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Factors Influencing Access andUtilization of Maternal Health Services in Berekum Municipality, BrongAhafo Region, Ghana

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Abstract
This paper examines the factors that influence access and utilization of maternal health services in Berekum Municipal in the BrongAhafo region of Ghana. It focuses on the centripetal and centrifugal forces that influence women utilization of maternal health services. Using data and information gathered from women, health workers and key informant interviews, the paper concludes that the utilization of maternal health services are influenced by centripetal factors such as availability of antenatal and postnatal services, availability of skilled or supervised delivery as well as affordably. The centrifugal forces were found to include unfamiliar hospital environment and unprofessional conduct of some health workers as well as availability of effective traditional birth attendants in the communities.

Keywords: Maternal health, utilization, traditional birth attendants, centripetal and centrifugal

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I. Introduction

The utilization of health services, especially maternal health care, is still an uphill task to may Ghanaian women, particularly those in the rural and hard to reach areas. Accessing and utilizing quality maternal health servicesare still considered as the most fundamentalchallenges to women. Indeed, health care serviceis largely an individual or family matter, even though government of Ghana since independence struggles to provide health facilities, doctors, nurses and other paramedical services. Individuals and families still bear their medical bills either through direct payment or by National Health Insurance or other various private health insurance service providers. This contributes to the high incidences of maternal deaths in Ghana, especially among the poor.

However, the relatively high number of maternal deaths[1] in Ghana compelled government to introduce "Free Maternal Health Care' in 2008. The Free Maternal HealthCare Initiativeprovidessubsidised health insurance to pregnant women. These includea comprehensivematernitycare(free antenatal, free delivery and free postnatal services)withsome notable exceptions such as ambulance service and postpartum family planning counselling(GHS, 2013).

Ghana's Free Maternal Care policy was introduced into the Nation Health Insurance Scheme to improve maternal health and reduce child mortality. Its main objectives were to facilitate access to free and quality maternal care delivery services to all mothers, reduce the number of women and children who die from preventable pregnancy and labour related problems and to encourage women to seek antenatal and postnatal care aswell as delivery at health care facilities. It is opened to all pregnant women resident in Ghana. Those who can access care under the programme are: All pregnant women who have registered under the policy, nursing mothers registered under the policy and all babies born to mothers registered under the program up to 90 days after birth(GHS, 2013;Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro, 2009). To reduce distance to health facilities, government has also provided Community-basedHealthPlanningServices(CHPS)throughout the country to ensure that pregnant women do not travel beyond five kilometers to access health services.

In spite of these interventions by the various governments, non-governmental organisations, as well as bilateral and multilateral institutions, access and utilization of maternal health services in Ghana is still bedeviled with considerable challenges and problems. The most important challenges include: poor quality health services, unprofessional conduct of health workers, frequent shortage of drugs, etc. (GHS, 2013; Ghana

[1] In 2016, nine hundred and fifty-five (955) maternal deaths were recorded nationwide.

Statistical Service (GSS), Ghana Health Service (GHS), and ICF Macro, 2009). The above-mentioned problems have resulted in the poor utilization of maternal health services. The privileged include urban residents who can afford the better-quality and comparatively higher fees charged by private (non-public) health facilities. The worst off include the poorest households in rural communitieswho compelled to attend Traditional Birth Attendants, CHPS compounds orovercrowded government health facilities in most of deprived communities (Abubakari and Yahaya, 2014).

This paper examines some of thecentripetal and centrifugal factors influencing access and utilization of maternal health services in the Berekum Municipality, BrongAhafo Region of Ghana. Specifically, it examines the pull and push factors to the utilization of maternal health services with particular focus on the level of patronage or attendance of ANC and PNC by women. It also examines skilled/supervised delivery, voluntary counselling and testing (VCT), access to health facilities and affordability as some of the centripetal forces or pull factors.

It further analyses, some of the centrifugal forces or factors that push away women from accessing and utilizing maternal health services, such as the hospital environment and attitude of health workersand the availability of effective TBAs. The paper argues thatunprofessional conduct of some health workers and the increasing participation of TBAs in the delivery of pregnant women, a service that is considered theresponsibility of doctors or skilled/ trained nurses tends to undermine the utilization of maternal health services in Ghana.

Health Infrastructure in BrongAhafo Region

BrongAhafoRegion is one of the well-endowed regions in Ghana. With a population of about 2,531,043 in 2014, the Region had 186 CHPS, 115 clinics, 18 districts hospitals, 83, health centres, 11 hospitals and 42 Midwife /Maternity homes. The number of doctors in the Region in 2013 was 148 as against 2,730 doctors nationwide, and the doctor population ratio was 16,695 as against 9,749 national average. The number of nurses in the region in 2013 was 815 as against 12,245 national average and the nurse population ratio was 1,072 as against 2,172 national average (Centre for Health Information Management (CHIM), Ghana Health Service, 2014)

In 2013, the regional target population of children less than one year and expected pregnancy(4%) was estimated at 101,242. In the same period, BrekumMunicipalityhad an estimated population of 141,972 and the target population of children less than one year and expected pregnancy (4%) was 5,679 (Centre for Health Information Management (CHIM), Ghana Health Service, 2014). This makes BerekumMunicipal the highest in the Region followed by PruDistrict with a population of 141,555 and the target population of children less than one year and expected pregnancy (4%) of 5,662.

Fertility rates in BrongAhafo Region

With regard to fertility rates, BrongAhafoRegion was leading in the whole country as at 1988, with a total fertility rate of 6.9, followed by Northern Region of 6.8and the national average was 6.4. However, there has been consistent decrease in fertility rate in theRegion, as follows: 1993 it was 5.5, reduced to 5.4 in 1998, then to 4.8 in 2003, and further to 4.1 in 2008 and then increased to 4.6 in 2011. In the same period, the national rates were as follows, 1988 was 6.4, in 1993 it was 5.5, then 1998 it reduced to 4.6, and in 2003 it was 4.4, and further reduced to 4.0 in 2008 andby 2011 it increased again to 4.3. However, Northern Region has been leading in fertility rate since 1993 (Centre for Health Information Management (CHIM), Ghana Health Service, 2014).

Infant and Under Five Mortality Rate

Table 1: Infant and Under Five Mortality Rate

Region	**Infant Mortality rate**					
	1988	1993	1998	2003	2008	2011
BrongAhafo region	65.0	48.7	77.3	58.0	37.0	66.0
National	77	66	57	64	50	53
	Under five Mortality rate					
	1988	1993	1998	2003	2008	2011
BrongAhafo region	122.6	94.6	128.7	91.0	76.0	104.0
National	155	119	108	111	80	82

Source: Centre for Health Information Management (CHIM), Ghana Health Service, 2014

Maternal Health Services in BrongAhafo(BA) Region

Access and utilization of maternal health services such as ANC, PNC, family planning in BrongAhafoRegion have consistently been higher than the national average since 2006. With the exception of 2010, where the national average of ANC attendance was slightly lowerthe regional, it has always performed above the national average in most of the indicators. See Table 2 for details.

Table 2: Some maternal Health Service in BrongAhafo region

Region	**Ante natal coverage**							
	2006	2007	2008	2009	2010	2011	2012	2013
BA	97.4	101.8	102.1	97.9	82.3	110.6	100.4	95.5
National	88.1	91.1	97.8	92.4	93.3	98.2	92.2	90.0
	Supervised Delivery							
	2006	2007	2008	2009	2010	2011	2012	2013
BA	47.4	34.5	49.8	53.7	54.0	46.8	65.7	65.0
National	44.5	32.1	42.2	45.6	49.5	52.2	55.6	55.0
	Post Natal Care							
	2006	2007	2008	2009	2010	2011	2012	2013
BA	53.8	57.1	57.2	53.7	59.2	64.0	66.0	71.3
National	53.7	56.7	57.5	56.4	58.1	65.3	62.7	64.1
	Family Planning Acceptors							
	2006	2007	2008	2009	2010	2011	2012	2013
BA	42.9	40.9	36.3	43.4	33.0	28.3	26.4	35.3
National	25.4	23.2	33.8	31.1	34.7	28.1	25.2	24.7

Source: Centre for Health Information Management (CHIM), Ghana Health Service, 2014

Level of Utilization of Maternal Health Services

In Ghana, the total number of antenatal registrants for 2006 was 791,166 representing 88.4% of expected pregnancies. This is a slight decline from that of 2005 (88.7%). The near 90% coverage implies that about 9 out of 10 women would pay at least a visit to a health facility during pregnancy. The average number of visits recorded was 3.3 in 2006 as compared to 3.4 in 2005. More than half (58.5%) of registrants made at least four visits in 2006. There was, however, a drop as compared to 2005 (62.0%). In 2006, the proportion of pregnant women who made their first antenatal care visit during the first trimester was 33.5%, an increase over that for 2005 (30.9%) (GHS/RCH, 2007).

Like Matua (2004) revealed in his study in Uganda, that behaviour is expected to change if pregnant women are aware of the implications of not attending ANC and if they are convinced of the benefits of practicing preventive care. Elo (1992), also revealed that amongst the maternal characteristics, education of women has been found to have the strongest association with the use of maternal health services. In Peru for example, formal education of women influences the use of maternal health services. Results from both the cross-sectional and fixed-effects model, controlling for service availability and the socio-economic status of the household, confirmed the importance of maternal education on the utilization of both prenatal care and delivery assistance.

Raghupathy(1996) also revealed similar findings in Thailand, that maternal education exerts a significant influence on the use of maternal health services; the odds of using prenatal care and formal delivery assistance are much greater for women with primary schooling, compared to women with zero years of schooling. Educated mothers are considered to have a greater awareness of the existence of maternal health services and benefited in using such services. Educated mothers are likely to have better knowledge and information on modern medical treatment and have greater capacity to recognize specific illnesses. As education empowers women, they have greater confidence and capability to make decisions to use modern health care services for themselves and for their children (Caldwell, 1990, Schultz, 1984). Education also enables women to take personal responsibility for their own health and the health of their children. According to Kausar et al, (1999), people living in poorer households in rural and urban areas have a lower utilization of maternal health services.

Evidence from other studies like in the case of Addai (2000), suggest that, a choice has to be made regarding the preferred source of service delivery between existing options. The study of Geurts (1997) and Alakija and Wole (2000) revealed that, the practice of traditional birth has a lot of impact on the health of the mother and child. Despite the introduction of modern health facilities, available statistics shows that the majority of children are born by traditional birth attendants (TBAs) especially in rural areas. The care given during the prenatal, postnatal period and the environment in which the women find themselves to a very great extent can determine the state of the health of women (Geurts, 1997). The practice of Traditional Birth Attendants (TBAs) needs to be encouraged through training, provision of enabling facilities and funds. It is important to recognize their services and give them the social recognition they deserve in the communities. A lesson can be learnt from Ghana when between 1980 and early 1990s the Ministry of Health organized, trained and provided materials to the locally recognised village midwives. There is need to foster interaction between TBAs and orthodox maternal health workers/government agencies especially Ministry of Health through broader education programmes, (Geurts, 1997, Alakija, and Wole (2000).

Factors that Promote or Hinder Utilization of Maternal Health Services

Addai (2000) revealed that perceptions are influenced from a multi-faceted perspective but in most of the cases challenges are associated with the attitude of healthcare services providers. According to Witter et al (2007) in resource poor countries, the high cost of user fees for deliveries limits access to skilled attendance and contributes to maternal and neonatal mortality and the impoverishment of vulnerable households. This has led to a growing number of countries experimenting with different approaches to tackling financial barriers to maternal health.

Poverty is a major factor which can inhibit one's access to maternal health and feminisation of poverty is seen to be one of the most hindering factors of women the world over especially in developing countries. It inhibits women in their decision-making processes and other vital areas of their lives of which maternal health cannot be isolated. To be able to have quality maternal health service there is the need for a sound financial backing. Even how to be able to take the decision on which service to access depends on one's status as an important part of any health system is the mechanism by which health costs are financed and pooled (United Nations Economic and Social Commission for Asia and the Pacific, 2008). Women's economic dependence on men for survival however has been a principal barrier to women's control over their reproductive life in developing countries. A study by D'Ambruoso (2005), Natukunda (2007) andOnasoga et al (2012) revealed that, the attitude of the health care provider and previous experience of the mothers about the care received, also influence utilization of maternal health services. This is not surprising since negative attitudes by health care providers elicit negative outcome in the utilization of maternal health services and on the other hand, positive behaviors of health care providers to women will bring about positive outcome. Various studies have shown that there is a relationship between attitude of health care providers and mother's choice of where to receive antenatal, delivery and postnatal care (Abubakari and Yahaya, 2014).

The attitudes and behaviours of maternal health care providers (MHCPs) are important elements of quality as they influence both positively and negatively how women, and their partners and families perceive and experience maternal health care. For example, disrespectful health care providers, such as doctors and midwives, may lead to dissatisfaction with the health system, diminishing the likelihood of seeking antenatal care (ANC), delivery and postnatal services. In addition, MHCPs attitudes and behaviours might directly affect the well-being of patients and clients, and the relationship between patients and providers. Moreover, negative attitudes and behaviours could undermine the quality of care and the effectiveness of maternal and infant health promotion efforts, in addition to compromising women's essential right to dignified and respectful maternal health care. Taken together, the attitudes and behaviours of MHCPs are important determinant of maternal and infant health outcomes, and women being able to enjoy their basic rights of freedom from violence and discrimination and achievement of the highest attainable standard of physical and mental health. A recent statement by the World Health Organization (WHO) and the Human Reproduction Programme calls for greater attention, research and advocacy around the maltreatment of women at the time of childbirth in facilities (Mannava et al., 2015).

Patronage of Maternal Health Services

Utilization of health services is a complex behavioural phenomenon. Empirical studies of preventive and curative service have often found that the use of health services is related to availability, quality and cost of services as well as to social structure, health beliefs and personal characteristics of the users. Pregnancy is not a disease and pregnancy related mortality is almost always preventable yet more than half a million women die annually worldwide (about 1,600 women die every day) due to pregnancy related complications (Addai, 2000; Alakija, 2000).

The practice of traditional birth has a lot of impact on the health of the mother and child. Despite the introduction of modern health facilities, available statistics shows that the majority of children are born by traditional birth attendants (TBAs) especially in rural areas. The care given during the prenatal, postnatal period and the environment in which the women find themselves to a very great extent can determine the state of the health of women. (Geurts, 1997). The practice of Traditional Birth Attendants (TBAs) needs to be encouraged through training, provision of enabling facilities and funds. It is important to recognize their services and give them the social recognition they deserve in the communities. A lesson can be learnt from Ghana when between 1980 and early 1990s the Ministry of Health organized, trained and provided materials to the locally recognised village midwives. There is need to foster interaction between TBAs and orthodox maternal health workers/government agencies especially Ministry of Health through broader education programmes, (Geurts, 1997, Alakija and Wole (2000).

The World Health Organization (WHO) recommends at least four visits to antenatal care facilities throughout pregnancy. Evidence has shown that more than four visits are only recommended in case of complication Villar, et al(2011). Utilization of health facilities are determined by many factors. Maternal age, parity, income, standard of living of households, ANC users' fees and travel distance to antenatal care provider are the common economic factors that have been cited by previous researchers (Russo, Herrin and Pons, 1996).

Access to skilled assistance and well equipped health institutions before and during delivery can reduce maternal mortality and morbidity and improve pregnancy outcomes. In accessing obstetric care, women can be influenced by health system factors, such as a respectful provider attitude, competency, and availability of drugs and medical equipment as rightly reported by Kruk, et al (2009).

Despite the existence of national programs for improving maternal and child health in most nations, maternal mortality and morbidity continue to be high and studies suggested that the majority of maternal deaths and neonatal deaths can be prevented or reduced if women had access to, or visited maternal health services during pregnancy, childbirth and the first month after delivery (Dayaratna, 2000; WHO, 2004). However, many women in developing countries do not have access to maternal healthcare services and it is reported that the use of such services remain low in Sub-Saharan Africa including Ghana (Babalola and Fatusi, 2009).

II. Study Area and Methodology

Study Area

Berekum Municipal Assembly is one of the twenty-seven administrative districts in the Brong-Ahafo Region of Ghana. It shares boundaries with Wenchi Municipal and Jaman South and North Districts to the northeast and northwest respectively, Dormaa Municipal to the south, northwest to Tain District, southwest to Asunafonorth Municipal Assembly and to the south-east is Sunyani West District and Sunyani Municipal respectively. Berekum, is the Municipal capital.

The total population of the Municipality was estimated at 120,354 with annual growth rate of 3.3% according to 2010 Population and Housing Census (Ghana Statistical Service, 2013) made up of 51.4% females and 48.6 % males. There are thirty-six settlements in the Municipality with Berekum, Jinijini, Senase, Kato, Koraso, Fetentaa, Mpatasie, Biadan, Jamedede, Botokrom, Nsapor, Kutre No. 1, Kuture No. 2, Ayimom, Domfete, Namasua, Akroforo, Adomabisaase, Benkase, Ayinasu, and Nanasuanoas the major towns. These urban towns together accommodate about 64 percent of the population and the remaining 36 percent in the rest of the settlement. Berekum, the Municipal capital alone accommodates a little over one third of the total population (BMA, 2013).

With regards to healthcare and education, there is one Municipal hospital, the Berekum Holy Family Hospital. The hospital serves the Municipality and the adjoining districts. There is one Health Centre, which is located at Jinijini, which performs the second highest (level B) functions in the PHC system. In addition, there are seven Rural Clinics, which are located at Akrofro, Koraso, Namasua, Mpatasie, Kutre, No. 1. Amomaso and Botokrom. These are rural clinics, which perform level A, and B functions in the PHC system. There are also seven maternity homes, one private hospital, three private clinics, seven Community-Based Health Planning Services Compound (CHPS Compound) and about 32 Out-reach Posts (BMA, 2013).

The Municipality has the following educational facilities; Ninety-six (96) kindergarten, ninety-three (93) primary schools, seventy-four (74) Junior High Schools, eight (8) Senior High Schools, one Teacher Training College, and one Nursing Training College (BMA, 2013).

Study Design

The study was non-experimental. It was modelled on a case study design when a specific area was investigated in order to get more information. This study adopted a descriptive cross-sectional study type since it aimed at describing the perceived influence ofaccessknowledge, perception and utilization of maternal healthcare services within the Municipality.

A descriptive study is one in which information is collected without changing the environment (i.e., nothing is manipulated). It is used to obtain information concerning the current status of the phenomena to describe "what exists" with respect to variables or conditions in a situation. A descriptive study design is one in which the primary goal is to assess a sample at one specific point in time without trying to make inferences or causal statements (….). This study adopted a descriptive study because it specifies the nature of a given phenomenon and given a particular picture of a situation or population. Descriptive research can be either quantitative or qualitative. A descriptive survey study is concerned with collection of data for the purpose of explaining or predicting the conditions or relationships that exist, opinions that are held by people and practices that are in vogue. The designed is to depict the participants in an accurate way.

The reason for choosing descriptive design was that, it offers the researchers an opportunity to observe, describe, and document aspects of the situation as they happen naturally. It also helped the researchers to interpret the data from the respondents concerning their, access, utilization knowledge and perceptions about maternal health services. Using this design therefore allowed the researcher to study and presented in a systematic manner the views of the respondents. The descriptive survey has the potential to provide accurate information from majority of people in a study (Fraenkel and Wallen, 2000). In this study, the BerekumMunicipality became the case under study. Issues that pertain to maternal health were explored in the

Municipality from the results, various conclusions were inferred and relevant recommendations given to enhance the maternal health in the Municipality.

Study Population and Sampling Techniques

The study population comprised of women in their fertility ages that have had at least a child. This comprised mainly women between the ages of 15 – 49 years. These women were selected from the general public in the Berekum Municipality. Health officials especially nurses in the health facilities in the Municipality were also included in the study.

The study units were women in their fertility age 15 – 49 years found in the Municipality as well as health workers. The health workers included the Municipal Director of Health Services, the heads of the various health facilities in the municipality and the nurses who were directly related to maternal health delivery.

The Municipality was clustered into six sub-districts/zones. These were Berekum Central, Berekum North, Berekum East, Berekum West, Berekum South and Jinijini. These sub-districts were further clustered into various groups which included health facilities, markets, households and community centres. Three hundred and eighty-five women were selected using a multi-stage and cluster sampling techniques. Convenience sampling was used to select the women and health workers from various households and facilities. In addition to this number, the study purposely chose twenty-three 23 health workers from eleven facilities across the Municipality and 12 Traditional Birth Attendants (TBA), two from each cluster.

III. Results and Discussions

Factors Influencing Access and Utilization of Maternal Health Services in Berekum Municipality, BrongAhafo Region.

This section discusses the findings from the field and focuses on the factors that influence the utilization of maternal health services. These factors are broadly classified under centripetal and centrifugal factors. The former are the factorsthat attract or pull women to utilize maternal health services, while the latter are factors that push them away from the utilizing of maternal health services. Table 1 shows these factors.

Table 3: Centripetal and Centrifugal Factors

Centripetal factors	Response	Women respondents		Health Workers	
		Freq.	%	Freq.	%
Availability of Antenatal services	Yes	382	99.2	19	82.6
	No	3	0.8	4	17.4
	Total	385	100	23	100
Availability of Postnatal services	Yes	361	93.8	18	78.3
	No	24	6.2	5	21.7
	Total	**385**	**100**	**23**	**100**
Skilled/supervised delivery	Yes	330	85.7	10	43.5
	No	52	13.5	13	56.5
	Total	**382**	**100**	**23**	**100**
Voluntary counselling and testing (VCT)	Yes	296	76.9	7	30.4
	No	86	22.3	16	69.6
	Total	**382**	**100**	**23**	**100**
Access to health facilities	Yes	335	87	15	65.2
	No	50	13	8	34.8
	Total	**385**	**100**	**23**	**100**
Affordability/income	Yes	354	92	14	60.9
	No	31	8	9	39
	Total	**385**	**100**	**23**	**100**
Centrifugal factors					
Hospital environment and attitude of health workers	Yes	260	67.5	18	78.3
	No	125	32.5	5	21.7
	Total	**385**	**100**	**23**	**100**
Availability of TBAs	Yes	296	77.5	7	30.4
	No	86	22.5	16	69.6
	Total	**382**	**100**	**23**	**100**

Source: Field Data, 2015

Antenatal Services

The study first of all attempted to establish the availability of maternal health services before focusing on their level of patronage of these services. With respect tomaternal health services that were rendered in the health facilities in the Berekum Municipality, the study found that the majorityof the health workers (82.6%) claimed that all the facilities in the Municipality provide antenatal services, while (17.4%) said antenatal services are not available in all.The majority (99.2%) of the women respondents also share similar view that all the health facilities provide ANC services and that motivate them to utilize these services(see Table 3 for details).

They argued that, attending ANC has a lot of benefits, such as managing complications during pregnancy, knowing the expected period of delivery, knowing the sex of the child, reducing the risk of miscarriages, and reducing incidence of maternal mortality. Almost all the respondents(96%) were of the view that, they were motivated to attend ANC because of the free maternal health service, availability of health facilities, counselling from health workers andsupport from their husbands and families. This finding corroborates that of Russo et al (1996) who indicated that the utilization of health facilities was determined by income, standard of living of households, ANC users' fees and travel distance to antenatal care providers.Similarly, Kruk et al (2009), found that access to skilled assistance and well equipped health facilities before and during delivery can reduce maternal mortality and morbidity and improve pregnancy outcomes. This paper further found that access to obstetric care, the conduct of health service providers (respect of clients), good care by health workers, encouragement, competency of the health workers, and availability of drugs and medical equipment are some of the factors that influence women ANC attendance.

Postnatal (PNC) Services

Postnatal (PNC) services are also provided under the Free MaternalProgramme. The study found that the majority (78.3%) of the health workers and 93.8% of the women respondents said the health facilities offered PNC service. As shown on Table 3, most of the women (93.8%) also reported that PNC services are available two times per week in each facility and that patronage is always high. The respondents intimated that they attend PNC because it helps to improve the health of both the child and the mother. They indicated that their children are immunized and vaccinated against all manner of diseases. They also confirmed that they learn a lot about how to take good care of their babies, breast feeding, changing of baby dupers, how to manage their children body temperature, how to avoid diarrhea and how to provide balance diet for their children among others.

One of the women at Jinijini intimated during the focus group discussion that:

> "when I delivered my first child, I did not attend PNC because I did not know the benefits of it. As a result, I did not practice safe mother and child practices. I used to feed my child a lot of water. Iused not to wash my breast before breast feeding. I did not practice exclusive breast feeding, my child was not immunized or vaccinated against any disease. Consequently, she was always crying, running diarrhea and falling sick. She died after one and half years. I was so devastingbutI learnt lessons from that. With my second pregnancy and delivery, I regularly attended ANC and PNC. I learnt a lot about how to care for my baby. I practice exclusive breast feeding, he has been immunized and vaccinated against a lot of diseases. He rarely run diarrhea and when it happens I know how to manage it"

The Municipal Health Director's views corroborated the above assertion. According to him:

> "incidence of infant mortality in the Municipality has reduced significantly. Stunting, wastingand cases of severe malnutrition among mothers and children have also reduced tremendously since the implementation of the Free Maternal Health Care".

This gives an impression that, nursing mothers might be receiving the requisite knowledge on how to care for their babies after birth. This could further be attributed to regular education the women received from the midwives during PNC class at the facilities. The finding is contrary to the claim made by Babalola and Fatusi (2009) that many women in developing countries do not have access to maternal healthcare services and that the use of such services remain low in Sub-Saharan Africa including Ghana. The finding is in line with Dayaratna's (2000) and WHO (2004) suggestions that maternal deaths and neonatal death can be prevented or reduced if women had access to, or visited maternal health services during pregnancy, childbirth and the first month after delivery.

Skilled or Supervised Delivery

Another important determinant that influences the utilization of maternal health services is skilled or supervised delivery. More than half (56.5 %) of the health workers interviewed indicated that skilled delivery at health facilities contributes significantly to the utilization of maternal health services. Similarly, the majority of the women (85.7%) were of the view that, they deliver at the health facilities because of supervised delivery.

The reasons they frequently cited included the fact that, at the health facilities, doctors or nurses would be able to manage complications such as excessive bleeding during labour and after delivery. Cases like hypertension

and anemia during labour couldalso be managed by health workers. If the pregnancy requires caesarian, at the facility, doctors can perform this. According to the respondents, the above-mentioned services cannot be obtained at home delivery by TBAs.

Both health workers and the women were unanimousin their view that delivery at the health facilities was also free because of the free maternal health care. Thus, the unitization of the maternal health services was high in the BerekumMunicipality. Thus, the World Health Organization (2007) contention that the immediate cause of maternal deaths is the absence, inadequacy or underutilization of the healthcare system, was not a serious cause for concern in the study area.

Voluntary Counselling and Testing (VCT)

Another factor that contributes to the high utilization of maternal health service in the area is the fact that most health facilities provide VCT services. VCT services can only be obtained at the health facilities. However, while 30.4% of the health workers claimedthe service is available in all health facilities, 69.6% indicated that the service is not available in all the health facilities in the Municipality. Notwithstanding, the majority of the women (76.9%) revealed that they benefited from VCT services at the health facilities.

The respondents frequently mentioned the benefits of the VCT to include the fact that they get to know their general health status. They get to know about their HIV/AIDS status, sickle cell, hepatitis B and C status, hypertension, anemia, and even their blood groups. They also get counselling on how to keep their pregnancy safe and how to space their childbirth and plan their families. All these testing and counselling are good and geared towards not only for safe motherhood and safe child delivery, but also for their general wellbeing. As one of the women stated during the focus group discussion:

"Knowing much about my health is very important for my general wellbeing. Since I received VCT from the hospital, I have been able to save from spending on avoidable health problems, such as malaria, headaches, anemia, and other pregnancy related problems. This spared time from going to hospital and also save me from pain to concentrate on my work. I had very safelabour and delivery last time because I benefited from VCT"

Although VCT might not be available in all the health facilities, the women themselves share ideas and experiences from each other. For those who could not read, they might have heard this from television or radio discussions.

Access to Health Facilities

Access to health facilities also contributes to the utilization of maternal health services. In situation where health facilities are far away from the women, they tend to resort to self-medication or rely on TBAs. In the case of Berekum Municipality, there are plethora of health facilities, including the Holy Family hospital, which serves the Municipality and the adjoining districts. There is one Health Centre, at Jinijini, which performs the second highest (level B) functions in the PHC system. In addition, there are seven other Rural Clinics, located at Akrofro, Koraso, Namasua, Mpatasie, Kutre, No. 1. Amomaso and Botokrom respectively. Additionally, there are also seven maternity homes, one private hospital, three private clinics, sevenCommunity -Based Health Planning Services (CHPS) Compounds and about 32 Out-reach Posts (BMA, 2013).

Consequently, access to maternal health services was not of a challenge as indicated by 87% of the women. Similarly, both the Municipal Health Director and almost all (87%) health workers interviewed indicated that the availability of these facilities greatly contribute to the high patronage and utilization.

Affordability/Income

The study also shows that, affordability of maternal health services can affect their utilization. If the cost to be paid at the facility is high, plus cost of transportation which the women bear, it will discourage most low income earning families to utilize these facilities. This study found that, the majority (92%) of the respondents indicated that maternal health services are within their means. Similarly, the health workers said that, maternal health services are relatively free and within the means of the average family. The respondents indicated that, the relatively free maternal health service is responsible for their high patronage of such a service.

Likewise, the study of Mekonnen and Asnaketch (2002) revealed that, the likelihood that a household will utilize health facilities is a function of its socioeconomic, demographic and supply variables and that substantial difference exist in utilization pattern by various income classes. In addition, their study showed that households in the highest income quintile are approximately twice more likely to utilize private hospital services than those in the lowest, ceteris paribus. In the BerekumMunicipality, some of the facilities are private and considering the demographic characteristic of the respondents, most were just subsistence farmers, unemployed, illiterates, single parents, divorced women, and yet they constantly revealed that, utilization of maternal health services among these groupswere encouraging, means they can afford these services.

Centrifugal Factors

This section discuses some of the factors that impede or push away women from the utilization of maternal health services in the Berekum Municipal**.** The study found these factors to include i) the hospital environment and poor attitude of health workers to the women, ii) availability of Traditional Birth Attendants (TBAs), iii) ignorance and v) poverty respectively.

The hospital environment and poor attitude of health workers to the women are serious centrifugal factors to effective utilization of maternal health services. More than half (56%) of the women claimed that, sometimes there is too much bureaucracy at the health facilities. Therespondents mentioned processes such delay in accessing their folders, waiting in long queues for several hours to be attended to by nurses or doctors, and stated by oneof the women during a focus group discussion at Mpatasie. "Sometimes even how to navigate our way in the hospital environment that is unfamiliar to us is burdensome to us, especially when heavily pregnant or carrying a baby".

Hospital environment is also strange to most women, especially the illiterates. It is difficult for them to find their way to the various departments and wards without assistance. For most of them, labelssuch as OPD, consulting room one, or consulting room two, labour ward, female or children ward, theater, etc are meaningless to them without guidance. .

Another repelling factor is the attitude of some health workers. Similarly, most of the women in all the focused group discussions indicated that they are sometimes discouraged to go for maternal health services because some of the health workers are rude and disregard them. One of the women at Botokromrecounted her experience as "Even when I was struggling with the pain of labour, the nurse was shouting at me saying "lie down well and stop struggling. Was that how you were laying when your husband was having sex with you?' You better push, otherwise you will die here" She added that "statements like these from a health professional are very insulting and debasing"

Contrary to the above allegations, from the women, the health workers vehemently denied being rude to them. For example a nurse at Akroforosaid "it is unprofessional to mistreat a patient'. The health workers frequently maintained that they do not disrespect patients. "At times in attempt to correct or direct them to do the right thing, such as not to jump the queue, they think you are despising them".

Our observation at the OPDs and ANC centresat some of the health facilities at Adomabisaase, Ayimom, Ayinasu, BenkaseBiadan, Domfete, Kuture No. 2, and Senase revealed chaotic scenes, as health workers struggled to serve multitudes of women. Situations like these can really be repelling and frustrating.

Effective Traditional Birth Attendance (TBAs)

Effective TBA services in some communities tend to entice some of the women to them, especially for delivery. TBAs are community-based servicesproviders, who mostly attend to pregnant women in their matrimonial homes. Accessing their services required no or little bureaucracy, little or no waiting time, and women are attended to at the comfort of their homes where their privacy is guaranteed.

The study revealed that, for the women who resort to TBAs services, they do so because of either their previous successful experiences or their family members have successfully delivered by TBAs. Another reason was that the TBAs understand them better than health workers.

Our interview with some of the TBAs revealed that they attend to between five and ten women in a month. They also indicated that they have been trained to handle delivery but problems and situations that they cannot manage are referred to hospitals.

From the standpoint of the health workers, there was almost a split in the response in relation to whether women sometimes resort to TBAs. Although 52.2% stated that women do sometimes resort to TBAs, the remaining47.8%were of the view that per their observations in the health facilities the women do not patronize TBAs services.

The majority of the women, (83.9%) were of the opinion that they do not resort to TBAs because they cannot manage labor complications, give blood transfusion, perform surgery and do not give drugs. In the BerekumMunicipality there are many remote farming communities without health facilities. Despite the introduction of modern health facilities, available statistics shows that the majority of children are born by Traditional Birth Attendants (TBAs) especially in the rural areas. The care given during the prenatal, postnatal period and the environment in which the women find themselves to a very great extent can determine the state of the health of women (Geurts, 1997). The practice of Traditional Birth Attendants (TBAs) needs to be encouraged through training, provision of enabling facilities and funds. It is important to recognize their services and give them the social recognition they deserve in the communities. A lesson can be learnt from Ghana when between 1980 and early 1990s the Ministry of Health organized, trained and provided materials to the locally recognised village midwives. There is the need to foster interaction between TBAs and orthodox maternal health workers/government agencies especially the Ministry of Health through broader education programmes, (Geurts, 1997, Alakija, Wole (2000).

IV. Conclusions

This paper examined the forces that either attract or repel women away from accessing and utilizing maternal health services in the Berekum Municipality in the BrongAhafoRegion of Ghana. The study found two broad forces responsible for utilization of these services: centripetal and centrifugal forces.

Under the centripetal forces, the study shows that availability of prenatal and postnatal services, effective skilled/supervised delivery, voluntary counselling and testing (VCT), access to health facilities and affordability/income of the women influenced their access and utilization of maternal health services.The paper shows that the plethora of maternal health facilities (27 facilities, including CHPS and 32 outreach posts) are responsible for the high utilization of ANC and PNC services in the Municipality.

Contiguous to the abovementioned factors are the availability of skilled/supervised delivery and VCT services which could not be obtained outside these facilities. Skilled or supervised delivery is more crucial for women who suffered complications in the course of their pregnancy. Coupled with the fact that most of the maternal deaths occur during labour make delivery at health facility a preferred place for most women. Similarly, VCT services are important for women to know more about their health status. They also received counselling and treatment and difficult cases are referred to specialists for proper attention. The fact that there are many health facilities within reasonable distance andalmost free maternal health services make themaffordable for even lowincome families to utilize.

However, the study shows that there are centrifugal factors that also serve as disincentive for women to utilize maternal health service. Principal among them is the unfamiliar hospital environment and the hostile attitude of some health workers. These factors have considerable negative impact on rural and illiterate women.

Finally, the study also shows that the availability of TBAs in many communities undermined the utilization of maternal health services. Even though TBAs services are limited to only delivery, they neither prescribe drugs nor perform operations, some women still patronize their services because they are less bureaucratic and deliver their services at the comfort of their clients.

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