attachment to their mothers. Fortes (1950) has spoken of the strong affective relationship that exists between children and their mothers, particularly daughters, in Akan society. It appears therefore, from the findings of this study, that mothers participated very closely in their daughters' lives and played a key role in managing health problems within the household. There were numerous examples of cases where women were following advice or medical treatment provided by the mother, either to treat a child's illness or to take care of their own health. And, as mentioned earlier, it is still a practice for women to return to stay with their mothers or families during pregnancy and childbirth. Hence, whether a woman decides to use ANC or delivery services may very well depend on the opinions of the mother. This finding is illustrated in the comments written below as described by the translator.

> Interview A:
> (She said) *That she has been with the mother for a long time, that her mother can, also, deliver so she doesn't find it necessary to go to someone else* (The same woman had delivered all previous children with her mother).
>
> Interview B:
> (She said) *The husband, he's the one who helps. Ok, he's the head of the household, anything at all, he's the main person to see. If the husband is not around, it is the mother who helps, the mother, also, look after the children.*
>
> Interview C:
> (She said) *That she first tells the mother, that maybe the mother will prefer to treat the child on herbs or help with money to go to the healthpost.*

Other family and/or kin relatives, friends and neighbours will also lend their support in different ways. Aunts, grandparents and mothers-in-law often helped with health problems, providing herbal remedies during pregnancy, and assisting directly in childbirth. According to Kumekpor and Richardson (1993) and other authors (McClain, 1981; Cominsky, 1977), the role of family and kin is, also, in providing emotional and psychological support, which is especially crucial during the difficult stages of labour and childbirth. Jordan (1978), in a study of birth practices in Yucatan Mexico, also, characterizes childbirth as "a social affair in which other family members participate closely".

Hence, the support of family and kin, and the resources they can offer, may be crucial in determining the strategies women adopt and their therapeutic choices. This may partly explain why women in Tarkwa, for example, called on women who were related to them, rather than the 'trained' TBA. But support and assistance may also come from individuals who are not close relatives, such as neighbours or friends. The quotes below from the translator provide an illustration of the range of people who were involved in different ways in selecting and arranging for health care services or therapies for women.

> Interview A:
> *(She says) The mother's sister, she, also, knows some of the herbs, so when she comes from the farm she go*(es) *to her to ask for some herbs to use. The aunt helps her in all aspects, because she is the older mother, so anything at all, she goes to her.*
>
> Interview B:
> *(She said) Since she hasn't got money she doesn't go* (to the healthpost). *Some people have been giving her medicine when the children are not well. The mother* (referring to the mother-in-law) *and a certain woman nearby. She doesn't know the name of the medicine. She will go there and inform them that they should give her something or show her.*
>
> Interview C:
> (She says) *That the husband is giving her money to go to the clinic, and to buy drugs. The old man who is in this house, he is the landlord, he also knows some of the herbs so he has been attending to her,giving her some herbs to syringe"*(pregnant woman)

The importance of kinship ties in Ghanaian society is, also, expressed in the terminology used to refer to certain members of the family, such as 'older mother' or 'older father', who are, according to matrilineal kinship rules, a person's maternal uncle and aunt. A few women mentioned that, if they needed additional help - if support from parents was inadequate - they could turn to their mother's sister who was their 'older' or 'younger' mother for help at home, or to their uncle for financial assistance. But not everyone may be able to count on the support of extended kin. Some members of the household may be dispersed and living or working elsewhere. It was mentioned that in some cases the resources of the household or family were already very stretched and barely able to meet existing demands.

The structure and organization of the household, also, has implications for women's decision-making power and their ability to exercise control over decisions that affect their own and their children's health (UNICEF, 1990). Women indicated that husbands, as the head and primary decision-makers, were ultimately responsible for determining what action would be taken and for covering medical expenses. They maintain control of the family's income and the allocation of resources within the household, which places them in a position to deter or influence their wives to utilize MCH services. Although there is evidence that husbands can serve as barriers (Chika-Ezeh, 1993), there were examples cited in this study where they had played a positive role and encouraged their wives to attend ANC clinics. When husbands were not available, or when women were unmarried, a woman's mother or mother-in-law might assume some of the responsibilities. Husbands' living outside were, also, expected to send remittances home, but it is unclear to what extent women could rely on this as a source of income.

Elders of the family who resided in the household, compound or in the community, also appeared to exercise considerable authority in decision-making. They could determine, for example, whether someone should be sent to the modern or to the traditional sector. One young woman even remarked, *"when something is wrong you have to see the elders!"*. In another interview, a woman mentioned that in the past it was the 'grandfather' or husband's father who would assist her during deliveries, but after he passed away it was an aunt who was called in to help, for the basic reason that she was the 'eldest among them' and was, therefore,

more experienced. Thus, kinship networks and structures of authority may have a direct bearing on a woman's ability and/or inclination to use MCH services. Because of their lower social status, it may not always be women who make the determinations themselves. The choice may actually be in the hands of others who exercise more authority.

A earlier study by Janzen (1978) in "The Quest for Therapy in Lower Zaire" provides one of the most detailed accounts of the role of kin and family in the management of health problems and in the selection of treatment. He claims that the selection of therapy is largely the responsibility of kinfolk and it is they who must be studied in order to understand how people make their way through the complex array of choices (Janzen, 1978:4). When a person falls ill, his/her close relatives will come together to provide assistance, make the decisions about diagnosis and arrange for the therapy. This group of people constitute what he calls the 'therapy management group'. But, according to Janzen, among members of a therapy management group, one should make a distinction between those "individuals who have rights to make the decisions, and others who assist in lending support, solace or aid in treatment" (Janzen, 1987:77). Not every member will possess the same level of authority or influence. Chavunduka (1978:45), in another in-depth account of therapy management among the Shona of Zimbabwe, also concluded that the 'therapy management group' is the critical decision-making body, arguing "that kinsmen, both uneducated and educated, jointly take the decisions throughout the illness and are responsible for paying the medical fees".

Although it has apparently been fairly well-established or is recognized that social bonds or social networks are important (McCauley et al., 1992; Fosu, 1986; Kroeger, 1983), there is surprisingly little attention paid to this in the literature on ethnomedicine in Africa. The issue is either ignored or is described only sketchily. The issue of gender has also been recognized in the literature and among professionals in the field, which is why in recent years, more attention has shifted to men and their role in making health-related decision, particularly on family planning. Yet it seems we may still lack an adequate understanding of the dynamics that underlie these networks and social relationships. Janzen (1978) and Chavunkuka (1978) portray therapy management as a process that often involves complex negotiations between participants whose views, preferences and attitudes will sometimes vary. Both authors argue,

however, that in order to be effective, the therapy management group has to be able to reach a consensus or compromise. Yet, recent evidence from a study conducted in the north of Ghana seems to suggest that a consensus or compromise may not always be reached and that women may sometimes act independently of the 'therapy management group'. It was reported in discussions with key informants in rural communities in the north that women would travel to clinics on their own, and sometimes far away from their homes, to receive an injection of Depo Provera, because it was a contraceptive they could use without their husband's knowledge or approval (Livingstone (DANIDA), 1995).

Sargent's (1982) work in Benin also reveals that there may be certain areas of decision-making in the household where women have more autonomy and control. She claims that when complications arise during the birth process, it is the senior women in the household who take charge and make the key decisions. Male members of the family, and even the birth attendant if she has been called from outside, are only expected to play a limited role. It would be interesting, therefore, to examine further, the dynamics in social relationships, and to map out how categories of gender and age interact with other issues of control, power and access to resources, to influence the pattern of therapeutic choice and health-care seeking strategies within the household.[17]

7.7 Problems in the Design and Planning of Programs

Patterns of utilization and participation also appear to be shaped by processes that occur at the level of program planning and implementation. The lack of support for the 'trained' TBA in Tarkwa in particular can be blamed on weaknesses in the design and implementation of the strategy, such as: the lack of attention paid, at the design stage, to local level factors and existing structures; and the lack of community involvement in the decision-making and planning.

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17 Perhaps studies of therapy management would benefit from recent discussions on the subject of domestic relations and "attempts to reconceptualize the household, not as an arena of cooperation and harmony, but often as a source of contention, conflict and negotiation" (Oppong, 1994).

7.7.1 Lack of Attention to Community Factors

As indicated earlier, the TBA program has received a varying response from women in the different villages and in two of the communities, Tarkwa and Achiasi, the results suggest that the program remains weakly or poorly integrated. The data show that in Tarkwa and Achiasi support for the 'trained' TBA was low, while in Mampong, the TBA has effectively become the primary source of care for pregnant women in the community. What is not revealed by the quantitative results, however, is that in Mampong, as well as in Tarkwa, some tension and conflict existed between the so-called 'untrained' and 'trained' TBAs[18]. In Tarkwa the conflict had become so severe that 'untrained' TBAs were assisting deliveries 'in secret', in fear that they might be fined by the TBA or by the chief and elders. It was, also, expected that once trained, TBAs would return to their communities and pass on the knowledge to other midwives in the village and that groups of TBAs would work together, under the guidance of the 'trained' TBA. Although 'trained' TBAs in Tarkwa and Mampong claimed they had shared information with other midwives about the training, there appeared to be either little or no cooperation between them. The training and midwifery kits essentially remained the 'property' of the 'trained' TBAs.

The problems encountered seem to result in part from the 'lack of fit' between the design of the program and the established relations between TBAs and the pattern of maternity care within the community. Although only one, or in some cases two TBAs were officially 'trained', there were several other women in the community who were known as 'birth attendants' and who assisted women within their family, compound or outside. TBAs in the community were also known to possess different skills and talents. In two communities, for example, there was a midwife who was also a practising 'faith healer' and each one claimed she could treat women with all kinds of difficulties, including 'spiritual' and 'physical'. In the

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In the absence of more appropriate terminology, the labels 'untrained' and 'trained' will be used to refer to the different classes of TBAs. But I would agree with Laderman (1983:119) that characterizing local midwives as untrained is "an expression of cultural bias in favour of more formal schooling over traditional apprenticeship. It is not an objective description of fact".

same village, there were other TBAs who indicated their specialty was strictly in assisting birth, but some were also very skilled in the use of herbal medicine.

Yet, when the program was implemented, villagers were told, either implicitly or directly, that all deliveries should from that point on be assisted by the 'trained' TBA or conducted under her supervision. In Tarkwa the 'trained' TBA was even given the right to fine women who failed to 'obey'. 'Untrained' TBAs were therefore being asked to surrender their role to the 'trained' TBA, which one TBA interviewed rejected, while the others accepted the rule only grudgingly, arguing the decision had to be accepted because it had been ruled by elders. It should be noted, however, that some of the other TBAs were apparently approached by the healthpost when the program was first being proposed but declined to participate. Nevertheless, the introduction of the program caused a major disruption in relations between TBAs, which seems understandable given that other TBAs had always maintained a role within their community.

As we learned earlier, women may also prefer TBAs with whom they have an established relationship and/or in whom they have confidence. This seems to explain why in Tarkwa, for example, many women chose to deliver with other TBAs (in some cases mothers or other relatives) rather than the one who was 'trained'. In Mampong on the other hand, the response on the part of women was very different. The majority of those interviewed had called on the 'trained' TBA during their last pregnancy. When they were asked why, almost all of the women answered that it was due to the 'training' she had received and/or because they had been advised to do so. So women in Mampong were much more welcoming of the changes, perhaps because they were less inhibited by ties to other TBAs; felt more obliged to abide by the rule; or simply supported the decision.

What is particularly interesting about the findings in Tarkwa is that women who had delivered with the 'trained' TBAs lived on the same side or in the same section of the town, while the other women who delivered alone or with relatives were living in an opposite section. It has also been noted in an interview with a key informant that the town was divided into four sections, representing the different settlements, and some tension apparently existed between groups. Could it also be that the divisions reflected deeper kinship differences?. It

would have been interesting to examine these questions further but, unfortunately, time would not permit. In Achiasi the weak popularity of the 'trained' TBA seems to have less to do with the program than with the nature of the relationship and type of care, as was discussed earlier. It was also said that a good relationship had always existed between the two TBAs who were trained.

The conflicts between TBAs may also be a manifestation of the differentiation caused by the program in the roles and statuses of different TBAs. Because 'trained' TBAs were now associated with the Ministry of Health, their skills were viewed as more 'superior' and 'advanced', and in adding prestige and status to their role, the program had encouraged a kind of 'elitist' attitude among 'trained' TBAs. One TBA once even proudly declared that she was now a 'government worker'!. Although there is nothing intrinsically wrong with TBAs feeling pride in their new role, their identification with the 'modern' sector may only serve to further alienate other local midwives.

According to sources at the healthpost and findings from other recent studies, conflicts have apparently not been an uncommon feature of programs, and, contrary to planners' expectations, many women still choose to deliver with 'untrained' TBAs rather than switching to those who have been trained (MOH, 1992; Twumasi, 1987). The results from the present study have highlighted some of the problems, but the reasons for this are still unclear. It appears, however, that the difficulties are more at the level of implementation than conceptual. The example of Mampong and reports from other studies have shown that programs can succeed in improving the practices of TBAs and increasing referrals to health facilities (Twumasi, 1987; Shneider et al., 1992; Neumann et al., 1986). Nevertheless, one major shortcoming of the program is its almost singular focus on the activities of a few TBAs, rather than on the general practice of midwifery in villages, which ultimately limits the impact of the training and provision of services.

7.7.2 Lack of Community Involvement and Preparation

The lack of community involvement in decision-making is also to blame for the weak

support given the program in Tarkwa. In Mampong, women were not directly involved but were at least made aware of the program before its implementation, and TBAs were apparently given an opportunity to volunteer to participate. Whereas in Tarkwa, the project was presented as a kind of 'fait accomplit'; TBAs and women were only informed at the end, after the TBA had already been selected and trained. There were also allegations that favoritism, or as some called it, 'tribalism', was a factor in the decision.

In Tarkwa, the community was clearly not adequately prepared for the change. There were even hints that women in the community were still not fully aware of the program and, indeed, of its importance. Support for the program would probably have been stronger if there had been more discussion at the level of the community in the planning and implementation of the program, to find out women's views of the program and to receive suggestions on how it could be operated or applied within the community.

7.7.3 Lack of Follow-up and Support

In the implementation there also appears to have been little attention paid to how the program would actually be made to 'work'. Support for TBAs remains low because there was no process to supervise the actual integration of the program into the communities. It seems as though the MOH simply trained a cadre of TBAs, sent them back to their communities, and assumed that their acceptance would be simple and direct. But as we have seen, the issue was rather more complicated. The results, also, show that any form of cooperation between TBAs would not occur spontaneously. Some encouragment and support was needed from outside.

There is at present, some ongoing supervision of TBAs, although it appears limited to the activities of 'trained' TBAs. The midwife at the healthpost in charge of supervision claims, however, that is difficult for her to make regular supervisory visits to TBAs because of the existing financial and material constraints, e.g. lack of transportation. But as findings from Walt (1990) and numerous other studies (Leedam, 1985; Verderese and Turnbull, 1975) have shown, supervision and support are absolutely critical to the success of community-based programs. Often the main reason why programs have failed is that support or supervision have

either been absent or lacking . If TBAs are not given adequate supervision, for example, they may forget what they have learned and revert to their old practices (Senah, 1989). If we look at the example of Mampong, it is also very possible that the same results in participation and use would not have been achieved if there had not been continuous follow-up support from World Vision, not only in the form of financial assistance, but moral encouragement and support.

7.7.4 Bureaucratic Forces

According to health staff, it was recognized that not enough time and/or attention was spent on preparing communities and implementing the program, but it was argued that strict guidelines had been imposed by the donor or external agency. Apparently a limited timeframe had been set for the planning, training and implementation of the program. One of the staff members involved in the program recommends that, in the future, more flexibility has to be permitted in timing and resources so that processes can be followed through more thoroughly. As others researchers have emphasized, flexibility in plans is important because participation is inherently a very slow and gradual process, and, in order to succeed, it has to be given time to develop and take root (Rifkin, 1990; Askew, 1991; Johnson et al., 1989; Good, 1988).

7.8 Approach of Planners and Health Workers

As Pappoe (1993) has argued before, the interpretation that planners and health workers have of participation may also inhibit more active community involvement. It was indicated, for example, that in planning the TBA program, chiefs and elders of the community were presented with the idea and provided with a set of guidelines to use in selecting a TBA to train. No other steps were taken to involve other members of the community, although leaders were apparently advised to try to include women as part of the process. In the end however, there was little, if any, community involvement in either one of the communities.

According to a staff member of the healthpost, health workers purposely limit their

involvement in decision-making so as not to impose their will on the community and to respect the authority of chiefs and elders. They, also, view this as a way of encouraging communities to take control of projects and to promote local responsibility, which should, in the long run, ensure that projects have the support of the people. Yet, as evidenced in the implementation of the TBA program, the approach only seems to reinforce the traditional top-down way of decision-making. We might, also, ask whether requesting communities to select participants truly symbolizes the broad concept of 'participation' as an empowering process, or whether communities are not simply being asked to execute plans that have already been set by planners. The evidence seems to weigh more in favour of the latter conclusion.

The findings of Pappoe (1993) clearly demonstrate that health workers often define participation in very narrow terms. "A survey of sixty-two health workers from three different healthposts revealed that as much as 87% viewed community participation as consisting mainly of contributions of labour, materials and resources to projects. Other tasks associated with planning and managing projects were regarded as the exclusive domain of health workers" (Pappoe, 1993:50). So, indeed, the attitudes of health workers may effectively restrict the extent of community involvement.

One of the key reasons therefore, why participation remains low is that little attention has been focused on 'mobilization' and 'animation' at the level of communities, where health workers would take on a role as community workers and 'motivators'. Most, if not all, of their attention has been concentrated on the 'delivery' of care and 'technical' services. In Mampong, we have seen that a participatory strategy has been used successfully. But as noted by Askew (1991), NGOs like World Vision may find it easier to carry out participatory projects because of their very nature, which is oriented towards grassroots development, and their structure, which allows them the flexibility to be involved more deeply at the community level. World Vision also has trained community health workers, whereas the MOH is a large bureaucracy, with professionally trained and oriented health workers, who may lack the skills and training in community animation. Nevertheless, to achieve the goals of PHC, the MOH may have to adapt itself to this role, and this is, perhaps, where the importance of intersectoral collaboration comes in. Other governmental departments and local organizations do have

trained community workers or extension officers who can join hands with health workers in implementing and carrying out PHC activities.

7.9 Lack of Clarity in the Concept of Participation

The above interpretation of participation may, also, be a reflection of the lack of clarity in the concept of participation. In examining the TBA program, for example, one is left with the question: 'Where is there room for participation?'. The criteria to select TBAs, the number of participants, the content of the training, the role and functions of TBAs, etc., were all decided by planners. There was evidently little room for communities, and women in particular, to express their views or contribute any meaningful input into the design of the program. They were mainly expected to select participants and to contribute resources towards supporting 'trained' TBAs, either by paying for fees or providing some renumeration in return for their work. The strategy has, therefore, already set limits as to what kind of community participation is feasible or useful, which is indeed contradictory to the whole premise of community participation and PHC. But given the nature of planning and administrative processes, and the need to meet policy guidelines and governmental priorities, we can probably expect the same difficulties will always arise.

So, how do we arrive at a practical definition of participation that meets the broader goals of participation, as increasing people's capacity to maintain their health and to improve their conditions of life. Perhaps a solution might be, as Cohen and Uphoff (1980) suggest, to 'seek clarity through specificity'. The exact form of participation will have to be determined based on the characteristics of communities, the nature of the project, and the context in which participation should or will occur. The specific form of participation that is desirable or feasible within any given context will therefore vary.

7.10 Characteristics of Communities

The data also reveal how local conditions and aspects of village social structure may

influence project outcomes. The support which the 'trained' TBA has received in Mampong for example seems to rest, in part, on the strength of local leadership and community relations. The chief in Mampong appeared to command a lot of respect among villagers and was often spoken of as an effective leader. In the other villages, chiefs were absent most of the time, both were working and living outside and did not appear to return very regularly. There was also some apparent dissatisfaction with leaders in one of these communities. It has indeed been noted before that leadership can serve as the key to the success of programs (Wood, 1984:309). As health workers claimed, they can either break or make a project, which is why their approval is so crucial.

As mentioned earlier, the community in Mampong was, also, much smaller in size. As a result, the 'trained' TBA in Mampong had little difficulty establishing and maintaining contact with most households where women needed assistance. In Tarkwa, on the other hand, the population was considerably larger and households were a lot more dispersed, so it was understandably harder for the TBA to maintain contact, or even assist, every household in the community. In some corners of the village, there were even some women who seemed rather unfamiliar with the 'trained' TBA.

It may, also, be interesting to note that in selecting villages to provide support to, World Vision agents indicated they look for certain features or characteristics, such as good leadership and harmonious relations in the community. They also consider the size of the population to be an important criteria. In large communities, one of the agents argued, communal ties may be weaker and conflicts and differences are more likely to emerge that may interfere with project activities. So in determining which villages to assist, World Vision looks for evidence that a community has the potential and capacity to carry out participatory projects successfully. Fortunately in Mampong, these predictions appear to have come true.

7.11 Organization of PHC

From observations of activities in the communities and records from the healthpost, the impression we have is that PHC only exists in a 'weak form' (Wisner, 1988). As was indicated

earlier, very few activities, aside from outreach clinics, were carried out at the level of the villages. The emphasis in programs also appears to be more towards curative care and the 'delivery' of services, rather than on education and the mobilization of communities, as has been noted before (Pappoe, 1983).

The same, of course, can not be said of Mampong, where considerable time and effort was spent on involving people in health activities and in educating them about health matters. The emphasis placed on education and on participation in Mampong may partly explain why levels of use were much higher in the village in comparison to Achiasi and Tarkwa. As mentioned earlier, women in Mampong would often refer to the advice given by health workers, which, as argued earlier, may be some indication of the impact that health messages have had on attitudes.

World Vision has also dedicated substantial resources and time to a very broad range of activities, not only health, but including agriculture, literacy and income generation. Several representatives of World Vision were assigned to work closely with the community and to make regular visits to the village to assess the progress of programs and provide technical assistance and guidance. During the period of this study, a visit was made by four of these agents, including the WID (Women in Development) coordinator. The WID coordinator indicated in an interview that she has worked on a variety of projects with women and one of her main tasks has been to educate women about various health issues, e.g. nutrition, hygiene, prevention, etc. She also mentioned that each time she visits the village she organizes talks with groups of women to discuss issues that concern them and to give advice.

The results obtained in Mampong may serve as a good illustration of what health programs can achieve in changing health care behaviour, but they, also, underline the importance that must be accorded to the involvement of health workers or community workers at the local level. There is simply no substitute for linking communities to a health service or to health programs, and/or for mobilizing support and participation at the local level. Programs will not achieve their intended impact if the contact between health workers and communities is weak, and where there is no support to reinforce the messages delivered. As Belcher et al. (1975) found from studying the impact of program in other communities in Ghana, health

workers can make an important difference in motivating communities to participate in, and support, health programs. In Belcher's study, villagers served by volunteer health workers were better informed about clinics and more likely to attend clinics than villagers without a volunteer health worker, where reliance was on health centres outside the community, with limited contact between them and health staff.

There also appeared to be a better organization of outreach services in Mampong. World Vision was apparently donating funds to cover the cost of transportation and other expenses for nurses so as to guarantee that outreach clinics were held each month. In other villages, health workers admitted that sometimes clinics had to be cancelled or delayed for various reasons, either logistical or financial. It was also argued that in some cases, the scheduling and timing of clinics may be inappropriate for villagers. In Achiasi for example, during the period of this study, a clinic was cancelled because it conflicted with other activities taking place in the community. Nurses also claimed that due to the difficulties in obtaining transportation to villages they often arrived only after 9 or 10 am, which is long after people had left for their farms. Furthermore, it was observed that announcements to inform villagers about the clinic were only made once nurses had arrived, again, after women had left for work or for their farms. In Mampong on the other hand, the one clinic observed had started as early as 7am, which made it convenient for some women who wanted to leave for work. A teacher for example had asked to be seen before she left for school that morning. It was also surprising to find that within the other two villages, there were a couple of women who claimed they had not seen nurses over a span 2-3 months. Whether this reflects their lack of information or poor coverage remains uncertain, but it clearly suggests that services are not reaching everyone in the population. It further indicates that women may not be adequately involved in activities that take place at the level of the community, a reflection perhaps of their continuing marginalization within the society and within governmental programs, such as PHC.

7.12 Financial and Resource Constraints

According to health staff, the most significant constraints to the operation and

functioning of PHC activities are the lack of funding and resources. This affects every aspect of the health service: outreach clinics, home visits, health education, etc. Nurses claimed that outreach clinics were often difficult to finance because of the strict budgetary constraints. In order to compensate for the lack of funds, they relied on the returns they received from selling drugs at the clinics. But this was often insufficient to cover the cost of holding the clinic, particularly to pay for transportation, which was apparently 3000 to 4000 cedis per visit. This problem has now, however, been partly alleviated; the district hospital in Apam has arranged to lend one of its vehicles on a periodic basis to the healthpost to conduct clinics and other outreach activities. Nevertheless, significant constraints remain. Funding and transportation create difficulties for, among other things: the supervision and support of community health workers, including 'trained' TBAs; for community-based activities; and for home visits, which as indicated earlier, had to be restricted to villages within walking distance of the healthpost.

These inadequacies reflect larger imbalances in the distribution of resources within the health sector, as well as the government's own budgetary constraints. Evidence indicates that spending is still biased towards urban curative care. Out of the 1990 budget for example, 47% went to medical care alone, with 28% of this going to the two main teaching hospitals, Korle Bu and Komfo Anokye (MOH, 1991). PHC still receives less than 20% of recurrent budget, and significant rural-urban disparities in the distribution of resources and health facilities remain (Ghana Statistical Service, 1995). So although the government has officially endorsed the concept of PHC, this has not been accompanied by the reallocations towards PHC which are necessary to make it work.

In spite of increases in the MOH's budget over the years, overall financing for health remains low (Cassels and Janovsky, 1992). During the last five years, 1990-1995 health expenditures averaged at only 1.2% of GDP (World Bank, 1995:36), which is less than the five percent recommended by the WHO. Moreover, "in both the 3yr public investment programs of 84-86 and 86-88, the productive sectors have received roughly 33% (especially the export and supportive sectors), physical infrastructure 62%, while the social sectors (health, education and welfare) have only received 4.7-5%" (Kraus, 1991:141). In a recent document, the government even admits that its investments in health care are unlikely to increase significantly

in the near future on account of the current macro-economic constraints (MOH, 1995). Even aside from this, there may not be enough commitment at the policy and program level to support PHC and to promote community participation, which is still the only way to achieve longterm improvements in the health status of the population.

7.13 Resources and Capabilities of Communities

Another important factor that appears to affect patterns of participation is the resources and skills of community members. In Mampong projects were organized and lead by a group of active and committed leaders - members of the Town Development Committee (TDC) - who demonstrated enormous capability, in bookeeping, planning, etc. Although certain members of the TDC already had some formal education, they were given additional training through workshops and courses sponsored by World Vision (the organization apparently puts enormous emphasis on good bookeeping and accountability). In addition, the community has benefitted from substantial financial support from World Vision. There were, in fact, some fears among members of the community that once support was withdrawn, certain activities would have to be abandoned. In the other communities, financial and human resources were both more restricted. Each community had plans for different projects, but leaders claimed that without substantial external support there was little they could achieve on their own.

As other authors have indicated (Brownlea, 1987; Martin, 1983), people need training and skills to run projects on their own. Without the leadership and the skills, community participation is unlikely to occur spontaneously, nor is a process initiated from outside, likely to be sustained. As World Vision has recognized, some training is essential. People not only have to be given the resources but also the skills to manage those resources and the increased responsibilities that come with programs and external support. It must, also, be emphasized, however, that in order not to encourage an overreliance on external support, villagers should be encouraged to contribute something of their own, however small that may be.

The limited resources available within communities may also affect the sustainaiblity of PHC programs, such as the TBA program. Trained TBAs claimed that in order to replenish

the supplies contained in their kits, they needed to charge fees for their services, but women often complain they can not pay the fee, or they avoid paying until a later date. In Achiasi, the TBA claims she was forced to use her own resources to replenish her kit. If TBAs are unable to replenish their kits, their ability to implement new training practices may be hampered. Thus, the imposition of fees, also, complicates the issue of equity and affordibility. But it may be unrealistic to expect trained TBAs to work voluntarily when new tasks and responsibilities have been added to their role. It is only fair that they should be compensated in some way for their time. It seems, therefore, that the costs of supporting the program have been handed over to TBAs and women, who can barely afford to pay for regular services. We may, also, need to consider whether during this period of 'adjustment', women may not already feel overburdened, with bills for water, levies for community projects, household expenses, etc. In planning participation, perhaps we need to examine more closely what we can expect communities to finance, what people are ready to give, and what they can realistically afford. To ensure that projects are sustainable, it may, also, be necessary to establish in the design of projects exactly how activities can be sustained and to determine what resources can, or will be devoted by communities and external agencies, towards this purpose.

7.14 People's Perception of Participation

According to leaders in the community, participation is in general quite difficult to organize. Apparently, few people show up for communal labor when it is organized, so leaders argue they have to resort to coercive means, such as imposing fines, in order to get villagers to participate. Even in Mampong, where the level of participation was noticeably higher, communal labor was monitored very closely. Although this may be because the demands were much greater - people were expected to devote one day each week to communal labor. It is interesting, however, that even though public participation was low in the other two communities, women generally spoke of communal labor as representing a 'civic responsibility'.

Perhaps the difficulty in motivating villagers to participate is due, as Good (1988) has

suggested before, to the lack of perceived need or 'utility', or as health workers suggested, the lack of any clear incentives. It has been argued before that participation may sometimes be viewed as carrying an 'opportunity cost' (eg. time spent away from work), a cost which some may be reluctant to assume if they do not see any clear or practical benefits to participation. This view was expressed by one key informant who suggested that in Mampong villagers were more willing to contribute their time because their input was rewarded with financial support and concrete results in the form of projects and visible improvements in living conditions. In other words, people had witnessed what could be achieved through participation (Bossert and Parker, 1984:1019). This is in contrast to Tarkwa, where several projects which had been started were never completed.

People may, also, have a limited view of the role they can play (Pappoe, 1993). Women in this study for example spoke of participation as limited to providing labor or material contributions to a project. The majority did not expect nor perceive the possibility of playing an expanded role, one that would involve decision-making and planning. However, women in Achiasi were somewhat dissatisfied with the lack of power they felt to influence decision-making in the community, and wanted the ability to play a more active role. Thus, women may also be very aware of the other contributions they can make.

At the level of the community, people may also have their own ideas about what is needed. What people generally want are 'better roads', 'electricity', 'jobs' and 'clinics'. Programs like building latrines, improving environmental sanitation, etc., seem to rank lower on the list. It may be therefore, that villagers do not always share the same priorities as planners. Apparently, when World Vision first began plans for projects in Mampong, it took some time and 'coaxing' before people accepted the idea of building a KVIP or undertaking other preventive projects.

But above all, it seems women are most concerned about their economic welfare and desired programs, such as income-generating projects, credit, or jobs, that would improve their standard of living. In spite of this, people still appear willing to participate in different activities and contributing in whatever way they can to improve living conditions in their communities. Often there are many needs that exist, and given that rural areas have historically

been neglected, people are often satisfied just to receive any kind of support from an external agency, which raises important questions about the definition of 'felt-needs' - an issue which, also, deserves further discussion, but unfortunately, is beyond the scope of the present study.

7.15 Patterns of Mobility and Migration

As mentioned earlier, the level of migration and mobility is apparently quite high in these communities. Yet, as is common in Akan society, even after migrants leave they still maintain contact with their natal village, returning periodically to visit family and to participate in important social and cultural events. It was particularly interesting to find that members who had migrated to live or work elsewhere were still expected to make annual or periodic contributions to community projects or to other important events, such as funerals. They, also, appeared to maintain an important role in decision-making and planning at the level of the community. Some of the influential leaders of the community, even members of organizations like the Town Development Committee, were living outside. The influence they held, however, appears to have some consequences for the pace of planning and decision-making in the community. In all three villages, for example, people spoke of the meetings in August, during the annual Akwambo festival, as the most important time of the year to raise funds and to plan community projects. In one community, the chief was even waiting until August to form the Village Health Committee, because some of the candidates he wanted to nominate were then living outside. In discussions with health staff, this problem was raised as a major concern. It was mentioned, for example, that sometimes when they try to organize meetings with Village Health Committees they may find only two or three remaining members in the community. Others have left to work or moved elsewhere.

Migration may also affect the resources and capabilities of households. In a few interviews, women indicated their husbands were living outside and they depended on the remittances they sent home. In one particular case a woman claimed she was waiting for her husband to return to have enough money to attend the healthpost for a prenatal consultation. As men leave villages to work elsewhere, women are, also, left with much greater

responsibility for maintaining households, and as a consequence, may be forced to spend more time in productive activities to earn money to satisfy their family's needs (Livingstone (DANIDA), 1995). Male out-migration may, therefore, impose greater demands on women's workload and time and limit their ability to participate in health activities.

7.16 Articulation of PHC with Local Health Practices and Patterns

Throughout this paper the analysis has focused mostly on the structural, social, economic and spatial barriers to women's utilization of services and their participation in MCH activities. Limited attention has been paid to the cultural dimension of therapeutic choices, which some may rightly argue, is crucial to an understanding of the context and practices surrounding pregnancy and birth in Ghana. However, in the present study, cultural factors did not emerge as a major focus of discussion. Even though questions were directed at eliciting some of this information, it was seldom raised. Perhaps this is a limitation of the methodology used, and the focus of the study on women's utilization of 'modern' MCH services. It may also have been due to the identity of the researcher as a 'foreigner' and the unintended association with the healthpost and the 'modern' sector which undoudtebly had an effect on the nature and content of women's responses. Nevertheless, the findings of other recent studies, which are described below, raise some interesting issues which would be valuable to explore.

Several recent ethnographic accounts on childbirth in different cultures have shown us that although childbirth is a universal physiological event, in each society it is surrounded by a unique set of beliefs, rituals and practices (Jordan, 1978; Niehof, 1988; Cominsky, 1983). Practices which are embedded in the local social system and reflect how birth is viewed within the culture. The same studies have also highlighted the way in which these practices may differ fundamentally from Western birth practices, which are everywhere, a part of the local 'modern' sector. As we have seen earlier for example, the western medicalized view of birth is very different from the perception of pregnancy and birth as a 'normal' and 'natural' process which is evident in many cultures.

It has also been argued before that sometimes the environment of the 'modern' medical hospital may seem inappropriate and unsuitable to women. In Latin America and Tunisia for example, cultural prohibitions about dress and contact with male health personnel may deter women from delivering in hospitals (McLain, 1981; Auerbach, 1982). Women may also feel reluctant to deliver in a modern medical setting where they view the atmosphere as cold, impersonal and anxiety-ridden (Kumekpor and Richardson, 1993). In the home, a woman is in a much more supportive environment where she is surrounded and comforted by family and kin. Some authors have also argued that the main contrast between western birth practices with local practices is the approach and the role of the mother. Traditional birth practices represent an approach that focuses more on the mother and allows her to assume control of the birth process (Sargent, 1982; Appiah-Kubi, 1981; Laderman, 1983). In the institutional setting it is the doctor or professional midwife who takes control, and the emphasis is on the clinical capabilities of the professional, less on the needs of the woman.

Several studies have also drawn our attention to some of the customs and rituals which remain an essential part of the local way of managing pregnancy and childbirth. Rituals regarding care of the newborn, disposal of the placenta, herbal medications, and prayers to provide spiritual protection. Some of these practices may serve an important symbolic function, while others provide women with important psychological and social support (Cominsky, 1977). Yet many of these practices can not be implemented within an institutional setting. One particularly common practice is the rule about 'postpartum confinement', observed in parts of Asia, Latin America and Africa, where a woman is secluded after birth within her home, for a period ranging from one week in Ghana to one month in China[19]. Other recent findings have also shown that religious beliefs or religious affiliation may play a role in the choice of maternity care (Adetunji, 1992; Kumekpor and Richardson, 1993). As we have seen in the present study, women who belong to some of the new 'spiritualist' churches

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Confinement is universally intended to serve as a period for women to regain their health and to prepare them to reintegrate into society. It is also viewed, in a number of cultures, as important to protect a woman and her baby from harmful influences, such as 'cold' or 'evil spirits' to which they are particularly vulnerable at that time. Although to outsiders these practices may seem 'backward' or 'irrelevant', within the local setting, they may be viewed as beneficial and efficacious (Pillsbury, 1978).

may be expected to deliver with midwives designated by the church or under the care of church leaders.

Such evidence has lead some to conclude that the persistence of traditional maternity care may reflect a fundamental incompatibility in norms or in models regarding the management of pregnancy and birth (Jordan, 1978; Kumekpor and Richardson, 1993; Sargent, 1982). According to Kumekpor and Richardson (1993), MCH services in Ghana continue to be underutilized because women prefer the local system of traditional maternity care, which is more accessible and more adequately satisfies their needs and expectations, on an emotional, social and symbolic level. A similar conclusion was drawn by Sargent (1982) in her study of birthing practices in Benin. She argues that women prefer midwives or the local 'matrones' because they share the same assumptions about clinical reality and the same perceptions about the cause and management of complications of birth, complications such as breech delivery which were attributed to witchcraft or supernatural forces. But, as Feierman (1985) noted, in Sargent's study, the sharing of clinical assumptions may be only secondary to the fact that 77% of parturients lived in the same household or were related to the birth attendant.

Although the effect of cultural beliefs and values on therapeutic choices remains unclear, we can still assume that cultural factors will indeed play an important role in determining how people perceive and respond to health programs. This question does not appear, however, to have been adequately explored or even taken into account in the implementation of the TBA program. Yet, resistance to the TBA program was encountered, particularly in Tarkwa, in part because of the local traditions in maternity care and the preference women may have for home deliveries or for the assistance of particular TBAs. It was also noted that certain religious groups may expect women to deliver within a specific setting or with the assistance of selected midwives.

There is some evidence, therefore, that other factors aside from the question of cost, accessibility and convenience, are involved in the choices women make about where to deliver or whom to consult during the pregnancy. Planners, therefore, although well-intentioned, should not have assumed that women would automatically switch to 'trained' TBAs, once these became available. As we saw in the present study, women may still prefer to deliver with

the other 'so-called' untrained TBAs. Unfortunately however, the reasons for this are still unclear. More research may be needed to uncover some of the subtler issues involved.

Since other TBAs will continue to be serve women within their community, more effort should perhaps be directed to integrating or involving other midwives in the program. Admittedly, there are constraints and problems on both sides. Local midwives may not always be willing to cooperate, may feel suspicion towards the 'modern' sector and prefer to carry on their own practices. Modern medical professionals may have difficulty accepting the contributions of local midwives and in rejecting their own biases. Significant technical and financial constraints may also limit the possibility of integrating or 'training' other TBAs. But greater integration may be necessary to effectively reach a greater number of women. Since, as we have found in the present study, one 'trained' TBA may not be sufficient to reach the majority of women.

In continuing to pursue this strategy it may be valuable to examine more carefully the advantages and/or benefits of both systems, as well as their shortcomings and deficiencies. There may be certain practices developed within the traditional sector that can enhance care, such as the kneeling position for delivery, which, apparently, makes childbirth easier for women. Yet, there are also certain aspects of traditional medicine that may be less helpful and perhaps even harmful. More research is needed, however, in this area. We still do not have adequate knowledge of the health benefits or effects of traditional methods, or even of maternal child health care programs, including 'trained' TBAs.

CHAPTER 8

Conclusions

8.1 Summary of Findings and Recommendations

This study has been concerned with the attempt in poor countries to adopt a strategy of primary health care, looking at Ghana as a case study. It was found, however, that in Ghana the more ambitious goals of the program, such as increasing community participation, had not been achieved. In the rural areas, the major component of the program was the delivery of maternal child care services, which among other routine services, included the training of traditional birth attendants. Since the MCH program was one of the major components of the strategy and the most widely implemented in the country, this thesis has focused on the functioning of this program and the levels of participation in, and utilization of different aspects of the program, mainly antenatal care, delivery services, including 'trained' TBAs, as well as postnatal care and child welfare services. The study analyzed the factors that determined the level of participation and use. This was done through a combination of participant observation and semi-structured interviews. The study has revealed that a complex range of factors may influence patterns of participation and utilization.

To begin with, it has been found that among the factors of importance are problems of affordibility of, and accessibility to existing services, which are related to the poor economic circumstances of villagers and the constraints imposed by structural adjustment. SAP has been accompanied by rising costs for medical care and for everything from food, transport, education, to other basic services such as water. Structural adjustment and the existing state of the Ghanaian economy also weaken the government's ability to deliver services; affecting in turn, what can be achieved at the local level. Health workers cited the lack of resources and funding as the major constraints to carrying out health education activities in the villages, to maintaining adequate supervision of community health workers, such as 'trained' TBAs, and to providing adequate coverage.

Secondly, many women do not perceive as high a need for medical attention during

pregnancy and childbirth as was assumed in the design of the MCH program. This seems to stem, in part, from the view that uncomplicated pregnancies and deliveries can be handled easily at home, and in part, on the availability of alternative medical resources in the home or community which may be viewed by women as more convenient, affordable or appropriate for other reasons.

It has also been argued, however, that the decision not to attend the healthpost for antenatal care or delivery assistance may represent a lack of understanding of the purpose and/or benefits of MCH services. In other words, women may not always be fully aware of the need for services and may need to be more informed by from health workers. Yet, it may not only be a question of women's knowledge of, or access to health services that is critical, but their perceptions of the quality of care. The findings suggest that women may actually be quite selective in making choices between treatments or health care providers, especially for obstetrical care. In selecting TBAs women mentioned qualities such as patience, kindness and a caring attitude as key characteristics of the kind of care they preferred. It was also said however that judgments about the quality of care may affect the decision to utilize government health services. Poor drug supplies and the high cost of medication were mentioned as some of the factors that might deter people from using services.

The results of the study have further revealed that family and kin, and particularly husbands and mothers, play a key role in making decisions about therapy, and in the management of pregnancy and childbirth. It has been found, essentially, that women do not make decisions on their own. Other family members will be very closely involved in making decisions about which health service to use or which course of therapy to follow. Because of their lower social status, it may not always be women who make the determinations themselves. It is important, therefore, to view women's practices within the context of the household and to understand the dynamics of age and gender in shaping therapeutic decisions and outcomes.

The study has also revealed that factors at the level of program planning and implementation may have important consequences for the success of programs. The lack of support for, and utilization of 'trained' TBAs, particularly in Tarkwa, results in part from a lack

of fit between the design of the strategy and the existing patterns of maternity care within the community. The level of support for the program would likely have been stronger if women and/or other members of the community had been consulted beforehand, to find out their views of the program and to receive suggestions on how it could be integrated into the community.

There are several other shortcomings in the program that may have caused the lower than expected rates in utilization and participation. Programs still maintain the bias towards curative care and the 'technical' delivery of services. Only limited attention, if any, has been given to health education or to other community-based activities that involve local people in efforts to improve their health. Hence, a shift to primary health care, as envisioned in the original strategy, has not really been made. Bureaucratic forces, the biases of health planners and professionals, an entrenched bias towards 'modern' western medicine and political constraints all pose obstacles to the implementation of this goal. Evidence of these biases is reflected in the continuing unequal distribution of governmental resources directed to hospital services and primary health care. Yet, in order for PHC to succeed, more emphasis is needed on community-based programs, including health education and preventive and promotive activities.

Finally, there may be other factors to consider at the level of the community that will affect how people participate in, and respond to health programs. The varying success of the MCH program in Mampong and the other two villages raises this in evidence. It may be, as World Vision predicted, that conditions in Mampong were a lot more favourable to the implementation of the program. The chiefs and leaders of the TDC in Mampong, for example, had demonstrable skills in management and supervision and provided the community with the leadership needed.

The constraints in Achiasi and Tarkwa were, also, however, in the form of limited resources. While Mampong had received substantial support from World Vision to carry out its programs, in the other two villages, villagers often complained that projects were difficult to implement without some support from outside. The lack of resources at the level of the village may also affect the sustainability of programs. As we witnessed in the TBA program, participants may be forced to use their own resources to replenish their kits if villagers or

clients are unable to provide compensation.

It was also found, however, that villagers may not always share the same priorities as planners or external agencies. Women in general named economic problems as their primary concern. Health, in most cases, was only ranked as a secondary need. In spite of this, most women were still very willing to contribute in whatever they can to improve living conditions within their community. Finally, another issue, although less widely discussed in the literature, is the role of migration in affecting levels of participation and use. The trend towards migration, particularly that of males, seems to have a direct effect on the resources of the household, and by implication, its capacity to meet its needs. There was further evidence that the migration of villagers affected not only households, but the larger community, and had important consequences for the pace of planning and implementation at the local level.

Clearly, a host of factors will affect levels of participation and use. What the findings also emphasize, however, is the importance of adapting programs to their local contexts and taking into account existing social structures and the expectations and views of their intended beneficiaries. As Pappoe (1993) has indicated before, a blueprint approach will not work. Plans for operations research and consultations with villagers have to be built into the design of programs. The record of PHC in Ghana also shows that in spite of the commitment made at the policy level, participation still does not receive the attention it deserves. Yet, as examples from this study and others have repeatedly shown, programs that do not involve people in the planning and implementation or take into account the local social context, will either fail or receive only limited support from communities (see Justice (1986) and Lisbbet (1983)).

The conclusions of this study further emphasize the importance of flexibility in plans and the need to make adequate provisions, particularly in terms of time and costs, to spend time with communities and to follow through processes more thoroughly. Closer collaboration between health workers and communities is also essential to establish a more practical basis for participation. This is critical to determine for example, how a program will be sustained, what role communities, health workers and external agencies will play and what each can realistically afford to contribute in terms of labour, resources, and time to a specific program

or activity. Yet, in spite of the problems encountered in implementing programs in Ghana, the example of Mampong and results from other studies have shown that where programs have worked more successfully they can improve levels of utilization and participation. Although Mampong may represent a very special case study, and one that may not be easy to replicate, it is a concrete example that PHC can work, if sufficient resources, time and effort are devoted to make it work.

The present study has identified some of the key issues affecting women's utilization and participation in PHC, but it should be emphasized that not all of the factors may have been accounted for, particularly those affecting participatory processes in the communities, which, due to methodological and other constraints, could not be examined in greater depth. Some of the issues raised in this paper also remain unclear and should in no way be regarded as definitive. It has for example been suggested that women are often very pragmatic decision-makers and make choices between treatments, based on reasons that are less ideological than practical. But it was also noted in the study that more subtle issues were also involved in the determination of choices, such as the relationship with birth attendants. Unfortunately however, we still do not have a very clear understanding of the nature of those relationships and/or their significance.

In the literature, we also find that researchers tend to be divided into two camps (Thaddeus and Maine, 1994); while some emphasize the role of structural variables, such as accessibility, others stress the importance of cultural variables, and beliefs and attitudes (Kleinman, 1980). It would be interesting to investigate these issues in further depth; to determine for example to what extent the reliance on traditional or home-based care among rural women is a function of individual attitudes and preferences; whether it reflects the inadequacies of the 'modern' health care system and its failure to satisfy the multiple needs of women (Kumekpor and Richardson, 1993); or represents more accurately an attempt by rural people to adapt to an environment that continues to marginalize them within the larger socio-economic context and to deny them adequate access to 'modern' health care (Young, 1981).

Yet, throughout this paper, we are constantly reminded of how limited our knowledge is and how underresearched this area is; the literature on maternal and child health practices

in developing countries and particularly in Africa, remains very limited. There is a critical need for more systematic and in-depth research. Yet, it is crucial that we examine not only the use of 'modern' services but health practices in a much broader sense, as the range of different strategies women use or resort to, to protect their own and their baby's health during pregnancy, childbirth and the postpartum stage. It is only by learning to appreciate the measures women and their families have developed on their own, to cope with their circumstances, that we can begin to work in partnership with them to devise strategies that will more effectively meet their needs.

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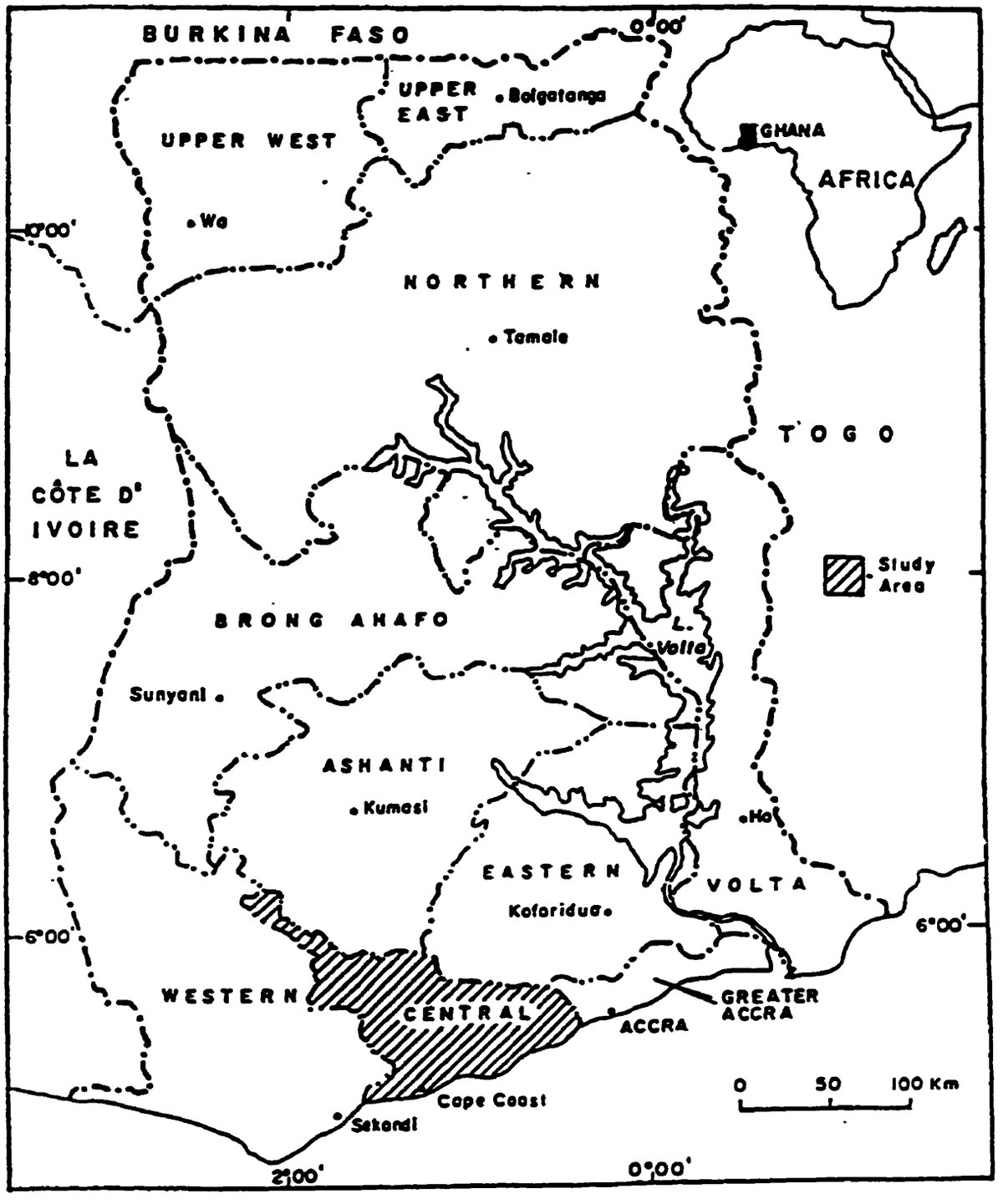
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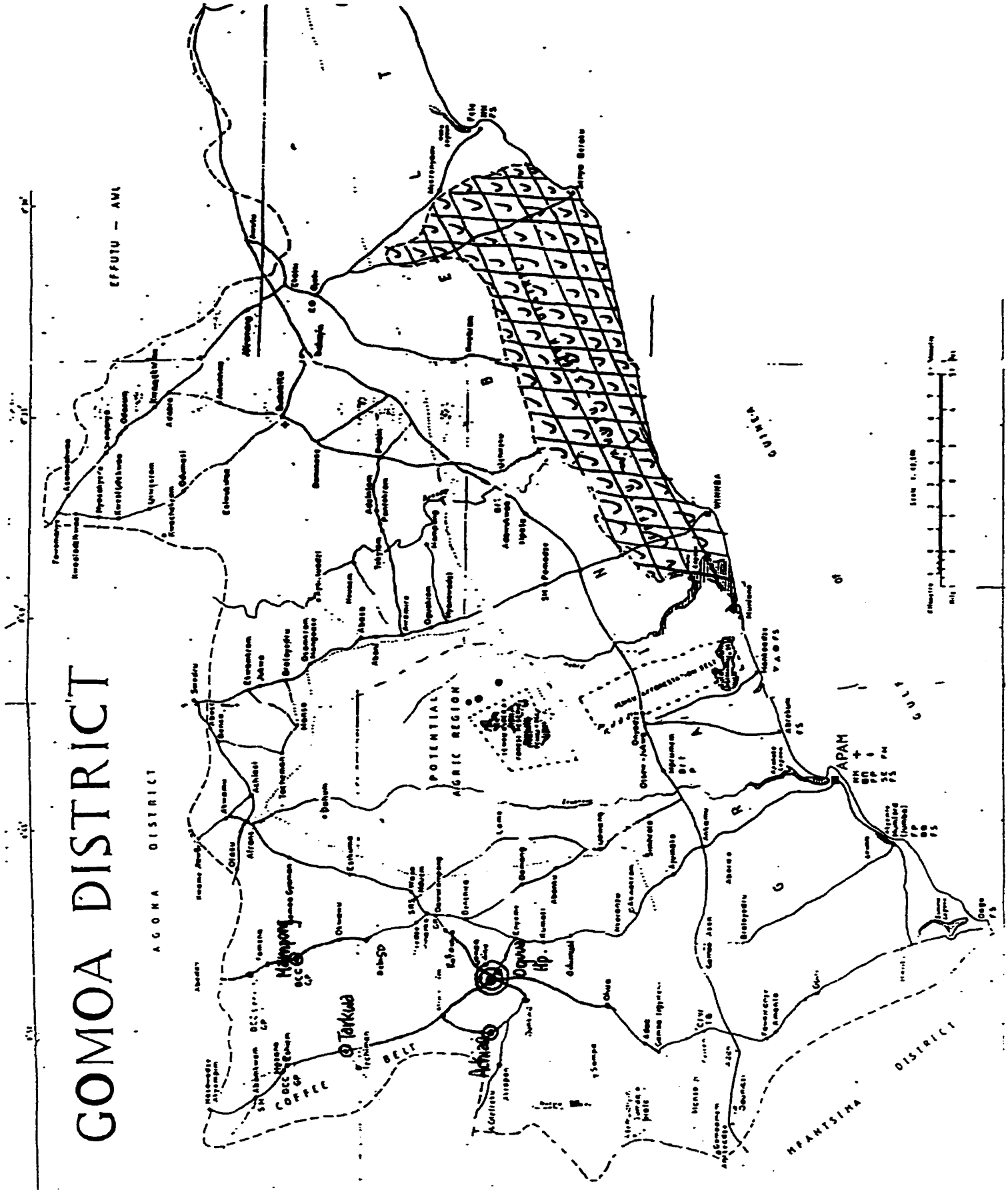
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APPENDIX A
MAP OF COUNTRY WITH ADMISTRATIVE REGIONS AND STUDY AREA



APPENDIX B

MAP OF DISTRICT WITH VILLAGES AND LOCATION OF THE HEALTHPOST



APPENDIX C

QUESTIONNAIRE GUIDE FOR IN-DEPTH INTERVIEWS

A. General Information

1. Age
2. Place of birth
3. Hometown
4. Ethnic group
5. Languages spoken and written
6. Religious denomination
7. Highest level of education attained
8. Occupation
9. Number of children
10. If pregnant, duration of the pregnancy.
11. Living arrangements: how many people in the compound can you draw on for help? Who do you live with? How many people are there in the compound or household?

B. Knowledge and Utilization of Services

1. What is the nearest health service? Where is it? What services are provided? How long has it been established? What other services are available?

2. Do you use the services sometimes?
   - If so, for what reasons? (ask for specific examples)
   - When was your most recent visit?
   - What was the reason for your visit?
   - Have you attended an antenatal, postnatal or child welfare clinic? (either at the healthpost or in the village?)

3. When you are pregnant, who usually attends to you first? Or most of the time? What type of attention do they give you? What type of care do they give you? What kind of treatment have they given?
   - Why do you find it necessary to see this person?
   - When do you find it necessary to attend clinics, and for what purpose?
   - What are some of the things you are not permitted to do while pregnant?
   - What are some of the things that you are encouraged to do while pregnant?
   - Is there anything that you have changed (e.g. diet, lifestyle, etc.) while pregnant?

4. Who delivered each of your children?
   - Why this person?
   - Were you satisfied with the care that was given?

Who normally takes care of pregnant women in the village?
Who takes care of women most of time? Who is the person that most women see?
Do you know how the TBA was selected? How did you find out about the program?
What do you think of the work of the TBA?

5. If the person attended the healthpost, clinic or outreach service in the village:
   What were some of the things that you liked about the services there? Were there things that you did not like?
   Is there anything that you think might discourage people from going?
   Is there anything that you think needs to change? Anything that could improve the services they give? Why? Why not?

C. Questions about the Care of their Children's Health

1. What are some of the things that you do to keep your child from getting sick? Or to make her/him healthy?

2. Who do you consult when your child becomes sick? How does this person help you?

3. Has your child (or any of your children) fallen ill recently?
   If so, what did they have?
   What type of care did you give him/her?
   What actions did you take? What did you do?

D. The Role of the Family

1. If you need medication, who procures it? Who provides it? Who pays for it?

2. If you or your child falls sick, who is there to help you?
   Who attends to your child? Who prepares the food for the person who is ill?
   If that person is away, who else is there to help you? What do they do?

E. Perception of Health Matters and Participation in the Community

1. What are some of the common diseases in the village? What are their main causes? What can be done about them?

2. If the people in the village wanted to set up a community clinic or some other project, how would it be done? How do you think it should be done?
   Will people participate? In what way?
   Do people usually participate?
   Do you think people should participate? Why or why not?
   What should be done with those who do not participate?

3. What projects are actually taking place in the community?
   How are people involved?
   How is the project working?
   What do you think is a priority for the village?
   What do you think the village needs most?

4. What is the situation of women in the community? What are some of the problems they face? How can the situation be improved?