

**RURAL GHANAIAN WOMEN'S EXPERIENCES OF SEEKING
REPRODUCTIVE HEALTH CARE**

by

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ABSTRACT

Ghana, a low-income developing country in sub-Saharan Africa is experiencing low maternal health service utilization and high rates of maternal mortality, especially in the rural areas. The Talensi-Nabdam District is one of the poorest and most remote districts in Ghana. The reproductive health status of women in the most remote communities in this District is poor. Dialogue about women's reproductive health care needs in Ghana have been influenced by health care authorities, professionals, researchers and experts' perceptions.

The purpose of this ethnographic research was to explore rural Ghanaian women's experiences of seeking reproductive health care from their own perspectives. The study was based on data collected from participant observations, unstructured face-to-face interviews and focus group discussions. A total of 27 women of varying socio-demographic backgrounds participated in the study.

Interviews were conducted at locations of the women's choice and in women's local dialect. Data were translated and transcribed verbatim, and analyzed thematically. Four major themes emerged from the findings: submitting to the voices of family, women's experiences of receiving nursing care, the community of gossip, and gaining voice.

The findings of this study have implications for nursing practice, education and nursing inquiry. Awareness of barriers that rural women encounter in meeting their reproductive health care needs among health care providers is important in facilitating positive health care seeking behaviours. Nurse educators should orient themselves to the challenges to meeting women's health care needs, and include in culturally sensitive approaches in nursing education programs.

Further research is needed to investigate strategies that will enhance women's reproductive health care seeking behaviours in rural settings and to focus on women's perspectives in particular. In addition, research is needed to examine nurses' perspectives on factors that influence quality care delivery to address women's reproductive health issues.

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DEDICATION

My mother, the late Madam Bugre Kawon Yakong who, in spite of the fact that she had no formal education herself, recognized the importance of education and did everything possible to let her two daughters receive education, even though education for girls was not the norm in the culture at that time. During her lifetime, she also devoted her time to community service and to women's progress. She provided leadership to women in the village and supported anybody in need of her time and services. Unfortunately, she did not live long enough to enjoy the fruits of her commitment to the progress of women. In recognition of her role in her girls' education, and her contribution to women's plight, I dedicate this special piece of work to her.

CHAPTER 1: INTRODUCTION

1.1 Background of the Study

Since the introduction of the Primary Health Care (PHC) concept in the 1970s and 1980s (United Nations Development Programme, 1999; Walley, Wright, & Hubley, 2001), the availability of health care has improved considerably for people in developing countries. The goal of PHC has been to provide health services that are available, accessible, affordable, and culturally acceptable to people in developing countries (Walley et al., 2001). Despite the availability of health care, maternal mortality rates (MMR) remain very high in these countries (United Nations Development Programme, 1999). MMR refers to “deaths during pregnancy, child birth and up to 42 days after delivery” (Biritwum, 2006, p. 78). Recent studies indicate that globally, 529,000 women die as a result of pregnancy, childbirth, or reproductive health-related issues each year (United Nations Millennium Project, 2006; World Health Organization, United Nations International Children’s Fund, & United Nations Fund for Population Activity, 2003). Most of these maternal deaths occur in developing countries, where MMR range from 200 to 800 deaths per 100,000 live births (Biritwum, 2006; Mauldin, 1994).

The highest maternal mortality rates in the world are found among 13 countries of Western Africa, including Ghana, and are on the increase, particularly in the rural areas (Klufio, Kwamukume, Danso, Sciarra, & Johnson, 2003). In Ghana, where about 70% to 80% of the population live in rural areas (Ghana Ministry of Health [GMOH], 1999; Molestsane & Manuh, 1999), MMRs have more than doubled (Ghana News Agency, 2007), with an estimated 214 per 100,000 live births in 2003 (Campana, 2003) and increasing in 2006 to 540 per 100,000 live births (World Health Organization, 2006).

In the northern part of Ghana, an entirely rural area of the country characterized by deprived standards of living, MMR varies from 330 to 500 per 100,000 live births (Campana, 2003). These are the highest rates in the country and are disproportionate to the national rates. These MMR death rates reflect health care disparities between urban and rural dwellers and are totally unacceptable, since deaths related to reproduction are preventable.

Although there is evidence that knowledge levels in both men and women regarding maternal health care services, particularly birth control methods and its access, is high (Hollander, 1995), most reports reveal that in the northern part of the nation, birth control use is significantly low and total fertility rates are close to seven children per woman (Althaus, 1990; Campana, 2003; Talensi-Nabdam District Health Administration [TNDHA], 2007). Despite the high fertility rates and the reported high reproductive health care service awareness, only 9% of all deliveries are supervised by a trained health care professional (Althaus, 1990; Campana, 2003; TNDHA, 2007).

Research findings also indicate that most women in the sub-Saharan Africa region, including Ghana, express the desire to have fewer births, yet do not use birth control despite availability of these services (Dodoo & Landewijk, 1996). It has also been noted in the literature that in sub-Saharan Africa, including Ghana, men have more control over household resources including decisions around reproductive health than women (Dodoo & Landewijk, 1996; Nukunya, 2004), leaving women with limited resources to make choices and decisions regarding their own health in general, and reproductive health in particular.

Reproductive health issues have been shown to account for high MMR in developing countries; therefore, the need to reduce maternal mortality is a matter of worldwide concern

which has been identified by the United Nations (UN) (2000) as one of its eight Millennium Development Goals in its Millennium Declaration.

There has been increasing attention on the provision of safe reproductive health care for women in developing countries through the use of educational campaigns. According to GMOH (2006), in Ghana, for example, reproductive health care is the health sector's top priority health intervention. Despite international efforts to improve women's reproductive health and make care more available and accessible, there are several factors impacting women's health care seeking behaviours. A major factor influencing women's health care seeking is culture, which individuals inherit as members of a particular society. Culture informs the way women view their world, how they experience it emotionally, and how they behave in relation to other people, to supernatural forces or gods, and to the natural environment (Helman, as cited in Hodgson, 2000). Cultural beliefs, values and practices that influence health seeking often lead individuals and communities to self-care or to consult with traditional healers, both of which may contribute to unmet health needs (Adongo, Binka, & Philips, 1998; GMOH, 1999; Shaikh & Hatcher, 2005).

In Ghana, cultural beliefs, practices, customs, and norms around childbearing accentuate the difficulty women experience trying to access reproductive health care (Awedoba, 2002). During my working period with women in rural Northern Ghana as a community health nurse, I realized that women, though concerned and interested in seeking reproductive health care, were constantly confronted by socio-cultural barriers. These barriers contribute to delays in seeking health care, or not seeking it at all resulting in increased maternal morbidity, complications and mortality.

While sociopolitical, socio-cultural and economic factors play a major role in women's access to health care in most rural communities, other factors also influence women's health

seeking behaviours (Osubor, Fatusi, & Chiwuzie, 2006). These factors include the poor quality of health care services (the attitudes of health workers and nurses towards patients; irregularity of staff at work; poor quality services; working practices and incomes of health workers), high cost of service and poverty; women's status in society (gender inequality, education); traditional beliefs, values, and religious practices; traditional norms; women's decision-making issues; and women's general health problems (Asenso-Okyere, Osei-Akoto, Anum, & Adukonu, 1999; Avotri & Walters, 1999; Awedoba, 2002; Hoga, Alacamtara, & de Lima, 2001; Jansen, 2006; Osubor et al., 2006; Sicchia & MacLean, 2006).

Ghanaian studies have examined factors affecting women's reproductive health-seeking behaviours, specifically related to birth control use and childbirth (Adongo et al., 1998; Awedoba, 2002; Biritwum, 2006; GMOH, 1999; Nazzar, Adongo, Binka, Philips, & Debpuur, 1995; Ngom, Debpuur, Akweongo, Adongo, & Binka, 2003). Many of these studies were limited to birth control practice, were primarily quantitative, and examined factors believed to be important by researchers. No studies have explored women's experiences of seeking reproductive health care in general and from their own perspective in particular. Furthermore, most of the research in Ghana related to women's reproductive health is urban based, with little attention given to rural women. This lack of attention is particularly true in the northern part of the country, where women are confronted with many barriers to seeking basic reproductive health care.

In order to appreciate the factors impacting women's health seeking behaviours, there is a need to understand the experiences of rural women in seeking reproductive health care. A better understanding of women's experiences regarding seeking reproductive health care will

serve to improve women's health and close the gap between what women really experience in seeking reproductive health care and what professionals perceive women's experiences to be.

1.2 Problem Statement

Reproductive health care is a top priority for health intervention in Ghana, yet few women seek it. Although some effort is being made to improve maternal health, reproductive health issues still remain a significant women's health problem and account for the majority of maternal morbidity and mortality in Ghana in general, and rural Ghana in particular. Maternal mortality rates are on the increase in Ghana, particularly in northern Ghana (Campana, 2003; GMOH, 1999). Sociopolitical and sociocultural factors such as beliefs, practices, customs, and norms around reproduction heighten the difficulty women face in their endeavors to access reproductive health care. These hindrances contribute to delays in seeking health care, resulting in maternal morbidity, complications and mortality.

To date, few research studies in Ghana have focused on women's reproductive health seeking behaviours from women's own perspectives, and more specifically, few studies focus on rural women, considering the reproductive health care disparities that exist between urban and rural women.

In order to increase the understanding of the barriers that confront women in their effort to seek reproductive health care, and to provide quality care for women and families, there is need for research that provides in-depth understanding of women's experiences of seeking reproductive health care from their own perspective.

1.3 Purpose of the Study

The purpose of this study is to understand rural Ghanaian women's experiences of seeking reproductive health care, specifically in the Talensi-Nabdam District (TND) of Northern

Ghana. While most researchers have examined factors influencing reproductive health care utilization, this particular study focuses mainly on women's own perspectives of seeking reproductive health care.

1.4 Research Questions

The broad research question that guided this study was: What are rural Ghanaian women's experiences of seeking reproductive health care? For this question to be answered I gave consideration to other contextual factors that might influence women's health care seeking behaviours in this particular rural setting. The following specific questions were developed to guide the research project:

1. Do women's lack of decision-making powers in rural Ghanaian community settings impact their reproductive health care seeking?
2. How does the type of living arrangement (living with extended family members including mother-in-law and father-in-law) impact rural Ghanaian women's reproductive health care seeking behaviours?
3. How do traditional beliefs and practices of rural Ghanaian women impact their reproductive health care seeking behaviours?
4. How do husbands influence women's reproductive health care seeking behaviours?

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In order to gain an in-depth understanding of the subject area, extensive literature has been examined. The examination of the literature has been organized around major factors that are perceived to be influential in patients' health care seeking behaviours in general and women's reproductive health care seeking behaviours in particular.

Researchers have examined the causes of poor patient health care seeking behaviours in the general population and in women specifically (Adongo et al., 1998; Asenso-Okyere et al., 1999; Avotri & Walters, 1999; Awedoba, 2002; GMOH, 1999; Helman, as cited in Hodgson, 2000; Hoga et al., 2001; Jansen, 2006; Osubor et al., 2006; Shaikh & Hatcher, 2005; Sicchia & MacLean, 2006). Factors that have been identified as influencing these behaviours have been classified into three categories: (a) access to health care, (b) socio-cultural factors, and (c) quality of health services and health facilities including attitudes of health workers and nurses towards patients. Each of these factors is considered below.

2.2 Access to Health Care

In developing countries such as Ghana, access to health care is a major concern (GMOH, 1999). Most significant among access concerns are physical, geographical, and economic factors. These factors play a major role in influencing patients' health care seeking behaviour in general, and women's reproductive health care seeking behaviour in particular.

2.2.1 Physical and Geographical Influences

Ghanaian studies have identified physical or geographical access to health care as a major barrier affecting health care seeking behaviours of patients generally, and women's reproductive health care seeking specifically (D'Ambruso, Abbey, & Hussein, 2005; GMOH, 1999; Nazzar et al., 1995). In developing countries including Ghana, several factors impede accessibility, including distance from health services, lack of available transportation, high transportation costs, and poor road conditions. All of these factors increase travel time and the difficulty of accessing a health service facility (GMOH, 1999; Nazzar et al., 1995; Shaikh & Hatcher, 2005).

In rural Ghana, physical accessibility remains a significant challenge to health service delivery. The scattered nature of village settlements in the rural areas of Ghana, seasonal flooding and poor roads make it difficult for the health care systems to meet the needs of the people living in those areas (GMOH, 1999; Nazzar et al., 1995). For instance, the district where this study was conducted has only one road network linking the district from one community to another, and the lack of and cost of transportation often prohibit use of health services. Most people living in remote areas, particularly in the Talensi-Nabdam District (TND) of Ghana, have little to no access to health services (Talensi-Nabdam District Assembly [TNDA], 2005), a factor that significantly impacts patients' health care seeking behaviours

Physical and geographical inaccessibility have a significant impact on the health care seeking behaviour of women living in rural areas. Pregnant women, especially women in labour, find it difficult to travel long distances on foot to access health care, and failure to access care increases the risk of maternal and infant complications and death. Without access, most pregnant Ghanaian women rely on help from their peers, older women, and Traditional Birth Attendants (TBAs) for health advice and for assistance in delivering their babies.

Typically, TBAs are women who may or may not have any formal training for their role, but who have been given recognition by their community members as trusted, experienced, and wise women who have accepted the responsibility to help their community by providing reproductive health care to women on a voluntary basis (Kruske & Barclay, 2004; Walsh, 2006). However, in some cases, there are men who practice as TBAs. In some rural areas such as in Ghana, community members show appreciation by offering TBAs goods or services such as food, chickens for meals, or help in carrying out their domestic tasks or on their farms (Kruske & Barclay, 2004). In most developing countries including Ghana, about 95% of deliveries in rural areas are conducted by TBAs and other family members (Goodburn, Chowdhury, Gazi, Marshall, & Graham, 2000; Kruske & Barclay, 2004; Smith, Coleman, Fortney, Johnson, Blumhagen, & Grey, 2000; Walsh, 2006).

In Ghana, TBA training started in the 1970s (Eades, Brace, & LaGuardia, 1993). TBAs are usually given approximately two weeks training on basic reproductive health care practices, with an emphasis placed on aseptic techniques. Although some TBAs are not trained and therefore do not adhere to hygienic practices during the performance of procedures, putting women at risk of postpartum infection, they have a significant influence on the reproductive care of women in rural areas because of their availability/proximity (Goodburn et al., 2000).

The role of the TBA includes provision of antenatal care, education on nutrition in pregnancy, recognition of complications of pregnancy and labour, delivery of babies, care of the newborn baby, education of mothers on breastfeeding, postnatal care, family planning services, and detection of signs and symptoms of sexually-transmitted infections. TBAs are expected to do appropriate and early referral of women with symptoms and complications of labour or

pregnancy-related conditions to health professionals for further assessment and treatment (Eades et al., 1993; Smith et al., 2000).

The shortage of trained health care staff is also a significant problem in accessing health care. The entire TND with a population of 100,789 are served by only one medical doctor and 20 nurses (TNDA, 2005). The other service providers include 55 Traditional Healers, and 60 TBAs (TNDA, 2005). The lack of educated health personnel, coupled with few health care facilities, limits the availability of health care practitioners, especially at night and for emergency cases such as women in labour. The lack of health personnel further limits service accessibility by the whole populace, especially those living in the most remote areas.

2.2.2 Economic Influences

Globally, economic issues affect much of the population, irrespective of age, gender, or race. This is no different in Ghana where about 30% of the population lives below the poverty line (Ashong & Smith, 2001; GMOH, 1999). Few and sub-standard economic resources have a significant impact in the arena of health care, especially in situations where fee for service is required, and payment is required upfront before receiving care. It has been observed that in most developing countries, as much as 80% of a family's income is spent on health care (Ha, Berman, & Larsen, 2002).

Studies conducted in Burkina Faso (Storeng, Baggaley, Ganaba, Ouattara, Akoum, & Filippi, 2008), Pakistan (Shaikh & Hatcher, 2005), Ghana (Bouwhuis & Davis, 2004; D'Ambruso et al., 2005; GMOH, 1999), Nigeria (Onah, Ikeako, & Iloabachie, 2006; Osubor et al., 2006), the Philippines (Jensen & Stewart, 2003), and India (Mohindra et al., 2006) reveal that economic ability to access health is a major factor affecting health care seeking behaviours in general, and reproductive health care of women in particular. For example, in Ghana, the

majority of women have limited control over family property and household financial resources and limited access to credit from financial institutions (Ankomah, 1996; Nukunya, 2004).

Women's financial dependence on their husbands affects their decision-making because health care options must be supported by husbands. Women lack the power to spend money on health care without their husbands' permission (Ahmed, Adams, Chowdhury, & Bhuiya, 2000; Shaikh & Hatcher, 2005). The socioeconomic issues affecting women's health care seeking also affects the whole family because the health of a woman is linked to the health of the family (Johnson, Greaves, & Repta, 2007; Senanayake, 1991). The low socioeconomic status of women puts them at greater risk of morbidity and mortality, and contributes to women resorting to other options such as self care/treatment that may jeopardize their reproductive health status (GMOH, 1999; Mohindra et al., 2006).

The introduction of "user fees" in African countries in the 1980s has also affected women's health care seeking behaviours (GMOH, 1999; Nanda, 2002). Charged to the individual patient for health care at the time of utilization of health services, user fees further reduce reproductive health care seeking behaviours by already economically vulnerable women (Nanda, 2002). In Ghana, the user fees system introduced in 1985, also known as "cash and carry," led to a reduction in the number of patients visiting the public health sector (GMOH, 1999). Although the impact of this user fee was felt by both men and women, women's reproductive health care seeking was most affected, with an associated increase in home births, maternal complications, and death (Nanda, 2002).

In 1998, the government of Ghana introduced a policy that exempted all women seeking antenatal health care from paying user fees and five years later, issued another policy that extended women's exemption as long as they delivered their babies in government health

facilities throughout the four most deprived and marginalized regions of the country. Later in 2005, the policy was extended to the whole country. Although free antenatal care and delivery for all women was meant to be a method for reducing maternal mortality in the country, there has been no significant improvement in maternal mortality rates or women's health care seeking behaviours regarding reproductive health, particularly in rural areas (Biritwum, 2006; Witter, Kusi, & Aikins, 2007). This lack of improvement in mortality calls for further investigations regarding women's health-seeking experiences related to reproductive health and their attitudes to health care.

2.3 Socio-Cultural Factors

Cultural beliefs, values, and practices shape an individual's knowledge and perception of health and illness/disease, and health care seeking practices and behaviours (GMOH, 1999). These shared norms guide self-care practices, and the use of traditional healers, both of which may support some healthful behaviours and contribute to unmet health needs (Adongo et al., 1998; GMOH, 1999; Shaikh & Hatcher, 2005). For example, in some cultures including Ghanaian cultures, the advice of elderly women in the communities and families is honoured and the adherence of younger women to this advice is expected (Jansen, 2006; Shaikh & Hatcher, 2005). This advice, usually based on the past experiences of elderly women, may contribute positively to improving the women's health. For example, to enhance nutrition in lactating mothers who have just given birth, older women advise husbands to provide their wives with guinea fowls with all meals for the first month post-partum to improve breast milk production and improve the woman's health status. Younger breast-feeding women, who have left the house for any reason, are advised to wash their breasts before feeding their babies as a way of preventing bad spirits that might have contaminated the breasts. They are also advised to eat only

hot foods after delivery, believed to be a way of healing the “sore-uterus.” Although the uterus does not need hot food to heal, eating hot food is a healthy practice for the prevention of communicable diseases such as cholera.

However, some elder advice may produce negative effects on the woman’s health. Younger women, for example, are advised against eating high protein foods during pregnancy such as meat in order to keep the baby small for easy delivery. This impacts the woman’s nutritional status during pregnancy and contributes to many women suffering anemia during pregnancy. Also, studies have shown that women are particularly vulnerable to HIV/AIDS in Africa, including Ghana, because of their lack of power over their sexuality and their social and reproductive lives (Manuh, 1998; Mill & Anarfi, 2002). Limited access to health information impacts women’s informed decision-making processes.

In Sub-Saharan Africa, traditional religious beliefs and practices are embedded in lineage systems that impact the structure of society which influences health decisions (Adongo et al., 1998). The marriage customs, the societal value of having many children, and strong extended family ties regulate reproduction (Gipson & Hindin, 2007; Nazzar et al., 1995).

Ghanaian culture places high value on large families and especially male children and, therefore, there is a lack of support for women’s use of birth control. There are usually tensions in marriages where the woman is interested in using birth control and these tensions may even lead to divorce. Women, therefore, exercise little control over their reproduction, and experience multiple pregnancies in a context of limited health services. This has a direct impact on the women’s overall health status. As well, some studies have demonstrated that women’s autonomy over their reproductive health can bring tensions in some families both for their husbands and the extended family members (Adongo, Phillips, Kajihara, Fayorsey, Debpuur, & Binka, 1997).

Contraceptive use by women in Northern Ghana has been reported to create tension in the marriage by associating contraception to violating the woman's cultural obligation and gender role to bear children. For example, the following statement from a participant in Bawah, Akweongo, Simmons, and Phillips' (1999) study is representative of what men think women are obliged to do: "We marry women to build our homes; therefore, women have no right to limit their births" (p. 60). Men also fear that if women are allowed to use birth control, they are likely to have extramarital affairs. In most African cultures, for example in Botswana, under customary law, men are allowed to practice polygyny and to be unfaithful to their wives, whereas women's unfaithfulness will lead to divorce (Van Hook, 1994). However, contraceptive use can also bring harmony to the couple since it improves sexual satisfaction and helps couples to achieve their reproductive objectives and live healthy lives (Bawah et al., 1999).

Given the significant value of large families in Ghana, polygyny is common and men who wish to have more children will marry another woman when the first wife reaches menopause (Adongo et al. 1998). The practice of polygynous marriages exposes women to sexually-transmitted infections since the man has more than one sex partner and may practice unprotected sex. Polygynous marriages can also lead to socioeconomic difficulties since couples are usually economically constrained and depend on the little that they have to provide necessities (i.e., food, shelter, and clothing) for their larger family. In these situations, it is not uncommon for women to ignore their own personal health needs. These beliefs, values, practices, and norms impact women's health care seeking behaviours and the entire family. These factors further influence self-care choices or rejection of reproductive health care programs.

Studies have revealed that in most West African countries, births are spaced by use of prolonged “postpartum abstinence” although this method tends to be unreliable (Bledsoe, Hill, D’Alessandro, & Langerock, 1994; Lesthaeghe, 1989). Husbands and wives face difficulties in maintaining the prolonged abstinence, especially when the marriage is monogamous. Despite difficulties women encounter in maintaining postpartum abstinence, and the desire to have fewer children, acceptance of family planning in most African cultures including Ghana is low and fertility rates are high (Campana, 2003; Dodoo & Landewijk, 1996; GMOH, 1999, 2006; TNDHA, 2007). In part, this is because women have limited choices regarding fertility regulation as a result of the traditional beliefs, values, and practices around childbearing. The high fertility rates endanger women’s health status in general and reproductive health in particular.

In Ghana, traditional beliefs and practices surround pregnancy and labour. To avoid coming into contact with bad spirits that will lead to abnormal babies, pregnant women are not allowed to go to public places. They are forbidden to eat high protein foods, including meat, fish, fresh milk, and snails to prevent the fetus from becoming so big as to cause obstructed labour. Prolonged labour is believed to be associated with extramarital sex and there is an expectation for confession. During prolonged labour, instead of sending the women to hospital, hot water is often poured on the abdomen and okra smeared on the vulva to expedite delivery. Special herbs are always given to women who retain their placenta and a bottle is given to the woman to blow for the placenta to be delivered. As well, the placenta is always buried in front of the household to indicate that the ancestors have accepted the baby. Before a baby breastfeeds, breast milk is tested by expressing it into a calabash. If an ant which is placed in the milk dies, the milk is thought to be not wholesome and needs purification (Mills & Bertrand, 2005). All these beliefs

and practices have significant health implications on the women's reproductive health as well as that of the baby.

Woman's reproductive health is also being jeopardized in cultures where female genital mutilation (FGM) is practiced (Jackson, Akweongo, Sakeah, Hodgson, Asuru, & Phillips, 2003; Manuh, 1999). FGM is commonly practiced in countries such as Sudan, Somalia, Djibouti, Ethiopia, Sierra Leone, and Ghana (Manuh, 1998). FGM has a significant impact on women's general reproductive health status throughout their entire life and most especially during delivery. During my work as a nurse in the maternity ward in Northern Ghana, I observed that most obstructed labours were a result of complications of FGM.

Women may also face barriers to participating in health programs because of cultural taboos. An Ethiopian study has demonstrated that women face barriers to participation in health programs such as HIV/AIDS prevention because of cultural expectations that prohibit open discussions of sexual issues among women, limiting women's knowledge and options for reproductive health (Cummings, Mengistu, Negash, Bekele, & Ghile, 2006). This is no different in Ghana where husbands do not allow wives to participate in health educational programs including HIV/AIDS prevention and birth control for fear that when women gain knowledge that equips them with options for sexual health, they will have extra marital affairs (Bawah et al., 1999). These factors impact the reproductive health care seeking behaviour of women in Sub-Saharan Africa, including Ghana.

2.3.1 Patriarchal Culture: Gender and Women's Decision-Making

In dominant patriarchal cultures such as that found in Ghana, men play an important role in determining what counts as a health care need for women; men are in control of almost all the resources in the family (Adongo et al., 1998; Hashemi, Schuler, & Riley, 1996; Jansen, 2006;

Rani & Bonu, 2003; White, Small, Frederic, Joseph, Bateau, & Kershaw, 2006). In rural Ghana, a woman may be permitted by her husband to seek health care only when her illness is considered serious. The determination of the seriousness of a disease is controlled by the husband and family members, even though they are not the ones experiencing the suffering. Shaikh and Hatcher (2005) report on a study in Pakistan which demonstrated that women reported their general health concerns less frequently than men did because men are the decision makers in the family and control all resources in the household and determine when a woman should seek health care.

Other researchers also report that women do not have the opportunity to report health concerns in many cultures because of their dependence on husbands or men and mothers-in-law in making decisions about their reproductive health (Jansen, 2006; Rani & Bonu, 2003; White et al., 2006). For example, a study on the Kassena-Nankana culture of Northern Ghana revealed that women were afraid to practice birth control without their husbands' consent/knowledge because of the belief that the ancestors may curse them for doing so (Bawah et al., 1999). Women's health care seeking behaviours were determined by a "gate-keeper." A gate-keeper in this context refers to an elder, usually a man in a compound, who serves as the head of the family and who is in charge of the welfare of the whole family. A compound in this context is a structure consisting of multiple households. Authorization is required from the gate-keeper before women can seek health care (Ngom, Debpuur, Akweongo, Adongo, & Binka, 2003).

Either gate-keepers or the husbands are responsible for deciding if a problem is serious enough for a woman or her child to seek health care—a practice that contributes to late reporting. Negotiating with her husband and mother or father-in-law for permission to seek help from a modern health practitioner is required of a woman, even in an emergency, and may also result in

delays in obtaining health care for themselves and for their children. Although women seek care if they perceive the health concern to be serious, they often rely on mothers-in-law and peers for health advice (White et al., 2006).

The male-dominated structure of the family in Ghana influences women's health care seeking behaviours. The male head of the family often approaches a disease condition by first employing the services of "soothsayers," who will contact the ancestral spirits to interpret the causes and treatment of a disease condition or any family misfortune. Approximately 70% of rural community members consult a soothsayer when sick and not the formal health sector (GMOH, 1999). Consequently, women are likely to seek medical care for treatment only after the condition is in the advanced stages or, depending on what the ancestral spirits have to say about the particular issue at hand, or not at all (Adongo et al., 1998). For instance, it has been noted that less than 20% of Ghanaian women associate the cause of malaria to the mosquito; it is also believed that some sicknesses, such as a condition like boils, are better treated by the traditional healer (GMOH, 1999). The role of the soothsayer is significant in determining whether women will seek additional help from health care providers, especially in reproductive health care such as labour.

Women's lack of power in making decisions about seeking health care may be further expressed through the practice of seclusion. Husbands may seclude their wives from the public domain for cultural and religious reasons (Mumtaz & Salway, 2005). This seclusion limits women's autonomy and isolates them from public space, further limiting their access to health care and health information and especially reproductive health care options in a culture where value is placed on having more children.

As well, gendered roles related to child care and household responsibilities also influence women's health. Results from studies in Ghana indicate that women generally assume more of the work in the family units than do men (Avotri & Walters, 1999). This heavier workload limits their freedom to take care of themselves and has an impact on their general health status.

2.3.2 Gender and Education

Although gender is socially and culturally constructed, its resultant inequalities have significant repercussions on women's health in general and reproductive health care in particular (Johnson et al., 2007; Manuh, 1998). Researchers often neglect women as participants because of their gender roles and thus deny them the benefits of such research findings (Johnson et al., 2007). In most African countries including Ghana, families emphasize the education of male children, thus limiting female opportunities for societal advancement such as employment (Manuh, 1999). Lack of education is associated with low income (Manuh, 1999) which has serious repercussions on the woman's life choices including health care for self and the whole family. A recent study on poverty and women's health reveals that as much as 70% of the world's poor are women, with a 50% increase in poverty among rural women in comparison to men as a result of lack of education (Sicchia & Maclean, 2006).

Education plays a significant role in women's reproductive autonomy and general health care seeking behaviours. For example, in an international survey of 26 developing countries, Martin (1995) found that women with lower levels of education had higher fertility rates. In another study it was noted that women with higher levels of education are more likely to seek reproductive health care compared with those with lower levels of education (Waiz, 2000). With regard to sexual health, results from a study in the Philippines reveal that young women are required to remain virgins until marriage, and after marriage, remain faithful to their husbands,

whereas young men are allowed to have multiple partners (Badiane, 2005). This is similar to women's experiences in Ghana where men do not allow women to practice birth control for fear that they may become unfaithful (Bawah et al., 1999).

Several factors act as obstacles to girls' education even for the few who attend school. Girls are likely to drop out of school as a result of pregnancy; parents may withdraw them for early marriage for economic reasons or to shoulder the greater burden of household work for which they have sole responsibility, since culturally boys are not allowed to participate in household chores (Addai, 2000; Manuh, 1999). This leaves girls with limited time for themselves and for their studies and career advancement.

Education enhances women's self confidence, their awareness of the world outside the home, respect for women in society, and their ability to acquire decision making skills. Not only does it give women greater control over decision making in the family, but over their personal reproductive health (Hogan, Berhanu & Hailemariam, 1999; Martin, 1995). Studies have also shown that in developing countries such as Ghana, educated women are more likely to have access to and use reproductive health care services than non-educated (Waiz, 2000).

The impact of gender on education is heightened for woman living in rural Ghana. As results from the 2003 Ghana Demographic and Health Survey (Ghana Statistical Service [GSS] & Noguchi Memorial Institute for Medical Research [NMIMR], 2005) indicate, in Ghana, many women—especially in rural settings—are not formally educated and this has an impact on their decision-making ability and health status. It has also been noted that the number of years of education a woman has corresponds to a delay in the age of marriage and first birth, a delay which serves to improve maternal health (Martin, 1995). Studies in 33 Sub-Saharan African countries indicate that the median age at first sexual encounter for women is between 16 and 20

years (Bongaarts, 2007). In Ghana, most marriages and first births occur at about age 15 years, with women averaging about 6 children each (GSS, & NMIMR, 2005). However, the number of children per woman varies from rural to urban. Whereas a rural woman may have between 6 and 9 children, an urban woman may have approximately three children (Campana, 2003; GSS, & NMIMR, 2005). Studies which examine the impacts of early marriage and childbearing have also attributed poverty as a factor in the number of children a woman bears (Rani & Lule, 2004).

Women's health care seeking behaviour is dependent on the autonomy they have to make decisions regarding their own health care, and on the cultural beliefs and values of the families with regards to gender roles (Bawah et al., 1999). Women's autonomy in health-seeking is influenced by the status of the woman in the family and community as well as their age and experience, economic stability and education, and leadership role.

2.4 Quality of Health Care and Health Facilities

Quality of care is another factor that influences an individual's health-seeking behaviour (GMOH, 1999). Donabedian (1969) refers to quality of care as the assessment of structures, processes, and outcomes. A number of studies, including ones conducted in Ghana, have identified poor infrastructure, incompetence of health care professionals, delays in receiving appropriate care at health facilities, non-availability of medical supplies such as drugs, lack of specialists, inadequate referral systems, and the attitudes of health care professionals as factors contributing to poor quality service (Asenso-Okyere et al., 1999; D'Ambruso et al., 2005; GMOH, 1999; Onah et al., 2006; Shaikh & Hatcher, 2005; White et al., 2006). These factors translate into the loss of the public's confidence in the health care systems in developing countries. An important factor associated with poor quality of health service provision in Ghana is overpopulation—where the size of a country's population exerts pressure on the already

inadequate health care facilities amidst limited resources (GMOH, 1999). With the introduction of user fees, quality of services has been found to differ among health care facilities depending on the type of facility. The types of health care facilities available in Ghana include community clinics, health centres, district hospitals, and regional hospitals (GMOH, 1999). For example, at the community clinic level, patients do not get the opportunity to access specialist care, and the cost of health care at the regional level is more expensive than at the community level. This reality limits the best form of care to the few who are able to afford to pay for the services (Asenso-Okyere et al., 1999). These factors influence health-seeking behaviours of women who are already economically vulnerable.

2.4.1 Attitudes of Health Care Providers

The attitudes of health care providers have been identified as a global issue that affects patients' health-seeking behaviours (Shaikh & Hatcher, 2005). Several studies in Ghana examining factors affecting patients' choice of health care facilities and health-seeking behaviours reveal that attitudes of the health care providers play a major role (Asenso-Okyere et al., 1999; D'Ambruso et al., 2005; Witter et al., 2007). Health care providers' attitudes towards patients, especially women seeking reproductive health care, is an important factor that determines acceptability and utilization of health services (D'Ambruso et al., 2005).

My experience working with many Ghanaian nurses, for example, indicates that most of them find it difficult to understand why women have trouble seeking reproductive health care despite the massive educational campaigns on the importance of reproductive health care for women. Ghanaian nurses assume that there is a significant public awareness about the importance of reproductive health care through public health educational programs and believe that women neglect their own health care. Nurses often seem unaware of other factors impacting

health care seeking behaviours. These assumptions and the tendency to blame the patient contribute to nurses' poor attitudes towards women seeking reproductive health care.

Studies in Ghana attribute the poor attitudes of health care providers to a number of factors including (a) low levels of nurses' education, (b) the patriarchal nature of education, (c) low salaries, (d) a shortage of health care personnel in the health care industry, and (e) heavier workloads on nurses (Asenso-Okyere et al., 1999; Witter et al., 2007). Witter et al., in a study on the impact of increased salaries for health care providers on patient care, reveal improvements in practice and job satisfaction. However, Witter et al.'s study did not include patients' perspectives, making it difficult to draw conclusions as to patients' responses to care provider attitudes. Nurses' attitudes have an impact on interpersonal relationships, which is crucial in women's health care seeking behaviour. A study by D'Ambrusoso et al. (2005) involving pregnant women and health service utilization in Southern Ghana revealed that health care professionals' attitudes was the most significant factor that influenced their health-care seeking behaviour.

2.5 Summary

In summary, the extensive literature reviewed demonstrates that researchers have begun to examine factors influencing women's health-seeking behaviours both in rural and urban areas in both industrialized and developing countries (D'Ambrusoso et al., 2005; GMOH, 1999; Ha et al., 2002; Mohindra et al., 2006; Nanda, 2002; Nazzar et al., 1995; Onah et al., 2006; Osubor et al., 2006; Shaikh & Hatcher, 2005; Sobralske, 2006; White et al., 2006). Researchers have identified lack of education, resources, attitudes of health workers, distance to health care services, transportation systems, long waiting hours, availability of staff and drugs, pattern of illness and duration, beliefs in spiritual influences on health problems and gender roles, and the

status of women in societies as some of the main influences impacting women's health care seeking behaviours (Eades et al., 1993; Johnson et al., 2007; Manuh, 1998; Martin, 1995; Ngom et al., 2003; Shaikh & Hatcher, 2005). The literature clearly indicates a significant absence of women's perspectives in this body of research and therefore a significant gap in our understanding of the issues.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

In order to gain a better understanding of rural Ghanaian women's experiences of seeking reproductive health care from their own perspective, a qualitative research method with an ethnographic approach was chosen for this study. The rationale of this chapter is to describe the research design of the study. In this chapter the theoretical framework guiding the study, the operational definition of the study, sampling methods, ethical considerations protecting participants' rights, data collection strategies, data management and data analysis of the findings will be discussed.

3.2 Design

Because the study aimed to understand the cultural influences on women's health-seeking behaviour, ethnography was chosen as the methodological approach. For the purpose of this study, focused ethnography was used (Knoblauch, 2005; Muecke, 1994). Using focused ethnography the current study explored rural Ghanaian women's experiences related to seeking reproductive health care.

3.3 Ethnography

Ethnography is a qualitative approach to social research that aims at understanding the behaviour of human beings in the context of a culture (Gillis & Jackson, 2002; Hammersley & Atkinson, 1995, Madison; 2002). As the "study of another culture" (Werner, Schoepfle, Ahern, 1987, p. 42) ethnographic studies explore the "routine ways in which people make sense of the world in everyday life" (Hammersley & Atkinson, 1995, p. 2) and can also be considered the "work of describing culture" (Spradley, 1980, p. 3). The roots of ethnography can be traced to as early as the 1900s within the field of anthropology (Denzin, 1997).

Ethnographic researchers assume that cultural beliefs, values, behaviours and practices are learned and transmitted within the group, and this worldview is transmitted and shared among individuals (Hammersley & Atkinson, 1995; Morse & Richards, 2002). Even though culture is not static, shared beliefs, values, behaviours, and practices can impact health. Ethnography, as a naturalistic approach to research, proposes that research be done in a natural setting, that is, in peoples' own natural environment, with the primary aim of describing what the researcher sees happening in the setting, how the people themselves see their actions, and how they also see the actions of others (Hammersley & Atkinson, 2005). Key to naturalistic study is that the researcher is required to respect and appreciate the social world of participants. In naturalistic studies researchers try to understand human behaviour by gaining access to the world of the people, that is, the meanings that guides the particular behaviour(s) of interest (Hammersley & Atkinson, 1995). Ethnographic research is underpinned by assumptions that distinguish it from other research strategies.

3.3.1 Assumptions Underpinning Ethnography

Ethnographic research design provides a means to explore cultural practices based on the assumption that culture is “shared values, beliefs, and behaviours within a cohesive group” (Morse & Richards, 2002, p. 48). One key assumption is that by engaging in an interaction with people in their everyday lives in a natural setting, ethnographic researchers are able to gain a better understanding of the beliefs and behaviours of their participants and motivation for their behaviours (Tedlock, 2000). Ethnographic researchers also assume that people construct the social world based on their own interpretations and act based on these understandings and interpretations (Hammersley & Atkinson, 1995). For example, culture shapes the way individuals come to understand and define health, and this varies from one culture to another.

This cultural variance could have both positive and negative impact on the individual's health. It is also assumed that meanings can be captured on the basis on which people act, thus, "meanings are not stable, nor are they properties of individuals, but rather reflect the constitution of subjectivities through language" (Hammersley & Atkinson, 1995, p. 13).

3.3.2 Focused Ethnography

Focused ethnography was used in this study to understand rural Ghanaian women's shared experiences of health care seeking. Focused ethnography, also referred to as particularistic or mini ethnography (Gillis & Jackson, 2002; Morse, 1994), shares certain features with other ethnographic approaches (Morse & Field, 1995) and has its roots in sociology and medical anthropology (Knoblauch, 2005; Muecke, 1994).

The approach derives its name from its particular characteristic of defining a focus for study. Focused ethnography is geared to obtaining information on a special topic or experiences shared by groups of people (Knoblauch, 2005; Morse & Richards, 2002). It focuses on a small section of a society, rather than the whole society, to investigate a specific area such as beliefs and the meanings held by a particular cultural group (Knoblauch, 2005; Muecke, 1994). For example, this approach has been used to study a support group for patients (Lipson, as cited in Morse, 1994), cross-cultural relationships between nurses and Filipino Canadian patients (Pasco, Morse, & Olson, 2004) and health-care seeking behaviours of Mexican American men (Sobralke, 2006). The recognition of local knowledge in health care is important, and supports the use of ethnographic studies.

Another feature of focused ethnography is its use of short-term, but intense, fieldwork that yields quality results. It is often used to meet the limited resources available for research such as budgets and time (Muecke, 1994) and uses multiple methods of data collection. The

intensive data collection techniques are usually aided by the use of technical equipment (Knoblauch, 2005) including audiovisual and video recording with less researcher writing in the field. Knoblauch notes technical equipment such as tape-recorders, videos, and photo-cameras enables the researcher to generate a considerable amount of data within a short period of time.

Focused ethnography lends itself to situations in which the ethnographer comes from the same society where the research is being conducted. The researcher usually has an in-depth knowledge and familiarity with the study setting which reduces the problem of strangeness. There is a considerable amount of trust between researcher and the cultural group and an already existing relationship that privileges the researcher over another who would enter into the culture as a stranger. The researcher focuses on a specific research topic and has in-depth knowledge of the field of study before entry into the community to begin the study.

In focused ethnography, data collection focuses on actions and interactions of the participants being studied. Data gathering generally includes participant observation, combined with unstructured and semi-structured interviews (Muecke, 1994). The use of technical equipment allows the researcher to invest more time in observation which helps with further exploration about the phenomenon of study (Knoblauch 2005). Although in a focused ethnography researchers assume that technical devices are equal to human observation techniques, traditional forms of observations are also applied (Knoblauch, 2005).

3.4 Theoretical Framework Guiding the Study

The theoretical basis of this research originates from the constructivist paradigm. Within this paradigm, individuals make meaning of the world or environment in which they live or work (Creswell, 2007). The constructivist paradigm is concerned with subjective meanings and experiences of human beings and recognizes the fact that these experiences and meanings are

developed by them based on whatever makes meaning, and what that meaning holds for them. According to Creswell, this paradigm argues that human beings individually and collectively construct or interpret the social world in which they live in specific social, linguistic, and historical contexts. The social world is seen as ever changing (Williamson, 2006) and meanings are multiple and varied in nature. Creswell explains how these meanings are not imposed on individuals; they form through interaction with individuals and as well through cultural norms, beliefs, and practices that influence individuals' lives. Based on constructivist theory, knowledge and truth are created rather than discovered. Researchers in this paradigm acknowledge that their own personal background influences the research and position themselves in the study in a way that acknowledges how their background shapes their interpretations.

3.5 Operational Definition

Reproductive health is defined as a:

State of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. (International Conference on Population and Development, as cited in Ghana Health Service, 2003, p. 2)

For the purpose of this study, reproductive health is referred to as “women’s health issues.”

These “issues” include care given to women during the prenatal or antenatal period, labour and delivery, birth control or family planning, treatment for sexuality transmitted infections, infertility, menstruation, and any concerns about the female reproductive organs. In the interview guide, the term “women’s health issues” is used to frame the semi-structured questions.

“Women’s health issues” is the term used by rural women in the Talensi-Nabdam, District (TND) to represent reproductive health.

3.6 Sample

3.6.1 Study Setting

This study was conducted in two rural communities within the TND in Northern Ghana. Ghana, located in West Africa, shares borders with Togo to the east, Burkina Faso to the north, Cote d'Ivoire to the west and Gulf of Guinea to the south. The country has a land area of 239, 460 square kilometres (km) with an estimated population of 22, 409, 572 people, with the majority of the population living in rural areas (Bouwhuis & Davis, 2004; Central Intelligence Agency, 2006; GMOH, 1999; Mba, 2004). Ghana is divided into 10 administrative regions and 138 district assemblies, with Accra as the capital of the nation. There are over 90 ethnic groups with a variety of cultural beliefs, customs, and values which impacts various aspects of the lives of the people, including types of marriages, reproduction, health care practices, social interaction and general attitudes (GMOH, 1999). Of the main religious groups, 63% are Christian, 16% are Islamic, and 21% are Traditional African (Central Intelligence Agency, 2006).

The district where the study took place is entirely rural and bordered to the north by the Bolgatanga Municipality, south by the West and East Mamprusi Districts, the Kassena-Nankana District to the west, and the Bawku West District to the east. Based on the 2000 Housing and Population Census document (TNDA, 2006), the district has a population of 100,789 people; 49.6% of the population is male and 50.4% is female. TND has a total land area of 912 square kms (TNDA, 2006). The physical environment is Savannah grassland. The district's population is comprised of two distinct ethno-linguistic groups, of which slightly more than half are Talensi-speaking and the remaining are mainly Nabit-speaking. Despite this dual-linguistic identity, the Talensi-Nabdams are in most respects, a homogenous group with a common culture.

This district is one of the most economically deprived areas in the country. Subsistence agriculture represents the main income of the people in the entire district. Approximately 90% of the district's population relies on rainfall to grow their food crops (TNDA, 2006). The erratic rainfall, limited to the June to October period, restricts farming to a single growing season. The limited and inadequate rainfall leads to food crises and severe poverty which impacts the health of the people. Maternal morbidity and deaths may occur as a result of food deprivation leading to malnutrition, especially in pregnancy.

The district has one public hospital, three health centers, and nine public and privately owned clinics. The health service providers comprise public sector, nongovernmental organizations, traditional healers and Traditional Birth Attendants (TBA). Although there are health care facilities located in the district, usage of these facilities is very low due to poverty, illiteracy, traditional beliefs, customs, practices, and attitudes of health care providers towards patients (TNDA, 2006).

The participating communities are located about 15 km north-east of Nangodi in the newly-created district of Talensi-Nabdam and Bolgatanga, 1 of the 8 administrative districts of the Upper East Region of Northern Ghana. The two communities have an estimated population of 600 people, the majority of whom are women and children due to polygynous marriage systems. The two communities are homogenous in terms of cultural traditions and language. The common dialect spoken by the people of the communities is Nabit. A motorable road links the two communities to the rest of the district; however, it is often flooded during the rainy season. Public transport available to the communities is only during the daytime and on market days. Market days in this context are particular days set aside for the entire sub-district to do economic

activities in a common market. This usually occurs every three days. The communities have neither electricity, post office, nor a bank.

The nearest health centre that serves the communities is about 15 km away (TNDA, 2006). The health center provides a broad range of maternal and child health services, which include antenatal, delivery, postnatal, birth control services, immunizations, child welfare, and curative health services. At the time of the study, the health center had a total of nine staff: one Medical Assistant (nurse-manager), one midwife, three community health nurses, one epidemiology staff and three health aids. The health centre had no access to an ambulance for emergency services. The only means of transportation for the health center were three motorbikes, all of which were in poor condition. The most senior staff of the health centre lived in the city while the most junior staff lived within the community when on call-duty. The health facility was not providing 24-hour service. Services were provided from morning (about 9:00 am) to evening (about 5:00 pm) due to inadequate staff and the rural nature of the communities.

The closest market where community members engage in income-generating activities to earn a living is approximately 10 km away. At the time of the study, a school was being constructed to serve the communities. Lack of potable water is a major concern of the community. Women and children may walk long distances to fetch water from boreholes, streams, and wells which are sometimes contaminated and unsafe for human consumption. Neither community has public toilet facilities nor urinals, and inhabitants use any available field for defecation, popularly called “free range.” The practice of free range results in poor sanitation and contamination of water bodies, leading to the spread of communicable diseases.

There were several reasons for choosing these communities as a location to conduct the following research. Little is known about women’s health concerns in these communities and no

research has examined women's experiences of seeking reproductive health. These communities are also the most economically deprived among the several communities in the district but are located fairly near to health care facilities that provide reproductive health care. I anticipated that this present study would serve to represent the voices of women in these communities so as to improve their health.

3.6.2 Sampling

The emphasis in an ethnographic study is on meaning, understanding, and interpreting the phenomenon of interest. This emphasis orients sampling so as to engage participants who have knowledge with respect to the area of inquiry (Barnes, 1992; Creswell, 2007; Gillis & Jackson, 2002; Higginbottom, 2004; Kuzel, 1999; Morse, 1991). To learn about the phenomenon of interest, a purposive sampling strategy was used in the study to access participants (Creswell, 2007; Fain, 2004; Morse, 1991). In purposive sampling, the researcher "selects individuals and sites for the study because they can purposefully inform an understanding of the research problem and central phenomenon in the study" (Creswell, 2007, p. 125). Participants are selected according to their willingness to participate (Fain, 2004; Morse, 1991). In order to capture the women's experiences of reproductive health seeking, effort was made to recruit informants of different ages, with diverse living arrangements, and from different types of marriages (Creswell, 2007; Hammersley & Atkinson, 1995; Higginbottom, 2004; Maykat & Morehouse, 1994).

3.6.3 Criterion for Sample Selection

The purpose of this study was to understand women's experiences regarding reproductive health care. Women who met the following criteria were recruited for the study: child-bearing age, between the ages of 15 and 49 years, and living in the rural community of TND.

3.6.4 Sample Size

In qualitative research, the purpose is to “explore meaning and phenomena” (Fain, 2004, p. 116), making small scale studies the preferred approach (Barnes, 1992). In qualitative research, smaller sample size is generally preferred (Kuzel, 1999) to give the researcher the opportunity to get to know the social world of participants, increasing both the depth and quality of data. The size of a sample also depends on the resources available to the researcher. These include time, money, travel distance and personnel (LeCompte & Schensul, 1999). The findings of qualitative research are not aimed at generalizing but understanding what is happening from the participant’s perspective. Thus, in qualitative studies, the emphasis is on the appropriateness and adequacy of the sample rather than sample size (Fain, 2004; Morse, 1991). Morse (as cited in Morse, 1991) refers to appropriateness as the “degree to which the choice of informants and the methods of selection fit the purpose of the study as determined by the research question and the stage of the research” (p. 134). Furthermore, Morse defines adequacy as “the sufficiency and quality of the data” (Morse, 1991, p. 134).

Sample size is usually not predetermined, but will vary depending on the type of data needed to understand the phenomenon being examined. After having met the inclusion criteria for sample selection, the sample size was also dependent on the willingness, interest and the enthusiasm that participants showed to share their experiences with the researcher during the recruitment period. The sample size for this particular study consisted of 27 participants. Twelve individual interviews were conducted and two focus groups consisting of 7 and 8 participants respectively were conducted.

3.6.5 Recruitment Procedures

Participants were recruited from two small and remote communities within the TND. Gaining access to participants involved a complex process in which I strove to be consistent with the cultural customs and expectations of the traditional setting where the study was conducted. First of all, led by a community sub-Chief and a youth leader in the community, I paid a first visit to the Chief of the two communities in a formal procedure necessary to secure access to participants (refer to Appendix A).

I introduced myself to the traditional leader, followed with respectful traditional greetings, and then explained the purpose of my visit in order to seek permission to conduct the research in the particular communities. After the first meeting and initial introduction, I held a second meeting after three days, this time with the Chief and elders of the communities to discuss the purpose of my visit and the research. After the meeting, I presented Cola nuts and tobacco to the Chief and elders of the communities as a cultural ritual to express my appreciation of their acceptance and permission given for the study to take place. Following the second meeting with the Chief and elders, I paid visits to some community members who were bereaved shortly before the beginning of the research as a cultural practice. This is consistent with the cultural expectation that you mourn with the bereaved to show your concern for their welfare.

After obtaining permission from the Chief, the second phase of the recruitment process was a meeting with women's group leaders as suggested by the Chief. Women's group leaders are respected, wise women selected by members of an organized woman's group. These group leaders coordinate the activities of the women in the village such as organizing group meetings, keeping their financial contributions on track and scheduling time for group members' farm work. For this study, the group leaders organized a meeting of all women in the village for me to

brief them about my intention. The purpose and general nature of the study was explained to women verbally as the majority of women did not have formal education and could not read or write.

The third phase of the process, a meeting with Community-Based Surveillance Volunteers (CBSVs) was arranged. CBSVs are individuals from each village selected by their communities to represent them at the health authority level on a voluntary basis. Their role in the community is to give first aid treatment (for which they are given training) in their respective communities and to make appropriate referrals, register households, births and deaths and vaccinations in their catchment areas (Kyei-Faried, Appiah-Denkyira, Brenya, Akuamo-Boateng & Visser, 2006). The purpose and general nature of the study was explained verbally to the CBSVs, again because the majority of them were not formally educated and could not read or write (refer to Appendix B). They in turn, communicated the information to women in the community verbally and invited them to participate in the research.

The fourth phase was a meeting with nurses who worked at a local clinic that serves the entire population included in the study area. An explanation of the purpose and general nature of the study was given to nurses and their support was sought to assist in participant recruitment (refer to Appendix C). Recruitment procedures were aimed at avoiding coercion, maintaining respect for participants, and encouraging voluntary participation.

3.7 Ethical Considerations

In addition to obtaining ethics approval from the University of British Columbia Okanagan Ethics Review Committee (see appendix H), a second non-formal approval was gained from the Chief of the communities. This was necessary in order to conduct the study in the communities within his jurisdiction. This approval is a cultural requirement. At the village

level, consent to recruit women for participation in the study was gained through an informal meeting with the Chief and elders (see Appendix A). In order to respect and protect human rights and avoid coercion, participants were recruited through CBSVs (see Appendix B), nurses (see Appendix C), and female group leaders.

The majority of rural Ghanaian community members, especially women, do not have formal education and cannot read or write, making verbal consent necessary. Therefore, for this study consent from participants was gained through a verbal rather than a written process. This consenting process was aimed at ensuring that participants were protected from harm and that they had access to full information about the research and researcher, their rights and responsibilities (see Appendix D). The purpose and nature of the study was explained to participants verbally and their verbal consent to participate was obtained.

The verbal consent to participate for each woman was audio-recorded prior to beginning the interview. Women participated at their own will and were told that should they desire to withdraw at any stage during the research process, they could without any consequences. They were also told they could decline to answer any specific questions with which they did not feel comfortable. Consistent with the Ghanaian tradition and culture, I offered participants some food to acknowledge their time for participation.

Confidentiality and respect for participants was maintained throughout the study by the use of pseudonyms, and by keeping all data under lock and key to prevent unauthorized access to them. Participants were also given the opportunity to choose places that were convenient for their interviews to take place. The interview setting—study communities and the health care facility, including nurses—has not been named in this thesis in order to protect participants’

identities. Audio recordings and transcripts were shared only among the researcher, a public health nurse who edited one transcript for accuracy of translation, and the thesis committee.

3.8 Researcher's Position

In qualitative research, quality of the research results is enhanced when the researcher's position is made clear from the onset (Kirby, Greaves, & Reid 2006). This clarity helps the researcher to become more aware of his or her potential biases and beliefs that may impact on the way the researcher approaches the study.

“Positionality” in this research context is referred to as the way that an individual's position in the social hierarchy compared to other groups potentially “limits or broadens” one's understanding of others (Kirby et al., 2006, p. 37). In this study, I locate myself within the culture in which the research was conducted. I was born and raised in parts of this community. According to Werner et al. (1987), when the researcher is part of the culture, it is difficult to achieve neutrality. I critically reflected on my assumptions and beliefs, and those of the participants in the research. I kept a reflexive journal during the process to enhance interpretation of the data.

I have a strong passion for issues around women's health, the health care system, as well as women's position in society and how this position may compromise a woman's right to access quality health care. As a member from this male-dominated culture, I have an insider's perspective of how women are socially placed. This perspective could contribute to biases regarding my perception about the experiences of women seeking reproductive health care. It could also limit my ability to look beyond the reality that exists before the community. On a positive note, in comparison to someone from a different culture going into the community, this

perspective provided me with a better opportunity to access women easily, and an ability to understand the culture, especially in a way that an outsider in the culture may not.

However, considering the nature of the study, some participants initially did not feel comfortable sharing their personal and real life experiences with me because I am an insider (Kirby et al., p. 37). The majority of participants in this research were women without formal education. Initially, there were feelings of intimidation because I am an educated woman. I made a special effort to respect women's perspectives and relate to them in a manner that promoted power sharing (Chinn, 2004). For example, I ensured that any time I had something to discuss with them, I put across the idea in a general manner and asked for their suggestions before I presented my contribution.

In order to reduce these potential implications for the research results, I remained reflexive throughout the study process. I also encouraged power sharing among women and ensured flexibility so that the women did not feel threatened or dominated. For example, I wanted, and I made sure that, women felt that we were equal and that I understood and appreciated their circumstances and situations. I appeared casual both in my dress and during my interaction with participants in order to ensure they felt respected, valued, and comfortable. Before we started any activity for the day, I always brought in a joke that was locally and culturally acceptable in order for the women to laugh and feel relaxed enough to be able to participate fully.

3.9 Method of Data Collection

The key methods used in collecting ethnographic data include participant observation, interview, and documentary analysis (Higginbottom, 2004; Morse & Field, 1995). In this study, face-to-face interviews and participant observations were employed to elicit data which enabled

me to describe the phenomenon of interest. Interviews were audio-taped with permission from participants, while field notes about observations and issues arising from interviews were kept.

3.9.1 Interviews

Interviewing has been used increasingly in qualitative research to obtain in-depth data from participants (Lloyd, Gatherer, & Kalsy, 2006). Interviewing facilitates an “understanding of individuals’ beliefs, perceptions, and accounts relating to particular issues” (Lloyd et al., 2006, p. 1386), the meanings they share, and the actions and knowledge they hold. The researcher becomes a student, ready to learn from participants who possess knowledge on a particular topic. Interviewing allows participants the opportunity to tell their story without the researcher interrupting the process (Morse, 1991).

Congruent with the theoretical framework guiding this study, face-to-face interviews guided by a semi-structured interview guide were used to gather data from participants (see Appendix F for interview guide). The semi-structured interview guide helped me to obtain information needed to understand the research question without forgetting important points, and served as a guide in helping to organize participants’ thinking and responses (Morse & Field, 1995). Open-ended interview questions were used to elicit women’s experiences in accessing reproductive health care and the influences they perceived that had an impact on their health-seeking behaviour. Demographic data was obtained using a series of closed-ended questions (see Appendix E). Obtaining demographic data was challenging because most women did not know their ages; their ages were therefore obtained through approximation to natural and historical events.

A total of 27 women were interviewed during sessions which lasted approximately 45 to 90 minutes. Twelve individual interviews and two focus group discussions—made up of 8 and 7

women respectively—were conducted. The first focus group discussion (which was the first interview) helped me ascertain whether the questions were appropriately framed in the cultural context, based on how participants answered and their reactions to questions. A few interview questions were modified for clarity and appropriateness.

Interviews were conducted at two different locations. The first set of interviews was conducted in an open field under a tree in the community because that was the participants' place of choice. Four individual interviews and two focus group discussions were conducted under the tree in the community. During the rainy season, there was an outbreak of black flies in the entire community that were biting us as we sat under the tree. The black flies sometimes caused a lack of concentration for both participants and me. The second focus group of 7 participants could not be audio-recorded as the memory of the recorder was full after two individual interviews and there was no electricity to download recorded interviews on to the computer in order to provide space for subsequent interviews. The interview time could not be postponed because access to the women was limited as a result of rains and flooding that limited accessibility to the area. Hence, I had to rely on hand-written notes which were later typed out. The second focus group discussion did not yield adequate data. I observed that the women were either feeling shy to talk or afraid of gossip and betrayal by their peers even though they were all within the same age range. Hence, limited data was generated from this particular group.

The interviews under the tree were frequently interrupted by men hanging around and by people passing on the way to their farms who always stopped to exchange greetings as culture demands, causing uneasiness and breaks in discussions. I had to always stop the recorder until greetings were done before continuing. However, for the most part, women spoke freely of their concerns.

The second set of interviews was conducted at the community clinic on Mondays and Thursdays. These were days that the clinic conducted its antenatal care and child welfare clinics where women came for those services. At the clinic, some women were interviewed in a consulting room on days that the Medical Assistant (nurse-manager) was absent from work, while other women were interviewed under a tree further away from the clinic. Choosing different locations at the clinic was necessary to provide privacy for the interviews. During the interviews, I observed that women were initially reluctant to tell their stories for fear of betrayal. I repeatedly reassured them of confidentiality before they felt comfortable voicing their concerns.

Before each interview started, participants' consents were audio-recorded with their permission. The interviews lasted between 45–90 minutes. About 3 to 4 interviews were conducted a day. Time of day was considered in interview schedules as it was farming season and women were generally in a hurry to go back to their farms. The interviews were conducted by the researcher who was born and raised in the village, and is fluent in the women's own local dialect (Nabit). I made brief field notes in a small notebook to supplement the interview data gathered. Following my observations of women during the interview and upon listening to the recordings after the interviews, I made further notes and raised questions about some of the interviews, such as why women were always laughing whenever a particular question was being asked. Probes that generated laughter from every woman were: How does your husband respond whenever you have a concern about women's health issues? What were the nurses like? How was your interaction with the nurses (friendly, not friendly, she appeared approachable/ not)? Tell me about birth control (have you ever used birth control before?). I had to use many conversation probes in order to get women talking as I realized that the women were either not

comfortable, feeling shy, or not used to elaborating on their answers; they would always laugh whenever certain questions were being asked and either say nothing or answer such questions very briefly. This behaviour was observed both in the individual and in focus groups. In line with the paradigm guiding the study, some questions were modified in order to assist the women to discuss or talk about their experiences in detail for better understanding of these experiences. When statements were not clear to my understanding, I asked participants to elaborate, or explain what they meant. In the Nabdam dialect, most things are said in parables and proverbs which sometimes make it difficult to understand unless the listener asks for further explanation or until he or she has reflected on it further.

Initially, I intended to transcribe the recorded conversations as soon as possible and after each interview was completed. However, this was not possible due to frequent power outages in the entire town. While in Ghana, in order to ensure accuracy, one interview was transcribed verbatim for editing by a public health nurse who understands the dialect and speaks English. This editing was to ensure accuracy in translation from the local dialect to English. Confidentiality was ensured by using pseudonyms. Upon my return to Canada, the remaining interviews were also transcribed verbatim to provide a better understanding of the conversations. Recordings were reviewed several times to ensure accuracy.

3.9.2 Field Notes

Field notes are brief jottings of important points during a conversation or observations that are described and written in detail as soon as possible following the interview. They serve to supplement data that cannot be tape-recorded and would have gone unnoticed but for the observation. Field notes include what the researcher sees, hears, experiences, and observes and ideas arising during the process. They also include the description of the participant, recordings

of the physical setting, who was present, what was said, how it was said and the tone of the voice, gestures, nonverbal communication (such as giggles or laughter); the researcher's impressions, and general reflections on what was happening at the time of the conversation or activity (Morse & Field, 1995; Richards, 2006; Speziale, 2003).

Keeping field notes provided a means for me to journal my reflections and detail my thoughts and questions evoked by the interviews. I reflected on the interview process itself, including my and the participants' actions during the interview, and I took into consideration what role I played in the interview and how that might have impacted the participants' responses and my own understanding of the responses. This was helpful in gaining insight about what emerged from the interview—insight which helped guide my subsequent interviews (Johns, 2004). Engaging in this reflective process (Johns, 2004; Richards, 2006) helped me identify my own biases, ignorance, and self-interests so as to address them in a manner that would help me obtain high quality research data.

3.9.3 Participant Observation

Observation in qualitative research helps the researcher to learn about behaviours that have been taken for granted, or have gone unsaid in an interview (Bogdewic, 1999, Morse & Richards, 2002; Speziale, 2003; Spradley, 1980). Participant observation is one of the most common data collection strategies in traditional ethnography (Morse & Field, 1995) and focuses on “what people actually do, as well as examines artifacts of any sort” (Agar, as cited in Bogdewic, 1999, p. 71). There are various types of participant observation techniques used in ethnographic studies (Barnes, 1992; Kuzel, 1999). However, for the purpose of this study, I used the “observer as participant” (Barnes, 1992, pp. 116–117) technique. In this technique, both researcher and participants are aware of the purpose of the field work.

Unlike traditional ethnography, in focused ethnography, observation is not commonly used because of the compressed time frame for data collection. I chose to combine observation with interviews to be able to elicit information that would have gone untold by participants. In order to enhance my observational skills, I employed Goertz and Lecompton's framework (as cited in Bogdewic, 1999, p. 54–55) for participant observation to guide my observations in both clinic and community settings. A semi-structured observational guide (see Appendix G) was used to focus my observations. I made observations of the women in the settings in which they chose to be interviewed. For example, at the community level and under the tree, I observed how women interacted with one another in a relaxed manner. Women dialogued, teased one another, and laughed; these are behaviours which are typical of the culture and another way to make one another happy.

During times that I was “hanging out” at the community clinic, I observed how women were received by nurses on arrival for service and how they interacted with them. For example, I observed that women were being interviewed about their health concerns in the presence of others. Some pregnant women were also being palpated while the curtains were raised, exposing their abdomen to people sitting outside in a shed either waiting for their turn or just visiting. Some of the findings from my observations were used to develop and ask further questions during my subsequent interviews.

3.10 Data Management

Following the interviews, I listened to the recordings to determine that the information conveyed by participants was clear and interpretable. I did a detailed translation of the audio-recorded interviews into English and transcribed simultaneously. I reviewed the recordings several times and compared the translations and transcripts for accuracy. For the sake of

accuracy and reliability as mentioned in the previous section, I invited someone who was a native to the area and well-grounded in the local dialect and in English, and had some knowledge in interviewing. This individual is a public health nurse who was working at a different location, thus ensuring confidentiality of the material. This volunteer edited one translation and transcript to make sure that I had captured the meanings correctly. In some instances during the translation period, it was not straightforward to make direct literal translations into English from the Nabit dialect, although conscious efforts were made to put across the spirit of the dialogue and occasionally including the irreplaceable Nabit expressions. Confidentiality was further maintained by using pseudonyms on each transcript for identification.

I created a back up system to ensure that I did not lose any data in the process by using a memory stick (pen drive) to store data. Transcriptions were kept in a safe and secure place under lock and key to avoid anyone other than myself and the thesis committee gaining access to the data.

3.11 Data Analysis

Data from this study were analyzed using thematic analysis. Thematic analysis requires that the researcher search for, and identify common threads that extend throughout an entire interview (Morse & Field, 1995). In order to identify themes, the researcher must step back and reflect on what the participants are saying, and why and how they are saying what they are saying (Morse & Field, 1995). Themes are usually indicated by the data, but not described specifically by the participants. It is upon critical reflection and being close to the data that the researcher can identify themes. I followed the Morse and Richards (2002) framework for thematic analysis which includes the following processes: a) topic coding, b) creating categories, and c) abstracting.

In this study, data analysis started simultaneously with data collection. This process is usual of ethnographic research as the continuous analysis serves as a guide for further data generation by posing new questions for subsequent interviews (Spradley, 1979). My initial step was to develop an in-depth understanding of the influence of the cultural setting on data collection and the meanings of those influences through observation. For example, although women were asked the same questions data collection varied according to whether it took place under the tree (a site chosen by women for the interviews in the community) or at the clinic. This is in part due to the influences of the setting and the contextual factors, and possibly specifically due to the presence of nurses.

In order to make sense of the data, following the interviews, it was necessary to listen carefully to the recordings several times to determine that the information conveyed by participants was clear and interpretable. Throughout the interview and observation process, I made sure that field notes were taken properly to augment the interview recordings. Field notes were also updated upon listening to each digitally-recorded interview and some issues were noted for further exploration. I did a detailed translation of the digital voice-recorded interviews into English and transcribed simultaneously upon my return to Canada from Ghana.

3.11.1 Topic Coding

Coding in qualitative research is a way of structuring the data into “meaningful segments and assigning names for the segments” (Creswell, 2007, p. 148). This process helps the researcher to group similar data segments together by topic (Morse & Richards). It also helps the researcher to reflect on differences and similarities in some particular topics discussed by the participants. Topic coding is done by physically bringing together copies of the text. The researcher then identifies parts of the passages that are similar or associated with a specific topic.

These similarities are copied from the original text and placed together in a file and labeled with the particular topic identified.

Once transcription was complete I began coding. I reviewed the recordings several times and compared them with translated transcripts for accuracy. After determining the accuracy of the transcripts, I coded under the following topics: factors facilitating women's reproductive health seeking behaviours, barriers to health seeking, the different types of reproductive health care concerns such as antenatal care, labour and delivery, birth control and other reproductive health issues, and how participants' discussed health-seeking behaviours regarding these concerns. Coding was done manually with most of the transcripts being coded line by line while making notations on the margins of the transcripts. The initial plan for data analysis was to use computer software (N'vivo) to assist in organizing data. However, access to this software was limited; therefore, data were organized and analyzed manually. Comments made by women under the various topics were outlined and compared while recognizing the context within which each woman sought care. This coding process allowed me to put the data into perspective and to convey relationships between what kinds of women's health concerns would cause women to seek care or not and the routines involved in seeking that care. This process led to generation of categories.

3.11.2 Creating Categories

Creating categories is the next step in Morse & Richards' (2002) process for conducting thematic analysis. According to Morse & Richards (2002) "categorizing is how we understand and come to terms with the complexity of data in everyday life" (p. 133). Categories serve as a filing cabinet into which the topics identified in step 1 are placed (Morse & Richards, 2002; Richards, 2006). Creating categories helps the researcher to think and ask questions about the

data (Morse & Richards, 2002). Category creation starts when the researcher begins to ask questions such as why am I interested in this particular issue in the data but not another? (Richards, 2006). Following a review of the transcripts, and with support from my supervisor and committee members, categories were identified. Some of the categories identified included husband/in-laws voices, health care provider influence, need for health information, and societal standards/village gossip. New subcategories were also generated out of the main categories when new ideas emerged from the data. This helps the researcher to think about the relationships between categories. The categories are named for example, nurses' attitudes towards patients. This process leads to abstracting.

After a review of the data, another recoding was done and new subcategories surfaced, giving way to emerging themes. For example, within the category of "health care provider influence," subcategories that emerged included nurses' attitude, lack of health information, differences in fee charges, respect, and clinic setup. All main categories were reexamined and subcategories were made. The data were reorganized through cutting and pasting several times to sort out similarities and commonalities. Coding continued until saturation was reached (Glaser & Strauss, 1967) and all themes were finally identified.

During the process of analysis, I kept a small journal in which I noted key points arising out of the data and my feelings about them, as well as opportunities for further exploration. For instance, most participants did not feel comfortable talking about birth control or sexual issues at the initial stages of the interviews. As well, most of the women also felt uncomfortable talking about cultural practices such as seeking care from traditional healers. Analysis was a continuous process throughout the thesis writing to ensure that the findings represented the women's voices.

3.11.3 Abstracting

Abstract thinking in qualitative research involves data transformation. Data is transformed by exploring and using general categories derived from the data (Morse & Richards, 2002). In abstraction, the researcher is required to actively explore the data to gain in-depth understanding of what the data is saying or what is emerging from the data (Morse & Richards, 2002). It involves critical thinking and reflection about what is going on. The steps involved in abstraction include categorizing and conceptualizing.

Conceptualization is a mental process that leads to a “general, higher-level, and more abstract construct” (Morse & Richards, 2002, p. 133). This process moves the study from description to analysis (Morse & Richards, 2002). Themes are identified for analysis. Themes are something more “pervasive than a topic or categories” (Morse & Richards, 2002, p. 121). Themes usually run through the data and used for analysis referred to as thematic analysis. This leads to the identification and linkage of categories to form themes based on what the data presents. Major themes that were identified in this data analysis include a) submitting to the voices of family, b) women’s experiences of receiving nursing care, c) the community of gossip, and d) gaining voice.

3.12 Discussion of Method

The research method used in this study was focused ethnography. The following section discusses the measures taken to ensure rigor and the limitations of the study.

3.12.1 Ensuring Rigor

Rigor or trustworthiness in qualitative research is concerned with the quality of the research which begins from the onset till the end (Richards & Morse, 2007). Ensuring rigor involves selecting an appropriate method or approach, appropriate questions and the appropriate

sampling and informants (Richards & Morse, 2007) to yield results. In evaluating quantitative research for quality within the positivist paradigm, terms such as validity and reliability are terminologies used, whereas in the interpretive paradigm, the terms credibility or dependability, confirmability or auditability, and transferability or applicability are used to determine the quality of the research (Golafshani, 2003; Sharts-Hopko, 2002). Therefore, in evaluating the trustworthiness or the validity and reliability of research findings, the criteria must be consistent with the approach in order to achieve the desired goals (Creswell, 2007; Horsburgh, 2003; Morse & Field, 1995). Sharts-Hopko argues that because qualitative research is based on multiple truths and that “truth is perspectival” (p. 84), assessing rigor in qualitative research differs from that of quantitative because of the differing perspectives. However, maintaining trustworthiness in qualitative research is highly important in order for users of such research findings to benefit from it.

Credibility or dependability refers to the truth of the research findings (Sharts-Hopko, 2002). However, the emphasis in qualitative inquiry is not based on truth, which assumes an objective view, but is based on trustworthiness and on multiple realities constructed by individuals or groups in the social world (Creswell, 2007; Golafshani, 2003). Consistent with this study’s paradigm, which is situated in the constructivist worldview (Creswell, 2007), rural Ghanaian women’s experiences may be illustrated in a variety of ways which may be socially, individually, or collectively constructed. The constructions of stories based on their experiences may change with time, and is dependent on the context and women’s social location at a particular given time, their state of mind within that given time, and with whom they are engaged. This worldview was considered consistently in this study. The method chosen for the

study was also complementary to the study since I aimed to examine participants' behaviours in seeking health care with a cultural orientation (Richards & Morse, 2007).

Sharts-Hopko (2002) notes that member-checking is a means by which findings of the study are shared with the participants to determine accuracy. Although member-checking has been noted in the literature to be a straightforward way to achieve accuracy, this was not possible in this study due to resource constraints such as timelines. However, throughout the study, transcripts, data coding, categorization, and themes were constantly and closely shared with the supervisory committee members for cross-checking and questioning. Triangulation was also used in the study (Golafshani, 2003; Richards & Morse, 2007; Sharts-Hopko, 2002). This included the use of various data collection methods such as face-to-face interviews and participant observation as well as audio-recording.

An important factor that enhances credibility in qualitative research is the extent of time that the researcher engages with the study participants (Sharts-Hopko, 2002; Speziale, 2003). The length of time the researcher engaged with participants yielded quality data. Each participant was interviewed between 45-90 minutes. Also, I constantly asked for clarification of comments from participants to ensure clear understanding of what has been said.

“Auditability” is a process by which procedures involved in the various stages of the research such as data collection, analysis of the data through the interpretation of the results are fully described and reported in the write up in a manner that is explicit (Sharts-Hopko, 2002). Sharts-Hopko defines this as the “audit trail” (p. 85). Throughout the entire research process, I ensured that all the processes including the data collection methods, sampling strategies, data analysis and management strategies, coding, themes, and the interpretation of the findings were clearly described. All sources of information and data related to the research have also been

clearly referenced for easy location by readers. Data from reflexive journaling of my thoughts during the data collection and analysis period were also used in the write up. Quotations were used from participants' stories to demonstrate the spirit and value of the stories and to include representation of their voices. Discussions of the findings of the study have also been constantly linked to the related literature and field observations.

“Transferability” refers to how applicable the findings of a study are to those reading or using it (Golafshani, 2003; Sharts-Hopko, 2002; Speziale, 2003). The concern of qualitative research in this context is to adequately describe participants' experiences and the context influencing such experiences so that evaluation of the report can be done and applied by people in similar situations, instead of generalizing as occurs in quantitative research (Sharts-Hopko, 2002). In this thesis project, I made a conscientious effort throughout the study to describe the study setting as well as participants' socio-demographic profile. The processes involved in accessing participants in the study setting were discussed, as well as decisions regarding the place of interviews. Samples of interview and observational guides have also been included in the study report (see Appendices A–G). A clear description of data analysis and interpretation processes was made with the involvement of research committee members to ensure that multiple understanding was adhered to and that all interpretations were true to the data gathered and represented the voices of the participants.

3.13 Summary

Focused ethnography as a qualitative research methodology was chosen for this study because it was considered the most appropriate research method for exploring a subcultural group from their own perspective. Rural Ghanaian women's reproductive health care seeking behaviours were explored in this study. Participants were purposefully selected based on their

knowledge about the topic and having met the pre-specified criteria for selection. Data were collected using in-depth individual interviews, focus group discussions and participant observations. Data were thematically analyzed.

CHAPTER 4: FINDINGS

4.1 Introduction

In this study I explored rural Ghanaian women's experiences of seeking general reproductive health care in two small communities in Northern Ghana, West Africa. Findings reveal that the women participants were not only concerned about their reproductive health care but made consistent efforts to seek help or health care to meet their needs. However, these women's efforts were constantly thwarted by factors and challenges that were beyond their control and which had serious implications on their reproductive health care seeking behaviours on one hand, and their health benefits on the other hand. These factors and challenges included the context within which women sought care such as socio-cultural structures, including norms, beliefs and practices; family influences; socioeconomic factors; the nature of the health care system, and the health care providers' attitudes, particularly those of nurses. Women's health care seeking was dominated by multiple voices but there was a striking absence of the voices of the women themselves.

The major themes that emerged from the women's stories revealed women's voices being silenced and made invisible during times that they needed to seek reproductive health care. The themes included: (a) submitting to the voices of family, (b) women's experiences of receiving nursing care, (c) the community of gossip, and (d) gaining voice.

To begin, in this chapter I offer a brief description of the participants' demographic profile, followed by description of the themes that emerged from the women's stories regarding their reproductive health care seeking. Direct quotations from the women's narratives are used to exemplify my interpretations.

4.2 Demographic Profile of Research Participants

Some of the demographic information that could not be obtained included the number of pregnancies and number of children per woman. This data was perceived to be very personal and was also associated with the peoples' traditional beliefs concerning disclosure of certain types of personal information. Of the 27 participants, 8 focus group participants' demographic data were not obtained in detail. However, based on the information collected, participants' ages ranged from 15 to 49 years. Seven participants were between the ages of 15 and 25; twelve were between 26 and 30; four were between 31 and 35; and four were between 41 and 49 years old. The majority of the participants' ages have been estimated because they did not know their exact birthdates. Some ages were estimated by associating a woman's birth with events that happened in the community in the past. Another way ages were estimated was by adding a participant's first child's age to the estimated age the participant might have been when she had her first pregnancy. In some instances, some women could not remember their child's age. Therefore, ages reported in these findings are estimates. Seventeen participants estimated they had their first pregnancies when they were between 15 and 20 years while two participants reported their first pregnancies at age 21 to 30 years. Participants' reactions to questions regarding dates of birth or ages suggest that age was not perceived to be significant in the lives of people in the study setting.

Twenty-four participants were married at the time of study, two participants were single women, and one participant was widowed. Of the twenty-four married women, seventeen were engaged in monogamous marriages while eight were in polygynous marriages. Husbands of those participants involved in polygynous marriages had two to five wives who lived in the same house with their husbands, rivals or co-wives, children, and other extended family members. The

number of people living in one house ranged from five to forty people. Fifteen women had between one and five pregnancies; four participants had between six and ten pregnancies.

Some of the demographic questions focused on religious affiliation, education, socioeconomic status, and ethnicity and culture. In terms of religious affiliation, thirteen participants were practitioners of African traditional religion and fourteen were engaged in Christianity at the time of study. As for educational background, nineteen participants had no form of formal education and formed the majority. Two participants had had some non-formal education; four had some level of primary education, forming the highest number of participants with education; one had some junior secondary school education, and one had senior secondary school education—the highest level of education attained. The majority of participants fell within a low socioeconomic status group as indicated by their occupation: fifteen participants were subsistent farmers, seven were petty traders, and five were housewives. Participants in this study were from the same ethnic and cultural background and spoke the same dialect (Nabit).

In the following section I describe the themes that emerged from the data and the women's stories, and I describe the factors influencing women's health care seeking behaviours and how their voices were being silenced.

4.3. From Being Silenced to Gaining Voice

In the rural communities in Ghana in which this study was conducted, women's voices were being silenced across the reproductive health-care seeking continuum. Whether seeking care related to the prenatal period, labour and delivery, postnatal or birth control, women's voices were muted by the overpowering voices of others. The voices that prevailed over the women's voices were those of their family, nurses, and their rural communities. It was these powerful voices that determined basic aspects of women's health-care seeking behaviours such

as for what, when, where, and from whom they would seek care. These other voices also controlled the channels of communication the women needed to navigate in order to obtain permission to seek such care. In making decisions around care seeking, women's voices were not heard, even while their personal health issues were a primary concern and rose to the foreground in decision-making. Rather, women's voices were suppressed and often disregarded; the other voices limiting their health seeking and leaving them with unmet reproductive health care needs.

4.4. Submitting to the Voices of Family

There was a silencing of women's voices in the complex and culturally defined hierarchy of communication that is particular of Ghanaian culture and specifically, rural Ghana. Within this system, women's voices were so devalued that the only mechanism they had to seek health care and obtain the help they needed was to submit to the decisions of others. To get the help they needed, these rural women carefully navigated the process of gaining permission to seek health care while being careful not to violate family and societal norms that might undermine their attempts. In addition, women's submission to the voices of others can be described with three additional themes: family as gate-keepers, being over-ruled by money, and enduring a husband's neglect.

4.4.1 Gaining Permission

The processes involved in obtaining permission to seek health care were complex and women navigated the hierarchy within the constraints of their individual contexts while counting on strokes of luck. Rural Ghanaian women in this study navigated the appropriate channels of communication influenced or dictated by their living arrangements with its associated authority structure. Women living with extended family communicated indirectly with their husbands through their in-laws. In some instances, women sought permission from their fathers-in-law

first, while in other cases, the mothers-in-law were the first point of contact in health seeking. For example, in seeking antenatal care, Azumah (28 years old, 4th pregnancy, in a monogamous marriage, no education) stated, “I tell my father-in-law first. It is my father-in-law who will give me the permission and I will now tell my husband before I go to the clinic”. On the other hand, for help with labour and delivery care Moopoka (26 years old, 6th pregnancy, in a monogamous marriage, and no education) sought out her mother-in-law: “I will ask my mother-in-law who will ask my husband to go and call the Traditional Birth Attendant (TBA) to help me deliver”. Although the husband may refuse his wife permission to seek health care, much depends on the influence the husband’s father or mother has on him.

The mother-in-law plays a very important role in women’s health seeking, either in giving advice, mediating with the husband for money for health care seeking, or discussing their health concerns. In seeking health care for a reproductive health issue Moopoka explained, “I will tell my mother-in-law first. She will now inform my husband and ask him to give me money to go to the hospital”. Daughters-in-law honour their mothers-in-law and respect them for their wisdom and lay knowledge. Because of the older women’s positions in the family, their life experiences, and wisdom, women become dependent on them for solving their health issues. Apoka (26 years old, three deliveries, monogamous marriage, no education), stated:

Whenever I have a women’s health concern, I inform my mother-in-law because of her experience. Because she [mother-in-law] is elderly and has also given birth before, she knows the types of diseases. So when I am sick or my child [is], I tell her and she is able to suggest something for treatment.

Mothers-in-law with much influence on their sons were the mediating voices for the women, sometimes ignoring their sons’ decisions in order to help their daughters-in-law to seek care. For example, Lamisi (48 years old, five deliveries, in a monogamous marriage, no education) stated:

If my daughter-in-law is in labour, I will go and call the TBA and if he [landlord] wants he can go and do his soothsaying because he is not the one suffering it. I will go for the TBA and by the time he will get home, the woman would have delivered.

The role of mothers-in-law in women's lives and health care seeking therefore, was vital to women's well-being.

Due to these hierarchical channels of communication and to the powers that mothers-in-law have to make decisions on behalf of daughters-in-law regarding their own health needs, daughters-in-law tended to overly rely on their mothers-in-law. This reliance tended to silence their voices and position the women as nonassertive. For example, one woman who was asked during her antenatal care period by nurses to give birth at the health facility in order to get her perineal tear repaired did not do so because she felt that it was her mother-in-law's responsibility to ensure that she delivered at the clinic. During a focus group (FG) session, she stated:

The nurses told me that when I am going to deliver I should come to the clinic but when I was in labour, they [mothers-in-law] did not send me to the clinic. I did not say anything [meaning she did not ask her mother-in-law to send her to the clinic] because they [mothers-in-law] should have sent me to the clinic. (FG#3)

Although women not living with extended family had direct access to their husbands, there was the expectation they would use sanctioned hierarchical structures to obtain access to health care. For example, women whose husbands refused them permission to seek health care secured help from other authorized family members. As Teni (32 years old, seven deliveries, in a polygamous marriage, primary education) described: "I have to tell my husband and if he says I should go I can then go. If he says nothing, I can tell my brothers-in-law for permission to go for the treatment [health care]".

Sanctioned hierarchical structures applied not only to married women, but to unmarried women as well. Single women, while having more flexibility than married women, were also subject to a hierarchy in seeking care and had to respect the authority of others. For example,

Payeeh (17 years old, two deliveries) a single woman, involved her parents and brothers in making a decision. She stated: "I inform my mother whenever I have a women's health concern, who will also inform my brother for permission to go for health care". The level of hierarchy involved in obtaining permission to seek care silences women and influences their health-seeking behaviours.

The rigidly prescribed hierarchy of communication in the rural Ghanaian community meant that women were often prevented from seeking help outside the family. Although non-family villagers were willing to help women seek health care, culturally defined channels of communication imposed restrictions on the women accepting their offers of help. These limitations contributed to women's silencing and living with their predicaments. For example, Teni could have sought help from neighbours by talking to them to get ideas about treatment, but cultural norms prevented her from doing. As she explained:

As for here, the way our village is, if you want to tell someone [outside the family] that this is my problem, it is that you are betraying him [husband] to outsiders, so you just forget about it. It is only his junior brothers [brothers-in-law] that I can say to them that I have a problem.

Regardless of the extent of their pain and suffering, women kept their concerns within the family domain out of fear of being beaten or being embarrassed, and resigned themselves to dealing with their health concerns alone. One woman whose husband had denied her financial support to see a health worker stated:

When he [husband] is drunk, he will attack me and when people come to find out, he is going to say that I have been discussing my health concerns with a neighbour and he is not aware. That is why I am just quiet about it and I am just there. We women when we have our problems, we just deal with it alone. (Lariba, 28 years old, three deliveries, in a monogamous marriage, nonformal education)

4.4.2 Family as Gate-Keepers

Even as women navigated the hierarchy of communication, they were left to wait for family members to make unilateral decisions about when, where, and from whom they could seek health care. Family decision making about women's health seeking was based on the nature and severity of the health issue as well as on what the family considered was a legitimate issue for seeking health care. It was a common practice in the rural Ghanaian families for women first to be treated at home before they were allowed to seek health care outside the home. Bugpogbil (43 years old, seven deliveries, in a polygamous marriage, and no education) stated: "Whenever I am pregnant or have a women's health concern, my family treats me in the house and if it does not improve, they then allow me to go to the clinic".

Perceived seriousness of the reproductive health situation influenced the expediency of health seeking in women's lives. In all situations related to women's reproductive health, family as gate-keepers to health care seeking was guided according to the seriousness of the situation. In the early stages of labour women were not permitted to seek help outside of the family from a TBA or a midwife because it was not considered to be serious enough:

You know when you are in labour and you even want to go to the clinic, the family will always ask you to wait, and they would say the labour has just started, so it is when it is serious and you can no more walk to the clinic that they will then call the TBA, and if he/she is not able to help, they now send you to the clinic. (Azumah)

Severity or seriousness of the health issue was strongly internalized by women in this study and this indirectly limited their self-advocacy for maternity care. Influenced by this perception, women in this study thought it appropriate to only seek help from a TBA to deliver their baby if the labour was prolonged or perceived as "difficult". Bamizina, a 42 year old woman who was in her eighth pregnancy at the time of interview stated her reason for not seeking help for labour and delivery:

I have never called a TBA to come and help me. My delivery has always been simple. The TBAs are there to help but if the delivery is not difficult I do not call them. Those that have difficult labour, they call them to come and help them but when it is not difficult I do not call them.

The family's beliefs about the causation of health problems also led to delays in health seeking. For example, the family's culturally embedded beliefs and practices surrounding prolonged labour often left women waiting to seek help until family consulted with the ancestors to locate the cause and take steps to ensure a safe delivery. Furthermore, cultural practices dictated that in such situations, women were not permitted to know the outcome of the consultations. For example, Nyaamah (43 years old, 9th pregnancy, in a polygamous marriage and no education) stated:

If you are in labour and there is so much pain, the landlord [husband or father-in-law] will go to do soothsaying to find out from his ancestors about what is happening and what to do. But if the pain is not too much and the labour does not prolong, then the family will wait for you to deliver. Depending on what the ancestors say to him [only known to the landlord], when he [landlord] comes back he might perform some sacrifices to the gods for a safe delivery. But I will not know what the ancestors say the cause was.

4.4.3 Being Over-Ruled by Money

Rural Ghanaian women's economic dependence on their husbands served as an additional obstacle in seeking care for both their general and reproductive health needs, or for their concerns. Money was at the core of these women's health seeking behaviours and severely constrained not only their efforts in seeking care, but also their access to recommended care—both of which jeopardized their health status. According to a focus group participant, “If you do not have money on your own to take care of yourself, then you will suffer” (FG #2).

The issue of affordability cut across the range of women's reproductive health care. Affordability influenced women's health seeking behaviours in several ways, including the types of reproductive care they sought, and whether they continued with care once it began. Antenatal

care was the reproductive health care that was most accessible to women because of its relatively lower cost compared to other reproductive care such as delivery and birth control. In total, twenty-six participants had sought antenatal care as compared to five participants for labour and delivery, and seven participants for birth control. For example, Azumah stated: “It is only when I am pregnant and want to go to the clinic that he [husband] will agree but if I am sick of a different thing and I want to go to the clinic, he normally says no money”. In the same vein, a focus group participant (FG # 1) who had had several deliveries that placed her at risk of poor health was advised by nurses to practice birth control. She explained, saying:

I have been advised by nurses at both public and private clinics to do birth control because I have had many deliveries but because of lack of money, I have not yet gone back [to the clinic] to do it.

Financial constraints often influenced sustainability of health seeking. Cost was often described by women as a primary reason for discontinuing birth control. Often women were advised to seek health care by clinic nurses but affordability did not allow them to follow through on what would be a health benefit. For example, Bugpogbil, who was unhappy at the time of interview that she could not continue to practice birth control, stated her reason for discontinuing its use: “The family planning injection is expensive and that is why I cannot continue to do it”. Affordability always outweighed suitability in health seeking behaviours, especially around birth control. Women in this study sought reproductive care based on how much they could afford to pay instead of what kind of birth control best suited them. For example, FG #5 who chose a method based on affordability stated:

They [nurses] wanted to insert me with the intra-uterine device but you know if you do not have enough money you cannot insert that one. So I chose the injection and with that one, I was always bleeding twice every month and because of that I was not in good health; I was growing lean. That is why some of us do not want to do it.

Neither the significance nor seriousness of the health issue over-ruled economic barriers to health care. Nyaabmah, who did not seek health care for some reproductive health ailments, stated:

It is normally because of lack of money. When you do not have the money you cannot go to the clinic. When they [nurses] charge you, you cannot pay so there is no need coming when you do not have money.

This means that regardless of the importance of the health issue, the pain or suffering, women were deterred from seeking health care because of their inability to pay for the services offered them.

Some women gave up total hope and allowed nature to take its course. For example, a 28 year old woman in a monogamous marriage who, at the time of interview was experiencing itchy skin rashes that were keeping her awake at night, gave up hope and was waiting for her death should it happen because she could not afford to go for care on her own and her husband denied her financial support to seek care for her skin rashes. She stated:

If it will kill me fine. If it does not kill me fine. What can I do? I have talked about it and he [husband] is saying nothing. If I were to have my own money I would have gone to the clinic. If we women were to be having our own money, we will know how to take care of ourselves to save our lives. When we [women] are asking our husbands for money, they tell us that they do not have it themselves let alone to give us. And if you still continue asking, he will one day attack you with his anger and it will not solve any problem. (Lariba)

Women's lack of access to a health care provider due to economic dependence was not only limited to modern health care services which were considered to be expensive, but also the traditional healers whose services are less costly. Although traditional healers do not demand immediate cash payments, which one would assume might be more favourably received by husbands, women in this study were still denied access and support for such services. For example, when Lariba failed to seek modern health care for her skin rashes because of lack of

money, she wanted to seek a traditional healer as a last resort for healing. This involved payment with a fowl. For this again, her husband refused to provide payment in order for her to receive treatment. She stated:

There is a certain man here [traditional healer in the village] and he saw me sometime ago when the rashes were all over my body and he said he treats those kinds of conditions and the cost of treatment is a fowl. So I came home and told my mother-in-law and she then told my husband. But he did not say anything about it. Finally, it was serious and I was now just lying down and could not get up and yet he said nothing.

Health care costs, which differed between public and private clinics, often left women to seek less than optimal health care. Azumah chose to go to the government clinic because of difference in charges: “Private clinics take good care of everybody but their charges are higher than the government clinic so I decided to go to the government clinic”.

4.4.4 Enduring a Husband’s Neglect

Even though women in this study may have successfully navigated the channels of communication to obtain health care, all too often they discontinued health seeking because of their husbands’ lack of support. Descriptions provided by women in this study suggested their husband’s unsupportive behaviours included negative feelings (anger), resentment, passive aggression, procrastination, and stubbornness. Non-supportive husbands were notorious for using meaningless affirmation in responding to their wives’ health seeking efforts. One focus group participant, FG #2, described this appearance of support that was not followed up with action: “Truly speaking when you come home and tell your husband, all that he says is ‘Okay’ but he will never do it for you”. Women who attended antenatal care and were diagnosed with anemia received the same response when they shared the nurse’s advice that they take special diet such as eggs: “They [husbands] just say yes but nothing ever happens”. Participants in the FG laughed

in response to this statement. Women's laughter was a common symbol observed throughout the interviews. Their laughter affirmed the universality of the experience.

In other cases, men responded with anger and passive aggression, making statements that were hurtful, demeaning, and dehumanizing. For example, another woman who attended antenatal care and was diagnosed with anemia was asked by nurses to come back to the clinic with her husband for a discussion about her health problem. Her husband, upon receiving the message from the wife, made statements that were hurtful and demeaning to the wife. She stated:

All they [husbands] tell you is that they did not ask you to go to the clinic and that when you go there, you connive and condone with the nurses for them to say that you need special food. [They asked] "How did the nurses enter into your body to know that you do not have enough blood?" (FG #5)

Husbands' unsupportive behaviours were further manifested in a refusal to go with their wives to the clinic at the request of the nurses or if the woman had to be admitted for labour and delivery care. This provoked feelings of disgrace for women that prevented them from initiating or following up with care. However, those women who had the courage to go back to the clinics on their own indicated they received negative comments from nurses that made them feel stupid. Instead of nurses helping to support women to deal with their emotional stress and embarrassment of their husbands' lack of concern, rather, some women reported that nurses tended to insult and demean them. One woman revealed:

When I was pregnant the other time and went to the clinic, I was asked to come back to the clinic with my husband and when I came home and informed him, he told me that he did not ask me to go to the clinic and he never went back to the clinic with me. When I went back to the clinic, the nurses asked me that if he has refused to come, why do I have sex with him? (FG #1)

Teni expressed her discomfort in seeking help for labour and delivery care at the clinic because her husband would not follow up. She stated:

When you are in labour and want to go to the clinic, the man says what is it that you need a nurse for, and you know, you cannot go to the clinic alone. We are always afraid and have to stay back home and deliver. If you go on your own, he [husband] will not come there to say “This is my wife.” And you know, when you go to the clinic, they will be asking for your relative, and there will be nobody. Is it worth going? That is why we just stay back.

It was clear in all narratives that women were dependent on others to decide when, where, and how health care should and could be sought. Decisions regarding their reproductive health care needs (antenatal care, labour and delivery care, postnatal care, and birth control) were in the hands of family members while women’s own input was limited. Husbands’ lack of support and concern for their wives discouraged dialogue with their wives whenever they were in need of help from their husbands to seek care.

4.5 Women’s Experiences of Receiving Nursing Care

In rural Ghana, health care providers have various levels of skills and qualifications. They may or may not all be nurses. The word “nurse” often refers to anyone who works in the health care facility, particularly females. In this study, women referred to all categories of health care staff who provided care as nurses. Women talked about different approaches nurses used in providing care. Themes are used to describe the experiences women reported about the care they received from nurses, and are each described in the following sections.

4.5.1 Women’s Experiences of Receiving Information

In certain health care facilities, women perceived nurse-patient interactions to be much friendlier and welcoming than what they had experienced elsewhere. In those instances, women commented positively about nurses’ attitudes and response to their health seeking behaviours. Women in these instances did not feel like they lacked information or were being silenced. The nurses at those health care facilities were perceived to be cordial, and engaged in patient teaching and providing information about self care. This motivated women’s health seeking behaviours

and women preferred to go to those clinics. For example, Azumah explained she chose a particular clinic for the following reason: “It’s good [clinic] because when I go there, they [nurses] do not quarrel with me and they also teach me what to do to keep myself healthy”.

Similarly, another woman chose a different clinic (a public clinic) based on the teaching that was provided. She stated:

Here [at the clinic], the nurses are able to teach how to take care of my child to be well and also when the child is sick what to do. But at the private clinic, the nurses do not do that. (Apoka, 26 years old, monogamous marriage, three deliveries, no education)

Regarding women’s comparison of the private versus government clinics and patient teaching, most women preferred the private clinics because the nurse clinician related well with them; whereas with regard to receipt of information, the women preferred the government clinics because those nurses provided patient teaching. This inconsistency in practice may be associated with the fact that at the private clinic, apart from the nurse clinician, the rest of the health care providers are not professionally trained nurses (health aides) and therefore, may not be able to do effective patient education. In contrast, at the government clinics are staffed with nurses who are professionally trained.

Women who received information from nurses expressed a feeling of empowerment and this facilitated their ability to make informed decisions and choices regarding their health care. For example, Bamizina, in her eighth pregnancy, sought birth control because she remembered what nurses had told her during one of her visits to the clinic: “I remember the nurses have ever told me that I should do family planning because I have delivered a lot so I was even afraid to deliver again and that was why I wanted to do it and rest”.

4.5.2 Women's Experiences of Being Scolded

The women reported that a majority of nurses who represented the health care system in rural Ghana related to them in ways that mirrored the larger societal devaluation of women and nurses' general dominant attitudes. In observations at clinics, women were observed to routinely stand up when speaking to nurses, even pregnant women. Nurses were observed to spend very little time with women during times that they provided care. Many of the women recalled experiences in which they were scolded, treated "like children," and disrespected; some reported they received silent treatment from nurses, although in the observations conducted at the clinics this was not observed. For example, FG #1 described her experience with nurses while seeking antenatal care:

I went to the clinic when I was pregnant and they [nurses] insulted me, so I was angry and decided to go to another clinic. The nurse said why is it that I am pregnant and sat in the house up till six months before coming to clinic to tell her [nurse] that I am pregnant. Was she the one who impregnated me?

Another focus group participant who sought health care for labour and delivery described her experience:

As for the nurses when you are in labour and get there, they start to shout at you as if you are a small child. When you are not able to do what they want you to do quickly because you are in pain, they will push you down into the bed and say they are asking you to lie down and you are behaving towards them as if they were the ones who impregnated you. But you know, as for the TBA, whether she knows you or not, she respects you. (FG #4)

Women believed they needed to put up with any disrespect they received from nurses if they were to obtain the care they sought. As such the women sought to avoid conflict with the nurses who cared for them by not expressing their feelings. For example, one FG#1 participant, although angry, felt that she was being favoured by the nurses who were providing her care, and so could not express her feelings of anger:

Well, the nurses are suppose to tell you what is wrong with you but when you go to them, they start saying nonsense to you, but because you are also looking for help from them, you cannot say anything so you just keep quiet.

Sometimes, women reported that their relationship with some nurses deteriorated to such an extent that they did not want to seek care from particular clinics and nurses regardless of the seriousness of the condition, not only for themselves but also for their children. For example, a woman who sought care for her sick child regretted her visit to the main public clinic serving the communities:

The only problem is if that man [the male nurse] is there. There are times that when a child is sick and you run there in the middle of the night, he will shout at you and ask you that where were you and you are now coming? He will say he has no drugs for you. So because of that we all [women] hate to go to the government clinic whenever that man is there. Unless we have no enough money, otherwise we go to the private clinic. (Lariba)

Another participant described choosing a private clinic over the government clinic because of how the clinician related with patients: “The government clinic nurses yell at you. As for the private clinic, [clinician] will speak respectfully to you even though [clinician] will not give you medicine on credit but you will be happy” (Lamisi).

4.5.3 Women’s Experiences of Limited Choices

The women in this study reported that nurses limited their choices of place to give birth by directing them to the clinic to have their babies delivered without understanding their preferences or choices in the matter. Dokmah, a senior secondary school graduate, the most highly educated and influential among the 27 women in the study stated:

The nurses told us that when we are in labour, we should call the TBAs and they will come to the clinic and inform the nurses and that they do not want the TBAs to be delivering women again in the homes.

The families who adhered to nurses’ authority to call them instead of the TBAs to help women deliver whenever they are in labour were turned down by nurses when they made the effort to do

so. For example, one focus group participant recalled a time she was in labour and her family called on nurses in an outreach program in the community:

When I was going to deliver it was an outreach clinic day at our village, so my family called the nurses but they said they could not come to the house unless they bring me to the clinic. So my mother-in-law was sending me to the clinic but I could not walk and had to go back home and deliver in the house. (FG #3)

Choice of place of birth and health care provider, although influenced by distance, family members' decisions, and cost, was in most instances perceived to be controlled by nurses and women were left without much say in this matter.

4.5.4 Receiving Silent Treatment: Women's Experiences of Nurses Withholding

Information

Women repeatedly described receiving treatment or care from nurses without any accompanying teaching or explanations. For example, a woman who received a birth control method from nurses was not given any information regarding the method. "They said nothing," reported Dokmah. The lack of information sharing made it difficult for women to make informed decisions or to be aware about what they should expect regarding the use of certain maternal health services, especially birth control methods. Payeeh, a 17 year old single woman and the youngest of the participants, explained how having adequate information was critical to her decision to practice birth control. She stated: "If I get it [birth control], I will like to do it. If someone is able to teach me how it works, I will like to do it but I have not had someone that will really tell me what it is all about for me to understand very well".

Field observations revealed nurses who labeled women as ignorant, uneducated, rural, and local people who lacked simple understanding. This resulted in nurses offering the women little information regarding care provided. For example, during my observation at a prenatal care clinic session, professionally trained nurses immunized women without any explanations about

the type of immunization given. I learned from the women how nurses persistently denied them information regarding the potential side effects of birth control even though it is an expected part of nurses' role to educate women on every possible side effect before administering any type of birth control method. Without adequate information to make informed decisions, women were further disadvantaged in addressing their health needs. Yet pervasive throughout the women's narratives was the idea that the lack of information about birth control led them to discontinue the practice when side effects arose. Although on observation, I found the clinic walls to be well-decorated with posters and pictures containing information regarding birth control and immunizations and I saw most women admiring them, this form of information dissemination had no impact because the majority of the women were not educated. They did not speak nor read or write English, and therefore could not interpret such information designed and displayed to benefit them.

A focus group participant described her experience with seeking health care for birth control: "They do not tell you anything. They just give you a card and inject you, and when you come home and you are having problems, what you do is just stop it". Other women who sought birth control similarly encountered the same lack of information from nurses:

No they [nurses] do not tell you anything. For me I went for the injection [birth control method] too and I was not told anything concerning how it works and I was also bleeding all the time. So the way their [nurses] thing is, it is not good for some of us so I did not go back again. I did it only once. (FG #6)

Dokmah, considered the most highly educated among all participants, shared the same experience of seeking birth control:

Oh, when I got to the clinic and said I wanted the injection [birth control], the nurse did not say anything. She [the nurse] just injected me and said I should come back every three months. She did not say anything at all.

Among study participants, the injectable birth control method, taken every three months, was the most common method chosen by the women on the basis of convenience rather than on being the most physiologically advantageous for them. Specifically, Dokmah explained the reason for her choice: “I just felt that because that one [injectable] is every three months it will be easier for me”.

Nurses’ reported failure to provide information was not only in relation to birth control use, but also cut across other reproductive health issues. For example, women who made efforts to seek antenatal care reported they did not get information concerning how well they were doing even though nurses performed health assessments on them. One of the participants, FG #2, stated: “Well I went to the clinic for antenatal care and all they did was weigh and check blood, and palpate my stomach and that is it. After that they did not tell me anything”. A woman who received an immunization (possibly an anti-tetanus toxoid) during antenatal care was not told what it was for. She stated: “They [nurses] inject us [all pregnant women] on the arm. They do not tell us anything. They have never told us what type of injection they are giving us” (Nyaabmah).

Sometimes the women received inaccurate information from nurses that was not helpful in addressing their reproductive health needs. For example, a woman who received information about repair of a perineal tear stated: “The nurse looked at it [perineal tear] and said they can only repair it when I get pregnant and come to deliver at the clinic” (FG #3).

Unmet informational needs led some women to seek information elsewhere and make decisions that were not always in their best interests. For example, women obtained information regarding birth control side effects from friends, who often were equally uninformed about side

effects. When Dokmah was experiencing side effects from birth control, instead of going back to the clinic, she decided to ask her friend about what was happening to her:

I asked one of my friends that why is it happening like that to me and she said it means that it is not good for me because she is doing the same thing but she does not have her menses twice. She said she gets her menses when it is getting to the 3rd month. So I just stopped.

Not only did nurses fail to give accurate or adequate information, but they were also reported to be unwelcoming and unreceptive in responding to the women who occasionally did ask questions. For example, Dokmah revealed a story about questioning a nurse about being charged for tuberculosis (TB) treatment when it was supposed to be free and receiving an unhelpful response:

Yes I have ever asked them about it [free treatment TB] and they [nurses] told me that they were not doing that at their clinic and that if I want I should go to places where they are treating free.

She recounted another situation of asking for information about the cost of treatment for her 70 year old mother-in-law which was supposed to be free and receiving a similar response: “They told me that I should not talk about those things here because they are not doing that here, hmmm” (Dokmah).

These rural women believed nurses to be highly educated, knowledgeable, skillful professionals; as a result, they accepted what the nurses offered them. Women expressed confidence and trust in nurses to provide for their safety and to know what to do. For example, Dokmah stated: “I just think that since they have been educated on what to do they are doing the right thing and that they will not give me a bad thing”. The women sometimes interpreted nurses’ silences as a positive indication that all is well with them. One woman stated: “Well if they [nurses] do not say something then you just assume that all is good that is why they did not say anything” (FG #5).

4.6 The Community of Gossip

Not only were women silenced by their families, husbands, and some nurses, but they were also silenced by their communities and particularly by other women living in their communities. Fear of gossip in the community at large and their peers in particular emerged as a significant element in the women's stories and deterred their reproductive health care seeking. Women viewed gossip as having damaging effects. One woman claimed, "It is the gossip that is destroying us" (Lariba); all focus group participants "argu[ed] that gossip made them backward in their villages". Gossip occurred at both the community and at peer levels.

4.6.1 Community Level Gossip

The sense of community was observed to be very strong in this rural setting and provided women with social support. During the field work, there was immense community involvement. For example, both men and women went out to clear weeds so that we could sit for our meetings and interviews. Community members were observed chatting and laughing together. However, this togetherness did not go without unintended consequences. Gossip pervaded the community which influenced women's reproductive health decisions.

Fear of gossip was a powerful deterrent to women's health seeking about reproductive issues. Women's fears of being judged or mocked by the community for falling outside culturally-defined reproductive standards often meant that they did not speak up. Women were very conscious that health seeking related to reproductive issues would be frowned upon because it disrupted cultural norms related to pregnancy and childbearing. Women spoke repeatedly of situations in which they feared being ridiculed by their communities—either because of getting pregnant or failing to get pregnant at the right time. For example, one woman described her delay in seeking antenatal care as a result of her own embarrassment in falling outside cultural norms:

When I was pregnant with my last child now (her 7th baby), everyone here knew that it was not the right time for me to become pregnant because the one I left before this one was still too young and breastfeeding. I could not even go to the clinic because it was so shameful. I knew the nurses would insult me if I went and my colleagues will also tease me and gossip about me. So I could not go to the clinic for antenatal care. But finally I went only once. When I got to the clinic, everybody at the clinic was looking at me and I was feeling shy. (FG #2)

Another woman spoke of the gossip she had experienced from the community for not becoming pregnant in the culturally expected time following the loss of her baby due to no fault of her own:

As for me since I lost my child, I have not become pregnant for a long time now but that is what people are saying about me. They just say “you do not want to give birth and you are just roaming as if you are a male donkey” [laughed]. They think I am doing birth control. (FG #8)

This woman’s experience was echoed by all of the focus group participants: all knew of a certain woman in the village that was not getting pregnant and that people thought she was using birth control so the community was always talking about her.

Community gossip served as an obstacle to women’s reproductive health care seeking especially when timing of pregnancies and other health issues fell outside the community norms and standards and were perceived as shameful and embarrassing.

4.6.2 Gossip at Peer Level

A fear of betrayal by peers was evident in women’s stories and also affected their reproductive health seeking. Instead of helping and supporting one another in solidarity so that their voices could be heard in seeking reproductive care, women contributed to their own silencing. One participant did not seek birth control out of concern that her peers would talk about its inappropriateness with her child being so young: “My colleagues will go about saying that; look at how small [young] her child is and she is doing birth control” (Lariba).

Peer gossip was promoted primarily because of the lack of private space in women's daily lives. First, the cultural expectation that women do most of their daily activities together, such as attending clinics and market, contributed to a lack of privacy. As observed during the initial meetings with women in the field leading to recruitment and subsequently in the interviews, women came in groups. Some women reported waiting for their peers which resulted in arriving late for the meetings. The sense of community and togetherness in the cultural setting is unique but also carries negative influences. For example, Azumah stated: "Anytime we are going to the clinic, we go together [with other women] and you know I cannot do it [birth control]".

Second, peer gossip was exacerbated by the lack of private space at the clinics, the place the women most often identified as a venue for gossip. The clinic floorplan and traffic flow from the entrance to the reception area can be likened to a grocery store where every customer can be viewed openly without privacy. The clinic is also located close to the main highway and every passer-by, both on foot or on a bicycle, can see and identify every woman visiting the clinic. The reception area is an open area with a few benches lined up for women to sit and wait for their turn. There are no divisions to ensure privacy. Case histories were taken in the midst of other clients in the reception area. The atmosphere during history-taking was quiet as if the rest of the clients were keen on hearing from others what they had to say about their concerns. In addition, the clinic was normally not busy enough to generate noise. Although there was a television set placed on a wall, there was no electricity at the clinic at the time of interviews to turn it on and use it to distract those waiting for their turn. The lack of privacy was further compounded by the tendency of nurses to interview women in a loud voice, making it easier for the rest to hear whatever others had to say about their concerns.

Women were also observed exchanging greetings and chatting, a practice that suggested everyone present at the clinic was familiar to the other and this had impact on privacy. The lack of privacy cut across all reproductive health issues. Sometimes I observed pregnant women being palpated with curtains opened. Their abdomens were seen by people either waiting outside to be attended to or by relations and friends waiting for their significant others.

Women expressed considerable fear of peers judging their reasons for being at the clinic other than for sickness. This was especially true around birth control. For example, Teni, a 32 year old woman who had seven deliveries and who had interest in practicing birth control, described being afraid that peers would report seeing her at the clinic:

I actually did not go to do it [birth control] because all our village people go there too [to the clinic], and when they see you there and it is not like you are sick, they suspect and when they come home, they will say to your family and other people that they saw you at the clinic.

Family and husbands' reprisals were a source of worry for women when seeking birth control without permission. For another woman, this fear of being judged by peers and the ensuing fear of gossip reaching the family and its consequences were of great concern in seeking reproductive health care:

They [peers] will say "oh, I saw this woman at the clinic. She pretended that she was going to the grinding mill only to be seen at the clinic" [laughs]. They may even let this enter your mother-in-law's ears and she will in turn feed the son's ears [husband] with the news [laughs] where is it going to end and they will not get to know about it? (Lariba)

The lack of privacy led to women not talking about or revealing their "real" health concerns that had motivated them to seek health care. For example, Dokmah stated her concerns about limited opportunities for self-disclosure:

As for that place [reception area] everybody is sitting there and looking at each other. You cannot talk about all your concerns. The kind of sickness that brought you there you cannot say it before other people sitting there. If you want to talk about how your sickness started, it is not easy to say everything in front of others. You feel that they are

listening. And after that someone will go out and now say, “oh so this person is suffering from this kind of disease.

Community and peer gossip, coupled with lack of privacy at the health care facility, acted as barriers to reproductive health care seeking. Paralyzed by fear of rejection and ridicule by community, family, and peers, women in the study were led to conform to the reproductive norms and standards of their culture with the consequence of having unmet reproductive health care needs. In addition, women spoke about a shroud of secrecy that surrounded birth control use. Lamisi lamented that peers who had used birth control before did not share information with other peers who were interested: “No one from our house has ever gone for birth control and those who have ever used it, when you ask too they [peers] will not tell you”.

4.7 Gaining Voice

There was evidence in the data that women were beginning to make changes and take a more active role in accessing health care and breaking the silence of suffering and suppression.

4.7.1 Finding Ways

Social change was perceived by women in this study as influencing how they were coming to new ways of viewing their lives. The women were witnessing a change in the way things had been to a way of life that held new possibilities for them. A woman who had suffered a perineal tear at home during her previous delivery and had been given misinformation about having it repaired reflected on gaining insight that would have changed her health seeking behaviour in the present day. She stated: “You know, those days we were not wise like we are now” (FG #3). Although women expressed shame and embarrassment, they also spoke of needing to change their ways of thinking and health care seeking behaviour to keep pace with societal change:

Now I think about it [birth control] every night when lying in bed that now things have changed but it is only this village that has not yet changed. But now that I know, I have to find a way out. (Lariba)

Knowing that alternative ways to seek reproductive health care existed motivated women to find a way to have it for themselves.

Women repeatedly described circumventing their husbands' refusal or indifference to health seeking and finding ways to meet their own and their children's needs for health care despite the barriers. Quietly finding a way of seeking care without their husbands' knowledge represented the most common way women used. For example, one focus group participant who had been taking birth control stated, "I will tell him but if he does not agree I will then find a way of going without him knowing" (FG #4). Another focus group participant resolved to seek birth control without telling her indifferent husband, both for her own and her children's wellbeing:

I just do not feel like telling him anything about my concerns because even if I tell him, he is not going to do anything for me. What I want to do now is to go and do the BC. I do not want to joke with my life. If I die and leave my children now, they will suffer. (FG #2)

Yet another woman described unobtrusively sneaking in and out the back door to seek care for her child to avoid her husband's refusal related to health care seeking.

Our husbands cannot control us like that again. Sometimes when we give birth to a new born baby, they [husbands] can say that you should not send the child to the clinic but the woman will still go. She will pass through the back door of the house to the clinic and come back through the back door to the house [it is assumed that ancestors sit in front of the house to watch over his/her people]. You will not tell the landlord that you are going to the clinic. (Lamisi)

Still another woman described quietly waiting for her husband to do soothsaying to determine the cause of the baby's disease and then she sought care for her sick baby:

So I told my husband again and he said I should wait for him to go and do soothsaying before we can go to the clinic. So I waited for him to go out and I also left with my child to the clinic. So you have to use your common sense since you are suffering or your

child. You do not always have to wait for the man. I used my common sense and saved my baby's life. (FG #4)

There were women who circumvented situations in which they anticipated their husbands' negative responses to their requests to seek health care. To avoid refusal and resultant conflict associated with these requests, especially related to birth control which women assumed would be negatively received by their family and husbands, women proceeded without telling them. For example, Bamizina who sought birth control services without discussing her decision with her husband, stated:

He [husband] did not know anything about it. I never told him about it. He will not agree for me to do it. You know not all the men agree for you to do it, so we are always afraid to tell them about it. But I have never told him about it anyway, but just because most men do not agree. My friends talk about it and I hear so I know that it is going to be the same if I told him about it.

Financial independence also gave women an alternative way to seek care. A woman who had gained financial independence sought care whenever necessary without having to go through the hierarchical channels of communication to obtain permission and money. She stated:

Now that I have something in my hands [money], I will not ask my husband for money to go to the hospital. Whenever I want to go to the hospital, I do. Those days that I did not have anything on my own and was relying on him for money, I used to just say yes to everything that he says. (Lamisi)

Some participants engaged in paid work to earn the money they needed for self-care. For example, Payeeh, received little to no support from her boyfriend with whom she had two children. To earn a living while pregnant, she had to work hard for another woman in the city who sold cooked rice; therefore, she had limited time left for herself to seek antenatal care including when she was sick. Yet Payeeh was able to buy medicine. She stated:

Any time I was sick, I did not go to the clinic. I used to go and buy medicine from the drug store and treat myself in the city. I was not always having time to go to the clinic. I was always working for a woman who was selling cooked rice to earn some money.

4.7.2 Breaking the Silence of Suffering

Suffering and poor health compelled some women to seek care regardless of their husbands' responses. Despite family members' refusal to permit them to seek health care, these women became assertive in protecting their own health. Some women reserved this independent action to obtain health care only when health issues they were experiencing were severe enough to seek care. For example, Teni stated: "When it is serious, I can go to the community-based surveillance volunteers for help".

Although gossip in the village concerning birth control practice had significant impact on reproductive health care seeking behaviours of these women, some women believed that it was time they ignored circulating gossip and do whatever was necessary to make a difference in their lives, and in the lives of their children. For example, there was consensus among the focus group participants about the directions women needed to take.

Do not mind them [society members or peers who gossip] because no one is taking care of your child for you. As we [women] want to send our children to school now, we have to take care of them because the men do not care. You have to think of what to do to let the child stay in school. (field note from focus group)

Another woman stated: "When I know that I am suffering, I will go to the clinic. I will tell them [family members] but if they do not agree, I will still go" (Apoka). Feeling they were not healthy enough to carry another pregnancy compelled some women to seek birth control. One woman described opting for birth control because of poor health following her last delivery: "I wanted to rest for a while. When I gave birth the last time, I was not well and so I wanted to rest that was why I decided to do birth control" (Bamizina).

4.8. Summary

In this chapter I described and explained rural Ghanaian women's experiences of seeking reproductive health care within the context that influenced their health seeking behaviours and

how their voices were being silenced. It was evident in the findings that women were concerned about their reproductive health issues but had obstacles that they had to overcome in order to seek care. Some of these obstacles included types of living arrangements, family members' influences (especially in-laws), rural community norms and values, the nature of health care systems including health care provider's attitudes, (particularly nurses), and socioeconomic and socio-cultural factors.

Generally, family members and nurses made unilateral decisions around women's health seeking and effectively suppressed women's involvement and voice in decisions affecting their own health. A significant factor that facilitated health seeking that arose from the women's narratives was the seriousness of the health condition. This practice that limits health care seeking to serious health conditions meant other health care needs were not addressed.

Husbands were perceived to be less supportive of their wives' reproductive health care seeking, particularly for issues related to birth control. However, some women made efforts to manage their reproductive health care issues, especially birth control.

Poverty, although prevalent in rural Ghana, is most predominant among the rural women. Culturally, women have limited access to family property and economic resources in rural Ghana. This contributes to the high prevalence of women's economic dependence. Unlike women who were economically independent, the women who experienced lower socioeconomic status in the study reported significant difficulties seeking health care. This economic dependence was an important barrier that limited their voice in decision-making, not only for their reproductive health care in particular, but also for their own general health needs and those of their children as well.

CHAPTER 5: DISCUSSIONS OF FINDINGS, IMPLICATIONS AND CONCLUSIONS

5.1 Introduction

In the preceding chapter, I presented the analytic findings of the ethnographic study describing rural Ghanaian women's reproductive health care seeking behaviours. In this chapter, I discuss the most salient aspects of the findings in connection with relevant research and field observations, and my own clinical experience and cultural background.

This study is the first of its kind to examine rural Ghanaian women's experiences of seeking reproductive health care in a broader context and most especially from women's own perspectives. The study's findings were based on in-depth interviews with 12 women and two focus group discussions of 7 and 8 women respectively. Participants represented a diversity of age groups, marital status, and educational backgrounds. The results of the study may not be generalizable or transferable to all women in rural areas across Ghana due to Ghana's diverse cultures and differences in availability of health services. The results, however, will be helpful in identifying approaches to support women's health seeking in the study setting and in other villages of northern Ghana that share similarities in health care services and cultural practices. The results also provide direction for further research.

In the next section, the pertinent issues that emerged from the study are discussed. The implications of the study's findings for nursing practice, nursing education and further inquiry are also addressed. The chapter concludes with a discussion of the strengths and limitations of the research and a summary of the study.

5.2 Women's Voice in Health Care Seeking Silenced by Layers of Factors

This study is unique in uncovering a lack of voice that is central to rural Ghanaian women's experiences in seeking reproductive health care. The findings of this study reveal that

rural Ghanaian women who participated in this study were silenced in their reproductive health care seeking by the convergence of several factors: norms related to women's roles and health seeking practices within families, women's lack of access to financial resources, health care system and provider issues, and the women's collective relationships. Hajdukowski-Ahmed, Denton, O'Connor, & Zeytinoglu (1999) contend that "the silencing of voices goes along with the erasure of women's bodies, of their needs and contributions" (p. 31). Women in this study were often thwarted in their efforts to seek reproductive health care because decisions to seek health care were made by husbands or other relatives. As the object of other dominating voices that made choices and decisions, women were denied a voice about their own bodies. So embedded was silence within the patriarchal culture (Hajdukowski-Ahmed et al., 1999) of rural Ghana that women in this study internalized this erasure and objectification of their bodies by self-silencing their own health needs at times.

The impact of sociocultural factors on people's health care seeking has been reported in other developing countries (Shaikh & Hatcher, 2005). In the current study, although access to financial resources was an important influential factor, women's lack of voice in constructing their health care needs and accessing health services was deeply embedded in the gender roles of Ghanaian culture. A woman's role in childbearing is dominant in many cultural practices (Avotri & Walters, 2001) and reflected by the valuing of large families (Gipson & Hindin, 2007; Nazzar, et al., 1995). In most patriarchal cultures including Ghanaian culture, a woman's reproductive role is an instrumental one primarily serving the needs of her husband for status, socioeconomic gains, and the provision of a male child to carry on the family lineage (Awedoba, 2002; Bawah et al., 1999; Nazzar et al., 1995; Tian, Li, Zhang, & Guest, 2007). Child bearing is used to measure a woman's worth and her mother-in-law's desire to have grandchildren (United Nations

Millennium Project, 2006). Yet despite the importance of women's reproduction, women had almost no autonomy in making decisions about their reproductive health care seeking.

Within their sociocultural context, women's voices were silenced, their health care needs minimized, and their reproductive health seeking severely limited—regardless of the seriousness of their health concerns. The primacy of women's reproductive role to maintain large families influenced women's health seeking. The majority of the women in this study had married at a young age, and early childbearing contributed to high parity and increased health risks. Women's reports of seeking antenatal health care more frequently than labour and delivery care and birth control are consistent with institutional reports demonstrating high antenatal care usage and low delivery and birth control patronage in the study area (TNDHA, 2007). As reflected in this current study, birth control was sought by only a quarter of the women.

5.3 The Influences of the Dominant Family Structure and Voice

In this study, the role of family was very significant in women's lives and was one of the most important and legitimized ways that women could negotiate access to health care. Although the role of the family has been found to have both a positive and negative impact on women's health care seeking behaviours and decisions (Grewal, 2003; Grewal, Bottorff, & Hilton, 2005; Jansen, 2006; Shaikh & Hatcher, 2005), in this study it was found to negatively impact women's health seeking. In the patriarchal culture of northern Ghana, the male voice was dominant and women's subordinate voices were heard only through the sanctioned hierarchy of communication. Gaining permission to seek health care from a "gate keeper"—either husband or compound head—was an accepted cultural practice described in an earlier Ghanaian study (Ngom et al., 2003). In this study, women's dependence on a "gate keeper" often led to delays in seeking care with associated serious health implications. Current findings extend understanding

of the process of gaining permission from a single gatekeeper to a complex, multi-layered, and structured system that the women had to carefully navigate to seek health care. This was the case regardless of women's marital status (single or in polygamous or monogamous relationships) and living arrangements (with extended or nuclear family). Although severity of a health situation as a key determinant for gaining permission to access health care has been reported in a previous Ghanaian study (Ngom et al., 2003), this study reveals the complexity of the sanctioned channels of communication serving only to increase the potential for women's suffering by extending their wait times for reproductive health care seeking.

Within this culturally accepted system of communication, husbands were pivotal to wives gaining permission to seek reproductive health care because they were the custodians of financial resources. Because husbands controlled and managed family finances, women had limited control over money and property—a finding consistent with other studies of patriarchal societies such as Ghana (Ashong & Smith, 2001; Nukunya, 2004), Pakistan (Shaikh & Hatcher, 2005) and Bangladesh (Yunus, 2003). Women in this study were almost completely dependent on their husband's financial support to seek care. Women were silenced by their husband's decision-making that based health care seeking solely on finances and not on care and compassion for their specific health issues. This objectification of women is evident in the women's recurring descriptions of their husbands responding passively and often distancing themselves from their wives' health concerns and efforts in reproductive health seeking. Not only did economic dependence affect women's health care seeking but it affected their health status, which has been found to have a direct link to the health of the entire family (Yunus, 2003), including the health of children.

Mothers-in-law hold a very unique position in the Ghanaian family structure, and give voice to, or negate or ignore the health concerns of their daughters-in-law. Having successfully fulfilled gender role expectations and responsibilities of childbearing, mothers-in-law have achieved a new status through their rite-of-passage. In this position, they are ascribed voice that is used to advocate and help their daughters-in-laws to navigate the hierarchy of family communication channels in seeking reproductive health care. The majority of women in this study disclosed their reproductive health issues first to their mothers-in-law before any other person. While mothers-in-law were very influential in mediating women's voices in gaining permission to seek care, they also contributed to silencing women. Often women's voices became lost as they developed dependency on their mothers-in-law as the mediators. Women's over-reliance on the voices of external and expert authority such as mothers and grandmothers has been documented by Belenky, Clinchy, Goldberger, and Tarule (1986) in studies investigating women's ways of knowing. Women in this study demonstrated similar ways of knowing because they relied on their mothers-in-law's knowledge and experience to guide and mediate for them, which often led to self-silencing.

5.4 Health Care System/Nurses Voices

Compounding the silencing of women's voices in this patriarchal Ghanaian culture was a health care infrastructure that severely restricted women's health care seeking behaviours. Similar to other studies in Mali (Gage, 2007), Pakistan (Shaikh & Hatcher, 2005), Burkina Faso (Storeng et al., 2008), and Ghana (D'Ambruso et al. 2005; GMOH, 1999; Nazzar et al., 1995) findings of the current study indicate that health care service quality, availability, and accessibility influenced individuals' health seeking behaviours and service use and, in turn, women's health status.

Nurses, the majority of whom were women themselves and who were also women's primary contact with the health care system in rural Ghana, sometimes contributed to silencing women by providing them with less support than the women had anticipated. Women had not differentiated between professionally trained nurses and others who provided care in clinics (e.g, health aids). Participants reported that some "nurses" deterred them from reproductive health seeking. Women reported that although nurses reinforced the importance of seeking them to obtain regular health care, when they arrived at the clinics, they did not consistently receive the support they expected. Nurses themselves were also influenced by cultural practices related to the hierarchy of decision-making that affected women's autonomy with respect to health matters (Lee & Saeed, 2001). The participants reported that nurses often told them what to do without seeking their input, appeared uncaring because they did not take time to explore health concerns from their point of view or show respect, and criticized them for not attending to health problems sooner.

These nursing practices may well reflect the disparity in socioeconomic status and educational backgrounds between nurses and the rural Ghanaian women (Mayhew, 2000). All but 4% of women in the current study had little to no education compared with all nurses having two to five years of nursing education beyond high school. Some of the women participating in this study were reluctant to seek health care such as birth control out of fear of not understanding the information received or knowing the questions to ask. This also kept women from asking questions. The women had no choice but to accept the information they received and the authoritative stance of the nurses. Similar to Belenky et al.'s (1986) classic study of affluent white women in the United States, silent women "cannot trust their ability to understand and to remember what was said" (p. 28). Others have suggested that in situations where nurses hold

negative attitudes towards women, these attitudes can in part be attributed to power issues, and that the nature of their training and education (D'Ambruso et al., 2005) serves only to reinforce women's self-silencing.

The negative impact of health care provider attitudes on women's health care seeking has been demonstrated in many studies in various settings including Ghana (Asenso-Okyere et al., 1999; Camillo, 2004; D'Ambruso et al., 2005; Shaikh & Hatcher, 2005; Witter et al., 2007) while positive attitudes have been associated with increased maternal health care service acceptance and use (D'Ambruso et al., 2005; Sauls, 2007). Furthermore, the positive impact of relational care on women seeking reproductive health care in rural communities in south central Ontario has been documented (Sutberns, 2004). Sutberns found that women valued health care providers who "took time to talk to them and to answer their questions without feeling rushed" (p. 242). However, this was not the case in this current study. The women reported that "nurses" expected them to seek help and when they did not, nurses blamed and scolded them. This suggests that some nurses may lack sensitivity to the realities of women's lives and the geographical and sociocultural constraints they faced in seeking reproductive health care. The women in this small, rural, isolated Ghanaian village often lived between 15 and 20 kilometers from the nearest health facility. The concentration of health facilities in urban areas is typical of the rural-urban health service disparity (Gage, 2007; GMOH, 1999, 2006; Shaikh & Hatcher, 2005) in developing countries and posed a distinct disadvantage for rural women.

5.5 Competing Voices

Women were often caught between the competing voices of family and nurses. Women were left silenced between the family's voices that called for them to wait to seek health care and nurses' voices that encouraged them to seek health care early, regardless of the reproductive health care issue. Representing the voices of tradition, family preferred labour and delivery care at home, either supervised by family members, peers, or by a Traditional Birth Attendant (TBA). At the same time, nurses representing the dominant voices of modern health care discouraged the use of TBAs, even though the majority of those TBAs have been trained by the health ministry. Studies in developing countries, including Ghana, reveal that most remote rural women's deliveries are supervised by TBAs (Goodburn et al., 2000; Kruske & Barclay, 2004; Smith et al., 2000; TNDHA, 2007; Walsh, 2006).

Apart from distance and cost of services that contribute to silencing women's voices, to health care seeking behaviours, and to choice of provider, an important social factor that cannot be underestimated in this traditional setting is the societal value of respect. Women's choice of a TBA over a nurse during labour and delivery care in this study was based on their perception that TBAs respected, valued, and empathized with them during birthing. Some women were adamant that they would only seek care for labour and delivery from modern health care settings if they thought their labour was particularly difficult because they believed the nurses to be less respectful in their interactions with them. This may be one of the reasons for the higher number of deliveries supervised by TBAs reported in institutional reports of this study area (TNDHA, 2007).

5.5.1 Competing Internal and External Voices

Women also experienced competing influences embedded in culture and community practices that defined reproductive norms and their own personal needs. Similar to Jack's (1991) work related to self-silencing, and the externalized self described by women with HIV/AIDS, the women in this study based their health seeking on external standards and culturally defined norms out of fear of being judged for non-compliance. As women's voices became silenced and they internalized societal expectation of culturally accepted reproductive practices that defined norms for childbearing, number of children, and timing and spacing of children, they were discouraged from expressing their own feelings, thoughts, and needs (DeMarco, Miller, Patsdaughter, & Chrisholm, 1998). Some women in this study thought they needed a rest from pregnancies, and 70% of the women expressed interest in using birth control. Yet it was evident that these women who participated in this study had internalized and adhered to these societal norms and values. For example, larger family sizes took precedence over their own needs, with some women having up to eight children. Similar findings regarding societal norms shaping the meaning of reproduction/child-bearing in women has been documented by McPherson (2007) in a study investigating women, childbirth, and change in West New Britain, Papua New Guinea.

This high parity and low birth control use in the north and particularly in the study area has also been noted in some studies and institutional reports (Campana, 2003; TNDHA, 2007). The tendency for women in this current study to put the needs of their selves second to others has been documented by other researchers (Ashong & Smith, 2001; Belenky et al., 1986; DeMarco et al., 1998; Hajdukowski-Ahmed et al., 1999; Jack, 1991).

It has also been well documented that women have a high sense of relatedness and connectedness and a natural desire to remain in connected relationships (Belenky et al., 1986;

Jack, 1991). The rural Ghanaian women in this study were no different. But additionally the Ghanaian women were part of a culture that encouraged their daily life activities to be done in a collective and collaborative manner. This was often evident in the women's reference to the pronoun "we" instead of "I". Women's desires to stay connected and develop collective relationships in the community made it difficult for women to do things without their peers knowing. It also often meant that women experienced "secretive" collective support for reproductive health seeking but lived in mistrust and suspicion that their peers would not be supportive of their decisions, especially regarding birth control use.

The secrecy about birth control use by women in northern Ghana has been demonstrated in a study by Bawah et al. (1999). Living in conditions of oppression creates ways of thinking and patterns of behaviour that promote and sustain oppressive conditions (Lee & Saeed, 2001). Women in this study clearly revealed the extent of their internalized oppression and expressed feelings of being marginalized by community norms and peer gossip while contributing to their own marginalization through gossip and non-acceptance of those falling outside the norm by practicing birth control. The desire for more children reflected the oppressed group's acceptance of their marginalization and contributed to rural Ghanaian women becoming accomplices in their own oppression (Freire, 1968).

Gossip has been documented by Belenky et al. (1986) as one of women's ways of knowing and may have helped women in the current study to reflect on their own ways of thinking. Yet there were unintended consequences to gossip. Because of fear of gossip by peers and the general community about women who used birth control in particular, women reported of not feeling comfortable seeking birth control. Fear of gossip has been noted in other studies

with a diverse cultural group of women as a barrier to seeking reproductive health care (Shoveller, Chabot, Soon, & Levine, 2007).

Other studies related to women's reproductive health care seeking suggest that most women in Sub-Saharan Africa, including Ghana, though concerned about their reproductive health issues and desiring to have smaller family sizes, often lack decision-making powers over such issues (Adongo, et al., 1998; Dodoo & Landewijk, 1996; Manuh, 1998; United Nations Millennium Project, 2006). This fear of gossip and societal expectations may have been influencing factors for women in these studies to forgo birth control.

5.6 Getting Out of Fear: Taking Action and Gaining Voice

Women in this study were beginning to recognize the negative impact their culture and other outside voices had on their wellbeing and reproductive health care decisions. Personal reflection on their current situations within the context of broader "societal (social) change" appeared to be an important impetus. Women could see a change from the "olden days" when women would only abide by whatever decisions their families and husbands took. As they challenged the culture that engulfed them in fear and suspicion and marked their everyday lives, women were opened to new ways of looking at their situation and saw opportunities to take action, both for themselves and their children.

Gaining voice for women was described as "finding a way out". This is similar to findings among women living with HIV/AIDS who transitioned "from silence to action" (DeMarco et al., 1998, p. 542). Verbal silence or a lack of verbal expression—clearly evident among women in this study—does not mean they were silent (Hajdukowski-Ahmed et al., 1999). In the current study, women gained voice through acts of resistance to the patriarchal dominant voices of others. Such a gesture of resistance has been described by hooks (1989) as coming to

voice, and as reflecting points of tension and expressions of difference (Hajdukowski-Ahmed et al., 1999). Similar to the women with HIV/AIDS in DeMarco et al.'s study, whose silence was broken by a life-threatening diagnosis, gaining voice in most instances for the women in this study often occurred during extremes of suffering and when experiencing or anticipating serious health issues.

Allen (2007) found that birth control use is significant in poverty reduction for women and improved their status in society and family. It is clear that greater economic independence gave the women in this study voices that enabled them to seek health care— regardless of the health issue, and despite the oppressive voices of family, and particularly of husbands. For several women in this study, engaging in income-generation activities to earn extra income meant they were able to practice birth control and achieved rest from child-bearing. The women themselves, although desiring more children and remaining somewhat indecisive about whether they should accept birth control, still noted that birth control use would help improve their health and that of their children. As the women looked to the future they hoped access to credit would support them to either set up or increase their small village businesses to earn more income. Women believed that these businesses would help them gain economic independence and become self-reliant which would in turn increase their options for meeting their health needs (Avotri & Walters, 2001). They believed economic stability was one of the best ways to better their own lives and the lives of their children in rural Ghana.

5.7 Implications of Findings

The findings of this study highlight the significance of sociocultural, socioeconomic, family, and community roles in silencing the voices of rural Ghanaian women in reproductive

health care seeking and have implications for nursing practice, nursing education, and inquiry. In the next section, I discuss each of the implications.

5.7.1 Implications for Nursing Practice

The findings of this study add new knowledge and understanding of rural Ghanaian women's reproductive health care seeking behaviours. The centrality of voice to women's health care seeking experiences has implications for nursing practice. Professionally trained nurses are in a strategic position as they work closely with women to support them in breaking the silence and by giving women a voice in health care. The need for nurses as well as other clinic staff who are sensitive and responsive to the needs of rural women is demonstrated by the findings.

Giving voice to culturally diverse, rural women who face layers of barriers to seeking reproductive health care requires nurses to begin with themselves and engage in self-reflection to create awareness for change and challenge their own attitudes and practices (Johns, 2004). As suggested by DeMarco et al. (1998) in their study with women living with HIV/AIDS, health care professionals can "assist women with HIV/AIDS by initially exploring their own experiences with silencing at various times and contexts in their own lives to develop awareness and sensitivity" (p. 551). This awareness can help nurses address similar factors that contribute to silencing women's voices and can help them support women in gaining voice.

Raising nurses' awareness of their attitudes towards their clients and the impact on women's reproductive health care seeking may help them identify how they reinforce the hegemonic nature of power that oppresses women (Lee & Saeed, 2001). Reviewing everyday practices with this vulnerable group of rural women is a starting point to changing practices that contribute to silencing women's voices. For example, actively listening, answering questions, spending more time with women will assist nurses in understanding the challenges and larger

sociocultural forces women face in seeking permission to access health care. Doing these things can also reduce the nurses' tendency to blame women for not taking individual responsibility.

To enhance women's reproductive health seeking, nurses need to develop greater sensitivity to the conflicting voices women experience between conventional family-directed health care decision-making and modern health care practice. Bridging these two sets of competing voices has the potential to improve women's reproductive health care seeking. On the one hand, nurses might work more collaboratively with key family members, especially husbands and those serving in gate-keeper capacities.

One of the barriers is the nurses' expectation that women return to the clinics with their husbands. This expectation may need to shift. Instead, nurses could do routine home visits to women with special health issues. This is an opportunity for the nurse to meet the whole family and to assess the woman's living situation.

In addition, nurses might find ways to work more closely with TBAs as women's most preferred and readily available reproductive health care providers in the rural communities. To enhance safe deliveries, nurses could work with TBAs collaboratively and provide education and training to increase TBA skills (D'Ambruoso, 2005). The realities of rural living mean that nurses, TBAs, and families must work together to provide optimal reproductive care for women.

There is need for nurses to create a much more trusting and woman-centered environment (D'Abruso, et al., 2005; Shoveller et al., 2007) that encourages women to speak freely and openly about their concerns, and ask questions to get the information they need to make decisions. Reproductive health issues are intimate issues where respect, privacy and confidentiality are critically important.

Facility user fee charges have serious implications on women's reproductive health care seeking behaviours in developing countries such as Ghana (GMOH, 1999; Nanda, 2002; Storeng et al., 2008). Nurses play a pivotal role in the implementation of health care policies such as exemptions on prenatal care and labour and delivery. They should ensure that exemption policies aimed at improving women's reproductive health care seeking behaviours are implemented effectively and consistently to lessen the economic burden of rural Ghanaian women. By virtue of nurses' social status and responsibility, they stand a better opportunity to challenge the existing policies for change in order to give women a voice to meet their health care needs.

Lack of both formal and informal education silences women's voice in seeking information and creates low health literacy among women (Cutilli, 2005, Rootman, 2004; Mayer & Villaire, 2004). Nurses can give women voice by providing them with adequate information in simple and plain language to help them make informed choices and decisions (Sutberns, 2004). Since women rely on their families for permission to seek health care, it is in the best interest of nurses to extend this education and information sharing to family and community members to help increase the whole community's health literacy and understanding about women's reproductive health issues.

5.7.2 Implications for Nursing Education

The findings of this study have strong implications for nursing education. Nurse educators are in a critical place in shaping how nurses are educated. In addition, the findings of this study suggest that the nursing students in Ghana should be educated in such a way to enhance awareness of women's issues and cultural influences on reproductive health.

Nursing education should emphasize on the importance of basic relational practices such as smiling, giving warm greetings, encouraging women to ask questions, and listening to women.

These relational practices are important in helping women feel comfortable, respected and valued and in turn give women a voice in their health care. As well, nurses should also be encouraged to find ways to ensure privacy in settings that are conducive to this, so that women feel free to voice to their real health issues. This is especially important to consider when students and new nurses enter a new nursing situation where adequate and appropriate privacy practices may not be in place. As a newcomer to the location, the new nurse can use his or her arrival as an opportunity to effect change in a gentle, sensitive way.

As nurses are required by their training/education in Ghana to practice wherever their services are needed, including the rural deprived areas, nurse educators should ensure that nurses are educated with broad sociocultural perspectives to equip them with the necessary knowledge, skills, and competencies to deliver culturally sensitive, safe, and competent services (Callister & Vega, 1998). To this end, the nursing education curriculum in Ghana should be revised to ensure nurses are equipped with the necessary knowledge to recognize and to examine critically the social determinants of health such as culture, gender, education, poverty and politics (Oakley, 1993; Purkis, 1997) to provide a context for understanding women's behaviours. An understanding of the social determinants of health can provide nurses with a context to challenge pervasive dominant ideologies, both culturally and professionally that shape nursing practice and patient care, the health care system organization and delivery, and the impact these ideologies have on the health of women. The training of other health care workers should also be reviewed and revised along these lines.

The current practices in nursing education place little emphasis on the social realities that influence health. These social realities have implications for women's health (Oakley, 1993) and voice. The nurse is placed at the core of determining patients' health needs. Provision of health

education needs to be based on an understanding of the multiple realities influencing individuals such as the culture of a people and their interpretation of health and healing, lack of or low levels of education, and socioeconomic status. Nursing education in Ghana needs to have a stronger focus on rural nursing since the majority of Ghana's population lives in the rural areas, which makes access to health care difficult (GMOH, 1999).

5.7.3 Implications for Nursing Inquiry

The findings of this study strongly suggest that there is an urgent need for further research to explore women's perspectives and experiences with seeking reproductive health care, and ways to positively impact the involvement of women in meeting their health needs. Issues such as the influence of gender, professional power and patriarchal culture, and its impact on women's health should be further explored and documented using a feminist framework (Denzin & Lincoln, 1998). Examining the perspectives of husbands and extended family members including in-laws could provide a broader perspective on women's experiences of accessing reproductive health care. Further research on empowering strategies for women and ways to become economically reliant would be very helpful to improving their health status. Finally, health care providers' perspective, (e.g. nurses, health care aids, TBAs) should be explored to describe and compare perceptions regarding women's health care seeking behaviours and factors influencing the care they provide women. The results of this research would provide direction to make changes in the way health care services are delivered.

5.8 Strengths and Limitations of the Study

There are both strengths and limitations to this study that need to be considered in relation to the findings. All participants came from a relatively homogenous ethno-cultural group which allowed for a better understanding of the phenomenon under examination and supports the

transferability of study results to similar women in the geographical area. Throughout the study process, there was immense community involvement which contributed to the richness and strength of the research results. Most importantly, the use of multiple data collection methods provided rich data that would have not been elicited using only one strategy of data collection.

Ghana is a multicultural country with several different cultural beliefs and practices. The study was conducted within one relatively homogenous sub-cultural group in a rural area. Transferability of findings to other cultural groups or across the entire country including urban areas is limited. However, in the entire northern part of the country, which is predominantly rural with similar cultural practices, transferability is possible.

The process involved in accessing participants in this traditional area was very complex. This complex process led to increased use of the already limited resources available to me, such as time in accessing participants. This study was also conducted in a culture which I share with the participants and it involved an intimate aspect of participants' lives. Although most participants were eager to participate and share their stories, a few were reluctant to share experiences perceived as very personal and private. For example, some women were not comfortable discussing issues around traditional healing practices and issues related to sexuality. This reluctance may have impacted the study results.

The study itself raises concerns about the suitability of a focus group discussion in obtaining information on intimate issues such as reproductive health. Dominant members in the group could have influenced the rest of the members with their experiences, which may have silenced the voices of the other group members. In addition, some members may have chosen not to discuss intimate issues in the midst of others for fear of gossip and betrayal (Brown, 1999). Women may have felt uncomfortable revealing negative experiences about the health care they

received for fear of its implications on their future care. In the small communities where the study took place, women can easily be identified and there are limited options for health care. To minimize these possibilities, women were provided with the option for individual interviews and choices of interview locations.

The study was limited to the women's perspectives and did not include the nurses' perspectives. An even richer understanding would be obtained by future inclusion of nurses' perspectives. Furthermore, the women did not make distinctions between the different types of health care providers referring to all as "nurses." Interviews with the different types of health care providers, including nurses, and participant observations in health care settings would provide this richer understanding. In conclusion, my influence as an insider, both culturally and professionally, my position as an educated woman, and my passion for the phenomenon of study also needs acknowledgement.

5.9 Conclusion

The findings of this study demonstrate that rural women face complex constraints in seeking reproductive health care which silence their voices. The findings suggest that a better understanding of the factors influencing women's health care seeking behaviours is important to enhancing women's health and empowering women to access health care. Changes in nursing education and in the way health care is delivered in rural, economically deprived areas should be considered in light of the findings. Further research on women's health, family and provider perceptions about care received, and health care delivery in rural areas is needed.

Based on the findings of this study, it is evident that although women faced complex challenges both at the family level and the health care system level, they managed their health to the best of their ability. Notwithstanding the barriers that family structures and practices place on

women's autonomy, family ties remain strong in rural Ghana because of the high value placed on family. Innovative approaches are needed to support women's efforts in this regard. Finally, the need for nurses to ensure adequate quality care provision to women in need of reproductive health care services is important.

5.10 Summary

This study examined rural Ghanaian women's experiences of seeking reproductive health care in a broader context. The study addressed one major research question and four sub-questions. The broad question was: What are rural Ghanaian women's experiences of seeking reproductive health care? The four sub-questions were: (a) Do women's lack of decision-making powers in rural Ghanaian community settings impact their reproductive health care seeking? (b) How does the type of living arrangement (living with extended family members including mother-in-law and father-in-law) impact rural Ghanaian women's reproductive health care seeking behaviours? (c) How do traditional beliefs and practices of rural Ghanaian women impact their reproductive health care seeking behaviours? (d) How do husbands influence women's reproductive health seeking?

Focused ethnography was used to conduct this study. This method is a way to gain understanding of a subcultural group and their everyday life experiences and how they make sense of it and its impact on their lives. The method permitted me to examine the phenomenon of interest from an insiders' perspective.

Data were collected through the use of face-to-face individual interviews, focus group discussion, and participant observation. A total of 27 women from a variety of age groups, marital status, and educational backgrounds participated in the study. The research included women of reproductive age, ranging from 15 to 49 years. Women came from the same ethnic

group and all spoke the same dialect. Each interview was conducted by the researcher who spoke the same dialect as the participants. Interviews and focus group discussions were conducted with women at locations selected by the women. The interviews were translated into English and transcribed verbatim.

Thematic analysis was used in the study. Major themes identified included submitting to the voices of family, women's experiences of receiving nursing care, the community of gossip, and gaining voice. The data provided evidence that women's reproductive health care seeking behaviours were influenced by a complexity of factors including family members, as well as sociocultural and socioeconomic factors. Decisions regarding when, where, from whom, and how to seek care were usually made by family members. To a large extent, family members often made unilateral decisions for women and women's own voices were silenced. Culturally structured channels of communication limited women's direct access to their husbands for discussions about their health concerns. Community norms also had an influence on women's health care seeking behaviours, especially for birth control. In summary, women lacked autonomy in making decisions about their own health needs.

One of the most significant factors that influenced women's health care seeking behaviours was socioeconomics. Participants also reported that nurses' attitudes had a significant influence on their' health care seeking behaviours. However, despite all barriers that women faced in seeking health care, they still developed strategies to seek care to meet some of their reproductive health needs such as birth control.

The findings of this study provide implications for nursing practice, nursing education, and nursing inquiry. The implications for nursing practice call for nurses to be advocates for Ghanaian rural deprived women and to provide culturally competent and sensitive care in a

respectful and caring manner. Nursing education in Ghana should include the study of contemporary issues related to women's health in rural contexts and power issues that influence women's health care seeking behaviours. Interpersonal communication skills should be emphasized at the basic nursing educational level to improve nurse-patient relationships. Finally, there is the need for further research to examine the sociocultural, gender and socioeconomic issues confronting women and family influences on women's health. Examining health care providers' perceptions about factors that influence service delivery and their impact on women's reproductive health care seeking behaviours is a worthwhile topic of further study.

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APPENDICES

Appendix A

Background Information for Community Chiefs /Leaders Requesting Their Permission to Conduct the Study and Access Women

My name is Vida Yakong. I come from XXX community in the Talensi-Nabdam District. I am currently learning a higher level nursing at a University in Canada called University of British Columbia Okanagan. I have come home to learn about women's health issues in this community. This learning is part of what I am doing in the school in Canada. I am very interested in women's health issues in this community. I have gained support from my teachers at the school to come and learn about what women think are problems for them with regard to their own health and what they face when they need help from those who provide it.

I am asking for permission from you (the community Chief/ leaders) to carry out the learning process, which I would like to do over a period of one month. I will be staying in the village to talk with women who will like to talk with me about their experience. Deciding to take part in this learning experience is up to the women and no one will be punished for refusing to take part. This learning experience will not bring an immediate benefit to the women but the information they will give me will be used over the long term by community leaders, nurses and government officials to improve the health of women. I would be pleased to answer any questions you may have or clarify information that you have not understood. As tradition and culture demands, I will offer you cola nuts and tobacco for welcoming me and accepting my greetings and taking time off to talk to me.

Thank you.

Appendix B

Background Information for Community-Based Surveillance Volunteers (CBSVs)

My name is Vida. I come from XXX community of the Talensi-Nabdham District. I am learning nursing in Canada at the University of British Columbia Okanagan. I have come home to learn about women's health issues in this community. This learning forms part of the educational program that I am doing in the school. I will be doing this learning over a period of one month. I will be living in the XXX community to talk with women who are interested in talking with me about their experiences. I am therefore asking for your help to pass on verbal information about my study to women who come from the Talensi-Nabdham District (TND) and live in your communities. Here is the information I would ask you to give them:

Who wants to learn about women's health issues? Vida Yakong who comes from XXX community of the Talensi-Nabdham District.

What is the study about? Women's health issues.

What women can participate? Women between the ages of 15 and 49 years old.

What would you have to do? You will have a private conversation with Vida that will take about 60-90 minutes of your time, at a place that is convenient for both of you. It can take place in your home, at the clinic, or in the market. You might also talk to Vida in a group with other women. Deciding to take part is up to you and you will not be punished if you refuse to take part.

What will be done with the information? The information will be used by the leaders of this community, Ghana government officials, and nurses to improve women's health. Your name will not be used in the information that the community leaders and the general public will have access to after the study. There is no risk for taking part in this learning process.

If interested, what do the women do? Contact Vida Yakong, who will be at the community clinics and in the market on market days if you would like to talk with her. Thereafter, you and Vida can decide on a place that will be convenient for both of you to have a private conversation.

Thank You for your help.

Appendix C

Background Information for Clinic Nurses

My name is Vida Yakong. I am studying nursing at the University of British Columbia Okanagan in Canada. I am requesting your help with a study I am doing as part of the educational program at the University in Canada. My study is aimed at learning more from women about issues concerning their health. I am asking you to pass on information about my study to women who come from the Talensi-Nabdam District (TND) to the clinic. Here is the information you can give them:

Who wants to learn about women's health issues? Vida Yakong who comes from XXX community of the Talensi-Nabdam District.

What is the study about? Women's health issues.

What women can participate? Women between the ages of 15 and 45 years old.

What would you have to do? You will have a private conversation with Vida that will take about 60-90 minutes of your time, at a place that is convenient for both of you. It can take place in your home, at the clinic, or in the market. It can also be a group conversation. Deciding to take part in this learning process is up to you and no punishment if you do not want to take part.

What will be done with the information? The information will be used by the leaders of this community, people in Ghana government, and nurses to improve women's health. Your name will not be used in the information that the community leaders and the general public will have access to after the study. There will be no risk in taking part in this learning process.

If Interested, What do the women have to do? Contact Vida Yakong. She will be at the clinic and in the market on market days for any women who will like to talk with her. The two of you will then decide on a place to meet that will be convenient for both of you to have the conversation.

Thank You!

Appendix D

Participants' Consent Form

Faculty of Health Social Development

3333 University Way
Kelowna, B.C. V1V 1V7
Tel: 250-807-8077
Fax: xxx-xxx-xxxx
www.ubc.ca/okanagan/hsd

Participants' Consent Form

Title of Research Study: Rural Ghanaian Women's Experiences of Seeking Reproductive Health Care

Principal Investigator: Dr. Kathy Rush, PhD, RN, Associate Professor UBC Okanagan School of Nursing. Telephone number: (xxx) xxx-xxx. E-mail: xxxxx.xxxx@xx.xx.

Co-investigator: Vida Nyagre Yakong, BSN, RN., is a student learning nursing in higher level of nursing at the University of British Columbia Okanagan. Vida Yakong will carry out this study which will form part of her learning process and the information she gains will be put into public use to improve women's health.

Introduction:

The verbal explanation I am giving you is to help you understand what I would like to learn from you, how that will happen, and what you will be doing in the learning process. The information will tell you if there are any benefits or harm associated with this learning. This information also serves as an agreement between you and me (Vida Yakong) taking part in the learning process. I encourage you to ask me questions if you do not understand the information I am giving you. I have been given permission by the school to do this learning here.

Background:

Women's health issues are a problem in the villages of Ghana and some women die as a result of not getting the help they need from health workers. People learning about women's health issues have not done enough in terms of asking women in this village to talk about their experiences of asking for help from health workers about the issues that bother them. Understanding women's experiences is important in order to improve health care for women in the villages of Ghana and to develop health care policies that promote women's health.

Purpose:

The reason for doing this learning project is to understand women's experiences of asking for help concerning women's health issues. I am asking you to take part in the learning

process because you fall within the age, stage in life, and location of women who can help me understand women's experiences. This means that you must be:

1. A woman of childbearing age
2. Between 15 years and 49 years old
3. Live in Nyobok-Nkenzesi community of TND

Your decision to take part is voluntary:

After my explanation, it is up to you to decide whether you would like to meet and talk with me to share your experiences. If you decide you would like to talk with me and then change your mind that is fine. We will stop and it will not be a problem.

What this learning process involves:

You will need to commit approximately 60 to 90 minutes of your time if you decide to take part in this learning. You will have a face-to-face private conversation with me at a place and time that is agreeable for both of us. This may be in the clinic, your own home, my home or in the market. During this conversation, I will ask you some questions. The questions will ask for some personal information, your experiences in asking for help about women's health issues, and the factors that encourage and/or prevent you from asking for help related to these issues. I will also like to know from you if you understand the questions I am asking you to talk about. I would like to record your agreement to take part in this learning and the conversation we have about your experiences. Once I have listened to the recording, I may need to contact you again to get you to help me understand some of the information you share that was not clear. The recorded information will later be written into English and typed up for me to look at.

Risks/Harm:

This study will not pose any harm to you personally. Some of the questions that require personal information or that ask you to talk about your own health issues may make you feel uncomfortable. If you do not want to answer particular questions, we will move on to other questions. Before agreeing to talk with me, you are encouraged to ask questions and discuss with me any of your doubts or fears.

Benefits:

This learning may not directly help you but may cause you to think about your health and lead you to make changes in your life. The information collected in the study will be used to improve women's health issues and may be also used to teach nursing students about women's health care needs, develop policies related to women's health issues, and influence health care in this region.

Remuneration/compensation:

In recognition of your valuable contribution to this learning experience and taking time to talk with me, you will be given a bag of rice worth ₵40,000.00 (Ghanaian cedis) (Canadian \$5.00). Your decision to drop out, refusal to answer certain questions that make you feel uncomfortable, or refusal for a request for second interview will not affect the gift you receive.

Confidentiality:

All of the information you provide will be kept private so only myself and the people who are helping me with the study will be able to see it. The recordings and printed conversations will be kept in a safe place with lock and key. You will be assigned a nickname chosen by you if you would like and only that name will be used in the typed up notes and reports of study results. After the learning period is over, all the information including the recordings will be kept in a safe place by my teacher for 5 years as part of what the University always does. Parts of the information you provide may be used word-for-word in final print form but you will not be identified by name.

Contact for information and about the study:

If you have any doubts or concerns about your rights to take part, and the reasons for what I am learning about and you want more information, you may find out from Dr. Kathy Rush, University of British Columbia Okanagan, School of Nursing, Canada at (xxx) xxx-xxxx (Telephone number) or by e-mail (xxxxx.xxxx@xxx.xx).

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services at xx xxx xxxx or if long distance e-mail to RSIL@ors.ubc.ca.

Consent form:

I understand the information Vida Yakong has explained to me concerning what she is doing and I agree to take part. I understand that I am volunteering to talk to her but I can decide at any time not to continue the conversation and there will be no problem. I may refuse to answer any specific questions or I may stop the interview at any time if I feel uncomfortable continuing. I understand that I will give approximately 60-90 minutes of my time for our conversation. I understand that some of my exact words may be used in the final print form which the general public may have access to later, but my name will not be used. I have also been encouraged to ask questions, and all questions have been answered to my satisfaction. I do understand that I will be given a gift in the form of one bag of rice worth ₵40,000.00 (Ghanaian Cedis) (Canadian \$5.00) in recognition of my contribution towards the learning process and for taking time off to talk to her.

Note:

The written consent form for participants will not be signed as participants in this cultural group do not usually feel comfortable signing documents for participation in research. The majority of participants cannot read and write. I will explain to the participants for their understanding in their local dialect and ask for permission to record the consent process. Also note that the language use here may appear awkward but it is intended to meet the understanding of the participants at the rural level.

16. Husband's Work _____
17. Distance between home and the nearest clinic _____
18. Rating of current health status _____
19. *In the past year, who of the following have you talked to about your health?*
- | | |
|---------------------|-----------------------|
| Doctor _____ | Husband _____ |
| Nurse _____ | Mother _____ |
| TBA _____ | Mother-law _____ |
| Elderly woman _____ | Other women _____ |
| Peer _____ | Other, specify- _____ |

Appendix F

Semi-Structured Interview Guide for Participants

1. I would like you to tell me a story about a time when you had a concern about women's health issues.

Probes:

- What did you think the problem was?
- What did you think was causing the problem?
- What did you think needed to happen (their expectations and hopes)?
- How serious was it?
- How long did you think it would take to treat the problem?
- What were your worries or fears concerning the problem?
- How does your family (husband and mothers/fathers-in-law) respond whenever you have a concern about women's health issues?
- What does your family (husband and mother/father-in-law) normally do whenever you have concern about women's health issues?

2. Talk about what it has been like to ask for help for a women's health issue you have had.

Probes:

- Whom did you inform about it first (Husband, mother/father-in-law, friends)?
- What did they say (offered advice /what kind of advice)?
- From whom do you normally seek health care?
- What health care provider(s) are available to you? Whom do you prefer?
- Why do you prefer that particular provider?
- What encourages you to ask for help (eg. My personal need, husband, friends)?
- How did you decide to choose this particular health care provider?
- Apart from asking for help from someone, what else do you do on your own?
- If the woman has not asked for help probe: what has made it difficult to ask for help when you have had a woman's health issue?

3. Tell me what happened when you went for help?

Probe:

- What were the nurses like?
- How was your interaction with the nurses (friendly, not friendly, she appeared approachable/ not)?
- What did you think of the information given you?
- Did you understand it?
- What was it like for you?
- How did you feel about it?
- Best / worst experience?

4. Tell me about another time that you asked for help for a different kind of women's health issue. What was that like? Was the help you received different?

Probes: Common reproductive health issues

- Antenatal care
- Delivery
- Birth control
- Sexually transmitted infections
- Infertility

Appendix G

Observational Guide

Clinic Setting

1. How is the clinic set up? Where is the reception area? Where is the waiting area? Is it welcoming? What is the order of seeing patients?
2. What kind of women come to the clinic?
3. What time of the day do women come to the clinic?
4. Who accompanies the women (relatives, significant others, children, etc)?
5. How are women received/treated at the clinic by nurses when seeking help?
 - a. How do the nurses interact with or relate to the women?
 - b. How is information delivered to women at the clinic by health care providers?
 - c. How do women interact among themselves at the clinic?
 - d. Are there any language barriers?
 - e. Are the women given any privacy?
 - f. Are services available to them clients (eg., drugs)?
6. How are the routines of the clinic organized? For example, how much time does a client have to spend with a nurse (rushing, enough time to talk about problems)?
7. How are those who accompany the woman treated/received?

Appendix H

University of British Columbia Research Ethics Approval Certificate



*The University of British Columbia
Office of Research Services
**Behavioural Research Ethics
Board**
Suite 102, 6190 Agronomy Road,
Vancouver, B.C. V6T 1Z3*

CERTIFICATE OF APPROVAL - MINIMAL RISK

PRINCIPAL INVESTIGATOR: Kathy Rush	INSTITUTION / DEPARTMENT: UBC/UBCO Health & Social Development/UBCO Nursing	UBC BREB NUMBER: H07-01246
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:		
Institution	Site	
N/A	N/A	
Other locations where the research will be conducted: This study will be conducted in Nyobok-Nkunzesi community in northern Ghana. Nyobok-Nkunzesi community is located about 15 kms east of Nangodi in the newly created district of Talensi-Nabdam District (TND) and is one of the 8 administrative districts of the Upper East Region of Northern Ghana, Bolgatanga. Within this community, research will be conducted at Nangodi Health Center and in participants' homes.		
CO-INVESTIGATOR(S): Vida Yakong		
SPONSORING AGENCIES: N/A		
PROJECT TITLE: Rural Ghanaian women's experiences of seeking reproductive health care.		

CERTIFICATE EXPIRY DATE: June 27, 2008

DOCUMENTS INCLUDED IN THIS APPROVAL:		DATE APPROVED: June 27, 2007	
Document Name	Version	Date	
<u>Protocol:</u>			
Qualitative research proposal	1.0	June 4, 2007	
<u>Consent Forms:</u>			
Consent form	1.0	June 4, 2007	
<u>Advertisements:</u>			
Script Requesting Recruitment Assistance from Clinic Nurses and the Script for their use in Recruiting Potential Participants	1.0	June 4, 2007	
Script Requesting Recruitment Assistance from Community-Based Surveillance Volunteers (CBSVs) and the Script for their use in Recruiting Potential Participants	1.0	June 4, 2007	
<u>Questionnaire, Questionnaire Cover Letter, Tests:</u>			
Interview guide	1.0	June 4, 2007	
Observational guide	1.0	June 4, 2007	
Participants' demographic information	1.0	June 4, 2007	
<u>Letter of Initial Contact:</u>			
Script for Initial Contact with Community Leaders/Chiefs Requesting Their Permission To Conduct the Study and Access Women	1.0	June 4, 2007	
<u>Other Documents:</u>			
Map of Ghana indicating study area	1.0	June 4, 2007	
<u>Other:</u>			
N/A			
The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.			
<i>Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:</i>			
<hr/> Dr. Peter Suedfeld, Chair Dr. Jim Rupert, Associate Chair Dr. Arminee Kazanjian, Associate Chair Dr. M. Judith Lynam, Associate Chair Dr. Laurie Ford, Associate Chair			