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INFLUENCE OF MARRIED WOMEN'S AUTONOMY ON THE CHOICE OF PLACE OF DELIVERY IN GHANA: AN ANALYSIS OF THE 2014 GHANA DEMOGRAPHIC AND HEALTH SURVEY

BY

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DECLARATION

I, Doreenlove Akosua Serwah Osei-Nkrumah, hereby declare that this proposal is the result of my own original work, and that this dissertation proposal, either in whole or in part has not been presented in this University or elsewhere for another degree, except for the other people's work which I have duly acknowledged**.**

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DEDICATION

I dedicate this work to my loving and supportive husband, Ephraim, my two wonderful children, Ama Serwaa and Kofi Kwam. I also dedicate it to my brother Elvis and my mom Janet.

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LIST OF ACRONYMS

SDG: Sustainable Development Goals

NHIS: National Health Insurance Scheme

TBA: Traditional Birth Attendants

SBA: Skilled Birth Attendants

WHO: World Health Organization

UNICEF: United Nations Children's Fund

UNFPA: United Nations Population Fund

DEFINITION OF TERMS

Women’s Autonomy: A woman’s ability to make decisions affecting their personal circumstances free of external control or influence.

Place of Delivery: Place of Child birth.

ABSTRACT

Background: Sub-Saharan Africa has the highest record of maternal mortality. The World Health Organization defines maternal mortality as the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. In Ghana, maternal mortality rate stands at 319 deaths per 100,000 live births. Trends from the last five Ghana Demographic and Health Surveys show a steady increase in the percentage of deliveries in health institutions, however there is still a large gap between the prenatal coverage and actual deliveries in hospitals/clinics. A woman's choice in place of delivery is a key factor that influences maternal or child health. This study seeks to understand how married women's autonomy in the household influences her choice of place of delivery.

Methods: This study used data from the Ghana Demographic and Health Survey 2014, which is the most recent Demographic and Health Study to access the characteristics of the sample. The sample comprised of 2801 married women aged between 15-49 years who had delivered a child in the last five years at the time of the study. Descriptive statistics was used to examine the distribution of the sample and logistic regression to examine the relationship between married women's autonomy and choice of place of delivery. Data analysis was done using STATA 15.

Results: Married Women aged 35-39 years and those with spouses aged 35-39 years were observed to be more autonomous (76.7% and 74.5% respectively) than other women in the study. It was also observed that women with tertiary education, Christian women, women who had had four or more ANC visits were more autonomous than other groups. Occupation of mother and spouse was also observed to be significantly associated with autonomy.

Mothers aged 35-39 years and mothers aged 40-44 years with spouses had the most institutional deliveries. Mothers with tertiary education and those whose spouses received tertiary education, urban dwellers, Christians, women from wealthy households and mother's covered by insurance had the most institutional deliveries. Greater Accra region recorded the highest institutional births and the attendance of 4+ Antenatal visits was significantly associated with institutional delivery.

An increase in autonomy led to an equal increase in the odds of institutional delivery though after adjusting for other socio-demographic/economic factors, the level of influence fluctuated. Region, increase in education, type of residence, wealth and occupation were found to influence the odds of a mother having institutional delivery.

Conclusion: Education, religion, wealth, ANC visits and occupation influenced both autonomy and place of delivery. Female education was observed to increase autonomy and give rise to the number of institutional deliveries. However, some of the influential variables cannot be manipulated such as age of respondents but others such as education can be used as a tool to promote institutional delivery through civic education. The government should also focus on developing the health network (e.g. hospitals, road networks and utilities) in the rural areas.

CHAPTER ONE

INTRODUCTION

1.1 Background

Maternal mortality is one of the leading causes of death in women between the ages of 15-49years. It is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of pregnancy, from any course related to or aggravated by the pregnancy or its management but not from accidental causes (WHO, 2015). Studies have shown that In sub-Saharan Africa including Ghana, there is usually a high coverage of antenatal care services but unfortunately less deliveries in health institutions (Ghana Statistical Service, 2014; WHO 2014). The 2014 Ghana Demographic and Health Survey showed that 97% of women who received antenatal only 73% had deliveries in a health facility and 74% with a skilled provider. It is however worth noting that in looking at maternal trends over the years, there has been an impressive improvement in maternal health behaviour. Between 1988 and 2014, percentage of women receiving antenatal care from skilled provider has increased from 40% to 74%. There are so many pregnancy related complications that cannot be predicted. It is recommended by the World Health Organisation that all deliveries be done by a skilled birth attendant (Stanton et al, 2007).

How a woman's autonomy or absence of it in the home influences her reproductive outcomes including place of delivery is poorly understood. In a country like Ghana, which is mainly patriarchal with decisions in the household mainly taken by men, it is important to understand women's role regarding how decisions are taken and if this has any effect on choice of place of delivery.

According to the 2014 Ghana Demographic and Health Survey, 63% of married women who are employed and earn cash have the opportunity to make their own decisions on how to

spend their earnings. The ability of woman to make such financial decisions reflects their level of empowerment in the family which mostly reflect in her autonomy to make vital decisions concerning her health.

Studies have shown that decision-making ability of females influences their healthcare services usage in different pathways. Investigation of gender imbalances in females' access to healthcare services between sub-Saharan Africa and South Asia revealed that, women's capacities to control profit and impact family decision-making, especially about medicinal services are certain indicators for maternal healthcare services usage (Adegoke & Van Den Broek, 2009; Dangal & Bhandari, 2014; Kamiya, 2010). Other studies demonstrated that an increase in women's autonomy presents long term advantages, for example, reduced fertility, increased infant survival rates, and allotment of resources for children in the family (Anderson & Eswaran, 2009).

Studies have also revealed varying levels of healthcare decision-making autonomy in various nations and within various locales in the same nation. A low level of women's autonomy was observed to be a contributory factor to poor maternal healthcare usage in a study among women from Nepal (Thapa & Niehof, 2013).

Enhancing autonomy in decision-making and regarding women' independence are important objectives. Educating and engaging women will advance their independence and will add to the sustainable development objectives of good healthcare, quality education, and sex uniformity. Autonomy is viewed as fundamental for decision-making such as seeking a medical services and choosing from healthcare options (Osamor & Grady, 2016).

1.2 Statement of the Problem

In Ghana, maternal mortality rate for 2015 was 319 deaths per 100,000 live births (WHO et al. 2015). Various studies have observed that giving birth in an institutional health facility prevents maternal mortality (Campbell & Graham, 2006; Bhutta et al., 2014; Shah et al., 2018). This is because institutional deliveries provide the opportunity for health workers to intervene in critical complications and unpredictable consequences which may require access to emergency obstetric care (Shah et al., 2018). However, it is worth noting that along the years institutional deliveries has increased; from 42 percent in 1988 to 73 percent in 2014; the percentage of births attended by a skilled provider has increased from 40 percent to 74 percent over the same period (GDHS, 2014). Some of the factors that contributed to the above observations included number of ANC visits, location (urban/rural dweller), mother's education and wealth as well as birth order (GDHS, 2014). Even though there has been steady progress over the years, the rate still is far from reaching the SDG 3.1 of reducing the global maternal mortality ratio of less than 70 per 100,000 live births.

Factors that contribute to low institutional deliveries in Ghana have been observed to include cultural factors, attitude of health care providers, previous experiences with the health system, long waiting time, negligence of health care workers, alternative delivery services, transport to service facilities and expectations are factors that influenced their utilization of health facilities for delivery (Akum, 2013). Another critical factor identified to influence institutional delivery is decision-making autonomy. For instance, Ameyaw et al., (2016) observed that women with autonomous health decision-making power were more likely to utilise health facility for delivery as compared to those without.

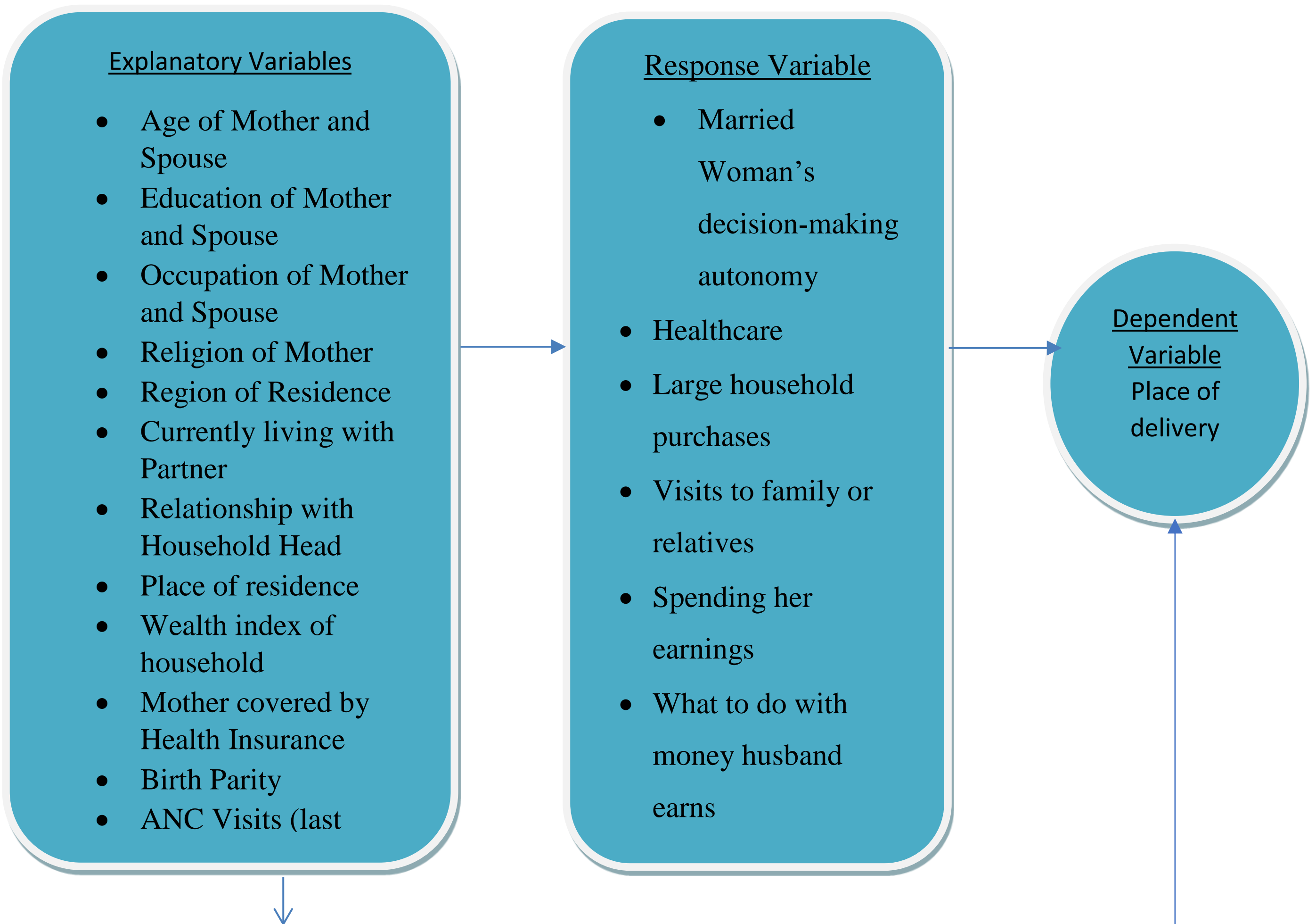
In sub-Saharan Africa, including Ghana, lineages are mainly patriarchal with men being the main decisions makers in the household. As such, it is not uncommon to find women submitting to men when it comes to household decisions including decisions on where and

when to seek health care. To avert complications and deaths associated with maternal deliveries, where and when a woman seeks professional assistance is very important. In situations where women need to wait on their husbands or partners and male family members to make critical decisions as to whether or not to visit a health institution could lead to an unnecessary delay. This delay contributes to maternal morbidity and mortality. Little is known about the extent to which women's autonomy influences health seeking decisions such as place of delivery. This study sought to investigate the influence of married women's autonomy in decision making could have on maternal health. The results will inform the society and stakeholders of the Ghana Health System.

1.3 Conceptual Framework

The conceptual framework for the study was adapted from the Commission on Social Determinants of Health (CSDH) Framework. This model uses structural and intermediary determinants to explain health inequities. It posits that structural determinants are those that generate social stratification in the society and that also define individual socio-economic positions. These mechanisms configure the health opportunities of social groups based on the placement within hierarchies of power, prestige and access to resources (economic status) (Solar & Irwin, 2007). The CSDH model has been used by Nguyen, Bernstien and Goel (2012) to study Asian-American elders' health and physician used by examining social determinants and lifespan influences. Newman and Lupianez-Villanueva (2015) discussed the challenges of combining different methodological approaches to investigate citizen' access to e-health by applying the CSDH model. Bahadori et al, (2015) also investigated the status of social determinants of health (SDH) and their association with health indicators in Iran, using the CSDH model (WHO, 2010).

Figure 1: Conceptual Framework



In this study, the explanatory variables were the socio-demographic/economic characteristics of the study population. These included both mother and spouse's age education, occupation, religion of mother, region of residence, currently living with partner, relationship with household head, place of residence, wealth index of household, mother covered by health insurance status of mother, parity and ANC Visits (last pregnancy). The explanatory variables also known as the independent variables are beyond the manipulation of the researcher. They form the individual's basis of making meaning of events in life.

The response variables in the study were married women's decision making autonomy which is a composite score made up of the following variables: Person who usually decides on how

to spend respondent's earnings, mother's health care, on large household purchases, visits to family or relatives and what to do with money husband earns.

Lastly, the dependent variable for the study was the place of delivery: institutional or non-institutional. Institutional is when the healthcare services of a hospital or medical centre is sought and non-institutional refers to healthcare sought from traditional medicinal men and women or home health care by non-licensed medical practitioners.

As explained earlier the demographics characteristics of women was the lens through which they make meaning out of life events or react to their environment. Socio-demographic factors such as education influences the type of delivery; for instance an uneducated woman is most likely to seek the help of a traditional medicine man or woman in child delivery. Also, type or place of resident is an influential factor in that women in rural communities where healthcare facilities are miles away would resort to the services of unlicensed medicine men and women in.

Though socio-demographic and economic variables rightly influence the type or place of delivery, response variable (married women's autonomy in decision making) causes variation in the direct expected outcomes of the independent and dependent variables. For instance if a woman in her home has the advantage of making healthcare decisions, then she is able to make the decision based her medical needs and the quality she deserves. Also if a woman makes decisions on how earnings of the husband is used it is most probable she can decide to obtain institutional care even if her own earnings cannot pay for that type of care thereby indirectly relying on the use of her husband's earnings.

1.4 Objectives

1.4.1 General Objective

The main objective was to determine whether autonomy in decision making for married women is significant in choice of place of delivery.

1.4.2 Specific objectives

1. To determine the proportion of married women that delivered in health facility by the background characteristics of the woman.
2. To estimate the level of autonomy by the background characteristics of the woman.
3. To examine the extent to which a married woman's autonomy affects choice of place of delivery

1.5 Research Questions

1. How many married women delivered in health facility by socio-demographic and economic factors?
2. What are the socio-demographic and economic factors that influence women's autonomy?
3. Does a woman's autonomy affect her choice of place of delivery?

1.6 Justification

Delivery in health facility under skilled health attendant can contribute to reduction of maternal mortality and its associated morbidity. This study provides an understanding of the factor that influence women's decision to give birth in health facilities especially how the woman's level of autonomy influences this decision. In Ghana where most families practice the patriarchal system, where women largely rely on their husbands/partners for decision making it is important to understand hoe married women's autonomy in the household affect their decision on choice of place of delivery.

This study would also provide/generate the important information for understanding women's autonomy in a patriarchal society.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews pasty studies and documents that are relevant to women's autonomy and institutional delivery. It also looks at the documents that are relevant to fully understand the effects of married women's autonomy on choice of place of delivery.

2.2 Autonomy

Autonomy, the ability to make decision from our own will has been a much researched subject as it forms the basis of human life. The basic components of autonomy – in particular the capacity and ability to settle on choices in a way that can impact one's condition – is reflected in different definitions, for example, that by Jejeebhoy (2000), autonomy is the "extent to which women exert control over their own lives within the families in which they live at a given point of time".

Fundamentally, autonomy is dormant and insubstantial, and conveys what needs to be in various courses, for example, having basic decision-making control; versatility; and order and control over assets. The empowering factor in practicing self-sufficiency are instruction; position in the family unit; closeness to kinfolk; monetary status of the woman and her family unit; access and accessibility of infrastructure; and standard and disposition of community as a whole. Autonomy has characteristics significance for a woman's own welfare. It decides to a degree her capacity to settle on compelling decisions, and to practice control over her life. It additionally has instrumental esteem, in that the woman's self-sufficiency contributes in extensive measure to improving personal satisfaction for the family and for the community as a whole (Arulampalam, Bhaskar & Srivastava, 2016).

A woman's welfare status is impacted by her access to and control over assets that influence food accessibility and her capacity to be in charge of her health needs (Mabsout 2011, sahn and Younger 2009). This over the years has driven a lot of attention towards empowering of women to have more choice right over the dimensions of their lives that influence their wellbeing and capacity in performing salary generating and parental figure duties (De Schutter 2013, FAO 2012).

2.3 Cultural Perception of Women in Ghana

Ghana is a nation with diverse ethnic groups and hence varied cultures are observed across the length and breadth of the nation. These ethnic groups however have basic similarities, especially when it entails the role of the basic component of the society that is the man and the woman. The Ghanaian society is gender-stratified. And other factors such as age, marital and wealth status of women determine women's position in the society (Darko, 2015).

In Ghana, women's role has been defined by culture as comprising of reproductive/parental (being the mother of children), occupational (engaging in economic activities), Domestic (being a homemaker), conjugal (being a wife), kin (being related to people), community (being a citizen) and individual (self-actualisation) roles (Agana & Millar, 2015).

2.4 Marriage in Ghana

In Ghana, marriage is a social get-together that is guided by the customary and regular laws of the nation. Distinctive avenues for marriage exist in the framework – customary marriage, religious marriage, and marriage under the law or statute marriage. Customary law marriage obtains its authenticity from segments in Parts 2 and 3 of the Marriages Act, 1884/5. The Act characterizes marriage as a union between a man and a lady's family; however it is additionally an agreement between two individuals – a man and a lady. Marriage in this manner is indicated to be a legitimate assenting between a man and a lady going into a perceived relationship. The assenting has the impact of making a specific status whereby the

couples appreciate certain rights and accept certain obligations (Addai, Opoku-Agyeman & Amanfu, 2015).

2.5 Marriage and Women's Autonomy

Autonomy is the ability to make decisions without any external influences. Many people define autonomy in different ways. It may be influenced by personal attributes of women as well as socio-cultural norms and values.

In Ghana, the limit of a man's claim as the authority of a woman's economic and domestic services depends on the particular ethnic group system of marriage and inheritance (Darko, 2015).

Women with autonomy in health decision-making are more likely to utilize health facility for delivery as compared to those without. This presupposes that autonomy of women in relation to health is important to enhancing health facility delivery which guarantees skilled birth attendance (Ameyaw et al., 2016). Women's autonomy in medicinal services decision-making is critical for better maternal and child health results, and is a reflection of their empowerment. Gender-based power inequalities can confine open correspondence between spouses about reproductive wellbeing choices and also women's access to healthcare services (Acharya et al, 2010).

Ganle et al., (2015) reported that, in nearly half (49.2 %) of the women he interviewed regarding non access, the final decision maker was the husband, followed by mothers-in-law (16.2%), while 12.4 % of the women said their husbands and mother-in- laws were the final arbiters. Only in 2.7 % of the cases were women themselves the final decision- makers.

Women's autonomy is a sensitive issue in marriage especially in the Ghanaian culture due to the element of Bride-wealth. Bride-wealth alludes to the property or riches the spouse's family exchanges to his bride's relatives at the commencement of the marriage (Bawa, 2015).

This Bride-wealth inadvertently suggests ownership of the husband over the wife. In Africa payment of bride-wealth secures rights over the lady to the man and his family regarding her family unit work, sexual and reproductive rights (Bawa, 2015). At times, it likewise gives men rights to the kids as found in some patriarchal societies in Ghana (Bawa, 2015). But we may argue that modernization has influenced the above observation in that women's empowerment is a concern all over the world and this includes empowerment in their autonomy to make decisions especially life changing ones such as whether to receive institutional maternal healthcare or not. The rights secured by husbands because of bride-wealth payment, has an influence on women's autonomy which is essential to different parts of their lives including family/child spacing and matters identified with their wellbeing.

According to the 2014 Demographic and Health Survey, women who participated in making decisions about their own healthcare were 77%, and the women who solely decided in making decisions about their own healthcare were, 27%, whilst 92% of men representing the vast majority are involved in decision about their own health care. Only 11 percent of men 23 of women reported that they made their own decisions about major household purchases. A little over one-fourth of women decided themselves on visits to their family or relatives.

2.5 Women's Autonomy: Contributing Factors

According to Mahmuda (2008),to achieve equality and peace in the family as well as the country, active participation of women at all levels of decision making is important. Alam (2011) argues that women's educational level, employment, income and other socio-economic variables are positively associated with their decision making power. Research discoveries reveal that women's decision making autonomy is firmly connected to their characteristics and the social settings in which they live (Atiglo, 2013). A research by Nigatu et al, (2014) revealed that socio-demographic and maternal factors (knowledge and attitude)

were found to be of influence in women's autonomy. Less than half (41.4%) out of 706 women had higher autonomy regarding their own and their children's health.

Women's autonomy can be seen as the control over their own lives, materials, access to knowledge and information, having equivalent say with their spouses on issues influencing themselves and their families.

The "theory of resources" was proposed by Blood and Wolfe (1960) to explain the contributing factors to autonomy. The theory indicates that husband -wife decision-making power depends upon the resources referring to income, educational achievements and occupation. The theory also indicates that when a woman's resources increase, the decision-making power may increase (Alam, 2011). Bloom, Wypij & Gupta (2001) also defined women's autonomy in three dimensions as: control over finance, decision-making power, and extent of freedom of movement.

However, Samari and Pebley (2015) pointed out that these measures often aggregate very different types and magnitudes of decisions, e.g., deciding what to cook with making decisions about children's schooling, health, or marriage. Also, freedom of movement cannot hold for women in South Asia where social norms associated with purdah typically prevent women from leaving their homes (Mumtaz and Salway, 2009).

Other studies consider factors such as age and family composition. On account of age, women may encounter distinctive levels of autonomy at various phases of the life course. Older women, past their conceptive years, commonly have more noteworthy opportunity of development and control over family unit choices (Rahman and Rao, 2004, Mahmud et al., 2012, Acharya et al., 2010). Family compositional variables like marriage and age gap between couples are essential in autonomy since women' personal control will be founded on the mentalities of others in her family unit (Rahman and Rao, 2004). Most researches on

autonomy and reproductive practices have been on married women (Upadhyay et al., 2014). Married women have more control over personal assets and income than single women according to Bawa (2015). However, Rahman and Rao (2004) suggest that the degree of control may depend on the level of consanguinity between the spouses.

Studies that have been done on factors influencing choice of place of delivery of women, have reported that demographic and socio economic characteristics, service accessibility and women's autonomy are key indicators in choice of place of delivery.

A study by (Akinyo, 2009) revealed that mothers who were unemployed were less likely to deliver in health unit. However, the businesswomen and employed mothers had relatively higher odds of delivering in health unit. These women were exposed to information about seeking medical care, most of them were urban residents and they could afford the requirements needed during delivery.

In Ghana as well as most countries, the affluent in society are more likely to have institutional deliveries than the less affluent. In a study by (Ameyaw, Tanle, Kissah-Korsah, & Amo-Adjei, 2016) it was established that delivery in health facilities increased with higher wealth quintile whereas home deliveries characterized poor women.

A study done in Kenya analyzing the Kenya Demographic and Health survey, (Kitui, Lewis, & Davey, 2013) found out that, even though 88% of mothers lived less than five kilometres away from a health facility, more than about 53% of deliveries took place outside health facilities and 93% of pregnant women having at least one ANC visit during pregnancy. Cost of healthcare services can be an influence on utilization of healthcare services and this might pose threat to the health status and maternal wellbeing of poor women. This is particularly critical because cost can also deter them from accessing quality healthcare for themselves and

their children even after delivery and this might constitute severe threat to their health status and their children.(Ameyaw et al., 2016)

2.6.1 Educational Background and Women's Autonomy

There are a number of stages in the decision making process such as identification of a problem, gathering data for analyses, developing alternative solutions, selecting an appropriate solution, implementing the solution and finally, evaluation. For decision to be made, background information and knowledge of the situation and alternative solutions need to be accessible and comprehensible for the individual. Hence, the level of one's education (as a measure of securing of information) is a potential compelling element on effective decision making (Darteh, Doku & Esia-Donkoh, 2014). It can be deduced that a woman's ability to make decisions about her sexual and reproductive health is dependent on her exposure to knowledge. Education is a contributing factor to defining a woman's status in society. It enables women to make important decisions regarding health for example, location of the health facility, kind of services provided and how to consult health personnel (Woldemicael & Tenkorang, 2010).

Education and opportunity to work preceding marriage may furnish women with a more noteworthy feeling of individual control, enhanced relational abilities, and maybe some independent resources (Murphy-Graham, 2010). The effect of women's education on independence in decision making relies upon the part of autonomy being examined. For instance, education has been found to affect women's basic decision making, yet no impact on mobility (Samari & Pebley, 2015).

2.7 Maternal Healthcare in Ghana

The Ghanaian Healthcare system has transformed through the many challenges it faced right after the nation's independence. From the system of 'cash and carry' through to policies such as the safe motherhood initiative (1995), in which the Ghana Health Service (GHS)

collaborated with the Ministry of Health (MoH) to reduce the high levels of maternal mortality (Derbile & van der Geest 2013; Seddoh & Akor 2012; Soors et al. 2013). The free antenatal care policy introduced in all public health facilities in 1998 to be attached to the safe motherhood initiative (Biritwum 2006). The free delivery care policy was eventually introduced by then Government of Ghana in September 2003 through funding from a World Bank debt-relief initiative the highly indebted poor countries initiative (HIPC).

However the in 2007, the free delivery care policy formally came to an end due to lack of funding and was incorporated into the NHIS, which was already functional since 2005 (Witter and Garshong, 2009; Ghana Statistical Service et al. 2009). Unlike the free antenatal and delivery care policies which were only efficient in public health facilities, the NHIS premium holders are entitled to seek medical care from all public and accredited private and faith-based health care providers (Dalinjong and Laar, 2012).

The NHIS in its functioning is supposed to encourage more women to make the decision to receive child-birth delivery services but challenges of public health system such as alarming healthcare professionals and patient ratio especially in the urban areas and inadequate health facilities (HERA7HPG, Final Report May 2013).

As per the Millennium Development Goal Report on maternal wellbeing (2014), about 300,000 maternal deaths in connection to pregnancy and labour were recorded all around in 2013 of which developing nations represented the greater part. Maternal mortality proportion in developing nations over the world is evaluated at 230/100000 live births with Sub-Saharan Africa contributing the most elevated proportion of 510/100,000 livebirths. These evaluations of maternal mortality proportion show a dismal picture about Africa. The Report likewise noticed the low levels of utilization of skilled delivery in developing nations (MDGR, 2014).

MOH (2014) discoveries have affirmed that women in many parts of the nation do not get to maternal healthcare services. A portion of the feasible variables that pose challenges on availability include: women's religious observations on healthcare practices, for example, the conviction that specific birth complexities are best treated spiritual representatives (Sackey, 1999); health worker attitude (D'Ambruoso, Abbey, and Hussein, 2005; Rominski, 2015); distance, cost of transport (D'Ambruoso et al., 2005; Zulka, 2011), and the cost of provisions required for delivery (Dzakpasu et al., 2012). These discernments have been solid obstructions to women's way in skilled maternal delivery healthcare.

In perspective of these elements, an attention on how women see maternal services and place of delivery decisions is crucial to enhancing use of the free maternal social insurance and a lessening in delivery intricacies and mortality.

2.7.1 Women's Perception on the maternal healthcare system in Ghana

Women's impression of care impacts their usage of maternal healthcare institutions (Kumbani, et al, 2012; Lubbock et al, 2008). Research indicates that low quality of care may prompt under usage of maternal healthcare facilities (Otis et al, 2008; Rani et al, 2008). Again, women will probably deliver in healthcare facilities when they view themselves as sheltered and secured.

Since the beginning of the Free Maternal Health Initiative, impression of the quality of its services has been opposing (Gurman & Becker, 2008). While some pregnant women report fulfilment with the care they get when they deliver at healthcare facilities (Emelumadu et al., 2014), others report poor delivery of services (Butawa et al, 2010). Some women announced the most fulfilments when attended to by traditional birth orderlies and paid no administration cost (Emelumadu et al., 2014). A portion of the reasons given for poor maternal care was that the healthcare facilities were not generally opened, absence of medicine and staff disagreeableness.

2.8 Women's Autonomy and Household Determinants

According to Upadhyay et al. (2014) it is fundamental to understand multilevel impacts from the family to community to large scale socio-political powers on women's autonomy. Women are not independent in a vacuum. Their autonomy is in context with the next individuals or groups that touch their lives. For women to be autonomous inside the family, they should bargain and practice control over family unit choices and connections. Since the family or family unit is the central setting in which women have (or need) and exercise autonomy (Acharya, Bell, Simkhada, Teijlingen & Regmi, 2010), it is imperative to comprehend family unit determinants of autonomy.

Research reveals that women living in patriarchal societies will have less autonomy when living with extended family and husbands and in-laws may control women's access to children, food, money, and health services and ultimate decision-making control (Acharya et al, 2010; Moss 2002). Family unit size is adversely connected with autonomy, yet these ladies could live in extended families, where their decision-making abilities might be reduced (Rammohan and Johar 2009). Women living in urban areas are not so much segregated but rather more prone to work outside the home so there is greater open door for women to control assets and settle on independent choices (Corroon et al. 2014).

Societal norms such as religious norms can also throw more light on variations in women's autonomy (Yilmaz, 2018; Rammohan and Johar 2009). For instance in Nepal, a nation with a great deal of sexual orientation stratification, the patterns of women' independence in decision making fluctuate significantly crosswise over districts contingent upon whether the prevailing standards and social frameworks are more prohibitive for ladies (Acharya et al. 2010).

2.9 The Household Theory and Women’s Autonomy

The household theory of economics gives a complete examination of family financial matters including intra-family unit designations of assets, selflessness in the family, family unit generation and venture, interest in and money related exchanges to children, coordinating in the marriage market, separation and child support, non-benevolent family exchanges, family formations and social connections. Specifically, the household decision-making theory gives a nitty gritty investigation of the associations between couples inside different parts of decision-making forms in the family unit. This theory further perceives women' autonomy through her danger utility in respect to her male partner with regards to helpful and non-agreeable associations in decision-making processes in the family (Khan, 2014).

According to both Eswaran and Malhotra (2011), and Anderson and Eswaran (2009), they indicate persuading proof regarding women' substantial risk utility in declaring their negotiating power with respect to their male partners in the family. All the more as of late, Eswaran, Ramaswami and Wadhwa (2013) decided family status and standing as the most critical factors in deciding women’s autonomy in the family in India. In any case, with regards to an agreeable model setting, Chen (2013) watches that the immigration impact of a male life partner subject to the negative stun seems insignificant to women's negotiating power in the family. So also, different disciplines including human studies, human science and demography feature the idea of women's autonomy inside the setting of sexual orientation disparity.

Human studies generally connects advancement with enhancing levels of women's autonomy in the public arena. Further, the human science hypothesis of asset control underlines women's proprietorship rights as identified with their independence inside the family unit and society all in all. Demographic studies recognize the key connection between women's autonomy and the statistic processes in the community (Khan, 2014).

Research additionally measure women's autonomy and present exact proof of its determinants inside different settings. The discussion below takes a look at the idea of autonomy from the household decision-making theory and examines the exact confirmation of its determinants, which have showed up in different examinations assembled inside other sociology fields.

2.10 Place or Types of Delivery in Ghana

It is expected that women encounter good experiences and a positive perspective of the help provided through the three phases of maternity care that is pregnancy, labour and birth and the postnatal period. However a few ladies either had bitter encounters all through these passionate moments whilst others wind up losing their lives. In this manner the most judicious approach to decrease maternal mortality is to urge women to look for skilled birth attendants at health facilities (Campbell & Graham, 2006).

2.10.1 Skilled Birth Attendance

Skilled birth attendance (SBA) has been recognized as imperative for alleviating the dangers of maternal deaths amid delivery. It comprises of care offered by trained healthcare experts amid labour, birth, and postnatal period. SBA offers security and life supporting condition for the both mothers and infants consequently decreasing odds of difficulties (WHO, UNICEF, UNFPA, World Bank, and United Nations, 2015).

In spite of the generous advantages of SBA to maternal health, 40 out of 115 million pregnant women delivered at home without skilled birth attendants in 2013. These deliveries have high dangers of complexities that can prompt avoidable maternal dreariness and mortality (Ameyaw et al, 2016).

2.10.2 Factors Women Consider in Choosing Place of Delivery

In developing countries decision-making on place of birth is not just the concession of women but dependent on a few actors and factors, some of which are past the remit of women. Enhancing empowerment status of women in developing nations constitutes one of

the perceived ways to deal with enhancing the use of maternal healthcare services (Lozano et al, 2011).

Some confirmation from northern Ghana demonstrates that pathways through which empowerment can enhance the use of medicinal services is to incorporate but not constrained to income, education, and ownership of assets, freedom from aggressive behaviour at home, and freedom to move without limitations. In any case, a mix of these components is required for women to have a last say in regards to issues relating to their use of healthcare facilities (Issah, Nang-Beifubah, & Opoku, 2011; Severin, 2011).

A study conducted in the Ga-East Municipality of Ghana which noted higher rate of health facility delivery among NHIS subscribers indicated that Health facility delivery is more likely among urban inhabitants when contrasted with those in rural settings. This may be attributable to the moderately less accessibility of health facilities in rural settings when contrasted with urban territories in the nation. If a woman in a rural region needs to employ a several miles before getting to the closest health facility, such a woman will not have the desire to reliably get to the health facility when contrasted with those in urban ranges where health facilities generally abound. In the meantime, urban areas have generally better street systems, which improve their ability to get to easily access health facilities for delivery (Dixon et al, 2014).

Also Ameyaw et al (2016) indicated that Ghanaian women with healthcare services decision-making autonomy will probably deliver in health facilities and this endured even in the wake of controlling for socio-statistic factors. It was likewise clear that higher wealth status is linked with health facility delivery. The investigation in this manner suggests that legislature and nongovernmental organizations worried about maternal and conceptive wellbeing should

target women who do not autonomously choose their own medicinal services with broad communications crusades pushing health facility delivery.

In another examination on topographical access to healthcare during childbirth in Ghana, 33% of women in Ghana live past the clinically critical two hour edge from getting to healthcare facilities that offer crisis obstetric and neonatal care which is a long ways past the standard or satisfactory distance (Gething et al, 2012). In the most remote locales, the distance is further away making it troublesome in offering life-saving administrations, for example, blood transfusion and surgery for women needing these crisis administrations (Gething et. al, 2012). Currently, the global benchmarks of maternal healthcare prerequisite are insufficient for these reasons since they neglect to assess the area and ease of access of services in respect to the women they serve in most piece of the nation (Gething et al, 2012).

Factors such as low maternal education, age, religion, unemployment among husbands, first pregnancies at under eighteen years old are among the conceivable reasons that improve the probability of home deliveries in Subuwar Unguwa, Magume region of Zaria (Iddrisu, Gwarzo, and Shehu 2006; Ekele and Tunau, 2007) on the determinants of place of delivery among ladies in semi-urban settlement in Zaria Northern Nigeria. It was reasoned that, keeping in mind the end goal to empower institutional delivery, girl child education, and income generating activities could help diminish to the barest least the high rate of home deliveries and its results.

In Ghana, the dispersion of healthcare facilities is skewed towards urban territories. More than 65% of medical doctors in the nation are packed in two urban-based teaching hospitals: Komfo Anokye in Kumasi and Korle Bu in Accra (Buor, 2008). In the Ashanti Region, one of ten locales in the nation, medical professionals in the Kumasi Metropolis alone constitute more than 85% of all medical professionals in that region. The medical professionals

essentially avoid posting to remote areas, even with additional compensation packages and this is because of poor ecological conditions and insufficient social infrastructure in these remote areas (Amoako, 2011).

The decision of place of maternal delivery can also digress into either public or private healthcare. A study by Tebekaw, Mashalla, and Thupayagale-Tshweneagae (2015) revealed that a notable number of pregnant women especially among slum residents still chose home delivery. Though women's impression of the private health sector in Addis Ababa is that it offers preferred quality healthcare services over that offered by people in public health facilities, still most respondents liked to deliver in public healthcare establishments in spite of the general doubts about the nature of services delivered. The inclinations were ascribed to short distances as well as low cost of healthcare at these public health facilities.

Women made decisions of place of delivery in perspective of the healthcare service provider’s behaviour. The women preferred traditional birth attendants (TBAs) in the community as they are considered to be more empathetic and caring. It was also indicated that TBAs allowed women more liberty on birthing positions was during home deliveries. Another factor revealed that discouraged women from giving birth in public facilities in this study were the longer waiting time reported. Also women being confined to bed during the entire labour and delivery period were issues that prevented women from delivering in health facilities.

The study admits there is quiet a couple of studies regarding women’s autonomy and their choice of place of delivery in Ghana. And also the government and other stakeholders of healthcare in Ghana have invested in investigating maternal healthcare an example of which is the Ghana Demographic Health Survey in 2014. This research sought to analyse data from

the Ghana Demographic Health Survey with particular attention to women's autonomy and how it influences their place of delivery in Ghana.

2.11 Summary

Literature reviewed provides a fair description of women's autonomy in a patriarchal society such as Ghana where cultural perception of women, marriage and socio-demographic and economic factors influence their wellbeing. However, the literature reviewed does not provide knowledge specifically on how such factors affect married women's decision to deliver in a health facility. Hence, this study is conducted to bridge this knowledge gap.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the methods used to attain the objectives of the study. It includes the design that was used, the research setting target population, sample and sample method used. It also gives information on tools that were used, method of data collection data management and analysis.

3.2 Type of Study

This study was a secondary analysis of data collected by the Ghana Demographic and Health Survey in 2014. The primary objective of the 2014 GDHS was to generate current reliable information on fertility, family planning, infant and child mortality, maternal and child health, and nutrition. The sole purpose of such data gathering was to assist policymakers and programme managers in evaluating and designing programmes and strategies for improving the health of Ghana's population. The 2014 GDHS used a two-stage sample design and was intended to allow estimates of key indicators at the national level as well as for urban and rural areas and each of Ghana's 10 administrative regions. Data was collected using three types of questionnaires namely the Household Questionnaire, the Woman's Questionnaire, and the Man's Questionnaire. A pre-test training and field practice of the GDHS was conducted using ten women and five men. 139 field data collectors (67 women and 72 men) and 55 health technicians (26 women and 29 men) were trained for data collection. Paper questionnaires were used to conduct the interviews. After the interviews, field editors entered the questionnaire data into laptops.

3.3 Research Design

The GDHS used the descriptive research design employing the use of a survey. The study obtained information concerning the current status of women, men and households with

respect to variables or conditions; the study was void of manipulation of variables. The descriptive survey research specifically involved asking questions of a sample of individuals who are representative of the group being studied, that is, not all men or women living in Ghana were part of the study.

This study uses a cross – sectional analytical approach to assess the effects of married women's autonomy on choice of place of delivery. Descriptive statistics including mostly frequencies were computed for categorical variables. Logistic regression models were also used to test the relationship between the socio-demographic /economic factors and levels of autonomy and relationship between these fore mentioned variables and choice of place of delivery.

3.4 Study Area

The GDHS covered the whole of country. Ghana is a West Africa country with a total land area of 238,537 square kilometres, and it is bordered on the east by Burkina Faso on the north and northwest, on the West by Cote d'Ivoire and the Gulf of Guinea lies to the South (GDHS, 2014). There are 10 administrative regions in Ghana.

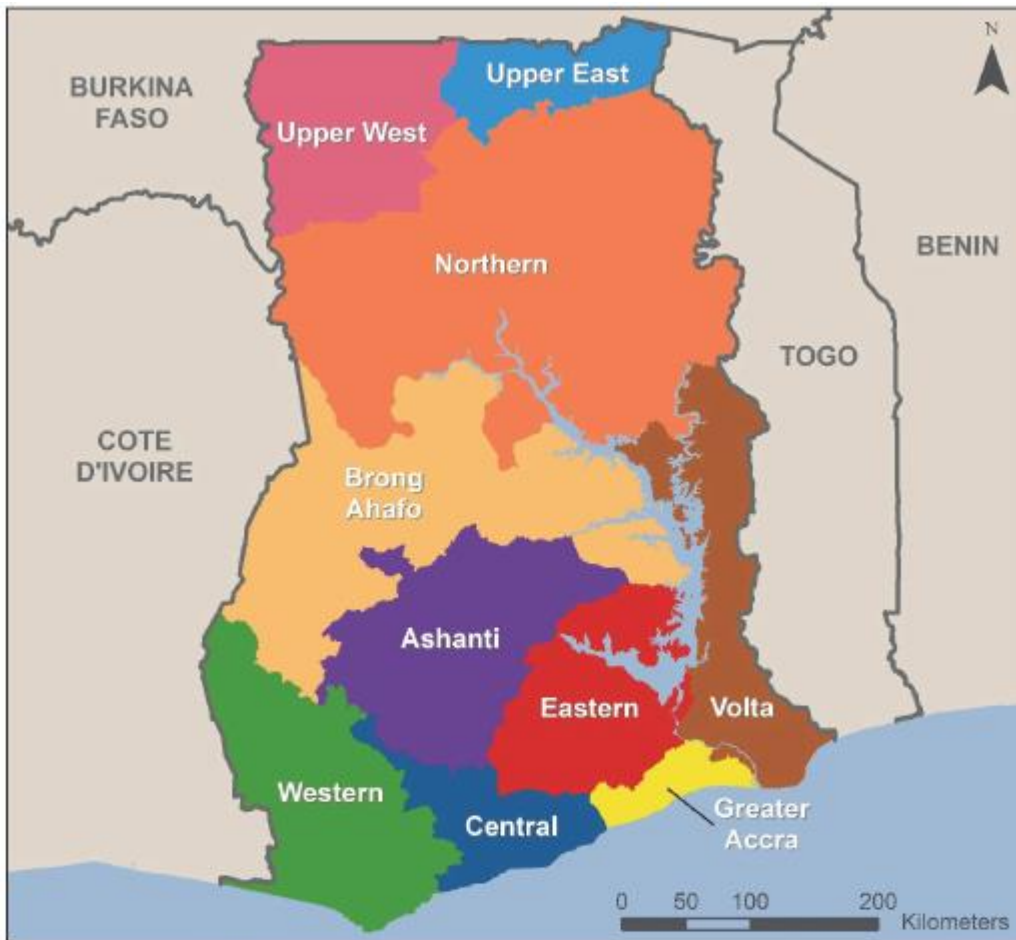


Figure: 2 Map of Ghana

Source: GDHS, 2014.

3.5 Study Population

The study population for this current research was married women aged 15-49 years given birth in the last five years. This was because the variable of interest which is "married women's autonomy on decision making" was most applicable to this group of women.

3.6 Inclusion criteria

The inclusion criteria for this study were married women age 15-49 that had given birth in the last five years.

3.7 Exclusion Criteria

The exclusion criteria for this study were non-married women aged 15-49 years.

3.8 Variables

The independent variable for this study is women's autonomy. In order to understand the full effect of married women's autonomy, some background variables were considered as explanatory variables. These are place of delivery, highest level of education of mother and spouse, place of residence (rural/urban), birth parity, mother's religion, occupation of mother and spouse, antenatal visits, mother and spouse's age, relationship with household head, currently living with husband/partner, health insurance cover for mother, decisions in relation to health, household purchases and visits to relatives/friends and wealth.

The following variables were re-coded for data analysis:

The independent variable was married women's decision making autonomy. It was computed – using five variables: the person who usually decides; on how to spend respondent's earnings, on mother's health care, on large household purchases, on visits to family or relatives and what to do with money husband earns. The responses for these five variables were respondent alone, respondent and husband/partner, and partner alone, someone else and other. Wherever the respondent was involved in such decisions, they were given a score of '1' otherwise '0'. The resulting total scores for each observation were then transformed as percentages. The dependent variable was type of delivery for their last child within the previous 5 years, i.e. whether institutional or non-institutional.

Government hospital, government health centre/clinic, government health post/chips, other public facilities, private hospital/clinic, mobile clinic, maternity home and other private medical facilities were re-coded as Institutional facilities. Respondent's home, other home and others were re-coded as Non-institutional facilities for place of delivery within the last five (5) years.

Age of mother was categorised into 15-19, 20-24, 25-29, 30-34, 35-39, 40-44 and 45-49 years. Husband/Partner's age was also categorised as follows; <30, 30-34, 35-39, 40-44, 45-49 and 50+.

Educational level of mother and husband was categorised as no education, primary, secondary education

Religion of mother was categorised as Christian, Muslim, no religion and others.

Responses for 'mother covered by health insurance' were yes and no.

Parity was defined in three levels; first birth (1), two– four births (2) and five and above births (3). We recorded Antenatal visits were also re-coded as less than 4 visits and 4 and above visits. All other variables for use is this study was used as recorded in the GDHS 2014.

Autonomy was estimated from the set of questions that determine the person who usually decides how to spend respondent's earnings, decides on respondent's health care, large household purchases, visits to family or relatives and what to do with money husband earns. Wherever the woman was involved, a score of '1' was given otherwise '0'. The sums of these scores were then transformed as percentages resulting in a scale of 0-100 with '0' being no autonomy at all and '100' being perfect autonomy. Autonomy on the percentage scale was categorized into three groups. Women with less than 50% autonomy in the various decision making variables that made up autonomy were considered as having low autonomy, while those with autonomy between 50 and 99% were classified as having partially good autonomy and those with complete autonomy scoring 100% in that regard. Design adjusted mean autonomy levels were then estimated per the socio-demographic/economic factors with F-tests of the means to determine if there were significantly different.

3.9 Sample Size

For the purposes of this study, the sample was limited to married women who have had given birth in the last five years. This is a sample of 2,801 married women. The reason for this is that, the variable of interest which is "women's autonomy on decision making" was most applicable for women in living in Ghana with a predominantly patriarchal society. Women by being married and sharing households with their husbands are most likely to negotiate and navigate the complex expectations of decision making in the home.

3.10 Quality Control

Since the data was not collected purposefully for this study, the researcher cleaned and re-analysed certain portions of the data to suit the intended data processing of this study. This was achieved using STATA to find missing values as well as errors in the raw data. Data was protected using a password only accessible to the researcher.

3.11 Data Processing and Analysis

Frequency and percentage distribution were the descriptive statistics used to examine the background and distribution of the sample. Also, the bivariate correlation coefficient analysis was used to determine the relationship between levels of autonomy by socio-demographic factors at a 95% confidence interval. The Multivariate Analysis of Variance (MANOVA) was used to examine the relationship between socio-demographic and economic factors and delivery at facility (institutional or non-institutional). Using a Multiple logistic regression analysis, odd ratios (adjusted and unadjusted) were generated for married women's autonomy, factors that influence it (socio-demographic and economic) as well as the choice of place of delivery. An outcome of less than 0 was interpreted as probability to have non-institutional delivery and an outcome of 1 was interpreted as probability to have institutional delivery at a statistical significance of 0.005 and 95% confidence interval. The adjusted ratios represent a single factor without the confounding effects of other factors whereas unadjusted

was a measurement obtained in the midst of confounding variables. The software for the analyses was Stata 15.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results of the study. The results are organized around the three objectives of the study.

4.2 Background characteristics

Almost a third (27.2%) of the women were aged 30-34 years with the least (1.1%) being 15-19-year-old (Table 4.1). Most of their spouses/partners were also aged 35-39 years. Most of their spouses or partners were also aged 35-39 years. Also, the majority of them (44.6%) had secondary school education with most of their spouses also having had at least secondary education. Only 6.4% of the target population had received tertiary education.

Respondents from the Ashanti Region had the highest representation (18.3%) with the Upper West having the least (3.9%). The majority (53.2%) were from rural areas. Christianity was the dominant religion with 70.4% representation. Eighty-three percent of the mothers were living with their spouses and 81.3% of these mothers had their husbands as the heads of their households.

There was almost equal number of mothers belonging to the poorest wealth quintile (24.6%) and the richest quintile (23.4%) and most of the mothers were working as salespersons or traders, followed by those in the agricultural sector. Most of their spouses (38.8%) were however working in the agricultural sector. Majority of the women (72.7%) were covered by some form of health insurance (Table 4.2).

Majority of the mothers (54.6%) had a parity of 2-4 children with only 15.2% being first time mothers. ANC visits for their last pregnancy was also impressive with 89.9% of the mothers having four or more visits.

Table 4.1: Background Characteristics

Characteristic	No. of observations	Estimated % within population
Age of mother (years)		
15 – 19	39	1.1
20 – 24	321	10.0
25 – 29	686	24.2
30 – 34	713	27.2
35 – 39	603	22.7
40 – 44	322	11.1
45 – 49	117	3.7
Husband/Partner's age (years)		
<30	337	11.2
30 – 34	556	19.7
35 – 39	629	24.1
40 – 44	533	20.9
45 – 49	339	11.6
50+	398	12.3
Highest education of mother		
No education	1,122	32.0
Primary	505	17.0
Secondary	1,031	44.6
Higher	143	6.4
Husband/Partner's highest education		
No education	940	24.9
Primary	347	10.4
Secondary	1,204	51.8
Higher	286	11.8
Don't know	24	1.1
Region		
Western	224	8.8
Central	259	10.1
Greater Accra	206	16.0
Volta	187	6.6
Eastern	202	7.7
Ashanti	273	18.3
Brong Ahafo	288	8.3
Northern	469	14.3
Upper East	368	6.0
Upper West	325	3.9
Type of residence		
Urban	1,169	46.8
Rural	1,632	53.2
Religion of mother		
Christian	1,830	70.4
Muslim	754	23.1
None/Other	217	6.5
Total	**2,801**	**100.0**

Table 4.1: Background Characteristics (continued)

Characteristic	No. of observations	Estimated % within population
Currently living with husband/partner		
Living with her	2,376	83.5
Staying elsewhere	424	16.5
Relationship to household head		
Head	311	13.1
Wife	2,314	81.3
Daughter	81	3.3
Daughter-in-law	47	1.0
Other	48	1.2
Wealth index of household		
Poorest	1,002	24.6
Poorer	511	17.5
Middle	420	15.4
Richer	440	19.1
Richest	428	23.4
Occupation of mother		
Not working	399	13.8
Professional/Technical/Managerial	136	5.9
Clerical/Services	48	2.3
Sales	894	37.2
Agricultural	947	27.8
Skilled manual	344	11.9
Unskilled manual	26	0.9
Husband/Partner's occupation		
Professional/Technical/Managerial	338	13.8
Clerical/Services	82	3.3
Sales	232	9.7
Agricultural	1,329	38.8
Skilled manual	456	19.1
Unskilled manual	345	14.9
Mother covered by health insurance		
No	718	27.3
Yes	2,082	72.7
Parity		
One	415	15.2
2-4	1,472	54.6
5+	914	30.2
ANC visits (last pregnancy)		
<4	310	10.1
4+	2,491	89.9
Total	**2,801**	**100.0**

4.3 Levels of Autonomy by Background Characteristics

The most (76.7%) autonomous age group was those 35-39 years with significant differences between the age groups (Table 4.2). Women whose spouses were aged 35-39 years were also the most (74.5%) autonomous with significant differences between the categories. Those with the Tertiary education were also the most (81.5%) autonomous and those without formal education being the least autonomous ($p<0.001$). Also, women whose spouses either had no education or did not know their husband's educational level had significantly less (68.5%) autonomy compared to those whose spouses had at least some form of education.

There were significant differences in autonomy across the various regions as well. Christian women were also more (75.3%) autonomous compared to other religions. Living with a husband was not a significant factor in this. Higher levels of wealth, occupation of the mothers and spouses were significantly associated with autonomy ($p<0.001$) (Table 4.2).

There were no significant differences in autonomy by parity although women who attended more than four ANC sessions had significantly higher levels of autonomy compared to women with less than four ANC visits.

Table 4.2: Levels of Autonomy by Background Characteristics

Background Characteristics	Weighted percent (95% CI)	P-value
Age of mother (years)		<0.001
15 – 19	64.9 (55.8, 74.1)	
20 – 24	63.2 (58.1, 68.3)	
25 – 29	74.2 (71.3, 77.2)	
30 – 34	70.6 (68.2, 73.1)	
35 – 39	76.7 (74.6, 78.9)	
40 – 44	71.8 (68.6, 75.0)	
45 – 49	69.4 (64.3, 74.6)	
Husband/Partner's age (years)		0.013
<30	70.4 (64.6, 76.1)	
30 – 34	70.3 (67.2, 73.4)	
35 – 39	74.5 (72.2, 76.9)	
40 – 44	73.7 (70.7, 76.7)	
45 – 49	72.0 (68.7, 75.3)	
50+	69.9 (66.7, 73.1)	
Highest education of mother		<0.001
No education	64.1 (61.2, 67.0)	
Primary	74.7 (72.3, 77.1)	
Secondary	75.4 (73.5, 77.3)	
Higher	81.5 (77.4, 85.6)	
Husband/Partner's highest education		<0.001
No education	63.6 (60.8, 66.4)	
Primary	72.6 (68.8, 76.5)	
Secondary	74.6 (72.8, 76.4)	
Higher	78.7 (74.5, 82.9)	
Don't know	68.5 (60.6, 76.5)	
Region		<0.001
Western	85.9 (82.9, 88.9)	
Central	79.5 (74.9, 84.0)	
Greater Accra	70.0 (66.4, 73.6)	
Volta	69.7 (66.8, 72.6)	
Eastern	82.4 (78.3, 86.5)	
Ashanti	73.3 (70.0, 76.7)	
Brong Ahafo	74.2 (70.1, 78.2)	
Northern	53.5 (49.8, 57.2)	
Upper East	77.1 (74.2, 80.0)	
Upper West	64.3 (59.8, 68.7)	
Type of residence		0.377
Urban	73.0 (71.1, 74.9)	
Rural	71.5 (68.7, 74.3)	
Religion of mother		<0.001
Christian	75.3 (73.7, 76.8)	
Muslim	64.8 (60.3, 69.3)	
None/Other	63.4 (58.0, 68.8)	
Total	**72.2 (70.4, 73.9)**	

Table 4.2: Levels of Autonomy (in %) by Background Characteristics (continued)

Background Characteristics	Weighted percent (95% CI)	P-value
Currently living with husband/partner		0.638
Living with her	72.1 (70.2, 74.0)	
Staying elsewhere	72.8 (70.2, 75.3)	
Relationship to household head		<0.001
Head	76.3 (73.6, 79.1)	
Wife	72.1 (70.2, 74.0)	
Daughter	63.2 (57.6, 68.8)	
Daughter-in-law	58.8 (50.8, 66.7)	
Other	68.1 (61.8, 74.4)	
Wealth index of household		<0.001
Poorest	63.3 (60.5, 66.1)	
Poor	74.5 (71.0, 78.1)	
Middle	75.5 (72.7, 78.4)	
Rich	73.8 (70.7, 76.9)	
Richest	75.9 (72.7, 79.2)	
Occupation of mother		<0.001
Not working	54.7 (51.7, 57.7)	
Professional/Technical/Managerial	82.5 (77.9, 87.1)	
Clerical/Services	84.5 (75.0, 94.0)	
Sales	77.3 (75.5, 79.0)	
Agricultural	67.9 (64.6, 71.2)	
Skilled manual	76.5 (72.9, 80.2)	
Unskilled manual	72.9 (59.0, 86.8)	
Husband/Partner's occupation		<0.001
Professional/Technical/Managerial	78.1 (74.6, 81.7)	
Clerical/Services	75.8 (68.8, 82.8)	
Sales	70.5 (66.9, 74.0)	
Agricultural	68.8 (66.1, 71.5)	
Skilled manual	74.8 (72.1, 77.6)	
Unskilled manual	71.9 (68.0, 75.8)	
Mother covered by health insurance		0.138
No	73.7 (71.2, 76.2)	
Yes	71.6 (69.7, 73.6)	
Parity		0.543
One	71.9 (69.1, 74.7)	
2-4	72.8 (70.4, 75.3)	
5+	71.1 (68.9, 73.4)	
ANC visits (last pregnancy)		0.015
<4	66.5 (61.6, 71.4)	
4+	72.8 (71.0, 74.6)	
Total	**72.2 (70.4, 73.9)**	

4.4 Delivery in a health facility by socio-demographic/economic factors

Design adjusted estimates of women who delivered their last child at health facilities showed significant differences across age the various age categories. Mothers aged 35-39 delivered at

a health facility the most (78.4%) and 45-49years at the least (58.3%). There was also significant association between health facility deliveries and ages of their spouses ($p<0.001$). Respondents whose spouses were aged 40-44 years were the most (81.7%) and those aged 50 years and above the least (61.3%) (Table 4.3).

Highly educated women married to highly educated men also had such institutional deliveries significantly more than those without ($p<0.001$).

There were significant differences across regions with Greater Accra leading the way with 95.9% of deliveries taking place at health facilities and the Upper West Region having only 65.9% of its deliveries at health institutions. Urban dwelling women also had significantly more institutional deliveries compared to the rural women and Christian women also had significantly more of institutional deliveries compared to the other religious groups ($p<0.001$) (Table 4.3).

Women from wealthier households also had significantly more institutional deliveries compared to women from poorer households. A significant association was also observed between place of delivery and occupation of the women. Women in professional, technical, managerial, clerical and service jobs had the highest institutional deliveries. Mothers covered by insurance also had more of their deliveries at health facilities. Women with more children were less likely to have had their last child at a health facility while women who attended four or more ANC sessions during their last pregnancy were more likely to have delivered at a health facility.

Table 4.3: Delivery in a Health Facility by Socio-demographic and Economic Factors

Socio-demographic and economic factor	Delivery at facility (%) Non Institutional	Institutional	P-value
Age of mother (years)			0.005
15 – 19	22.9	77.1	
20 – 24	29.9	70.1	
25 – 29	21.4	78.6	
30 – 34	23.9	76.1	
35 – 39	21.6	78.4	
40 – 44	27.8	72.2	
45 – 49	41.7	58.3	
Husband/Partner's age (years)			<0.001
<30	27.8	72.3	
30 – 34	22.3	77.7	
35 – 39	21.2	78.8	
40 – 44	18.3	81.7	
45 – 49	27.5	72.5	
50+	38.7	61.3	
Highest education of mother			<0.001
No education	45.0	55.0	
Primary	27.0	73.0	
Secondary	12.0	88.0	
Higher	1.5	98.5	
Husband/Partner's highest education			<0.001
No education	48.9	51.1	
Primary	31.1	68.9	
Secondary	15.9	84.1	
Higher	5.2	94.8	
Don't know	15.5	84.6	
Region			<0.001
Western	20.8	79.2	
Central	24.1	75.9	
Greater Accra	4.1	95.9	
Volta	34.3	65.7	
Eastern	27.6	72.4	
Ashanti	13.3	86.7	
Brong Ahafo	23.2	76.8	
Northern	59.6	40.4	
Upper East	15.3	84.7	
Upper West	34.1	65.9	
Type of residence			<0.001
Urban	8.2	91.8	
Rural	38.7	61.3	
Religion of mother			<0.001
Christian	19.1	80.9	
Muslim	28.5	71.5	
None/Other	68.5	31.5	
Total	**24.5**	**75.6**	

Table 4.4: Factors associated with delivery at Health Facility)

Socio-demographic/economic factor	Delivery at facility (%) Non Institutional	Institutional	P-value
Currently living with husband/partner			0.025
Living with her	25.5	74.5	
Staying elsewhere	19.3	80.7	
Relationship to household head			0.141
Head	19.1	80.9	
Wife	25.5	74.5	
Daughter	21.3	78.7	
Daughter-in-law	25.3	74.8	
Other	17.0	83.0	
Wealth index of household			<0.001
Poorest	50.5	49.5	
Poorer	39.2	60.9	
Middle	21.9	78.1	
Richer	5.8	94.2	
Richest	3.0	97.0	
Occupation of mother			<0.001
Not working	24.6	75.4	
Professional/Technical/Managerial	6.0	94.1	
Clerical/Services	4.8	95.2	
Sales	13.0	87.0	
Agricultural	46.7	53.4	
Skilled manual	21.3	78.7	
Unskilled manual	16.6	83.4	
Husband/Partner's occupation			<0.001
Professional/Technical/Managerial	6.7	93.3	
Clerical/Services	12.0	88.0	
Sales	8.0	92.0	
Agricultural	44.6	55.4	
Skilled manual	15.9	84.1	
Unskilled manual	13.5	86.5	
Mother covered by health insurance			<0.001
No	32.4	67.6	
Yes	21.5	78.5	
Parity			<0.001
One	12.0	88.0	
2-4	20.5	79.5	
5+	37.9	62.1	
ANC visits (last pregnancy)			<0.001
<4	65.9	34.1	
4+	19.8	80.2	
Level of autonomy			<0.001
Low	**36.0**	**64.0**	
Average	**23.2**	**76.8**	
Complete	16.8	83.2	

4.5 Influence of married woman's autonomy on choice of place of delivery

Logistic regression was carried out to determine the association between autonomy and place of delivery, adjusting for other socio-demographic and economic factors. Autonomy was highly associated with place of delivery for their last child with a 1% increase in autonomy leading to a 1% increase in the odds of delivery at a health facility which, means a 10% increase in autonomy will lead to a 10% increase in the relative odds of delivering at a health facility. However, after adjusting for the Age of the mother, Education, Region, Type of residence, Religion, Wealth index and Occupation of the mother, the association between autonomy and delivery ceases to be significant although a 1% increase in autonomy suggests a 6% increase in the relative odds of delivering at a health facility

The age of the mother did not have a significant association. The higher the education of the mother, the greater the relative odds of her delivering at a health facility. (Table 4.5). There were significant differences in the institutional delivery across the regions with almost all the regions having significantly lower odds compared to the Greater Accra Region. Type of residence also played a significant role with urban mother more likely to deliver at health facilities even after adjusting for the other variables.

Wealth also played a significant role with the richest women having higher odds of institutional delivery; 7 times more than those from the poorest households after adjusting for autonomy and other socio-demographic/economic factors (Table 4.5). Occupation of the mothers played a significant role initially with almost all mothers who were working having a higher odds of institutional delivery compared to the unemployed, however this association ceased to be significant in the adjusted model.

Table 4.5: Logistic regression analysis of factors associated with delivery at a Health facility

(0=Non-institutional, 1=Institutional)	OR (95% CI)	P-value
Age of mother (years)	0.99 (0.98, 1.01)	0.591
Highest education of mother		
No education	Ref	0.007
Primary	1.21 (0.89, 1.66)	
Secondary	1.75 (1.23, 2.50)	
Higher	8.81 (1.01, 76.76)	
Region		
Greater Accra	Ref	<0.001
Western	0.58 (0.21, 1.57)	
Central	0.46 (0.19, 1.11)	
Volta	0.61 (0.24, 1.57)	
Eastern	0.42 (0.17, 1.05)	
Ashanti	0.78 (0.33, 1.83)	
Brong Ahafo	0.85 (0.33, 2.15)	
Northern	0.38 (0.14, 1.02)	
Upper East	2.89 (1.13, 7.40)	
Upper West	1.02 (0.38, 2.76)	
Type of residence		
Rural	Ref	0.003
Urban	1.91 (1.25, 2.92)	
Religion of mother		<0.001
Christian	Ref	
Muslim	1.09 (0.68, 1.74)	
None/Other	0.34 (0.22, 0.54)	
Wealth index of household		
Poorest	Ref	<0.001
Poorer	1.5 (1.07, 2.09)	
Middle	2.48 (1.56, 3.95)	
Richer	8.18 (4.05, 16.51)	
Richest	7.75 (3.31, 18.10)	
Occupation of mother		
Not working	Ref	0.425
Professional/Technical/Managerial	0.76 (0.26, 2.22)	
Clerical/Services	2.19 (0.52, 9.32)	
Sales	1.56 (0.95, 2.58)	
Agricultural	1.19 (0.78, 1.81)	
Skilled manual	1.06 (0.61, 1.83)	
Unskilled manual	1.85 (0.34, 10.18)	
Level of autonomy		
Low	**Ref.**	<0.001
Partially good	**1.86(1.42, 2.44)**	
Complete	2.79 (1.85, 4.22)	

CHAPTER FIVE

DISCUSSIONS

5.1 Introduction

This chapter discusses the summary of the entire study conducted and findings from the data analysis. The findings of the study are also compared with previous literature to test the consistency of results. The researcher also explains the findings and its implications, strength and limitations encountered in this study and conclusions.

5.2 Summary of Study and Findings

The study sought to determine whether autonomy in decision making for married women is significant in choice of place of delivery. This was to be achieved by estimating and comparing the level of autonomy by socio-demographic/economic factors, determining and comparing the proportion of married pregnant women that delivered in a health facility by socio-demographic/economic factors and examining the extent to which a married woman's autonomy affects choice of place of delivery as well as factors associated with levels of married women's autonomy in Ghana.

5.3 Married women's autonomy by Socio-demographic/economic factors

Results from the study revealed that women within the ages of 25-29 years were the most autonomous and further women whose spouses were aged 35-39 years were also most autonomous. According to the Ghanaian educational system, with all things being equal, both women and men between the ages of 25-29 would have completed tertiary education or had an informal skill of trade from which they can draw some form of economic means. The economical means such women have grants them autonomy to make decisions regarding their upkeep and progress in life. Also married women at that age with all things being equal are now starting a family hence has less responsibility than those above 30 who may have had

more children than their younger counterparts. With less responsibility, there is less strain on finances which influences autonomy on health, household purchases and visits to friends and relatives.

Also women with the highest education were also the most autonomous with those without education being the least autonomous while women whose spouses either had no education or did not know their husband's educational level had significantly less autonomy compared to those whose spouses had at least some form of education. As earlier discussed autonomy in health can only be effectively implemented when one has knowledge on her own health. Also it was earlier established that a successful decision making process involves stages that can only be achieved with a level of knowledge. As Woldemicael and Tenkorang (2010) put it, education enables women to make important decisions regarding health for example, location of the health facility; kind of services are provided there, how to consult health personnel. Furthermore with respect to spouse education, it is perceived that education not only influences married women but also their partners in deciding place of delivery. Hence assuming a woman is not as well educated but her partner is, the likelihood for her to have autonomy is still greater and vice versa.

Autonomy varied across all the ten regions in Ghana. This is expected as the various regions have different ethnic groups which mostly influence the roles of married women in a household (Bawa, 2015). Marriages in Ghana are defined by one's cultural settings (Addai, Opoku-Agyeman & Amanfu, 2015).

Christian women were also more autonomous compared to other religions which are as a result of the different tenets or belief system held by the various religions. Where one religion may encourage equality, the other may subscribe to a different form of rule in marriage.

A higher level of wealth was significantly associated with autonomy just as occupation of the mothers as well as their spouses. Money is a very important resource in this world and defines one's wealth and influence in society. Occupation serves as a wellspring from which money or wealth is obtained.

5.3.1 Married woman's autonomy and Place of delivery

Results from the analysis revealed that an increase in the autonomy of a woman leads to an equal increase in the likelihood of institutional delivery. Thereby, the more control a woman has over her own life, materials, access to knowledge and information, having equivalent say with their spouses on issues influencing themselves and their families, the greater the odds of institutional delivery. However, the influence of socio-demographic factors such as age, education, occupation and others can influence the extent of this relationship. This implies that in order to increase institutional deliveries in Ghana, gender policies and strategies should be aimed at making women more autonomous in relation to decision making in the family and society at large.

5.3.2 Socio-Demographic Variables and Place of Delivery

Results revealed that highly educated women as well as those with highly educated spouses also had such institutional deliveries significantly more than their under-educated counterparts. Also, the higher the education of the mother, the greater the relative odds of the mother delivering at a health facility. Education is a tool to obtaining knowledge on all aspects of life especially health. It enables one to make important decisions regarding health for example, where is the health facility, what kind of services are provided from there, how to consult health personnel (Woldemicael & Tenkorang, 2010). With education, women and their spouses can make confident decisions regarding place of delivery.

Younger married women with their spouses frequently had institutional deliveries than the older women with their spouses. Older women may perceive themselves to have more

experience with child birth and hence may be reluctant in seeking medical assistance for delivery. Age may however interact with other variables such as previous medical history and risks involved with the pregnancy which was not examined in this study.

Women with more children were significantly less likely to have had their last child at a health facility though women whose last pregnancy had four or more ANC sessions were significantly more likely to have had the last baby delivered at a health facility. The hypothesis of experience comes into play here where women who perceive themselves to have more childbirth experiences perceive they can assist themselves during child birth.

A greater number of married women in the urban areas had institutional delivery than women living in rural areas and urban mothers were more likely to deliver at health facilities even after adjusting for the other variables. Rural areas mostly suffer from inadequate health facilities. These areas have inadequate and poor health services (Sulemana & Dinye, 2014). This is usually coupled with long distances to health facilities, lack of effective and efficient transportation systems, inadequate health personnel and high cost of health services (Lu et al, 2010). For instance more than 65% of medical doctors in the nation are packed in two urban-based teaching hospitals, Komfo Anokye in Kumasi and Korle Bu in Accra (Buor, 2008). These and many more are the challenges that women living in rural areas face in their efforts to seek quality maternal healthcare.

Occupational status contributes immensely towards the socio-economic status of women. Akinyo (2009) observed that mothers who were unemployed were less likely to deliver in institutional facilities. Mothers who had a source of employment however had relatively higher odds of delivering in health unit. These women were exposed to information about seeking medical care, most of them are urban residents and they can afford the requirements needed during delivery. Results from this study revealed that women involved in

Professional/Technical/Managerial and Clerical/Service jobs had the highest proportion of their deliveries being institutional. These types of jobs in Ghana are regarded at 'white collar' jobs and provide better and regular remuneration than the supposedly 'blue collar' jobs which mostly involves manual work. Hence the type of job one does influences the amount of resources (financial) available to them. Almost all mothers who were working had a relatively higher odds of institutional delivery compared to those unemployed. However certain aspects such as type of work were not accounted for. Some women though working may receive other incentives such as food stuffs and not necessarily money as payment of work done. Also being self-employed or institution-employed may influence a married woman's finances. Being self-employed comes with challenges in earning money but an institution worker is a salary worker who is assured of constant payment with or without an inflation rate.

As was discussed in the literature review, the Ghanaian health system has progressed from free antenatal care policy introduced in all public health facilities in 1998 (Biritwum 2006) to free delivery care policy introduced by then Government of Ghana in September 2003 through funding from the highly indebted poor countries initiative (HIPC). The free delivery care policy formally came to an end due to lack of funding and was incorporated into the NHIS, which was already functional since 2005 (Witter and Garshong 2009; Ghana Statistical Service et al. 2009a). The NHIS afforded women free medical care in both public and private institutions with sole purpose of encouraging more women to make the decision to receive child-birth delivery services. However there are other private health insurance firms to cater for the shortfalls of the NHIS. Results from this study reveals that mothers covered by insurance also had more of their deliveries at health/affiliated institutions. However, other variables such as availability and accessibility of healthcare facilities and professionals may interact with the usage of health insurance. It is also popularly perceived

that when patients are treated with less care when with NHIS than when paying cash for healthcare services. This may be attributed to the shortfalls of the NHIS.

Women from wealthier households also had significantly more institutional deliveries compared to the poorer women with the richest women having relative odds of institutional delivery 7 times as much as those from the poorest households after adjusting for autonomy and other socio-demographic/economic factors. Health care in Ghana is not free. Even with the use of NHIS, it requires an initial registration fee as well as renewal as the years go by. This is in line with observations made by Ameyaw, Tanle, Kissah-Korsah and Amo-Adjei (2016) that delivery in health facilities increased with higher wealth quintile whereas home deliveries characterized poor women. In a developing nation like Ghana, the affluent in society are more likely to have institutional deliveries than the less affluent.

Though efforts have been made to ensure equal distribution of resources across all the ten (10) regions in Ghana, it is not always successful. For instance some regions in Ghana have well established medical facilities than others especially in the case of the region of the capital city, Greater Accra. Some of these regions have better road systems than others. And these are the factors that usually influence women's accessibility to health care. It was earlier noted that more than 65% of medical doctors in the nation are packed in two urban-based teaching hospitals: Komfo Anokye in Kumasi and Korle Bu in Accra (Buor, 2008) which should not be the case. Medical personnel may sometimes reject to go to rural areas due to poor facilities and utilities as well as road systems. Hence it is not a surprise as Greater Accra region had the highest of institutional deliveries with the lowest being Upper West (65.9%). However, it is encouraging to know that even the Upper West had more than half of deliveries institutional. Almost all the regions had significantly lower odds compared to the Greater Accra Region. However, not all women deliver in the regions they live in. Some may prefer to travel to other regions with better health facilities for delivery. Also, married

women's perception on health care services offered by the facilities may greatly interact with their choice of place of delivery though that aspect was not catered for by this study.

5.4 Explanation of Findings and Implications

A critical philosophical issue is what it implies for people to be autonomous in any given culture or society. Given that individuals are constantly imbedded in their social setting, their choices frequently consider thought for others in their family units and community, and choices may not be completely autonomous.

Inquiries regarding autonomous decision making are particularly appropriate with regards to healthcare and medical services in which the individual hardly is "solitary" in decision making without thought for and impact of family, friends as well as partners. The idea of individuality in contemporary Western societies is regularly comprehended as freedom, independence, and self-directedness. Be that as it may, autonomy as an individualistic concept has received doubt due to its influence in neglecting or even downgrading the relevance of relationships, for example, loyalty, caring, friendships and responsibilities and furthermore overlooks the way that individuals are socially raised, with part of their personality being comprised by their social relations.

Autonomy on place of delivery is successfully made based on access to the right information which is usually as a result of education. This is confirmed by the findings of this study that women who with their spouses had higher education had institutional births. The more educated a woman is, the greater her opportunity in making the right decisions. Being educated also has a way of imparting feelings of self-worth and self-confidence which ensures successful decision making. However, for women who may not have received some form of formal education as it is, the findings of this study revealed that the education of partners also increased the opportunity for women to have institutional delivery. So either ways, institutional delivery can be promoted by also educating men on the need for women to

seek institutional healthcare. Even if not every Ghanaian can obtain formal education, the media, especially social medial is an important tool to promote institutional healthcare and delivery. In this global modernized world, information is easily disseminated at the lowest of costs. All one needs is a radio or a “smart” phone to get access to all sorts of information. If any government seeks to reduce mortality during child birth, the media is the first place to obtain the interest of all stakeholders including the partners of married women.

From the results of this study, it could be deduced that age could not act alone in providing autonomy for healthcare decisions such as delivery. Other confounding variables include experience in child birth, medical history of mother or identified risks during pregnancy. If an older woman who has had previous births encountered difficulties to the extent of near death experiences, it is likely such a woman would seek institutional delivery than home care in order to avoid life threatening risks. However, if experience in previous child birth has been uneventful, then one may convince herself that she has enough experience to do it on her own or be assisted at a non-institutional facility.

The low patronage of institutional delivery in the rural areas is commonly attributed to inadequate health facilities and most frequently poor road network. There has been cases in the media where women due had to be carried on make-shift stretchers for long distances by men in order to get to the delivery facilities. Such experiences are discouraging. Rather than go through the ordeal some may prefer to make use of whatsoever help they may find available.

Results from the study indicated that a greater number of working women gave birth in institutions than those not working. Working women have the opportunity of increase in resources (e.g. financial) increasing their autonomy and options of quality of healthcare. Such women may prefer to have fewer child births in order to pursue their careers and hence may

not frequently be in need of institutional delivery. Women who are not working may also find it necessary to depend on a partner who dictates how many children one is supposed to have and the resources available to decide on place of delivery. However, with the introduction of the NHIS, all one needs is an initial relatively small amount for registration. Hence women who are not employed can easily afford institutional delivery at any time they want to give birth.

Wealth makes a lot of things possible including affording the best healthcare system for delivery. As it was observed from the study, the odds of a woman having institutional delivery increased as wealth index increased. Wealth gives one access to healthcare no matter the cost or the challenge. Many women in the rural areas if they could afford would move to the cities where there are better amenities to deliver. Some women may even be able to afford home care delivery yet with in the presence of the best doctors she can pay.

5.5 Strengths and Limitations

This study used a nationally representative data from the GDHS 2014 which provided a rich set of information on all variables. The researcher could not have been able to obtain data on each of the variables from such a large population due to limited resources. Such a large data set covering women's reproductive health could not have been available but for the government collecting it. The data was made available to the researcher at no cost. Also, since the data has a large population distribution, results can be largely generalized.

However, the use of secondary data has its own setbacks. Since data was collected by the current government at that point in time, it is susceptible to biases of those in authority at that time. Also, the GDHS is four years old and though relevant may be far different from the outcry of present circumstances.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

Women’s autonomy in five areas namely, autonomy on how to spend respondent's earnings, autonomy on health care, autonomy on household purchases, autonomy on visits to friends and relatives and autonomy on money husband earns were tested and found to be significantly related to place of delivery (institutional/non-institutional). This indicates that women’s ability to make independent decisions in these three areas in the presence of socio-demographic/economic factors influenced their chance to seeking institutional delivery.

Younger women are the most autonomous as well as women whose spouses have higher education. Also, Christian women are more autonomous than those belonging to other religions. High wealth index and occupation are significantly associated with autonomy. An increase in a woman’s autonomy increases her odds of having institutional delivery.

Highly educated women and those with highly educated spouses deliver in institutional facilities than the undereducated. Younger women along with their spouses have institutional deliveries than older women with their spouses.

Majority of Christian and Muslim married women had institutional delivery whereas majority of women who had no/other religion had non-institutional delivery. Religion was also found to be significantly associated to place of delivery.

Type of residence a woman dwelt in, that is, urban or rural also was observed to be significantly associated with place of delivery. This was so as a greater number of women in urban areas delivered at institutions than rural areas. This was explained as being attributable to inadequate medical facilities in the rural areas as well as poor social amenities such as road

network. Almost all mothers who were working had a relatively higher odds of institutional delivery compared to those unemployed.

Married women with valid health insurance delivered at institutions with health insurance being significantly associated with place of delivery. Institutional delivery increased as wealth increased with a significant level of association. Greater Accra had the highest institutional delivery whereas Upper West region had the lowest. Women with more children were significantly less likely to have had their last child at a health facility while women whose last pregnancy had four or more ANC sessions were significantly more likely to have had the last baby delivered at a health facility.

Other variables found to influence place of delivery includes age of the mother and spouse, level of education for the mother.

All the above socio-demographic variables influenced a woman's autonomy to place of delivery at varying levels of significance.

6.2 Recommendations

From the study we observe that women's autonomy is highly associated with place of delivery. Education which plays a critical role in enhancing women's autonomy should be given much attention. Policies should be drafted to encourage female education as the higher a woman's education was, the more autonomous she is in making decisions for her wellbeing. The campaign for women empowerment should also focus on bringing men to an understanding of the benefits the society tends to accrue as women are empowered to make autonomous decisions. Free education as provided by government should be made mandatory particularly for women as it is an important tool to enhance women's autonomy in the household.

The GHS and NCCE should collaborate with each other to broadcast the need for women to seek medical assistance during pregnancy and delivery using all channels possible to reach the ordinary Ghanaian.

Education which also increases a woman’s chances of gaining employment and thus increasing her income levels will also have the snowballing effect of some enhanced level of autonomy in the household. As indicated in the study, women in the higher/richest quintile were more likely to deliver in health institutions.

REFERENCES

Acharya, D. R., Bell, J. S., Simkhada, P., Van Teijlingen, E. R. & Regmi, P. R. (2010). Women's Autonomy in Household Decision-making: A Demographic Study in Nepal. *Reproductive Health, 7*, 15.

Addai, I., Opoku-Agyeman, C. & Amanfu, K. S. (2015). Marriage and Subjective Wellbeing in Ghana. *African Review of Economics and Finance, 7*(1), 53–79.

Adegoke, A. A. & Van Den Broek, N. (2009). Skilled Birth Attendance lessons learnt. BJOG. *An International Journal of Obstetrics and Gynaecology, 116*(1), 33–40.

Agana, A. T. & Millar, D. (2015). Socio-cultural Practices and Girls Schooling System in the Upper West Region of Ghana. *Sky Journal of Educational Research, 3*(8), 097 – 112.

Akinyo, A. R. (2009). *Factors Influencing Mother's Choice of Place of Delivery in Soroti District, Uganda.* Dissertation Submitted in Partial Fulfillment of the Requirements for the Award of the Degree of Master of Arts in Demography of Makerere.

Akum, A. F. (2013). A Qualitative Study on Factors Contributing to Low Institutional Child Delivery Rates in Northern Ghana: The Case of Bawku Municipality. *J Community Med Health Educ, 3*, 236. doi:10.4172/2161- 0711.1000236

Alam, M. (2011). Factors Effect on Women Autonomy and Decision-Making Power within the Household in Rural Communities. *Journal of Applied Sciences Research, 7*, 18-22.

Ameyaw, E. K., Tanle, A., Kissah-Korsah, K., & Amo-Adjei, J. (2016). Women's Health Decision-Making Autonomy and Skilled Birth Attendance in Ghana. *International Journal of Reproductive Medicine*, 1–9. https://doi.org/10.1155/2016/6569514

Amoako, P. (2011). *Identifying pull and push factors of health workers in rural Ghana: a case study-Mpohor Wassa East District in the Western Region*. [Ph.D. thesis], Kwame Nkrumah University of Science and Technology, Kumasi, Ghana, 2011

Anderson, S., Eswaran, M. (2009). What determines female autonomy? Evidence from Bangladesh. *Journal Development Economics, 90*(2), 179–191.

Asante, F. A., Chikwama, C., Daniels, A. & Armar-Klemesu, M. (2007). Evaluating the economic outcomes of the policy of fee exemption for maternal delivery care in Ghana. *Ghana Medical Journal 41*, 110–17.

Arulampalam, W., Bhaskar, A., & Srivastava, N. (2016). Does greater autonomy among women provide the key to better child nutrition? *Warwick Economics Research Paper Series*. CAGE Discussion Paper No: 269

Bahadori, M., Sanaeinasab, H., Ghanei, M., Tavana, M. A., Ravangard, R. & Karamali, M. (2015). The Social Determinants of Health (SDH) in Iran: A Systematic Review Article. *Iranian Journal of Public Health, 44*(6), 728-741.

Balk, D. (1994). Individual and Community Aspects of Women's Status and Fertility in Rural Bangladesh. *Population Studies, 48*(1), 21-45.

Bawa, J. A. K. (2015). Bride Price in Ghana: An Assessment of its Social Representations in Selected Communities in Northern Ghana. *UDS International Journal of Development, 2*(2).

Biritwum, R. B. (2006). Promoting and monitoring safe motherhood in Ghana. *Ghana Medical Journal, 40,* 78–9.

Blanchet, N. J., Fink, G. & Osei-Akoto, I. (2012). The effect of Ghana's national health insurance scheme on health care utilisation. *Ghana Medical Journal 46*, 76–84.

Bloom, S.S., Wypij, D. & Gupta, M. D. (2001). Dimensions of Women's Autonomy and the Influence on Maternal Health Care Utilization in a North Indian City. *Demography, 38*(1), 67–78. doi: 10.1353/dem.2001.0001

Bobonis, G. J. (2009). Is the allocation of resources within the household efficient? New evidence from a randomized experiment. *Journal of Political Economy, 117*(3), 453-503.

Brunson, E. K, Shell-Duncan, B., Steele, M. (2009). Women's autonomy and its relationship to children's nutrition among the Rendille of Northern Kenya. *Am J Hum Biol, 21,* 55–64. doi: 10.1002/ajhb.20815

Buor, D. (2008). Analysing the Socio-Spatial Inequities in the Access of Health Services in Sub-Saharan Africa: Interrogating Geographical Imbalances in the Uptake of Health Care. *Professorial Inaugural Lecture, Kwame Nkrumah University of Science and Technology*, Kumasi, Ghana, 2008.

Butawa, N. N., Tukur, B., Idris, H., Adiri, F., & Taylor, K. D. (2010). Knowledge and Perceptions of Maternal Health in Kaduna State, Northern Nigeria. *African Journal of Reproductive Health, 14*(3), 71.

Campbell, O. M. & Graham W.J. (2006). *Strategies for reducing maternal mortality: getting on with what works*.

Chapman, R. A. (2010). The social determinants of health, health equity, and human rights. *Health and Human Rights Journal, 12*(2). https://www.hhrjournal.org/2013/08/the-social-determinants-of-health-health-equity-and-human-rights/

Chiappori, P. A. & Donni, O. (2009). Non-unitary models of household behavior: A survey of the literature. *IZA Discussion Paper No. 4603.*

Chiappori, P. A. (1988). Rational household labor supply. *Econometrica: Journal of the Econometric Society*, 63-90.

Chiappori, P. A. (1992). Collective labor supply and welfare. *Journal of Political Economy*, 437-467.

Cofie, L.E., Barrington, C., Singh, K., Sodzi-Tetteh, S. & Akalgaung, A. (2015). Birth location preferences of mothers and fathers in rural Ghana: Implications for pregnancy, labor and birth outcomes. *BMC, Pregnancy and Childbirth, 15*, 165.

Corroon, M., Speizer, I.S., Fotso, J.C., Akiode, A., Saad, A., Calhoun, L. & Irani, L. (2014). The role of gender empowerment on reproductive health outcomes in urban Nigeria. *Maternal Child Health Journal, 18*(1), 307-315.

Dalinjong, P. A. & Laar, A. S. (2012). The national health insurance scheme: perceptions and experiences of health care providers and clients in two districts of Ghana. *Health Economics Review, 2*, 13.

Darko, M. N. (2015). An Analysis Of Perceptions And Attitudes Towards Female Pastors In Two Districts In The Presbyterian Church Of Ghana. *Unpublished study, University of Ghana.*

D'Ambruoso, L., Abbey, M., & Hussein, J. (2005). Please Understand When I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana. *BMC Public Health, 5*, 140. doi:10.1186/1471-2458-5-140

Dangal, G. & Bhandari, T. R. (2014). Women's autonomy: New Paradigm in maternal health care utilization. *Global Journal of Medicine and Public Health, 3*(5).

Darteh, M. K. E., Doku, T. D. & Esia-Donkoh, K. (2014). Reproductive health decision making among Ghanaian women. *Reproductive Health, 11*(23). Published online 2014 Mar 15. doi: 10.1186/1742-4755-11-23

Der, E. M., Moyer, C., Gyasi, R. K., Akosa, A. A., Tettey, Y., Akakpo, P. K., Blankson, A & Anim, J.T. (2013). Pregnancy Related Causes of Deaths in Ghana: A 5-year Retrospective Study. *Ghana Medical Journal, 47*(4), 158-163.

Dev, R., Acharya, R. D., Jacqueline, S. B., Padam, S., R van Teijlingen, & Pramod, R. (2010). *Women's autonomy in household decision-making: a demographic study in*

Nepal. Accessed October 30 2017 http://www.reproductive-health journal.com/content/7/1/15.

De Schutter, O. (2013). Gender equality and food security: Women's empowerment as a tool against hunger. *Asian Development Bank.* http://www.adb.org/sites/default/files/pub/2013/gender-equality-and-food-security.pdf [Accessed November 2017].

Derbile, E. K. & van der Geest, S. (2013). Repackaging exemptions under national health insurance in Ghana: how can access to care for the poor be improved. *Health Policy and Planning, 28,* 586–95.

Dixon, J. Tenkorang, E.Y., Luginaah, I. N., Kuuire, V.Z & Boateng, G.O. (2014). National health insurance scheme enrolment and antenatal care among women in Ghana: is there any relationship? *Tropical Medicine and International Health, 19*(1), 98–106, 2014.

Dodoo, F.N.A. (1998). Marriage type and reproductive decisions: A comparative survey in SubSaharan Africa. *Journal of Marriage and the Family, 60*(1), 232.doi:10.2307/353454.

Durairaj V, D'Almeida, A. & Kirigia, J. (2010). Obstacles in the process of establishing a sustainable national health insurance scheme: insights from Ghana. *Technical brief for Policy-Makers. Accra: World Health Organization*.

Emelumadu, O. F., Onyeonoro, U. U., Ukegbu, A. U., Ezeama, N. N., Ifeadike, C. O., & Okezie, O. K. (2014). Perception of quality of maternal healthcare services among women utilising antenatal services in selected primary health facilities in Anambra State, Southeast Nigeria. *Nigeria Medical Journal, 55*(2), 148–155.

Eswaran, M. (2002). The empowerment of women, fertility, and child mortality: Towards a theoretical analysis. *Journal of Population Economics, 15*(3), 433-454.

Eswaran, M., & Malhotra, N. (2011). Domestic violence and women's autonomy in developing countries: theory and evidence. *Canadian Journal of Economics/Revue canadienne d'économique, 44*(4), 1222-1263.

Eswaran, M., Ramaswami, B., & Wadhwa, W. (2013). Status, caste, and the time allocation of women in rural India. *Economic Development and Cultural Change, 61*(2), 311-333.

Ganle, J. K., Obeng, B., Segbefia, A. Y., Mwinyuri, V., Yeboah, J. Y., & Baatiema, L. (2015). How intra-familial decision-making affects women's access to, and use of maternal healthcare services in Ghana: a qualitative study. *BMC Pregnancy and Childbirth, 15*(1), 173. https://doi.org/10.1186/s12884-015-0590-4

Ghana Statistical Service. *Ghana Multiple Indicator Cluster Survey with an Enhanced Malaria Module and Biomarker, 2011, Final Report.* Accra, Ghana: 2011. . Accessed July 23, 2014., [http://www.unicef.org/ghana/Ghana_MICS_Final.pdf]

Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International. (2015). *Ghana Demographic and Health Survey 2014*. Rockville, Maryland, USA: GSS, GHS, and ICF InternationalWHO, UNICEF, UNFPA, World Bank and United Nations Population Division. Maternal Mortality Estimation Inter-Agency Group. "Maternal Mortality in 1990-2015.

Ghana Statistical Service: *Ghana Multiple Indicator Cluster Survey with an Enhanced Malaria Module and Biomarker, 2011, Final Report.* Accra, Ghana: 2011. . Accessed July 23, 2014., [http://www.unicef.org/ghana/Ghana_MICS_Final.pdf]

Gething, P., Amoako, J., Frempong-Ainguah, F., Nyarko, P., Baschiieri, A., Aboagye, P., Falkingham, J., Zoe, M., & Atkinson, S. (2012). Geographical access to care at birth in Ghana: a barrier to safe motherhood. *Population and Development Review, 9, 35-60.*

Gurman, T. A., & Becker, D. (2008). Factors Affecting Latina Immigrants' Perceptions of Maternal Health Care: Findings From a Qualitative Study. *Health Care for Women International, 29*(5), 507–526. doi:10.1080/07399330801949608

Idrisu, S. H., Gwarzo, U.M.D, & Shehu, A.U. (2006). *Determinants of place of delivery among women in semi-urban settlement in Zaria, Northern Nigeria.*

Issah, K., Nang-Beifubah, A. & Opoku, C. F. (2011). Maternal and Neonatal Survival and Mortality in the Upper West Region of Ghana. *International Journal of Gynecology and Obstetrics, 113*(3), 208–210.

Jejeebhoy, S. (2000). Women's autonomy in rural India: its dimensions, determinants and the influence of context, in Harriet, P., Gita Sen Editors. *Women's Empowerment and Demographic Processes: Moving beyond Cairo*. Oxford University Press, Oxford.

Kamiya, Y. (2010). Endogenous Women's autonomy and the use of reproductive health services: empirical evidence from tajikistan. *OSIPP Discussion Paper, DP-2010-E-010, 2010.*

Kitui, J., Lewis, S., & Davey, G. (2013). Factors influencing place of delivery for women in Kenya: an analysis of the Kenya demographic and health survey, 2008/2009. *BMC Pregnancy and Childbirth, 13*(1), 40. https://doi.org/10.1186/1471-2393-13-40

Kishor, S. & Subaiya, L. (2008). Understanding women's empowerment: A Comparative Analysis of demographic and health surveys data. *DHS comparative reports no. 20*. Calverton, MD: Macro International; 2008.

Kumbani, L. C., Chirwa, E., Malata, A., Odland, J. O., & Bjune, G. (2012). Do Malawian women critically assess the quality of care? A qualitative study on women's perceptions of perinatal care at a district hospital in Malawi. *Reproductive Health, 9*, 30.

Lozano, R., Wang, H., Foreman, K. J. et al. (2011). Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. *The Lancet, 378*(9797), 1139–1165.

Lubbock, L. N. & Stephenson, R. B. (2008). Utilisation of maternal health care services in the Department of Matagalpa, Nicaragua. *Pan American Journal of Public Health, 24*, 75–84.

Lundberg, S. & Pollak, R. A. (1993). Separate spheres bargaining and the marriage market. *Journal of Political Economy*, 988-1010.

Lundberg, S. & Pollak, R. A. (1994). Noncooperative bargaining models of marriage. The *American Economic Review, 84*(2), 132-137.

Lundberg, S. & Pollak, R. (2008). *Family decision-making*. The New Palgrave, Dictionary of Economics. 2nd Edition.

Mabsout, R. (2011). Capability and Health Functioning in Ethiopian Households. *Social Indicators Research, 101*, 359-389.

Mahmud, S., Shah, N. M. & Becker, S. (2012). Measurement of Women's Empowerment in Rural Bangladesh. *World Development, 40*, 610-619.

Ministry of Health. (2014). *Holistic Assessment of the Health Sector Programme of Work 2013*. Accra: Minsitry of Health. p.35

Moss, N. E. (2002). Gender equity and Socioeconomic Inequality: A Framework for the patterning of women's health. *Social Science and Medicine, 54*(5), 649-661

Mumtaz, Z. & Salway, S. (2009). Understanding gendered influences on women's reproductive health in Pakistan: moving beyond the autonomy paradigm. *Social Science & Medicine, 68*, 1349-56.

Murphy-Graham, E. (2010). And when she comes home? Education and women's empowerment in intimate relationships. *International Journal of Educational Development, 30,* 320-331.

Newman, L. & Lupiáñez-Villanueva, F. (2015). A Framework to Research the Social Determinants of ICTs for E-Health. *Journal of Community informatics, 11*(3). http://ci-journal.net/index.php/ciej/article/view/1183/1163

Nigatu, D., Gebremariam, A., Abera, M., Setegn, T., & Deribe, K. (2014). Factors associated with women's autonomy regarding maternal and child health care utilization in Bale Zone: a community based cross-sectional study. *BMC Women's Health*, *14*, 79. http://doi.org/10.1186/1472-6874-14-79

Nguyen, D., Bernstein, J. L. & Goel, M. (2012). Asian-American elders' health and physician use: An examination of social determinants and lifespan influences. *Health, 4*(11), 1106-1115.

Nukunya G.K. (1999). Kinship and Marriage among the Anlo Ewe. *London School of economics monographs on social anthropology, 37*. The Athlone press. London and New Brunswick NJ.

Otis, K. E., & Brett, J. A. (2008). Barriers to hospital births: why do many Bolivian women give birth at home? *Pan American Journal of Public Health, 24*, 46–53.

Osamor, P. E., & Grady, C. (2016). Women's autonomy in health care decision-making in developing countries: a synthesis of the literature. *International Journal of Women's Health*, *8*, 191–202. http://doi.org/10.2147/IJWH.S105483

Penfold, S., Harrison, E., Bell, J. & Fitzmaurice, A. (2007). Evaluation of the delivery fee exemption policy in Ghana: population estimates of changes in delivery service

utilization in two regions. *Ghana Medical Journal, 41*, 100–9.

Rahman, L. & Rao, V. (2004). The Determinants of Gender Equity in India: Examining Dyson and Moore's Thesis with New Data. *Population and Development Review, 30*, 239-268.

Rammohan, A. & M. Johar. (2009). The Determinants of Married Women's Autonomy in Indonesia. *Feminist Economics, 15*(4), 31-55

Rani, M., Bonu, S., & Harvey, S. (2008). Differentials in the quality of antenatal care in India. *International Journal for Quality in Health Care, 20*, 62–71.

Rominski, S. (2015). Ghanaian Midwifery Students' Perceptions and Experiences of Disrespect and Abuse during childbirth. *The Lancet Global Health,3*(13). doi:10.1016/S2214-109X(15)70132-4

Sackey, B. M. (1999). Women and Health Seeking Behaviours in Religious Contexts: Reproductive and Antenatal Care In Ghanaian Religious Movements: A case Study of the Twelve Apostles Church. *Research Review, Institute of African Studies, 15*(2). doi:10.4314/rrias.v15i2.22885

Samari, G. & Pebley, A. (2015). Individual and Household Determinants of Women's Autonomy: Recent Evidence from Egypt. *UCLA CCPR Population Working Papers,* . Retrieved from http://papers.ccpr.ucla.edu/index.php/pwp/article/view/PWP-CCPR-2015-004

Safdar, U. K. (2014). *What determines women's autonomy: theory and evidence.* PhD, ePublications@bond, Faculty of Business. http://epublications.bond.edu.au/cgi/viewcontent.cgi?article=1178&context=theses

Sahn, D.E., & Younger, S. D. (2009). Measuring Intra-Household Health Inequality: Explorations Using The Body Mass Index. *Health Economics, 18*, 13–36.

Seddoh, A, & Akor, S. A. (2012). Policy initiation and political levers in health policy:

lessons from Ghana's health insurance. *BMC Public Health, 12*(1), 10.

Severin, D.D. (2011). Gender Relations and Maternal Health Services: On Prenatal Care Utilization in Rural Northern Ghana. *International Institute of Social Science, The Hague*, The Netherlands, 2011.

Solar, O. & Irwin, A. (2007). A Conceptual Framework for action on the Social Determinants of health. *Social Determinants of Health Discussion, 2* (Policy and Practice).

Soors, W., Dkhimi, F. & Criel, B. (2013). Lack of access to health care for African indigents: a social exclusion perspective. *International Journal for Equity in Health, 12*, 91.

Socioserve-Ghana. (2015). *Improving access to maternal health care in Eastern Region, Ghana.*

Thapa, D.K., & Niehof, A. (2013). Women's autonomy and husbands' involvement in maternal health care in Nepal. *Soc Sci Med, 93*, 1–10.

Tebekaw, Y., Mashalla, J. Y. & Thupayagale-Tshweneagae, G. (2015). Factors Influencing Women's Preferences for Places to Give Birth in Addis Ababa, Ethiopia. *Obstetrics and Gynaecology International, 7*. doi:10.1155/2015/439748

Upadhyay, U. D. & Karasek, D. (2012). Women's Empowerment and Ideal Family Size: An Examination of DHS Empowerment Measures In Sub-Saharan Africa. *International Perspectives on Sexual and Reproductive Health, 38,* 78-89.

Upadhyay, U.D., Gipson, J.D., Withers, M., Lewis, S., Ciaraldi, E. J., Fraser, A., Huchko, M. J. & Prata, N. (2014). Women's empowerment and fertility: a review of the literature. *Social Science and Medicine, 115*, 111-120.

Witter, S. & Garshong, B. (2009). Something old or something new? Social health insurance in Ghana. *BMC International Health and Human Rights, 9*, 20.

Woldemicael, G. & Tenkorang, E. Y. (2010). Women’s autonomy and maternal health-seeking behavior in Ethiopia. *Maternal and child health journal, 14*(6), 988–98.

Woldemicael, G. (2009). Women's autonomy and reproductive preferences in Eritrea. *Journal of Biosocial Science, 41*, 161-81.

WHO, UNICEF, UNFPA, World Bank, and United Nations. *Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015.*

WHO. *Health services coverage statistics.* Accessed June 29, 2017, [http://www.who.int/whosis/whostat/EN_WHS09_Table4.pdf]

Yilmaz, O. (2018). Female Autonomy, Social Norms and Intimate Partner Violence against Women in Turkey. *The Journal of Development Studies, 54*(8), 1321-1337.