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**UNIVERSITY OF GHANA**  
**SCHOOL OF PUBLIC HEALTH**

**ASSESSMENT OF WOMEN'S KNOWLEDGE AND ATTITUDES  
TO ANTENATAL AND POST NATAL CARE SERVICES IN  
SEKYERE WEST DISTRICT**

*BY*  
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## DEDICATION

This Study is dedicated to My wife, **Georgina Opere** and my children; **William Opere**,

**Angela Opere** and **Michael Opere**, for their inspiration towards this research work.



## DECLARATION

I hereby declare that this dissertation is an original work produced by me from research undertaken under supervision.



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**LIST OF ABBREVIATIONS**

1	WHO	World Health Organisation
2	MOH	Ministry of Health
3	MCH/FP	Maternal and Child Health/Family Planning
4	WIFA	Women in Fertility Age
5	TBA	Traditional Birth Attendant
6	OAU	Organisation of African Unity
7	UN	United Nations
8	DHMT	District Health Management Team
9	ANC	Antenatal Care
10	PNC	Postnatal Care
11	FGD	Focus Group Discussion
12	PHC	Primary Health Care
13	GDHS	Ghana Demographic Health Services
14	UNICEF	United Nations Children Fund
15	DDHS	District Director of Health Services

### ABSTRACT

The study assessed women's knowledge and attitude towards ANC and PHC in the Sekyere West District. The coverage of ANC has been persistently higher than PNC. Even though the DHMT was aware of the difference, they had no knowledge about the underlying factors. The information was needed by the DHMT, to help improve Information based planning.

The main objective was to find out women's knowledge and attitude towards ANC and PNC as well as any constraints the women might face in the use of PNC services. The study area is the Sekyere West District; study type was descriptive cross sectional in character. Multistage sampling was used to select the respondent consisting of women who had their deliveries within the last five years. Structured questionnaires and focus group discussions were used in data collection. Data collected were processed and analysed partly manually and partly by using the Epi info software.

The main finding were:

1. Most of the women (about 98%) were married and a greater majority of them were Christians with low educational level.
2. They had a fair knowledge about ANC and PNC. About 83% of the respondents knew the correct meaning of ANC and about 52% knew the correct meaning of PNC. The respondents had fair knowledge about the benefits and delivery points for both ANC and PNC.
3. About two thirds of the respondents have the opinion that a women should attend ANC more than five times and with PNC, 37.6% of the

respondents said a woman should attend more than four times. Most of the respondents (61.6%) think that if a woman does not attend PNC or ANC, the baby and/or mother may die.

4. The study revealed that, cost of PNC services and distance to health facilities for PNC services are not constraints in acquiring PNC services. However, the major constraints were the requirements for attendance at PNC e.g. dresses, new baby dress, new shoe. Gossiping and laziness on the part of the mothers were also contributing factors. The thought that they would be charged; children's tendency to get sick after immunisation, competition among mothers; having no time and single parenting were other constraints which prevent women from using available PNC services.
5. Poverty ranks first as a constraint for mothers not attending PNC. A more careful look at the results show that, poverty in this context is defined as inability to acquire the items the women consider as requirements for attendance at PNC.

Based on the findings from the study, the following recommendations have been made to the DHMT;

1. There should be health education messages to inform women that PNC attendance is not a fashion arena and as such one can attend in any dress or cloth. Furthermore PNC services could be offered at outreach points so that women could use their housedresses.
2. Mothers should be told that, the little fever that may follow

immunization is short-lived but the protection is of great benefit to the child.

3. Most of the women are Christians, as such a lot of health education messages could be delivered through the churches.
4. There is the need to intensify health education messages to let mothers know that ANC services are free.
5. The mothers should be taught about time management, so that amidst their perceived tight work schedule they could find time to attend PNC.
6. Husbands should be involved and invited to attend health education sessions because most of the respondents are married and the husbands have influence on their decisions.

## **CHAPTER ONE**

### **1.0 INTRODUCTION**

#### **1.1 BACKGROUND INFORMATION**

Women constitute an important asset crucially for the socio-economic development of the nation and hence need to ensure their continuous well being. More than 20 percent of the population in developing countries are women in their reproductive years (1).

The knowledge acquired at antenatal and postnatal services helps to reduce deaths and complications during and after pregnancy. Maternal mortality is the health indicator, which shows the greatest differential between developing and industrialized countries. The life time risk of death as a result of pregnancy or childbirth is estimated at one in twenty-three for women in Africa, compared to about one in 10,000 for women in Northern Europe (2). The Safe Motherhood Initiative which was launched at an international meeting in Nairobi, Kenya in 1987, brought attention to the fact that every year an estimated 585,000 women, more than one each minute, die of pregnancy- related causes. The vast majority occurs in the developing countries (3). Ghana has maternal mortality ratio 214/100,000 live births (4). Complications of pregnancy, childbirth and unsafe abortions are a major cause of death for women of reproductive age in Ghana. The major causes of maternal deaths include infection, haemorrhage, hypertensive disorders of pregnancy, obstructed labour and complications (5). All Maternal and Child Health/Family Planning (MCH/FP) facilities provide antenatal services, the aim of which is to promote the health of pregnant woman

and the birth of a healthy child. The service is comprised of the following activities:

- Physical and laboratory examination to monitor fetal growth and detect risk of pregnancy.
- Health education in nutrition, breastfeeding and family planning including AIDs/STDs.
- Tetanol toxiod immunization (6).

Antenatal Care (ANC)-care during pregnancy provides an important opportunity for discussion between a pregnant woman and a health care provider about healthy behaviour during pregnancy, about recognizing complications that may arise during pregnancy, and about delivery plan that will meet the needs of the individual woman. Antenatal care is also important in the provision of iron/folic acid tablets to prevent and treat anaemia (7). Postnatal care (PNC) refers to care given to mothers and their babies from the end of delivery through to six weeks after delivery. It is therefore, rather unacceptable that ANC coverage should be much higher than PNC coverage in Ghana (MOH, 1993).

**Table 1.1: National Maternal Health Service Coverage 1987-1993.**

TYPE OF SERVICE DELIVERY	YEAR/PERCENTAGE (%) COVERAGE						
	1987	1988	1989	1990	1991	1992	1993
Antenatal coverage	56	65	85	85	91	90	87
Supervised delivery coverage	18	19	27	27	29	30	40.6
Post natal coverage	6	9	13	13	14	17	29

Source: MCH/FP Ghana, MOH 1993.

With reference to table 1.1, the antenatal care coverage range between 56 and 91% whilst postnatal care coverage ranges between 6% and 29%. It is explicit that there is a gap between ANC coverage and that of the PNC. The situation is no different from that at Sekyere West District (Table 1.2.) The National ANC coverage for 1997 and 1998 are 85.2% and 87.5% respectively and those for PNC for the same period are 34.3% and 37.7% (8).

**Table 1.2: Maternal Health Service Coverage in Sekyere West District**

TYPE OF SERVICE DELIVERY	YEAR/PERCENTAGE (%) COVERAGE	
	1997	1998
ANC	75.3	96.2
Supervised Delivery Care	40.2	47.3
PNC	28.0	38.2

Source: Sekyere West DHMT Annual Report 1998.

The difference between ANC and PNC coverage could be the result of factors such as lack of relevant knowledge, negative attitudes of mothers, socio-cultural factors, geographical inaccessibility and others. However, the gap between the ANC coverage could be reduced if attempts are made to assess women's knowledge and attitudes to ANC and PNC in the Sekyere West District, and this information used to improve these services.

## 1.2 STUDY AREA

### 1.2.1 Location of the District.

Sekyere West district has Mampong as the capital. It is located in the Ashanti Region. It is about 57.5 kilometers from Kumasi. The land area is about 2346 sq.km, which constitute about 5.2% of Ashanti Region's land area.

### 1.2.2 Boundaries

The district is bordered on the south by Afigya Sekyere East District and North West by Ejura Sekeredumasi district. The inhabitants are mostly Ashanti. The northern part of the district is in the Afram Plains. The area predominantly inhabited by migrant farmers is sparsely populated, with about 20% of the district population, but covering about 50% of the district land area. The major towns in the District apart from Mampong are; Asaam Kofiase, Benim, Krobo-Dadiase, Kwamang, Ninting, all are located in the southern part of the district. The northern portion to the district also has the following towns; Birem, Oku Junction and Asubuaso. These lie in the Afram Plains portion of the district. Mampong, which is the district capital, is centrally placed and easily accessible by road from almost all the major towns. Part of the Afram Plains is however inaccessible most of the time, especially during the rainy season.

### 1.2.3 Topography

The district is partly on a scarp, which runs from south to westwards. The greater part is generally low lying with a few hilly areas, stretching north eastwards into the Afram Plains. Major rivers include the Afram and Offin rivers.

### 1.2.4 Climate and Vegetation

The area experiences both wet and dry seasons. It has a mild climate with a mean annual rainfall of 81.1 cm. The wet season starts from late February and stretches to September, after which comes the dry season, which begins late October and

ends in January. It has semi-deciduous savanna vegetation, which permits the growth of all kinds of crops example cassava, cocoyam and yam.

#### 1.2.5 Economic Activities

Farming is the major occupation, however there are a few people engaged in white colour jobs such as banking, teaching and nursing.

#### 1.2.6 Demography

The district has a population of 180,615 projected from the 1984 census.

the breakdown of the population is as follows:

0-11 months	4%	=	7,224
1-23 months	4%	=	7,224
24-60 months	12%	=	21,673
5-14 years	27%	=	48,766
15-49 years (men)	20%	=	36,123
15-49 years (women)	20%	=	36,123
50-60 years	8%	=	14,449
60 + years	5%	=	9,030

#### 1.2.7 The Health Care System and Facilities

##### 1.2.7.1 Health Facilities

The district has one district hospital located in Mampong and six health centres at Asaam, Kofiase, Kwamang, Krobo, Nsuta and Benim. There are two private maternity homes situated at Beposo and Birem. There are also 5 static MCH/FP points and 6 sub- districts. There are 6 sub-districts and about 122 communities and 60 hamlets in the district. The total number of outreach points is 91, all offering public health services

#### 1.2.7.2. Antenatal, Supervised Delivery and Postnatal Services

Antenatal services are offered by all the health centres, on days that suit each Health centres. Pregnant women are examined and progress of the pregnancies monitored. Health education talks are given before the clinics and Tetanol toxiod is given to those who are due. There are two private midwives in the district namely, Philipa and Nyame Adom Maternity Homes, who cater for a large number of antenatal mothers. The Mampong District Hospital is thus the referral point for all the health centres and maternity homes.

Supervised deliveries are carried out in all the health centres, which have maternity wings. Some 60 Traditional Birth Attendants (TBAs) have been trained to provide good ANC and delivery services to their clients. The total number of deliveries carried out in 1998 was 3315.

Postnatal care services are given in all health centres. New babies are examined and polio at birth and BCG vaccines are given together with health education talks. The total number of mothers who attended postnatal clinics in 1998 was 2679.

### 1.3 **STATEMENT OF THE PROBLEM**

Safe Motherhood is made up of a series of charts that outline key issues or problems focusing specifically on the antenatal period, labour, delivery postnatal, family planning and abortion. According to the Sekyere West 1998 Annual Report the coverage of postnatal care is lower than antenatal care with a consistent gap between these two components of maternal care, over the years.

Some studies have identified several factors which contributed to this problem of low coverage of PNC but the broad-based nature of these studies made their findings too general and hence not representative enough to account for all that pertains in all communities within the country. Even though the DHMT was aware of this unexplained gap between high antenatal care coverage and that of postnatal care they had no knowledge of the underlying factors in order to fashion out appropriate strategy in the district.

#### 1.4 RATIONALE OF THE STUDY

In the Sekyere West District supervised delivery and postnatal care services are located at the same antenatal care service points. Furthermore, midwives and other personnel providing antenatal care services also provide postnatal care services.

Health Education on antenatal care is packaged with postnatal care messages. Resource distribution for ANC match that for PNC. Nevertheless, coverage for PNC is much lower as compared to ANC coverage . Health personnel/workers in the Sekyere West District complain of the low PNC coverage and are of the feeling that there may be some community related factors that might explain this low coverage. The findings obtained by this study will be used by the DHMT to fashion out appropriate strategies to help improve the coverage.

#### 1.5 OPERATIONAL DEFINITIONS

**Supervised Delivery:** Deliveries handled by trained service providers  
(Trained Traditional Birth Attendants, Midwives,

Nurses, and Doctors both in the public and private sectors).

**Coverage:** The proportion of pregnant women of the expected number of pregnancies in a year that made use of any of these maternal health services (Antenatal Care, Supervised Delivery, Postnatal Care).

**Antenatal Care:** Care given to the pregnant woman and the fetus, up to the onset of labour.

**Post-natal Care:** Care given to mothers and their babies from the end of delivery through to six weeks after delivery.

**Knowledge:** Understanding information about a subject which has been obtained by experience or study, and which is either in a person's mind or possessed by people generally.

**Attitude:** Feeling of opinion about something or someone or a way of behaviour that follows from this and is used for a person's judgement of behaviour as good or bad.

## 1.6 OBJECTIVES

### 1.6.1 Main Objective

To find out women's knowledge and attitude towards ANC and PNC as well as any constraints they face in their use of PNC services and make recommendations to the DHMT.

### 1.6.2 Specific Objectives

- To find out about women's knowledge of ANC
- To find out about women's knowledge of PNC
- To find out about women's attitudes toward ANC
- To find out about women's attitudes toward PNC
- To find out about women's constraints in using PNC services.
- To make recommendations for improvement of PNC coverage.

## **CHAPTER TWO**

### **2.0 LITERATURE REVIEW**

#### **2.1 ANTENATAL CARE**

The rationale for antenatal care is essentially that of screening a predominantly healthy population of pregnant women to detect early signs of, or risk factors for disease, followed by timely intervention (9).

Antenatal care is the health care and education given during pregnancy, and is an important part of preventive and promotive health care. The knowledge the pregnant women acquire helps improve their living conditions. In Ethiopia, Kwast and others found that the maternal mortality rate for women who received antenatal care was 2.5/1000 as compared with 10.6/1000 for those who had none (10). The Ghana Statistics Service study in 1994 showed per 100,000 live births maternal mortality of 207 and 287 respectively for women who received antenatal care and those who did not (11).

The Primigravida's (a woman pregnant for the first time) experience of childbirth is influenced by the knowledge and expectations she has of childbirth. Her expectations of childbirth are based on the information she gets from the antenatal clinic, the nursing staff and her mother, friends and family (12).

During a health education study on pregnant women carried out in South Africa, a disturbing finding was that mothers had very little knowledge about the danger signs that may occur during pregnancy. They did not know the reasons for the examination and tests performed during pregnancy (13). In a study done to assess women's knowledge and expectations of childbirth in primigravida's, it

became clear that the respondents had insufficient knowledge of childbirth and the handling of pain during childbirth. This insufficient knowledge can mainly be attributed to the poor attendance of antenatal preparation classes, inadequate professional counseling and the mother of the primigravida as the primary source of information on childbirth (14).

A WHO technical group has recommended a minimum of four antenatal visits for a woman with normal pregnancy. However, some women require more than four visits especially those who develop complication (15). The estimates show that in the developing world, only two in three women receive any antenatal care, less than fifty five percent of the deliveries are attended by skilled personnel and just 40% take place in health institutions. Thus, currently more than 45 million pregnant women, annually, do not receive antenatal care. Some 75 million births still take place at home and almost 60 million without a skilled attendant present. South Central Asia, Western and Eastern African contribute heavily to these numbers, accounting for 49% of the world's births and also showing the lowest coverage of care during pregnancy and delivery. Nearly all maternal deaths occur in developing countries and among the most disadvantaged population groups. Greater coverage of care during pregnancy, delivery and the postpartum periods will help reduce deaths and disability of mothers and infants (16).

In Ghana, the proportion of expected pregnant women who received ANC was 81.2% in 1995 and 84.4% in 1996. Regional variations revealed the highest coverage as 97.4% by Central Regional and the lowest of 67% by Upper East Region (17).

### 2.1.1 Objective of ANC

Globally, ANC aims to:

- (i) promote and maintain the physical, mental and social health of mother and baby by providing education on nutrition, family planning, immunization, STD prevention HIV/AIDS, the danger signs of pregnancy, rest/sleep and personal hygiene.
- (ii) detect and treat high risk conditions arising during pregnancy whether surgical medical or obstetric.
- (iii) Ensure delivery of full term baby with minimal stress or injury to mother and baby.
- (iv) Help prepare the mother to breastfeed successfully, experience normal puerperium and take good care of child physical, psychologically and socially (18).

### 2.1.2 Strategies, Activities and Providers of ANC

The strategies of ANC are clinic-based services, community-based services and outreach services. The activities of ANC include monitoring of normal pregnancy, identification of high-risk pregnancy, management of high-risk pregnancy and complications, referral, immunization and health nutrition education. The providers of antenatal care are TBAs, nurses, midwives, physicians and obstetricians at antenatal care service delivery points at each level. The levels are; community, subdistrict, district, regional and national (19).

## 2.2 POSTNATAL CARE

Postnatal care refers to care given to mothers and their babies from the end of delivery through to six weeks after delivery.

Most mothers know the importance of PNC but refuse to attend. A study in Bangladesh found out that 79% of mothers felt that postnatal care is needed, yet only 26% attended the clinic (20). In Ghana, the PNC coverage for 1996 was 32.9%. Regional variations revealed 45% as the highest proportion recorded by Greater Accra and 19.1% as the lowest proportion by Volta Region respectively (21). In 1997, the postnatal coverage nationwide, was 34.3%. Regional variations revealed 49.4% as the highest proportion recorded by Greater Accra and 19.9% as the lowest proportion by Upper East Region respectively (22). In a study done to find out clients satisfaction with postnatal care, women who chose domiciliary care following early discharge, rated their postnatal care better than those women who stayed in the hospital (23).

#### 2.2.1 Objectives and Activities of Postnatal Care

- To promote and maintain physical and psychological well being of mother and baby.
- To perform comprehensive screening for the detection, treatment and/or referral of complications for both mother and baby.
- To provide health education on nutrition, family planning, breastfeeding and immunization of the baby.
- To provide family planning services at the different levels of Service delivery (24)

The activities carried out include, management of normal puerperium and normal baby, identification and management of complications of puerperium, management of referrals in puerperal stage, immunization of babies, breastfeeding promotion and family planning motivation, counseling and services for mothers during puerperium.

**2.2.2. Indicators Used for Risk Detection in Monitoring Postnatal Care include:**

1. Percentage of postnatal mothers making a minimum of one visit to service delivery points.
2. Percentage of postnatal mothers with no previous antenatal care.
3. Percentage of postnatal mothers accepting family planning.
4. Percentage of postnatal mothers who were supervised during the intrapartum (delivery) stage e.g. by trained health workers .

**2.2.2 Suggested Constraints in Using PNC Services**

It has been documented that factors contributing to the low PNC coverage could be attributed to attitude of providers. In Kenya, a study unravels the issue that a greater percentage of patients sought health care outside formal facilities because of the poor attitude of service providers (25). Furthermore, cultural attitude and practices may impede a woman's use of services that are available. Decisions about where to seek care are often made by the husband, mother-in-law, or other relations (26).

A number of discrete but inter-related variables appear to influence ANC and PNC coverage. Some are service-related: age, income, social status, family size, morbidity and religion (27).

In economic studies, low household income has often been identified as a barrier to the use of PNC services even when these are publicly provided. However, even economically oriented studies have frequently acknowledged the related issue of physical accessibility. Distance to a facility has been cited as a major variable influencing utilization of health care in Iraq and many other settings (28).

Researchers of Safe Motherhood have also identified that certain cultural attitudes and practices, like perceptions of women's role, block the ability of women to get care for themselves, hence impeding their use of available service (29).

An aspect, which influences public experience with the health care delivery system that has been studied is "waiting time". Long waiting time been identified as a factor that limits acceptability and coverage of health services. There is however, little empirical evidence on the actual time spent in health institutions by the public in developing countries. In a study on "waiting time", Bamisaiye et al. found that community perception of waiting time is greater than that expected and staff perception of the time spent in the clinic was considerably less than the actual waiting time (30). In Ghana the 1997 MCH/FP report attributed some of the constraints to the utilization of PNC services as:

- (i) Low priority given to postnatal services by Sub-District Health Teams contributing to discontinuity of care.
- (ii) Inadequate information to mothers on the importance of this service.
- (iii) Postnatal care services are not offered on a daily basis at all static and outreach sites.

- (iv) Some socio-cultural and economic factors militate against this service e.g. period of postpartum confinement, transport cost (31).

### 2.3 SOCIO-ECONOMIC VALUE OF WOMEN

Women play an important role in social and economic development of their countries as members of the workforce and as the backbone of households. It has been documented that one-fourth of male-headed households rely on female earnings for more than half of a total income (32). Women in most developing nations gather firewood, for cooking, fetch water, and clean the house, thus making tremendous contribution to household maintenance. In Africa, women grow most of the agricultural produce and as much as 80 percent of the food (33). Women play critical roles in society – reproduction and nurturing of future generations, household and community and political reasons for all to ensure that their (women's) rights including health are respected (34). It has been documented that if women's unpaid domestic labour were to be paid for, the gross national product of most developing countries would increase by one-third, a substantial financial gain (35).

The impact of investing in women can be more productive than investing in men. They tend to bear more responsibility and use more of their acquired resources to benefit their family (36). There is, therefore, the need to prevent morbidity and mortality among women. The WHO is seeking to stimulate a process whereby policies, research and programmes for women's reproductive health will become responsive to the perceptions and needs of women. This implies more than mere recognition of the importance of women's perspectives, but means using that knowledge to alter the focus of research or to change the way services are

provided. The assessment of women's knowledge, and attitude to ANC and PNC is one such effort to make recommendations to the safe motherhood health education programme.

### **CHAPTER THREE**

#### **3.0 METHODOLOGY**

To accomplish the objectives of this research, the methodology consisted of the collection and collation of relevant data using scientific techniques, procedures and tools. These methods and procedures are described in the following sections.

#### **3.1 STUDY DESIGN**

This was a cross sectional descriptive study.

#### **3.2 STUDY POPULATION**

The study population was women in the reproductive age group who had children below five years, in the Sekyere West District.

#### **3.3 SAMPLE SIZE**

Using a district population (women in reproductive age group) of 36,123 with a confidence level of 95% and postnatal coverage of 38.2% and a worst acceptable percentage of 32.18%, the Epi Info software gave a sample size of 249, but for convenience, this was rounded up to 250.

#### **3.4 SAMPLING PROCEDURE**

A multistage sampling procedure was used to select the study units. The whole district has been divided into the existing six health sub-districts namely: Mampong, Nsuta, Oku, Asubuaso, Birem and Kwamang. Three sub-districts were randomly sampled from the six sub-districts. Proportionate samples were selected from these sub districts based on their WIFA population (Table 3.1). In each sub district all the communities were counted and labeled. The communities were randomly selected and arranged in

an order such that the first randomly selected community was given number one. The second randomly selected community was given number two. This continued until all the communities in that sub district were selected and numbered. Starting from the first randomly selected community, all women who met the age and parity criteria in the target group were interviewed. This continued until the required target number for that sub district was reached. If the community boundary was reached and the number selected was not up to the required, then the second randomly selected community was entered until the required sample size was attained.

**Table 3.1: Selected Sub-District with their Corresponding Sample Sizes**

Subdistrict	Population	No. of Communities	WIFA Population	Sample Size
Kwamang	254,442	15	5088	58
Nsuta	34,346	31	6869	79
Mampong	49500	52	9900	113
<b>Total</b>	<b>109,288</b>	<b>98</b>	<b>21857</b>	<b>250</b>

### 3.5 INDEPENDENT VARIABLES

The independent variables used were age, religion, educational level, occupation, and marital status.

### 3.6 DEPENDENT VARIABLES

The dependent variables used were:

- Women's knowledge for ANC

- Women's attitude to ANC
- Constraints in using PNC services
- Women's knowledge for PNC
- Women's attitude to PNC

### 3.7 DATA COLLECTION TECHNIQUES AND PROCEDURES

The techniques used to collect data were interview by the use of a structured questionnaire containing both closed and open-ended questions and focus group discussion assisted with a guide. The focus group discussions were used to explore the underlying factors for low PNC coverage. Three focus group discussions were conducted. The findings were transcribed using the notes and the recordings made. Analysis was done manually.

Three field assistants who could speak the local language were recruited to help the data collection. They were trained for two days. The two days involved one-day theory and the second day for practical training on the field. For the theoretical training the three interviewers were introduced to the topic, its objectives rationale and data collection techniques. Explanation was provided on community entry, how to introduce themselves to the interviewees, how to ask for consent and how to close the interview. The interviewers were taught basic interview techniques such as questions in a natural, flexible, relaxed manner, how to recognize agreements, disappointments, or surprises and how to translate these into Akan language without losing its meaning.

### 3.8 PRACTICAL TRAINING

This involved the field-testing of the questionnaire in the communities. The field-testing was used to answer the questions as to how many questionnaires, an interviewer can complete in a day, and also the workload. Furthermore, there was a role –play in which a trainee assumed the role of the interviewer and another played the part of the interviewee. Others observed and critiqued.

### 3.9 DATA QUALITY

To ensure completeness, reliability, and validity, the principal investigator checked all the data collected on three different occasions.

### 3.10 CLEARANCE FROM LOCAL AUTHORITIES

Since the research was undertaken in communities, permission and clearance were sought from chiefs, opinion leaders, assemblymen etc. before entering the community, some background information was sought, in cases where there are some chieftancy disputes.

### 3.11 DATA PROCESSING AND ANALYSIS

To ensure good and accurate data processing and analysis, the entire questionnaires were numbered and responses coded. Computer programmes and manual checking using data master sheet were used in the analysis.

### 3.12 **ETHICAL CONSIDERATION**

Ethical issues were not overlooked in the planning and implementations of the research work. Selected respondents were only interviewed after gaining their permission, and confidentiality was ensured. There were no names on the questionnaires.

### 3.13 **LIMITATIONS OF THE STUDY**

Recall bias was a limitation. Some could not recall some events, which happened 5 years ago. Furthermore, the element of respondent bias cannot be claimed to have been ruled out completely. However, because of the assurance from interviewers about the confidentiality of the data, and the intended use of the findings to improve health services in the entire district, it is hoped that responses were genuine.

## CHAPTER FOUR

### 4.0 RESULTS

The results of both questionnaire and focus group discussions are presented below:

#### 4.1 Social and Demographic Characteristics

Table 4.1 SOCIO- DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS OF RESPONDENTS

Characteristic	Frequency	Percentage
<b><u>Age(years)</u></b>		
Under 20	20	8.0
20-35	178	71.2
Above 35	52	20.8
<b><u>Occupation</u></b>		
Farmers	101	40.4
Traders	101	40.4
Civil Servants	4	1.6
Hairdressers	12	4.8
Others	4	1.6
Unemployed	28	11.2
<b><u>Religion</u></b>		
Christians	213	85.2
Moslems	12	4.8
Traditionalist	5	2.0
No religion	20	8.0
<b><u>Education</u></b>		
Primary	48	19.2
Middle	134	53.6
Post secondary	17	6.8
No education	5	2.0
	46	18.4
<b><u>Marital status</u></b>		
Married	243	97.2
Not Married	7	2.8

Table 4.1 shows that most of the respondents (71.2%) were between 20-35 years of age, 20.8% were above 35 years and only 8.0% were below 20 years. The

respondents were predominantly farmers (80.8%), with quite a few of them being unemployed.

Some 85.2% were Christians. Most of the respondents had been to school but majority of them, (53.6%) attended middle school. When the respondents were asked about their marital status it was found out that 97.2% of them were married.

#### 4.2 WOMENS KNOWLEDGE ABOUT ANTENATAL CARE

Of the 250 respondents 207 (82.8%) knew the correct meaning of antenatal care.

This is encouraging because most of the respondents had been to school and 96.4% attended ANC the last time they were pregnant.

When the respondents were asked about the benefits of antenatal care, the following responses given are presented in Table 4.2.

Table 4.2: KNOWLEDGE ON THE BENEFITS FOR ATTENDING ANC

Benefits of Antenatal	Frequency of Responses* N-250	Percentage
Maintaining of normal pregnancy	169	27.8
Identification of high -risk pregnancy	180	29.7
Giving immunization	146	24.1
Health nutrition	107	17.6
No response	2	0.3
Other	3	0.5
<b>Total</b>	<b>607</b>	<b>100</b>

\* Multiple responses, hence 607

Table 4.3: KNOWLEDGE OF ANC DELIVERY POINTS

Service Point	Frequency of responses* N=250	Percentages
Hospital	178	58.9
Health Center	33	10.9
Clinic	61	20.3
Maternity Home	30	9.9
<b>Total</b>	<b>302</b>	<b>100</b>

\*Multiple responses, hence 302.

An appreciable number (99.2%) knew some of the benefits of attending ANC (Table 4.2). Out of the 250 respondents, 53.2% gave three responses, which were considered acceptable. Regarding ANC service points, 58.9% mentioned Hospital, and 20% said clinic, with a few mentioning maternity home. During a focus group discussion, the participants also mentioned hospital, health center, maternity home and TBA as service points for ANC. This implies that, the women had a fair knowledge about where to attend ANC services.

Table 4.4: KNOWLEDGE OF SERVICES PROVIDED AT ANC

Services	Frequency of responses* N=250	Percentage
Measure the heart beat of the baby	101	17.0
Measures the blood pressure of the mother	173	29.1
Measures the position of the baby	158	26.5
Checks the stool, urine of mother	94	15.8
Checks the stomach of the mother	65	10.9
No response	4	0.7
<b>Total</b>	<b>595</b>	<b>100</b>

\* Multiple response, hence 595.

From the study, 29.1% of the respondents knew measuring of a mother's blood pressure as a service at the antenatal care service point. Only 10.9% knew that

there is stomach examination of the mother. Out of the 250 respondents, 61.6% gave more than three responses, which were considered acceptable.

Table 4.5: KNOWLEDGE OF COST OF ANC SERVICES

<b>COST</b>	<b>Frequency of responses</b>	<b>Percentage</b>
Free	36	14.4
Between 2 to 5 thousand cedis	166	66.4
Between 5 to 10 thousand cedis	23	9.2
More than 10 thousand cedis	5	2.0
No response	8	3.2
I don't know	12	4.8
<b>Total</b>	<b>250</b>	<b>100</b>

The respondents gave various figures as the cost of antenatal services. Most of the respondents (66.4%) mentioned between two and five thousand cedis. Only 14.4% knew that ANC services were free. Some of them (4.8%) did not know the cost of ANC services (Table 4.5).

#### 4.3 WOMEN'S ATTITUDE TO ANC

From the study, 98% of the respondents were of the opinion that a woman should receive antenatal care when pregnant. A greater number of them (68.8%) were of the opinion that a pregnant woman should attend ANC more than 5 times. Only 27.2% of the women thought a pregnant woman should attend ANC five times or less often (Table 4.6)

Table 4.6: OPINION ON FREQUENCY OF ATTENDANCE AT ANC

No. of Times	Frequency of responses	Percentage
One	7	2.8
Two	7	2.8
Three	16	6.4
Four	15	6.0
Five	23	9.2
More than five	172	68.8
No response	5	2.0
I don't know	5	2.0
<b>Total</b>	<b>250</b>	<b>100</b>

Table 4.7: ATTITUDE ON WHERE A WOMAN SHOULD ATTEND ANC.

Facility	Frequency response * N=250	Percentage
Hospital	65	15.8
Health Center	190	46.4
Maternity Home	146	35.6
TBA	4	1.0
Untrained TBA	0	0.0
Other	5	1.2
<b>Total</b>	<b>410</b>	<b>100</b>

\* Multiple responses, hence 410

Table 4.8: OPINION ON RISKS ASSOCIATED WITH ATTENDING ANC.

Risk Factors	Frequency of responses* N=250	Percentage
Death of mother	147	32.7
Death of baby	167	37.2
Cord prolapsed	62	13.8
Retained placenta	55	12.3
Others	18	4.0
<b>Total</b>	<b>449</b>	<b>100</b>

\*Multiple responses, hence 449.

From Tables 4.7 and 4.8, about 47% of the respondents were of the opinion that pregnant women should attend ANC at a health center, and quite a number believed death of the baby was an associated risk for not attending ANC, followed by the death of the mother. Those who thought otherwise mentioned haemorrhage, malpresentation and the fact that the mother could be sick, as some of the associated risks for not attending ANC.

#### 4.4 WOMEN'S KNOWLEDGE OF PNC

Of the 250 respondents, 50.4% attended PNC, the last time they delivered and when asked about the meaning of postnatal care, 51.2% gave acceptable responses.

Table 4.9: KNOWLEDGE OF THE BENEFITS FOR ATTENDING PNC

Benefits	Frequency of responses*	Percentage
Immunization of baby	189	39.1
Advise the mother on how to breastfeed baby	142	29.4
Checks any complication after delivery	108	22.4
Advise the mother on family planning	42	8.7
I don't know	2	0.4
<b>Total</b>	<b>483</b>	<b>100</b>

\*Multiple responses, hence, 483.

From Table 4.9, majority of the respondents (99.6%) knew at least one benefit of PNC.

Very few (8.7%) could mention that mothers are given advice on family planning. A greater majority (65%) could mention more than three benefits of PNC, which were considered acceptable. Only 0.4% do not know anything about the benefits of PNC.

During a focus group discussion on the issue of the benefits of PNC, majority of the participants said PNC is beneficial because the providers check the health of the baby,

“inject the baby against diseases,” and physically examine the mother. The impression created by the participants indicated that woman generally knew PNC services are beneficial.

Table 4.10: KNOWLEDGE OF PNC DELIVERY POINTS.

Delivery point	Frequency of responses* N=250	Percentage
Hospital	22	7.1
Health Center	181	58.4
Clinic	25	8.1
Maternity Home	73	23.5
TBA	9	2.9
<b>Total</b>	<b>310</b>	<b>100</b>

\*Multiple responses, hence 310

From Table 4.10, most of the respondents knew health center as a delivery point for PNC and most of (57%) mentioned more than three delivery points which were considered acceptable.

Table 4.11: KNOWLEDGE ON COST OF PNC SERVICES.

Cost	Frequency	Percentage
Free	59	23.6
One thousand	64	25.6
Between one to two thousand cedis	56	22.4
Between two to five thousand cedis	26	10.4
Between five to ten thousand cedis	18	7.2
Other	15	6.0
No response	12	4.8
<b>Total</b>	<b>250</b>	<b>100</b>

From Table 4.11, some 23.6% of the respondents knew that PNC services were free but a greater majority (65.6%) knew that an amount was collected. From the



interview, 81.2% of the respondents knew some of the procedures carried out at PNC.

In a focus group discussion, mothers were asked what they knew to be the cost of PNC services. One participant said, “The charges is not much, only paracetamol is charged”.

#### 4.5 WOMEN’S ATTITUDE TOWARDS PNC

From the study, 95.8% of the women had the opinion that a woman should attend PNC after delivery and 37.6% of the respondents thought a woman should attend PNC more than 4 times (Table 4.12). Moreover, most of the respondents (62.4%) thought a pregnant woman should attend PNC four times or less.

Table 4.12 OPINION ON FREQUENCY OF ATTENDANCE AT PNC

No. of Times	Frequency	Percentage
One	55	22.0
Two	25	10.0
Three	26	10.4
Four	34	13.6
More than four	94	37.6
Other	12	4.8
No response	4	1.6
<b>Total</b>	<b>250</b>	<b>100</b>

Table 4.13 PERCEIVED RISK FOR NOT ATTENDING PNC

Perceived Risk	Frequency of responses* N=250	Percentage
Bleeding from cord	86	18.9
Death of mother	135	29.6
Death of baby	146	32.0
Bad breastfeeding habits	69	15.1
Other	20	4.4
<b>Total</b>	<b>456</b>	<b>100</b>

\*Multiple responses, hence 456.

#### 4.6 CONSTRAINTS FOR POSTNATAL CARE

Table 4.14. OPINION ON COST AS A CONSTRAINT TO PNC SERVICES  
BY RESPONDENTS.

Risk Factors	Frequency	Percentage
Very high	19	7.6
High	24	9.6
Just enough	133	53.2
Cheap	37	14.8
Free	30	12.0
Others	3	1.2
No response	4	1.6
<b>Total</b>	<b>250</b>	<b>100</b>

Table 4.14 presents responses obtained from women, when asked the question, what do they think of the charges for PNC? From the Table, 53.2% of the respondents said PNC charge was just enough and 7.6% said it was very high. When the respondents were asked about affordability, 5.4% said they were not able to pay for the services the last time they used the service.

Table 4.15: AVAILABILITY OF HEALTH FACILITIES FOR USE BY  
RESPONDENTS.

Risk Factors	Frequency of responses* N=250	Percentage
Hospital	57	19.8
Health center	224	77.8
Health post	3	1.0
Clinic	4	1.4
<b>Total</b>	<b>288</b>	<b>100</b>

\*Multiple responses, hence 288.

Most of the respondents (77.8%) said they have a health center facility available for their use (Table 4.15). However, 14% of the respondents stayed very far from

the facility and 2.8% get to the facility by vehicle. For about 1.0% of the respondents, they spent more than two hours getting to the facility whilst 89.6% got to the facility in less than 30 minutes (Table 4.16). Most of the respondents (97.2%) got to the facility by foot. In a focus group discussion, the participants were of the opinion that the facilities are not far and they got there by walking. They even said at times the nurses came to their community to attend to them. One participant even said “at times they (the service providers) even have to wait for them”

Table 4.8: TIME TAKEN TO GET TO THE FACILITY.

Time	Frequency	Percentage
Less than 30 minutes	224	89.6
Between 30 minutes and 1 hour	20	8.0
One to two hours	4	1.6
More than two hours	2	0.8
<b>Total</b>	<b>250</b>	<b>100</b>

From the study, 95.6% of the respondents assessed the attendants care to be nice with only 11 respondents (4.4%) saying service providers were not friendly. As indicated in Table 4.17, 40.8% of the respondents assessed the skills of the attendant to be very good. The same impression was obtained from the focus group discussion, when the greater majority of the participants considered providers of PNC services as very good.

Table 4.17 PERCEPTION OF SERVICE PROVIDERS SKILL TO CARRY OUT PNC BY RESPONDENTS.

Skills	Frequency	Percentage
Excellent	50	20.0
Very good	102	40.8
Fair	95	38.0
Bad	3	1.2
<b>Total</b>	<b>250</b>	<b>100</b>

Table 4.18: ITEMS REQUIRED BY MOTHERS TO ENABLE THEM ATTEND PNC SERVICES.

Requirements	Frequency of responses* N=250	Percentage
New cloth	193	24.8
A new footwear	172	22.1
A new bag	188	24.2
A new baby dress	180	23.2
Others	44	5.7
<b>Total</b>	<b>777</b>	<b>100</b>

\*Multiple responses, hence 777.

In order of importance, new dress, new footwear, new bag and new baby's dress were given as the requirements for attending PNC (Table 4.18) and 40% of respondents could not attend PNC because of these requirements.

During a focus group discussion the respondents also unanimously acknowledged that the requirements for PNC are, a new bag, a new cloth, new hair style, money and a new baby's dress. A fair proportion of the respondents (36.8%) owned up that they could not afford PNC services the last time they had to attend. Various reasons were given. From the interview most of the respondents (60%) could not afford the service because of poverty and 23.3% said because they were not gainfully employed.

Various reasons were given for not being able to attend PNC, including poverty, no support from husband and because of gossiping. On the other hand, 65.1% of the respondents agreed that their husbands supported them financially, or encouraged them to attend PNC. Only one respondent said the husband discouraged her (Table 4.19).

Table 4.19 HUSBAND'S SUPPORT AND PNC ATTENDING.

Support	Frequency of responses* N=250	Percentage
No support	20	7.7
Support financially	170	65.1
Discourages me	1	0.4
Encourages me	70	26.8
<b>Total</b>	<b>261</b>	<b>100</b>

\* Multiple responses, hence 261.

Table 4.20 REASONS FOR NOT ATTENDING PNC.

Reasons	Frequency of responses*	Percentage
Poverty	150	18.9
Competition	54	6.8
Shyness	30	3.8
Laziness	95	11.9
"Child not sick"	40	5.1
"Child will be sick"	70	8.8
"Thinks I will be charged"	50	6.3
Gossiping	104	13.1
Have no time	50	6.3
Single parenting	20	2.5
"Will ask my husband's name"	15	1.9
No dressing	111	14.0
"Too frequent hospital"	3	0.4
<b>Total</b>	<b>792</b>	<b>100</b>

\* Multiple responses, hence 792.

Respondents gave a number of reasons for not attending PNC (Table 4.20). Majority of the women gave reasons such as poverty, no dressing, gossiping, laziness, "think will be charged", 'have no time' for not attending PNC.

During focus group discussions the mothers who did not attend PNC the last time they delivered also gave as reasons, "I had no money to buy new cloth, new baby dress and new shoe", "I thought I was going to be charged", "Some mothers and nurses

laugh at you if you are a teenager and you do not have husband,” “I was in school and did not want my friends to know”, “My husband did not support me”. Gossiping was mentioned by some of the mothers. Others said they did not know the importance of PNC coupled with the fact that they are traders and farmers and have no time.

The attitude of the service providers was mentioned as a deterrent for a lot mother. Quite a few of them said they did not understand why a baby should become sick after immunization. Others also said they wait for a long time at the facility before they are attended to. Few of the respondents said they do not have husbands so they feel shy when they are asked about their husband’s name. Impressions from their responses indicate that the main reasons why mothers did not attend PNC are health care related, social and economic. Poverty seems to be a factor, which prevents most mothers from attending PNC.

## CHAPTER FIVE

### **5.0. DISCUSSION, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 DISCUSSION**

##### **SOCIAL, DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS.**

From Table 4.1, most of the respondents (71.2%) were between 20 and 30 years and only 8% were below 20 years. This is in conformity with Ghana Demographic and Health Survey 1998 report where high proportions of the women are in the younger age group, with more than half of them under 30 years (37). This means that most of the respondents were within the best age bracket to have children.

Most of the respondents were farmers and traders (80.8%). The consequences of this are that they might be too busy to attend to health care services. Employment rate is high, 88.8 % of the respondents are employed, a situation which could contribute to affordability of health care in the district. It is interesting that 85% were Christians. This could be a useful information to the DHMT, since educational messages could be passed on through the churches. Most of the respondents have had some level of education with most of them (71.85%) having attended either primary or middle school while 18.4% were uneducated. This is not too different from figures from the Ghana Demographic and health Survey (1998) which gave 28.9% as women with no education (37). With this low level of education, most of them might not be gainfully employed in the civil service. A greater majority of the respondents were married. This is an added information to the DHMT because in times where educational

messages are given to the women, the husbands should be involved because the husband could have influence on their wives' decisions.

- **WOMEN'S KNOWLEDGE ABOUT ANTENATAL CARE**

Most of the respondents (82.8%) knew the correct meaning of antenatal care and also have fair knowledge about the services being rendered at the antenatal service point. Moreover, most of them attended ANC the last time they were pregnant. This is contrary to a study, which was done to assess women's knowledge and expectations of childbirth in South Africa. This study found that the women had insufficient knowledge about childbirth and this was attributed to poor attendance to antenatal service (14). Furthermore, during a health educational study in South Africa on pregnant women, a disturbing finding was that the women did not know the test performed during antenatal care (13). Most of the respondents knew the hospital as an antenatal delivery point. This is useful information, which the DHMT could use to send a lot of health information on antenatal care. Quite a few of the respondents 14.4% knew that antenatal care is free. This means the DHMT has to intensify its health education messages to let them know that it is free because according to MOH policy antenatal care services should be free for four visits.

- **WOMEN'S ATTITUDE TOWARDS ANC.**

From the study, most of the respondents, (98%), had the opinion that a pregnant woman should receive antenatal care. It is not surprising that the antenatal coverage in the district was very high that (96.2%) in 1998, according to the DHA Annual Report (1998). Most of the respondents (68.8%) have the opinion

that a pregnant woman should attend antenatal care more than five times, this is in line with the WHO recommendation of a minimum of four visits for a woman with normal pregnancy (15). In addition, about 70% of the respondents had the opinion that if a woman does not receive antenatal care the baby or the mother could die. This means the women fear death. As study conducted in Ethiopia by Kwast and others found that, the maternal mortality was high for women who did not attend antenatal care (10).

- **WOMEN'S KNOWLEDGE OF PNC.**

Most of the respondents (51.2%) knew the correct meaning of PNC. When asked about the benefits of PNC, the highest response 39.1% was immunization. This is a strength that the district could build on. It shows that the immunization programme is going on well in the district.

The respondents have a fair knowledge about the benefits of PNC but surprisingly only 50.4% did attend PNC the last time they delivered. This is in line with a study done in Bangladesh, to evaluate maternal and child services. In the study 79% of the women felt PNC was necessary but only 26% did attend (20).

When asked about the delivery points, most of the respondents, (97.1%), said the formal sector and 67% of the respondents gave more than three correct answers, which was considered acceptable. This means the respondents had adequate knowledge about where PNC services are delivered. Interestingly, although the TBA programme is going on in the country and the Government has invested a lot of money, only 2.9% of the respondents knew TBA as delivery point for PNC.

- **WOMEN'S ATTITUDE TOWARDS PNC**

Most of the respondents (96.8%) had the opinion that a woman should attend PNC but this did not reflect in the PNC coverage in the district. The PNC coverage was 38.2% according to the DHA annual report for 1998.

Most of the respondents, (61.6%) had the opinion that the perceived risk for not attending PNC is the death of the mother and baby. The respondents had the opinion that mothers should attend PNC services more than four times. This is in line with WHO recommendation of minimum of four visits (15).

- **CONSTRAINTS FOR USING PNC SERVICES**

Most of the respondent had access to health center, and the distance to a health facility was reasonable according to 84% of the respondents. In the study 97.2% of the respondents got to the nearest health facility by foot and 89.6% got there in less than 30 minutes. This means that distance to a health facility was not a problem in the district. This is contrary to what has been found by other studies (28), which found distance as a barrier to health care utilization.

Moreover, while most of the respondents, 95.6% judged the attendants care to be very nice, this is contrary to a study done in Kenya where a greater percentage of patients sought health care outside the formal sector because of poor attitude of service providers (25).

The findings indicate that about 95% of the women can afford PNC services. However, poverty ranks first as a constraint for mothers, not attending PNC. A more careful look at the results show that poverty, in this context is defined as inability to acquire the items the women consider as requirements for attendance at PNC. A greater majority, 94.3% of the women had mentioned new

dresses for the mother and baby, new shoe as requirements for attending PNC and 36.8% could not afford these items. Thus 60% of the respondents attributed it to poverty.

## 5.2 CONCLUSION

By the use of structured questionnaire and focus group discussion in assessing women's knowledge and attitude towards ANC and PNC and the possible constraint in the use of PNC services, it has been found that the respondents have a fair knowledge of ANC and PNC. Furthermore they have a positive attitude towards ANC and PNC.

Poverty ranks first as a constraint for mothers not attending PNC, but a more careful look at the results shows that poverty in this context is defined as inability to acquire the maternal items considered as requirements for attending PNC.

## 5.3 RECOMMENDATION.

After assessing women's knowledge and attitude towards ANC and PNC and the possible constraints in the use of PNC services in the Sekyere West District, the following recommendations are offered to the DHMT.

1. A greater majority of the women are married and since husbands have influence over their wives, the husbands should also be targeted during health educational messages to the women.
2. Most of the women are Christians, in view of this, the Churches could be used to deliver health educational messages to the mothers.

3. There is the need to intensify health educational messages to inform the mothers that ANC services are free because only about 15% of the respondents knew that ANC services are free.
4. Majority of the women know that Hospital are ANC delivery points so it is recommended that most of the health educational messages on ANC be passed on through the hospital to the women.
5. Most of the women have the opinion that if one does not attend ANC or PNC the mother or the baby will die. This fear could be put in health educational messages to entice the women to use the service.
6. The district should let the women know that PNC services could also be obtained from the TBAs.
7. There should be health educational messages to tell the women that ANC and PNC attendance is not a fashion arena as such one can bring any dress. Furthermore, PNC could be done at the outreach point so those women could bring their housedress to prevent competition amongst the women.
8. There should be PNC service for teenage mothers to prevent the increasing gossiping among the mothers. Furthermore, the names of the husbands should be asked tactfully not to embarrass those who do not have husband.
9. There is the need to educate mothers that, the little increase in temperature that may follow immunization is short-lived and the protection is much more beneficial.
10. There is the need to educate mothers on time management so that they could apportion their time very well and attend PNC services and should be told that their time will not be wasted when they come to the facility.

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Appendix A.

**ASSESSMENT OF WOMEN'S KNOWLEDGE AND ATTITUDES TO  
ANTENATAL CARE AND POSTNATAL CARE SERVICES IN THE SEKYERE  
WEST DISTRICT.  
QUESTIONNAIRE**

**INTRODUCTION**

1. Name of sub-district.....
2. Name of community.....
3. House Number.....
4. Date.....
5. Name of interviewer.....
6. Interviewee's number.....

**BACKGROUND INFORMATION**

7. How old are you?.....
8. How many children have you given birth to?.....
9. Ethnicity.....
10. Educational status
  - a. Primary school
  - b. Middle school
  - c. SSS/Secondary
  - d. Post secondary
  - e. No education

## 11. Marital status

- a. Married
- b. Separated
- c. Widowed
- d. Divorced
- e. Single

## 12. Occupation

- a. Farmer
- b. Trader
- c. Civil servant
- d. Hairdresser/seamstress/apprentice
- e. Others (state)
- f. Unemployed

## 13. What is your religion?

- a. Catholic
- b. Anglican
- c. Methodist
- d. Presbyterian
- e. Pentecostal
- f. Islam
- g. Traditionalist
- h. No religion

**II. KNOWLEDGE ABOUT ANTENATAL CARE**

1. What is antenatal care?
  - a. Health care and education given to a pregnant women
  - b. Health care and education given to a woman in labour
  - c. Health care and education given to a woman during delivery
  - d. Health care and education given to a woman after delivery
  - e. Other (state)
  - f. No response
  - g. I don't know
2. Did you attend antenatal care when you were last pregnant? Yes/No
3. What are some of the benefits of antenatal care?
  - a. Monitoring of normal pregnancy
  - b. Identification of high risk pregnancy
  - c. Giving immunization
  - d. Health nutrition education
  - e. No response
  - f. I don't know
4. What are some of the antenatal service points in this community?
  - a. Hospital
  - b. Health Center/Post
  - c. Clinic
  - d. Maternity Home
  - e. Other (state)
  - f. No response
  - g. I don't know

5. What are some of the services rendered at the antenatal clinic?
  - a. Measures the heartbeat of the fetus
  - b. Measures the blood pressure of the mother
  - c. Measures the position of the baby
  - d. Checks the stool, urine of the mother
  - e. Others (state)
  - f. No response
  - g. Don't know
  - h. Checks the stomach of the mother
6. How much does it cost to get an antenatal care service?
  - a. Free
  - b. Between two to five thousand cedis
  - c. Between five to ten thousand cedis
  - d. More than ten thousand cedis
  - e. No response
  - f. I don't know

### III. ATTITUDES TOWARD ANTENATAL CARE

1. Do you think a woman should receive antenatal care during pregnancy? YES/NO
2. If yes, how many times do you think a woman should attend antenatal care during pregnancy?
  - a. One
  - b. Two
  - c. Three
  - d. Four
  - e. Five

- f. More than five
  - g. No response
  - h. I don't know
- 2b. If No why?
3. In your opinion, where should a pregnant woman go for antenatal care?
- a. Hospital
  - b. Health center/clinic
  - c. Maternity Home
  - d. Trained traditional birth attendant
  - e. Untrained traditional birth attendant
  - f. Other (state)
  - g. No response
  - h. I don't know
4. What do you think are the risks associated with not attending antenatal care?
- a. Death of mother
  - b. Death of baby
  - c. Cord prolapsed
  - d. Retained placenta
  - e. Others (state)

**IV: KNOWLEDGE ABOUT POSTNATAL CARE**

1. Did you attend postnatal care after your last delivery? Yes/No. If no, give reasons.
2. What is postnatal care?

- a. Health care given to mother and baby from end of delivery through to six weeks after delivery.
  - b. Health care given to mother from end of delivery through to six weeks after delivery.
  - c. Health care given to a baby from end of delivery through to six weeks after delivery.
  - d. Health care given to baby and mother after delivery.
  - e. Other (state)
  - f. No response
  - g. I don't know
3. What are some of the benefits of postnatal care?
- a. Immunization of baby
  - b. Advice the mother how to breastfeed the baby
  - c. Checks any complication after delivery
  - d. Advice the mother on family planning
  - e. Other (state)
  - f. No response
  - g. I don't know
4. What are some of the postnatal care delivery points in your community?
- a. Hospital
  - b. Health center/post
  - c. clinic
  - d. Maternity Home
  - e. Trained traditional birth attendant
  - f. Untrained traditional birth attendant

g. Other (state)

h. No response

i. I don't know

5. What is the cost of postnatal care service?

a. Free

b. One thousand cedis

c. Between one and two thousand cedis

d. Between two and five thousand cedis

e. Between five and ten thousand cedis

f. More than ten thousand cedis

g. Other (state)

h. No response

i. I don't know

6. Do you know some of the procedures at postnatal care service? Yes/No If yes what are they?

**V: ATTITUDE TOWARDS POSTNATAL CARE**

1. Do you think a woman should attend postnatal care after delivery? Yes?No

2. If yes give reasons.....

3. If no give reasons.....

4. How many times do you think a woman should attend postnatal care?

a. One

b. Two

c. Three

d. Four

e. More than four

- f. Other
  - g. No response
  - h. I don't know
  - i. When one feels like
5. Where do you think a woman should attend postnatal care?
- a. Hospital
  - b. Health center/post
  - c. Clinic
  - d. Maternity Home
  - e. Trained traditional birth attendant
  - f. Untrained traditional birth attendant
  - g. Respondents Home
  - h. Other (state)
  - i. No response
  - j. I don't know
6. What do you think are the perceived benefits of postnatal care?
- a. To immunize the baby.
  - b. To provide health education on nutrition
  - c. To provide health education on family planning and breastfeeding and perform screening for the detection, treatment and /or referral of complications due the mother or baby.
  - d. Other (state)
  - e. No response
  - f. I don't know

7. What do you think are some of the perceived risk for not attending postnatal care?
1. Bleeding from cord
  2. Death of mother
  3. Death of baby
  4. Bad Breastfeeding habits
  5. Other (state)
  6. No response
  7. I don't know

**VI: CONSTRIANTS FOR POSTNATAL CARE ATTENDANCE**

**1. COST OF POSTNATAL CARE SERVICE**

What do you think of the charges for postnatal service?

- a. Very high
  - b. High
  - c. Just enough
  - d. Cheap
  - e. Free
  - f. Other (state)
  - g. No response
  - h. I don't know
2. Were you able to pay the charges the last time you needed postnatal service?
- a. Yes
  - b. No
  - c. Yes but had to borrow money
  - d. Yes but assisted by relatives

**PHYSICAL ACCESSIBILITY TO FACILITY**

1. What health facilities are available for your use?
  - a. Hospital
  - b. Health center
  - c. Health post
  - d. Clinic
  - e. No health facility
  - f. Other
2. How far is the health facility from your place of residence?
  - a. Very far (more than twenty kilometers)
  - b. Far (between two to twenty kilometers)
  - c. Near (less than two kilometers)
3. By what means do you get to the facility?
  - a. By foot
  - b. By vehicle
4. If by vehicle how easy is it to get a vehicle?
  - a. Readily available
  - b. Have to wait for less than half an hour
  - c. Have to wait between one to two hours
  - d. Have to wait for more than two hours
5. If by foot, how long does it take you to get to the facility?
  - a. Less than thirty minutes
  - b. Between thirty and one hour
  - c. One to two hours
  - d. More than two hours

**QUALITY OF SERVICE**

1. How did your attendant care for you the last time you were there?
  - a. Was nice to me
  - b. Not friendly
  - c. Shouted on me
  - d. embarrassed me
  - e. Other (state)
2. How can the presence or absence of the required drugs influence your use of the facility?
3. How do you rate the skills of the service providers?
  - a. Excellent
  - b. Very good
  - c. Good
  - d. Fair
  - e. Bad

**DRESSING**

1. What are some of the maternal items required for attending postnatal care?
  - a. A new cloth
  - b. A new footwear
  - c. A new bag
  - d. A new baby dress
  - e. Other
2. Could you afford these requirements before attending postnatal care? Yes/No
- 2b. Give reasons?

3. Could you have gone to the postnatal care without these requirements? Yes/No
4. How does your husband's support (financial of action) influence your ability to use PNC service?
5. What do you think discourage mothers from attending postnatal care?

### **FOCUS GROUP DISCUSSION GUIDE**

Participants: Women who did not attend PNC the last time they delivered.

1. When women get pregnant, where do they seek health services?
2. Where do they go to deliver?
3. Where do they go for PNC?
4. Why do they go there?
5. Why is it that some women do not attend PNC?
6. Why did you not attend PNC the last time you delivered?
7. What do you think of the charges for PNC services?
8. Were you able to pay for the services the last time you needed it?
9. How far is the health facility from your place of residence?
10. By what means do you get to the facility?
11. How did your attendant care for you the last time you needed the services?
12. What are some of the maternal items needed for attending PNC?
13. Are there any socio-cultural factors, which prevent PNC activities?

**THANK YOU.**



# DISTRICT PROFILE

## DISTRICT MAP

