PROVIDER-PATIENT COMMUNICATION IN MATERNAL HEALTH

BY

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DECLARATION

I hereby declare that, with the exception of works that have been duly referenced, this dissertation is the result of a research undertaken by me under the supervision of Dr. Sarah Akrofi-Quarcoo at the Department of Communication Studies, University of Ghana. This dissertation has not been presented anywhere else for the award of another degree.

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Date ……………………….      Date ……………………
ABSTRACT

The health issues of pregnant women cannot be effectively addressed without due consideration to communication. The way in which health providers communicate with pregnant women can have significant effects on health outcomes. Effective communication can help bridge information, knowledge and awareness gaps to enable pregnant women play active roles in their health issues and motivate them to patronize maternal services. The purpose of this study was to find out the perceptions of pregnant women of the provider-patient communication, using the Communication Accommodation Theory. A quantitative approach was used to conduct a survey using 120 pregnant women, seeking antenatal care at the University of Ghana Hospital. The quantitative data obtained was analysed using SPSS.

The study found that pregnant women were happy with the provider-patient communication, motivating them to patronise maternal services. Also, the health providers did not discriminate among pregnant women who sought antenatal care at the hospital, on the basis of their age and education. Though the perceptions of the pregnant women were very reassuring, waiting time and lack of training for health providers were identified as barriers to effective communication. This brings to fore the need for interventions to encourage healthcare providers to communicate effectively with pregnant women.
DEDICATION

I dedicate this work to my snuggle bunnies, Sedem and Kekeli.
ACKNOWLEDGEMENT

For believing in me and being my rock, my outmost appreciation goes to my husband, Reginald Edem Wordi.

Thank you Dr. Sarah Akrofi-Quarcoo, for your guidance and patience leading to a successful completion of this work.

I am exceptionally grateful to my mother-in-law, Mrs. Patience Wordi, for holding the fort for me during my time of study.

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LIST OF ABBREVIATIONS

ANC- Antenatal Clinic
WHO- World Health Organisation
CAT- Communication Accommodation Theory
UGH- University of Ghana Hospital
MCH- Maternal and Child Health
CHAPTER ONE
INTRODUCTION

1.0 Background of the study

Communication is considered a critical component in healthcare as it builds further the relationships between health providers and patients. All processes in the delivery of care, from obtaining medical history to conveying treatment plan, rely greatly on effective communication. According to Sabherwal, Mittal, Pandey, Kaushal and Kaustav (2015), it is an ethical imperative, essential in obtaining a patient’s informed consent, prevents medical errors and promotes effective patient engagement. Effective communication between a health provider and a patient has also been linked to better patient outcomes (Davies, 2011; Doyle, Lennox & Bell, 2013; Marcus, 2014; Doherty, Landry, Pate & Reid, 2016; Ames, Glenten & Lewin, 2017).

As a key feature, communication requires both provider and patient to positively and willingly collaborate in achieving a conducive atmosphere; of a common understanding of a patient’s symptoms and feelings, and the provider’s goals (Street Jr., 2001; Travoline, Ruchinskyas, & D’Alonzo, 2005; Higginbottom, Hadziabdíc, Yohani & Paton, 2014). According to Nadzam (2009), communication may include numerous exchanges, such as written and oral forms. It can also occur indirectly through non-verbal means e.g. tone, body language and attitude. It is therefore not concerned with what is said, but also how it is said. How communication is done can hence determine the satisfaction for both the provider and the patient. It can be inferred that the manner in which a health provider communicates to a patient is as crucial as offering treatment.
Chang et al. (2016) affirm that patients who are communicated to clearly in a way they deem preferable have a higher chance of admitting their health issues and understanding their treatment options. They are also more likely to comply with health condition management strategies recommended by providers and follow through with their medication plans (Travaline, Ruchinskas, & D’Alonzo, 2005; Berman & Chutka, 2016). Thus, in a situation where health providers have almost equal technical abilities, the patient prefers the professional that communicates effectively (Klisiari & Gaki, 2012).

It is acknowledged that the dignity of individuals seeking medical care is threatened when they visit healthcare centres. They are required to disclose personal information, endure pain, anxiety and may also be required to expose certain parts of their bodies for examination (McQueen, 2000). These are heightened especially in the case of pregnant women (Kumbani, Bjune, Chirwa, Malata & Odland, 2013). McQueen writes, allowing the individual to make informed choices and to maintain control helps to reclaim some feelings of self-worth (McQueen, 2000).

Building a positive relationship may also be one of the ways to ensure that dignity is restored. This can be facilitated by behaviours such as being polite, using positive non-verbal expressions, giving detailed information, encouraging two-way dialogue and choosing the right words (The Joint Commission, 2010). Adding a human touch to the interaction is also important in fostering close, family-like, warm and loving relationships (Mensah, 2013).
In maternal health, physicians and nurses serve as a hub of all communication along the continuum of care of women; relaying information between other health professionals, family and patients. Communication between health providers and women at this phase of their lives is a central factor in assessing the quality of healthcare, as it increases the likelihood of positive maternal outcomes (WHO, 2016). It must therefore entail more than providing quality care to meet physical, social, emotional and psychological needs. It should encompass providing unrestricted opportunity for pregnant women to play active roles in issues affecting their own well-being.

Effective communication and nurturing a positive patient-provider relationship is essential, to aid pregnant women to acquire more health information, make numerous choices and have increased encounters with the health system.

There is also evidence to support the claim that health providers can influence the likelihood that pregnant women will adopt changes in behaviours (Leiferman, Sinatra & Huberty, 2014). Health providers therefore play an important role in ensuring pregnant women are educated and well-informed on health issues, to serve as motivation to attend antenatal clinics and also to seek delivery and postnatal services (Anya, Hydara, & Jaiteh, 2008; Madula, Fatch, Kalembo, Yu & Kaminga, 2018).

A breakdown in communication may however, increase the vulnerability of pregnant women considering the anxiety and distress associated with pregnancy. Eventually, they may not want to patronise services at health facilities. For instance, Ganle, Fitzpatrick, Otupiri & Parker (2015) reported the lack of involvement in decision making and unfriendly attitudes of providers as hindrances to seeking professional maternal services.
Similarly, the need for providers to use open communication and show compassion, have been found to encourage pregnant women to patronise maternal health services (Avortri and Lebitsi, 2018).

Globally, 830 women die daily from pregnancy-related causes. Ninety-nine percent of these deaths happen in developing countries. Fortunately, these causes including haemorrhage, obesity, diabetes and hypertensive disorders are preventable through quality healthcare during pregnancy (WHO, 2016). Managing these conditions carefully can alleviate the negative effects they have on maternal health outcomes.

Maternal health is considered a national emergency in Ghana; attracting substantial policy effort including the implementation of the free maternal health system in 2008, to encourage the use of health facilities during pregnancy (Ganle et al., 2015).

Regardless of the fact that 99% of pregnant women in Ghana have at least one antenatal visit, the country still grapples with high maternal mortality (Afulani, 2015). Obviously, the antenatal visits do not translate into the utilisation of other professional maternal health services and leads to negative health outcomes (Atinga & Baku, 2013). There is the need for a focus of attention on areas like the provider-patient communication, which may help to change this narrative. Communication can play an important role in the engagement and education of pregnant women, to help to successfully manage pregnancy-related complications (Attanasio et al., 2013). It is therefore vital in all aspects of a health provider’s work including therapy, prevention, treatment, health education and promotion (Lambrini & Loana, 2014).
The recent WHO guidelines for improving maternal health suggest that communication with women must be effective and respond to their needs and preferences (Standard 4, WHO, 2016). Asifere et al. (2018) also contend that communication is key in examining the extent to which maternal services meet the needs of patients. The researchers add that communication can be considered an important indicator of the patronage of these services.

The health needs and preferences of pregnant women are unique, requiring health providers to tailor their communication accordingly. A focus on the perspective of pregnant women could be useful in motivating them to patronize professional maternal services. This study is therefore to explore pregnant women’s perceptions of the provider-patient communication, at the Maternal and Child Health Unit of the University of Ghana Hospital.

1.1 Problem Statement

Research available suggests that perceptions of patients of the provider-patient communication predict patients’ outcomes better, than providers’ perceptions or observation (Hudon et al., 2011; Verlinde et al., 2012. It has also been documented that effective provider-patient communication results in improved maternal outcomes such as patient satisfaction, adherence to provider recommendations and continued uptake of professional maternal services (Babalola et al., 2016). This implies that for pregnant women to continually seek prenatal, delivery and postnatal services, health providers must communicate effectively to persuade them to utilise these maternal services (Ith et. al, 2013; Roberts et al., 2015; Madula et al., 2018).

Provider-patient interactions present a useful opportunity to inform pregnant women on ways to mitigate pregnancy related complications, which could otherwise result in maternal mortality.
Pregnant women can also clear doubts on issues and ask questions that can aid in making informed decisions about pregnancy care, birth plans and postnatal care (Myer & Harrison, 2003).

In the Ghanaian context, studies available on the provider-patient communication in maternal health have mostly focused on public hospitals. These studies found poor communication between pregnant women and health providers. Specifically, pregnant women cite the lack of adequate and clear information, lack of involvement in decision making, negative attitudes of health providers among others (D’Ambruoso et al, 2005; Tuncalp et al., 2012; Asundep et al., 2013; Sumankuuro et al., 2017).

For example, Atinga and Baku (2013) conducted a study in two public hospitals. They found out that unpleasant interactions with providers did not encourage pregnant women to patronize professional maternal services. Similarly, Avortri and Lebitsi (2018) highlighted the lack of attentive health providers. They also reported that pregnant women were not allowed to actively participate in decision making, in public hospitals.

Inadequate health personnel and the lack of the infrastructure have been reported in public hospitals (Van den Boom et al., 2004; Avortri et al., 2011; Ayensu, 2016). These challenges tend to have negative effects on the provider-patient communication (Atinga & Baku, 2013; Aduo-Adjei, 2015). Nonetheless, there are concerns that the care given at private hospitals is below the required standard (Nkya, 2000). Reinikka and Svensson (2003) stated that the quality of healthcare and the know-how of health personnel in both private and public hospitals are at par.
This study focuses on what pertains in the private hospital. Since there has been little or no research into this area, there appears to be a research gap which this study aims to fill. A quantitative study on the perceptions of pregnant women of provider-patient communication in a private hospital, is therefore of utmost importance.

1.2 Objectives of the Study

The general objective of this study is to examine the provider-patient communication in maternal health.

The specific objectives are:

1. To find out how pregnant women perceive the way health providers communicate with them.

2. To determine whether age and education of pregnant women affect their perceptions of provider-patient communication?

3. To determine whether the perceptions of pregnant women of provider-patient communication affect their patronage of maternal services.

4. To ascertain the barriers to effective provider-patient communication.

1.3 Research Questions

This study will be guided by the following research questions:

1. How do pregnant women perceive the way health providers communicate with them?

2. How do age and education of pregnant women affect their perceptions of provider-patient communication?

3. How do the perceptions of pregnant women of provider-patient communication affect their patronage of professional maternal services?
4. What are the barriers to effective provider-patient communication?

1.4 Significance of the Study

This research will add to literature on provider-patient communication in maternal health in the country. It will be useful for education in the provider-patient communication with pregnant women. In this regard, the findings of the study can contribute towards enhancing training in the maternal health sector.

The findings of the study will be useful for strategies to improve the communication between health providers and pregnant women, for positive maternal health outcomes. It will also serve as a guide for policy interventions on maternal health communication.

Finally, the results and recommendations will be useful as a secondary source of information, for further research on provider-patient communication in maternal health.

1.5 Organization of the study

This study is organized into five chapters. Chapter one represents the background to the research, problem statement and objectives. It also outlines the research questions, significance of the study, as well as the organization of the study.

The second chapter reviews relevant literature on the concepts and relevant theories and models for the study. Chapter three explains how the study was conducted. It outlines the methodology used for the study and includes the research design, target population, sampling procedure, data collection method and instrument, data analysis and presentation. Chapter four focuses on analysing the results of the study, whiles chapter five consists of summary, recommendations and conclusion for the study.
CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

As suggested by Machi and McEvoy (2009), literature review is a written document containing a comprehensive understanding of all relevant knowledge on a topic of study. It basically sets the tone for any study and guides the researcher throughout the work, by providing a framework for establishing the importance of a study (Creswell, 2014). It is also germane in terms of the theoretical framework selected for the study. The literature review, therefore “involves summarization, analysis, evaluation, and synthesis of the documents” (Onwuegbuzie, Collins, Leech, Dellinger & Jiao, 2010, p.173). It provides a standard for the results of a study to be compared with other existing findings. Furthermore, it helps the researcher to be acquainted with previous work in a particular field of the research (Day & Gastel, 2012).

The section reviews literature in the global and local scene in tandem with the objectives of the study. The section relied on databases including ResearchGate, UGSpace, Science Direct and Google Scholar.

2.1 Theoretical framework: Communication Accommodation Theory (CAT)

CAT “is a framework for understanding the interpersonal and intergroup dynamics of speakers (and communicators) adjusting their language and nonverbal patterns to each other” (Farzadnia & Giles, 2015, p. 17). The theory basically states that “a speaker adjusts his or her speech for the listener” (West & Turner, 2010, p.466). A person will engage with another depending on how the communication is done. Therefore, a speaker may increase his/her tone or switch to a particular language to enable the message to be effectively carried across to the listener.
Although people are individually unique, everyone belongs to different social groups based on age, values, ethnicity, socioeconomic status and interest. People therefore make judgements about others in terms of whether they do or do not belong to their group (Wright, Sparks & O’Hair, 2013). Additionally, the features of a particular circumstance and the socio-historical context within which it occurs, may influence communication (Giles & Orgay, 2007).

For instance, in years past providers used the paternalistic approach in communicating with patients, which put them in a position of power. This resulted in patients having little or no say in issues concerning their health, based on the assumption that the ‘provider knows best’ (Mira, Guilabert, Perez-Jover & Lorenzo, 2012). However, providers who adjust their communication by listening to patients, giving opportunity for questions to be asked and communicating clearly to patients, enable the latter to play active roles in their care. Such patients reported a positive experience and positive health outcomes (Baker & Watson, 2015).

According to Bylund et al. (2012), CAT helps to predict and explain both the verbal and nonverbal modifications that occur within the provider-patient communication. Adapting the verbal and nonverbal communication, aids in aligning both the patient and health provider across several areas including shared understanding and involvement in decision making. A major defining component of patient-centred communication is the ability of the health provider to monitor and adjust consciously communication, to meet the need of the patient (D’Agostino & Bylund, 2014). When the health provider explains the problem and the recommended treatment in a language that is easily understood by the patient and uses open-ended questions, it is more likely that the patient will also adjust his/her communicative behaviour to reflect similarities to that of the provider. This is referred to as convergence.
On the other hand, using medical jargons, disrespectful and intimidating behaviour, patronizing or chastising patients; lead to divergence, in which case the parties involved rather exhibit behaviours that emphasize their differences. Nevertheless, both convergence and divergence may work differently in different situations, even with similar conversational counterparts (Wright, Sparks & O’Hair, 2013). The theory hence stresses the beliefs and motivations underlying a person’s communicative behaviour in a given situation (Farzadnia & Giles, 2015). It can therefore explain why patients, or providers will adjust their behaviour to suit the circumstance during an interaction.

In applying the theory to this study, it will enable the researcher to understand the provider-patient communication in maternal healthcare as it takes into account the perceptions and needs of the target audience. Specifically, it may help to know why some pregnant women are motivated to patronise maternal services whiles others are not.

Though CAT is useful in studying interactions between people, it has its own limitations. It is unclear whether communicative behaviours are consciously or unconsciously used during an interaction (Giles, 2008). The theory also assumes that parties involved in an interaction communicate in a rational manner. However, this is always not the case, as people can become irrational during interactions (West & Turner, 2010).

2.2. Related Works

2.2.1 Provider-Patient Communication

For both provider and patient, both verbal and non-verbal communication are essential. Positive non-verbal communication, like maintaining eye contact, nodding and paying attention is likely to leave a lasting impression than verbal forms.
Simple choice of words, showing empathy, giving detailed information and thoughtful questioning make patients feel important and worthy; thereby enhancing the interpersonal communication between provider and patient (Travaline, Ruchinskas, & D’Alonzo, 2005).

Hochman, Itzhak, Mankuta and Vinker, (2008) conducted a study in which twelve providers were assessed (real-time) during consultations and 117 patients filled out assessment questionnaires, in Israel. Results revealed that communication had a positive and significant correlation with a patient’s satisfaction. Mannava, Durrant, Chersich & Luchters (2015) also concluded that effective communication is very key in delivering quality service, consistent with the assertions made by Hochman et al. Their review of studies in maternal health revealed that women viewed the provider-patient communication to be unsatisfactory, if the communication skills of the provider was poor.

Similarly, Ojelade et al (2017) found that the communication needs of women vary. Pregnant women who participated in the study, wanted their health providers to show empathy, be attentive and respectful. They also wanted providers to be discerning in terms of switching to the local language and also to avoid medical jargons during interactions with them. This study used in-depth interviews and focus group discussions.

Uitterhoeve, Bensing, Dilven, Donders, deMulder and van Achterberg (2009) analyzed 100 previously recorded provider-patient interactions. They argued that patients rarely express their concerns and emotions directly and spontaneously, but instead express indirect cues that something is worrying them.

A provider therefore needs the skill to be able to recognize clinically relevant cues which are not directly expressed; and intervene appropriately.
If the provider fails to observe and understand these nonverbal cues, the care delivered will not be satisfactory to the patient. The researchers state that being attentive and focusing on a patient is very important in the provider-patient interaction.

In a qualitative study involving three focus groups discussions with twenty-four pregnant women, Lefiman, Sinatra, and Huberty (2014) discovered that pregnant women viewed their antenatal visits as opportunities to receive behaviour change information. However, the lack of trust and rapport in the provider-patient communication was reported by participants. They also cited a lack of complete and consistent information, which discouraged them from adhering to recommendations by health providers.

Another study was conducted in Cambodia using thirty in-depth interviews with women who had recently given birth. Twenty of these women patronized public hospitals whiles the other 10 patronized private hospitals. Ith et. al (2013) found that improper staff attitudes were mostly reported in the public hospitals. Participants state that their interactions with health providers were characterized by verbal abuse, inadequate explanation of procedures and unfriendliness. In the private hospitals however, the researchers discovered that the participants received respectful care and were involved in decision making. Additionally, they received adequate information on all procedures and were satisfied with the services at these hospitals.

Similarly, Avortri et al. (2011) used a structured questionnaire to obtain data from 885 women who delivered their babies in two district hospitals in Ghana. The results submitted that friendliness, the amount of information given on condition and treatment and being treated with respect, were the key predictors of effective communication. This resulted in satisfaction with maternal services for the respondents.
2.2.2 Provider-Patient Communication and Demographic Variables

In a systematic review of twelve original research papers, Willems et al. (2005) explored the correlation between socio-economic status and provider-patient communication. The study revealed that providers gave less information to clients with lower levels of education and income. These patients were also not presented with the opportunity to ask questions and to be involved in their treatment decisions. The researchers attributed this to the erroneous assumption that such patients were not interested in playing active roles in their health or could not understand this information.

Atinga and Baku (2013) examined the factors affecting the quality of antenatal care in Ghana. The quantitative approach was employed for this study using a random selection of 363 pregnant women. The participants of the survey were aged from 15 years to 39 years. Pleasant interactions with providers and attentiveness of providers (effective communication) were found to be predictors of quality care. The researchers also discovered that perception of quality was high among women between the ages of 30 and 34 years. Women who had received some form of education also reported as good the quality of antenatal care as compared with uneducated women.

Three hundred and thirty-two women attending antenatal clinic in Ethiopia, participated in a survey conducted by Asifere et al. (2018). Most of the participants were between the age range of 25-34 years (46.5%, n=145). The largest percentage 53.5% (n=167) of them also had no formal education. On the attitude of providers, 70.8 % satisfaction was reported. On the other hand, 54.7% dissatisfaction was reported on provider’s information giving.
The researchers found a positive relationship between satisfaction with provider-patient communication and women’s educational status. Occupation and marital status were also predictors of satisfaction.

2.2.3 Provider-Patient Communication and Patronage of Maternal Services

In maternal health, women are motivated to use skilled care at health facilities when there is effective communication between patients and health providers. This is achieved when providers show concern, provide adequate information that is sensitive to the needs and preferences of women and treat them with respect (Kwast, 1998; Curry & Singlair, 2002).

The interpersonal relationship between pregnant women and health providers emerged as the strongest predictor of the quality of antenatal care received, in a study by Oladapo et al. (2008). This was a descriptive cross-sectional survey, carried out at three public health facilities. The researchers employed a systematic random sampling technique to select 452 respondents. The majority of respondents reported that they were: involved in decision making, received adequate information, treated with respect and empathy. Hence, they continuously patronised the services and will recommend it to others. Though other indicators of quality were found, the researchers concluded that the positive relationship between the pregnant women and health providers overshadowed those aspects that the respondents were unhappy with.

Madula et al. (2018) conducted a study in Malawi to find out women’s perceptions of the communication with healthcare providers in the maternity ward. The researchers conducted 30 in-depth interviews with women on admission for delivery in 6 health centres. Three of the centres selected were government-owned whiles the other three were privately-owned.
The themes that emerged included unwillingness of providers to answer questions, verbal abuse and lack of respect, discrimination with respect to status and language barriers. They found out that women who had a positive experience in terms of the communication with health providers were motivated to deliver at the health centre.

To assess the interpersonal communication regarding pregnancy-related services, a research was done by Dougherty et al (2018) using baseline data from a behaviour change project in the Upper West Region of Ghana. The objective of the project was to increase patronage of professional maternal services. Demographic and network data was collected from 1606 women (between 15-49 years) who had given birth 5 years prior to the project. Four outcomes were then examined namely early antenatal care, four or more antenatal care visits, skilled birth attendance, and perinatal care. The study showed that among friends, family and health providers, open communication with a health provider had the greatest impact on pregnant women accessing maternal services.

A systematic review of 34 studies from 17 countries was done by Bohren, Hunter, Munthe-Kaas, Vogel & Gülmezoglu (2014). It was established that reports of inadequate information on birth plans, disrespectful attitude and verbal abuse by health providers resulted in low patronage of professional delivery services. Another factor that led to home deliveries in these middle and low-income countries, was the fear of being discriminated against. As such, even in situations where the pregnant women attended antenatal clinic and were fully aware of the risks, they preferred traditional birth attendants.
In Ethiopia, the attitude of health providers and the provision of adequate information to pregnant women had significant associations statistically, with the utilisation of delivery service. The researchers surveyed 326 pregnant women in a cross-sectional study. The sampling frame used was the antenatal clinic attendance register for six selected administrative units. The age range of the respondents was 16-35 years, with the majority (43.9%) aged between 20-24 years. The percentage of pregnant women who agreed that health providers showed respect in their interactions was 74.8 (n=224) (Lera, Admasu & Dirar, 2017).

Roberts et al. (2015) also conducted a qualitative study in two hospitals. Using purposively sampling, they interviewed 20 pregnant women and 8 heath workers on the uptake of prenatal care. The participants were aged between 18-49 years. The greatest percentage of women were aged between 30-35 years (50%, n=10) and those in the second trimester constituted 75%, n=15) of the participants. Results suggest that the patient-provider relationship had the greatest impact on the patronage of prenatal services. Pregnant women complained of a lack of respectful care. Specifically, they reported that they were verbally abused and they felt demeaned.

2 focus group discussions and 21 interviews were conducted to find out the perceptions of care of pregnant women, which influenced satisfaction and their patronage of maternal services. D'Ambruoso et al. (2005) found that attitude of health providers was of great importance to the participants and it considerably influenced the patronage of maternal services. The participants indicated that they “expect humane, professional and courteous treatment from health professionals.” (D'Ambruoso, Abbey & Hussein, 2005, p. 140).
2.2.4 Barriers to Provider-Patient Communication

The nature of the work environment in healthcare is usually pressurised and stressful, resulting in limited communication time. As a result, the provision of effective communication is complex and very demanding (Bramhall, 2014).

Na and Pei-Luen (2017), carried out field observations of seven health providers in China. In total, 182 consultations were evaluated. The results revealed poor communication between providers and patients. Low medical literacy of patients, low awareness of communication skills, high workload and the adoption of defensive behaviours among providers; were the four barriers to effective communication that were identified.

In a study in Ghana, Avortri and Lebitsi (2018) revealed that the provider-patient relationship was characterized by the lack of empathy, lack of involvement in decision making and inadequate information giving. Participants blamed high workload of providers and inadequate professional training for the poor communication, which influenced negatively their perceptions of maternal services. These findings resulted from interviews conducted by the researchers with 15 women, in two district hospitals.

Focus groups and in-depth interviews were conducted by Higginbottom et al. (2016) with 23 social service providers, 29 health providers and 34 immigrant women. A qualitative ethnographic study design was employed, as the study site was a very small community and the population comprised immigrants from diverse backgrounds.

The participants were purposively sampled to investigate their maternity healthcare experience. The lack of information and language differences were found to be barriers to the maternity care provided to immigrant women in Canada.
The lack of information resulted in misunderstandings, challenges with obtaining informed consent, inadequate comprehension of diagnoses and treatment, leading eventually to preventable mortality.

Ganle, Fitzpatrick, Otupiri and Parker (2015), conducted a study on the barriers to access to and use of skilled delivery services in Ghana. Participants cited the lack of training, non-involvement in decision making, unfriendly provider attitudes and inadequate staffing in health facilities as barriers to good provider-patient interpersonal relationships. This qualitative research had a total participation of 185 expectant and lactating mothers and 20 health providers in 6 communities.

Norouzinia, Aghabarari, Shiri, Karimi and Samami (2016) conducted a survey on “communication barriers perceived by providers and patients”, using 50 health providers and 20 patients in two hospitals in Iran. Their results showed that the most recurrent barriers from the providers’ viewpoint were: differences in languages, high workload, interference by family of patients, and the presence of emergency patients in wards.

Conversely, patients referred to gender differences, nurse’s unwillingness to communicate, hectic environment of the ward, and anxiety and discomfort from illness. The researchers recommended communication skills training for providers based on their findings, as a measure to improve communication. It can be concluded that the barriers to effective communication could either be provider barriers (e.g. high workload, unfriendly attitudes, lack of time, language differences) or patient barriers (e.g. language differences, low literacy). For the purpose of this study, only provider barriers are considered as the perceptions of pregnant women are being sought.
2.3 Chapter Conclusion

The chapter has presented a wide array of literature related to the study, to confirm that the provider-patient communication is essential in maternal healthcare. Both verbal and non-verbal forms are invaluable to this communication. Effective provider-patient communication results in the adherence to recommendations, satisfaction and the delivery of quality care. It has also been noted that demographic variables including, age, socioeconomic status, occupation and marital status; can influence the provider-patient communication.

It establishes that similar to any service rendered, pregnant women will patronize maternal services only if the communication with health providers is effective. This requires that information should not only be sent but must be understood by both health providers and pregnant women. Communication should also be done in a way that promotes involvement in decision making and a feeling of self-worth, based on the individual needs of pregnant women.

Effective provider-patient communication is hampered by several factors. The differences in language, high workload of providers and inadequate professional training are some of the barriers. Although other studies exist in maternal health, most of them focused on quality and satisfaction. There is paucity of research into the communication aspect. It is vital therefore to know how pregnant women view the provider-patient communication. This will allow for changes to be made, to ensure improved patronage of professional maternal services.
CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter briefly describes the procedures and methods that were used to collect and analyze data for the study. The study was carried out at the Maternal and Child Health unit of the University of Ghana hospital, located in the Greater Accra region of Ghana. The rest of this sub section explains the research design used and the target population for the study. It also discusses the sample and sampling procedure, the data collection procedure and analysis of the results obtained.

3.1 Study Site

The University of Ghana hospital (UGH), located in the Greater Accra region of Ghana, was established in 1957. It is located at the staff village community of the University of Ghana campus. It renders general services to students, staff and the surrounding communities. According to the administrator Mr. E. H. Gaisey, the hospital has a bed capacity of 130. The UGH has several units including Paediatric Unit, Casualty and Emergency Ward, General Wards, Dental Unit and Maternity Wing.

The Maternal and Child Health unit is ran by a senior midwife, who is assisted by four other midwives. Pregnant women are referred to a physician if need be. According to Mrs. Stella Hiadzi, the senior midwife, there are five rotation nurses assigned to the unit. One of these nurses is available every day. Trainee nurses are also available to conduct the initial assessment of the pregnant women, which includes their temperature, body weight and blood pressure. The unit runs antenatal clinics from Monday to Thursday, and a postnatal clinic every Friday. Pregnant women who are not either staff or dependants of staff of UGH pay for antenatal services.
The UGH is perceived to have well qualified health personnel and therefore should render services that are of a better standard than what pertains in other hospitals in the country, due to its positioning as a private and a university hospital. It is relevant therefore to find out the perceptions of pregnant women of provider-patient communication at the Maternal and Child Health unit. The study was conducted only at the antenatal clinic, in line with the objectives of the research, as pregnant women were the target group.

3.2 Research Design
A quantitative approach was used to gather data considering the objectives of the study. The use of a survey enabled the researcher to ascertain whether demographic variables influence the provider-patient communication and also the relationship between the provider-patient communication and the patronage of maternal services. Additionally, it helped to collect a large amount of data from respondents in a short time. It also enables the researcher to compare and to be able to generalise the results of the study.

3.3 Sampling size and sampling technique
The study population comprised all pregnant women who accessed antenatal services within the period of the study. Sampling allows a researcher to select a relatively smaller number of elements from a population, in a systematic way. The researcher employed the simple random sampling method to recruit the respondents. This method gives every element an equal chance of being selected and as such, eliminates bias. However, it could be very time consuming and costly.

The Antenatal Care Attendance Register for the year, 2018 was used as a sampling frame. A total of 120 pregnant women above 17 years were randomly selected from the register, for this study.
The Maternal and Child Health unit of UGH keeps the register and it is updated as new pregnant women attend antenatal clinic. Since the register is numbered systematically, the numbers were written on a separate piece of paper. They were all folded into a box. The folded papers were randomly selected until the desired number of respondents was obtained.

A Senior midwife at the Maternal and Child Health unit first contacted the selected pregnant women on behalf of the researcher, through their phone numbers contained in the register. The researcher then followed up to book appointments with the pregnant women. Most of the respondents agreed to meet at the hospital. Some of them preferred the University of Ghana campus and a few of them also chose locations very close to the community within which the hospital is located.

3.4 Data Collection

The researcher used a 21-point questionnaire adapted from a wide selection of relevant literature to collect data from the sampled pregnant women.

The first part of the questionnaire sought to obtain demographic details of the respondents - age and educational background.

The second part contained questions on the perceptions of the provider-patient communication and barriers affecting it. These questions were measured on a 5-point Likert scale (1- Strongly disagree, 2- Disagree, 3- Neutral, 4- Agree and 5- Strongly Agree).

Data was collected in January 2019 over a period of three (3) weeks. After explaining the study objectives to the respondents and obtaining informed consents, the researcher administered the questionnaire. One of the exclusion criteria was the inability to communicate in English language or Twi as those are the languages broadly spoken by the researcher and most Ghanaians. Respondents who were unwilling to participate in the study were also excluded.
3.5 Data analysis

According to Saunders et al. (2009), the analysis of data aids the researcher to organize data collected, to evaluate the results and to arrive at some valid, reasonable and relevant conclusion. Each questionnaire was given a unique code to make it easy to check for missing information. The results were analysed with the help of the Statistical Package for Social Sciences (SPSS). Data was analysed using both descriptive and inferential statistics. The findings are presented using figures, tables and charts, for the descriptive statistics.

To assess how age and education affect the perceptions of pregnant women of the provider-patient communication, correlations tests were performed. Correlation tests were also used to evaluate how perceptions of the provider-patient communication affect the patronage of maternal services. In both cases, a p-value of less or equal to 0.05 (p≤ 0.05) was used as the significance level.

3.6 Reliability and validity

Reliability deals with consistency or stability of the response (Creswell, 2013), whereas validity is a check of whether the instrument adopted measured what it was supposed to measure (Polit and Beck, 2012).

The questionnaire and constructs used in this research were adapted based on other similar studies by Avortri et al. 2011, Lambrini and Loana, 2014 and Baker and Watson, 2015. Notwithstanding, it was important to check for reliability and validity as they were rephrased to fit the objectives of this study.

A pilot test was conducted with five pregnant women at a different hospital from the one used for this study. This enabled the researcher to check for completeness and understanding of the questionnaire.
The academic supervisor reviewed the questionnaire and constructs thoroughly to ensure that the reflected the study’s objectives. Cronbach’s Alpha was calculated for the three constructs used. Attitude of provider had six items in the questionnaire with a Cronbach’s alpha of 0.791. Accommodation had six items with a Cronbach’s alpha of 0.814. Information giving had four items with a Cronbach’s alpha of 0.672. The low value for the latter could be due to the number of questions measuring information being small.

3.7 Ethical Consideration

An introductory letter from the University of Ghana, Department of Communication Studies was sent to the University of Ghana Hospital for approval. The informed consent of respondents was subsequently obtained. Respondents were informed of their right to opt out at any point of the research. For anonymity and confidentiality, coded identifiers were used for the answered questionnaires.

3.7 Operational Definitions

Provider: It refers to physicians, midwives and nurses who interact with pregnant women at the Maternal and Child Health unit of the hospital.

Antenatal: For the purpose of this study, it refers to the period before birth during which a woman visits the Maternal and Child Health unit for care.

Postnatal: The period after delivery/ childbirth.

Maternal services: This comprises antenatal services, delivery services and postnatal services.

Perceptions: It refers to the impressions of pregnant women or what they think about the subject under study.

Attitude of provider: The way a health provider acts towards a patient, leaving a positive or negative feeling.
**Accommodation:** This refers to the adjustments made by a health provider to enable a pregnant woman to play an active role during an interaction.

**Information giving:** In the study, information giving refers to the willingness and the ability of a health provider to ensure the pregnant woman receives complete and adequate information, based on her needs.

**Positive response:** A response greater than 3 on the Likert scale used (1-5) on the questionnaire.

**Negative response:** A response less than 3 on the Likert scale used (1-5) on the questionnaire.
CHAPTER FOUR

FINDINGS

4.0 Introduction

The findings of the research are presented in this chapter. They are organised based on the objectives of this study. All the questionnaires distributed were completed, indicating a 100% response rate. The demographic characteristics of the respondents are described first, followed by the perceptions of respondents on how health providers communicate with them. Then the results obtained on how age and education of pregnant women affect the perceptions of provider-patient communication are presented. This is followed by the findings on how perceptions of the provider-patient communication affect patronage of maternal services and the barriers affecting the provider-patient communication.

4.1 Demographic characteristics of respondents

The majority of the respondents were aged between 36-45 years (42.5 %, n=51). With respect to educational background, most of the pregnant women (65.8%, n= 79) had tertiary education.

4.2 Perceptions of pregnant women of the provider-patient communication

One of the objectives of the study was to know how pregnant women perceive the provider-patient communication at the hospital. The perceptions of the patient-provider communication have been categorised into three components namely: attitude of the provider, accommodation and information giving.
4.2.1 Attitude of the provider

For each of the parameters under attitude, a greater percentage of respondents gave a positive response (Agree and Strongly agree), with treated with respect and dignity obtaining the highest (94%, n=113). The parameter which received the lowest positive response was the use of positive non-verbal expressions (74%, n=87).

Table 1 shows that the attitude of health providers was generally good as they interacted with pregnant women. The percentage of respondents who agreed that health providers use warm and appropriate greeting was 54.2, 44.9% strongly agreed that their concerns are treated as important, 52.5% agreed on the use of positive verbal expressions, 48.3% agreed that the providers show empathy and concern, 55% also agreed that they were treated with respect and dignity. The percentage of pregnant women who strongly disagreed on all five parameters was almost 0.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm and appropriate Greeting</td>
<td>0 (0.0%)</td>
<td>2 (1.7%)</td>
<td>17 (14.4%)</td>
<td>64 (54.2%)</td>
<td>35 (29.7%)</td>
<td>118 (100%)</td>
</tr>
<tr>
<td>Concerns treated as important</td>
<td>0 (0.0%)</td>
<td>4 (3.4%)</td>
<td>13 (11.0%)</td>
<td>48 (40.7%)</td>
<td>53 (44.9%)</td>
<td>118 (100%)</td>
</tr>
<tr>
<td>Positive non-verbal expressions</td>
<td>1 (0.8%)</td>
<td>4 (3.4%)</td>
<td>26 (22.0%)</td>
<td>62 (52.5%)</td>
<td>25 (21.2%)</td>
<td>118 (100%)</td>
</tr>
<tr>
<td>Empathy and concern</td>
<td>0 (0.0%)</td>
<td>8 (6.7%)</td>
<td>12 (10.0%)</td>
<td>58 (48.3%)</td>
<td>42 (35.0%)</td>
<td>120 (100%)</td>
</tr>
<tr>
<td>Respect and dignity</td>
<td>0 (0.0%)</td>
<td>1 (0.8%)</td>
<td>6 (5.0%)</td>
<td>66 (55.0%)</td>
<td>47 (39.0%)</td>
<td>120 (100%)</td>
</tr>
</tbody>
</table>

Source: Field data 2019
4.2.2 Accommodation

This was assessed by a total of six parameters. For each of the parameters, a greater percentage of respondents gave a positive response (Agree and Strongly agree), with the use of appropriate language obtaining the highest (100%, n=120). The parameter which received the lowest positive response was motivation to comply (80.8%, n=97). Generally, the use of accommodative behaviours by health providers seems very encouraging as can be observed in Table 2.

The percentage of the pregnant women who strongly agreed on the ability to freely express concerns was 52.5, whiles 56.8% of them agreed they are not interrupted by health providers. Issues are clearly explained to the respondents as agreed by 53.5%, 57.5% strongly agree with the use of appropriate language, 62.5% agreed to being involved in decision making and 58.3% agreed that health providers motivate them to comply with recommendations and treatment. None of the respondents strongly disagreed on the use of accommodative behaviours.
Table 2: Accommodation

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to freely express concerns</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>8 (6.7%)</td>
<td>49 (40.8%)</td>
<td>63 (52.5%)</td>
<td>120</td>
</tr>
<tr>
<td>Listening without interrupting</td>
<td>0 (0.0%)</td>
<td>2 (1.7%)</td>
<td>5 (4.2%)</td>
<td>67 (56.8%)</td>
<td>44 (37.3%)</td>
<td>118</td>
</tr>
<tr>
<td>Clear explanation of issues</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>10 (8.3%)</td>
<td>63 (52.5%)</td>
<td>47 (39.2%)</td>
<td>120</td>
</tr>
<tr>
<td>Use of appropriate language</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>51 (42.5%)</td>
<td>69 (57.5%)</td>
<td>120</td>
</tr>
<tr>
<td>Involvement in decisions making</td>
<td>0 (0.0%)</td>
<td>3 (2.5%)</td>
<td>13 (10.8%)</td>
<td>75 (62.5%)</td>
<td>29 (24.2%)</td>
<td>120</td>
</tr>
<tr>
<td>Motivation to comply</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>23 (19.2%)</td>
<td>70 (58.3%)</td>
<td>27 (22.5%)</td>
<td>120</td>
</tr>
</tbody>
</table>

Source: Field data 2019

4.2.3 Information giving

Health providers fared very well on the giving of information to pregnant women as shown in Table 3. For each of the four parameters, a greater percentage of respondents gave a positive response (Agree and Strongly agree).

The highlights of individual items on information giving shows that 54.2% agreed on the willingness of health providers to answer questions, 67.5% agreed that they are urged to ask additional questions. Furthermore, 61.7% agreed to receiving adequate information about pregnancy and 71.7% strongly agreed to receiving adequate information about delivery.
Here again, none of the respondents strongly disagreed on the information giving behaviours of the health provider. Information giving was the most highly-rated among the three components.

**Table 3: Information giving**

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>My health provider is willing to answer questions about my concerns</td>
</tr>
<tr>
<td>My health provider urges me to ask additional questions</td>
</tr>
<tr>
<td>I receive adequate information about my pregnancy from my health provider</td>
</tr>
<tr>
<td>I receive adequate information on childbirth/delivery from my health provider</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>My health provider is willing to answer questions about my concerns</td>
<td>1</td>
<td>18</td>
<td>65</td>
<td>36</td>
<td>120</td>
</tr>
<tr>
<td>(0.8%)</td>
<td>(15.0%)</td>
<td>(54.2%)</td>
<td>(30.0%)</td>
<td>(100%)</td>
<td></td>
</tr>
<tr>
<td>My health provider urges me to ask additional questions</td>
<td>1</td>
<td>6</td>
<td>81</td>
<td>32</td>
<td>120</td>
</tr>
<tr>
<td>(0.8%)</td>
<td>(5.0%)</td>
<td>(67.5%)</td>
<td>(26.7%)</td>
<td>(100%)</td>
<td></td>
</tr>
<tr>
<td>I receive adequate information about my pregnancy from my health provider</td>
<td>2</td>
<td>4</td>
<td>74</td>
<td>40</td>
<td>120</td>
</tr>
<tr>
<td>(1.7%)</td>
<td>(3.3%)</td>
<td>(61.7%)</td>
<td>(33.3%)</td>
<td>(100%)</td>
<td></td>
</tr>
<tr>
<td>I receive adequate information on childbirth/delivery from my health provider</td>
<td>1</td>
<td>5</td>
<td>28</td>
<td>86</td>
<td>120</td>
</tr>
<tr>
<td>(0.8%)</td>
<td>(4.2%)</td>
<td>(23.3%)</td>
<td>(71.7%)</td>
<td>(100%)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Field data 2019

In assessing the perceptions of respondents on how health providers communicate with them, each respondent’s total score on the three components of communication were computed. The averages of these figures were then found. Each question was measured on a score of 1 (strongly disagree) to 5 (strongly agree). The Attitude component was measured using 5 questions. The highest score obtainable was 25.
The Accommodation component was measured using 6 questions. The highest score obtainable was 30. The information giving component was measured using 4 questions. The highest score obtainable was 20.

<table>
<thead>
<tr>
<th></th>
<th>Attitude</th>
<th>Accommodation</th>
<th>Information Giving</th>
</tr>
</thead>
<tbody>
<tr>
<td>N (Valid)</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Mean</td>
<td>20.5250</td>
<td>25.6833</td>
<td>17.2583</td>
</tr>
<tr>
<td>Std. Error of Mean</td>
<td>.24425</td>
<td>.20497</td>
<td>.13098</td>
</tr>
<tr>
<td>Actual Mean Rating</td>
<td>4.105</td>
<td>4.2806</td>
<td>4.3146</td>
</tr>
</tbody>
</table>

Source: Field data 2019

From the results, it was evident that across the board, respondents had a good perception about how health providers communicate with them, suggesting that the provider-patient communication at the hospital is effective.

4.3 Age and provider-patient communication

A Pearson correlation test indicated that there was no statistically significant relationship between the age of respondents and the provider-patient communication ($r = -0.018, n = 120, p = 0.842$).

The results obtained is an indication that health providers did not discriminate among pregnant women based on their age, when communicating with them.
Table 5: Correlation between age and provider-patient communication

<table>
<thead>
<tr>
<th>Provider-Patient Communication</th>
<th>Provider-Patient Communication</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>1</td>
<td>-.018</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.842</td>
<td>.639</td>
</tr>
<tr>
<td>N</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

Source: Field data 2019

4.4 Education and provider-patient communication

The results obtained for the correlation test conducted showed that the relationship between the education of respondents and the provider-patient communication was not statistically significant ($r = 0.043, n = 120, p = 0.639$). This proves that education of pregnant women did not affect how health providers communicated with them at the antenatal clinic.

Table 6: Correlation between education and provider-patient communication

<table>
<thead>
<tr>
<th>Provider-Patient Communication</th>
<th>Provider-Patient Communication</th>
<th>EDUCATIONAL BACKGROUND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>1</td>
<td>.043</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.639</td>
<td>.639</td>
</tr>
<tr>
<td>N</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

Source: Field data 2019

4.5 Patronage of maternal services

This was assessed by whether respondents were encouraged to attend antenatal clinic (prenatal service), to whether they would deliver at the clinic (delivery service) as well as their willingness to utilize postnatal services at the hospital.
The results show that the majority of respondents gave a positive response (Agree and Strongly agree) on the patronage of maternal services. Patronage of postnatal service had the highest percentage, 99% and the patronage of prenatal service had the lowest, 89%.

Figure 1: I am encouraged to attend antenatal clinic

From figure 1 above, 57% of pregnant women are encouraged to attend antenatal clinic, 32% strongly agree and 11% are neutral. It is very encouraging that none of the respondents either disagreed or strongly disagreed on this question, as attending antenatal clinic is very vital in maternal health.
From figure 2 above, 54.2% of pregnant women agree on being willing to deliver at the hospital, 40.8% strongly agree and 5% are neutral. Though the trend in Ghana suggests a lower rate of the patronage of professional delivery services, the hospital seems to have fared very well on this score.

A summary on the patronage of post-natal services shows that post-natal services are very important to the expectant mothers. Almost all of them were in favour of utilising this service. The percentage of the respondents who strongly agreed was 59, 40% agreed and 1% was neutral.
4.6 Provider-patient communication and patronage of maternal services

To assess how the perceptions of pregnant women of the provider-patient communication affects the patronage of maternal services, correlation tests were conducted.

4.6.1 Provider-patient communication and patronage of prenatal service

Table 7: Correlation between the three components of provider-patient communication and prenatal service

<table>
<thead>
<tr>
<th>PRENATAL SERVICE</th>
<th>Attitude</th>
<th>Accomodation</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>.334**</td>
<td>.211*</td>
<td>.364**</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.002</td>
<td>.000</td>
</tr>
<tr>
<td>N</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).
Source: Field data 2019
The test of correlation indicated a statistically significant relationship between the possibility of respondents patronizing prenatal service and their perceptions of health providers’ attitude ($r = 0.334, n = 120, p < 0.001$), accommodation ($r = 0.211, n = 120, p = 0.002$) and information giving ($r = 0.364, n = 120, p < 0.001$).

4.6.2. Provider-patient communication and patronage of delivery service

Table 8: Correlation between the three components of provider-patient communication and delivery service

<table>
<thead>
<tr>
<th>DELIVERY SERVICE</th>
<th>Attitude</th>
<th>Accomodation</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>.122</td>
<td>.238**</td>
<td>.172</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.184</td>
<td>.009</td>
<td>.061</td>
</tr>
<tr>
<td>N</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).
Source: Field data 2019

The test of correlation indicated the possibility of respondents patronizing delivery service and their perceptions of the health providers’ attitude ($r = 0.122, n = 120, p = 0.184$) and information giving ($r = 0.172, n = 120, p = 0.061$) were not statistically significant.

However, there was a statistically significant relationship between the possibility of respondents patronizing delivery services and their perceptions of health providers’ accommodation ($r = 0.238, n = 120, p = 0.009$).
4.6.3 Provider-patient communication and patronage of postnatal service

Table 9: Correlation between the three components of provider-patient communication and postnatal service

<table>
<thead>
<tr>
<th>POSTNATAL SERVICE</th>
<th>Attitude</th>
<th>Accomodation</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>.321**</td>
<td>-.035</td>
<td>.285**</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td>.702</td>
<td>.002</td>
</tr>
<tr>
<td>N</td>
<td>120</td>
<td>120</td>
<td>120</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).
Source: Field data 2019

The test of correlation indicated that the possibility of respondents patronizing postnatal services and their perceptions of health providers’ information giving \((r = -0.035, n = 120, p = 0.702)\) was not statistically significant. However, there was a statistically significant relationship between the possibility of respondents patronizing delivery services and their perceptions of health providers’ attitude \((r = 0.321, n = 120, p < 0.001)\) and accommodation \((r = 0.285, n = 120, p = 0.002)\).

4.7 Barriers to the provider-patient communication

On the barriers to the provider-patient relationship, the responses received were diverse with a majority of respondents indicating that there was no barrier.

Some of the barriers raised were: lack of training, workload of provider, long queues, waiting time, negative attitude of provider and differences in upbringing.
Table 10: Barriers to provider patient communication

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differences in Upbringing</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td>Lack of Training</td>
<td>8</td>
<td>6.7</td>
</tr>
<tr>
<td>Long Queues</td>
<td>10</td>
<td>8.3</td>
</tr>
<tr>
<td>Negative Attitude of Provider</td>
<td>3</td>
<td>2.5</td>
</tr>
<tr>
<td>No Issues</td>
<td>65</td>
<td>54.2</td>
</tr>
<tr>
<td>Lack of Refresher Courses</td>
<td>10</td>
<td>8.3</td>
</tr>
<tr>
<td>Waiting Time</td>
<td>21</td>
<td>17.5</td>
</tr>
<tr>
<td>Workload of Provider</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Source: Field data 2019
CHAPTER 5
DISCUSSION

5.0 Introduction
This chapter presents a discussion of the findings based on the research objectives. Also, findings are discussed in relation to previous studies and literature where necessary, to highlight the similarities and differences in results obtained.

5.1 Demographic Characteristics
The majority of respondents were aged between 36-45 years (42.5 %, n=51). This could be attributed to the fact that the respondents may not be first time expectant mothers. A study by Ojelade et al. (2017) also had the majority of participants in an age range closer to that of this study (30–45years). Oladapo et al. (2008) on the other hand, found a lower age range of 20–29years). With respect to educational background, most of the pregnant women (65.8%, n=79) had tertiary education. This is not surprising as the hospital caters largely for university students and staff of the University.

5.2 Perceptions of the provider-patient communication
Provider-patient communication involves much more than giving and receiving information. In maternal health, it presents an opportunity to educate women on issues that may eventually avert mortality. According to Ledford et al. (2010), communication that focuses on these women requires health providers to seek to understand their perceptions to be able to deliver care that is satisfactory.

The study affirmed that pregnant women were happy with the provider-patient communication, as the responses of the majority of the pregnant women were positive. The actual mean ratings as shown in Table 5 were all above 4.
This indicates an effectiveness of the communication process which entails attitude (actual mean rating of 4.1050), accommodation (actual mean rating of 4.2806) and information giving (actual mean rating of 4.3146). Perhaps there is effective communication at the antenatal clinic partly because pregnant women pay for the services rendered at the University of Ghana hospital. This study suggests that respondents had a positive perception of the provider-patient communication. This finding is not supported by Lefiman et al. (2014) and Madula et al. (2018) and who found negative perceptions in private hospitals. Other studies reported that negative perceptions of patients of the provider-patient communication are rather widespread in public hospitals (Wiredu-Mensah, 2008; Korsah, 2011; Narkotey, 2015; Aduo-Adjei, 2015). The various components of the provider-patient communication are subsequently discussed below.

5.2.1 Attitude of provider

The majority of respondents in this study rated the attitude of health providers as positive, implying that the patients were content with the attitude of health providers during interactions. 72.5% of the pregnant women agreed on the use of positive verbal expressions and 75% also agreed that they were treated with respect and dignity, which led to positive outcomes. These findings correspondent to suggestions by Travaleine et al. (2005) and Uitterhoeve et al. (2009) that attitude is likely to leave a lasting impression as patients want providers to treat them with respect and show empathy. Similarly, Hochman et al. (2008) and Mojdeh et al. (2013) also found out that patients were satisfied with positive non-verbal communication like maintaining eye contact, nodding and being attentive.
5.2.2. Accommodation

The parameters used in assessing the accommodation of providers collectively scored high as compared to attitude and information giving. This is very encouraging to know as the provider-patient communication is increasingly becoming patient-centred. As such, patients now prefer to play active roles during interactions and exercise independent judgement in decision making (Wright, Sparks & O’Hair, 2013).

The study conducted by Ith et al. (2013) agrees with the findings that clear explanation of issues is important, as a provider is likely to confuse a patient by using medical jargons. The use of appropriate language obtained the greatest positive response (100%, n=120). This may enable providers to precisely convey messages devoid of ambiguity as a result of slang or lack of knowledge and puts messages in a familiar contest. Respondents also reported non-interruption by providers (84%, n=24).

The theory underpinning this research, the Communication Accommodation Theory, suggests that the use of accommodative behaviours during interactions, allows patients to provide complete information and convey their needs and preferences to health providers (D’Agostino & Bylund, 2014).

Judging from the fact that pregnant women were happy with the parameters measured under accommodation, the theory posits that they culminate in convergence–which has positive outcomes on the provider-patient communication (Baker & Watson, 2015).
5.2.3 Information giving

The study revealed that pregnant women received adequate information on maternal services, were urged to ask additional questions and providers were willing to answer their questions. It suffices to say that there is effective communication at the University of Ghana hospital. This is in tandem with the findings of Ith et al. (2013) that pregnant women cited the receipt of adequate information from health providers in private hospitals. Madula et al. (2018) concluded that there was no effective provider-patient communication between pregnant women and health providers, as health providers were found to be unwilling to answer questions.

5.3 Age and provider-patient communication

The results have shown that there was no statistically significant relationship between the ages of the respondents and their perceptions of the provider-patient communication. The CAT posits that age can influence the communication behaviours of people. It further asserts that people can modify these behaviours to match that of the other party in an interaction. For this study, the accommodation component of the provider-patient communication reported was very encouraging. This could explain why age did not affect the communication of pregnant women with health providers at the hospital.

This finding is consistent with a study conducted in Ethiopia, which showed that a positive interpersonal relationship between provider and patient was not a function of age (Lera, Admasu & Dirar, 2017). The findings of Atinga and Baku (2013) however, provide evidence contrary to that of this study. The researchers discovered that effective communication (pleasant interactions with providers and their attentiveness) had a statistically significant relationship with age. They stated that the perception of effective communication was high among women between the ages of 30 and 34 years.
5.4 Education and provider-patient communication

Most of the respondents had some form of education (n=108), with the greatest percentage having tertiary education (n=79).

The educational background was found not to have affected the provider-patient communication at the University of Ghana hospital. This is not surprising as most of the respondents (65%) had tertiary education. Furthermore, respondents gave positive responses on the providers’ use of appropriate language (100%, n=120) and clear explanation of issues (91.7%, n=110). 62.5% agreed to being involved in decision making, 75% also agreed that they were treated with respect and dignity. These behaviours as suggested by the CAT, help to bridge the differences in the socioeconomic status of the parties involved in communication by creating trust, leading to open communication.

Willems et al. (2005) rather found that patients of lower education received less information, were not given the opportunity to ask questions and were not involved in decision making. They further stated that providers assumed that these patients did not ask questions because they did not know what to ask or they were content with what they already knew. Another assumption was that patients could not understand the information (if given by health providers), to be able to play active roles in health issues. Asifere et al. (2018) also reported that pregnant women were not given adequate information if their level of education was low.

5.5 Patronage of maternal services

The patronage of maternal services received positive responses across prenatal, delivery and postnatal services. This could be as a result of the majority of respondents being educated. Hence, there is the possibility that they are knowledgeable on the advantages of patronizing maternal services.
5.6 Provider-patient communication and patronage of maternal services

Although the responses of respondents were positive across the board, the study revealed that the components of the provider-patient communication affected the patronage of maternal services in diverse ways. These findings are discussed below:

5.6.1 Provider-patient communication and patronage of prenatal service

The patronage of prenatal service was found to be affected by the health providers’ attitude (p<0.001), accommodation (p=0.002 and information giving (p<0.001). This finding echoes the importance of effective provider-patient communication at the prenatal stage. The percentage of pregnant women who agreed that they were urged to ask additional questions was 67.5, 61.7% agreed to receiving adequate information about pregnancy and 71.7% strongly agreed to receiving adequate information about delivery.

The results affirm the assertion that effective communication enables pregnant women to clear doubts on issues and ask questions that can aid in making informed decisions about pregnancy care, birth plans and postnatal care (Myer & Harrison, 2003). This is confirmed also by Atinga and Baku (2013), that the continuous uptake of prenatal service for expectant mothers depends on being treated humanely and an overall positive interaction with health providers. Similarly, Oladapo et al. (2008) reported that pregnant women were involved in decision making (accommodation), received adequate information (information giving) and were treated with respect and empathy (attitude). Hence, they continuously patronised prenatal services.
5.6.2. Provider-patient communication and patronage of delivery service

The patronage of delivery service was found to be affected by the health providers’ accommodation (p=0.009), but not with attitude (p=0.184) and information giving (p=0.061). This is different from the results of Madula et al. (2018) which indicated that the willingness of providers to answer questions, the use of appropriate language and respectful treatment were associated with the patronage of delivery service.

Similarly, studies conducted by Munthe-Kaas et al. (2014) and Dirar et al. (2017) suggested that information giving and attitude of health providers were related to the patronage of professional delivery services. D'Ambruoso et al. (2005) also reported that negative provider attitudes resulted in low patronage. Perhaps at the delivery stage, the respondents are more concerned about being involved in decision making, providers explain things clearly to them and the use of an appropriate language as indicated by Ojelade et al. (2017).

5.6.3 Provider-patient communication and patronage of postnatal service

The attitude (p<0.001) and accommodation (p=0.002) of health providers affected the patronage of postnatal service. This implies that respondents preferred that providers treat them with respect, show empathy, use positive non-verbal expressions and also treat their concerns as important. They also want to play active roles in terms of the provider-patient communication. The findings are in contrast with the results obtained by Dougherty et. al (2018). This may be due to the fact that the health of a baby is involved at this stage of the maternal services provided.
5.7 Barriers to the provider-patient communication

The study indicated that pregnant women perceived the provider-patient as effective. This could explain why the majority of respondents (54.2%, n= 65) indicated that they had no issues in terms of barriers. Waiting time was the barrier that was reported most (17.5%, n=21). This is a little surprising as there is a good number of providers available to attend to pregnant women at the hospital, as compared to other hospitals in Ghana. This can also explain why only two respondents gave the workload of provider as a barrier to the provider-patient communication. Respondents reported long queues, lack of refresher courses, lack of training, negative attitude of provider and differences in upbringing as barriers to effective communication.

5.8 Conclusion

From the findings, pregnant women deem relevant both the verbal and non-verbal forms in the provider-patient communication. This confirms that communication is not concerned with what is said, but also how it is said (Nadzam, 2009).

It also highlights the fact that health providers exhibit positive attitudes and use accommodative behaviours to ensure that pregnant women are well informed on health issues, based on their individual needs. The providers’ use of appropriate language at the University of Ghana hospital as a way of giving complete and unambiguous messages to pregnant women is very encouraging, as evident in the 100% positive response obtained. This reflects convergence as stated by the communication accommodation theory to ensure effective provider-patient engagement.
It can be concluded from the study that the components of effective communication are not
discrete but rather interlinked. For instance, warm and appropriate greeting, maintaining eye
contact and showing empathy can create a conducive environment, for a pregnant woman to
feel at ease in discussing health issues. Explaining things clearly, using an appropriate language
and giving detailed information can also make a patient feel respected, thereby enhancing the
provider-patient communication (Travaline et al., 2005).

The health providers do not discriminate among pregnant women who seek antenatal care at
the hospital on the basis of their age and education. The generally high ratings on the
parameters assessing the effectiveness of the provider-patient communication, supports this
conclusion. This proves that health providers use accommodative behaviours during
interactions with pregnant women. This makes meaning of the aspect of the communication
accommodation theory that suggests that accommodative behaviours help to bridge age and
education gaps.

The effectiveness of the provider-patient communication positively affected the patronage of
maternal services. This confirms existing literature which suggests that effective provider-
patient communication has positive outcomes including the uptake of professional maternal
services (Babalola et al., 2016).

Most of the women seeking antenatal care at the University of Ghana hospital are happy with
the provider-patient communication. Also, 54.2% of respondents reported that there were no
barriers to effective communication. However, the waiting time was of concern to 17.5% of
the pregnant women.
5.9 Recommendations

The study generally painted a positive picture of the provider-patient communication. However, as compared to other aspects of the attitude of provider such as treated with respect and dignity, the use of positive non-verbal communication received the lowest positive response (74%, n=87). Health providers should therefore be mindful of their non-verbal forms of communication including maintaining eye contact, nodding and body language in their interactions with pregnant women.

The study revealed that there is effective provider-patient communication at the University of Ghana hospital from the perspective of pregnant women at the Maternal and Child Health Unit. Further studies should focus on the perspective of the health providers. This can give a wholistic account of the provider-patient communication.

Limitations of the study

There exists a limitation with respect to sampling. The study sought to determine whether age and education affect the provider-patient communication. However, the two independent variables were not considered during sampling, as a simple random method was used.

All the questionnaires were administered by the researcher. There is the possibility that the presence of the researcher may have influenced the respondents to give more socially desirable responses.

The pregnancy discomfort signs shown by some of the pregnant women may have affected the kind of responses they provided. This made them eager to complete the questionnaire in the shortest possible time. Responses may have not been given careful thought.


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APPENDIX A: QUESTIONNAIRE
UNIVERSITY OF GHANA
DEPARTMENT OF COMMUNICATION STUDIES

This questionnaire seeks to assess the communication between providers and patients at the Maternal and Child Health Unit. The study is solely for academic purposes. You are also assured of absolute confidentiality and anonymity. Please freely participate and provide answers that reflect your opinion.

Thank you.

SECTION ONE: SOCIO-DEMOGRAPHIC CHARACTERISTICS (Please tick)

1. Age?
   18-25 years [ ] 25-35 years [ ] 35-45 years [ ] Above 45 years [ ]

2. Educational Background?
   None [ ] Primary [ ] Junior High [ ] Senior High [ ] Tertiary [ ]

SECTION TWO: PROVIDER-PATIENT COMMUNICATION (Please tick)

3. My health provider greets me in a warm and appropriate way.
   [ ] Strongly Agree [ ] Agree [ ] Neutral [ ] Disagree [ ] Strongly Disagree

4. I am able to express freely concerns about my pregnancy with my health provider.
   [ ] Strongly Agree [ ] Agree [ ] Neutral [ ] Disagree [ ] Strongly Disagree

5. My health provider listens to my concerns without interrupting me.
   [ ] Strongly Agree [ ] Agree [ ] Neutral [ ] Disagree [ ] Strongly Disagree
6. My health provider is willing to answer questions about my concerns.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

7. I feel like my concerns are treated as important.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

8. My health provider urges me to ask additional questions.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

9. My health provider uses positive non-verbal expressions when communicating with me.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

10. My health provider shows empathy and concern.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

11. My health provider explains health issues clearly, so that I can understand.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

12. My health provider uses a language that enables me to understand what he/she says.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree
13. My health provider takes my preferences or opinions into account when making decisions about treatment options and birth plans.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

14. My health provider motivates me to comply with treatment and recommendations.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

15. My provider speaks to me with respect and dignity.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

16. I receive adequate information about my pregnancy from my health provider.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

17. I am encouraged to attend antenatal clinic due to the way my health provider communicates with me.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

18. I receive adequate information on childbirth/delivery from my health provider.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree

19. I would like to deliver at this clinic due to the way my health provider communicates with me.

[ ] Strongly Agree  [ ] Agree  [ ] Neutral  [ ] Disagree  [ ] Strongly Disagree
20. I think it is necessary to utilise professional post-natal services.

[ ] Strongly Agree   [ ] Agree   [ ] Neutral   [ ] Disagree   [ ] Strongly Disagree

21. What do you think influences negatively effective communication between you and your health provider?

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........................................................................................................................................