

# Unmet reproductive health care needs among rural Ghanaian women

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## Summary

## **Unmet reproductive health care needs among rural women in Ghana**

### **Summary**

The principal aim of this dissertation was to increase our understanding of unmet maternity and reproductive care service needs over a woman's life course in rural Ghana. To meet safe motherhood goals in Ghana, it is important to understand contextual unmet demand for reproductive care. Evidence on women's unmet reproductive care is scarce in many developing countries. This challenge in most developing countries could be attributed largely to non-existing or poorly coordinated vital data registration systems. In Ghana, most targets on maternity and reproductive care capture general measures such as supervised delivery coverage, and antenatal and postnatal coverages. Others include frequency of antenatal care (ANC) visits among others. Furthermore, the adequacy of focused maternity care has minimally been investigated across previous studies in Ghana. This dissertation provides an analysis of the adequacy of maternity care received by women during their last birth. Stakeholder views on maternity care shortcomings and context-specific determinants for contraceptive use are also worth investigating in rural northern Ghana. In addition, we analyse stakeholder's experiences, expectations and decision making processes on reproductive care. In this dissertation, we provide evidence on the above gaps by addressing three principle research questions: what is the adequacy of outcome measures and determinants assessed in previous reproductive studies across West Africa, what are stakeholder views on maternity care shortcomings in rural Ghana, and what context factors drive unmet reproductive care in a rural district of northern Ghana.

This dissertation aims to contribute to a further understanding of unmet reproductive care among rural Ghanaian women. The dissertation consists of seven chapters, summarized here as follows.

**Chapter 1** provides a brief history of health sector reforms and key health sector performances on maternity and reproductive care in Ghana. The chapter further outlines the concept of unmet needs and key operational definitions. The history, relevance and key challenge of unmet needs are later examined. In Chapter 1, we also outline the trends in unmet needs globally and in the Ghanaian context. In addition, we outline the aim, objectives, and methods applied in all chapters of this dissertation. The principle goal of this dissertation is to understand unmet maternity and reproductive care service needs over a woman's life course in rural Ghana. To attain this aim, a review of the adequacy of outcome measures and determinants applied to assess unmet reproductive health needs among women

in West Africa was undertaken. The chapter concludes with a brief outline of the dissertation.

In **Chapter 2**, we provide a systematic review of the literature on the adequacy of outcome measures and determinants to assess unmet reproductive health needs among women in West Africa. The review was undertaken for studies published from January 2009-March 2014. Seven databases were searched in this review; PubMed, Econpapers, CINAHL, Psych INFO, Science Direct, Embase and Biomed. In the PubMed search, MsSH term categories were applied across all key words to ensure relevant publications were extracted for the review. Only English language publications were reviewed. Three broad indicator measures, a) contraceptive use, b) abortion care and c) ANC services use were included in the review. Clinical studies particularly on obstetric care services and reproductive services in relation to HIV/AIDS were excluded from the review. The reference lists of publications were also reviewed and those found to meet the review criteria were added to the list of reviewed publications. In total, 78 publications across seven countries in West Africa were identified and included in our review. The findings from this review show the existence of a broad range but similar outcome measures and determinants for evaluating reproductive care needs in these examined countries. We however found that, a high rate of unmet reproductive care needs still exist across many of these examined countries. This is associated with poor socio-economic indices, deep and varied social norms and beliefs across cultures and traditions that place marriage and a woman's reproductive health needs as the male spouse responsibility at the family, and community level. Our results show poor institutional arrangements divest women reproductive health seeking behavior's across many West African community settings as evidenced in the review. The multiple social, economic, and environmental factors that affect the continuum of reproductive care require multiple stakeholder engagements to bring about health system improvements. Evidence from the review indicates that currently applied measures of women's reproductive health needs might be inadequate in attaining the best maternal outcomes since they appear rather broad. We advocate the need to incorporate country level context measures in benchmarking progress on reproductive health needs among women. This will support a better evaluation in each country level of the progress on meeting women reproductive health outcomes. At the policy level, reforms that improve access (e.g. legislative reforms on restrictive abortion laws) will go a long way to support reduce unmet need levels and improve women reproductive health care needs in West Africa.

**Chapter 3** examined maternal care utilization components in Ghana based on the 2008 Ghana Demographic Health Survey (GDHS) dataset. Demographic Health Survey (DHS) data have been collected and analysed in Ghana since 1988.

The 2008 GDHS was implemented by the Ghana Statistical Service and Ghana Health Service with technical support from ICF Macro and MEASURE DHS program. In total, data from 2,147 eligible women who reported childbirths 5 years prior to the study were analyzed. Using a cluster analysis methodology and WHO guidelines on focused maternity care, we provide a segmentation of woman's met and unmet care needs at last birth. Three classifications assessed maternity care adequacy: adequate, less and least adequate care. Overall, more than half of Ghanaian women received adequate prenatal and postnatal care. Worrying was the equally approximate share of women who received less and least adequate care. We found that focused care components in the overall antenatal utilization were low compared with less or least adequate care groups. We also establish that the frequency of antenatal visits is not associated with the adequacy of care received. Our cluster analysis findings reinforced that women, who were attended by skilled personnel, were more likely to report adequate care irrespective of the frequency of antenatal visits reported. Furthermore, the indirect impact of the lack of public health insurance was positively associated with least adequate care reported by women. Across regions and within rural settings in Ghana, disparities exist, which is often compounded by supply-related factors. Efforts at addressing skilled workforce shortages, greater accountability for quality and equity, and those that improve women urgency, choices and active participation in reproductive care decision making are important policy strategies to improve maternity care outcomes in Ghana. We advocate that the broadening of opportunities for women beyond having a say on their health needs can help alienate socio-cultural values that devalue women reproductive care seeking. In addition, we posit the need for long term planning and systemic reforms on health insurance membership for maternity care policies in Ghana. Improving health system arrangements on skilled professionals and curricula trainings for health staff would further enhance the quality on focused maternity care in Ghana. Given the potential benefits of health insurance ownership and use for improved prenatal and postnatal care outcomes, there is an urgent need to improve structural deficits under the current National Health Insurance Scheme in Ghana. Improving structural deficits under the health insurance scheme would improve user confidence among non-active members who have lost out due to issues of reported inefficiency and poor quality services delivery nationwide.

Three stakeholder group views on shortcomings for maternity care are examined in **Chapter 4**. This aim evolved from the understanding that formal networking and stakeholder interactions are essential to meet patient-centered maternity care needs. We first explored women's views and juxtaposed these with the views of frontline health care staff (midwives/nurses/community health officers) and public and private policy decision actors at regional and district

levels. An ethnographic design was adopted which enabled a simultaneous reconstructing of lived stakeholders experiences. This approach also enriched the process of understanding stakeholders' arguments on shortcomings for maternity care in rural Ghana. Two kinds of qualitative field data were collected in the same districts during this period of the dissertation. This was related to: a) shortcomings in maternity care provision and use, and b) reproductive care experiences, expectation and decision making processes. The first component was analyzed in Chapter 4 for this dissertation while the latter was analyzed in Chapter 6 of the dissertation.

Our findings presented in Chapter 4 reflect a broad range of factors on maternity care shortcomings. Emergent themes include factors related to social arrangements in the community, health system (payments and provision of maternity care) and health policy frameworks for service provision. Despite differences in stakeholder opinions, many shortcomings put forward in this study, reflect consensus on maternity care shortcomings. Socio-culturally, women's reproductive seeking behavior is influenced by male and family relational environments that devalue women choices on reproductive care. Travel time, direct and in-direct costs and poor facility level conditions are major barriers to maternity care seeking. Poor facility level conditions, poor focused care, and inhumane treatments impugned by health staff were also reported by women. Also, reports of poor bedside manners, poor delivery room environments (including noisy delivery room environments) were cited. In addition, stakeholders admitted that knowledge and skills for both mother and new-born care is a determinant for a woman's trust and use of facility birthing services. Within the policy framework for improving maternity care, the culture of "gift assurance" as coined by women is espoused. However, the extent to which this impacts on the equity dimensions of maternity care was not examined in this dissertation. We advocate inclusiveness and the effective dissemination of patient care delivery standards among women and health staff at all levels. This has the potential to create a culture of trust, transparency and openness regarding ways to tackle barriers for adequate care provision and seeking. Aside this, our results show that maternity policy strategies such as the free-fee delivery policy in Ghana, have not been able to tackle indirect costs for maternity care. At the individual level, patient-staff conditions that create a culture of trust and respect should be advocated to improve patient-centered care and address traditional roles and social norms in birthing practices. Above all, a strong political environment that improves the rural road infrastructure and takes steps to ensure a more effective decentralized national ambulatory service system will better ensure women effectively benefit from the country's free maternity care policy.

**Chapter 5** outlines the context-specific factors associated with contraceptive use in a rural district of Ghana. The study employed a descriptive cross-sectional

design. Data were collected between February and March 2012. Three main measures were investigated; current contraceptive use, access on demand for contraceptives and future use intentions for contraception. An individual woman access to, and use of contraception is influenced by clinic arrangements. Furthermore, young women's satisfaction with contraceptive use significantly impacts current user intentions. The results show a user preference for friendlier clinic working hours. Contextual factors such as focused counselling/education further enhances women contraceptive use abilities. We argue that adequate and timely education assists women to attain the principle of the "calculus of conscious choice" with contraceptive use. In addition, focused counselling provides an alternative route for many rural context health providers to reach underserved and un-educated population groups with contraceptive products. We advocate that integrated health services delivered in rural settings should include a critical component of individualized counselling for women. Despite the dominant patriarchy roles in rural settings that impact reproductive care seeking, focused counselling plays an important role in upscaling user satisfaction and use for contraception. Our results support the need to provide client centered, culturally sensitive and acceptable care that respects women's preferred convenient clinic hours for contraceptive use. At the wider policy level, clinic settings must design structures that guarantees continued confidentiality and provide mechanisms to address individual health concerns after use. At local community level, health advocacy and campaigns must address poor health seeking behavior that perpetuate myths and misinforms clients about safe and beneficial contraceptive clinic services.

**In Chapter 6**, we mapped out varied stakeholder views on reproductive care services use in rural Ghana. Specifically, stakeholder experiences, expectations, and policy decision making processes for reproductive care in three rural districts were examined. Ethnography was adopted as a study design. The methodology enabled a simultaneous reconstruction of stakeholders' experiences among three stakeholder groups: women, health staff and policymakers. Four themes emerged: the impact of gender roles on reproductive care needs, experiences with meeting reproductive care needs, expectations about reproductive care needs, and the policy setting and decision making processes on reproductive care needs. On the gender role impact for contraceptive use, our results point to the fact that male perceptions on sexual passivity of women drive male beliefs and desire to control women sexual behaviors. Complementarily, where male spousal control neglects women's needs, covert use of reproductive care services exist. Women reported health staff cluttered control mechanism limits use of reproductive care. Chapter 6 demonstrates that health staff exercises control and supremacy and this has the tendency to shy women away from meeting their reproductive care needs. Reproductive care experiences show that reproductive services non-

differentiation at the point of service provision influences individual reproductive choices and use. In addition, fee payments during post abortion care and management is reported as a major barrier to health facility utilization. We also found that social stigma can reduce user's willingness to report poor reproductive experiences at the health facility level. Where reproductive services for STIs, abortion/post-abortion care, and infertility treatments services are limited in scope, myths on what defines sexuality and womanhood in the society further foil social stigma on care seeking among women. Additionally, the non-availability of psychological support at health facility centres lead to low self-esteem among reproductive care users. Stakeholder's expectations differed on what levels of counselling were adequate to meet user reproductive care expectations. Women's views on counselling services differed from that of health staff and policymakers. Health staff and policymakers stated that policy processes for decision making on reproductive care services is driven by previous and current donor funding needs. The two stakeholder groups also acknowledged the difficulties in prioritizing local reproductive care needs at health facility levels. Additionally, all stakeholder groups stated the need to design health systems that are more integrative and supportive on reproductive care delivery. Systems and structures that create conditions of mutual respect among provider-user, and empower women in their healthcare seeking behaviors also need to be encouraged. Stakeholder advocate for clear guidelines on reproductive care to be contextualized to meet user care needs. We stressed the need for efforts to delimit cluttered relationships that exist between health staff and reproductive users at facility levels. We also propose the inclusion of post-abortion care and post-pregnancy termination management issues into the National Health Insurance benefit package. A holistic health system that ensures sexual and reproductive health needs are truly subsidized or provided essentially at lower fee cost will benefit rural Ghanaian population groups.

**Chapter 7** discusses the main results of Chapter 1-6. We also reflect on the policy implications our results have on reproductive care in Ghana and beyond. From this dissertation, reproductive health targets related to service quality and user satisfaction are drivers of reproductive health service utilisation among women in West Africa. This dissertation also shows that reproductive care quality and satisfaction have the tendency to determine reproductive care use and caring practices received from health care providers. Quality and user satisfaction attributes enumerated here support existing evidence that patient satisfaction is indispensable to quality improvements in the health systems. Our review indicates that the quality of reproductive care outcome estimates remains largely documented at the clinical and patient reported levels. In addressing service quality and user satisfaction needs for women, tailored policies to improve



poor health system arrangements for reproductive care service delivery remain persuasive to meet user's satisfied demands for reproductive care.

Furthermore, focused reproductive counselling must be integrated into interventions aimed at scaling up family planning and broad reproductive health services use in rural Ghana. Even among women without formal education, focused reproductive counselling addresses contraceptive misconceptions, myths and wrong cultural norms on fertility control. Focused reproductive counselling also has the propensity to enhance women's contraceptive autonomy by expanding their productive reproductive health choices. In addition, prompt and adequate focused reproductive counselling facilitates health staff and user's shared decision making on reproductive care service use. Clinic counselling services must move beyond the health system and recognise the social patriarchal dimensions for reproductive services delivery. In addressing women's contraceptive needs in a given context, clinic settings must design structures that guarantee not only confidentiality, but suitable working hours to further enhance women access and use for services all year round. Also, the provision of reproductive care services must be more client-centered and respond to culturally sensitivities of the population in need.

The significant role of health insurance in influencing cost and care adequacy levels among women in Ghana is also highlighted in this dissertation. Specifically, insured women were more likely to seek several components of maternity care compared to non-insured in Ghana. We also show that regional variation in health insurance access and use influence disproportionally the adequacy of maternity care across all regions in Ghana. In environments where women report travel time and financial cost barriers as impediments for maternity care utilization, greater disparity for general health use is hardest among women living in rural dwellings. Although the insured will be more likely to use health services at times of need, insured individuals may at times use more services than required (moral hazard).

The frequency of antenatal visits alone does not correspond with focused maternity care quality and user satisfaction. Thus, focused maternity care during antenatal periods will depend very much on the care components delivered and the times spent in addressing individual health needs and concerns during antenatal. Our results emphasize the need for a careful application of the WHO recommended minimum of four visits among women identified as low risk pregnancy during the first trimester visits for ANC.

The factors impacting reproductive and maternity care in rural Ghana are multifaceted and complex, operating at household, community, and health system and policy formulation or coordination levels. Hence, the need to strengthen

not only the institutional care infrastructure, but improve social conditions and facilitators to deliver effective reproductive care services at point of service use. Evidence espoused for this dissertation show health system barriers that need policy reformation and coordination to improve reproductive inequalities in rural Ghana. We state that policy processes for informed decision making on reproductive care services is largely driven by previous and current donor funding needs. Stakeholders acknowledged difficulties in prioritizing to meet local reproductive care needs at facility levels is partly due to donor funding schemes. Stakeholders' strongly advocated for clear guidelines on reproductive care to be contextualized to meet user care needs. Health counselling and the need for individualized care have increasingly been evidenced as an entry approach to reach new users of health services.

More so, providing patient-centered, culturally sensitive and acceptable care that respects women's preferred convenient clinic hours enhances reproductive service use. These also have the propensity to improve reproductive user satisfaction. Agreeably, delivering patient-centered reproductive health care services require multiple stakeholder involvement and integrative and supportive health systems. We illustrated that patient-centered care is difficult to attain, where supply related factors such as adequate health staff and psychological support is lacking. This dissertation did not establish a direct relationship between patient-centered care and overall health benefits. However, there is ample evidence to show that, patient-centered approaches play an important role in attaining positive reproductive health outcomes for women. Reproductive counselling services must be designed to be user-specific.

In providing support for enhanced decision making, health system designs that allow continual feedback and psychosocial support among users and improved professional skills to deliver the needed care are very important. Our results advocates for inclusiveness and the effective dissemination of patient care delivery standards among stakeholder groups involved in the provision and use of services. Such culture of inclusiveness has the potential to promote trust and mutual respect required in the provision of patient-centered reproductive care services.