Faculty of Social Sciences

Socio-Cultural Dimensions of Maternal Healthcare in Ghana

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DECLARATION

I Bassoumah Bougangue, 14010096, Faculty of Social Sciences hereby declare that the work entitled Socio-Cultural Dimensions of Maternal Healthcare in Ghana is my original work. I have not copied from any other students' work or from any other sources except where due reference or acknowledgment is made explicitly in the text, nor has any part been written for me by another person. The thesis has not been accepted for any degree and is not concurrently submitted in candidature of any other degree.

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ABSTRACT

About 99% of the 830 women who die every day from maternal causes worldwide are from developing countries. Regardless of the 45% improvement in maternal deaths in 2013, the WHO recorded an increase in indirect causes of maternal deaths from 9.1% in 1990 to 10.2% in 2013. Africa contributes only 14% of global population but accounts for more than half of global maternal deaths. The WHO/World Bank current estimate of Ghana's maternal mortality ratio at 320/100,000 live births is unacceptably high in the face of interventions such as National Health Insurance Scheme, safe motherhood protocol and national ambulance system amongst others. Between 2011 and 2012 the Northern Region of Ghana recorded the highest maternal deaths of 302 with 72.8% home deliveries, out of which about 36% were assisted by untrained traditional birth attendants. This qualitative study uses culturally appropriate methods to explore the experiences of women in childbirth and decision-making towards utilisation of maternal healthcare services. In 30 individual and 15 focus group interviews, the study purposively sampled key actors in maternal healthcare such as women aged 15-49 years ever-pregnant or given birth within two years preceding data collection, their spouses, traditional practitioners and health professionals in the Yendi Municipality and Chereponi District of the Northern Region. Guided by the structure-agency theory and the delays model, this study thematically analysed utilisation of maternal healthcare services in the three inter-connected stages of maternity. Amongst other things, the study discovered systemic-structural delays in care-seeking within households inherent in gender norms and religious beliefs such as dietary taboos and behavioural codes that governed women's care-seeking behaviour. The socio-cultural system within households were structured hierarchically and characterised by oppression and marginalisation of women, especially in decision-making towards care-seeking. This male supremacy and gender discriminatory practices facilitated male-dominance in decision-making for care seeking, which denied women timely clinical intervention. Dualism of care characterised by the use of traditional

and pharmaceutical medicines was observed amongst participants as an outcome of dual-faithism. Moreover, attention on maternal healthcare was focused more on delivery, neglecting the inter-connectedness of antenatal, delivery and postnatal care. Facility-based challenges were inadequacy of facilities, equipment and health professionals, lack of professionalism and collection of illegal fees amongst others. In the light of these findings, the thesis has developed a model for viewing maternal healthcare services utilisation. There is the need to adopt gender responsive and mainstreaming policies and programmes as well as a culturally competent and structurally transformative agency strategy to empower women at the household and community levels in all spheres of life through active engagement of men.

Keywords: gender, male-dominance, decision-making, utilisation, maternal healthcare, oppressive, marginalisation, dualism, transformative.

Dimensi Sosial-Budaya di dalam Penjagaan Kesihatan Ibu di Ghana

ABSTRAK

Kira-kira 99% daripada 830 orang wanita yang meninggal dunia semasa kelahiran bayi setiap hari di seluruh dunia berasal daripada Negara membangun. Walaupun pada tahun 2013 sebanyak 45% pengurangan kematian ibu telah dicapai, WHO telah melaporkan peningkatan sebab-sebab tidak langsung kematian semasa kelahiran iaitu daripada 9.1% pada tahun 1990 kepada 10.2% pada tahun 2013. Afrika menyumbang hanya sebanyak 14% jumlah penduduk dunia tetapi menyumbang lebih daripada separuh kematian ibu semasa kelahiran. Anggaran semasa WHO/Bank Dunia bagi kadar nisbah kematian para ibu di Ghana ialah pada kadar 320/100,000 kelahiran adalah terlampau tinggi mengambilkira adanya intervensi melalui Skim Insuran Kesihatan Kebangsaan, Protokol Keselamatan Ibu dan Sistem Ambulan Kebangsaan. Antara tahun 2011 dan 2012, Wilayah Utara Ghana telah merekodkan kematian semasa kelahiran yang tertinggi iaitu seramai 302 (72.8%) orang ibu yang memilih untuk melahirkan anak secara tradisional di rumah dan 36% kelahiran anak tersebut dibantu oleh bidan tradisi tidak terlatih. Kajian kualitatif ini menggunakan metodologi yang sesuai dengan budaya untuk meneroka pengalaman wanita semasa melahirkan anak dan pembuatan-keputusan dalam penggunaan perkhidmatan penjagaan kesihatan ibu. Temubual bersama 30 individu dan 15 kumpulan sasar merupakan sampel bertujuan yang terdiri daripada mereka yang terlibat secara langsung dalam penjagaan kesihatan ibu seperti wanita berumur antara 15-49 tahun yang pernah mengandung dan melahirkan anak dalam tempoh dua tahun pengumpulan data berjalan; pasangan kepada ibu-ibu tersebut, pengamal tradisional dan perubatan moden di Yendi Municipality dan Dearah Chereponidi dalam Wilayah Utara. Didukungi oleh teori struktur-agensi dan model delay, kajian ini secara tematik menganalisis penggunaan perkhidmatan penjagaan kesihatan ibu dalam tiga fasa yang saling berkaitan. Kajian mendapati kelewatan yang bersifat systemic-structural *untuk mendapatkan penjagaan dalam kalangan*

isirumah disebabkan oleh norma gender dan kepercayaan agama seperti pantang larang pemakanan atau resam tingkahlaku. Sistem sosio-budaya dalam kalangan isirumah berdasarkan hieraki yang bercirikan penindasan dan peminggiran wanita terutama dalam pembuatan-keputusan untuk mendapatkan penjagaan. Sistem diskriminasi gender memudahkan dominasi lelaki dalam proses pembuatan keputusan untuk mendapatkan penjagaan yang mana menafikan intervensi klinikal tepat pada waktunya. Dualisme penjagaan dicirikan oleh penggunaan perubatan tradisional dan farmaseutikal diperhatikan dalam kalangan peserta sebagai hasil daripada dwi-pengamalan. Di samping itu, perhatian kepada penjagaan kesihatan ibu lebih menumpukan kepada aspek kelahiran sehingga mengabaikan kesaling-keterikatan antinatal, kelahiran dan penjagaan selepas bersalin. Kesulitan ini ditambah pula dengan kekurangan kemudahan, peralatan dan pakar kesihatan, kekurangan kepakaran dan wujudnya pengutipan yuran haram. Dengan mengambilkira dapatan kajian, tesis ini telah membina satu model untuk menilai penggunaan servis penjagaan kesihatan ibu. Terdapat keperluan untuk mengarus perdana gender melalui dasar dan program serta strategi transformatif yang mengambilkira budaya di dalam memperkasakan wanita di peringkat isi rumah dan komuniti dalam semua bidang kehidupan melalui penglibatan golongan lelaki secara aktif.

Kata kunci: *gender, dominasi lelaki, pembuatan-keputusan, penggunaan, penjagaan kesihatan ibu, penindasan, peminggiran, dualisme, transformatif.*

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMTSL	Active Management of Third Stage Labour
ANC	Antenatal Care
ATR	African Traditional Religion
AU	African Union
CCT	Controlled Cord Traction
CEDAW	Convention on Elimination of all Forms of Discrimination Against Women
CHO	Community Health Officer
CHPS	Community-based Health Planning and Services
CRS	Catholic Relief Services
EoC	Emergency Obstetric Complication/Care
FAO	Food and Agriculture Organisation
FCUBE	Free Compulsory Universal Basic Education
FGD	Focus Group Discussion
FHI	Family Health International
GBV	Gender-Based Violence
GDHS	Ghana Demographic and Health Survey
GHS	Ghana Health Service
GSS	Ghana Statistical Service
HIV	Human Immunodeficiency Virus,

ICRW	International Centre for Research on Women
IDI	In-Depth Interview
IMMPACT	Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials
IPT	Intermittent Preventive Treatment
JSS	Junior Secondary School
JHS	Junior High School
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MPS	Making Pregnancy Safer
MSLC	Middle School Leaving Certificate
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
PHC	Primary Health Care
PNC	Postnatal Care
RBM	Ghana Roll Back Malaria Programme
SD	Skilled Delivery
SP	Sulphadoxine-Pyrimethamine
SSA	Sub-Saharan Africa
SSS	Senior Secondary School
SSSCE	Senior Secondary School Certificate Examination
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TP	Traditional Practitioner
UN	United Nations
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

1.1 Background

The need to improve the health of women in maternity has always been a serious global concern since the mid 1980s when researchers drew the attention of the world to the alarming rates at which women were dying from pregnancy and childbirth, especially, in developing countries. This led to the establishment of the safe motherhood initiative in the late 1980s by the World Health Organisation (WHO). In recognition of the importance of women's health, the United Nations (UN) has set up the Commission on Information and Accountability for Women's and Children's Health in support of Global Strategy for Women's and Children's Health. The establishment of this commission is to enable the UN develop a framework for global reporting, oversight and accountability on women's and children's health, especially, in high burden and low income countries (WHO, 2013).

The United Nations Development Programme (UNDP) in 2004 attaches particular importance to the health of women in the quality of life, level of productivity, and life expectancy of the women, their families, and the citizenry at large. A better health for women is a necessary priority and an improvement in maternal mortality and morbidity should be a target of all nations (WHO, 2013), because improved women's health constitutes a critical input into economic growth, poverty reduction and a long term socio-economic development (African Union (AU), 2006; UNDP, 2007).

Almost three decades after the establishment of the safe motherhood initiative by the WHO, deaths related to pregnancy and childbirth, and the associated complications still confront the world, especially the developing countries where access to the inadequate healthcare services are mediated by social and cultural factors (WHO, 2013). The 2000 World Summit came out with the

Millennium Development Goals (MDGs) of which the goal number five was to improve maternal health by reducing maternal mortality by three quarters between 1990 and 2015, and to achieve universal access to reproductive health by 2015. The key target in reducing maternal mortality is to record 100% of deliveries assisted by skilled health personnel. There have been some improvement in many countries especially regarding increase in antenatal care coverage. However, assistance by skilled personnel remains a challenge especially in South East Asia and Africa Regions (WHO, 2011, 2012, 2013, 2015).

Maternal mortality continues to be an indicator that shows the largest disparity between the developed and developing regions. Many women in developing countries, most often in rural Africa, register high antenatal care attendance but very low attendance for institutional deliveries and postnatal care (WHO, 2013). According to WHO, only 48% of deliveries in Africa is assisted by skilled health professionals compared with 98% in Europe. Again, postnatal care during the critical period registered very poor attendance of only 37% of the deliveries in the year under review. The postnatal period is the critical phase in the lives of mothers and newborn babies and most of maternal and infants deaths occur during this time (WHO, 2013; Ghana Statistical Service (GSS), 2015), yet this is the most neglected period for the provision of quality care (WHO, 2013). Postnatal care is very important for medical professionals to screen for signs of infections and haemorrhage (bleeding), which currently accounts for 20% of maternal deaths in Ghana and the leading cause of maternal mortality in the world (GSS, 2009).

Even though maternal mortality has dropped globally by 45% from 1990 to 2013 (WHO, 2013; World Bank, 2014), only 50% of the women in developing regions receive the recommended healthcare during pregnancy, and only 51% of women in low income countries access skilled care during childbirth (WHO, 2015). About 830 women die everyday due to complications during pregnancy and childbirth, and 99% of these deaths occur in developing countries (WHO et al., 2015). Maternal mortality is five times higher in developing regions as

compared to those of developed regions, with an increase in indirect causes from 9.1% in 1990 to 10.2% in 2013 (World Bank, 2014).

One out of 40 women in Africa has a lifetime risk of dying from pregnancy related complications as compared to one in 3,300 women in Europe. The majority of these maternal deaths occur in sub-Saharan Africa (SSA), which accounts for 56% of global maternal deaths (WHO, 2013). In Africa, most of the maternal deaths and complications are from indirect causes which have direct link with the cultural and traditional beliefs and practices (AU, 2006). Africa accounts for about 20% of births in the world, but contributes to 40% of maternal deaths with many more suffering injuries and lifetime disabilities, estimated to be about 15 million women a year (AU, 2006).

Human reproduction is a biological event, but strongly determined by cultural factors (Dubois, 1985). Thus, pregnancy and childbirth in Africa are prone to crises due to socio-cultural factors (Nwokocha, 2007). Cultural beliefs and traditional practices together with poor medical system hinder women's access to and use of hospital facilities, especially during emergencies (Nwokocha, 2007; Bawah, 2008; Nyanzi, 2008).

About 60% of African population is rural based, and as a result, cultural norms and practices still exert strong influence on reproductive healthcare (Nyanzi, 2008). This makes traditional healthcare system the first option for healthcare in most instances (Addai, 2000; Nyanzi, 2008). The role of traditional birth attendants (TBAs) often reflects the culture and social organisation of the community in which they operate. As a result of the strong attachment to socio-cultural factors, high quality maternity is often unavailable and home delivery remains a strong preference for many women (Mainbolwa, Yamba, Diwan & Ransjo-Arvidson, 2003; Nyanzi, 2008).

The complex interaction between biology and socio-cultural environment means that even when skilled care is available, women may not seek or receive it (WHO, 1999; Senah, 2003). This is because the attitudes of women towards maternal healthcare services, their perceptions

about health facilities, and the utilisation of such facilities are strongly influenced by their socio-cultural environment (Andersen, 1995; Andersen & Newman 2005; Furuta & Salway, 2006; Cannavan, 2008; Ononokpono & Odimegwu, 2014). Meanwhile, delivery in health facility is associated with lower maternal and newborn deaths and morbidity rates compared with home delivery (GSS, 2008, 2009; WHO, 2011, 2013; Ononokpono & Odimegwu, 2014).

According to AU (2006), an important factor in the utilisation of maternity care services is the cultural background of the woman. In most African rural communities, maternal health services co-exist with indigenous healthcare services; therefore, women have to choose between these options, and the culture of the women usually determines the choice (Addai, 2000). Factors that influence maternal healthcare services utilisation operate at various levels - the individual, household, community and state levels (Babalola & Fatusi, 2009; International Centre for Research on Women (ICRW), 2010; Abel & Frohlich, 2012). Thus, the cultural and social organisation of the individual's family, community and state at large defines the option to make in terms of choice of healthcare services.

It has been established in many studies that background variables such as ethnicity, religion, income level, educational attainment, place of residence, age amongst others also have impact on the use of healthcare facilities by women (Tsikata, 2007; UNDP, 2007; GSS, 2008, 2009, 2015). Again, the means and cost of transportation, the behaviour of health professionals, have influence on the utilisation of maternal healthcare services (Addai, 2000; GSS, 2008, 2009).

The MDG 3 aims to promote gender equality and empowerment of women. Gender equality implies equal rights and opportunities for both sexes. It involves changing how men and women relate to each other and bringing about distribution of power and resources and care-giving responsibilities (UNFPA & ICRW, 2014). Article 12 of the convention on elimination of all forms of discrimination against women (CEDAW) requires states to ensure equality of men and women on basis of access to healthcare services especially, reproductive health and granting free services

where necessary. The Beijing Declaration and the Platform for Action set strategic objectives and actions for advancement of women and the achievement of gender equality in 12 critical areas including women and poverty, education and training of women, women and health, violence against women and human rights of women amongst others. Gender inequality, which is socially created within cultures creates a position for women within households, which in turn determines their utilisation of maternal healthcare services (McAlister & Baskett, 2006; WHO, 2014).

Article 25 of the 1992 Republican Constitution of Ghana recognises and protects gender equality and women's human right to healthcare. Again, the revised version of 1994 Population Policy of Ghana enjoins all institutions to protect the reproductive right of women and promote maternal health at all levels of the public healthcare system. This policy calls for the collaboration between the traditional institutions and the healthcare institutions for the elimination of all social and cultural barriers to healthcare access.

Decision-making at the household level is a very important determinant of the choice of healthcare services by women. When women have the power to decide they can make meaningful decisions that can positively affect their lives (Babalola & Fatusi, 2009; Hagman, 2013). However, differences in the status of women and men lead to differences in opportunities to claim, benefit from, and enjoy human rights including the right to decision-making and health (WHO, 2013, 2014). In many parts of Africa, women's decision-making power is extremely limited, particularly in matters of reproduction and sexuality. In this regard, decision about maternity care are often made by husbands or other family members usually, males (WHO, 2001).

Gender inequality is capable of rendering women vulnerable and affecting their demand for services including healthcare at all socio-economic levels (Nwokocha, 2007), because gender factors affect the individual's autonomy to make decisions like seeking healthcare, engaging in social interaction, moving freely outside the home, controlling vital resources like income and assets (ICRW, 2008). Gender inequality which manifests in the decision-making process within

the household is a critical and neglected factor in the utilisation of maternal healthcare services. Deeply entrenched gender inequalities exist in many low-income countries where maternal deaths are high and health services utilisation is low (Nyanzi, 2008; ICRW, 2008; WHO, 2013; UNFPA & ICRW, 2014). Gender inequality is defined and perpetuated by social norms and culture, and reflects differences in power between men and women both within the household and in the wider society (WHO, 2001; Nukunya, 2003). The effects are relatively high rates of poverty and lower levels of education amongst women than men, women's lack of autonomy and mobility, intimate partner violence and overall, lower social status and disempowerment of women relative to men (UNDP, 2007).

Women's low social status and constraints relative to men significantly impact women's health, the health of mothers and overall demand for maternal healthcare services. In many conservative communities, cultural and social norms restrict women's mobility and prevent them from seeking healthcare (WHO, 2001; Nwokocha, 2007). This is compounded by their limited access to education which deprives them of the knowledge and tools to make informed decisions and choices (McAlister & Baskett, 2006; GSS, 2009; Hagman, 2013; UNFPA & ICRW, 2014).

According to UNDP (2007), gender role in decision-making interacts with age to make young women particularly vulnerable to the ill effects of gender inequitable norms on maternal healthcare access. These norms may dictate early marriage for girls which may in turn lead to early child bearing and its consequential increase in total fertility, both of which are linked to higher risks of maternal morbidity and mortality (GSS, 2008, 2009, 2015).

In recent times, the impact of gender-based violence (GBV) on maternal health is great. The physical, sexual, psychological and economic abuses resulting from women's subordinate status in society and controlling behaviours that restrict women's access to resources impact the utilisation of healthcare services by women (Nwokocha, 2007; ICRW, 2008). Most often, these abuses are perpetuated by intimate partners and may begin or become aggravated by pregnancy

thus, compromising maternal health with outcomes like maternal deaths caused by direct trauma and stress, unintended pregnancies, vaginal and cervical infections, kidney infections, miscarriages, abortions, premature labour, preterm labour and pre-eclampsia (ICRW, 2014).

Under free medical care system women prefer to deliver at home because they perceive the medical settings to be of very low quality and unsafe (WHO, 2007). Just like in Ghana (Arhin, 2001; UNDP, 2007), in Zimbabwe (Van den Heuvel et al., 1999), religious beliefs and practices have significant influence on maternal health services utilisation. In spite of the interventions by the government and stakeholders in Ecuador to encourage institutional delivery, women have a very strong preference for the traditional birthing system under the supervision of a spiritual father (yatchak), who oversees the spiritual dimension of the birthing process and ensures it follows ancestral cosmic laws (Soguel, 2009).

In Ghana, pregnancy and childbirth are significantly influenced by cultural codes of the community (Arhin, 2001; Kwarpong, 2008). Pregnant women are not supposed to show early signs of pregnancy until it is visible to avoid spiritual attacks (Arhin, 2001). The expectation of any sexual activity especially within marriage is childbirth. Based on this, the Asantes of the Akan ethnic group in Ghana request the womb of an elephant for newly married woman for healthy and stronger children to be born, whilst the Gas of the Ga-Adangme ethnic group request ten children for a couple and the man is awarded with a very big white ram for having ten children with one woman (Kwarpong, 2008). Though pregnant women in Ghana can enrol into the national health insurance system, many pregnant women prefer home delivery due to cultural barriers and traditional medical practices (GSS, 2008, 2009). According to Senah (2003), in the remote areas of the Upper-West Region of Ghana, herbal remedies are used to induce labour and some of these herbs are concoctions which can be toxic.

Improvement of maternal health is a global obligation (UN, 2000), and failure to make motherhood safe is a discrimination against women (AU, 2006). The 2000 World Summit on

Population and Development came out with the MDGs as mandatory guidelines for countries to follow to ensure development in all aspects of human life. To achieve the MDGs 3, 4 and 5 which are centred on achievement of gender equality, reduction of child and maternal mortalities respectively, a number of policies and programmes in the form of interventions have been instituted, especially, in the developing countries to ensure safe motherhood (GSS, 2009). Some of the interventions in Ghana are the creation of a Ministry for Gender, Children and Social Protection, investment in girl-child education and general universal basic education under the Free Compulsory Universal Basic Education (FCUBE) programme. Others are training of traditional birth attendants (TBAs), upgrading and expansion of various health facilities, introduction of the National Health Insurance Scheme, free antenatal and delivery care, establishment of the CHPS (Community-based Health Planing Services) compounds in rural communities to make health services closer to the door steps of rural women. There is also introduction of safe motherhood protocol at all levels of the healthcare system, the establishment of family planning services as part of public healthcare system and improvement in transportation and ambulatory services to improve upon referral system.

1.2 Ghanaian Women's Status and Maternal Health

Several decades after independence, Ghanaian women are still not enjoying full citizenship rights, including the right to safe childbirth (Tsikata, 2007; Food & Agriculture Organisation (FAO), 2012a, b; UNDP, 2016a, b), which is a constitutional mandate (Republic of Ghana, 1992). Their rights are undermined by discriminatory policies and practices in public, private and within the state and society (Tsikata, 2007). Ethnicity, kinship, and marriage are influential institutions, which are all underpinned by religious beliefs and practices within traditional religion, Christianity and Islam. The rules and regulations governing these institutions and their gender ideologies have been very strong in normalising gender inequalities, hence, rendering women as

perpetual minors (Tsikata, 2007; FAO, 2012a).

In Ghana, there are unequal and discriminatory gender practices. For instance, traditionally, women are discriminated against in inheritance rule, which indirectly deprives them of critical life resources (Ammah, 1992; Oduyoye, 1992; Amoah, 2002). Using ritual performances, religion works as a determiner of power, influence, domination and oppression (Oduyoye, 1992), and this power is usually positioned in men who control spiritual affairs of the households and the communities at large (Nukunya, 2003). Regardless of the previous efforts by some earlier women to promote the inclusion of females in leading Christian and Muslim worship, women still do not have the place especially, in Islam to lead prayers (Abbey, 2001; Acolatse, 2001; Tsikata, 2007).

In spite of the efforts by various stakeholders in promoting maternal healthcare, female education and gender equality, there are still remarkable signs of inequalities between men and women, especially, in areas of education and decision-making at the national level (GSS, 2011). Currently, women occupy only 19 parliamentary seats in Ghana forming 8.3% as against 211 seats for men. This is a clear indication that even at the national levels women are discriminated against in decision-making.

Over a decade after the implementation of the National Health Insurance Scheme, maternal mortality continues to be a major problem to the Health Ministry of Ghana. The maternal healthcare system is associated with high ANC coverage without a significant improvement in skilled delivery, with lower number of ANC visits as well as poor timing for both ANC and PNC attendance (GSS, 2008, 2009). According to GSS (2009), maternal mortality ratio stands at 450/100,000 live births, which is unacceptably high. This ratio is three times higher than the given target and the country could not achieve the MDG 5 at the end of 2015. Even though some progress has been observed in ANC coverage, there has not been a significant progress in improvement of maternal health in Ghana, especially, in the area of institutional delivery (Bawah, 2008). There is no equity in access to and use of health facilities by pregnant women, with the

southern sector having greater access than the north (Bawah, 2008; GSS, 2010). According to GSS (2009), only 42% of births in rural Ghana were delivered in facilities compared with 82% in urban areas. Again, only 57% of births in the Northern Region was medically assisted (GSS, 2012).

1.3 The Study Setting

Ghana is divided into 10 administrative regions, and 170 districts, including 164 districts and 6 metropolitan areas (Figure 1.1), with an estimated total population of 27 million people (GSS, 2014a). The Northern Region of Ghana, the biggest in terms of land size, is inhabited by many ethnic groups with diverse cultures and belief systems. The choice of this region for the study is based on the rationale that the region recorded the highest number of maternal deaths (302) between 2011 and 2012.

Figure 1.1: Map of Ghana Showing the ten Administrative Regions

Source: World Maps 2014.

It also recorded the highest percentage (72.8%) of women who had home delivery amongst the

ten regions in the country. Aside, as high as about 36% of the home deliveries in the region were assisted by untrained TBAs. Also, about 65% of the women who had home deliveries had no formal education and 10% of them received their first PNC from untrained TBAs (GSS, 2012). Further, since the mid1990s this region has suffered several ethnic conflicts which for security reasons prevented researchers to collect primary data especially, regarding ethnic and cultural issues. This additionally makes the region a suitable site for research discovery. Details of the rationale and background of study setting are presented in Chapter 2.

1.4 Gaps in Existing Studies

It is ethical and necessary to acknowledge some studies in Ghana (Senah, 2003; Bawah, 2008; Galaa & Daare, 2008; GSS, 2008, 2009; Hagman, 2013; Abor & Abekah-Nkrumah, 2013; Mensah, Mogale & Richter, 2014) that sought to build understanding on the factors influencing utilisation of maternal healthcare services. In the Greater-Accra Region of coastal south of Ghana, Mensah et al. (2014) concentrated on utilisation of maternal healthcare services using pregnant women and nursing mothers who were clients of the 37 Military Hospital in Accra. Again, other researchers like Bawah (2008) and Abor & Abekah-Nkrumah (2013) conducted research on maternal healthcare in Ghana using secondary data from Ghana Health Service and GSS.

Even though groundbreaking in their attempt to explain maternal healthcare services utilisation, some knowledge gaps exist in the literature which require further research. Previous studies limited the scope of traditional birthing to the traditional birth attendants (TBAs), neglecting equally important stakeholders like the spiritualists and herbalists. There is the need to investigate the preference for traditional care and how the communities go about pregnancy and childbirth outside the health facility. Indigenous practices and processes of giving birth and healthcare during pregnancy, delivery and the post-delivery periods as well as the experiences of women in home care have not been given adequate attention.

The existing literature on the use of the delays model in maternal healthcare concentrates heavily on emergency obstetric complications, neglecting the direct causes of maternal mortality and other medical conditions which produce the emergency complications. Again, ANC, delivery and PNC are inextricably connected. The three stages of maternity need to be analysed as inter-connected parts of maternal healthcare system. This is because the outcome of each stage in the pregnancy-postpartum continuum affects other stages (Nwokocha, 2007). The limited literature on qualitative research adopted the homogeneous sampling technique of the purposive sampling method to select only women. The views of both women and their spouses on decision-making towards the choice of healthcare services is missing in the current literature, yet, cultural norms and practices are controlled and perpetuated by traditional leaders usually, men and monitored by families headed by men (Nukunya, 2003). Under the influence of culture women are made to seek home care from these traditional practitioners (Senah, 2003; Maimbolwa et al., 2003; Nyanzi, 2008).

Further, the previous literature does not adequately cover the issue of maternal healthcare services utilisation at district, regional and national levels. Typical of previous studies, the use of secondary data and quantitative methods gives a superficial understanding of the participants' thoughts and feelings and therefore, leading to missing of contextual details (Ling, 2004; Smith, 2006, 2012). The study of cultural ways of handling pregnancy and childbirth requires an in-depth exploratory approach in a very warm, motivating and interactive process to unfold issues of research interest (Family Health International (FHI) & United States Agency for International Development (USAID), 2011). Unlike in qualitative study, mostly the responses provided by respondents in quantitative research are limited to the provision of the research instrument.

The figures often presented by health researchers and organisations to describe maternal deaths and morbidities only show the extent and the risks of pregnancy-related deaths. However, this numerical information has the tendency of masking the realities of these incidences (Combs

Thorsen, Sundby & Malata, 2012). Thus, the direct causes of maternal deaths such as haemorrhage, obstructed labour, abortion, and HIV and AIDS are the outcomes of long term fragmented issues (Senah, 2003; Combs Thorsen et al., 2012).

If the use of figures and associated interventions or policies could simply improve maternal morbidity and mortality, Ghana would have achieved the MDG 5 by the end of 2015. Again, the WHO (2014) would not have recorded an increase in indirect causes of maternal deaths in the face of remarkably improved healthcare system. However, because this is not the case, researchers have to go beyond the indicators presented in figures (Combs Thorsen et al., 2012) to discover the underlying reasons why women in Ghana continue to seek home care in maternity or why they experience maternal morbidity and disabilities or die in the face of safe motherhood interventions like introduction of CHPS compounds, expansion of health facilities, national health insurance scheme (NHIS) and safe motherhood protocol amongst others.

1.5 Statement of the Problem

It is argued that maternal mortality and utilisation of healthcare services can be improved through interventions that provide access to skilled delivery and emergency obstetric care (World Bank, 2014). However, adopting these interventions did not work as expected in Ghana (GSS, 2012; GSS, 2015), justifying that putting services alone in place will not in itself achieve results. To be effective, the services need to be both acceptable and accessible to the women who need them (UNFPA & ICRW, 2014). This is because medical need is determined not only by the presence of physical disease, but also by cultural perception of the illness (Andersen & Newman, 2005; Rebhan, 2008). Even though pregnancy is not an illness, it is associated with health complications.

Women's choice of healthcare services during pregnancy and childbirth may be informed by their belief systems (Naser, 2012). Thus, understanding why people use traditional medicine is key

towards promoting maternal healthcare (Rebhan, 2008). Knowledge about the worldviews and health beliefs of people is a necessary precondition towards improvement of healthcare services utilisation (Baer & Nichols, 1998). Therefore, knowledge about the worldviews and health beliefs around pregnancy and childbirth is a prerequisite for improving maternal health. This is because it is crucial in explaining why people choose the conventional healthcare or alternative sources (Baer & Nichols, 1998).

Given that gender inequality is a critical and neglected issue in maternal healthcare, which manifests in decision-making process within the household (ICRW, 2008), it is equally necessary to know about traditional gender roles from both men and women and how they inform decision-making towards maternal healthcare services utilisation.

Institutional and organisational structures of the healthcare system and the socio-cultural orientation of both the care-seeker and the care-giver are potential factors that influence maternal healthcare (Banchani & Tenkorang, 2014). Hence, the need for a balanced comprehensive data from the women and health professionals because seeking data from only women or professionals will only produce limited information.

The position of this study is based on the assertion that the conditions which promote maternal and child health or cause maternal and child morbidities and mortalities are not purely genetic or biological, but can be social, cultural, economic and psychological (ICRW, 2010; Combs Thorsen et al., 2012; WHO, 2013, 2014). Therefore, understanding maternal healthcare and health services utilisation needs to be examined from the socio-cultural environment.

The focus of this study is to understand the dynamics of maternal healthcare in both the traditional setting and within the health facilities. Using an in-depth exploratory approach, the study seeks the views of stakeholders in maternity care such as men, women, traditional practitioners and healthcare professionals on the experiences of women in maternal healthcare, how the traditional practitioners provide healthcare, the contribution of spousal decision-making

towards the choice of health care services, and the factors that influence effective provision and reception of maternal healthcare services. Premised on the position that ANC, delivery and PNC are important inter-connected parts of maternal healthcare system (Nwokocha, 2007), this study attaches equal importance to these individual stages. Therefore, the study investigates the cultural, social, gender and structural factors that impact the provision and reception of maternal healthcare services in the selected communities.

1.6 Research Questions

This study aimed to explore the following research question: What, if any, socio-cultural structures and conditions associated with pregnancy and childbirth influence utilisation of maternal healthcare services in the Northern Region of Ghana? The study sought answers to the following specific research questions:

i. What values, norms, beliefs and perceptions inform pregnancy and childbirth practices? This is informed by the need to know about the worldviews and health beliefs of the people about pregnancy and childbirth and how these impact healthcare services utilisation.

ii. How is maternal healthcare provided or received in the traditional setting? The limited literature on qualitative research adopted the homogeneous sampling technique of the purposive sampling method to select only women. This research question seeks to find answers to the role of traditional practitioners such as TBAs, herbalists and spiritualists as well as the methods, materials and substances they use during pregnancy, delivery and the post-delivery care.

iii. How does spousal decision-making inform the choice and practice of maternal healthcare? This is motivated by the need to know about traditional gender roles from both men and women and how they inform decision-making towards maternal healthcare services

utilisation.

iv. What are the institutional/organisational factors that influence effective provision of maternal healthcare services? This is informed by the need for balanced data from both the care-seekers and care-givers on utilisation of maternal healthcare services and healthcare delivery for even analysis and discussion.

1.7 Objectives of the Study

The main objective of this study was to analyse the experiences of women in maternal healthcare in the socio-cultural environment. The specific objectives were to:

i. Discover worldviews and health beliefs around pregnancy and childbirth, and how they influence the reception of maternal healthcare services;

ii. Explore indigenous birthing practices to uncover the role of traditional practitioners;

iii. Uncover the role of gender in intra-household decision-making towards the choice and use of maternal healthcare services and

iv. Provide insights into the provision of effective maternal healthcare services.

1.8 Significance of the Study

Ensuring healthy lives and promotion of well-being for all at all ages as well as promotion of gender equality and women's empowerment are Sustainable Development Goals (SDGs). The findings of this study will be able to help the government, NGOs and all stakeholders to adopt strategies of making health services more accessible to pregnant women, nursing mothers and newly-born babies from different backgrounds for the achievement of these goals.

Safe motherhood is a constitutional right recognised by the Constitution of Ghana and the Millennium Development Goals. The findings from the study will be illuminating on the extent to which this right is enjoyed by women or held up by the socio-cultural environment. Furthermore,

the findings indicate how cultural factors mediate to influence the utilisation of the maternal healthcare services and this will facilitate understanding of who uses which services, why they access these services and when those services will be utilised. This provides crucial guidelines to inform policy formulation and implementation on maternal healthcare services utilisation.

The study reveals how traditional practitioners manage pregnancy and related complications and suggest ways of improving maternal healthcare. Also, this study provides guidelines to traditional leaders and healthcare authorities on structural transformation at the familial, communal and institutional levels to promote maternal healthcare. Thus, the study provides guidelines on cultural norms to stakeholders for the promotion of safe motherhood by recognising the culture and tradition of people as a basis for positive outcome.

Further, this study recognises the inter-connectedness of all pregnancy-related conditions, and the various stages of maternity and suggests strategies for effective health campaigns, policy formulation and health promotion programmes for prevention and treatment of complications related to pregnancy and childbirth. Previous studies have limited emergency care and attached importance to only emergency obstetric complications or the delivery stage. The present study recognises all the stages of maternity as inter-connected parts of maternal healthcare system. Since these stages are inextricably connected, they are all equally important and deserve the best of medical attention.

Above all, harmful gender roles to women's health which have been discovered will be used to educate the public especially, men on women's rights to health and the need to take collective decisions within the household to promote maternal and child health. This will also serve as additional source of literature on gender and health promotion for further research. The study also provides insight into how the country will achieve the SDGs 3 and 5 through gender responsive and mainstreaming policies with culturally sensitive and structurally transformative strategies.

Finally, this study has developed a conceptual model to explain utilisation of maternal

healthcare services, which adds to theory building by addressing limitations in the reviewed theories and models on maternal healthcare services utilisation. This contributes to knowledge by adding to existing theories and showing a new dimensional approach to promoting safe motherhood.

1.9 Scope of the Study

Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the healthcare dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2013). In medical sciences, the study of maternal health is normally viewed with two lenses; the medical/clinical perspective and the socio-cultural perspective. The medical perspective explains the causes of maternal mortality and morbidity using the medical models by focusing on the direct causes such as haemorrhage, infection, high blood pressure, unsafe abortion and obstructed labour amongst other conditions, whilst the socio-cultural dimension examines this phenomenon with a sociological view on the indirect causes - resulting from factors in the socio-cultural environment which impede or mediate to delay or deny women's access to maternal healthcare services (Thaddeus and Maine, 1994; WHO, 2001; Senah, 2003). Some of the socio-cultural factors include social infrastructure like road network, health facilities, equipment and drugs, and cultural factors like worldviews and health beliefs of people about the causes and treatment of diseases, gender, socio-economic status of the woman/family and the behaviour and competence of health professionals.

Most often, people tend to centre issues on maternal healthcare around women and in most instances, men are taken out of research and interventions in the promotion of safe motherhood. This way, the interventions are normally targeted at just a part of the group thereby resulting in poor performances or no solution to the problems (Abor & Abekah-Nkrumah, 2013). To ensure

appropriate and expected returns of interventions, the safe motherhood programme targets many categories of people such as married couples and individuals, adolescents, pregnant women, women and adolescents in their puerperium and their babies, men as well as families and communities (GSS, 2008, 2009). To ensure effective management and monitoring of the programme, it has been sub-divided into six major areas; antenatal care, labour and delivery care, postnatal care, family planning, prevention and management of unsafe abortion, and finally health education. However, for the purpose of this study, only the first three areas - the pregnancy-postpartum period is covered with the focus on women and spouses, traditional care-givers and health professionals as participants for the study.

1.10 Research Methods

Using a cross-sectional design, this qualitative study adopts culturally appropriate methodologies to explore the experiences of women in indigenous birthing, and decision-making towards utilisation of maternal healthcare services. In 30 individual interviews and 15 focus group discussions, the study purposively sampled informants such as women aged 15-49 years ever-pregnant or given birth within two years preceding data collection, their spouses, traditional practitioners and health professionals in the Northern Region of Ghana. Guided by the delays model and the structure and agency theory, with thematic analysis, the study analysed utilisation of maternal healthcare services holistically by linking up the inter-connected stages of antenatal care, delivery and postnatal care.

1.11 Organisation of the Thesis Chapters

This thesis is organised in seven chapters. Chapter 1 is the introduction comprising background to the study, Ghanaian women's status and maternal health, the study setting, gaps in existing studies and problem statement. In addition, the research questions, study objectives,

significance of the study, scope of the study and a brief description of research methods are presented in Chapter 1.

Chapter 2 concentrates on background of Ghana and maternal healthcare including the geographical and socio-demographic information, and maternal healthcare policies and challenges. Also, the rationale for the choice of study site is presented in this chapter. Chapter 3 presents review of previous studies as well as theories and models on healthcare services utilisation. The main issues include review of Andersen's health behaviour model, the structure and agency theory, gender empowerment framework, and the three delays model. Apart from the Andersen's model which has been thoroughly subjected to scrutiny, critical review of the previous studies, the structure and agency theory, the gender empowerment framework and the three delays model are presented in this chapter. In addition, the theoretical framework for this study is also presented in this chapter.

Chapter 4 is dedicated to methodology which discusses the research design, sources of data, target population, sample size and sampling procedures, research instrument, pilot study, ethical and political considerations, and training of a field rapporteur for focus group discussions. It further addresses how trustworthiness and dependability were ensured in the research, how the actual field work was organised in the study, data management and anlysis, and field challenges and how they were solved.

Chapter 5 is focused on results and discussions on worldviews, health beliefs and indigenous birthing practices whilst Chapter 6 presents results and discussions on gender, decision-making and utilisation of maternal healthcare services. Finally, Chapter 7 presents key findings of the study, conclusions to the key findings, the contribution of this study to knowledge, implications of the findings for healthcare, education and policy development as well as recommendations for policy consideration and further research. Finally, the general conclusion of the thesis is presented at the end of Chapter 7.

CHAPTER 2

BACKGROUND OF GHANA AND MATERNAL HEALTHCARE

2.1 Introduction

This study attaches importance to socio-demographic profile and geographical position of the study site in the provision and reception of maternal healthcare services. As a result, this chapter briefly discusses the geographical and socio-demographic background of Ghana, and maternal healthcare policies and interventions. In addition, a brief background of the Northern Region which is the selected site for the study and the rationale for the choice of the site are discussed.

2.2 Profile of Ghana

The Republic of Ghana is a constitutional democratic state in West Africa bordered by Cote d'Ivoire in the west, Burkina Faso in the north, Togo in the east and Gulf of Guinea in the south (Figure 2.1 & 2.2). Ghana is almost landlocked from three sides and has only 539 km long coastline with a total area of 238,533 sq. km making it the eighty second largest country in the world. Geographically, Ghana is estimated to be the closest country to the centre of the earth. It is also located in closer proximity, north of the equator, with tropical warm climate. The position of Ghana is 4°S to 12°N latitudes and 4°W to 2°E longitudes. The prime meridian passes through the town of Tema in Ghana. Accra is the capital city. The country gained independence from the colonial British administration in 1957. Ghana is divided into 10 administrative regions (Figure 2.3), and 170 districts, including 164 districts and 6 metropolitan areas.

Figure 2.1: Africa Map showing the Position of Ghana

Source: World Maps, 2014.

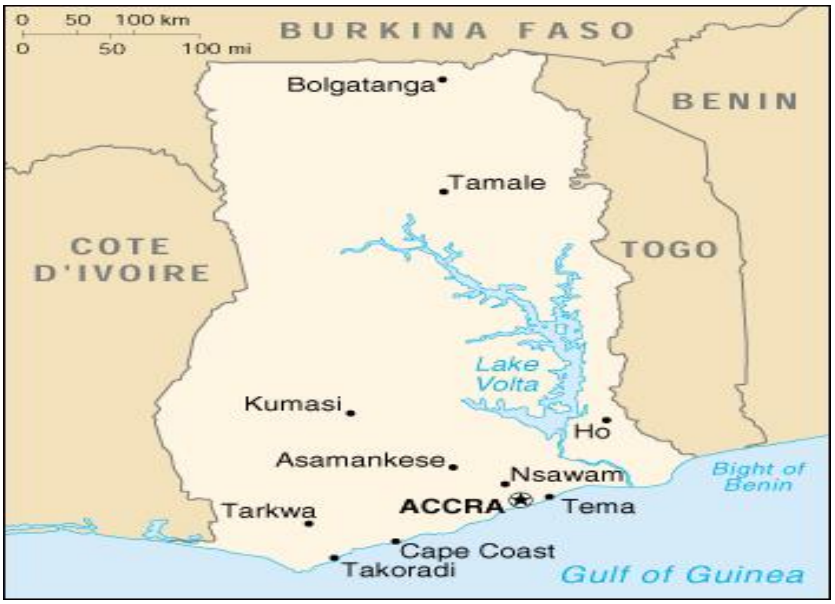

Figure 2.2: The position of Ghana in West Africa

Source: World Maps, 2014.

The 2014 estimates by Ghana Statistical Service presents a total population of 27 million people. The males constitute 12,024,845 and the female population is 12,633,978. The intercensal growth

rate of 2.5% indicates that it will take approximately 28 years for Ghana's population to double (GSS, 2015). The population density rose from 79 to 103 persons per a square kilometre from 2000 to 2010, signifying more pressure on the existing social amenities and infrastructure, which do not grow at the same pace. The Greater Accra Region is the most densely populated (1,236 per sq km), whilst the Northern Region is the most sparsely populated with 35 per sq km (GSS, 2012).

Ghana has a youthful population consisting of a large proportion of children under 15 years and a small proportion of the elderly persons (65years and above). The urban population constitutes 50.9%. Apart from the Greater Accra and Ashanti Regions, the remaining eight regions are predominantly rural (GSS, 2012).

In terms of ethnicity, the Akans (47.5%) are the predominant ethnic group in Ghana followed by the Mole-Dagbani (16.6%), the Ewe (13.9%), and Ga-Dangme (7.4%). The Mande (1.1%), forms the smallest ethnic group in the country (GSS, 2012).

In Ghana, 71.2% of the population profess the Christian faith, followed by Islam (17.6%). Only 5.2% of the population adheres to the traditional religion or are not affiliated to any religion (5.3%). Apart from the Northern Region where Islam is the predominant (60 %) religion, higher proportions of the population in the remaining nine regions are Christians. The Upper East Region has the highest proportion (27.9%) of members of the traditional religion, followed by the Northern Region (16 %) and Volta Region 14.1% (GSS, 2012). Data from GSS (2015) indicate that the majority (74.1%) of the population aged 11 years and older is literate, of which males form 80.2% more than females (68.5%). The three northern regions have less than 50% of the population aged 11 years and older as literates, whilst the other regions have at least 69% of their population being literates.

Agriculture remains the main economic activity. It is estimated that 54.2% of the population is economically active, out of which 95% are employed. Again, 41.2% of the economically active

population aged 15 years and older are skilled agricultural, forestry and fishing workers. Also, 21% is engaged in service and sales work, whilst 15.2% are engaged in craft and related trade works (GSS, 2015).

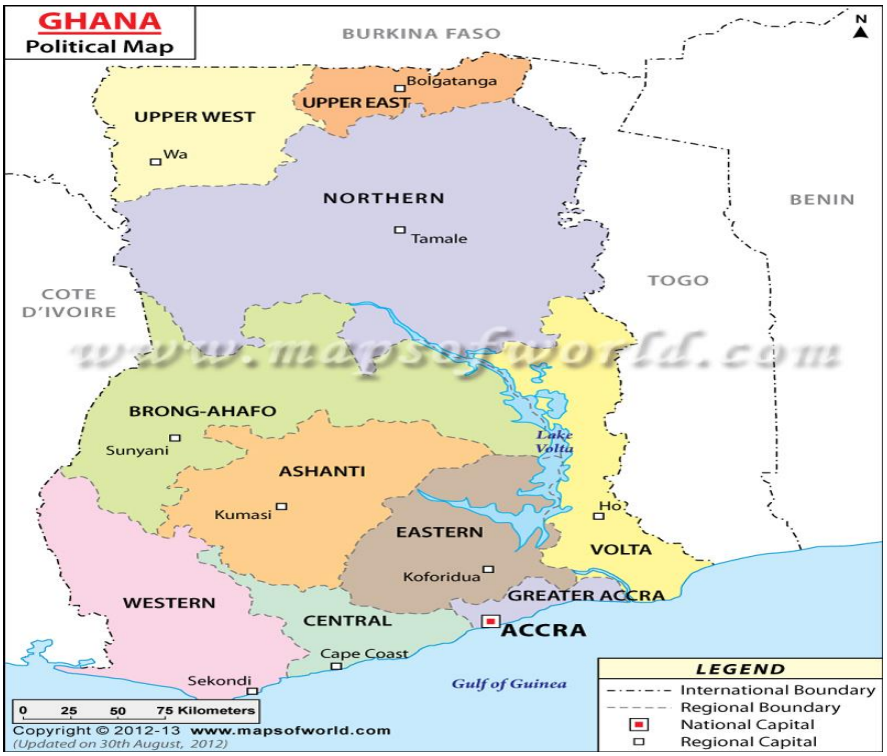

Figure 2.3: Map of Ghana showing the Ten Administrative Regions

Source: World Maps 2014.

The 2014 Ghana Demographic and Health Survey (GDHS) results show that 97% of women who gave birth in the five years preceding the survey received antenatal care from a skilled provider at least once for their last birth. Almost nine in ten women (87 %) had four or more ANC visits. Urban women are slightly more likely than rural women to have received ANC from healthcare professionals (99% and 96% respectively) and notably more likely to have had four or more ANC visits (93% and 82% respectively).

According to GSS (2015), the proportion of live births delivered by a skilled provider and the

proportion delivered in a health facility have increased steadily and substantially since the 1988 GDHS survey. The proportions of women who were assisted by a skilled provider and delivered in a health facility were highest in the Greater Accra Region (92% and 93%, respectively) and lowest in the Northern Region (36% and 35% respectively).

Out of the 78% of women reported having received a PNC checkup in the first two days after birth, the proportion of women is higher in urban than rural areas (87% and 71% respectively). Women in the Northern Region are least likely to have received a PNC checkup in the first two days after birth (57%) compared with 93% in the Greater Accra Region (GSS, 2015).

Data from WHO, UNICEF and World Bank (2015) estimate Ghana's maternal mortality ratio at 319 per 100,000 live births. Total fertility in Ghana stands at 4.2%, with the rural communities producing 5.2% whilst urban communities produce 3.4%. Under five, child and infant mortalities currently stand at 60, 19 and 41 per 100,000 live births respectively (GSS, 2015).

The human resource base of the country in the health sector is not adequate. According to 2010 population and housing census, there are only 1,880 medical officers in the country, 31 dental surgeons, 1,129 pharmacists, 464 medical assistants, 9,775 professional nurses, 6857 auxiliary nurses, and 68 physiotherapists. Amongst others, there are also 57 health educators serving the whole country, and only 41 health research officers (GHS, 2010, 2011, 2012; GSS, 2012). There are only 5 medical schools and 5 teaching hospitals in addition to the regional hospitals. At least each of the 10 regions has a regional hospital and the 170 districts also have at least a polyclinic or district hospital each (GSS, 2015).

Amongst the top ten causes of hospital admissions are malaria, pregnancy and related complications, anaemia, and gynaecological conditions. The first three of top ten causes of deaths in the country are malaria, HIV and AIDS and anaemia which are also associated with pregnancy and childbirth (GSS, 2015).

2.3 Safe Motherhood Interventions in Ghana

The global safe motherhood initiative was established at the Nairobi Conference (1987) and revisited in other international conferences including the 2000 World Summit which formulated the MDGs 4 and 5 for countries to achieve by 2015. In Ghana, successive governments have adopted policies directed towards the achievement of MDG 4 and 5 in line with recommendations by the WHO (1987). Ghana adopted the Safe Motherhood Initiative, as a National Reproductive Health Service delivered through the Primary Health Care (PHC) Programme. The major components of the safe motherhood programme include; antenatal care, labour and delivery care, postnatal care, family planning, prevention and management of unsafe abortions, and health education (Ghana Health Service, 2008). The interventions for making pregnancy safer in Ghana are mostly provided at the grass root level by the various district hospitals, clinics, health centres and posts (Biritwum, 2006). The safe motherhood interventions implemented since 1990s are as follows:

One of the interventions is the Prevention of Maternal Mortality Programme (PMM) which focuses on interventions that improve the availability, quality and utilisation of emergency obstetric care. Activities range from improving services at health facilities to improving access to care (Ghana Ministry of Health, 2007).

Making Pregnancy Safer (MPS) is a major component of the Safe Motherhood Initiative which is delivered through the Primary Health Care Programme. The interventions are in four parts: Care during pregnancy; Care during and after delivery; Postpartum family planning and Community component which includes CHPS, TBAs, Community Empowerment Programme for MPS, and Prevention and Management of Safe Abortion Programme (Ghana Ministry of Health, 2007). The Ghana VAST Survival Programme is an intervention aimed at controlling the problem of Vitamin A deficiency and reducing maternal and child mortality associated with vitamin A deficiency. The programme entails the promotion of Vitamin A as part of standard treatment for

measles, and periodic supplementation for children over 6 months of age and mothers within 4 weeks of delivery.

Another policy is the Maternal Health Project which emphasises the prevention and promotion of safe motherhood interventions, including: dissemination of a revised reproductive health service policy and standards, and protocols for reproductive health programmes; strengthening of institutional capacities to provide essential obstetric care; implementing exemptions for supervised delivery in deprived areas; strengthening post abortion care services; ensuring contraceptive commodity security and intensifying health promotion activities in safe motherhood and family planning amongst others (Ghana Ministry of Health, 2007).

The Intermittent Preventive Treatment (IPT) was also introduced to control pregnancy associated malaria. The programme is based on the assumption that every pregnant woman living in areas of high malaria transmission has malaria parasites in her blood or placenta, whether she has symptoms of malaria or not. The intervention includes: integrating IPT package of interventions within the Safe Motherhood Programme, iron and folate supplementation, deworming, increasing awareness at all levels about integrated strategies of malaria during pregnancy and ensuring that all health facilities/staff in the country are fully equipped to provide IPT with Sulphadoxine-Pyrimethamine (SP) according to national guidelines. Other aspects are regularly assessing the efficacy of drugs used for IPT and regularly assessing the effectiveness of IPT including monitoring side effects (Ghana Ministry of Health, 2007; GSS, 2008, 2009).

The Ghana Roll Back Malaria Programme (RBM) was implemented to give direction and guidance to malaria control activities and four main strategies have been adopted and being pursued to control malaria in conformity with those recommended and promoted by the WHO and the RBM partnership. These include; Improved Malaria Case Management by ensuring prompt and correct treatment of malaria illness at household, community and health facility levels,

Multiple Prevention especially but not exclusively promoting the use of treated nets, prophylaxis for pregnant women, environmental management, improved partnership at all levels of society and focused research for evidence-based decision making for efficient and effective implementation of malaria control (Ghana Ministry of Health, 2000, 2004, 2007).

In 2003 the cash and carry system was replaced with free maternal healthcare policy by the Ministry of Health (MOH) in order to make maternal healthcare services more accessible to meet the deadline of MDGs 4 and 5 (Ofori-Adjei, 2007; GSS, 2008). This policy covers services such as normal deliveries, assisted deliveries including caesarean section and management of medical and surgical complications resulting from deliveries including the repair of vesico-vaginal and recto-vaginal fistulae (Ghana Ministry of Health, 2004). The policy commits the public, private and faith-based health facilities for its success. This policy faced problems of disbursement of funds from the government to the health facilities. It also favoured the rich rather than the poor and could not address maternal health problems as expected (Ofori-Adjei, 2007). Ofori-Adjei's evaluation also indicated that conditions such as poor transport system, lack of medical supplies, distance factors, socio-cultural barriers and preference for TBAs adversely influenced service use. The ineffectiveness of the exemption policy led to the introduction of the Free Maternal Healthcare Initiative which was launched in 2008 under the National Health Insurance Scheme (NHIS). This intervention subsidises health insurance to pregnant women by giving them access to insurance benefits such as comprehensive maternity care with ambulance service and post-delivery family planning services. The Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials (IMMPACT) studies indicated that the fee exemption for delivery policy increased the number of deliveries in facilities especially amongst the poorest and least educated women. However, the quality of service was not significant; especially, the attitudes of all the professionals (from the doctor to the nurse) who were involved in delivery care were

questionable and needed attention (Biritwum, 2006).

To facilitate implementation of the above-mentioned policies, the government through the Ministry of Health and Ghana Health Service has been committed to the construction of roads and improvement of existing ones to link up communities to facilities. The quest for improvement of transport and referral system led to the introduction of the national ambulance service (GSS, 2008). This system is enhanced by development of the telecommunication system across the country which enables easy access to the ambulances and health professionals as well. This programme is also supported by safe motherhood protocol at all levels of the healthcare system. There has been conscious efforts and commitments by the Ghana Government and the private sector to train more health personnel to augment the limited human resource base. In addition, TBAs are being trained on how to facilitate referrals as liaisons, and how to assist at delivery safely (Bawah, 2008; Ghana Health Service, 2010).

The CHPS system was adopted by the Ghana Health Service to make maternal or reproductive healthcare more accessible to women especially in the rural areas. The focus on CHPS became very necessary after evaluation of the free maternal healthcare policy identified distance and cost factors as barriers. This system involves all community members such as men, women, traditional leaders and political figures and health workers to be part in healthcare promotion (GSS, 2008). Upgrading and expansion of existing healthcare facilities are further steps taken to improve maternal healthcare in Ghana. District hospitals are established in almost all the districts. All the ten regions also have regional hospitals. These facilities serve as referral points to other facilities which need the services of specialists. In addition to the regional hospitals there are five teaching hospitals (Ghana Health Service, 2010).

Above all, the creation of Ministry of Gender, Children and Social Protection and the implementation of Girl-Child Education Policy under the Free Compulsory Universal Basic

Education programme were actions directed towards empowerment of women, eliminating gender inequality and making health services accessible to women. Presently, Emergency Obstetric and Neonatal Care is being implemented in all 10 regions, but not yet with full complement of required resources (GSS, 2015).

2.3.1 Challenges to Implementation of the Safe Motherhood Policies

Ghana has not been able to sustain progress made with the interventions over the years. The various evaluation research reports (Biritwum, 2006; Ofori-Adjei, 2007; Ghana Ministry of Health, 2007; GSS, 2008, 2009, 2015) point to the following factors as implementation challenges:

i. Delays in transporting women in labour to referral centres due to poor transport system. The national ambulance service is expensive and ineffective at the district level;

ii. The NHIS does not cover the cost of conveying women in labour to the facilities. The fact that the additional costs of transporting the women in labour together with the responsible TBA to the nearby hospital or health facility are not covered is one of the major factors explaining the reluctance of mothers to deliver at the facility;

iii. Unavailable data set on maternal healthcare for systematic investigation into maternal health and lack of well-structured plans and procedures to check and assess where maternal health programmes are absent; and

iv. Barriers to access to critical health services by families and communities, mainly due to inadequate financial capabilities of families or mothers, long distance to the health facility and low female literacy rate as well as poor health-seeking behaviours amongst the poor, and socio-cultural factors such as men's influence in healthcare decision-making.

Regardless of these shortcomings, there are improvements in ANC, Skilled Delivery, PNC and family planning acceptor rates (Ghana Ministry of Health, 2007; GSS, 2009, 2015), with over 50% of women receiving at least two doses of tetanus toxoid for their recent birth. More women in labour are now receiving delivery assistance from trained medical personnel (GSS, 2015). The adoption of IPT as the strategy for reducing the incidence and complications of malaria in pregnancy since 2003 has also led to sustained improvements and ensured effective risk detection, management of complications and improvement in pregnancy output (Ghana Ministry of Health, 2007; GSS, 2015). Uptake of postnatal care amongst mothers and babies up to six weeks after delivery to maintain the physical and psychological well-being of the mother and child is also on the increase. However, there are wide differences amongst the regions, districts and between rural and urban communities (GSS, 2015).

2.4 Rationale for the Choice of Study Site

The Northern Region of Ghana was chosen for the study based on the rationale that it recorded the highest number of maternal deaths (302) between 2011 and 2012 (Ghana Health Service, 2012; GSS, 2012). The region also recorded the highest percentage (72.8%) of women who had home delivery amongst the ten regions in the country. Aside, as high as 35.5% of the home deliveries in the region were assisted by untrained TBAs (GSS, 2012). The report further shows that 64.4% of the women who had home deliveries had no formal education and 10% of them received their first postnatal care from untrained TBAs. Above all, since the mid-1990s this region has suffered several intra-ethnic and inter-ethnic conflicts which for security reasons prevented researchers to collect primary data especially regarding ethnic and cultural issues. This additionally makes the region a suitable site which will provide insightful data for the study.

The Yendi town (Figure 2.4 below) is the paramouncy of the Dagban Kingdom. It is expected

that traditional beliefs and practices of the Mole-Dagbani ethnic group who form the Dagban Kingdom would be strongly enforced in the Yendi Municipality compared to other districts in the region. Also, the settlements in the Yendi Municipality are discrete indigenous communities (GSS, 2014b). The Yendi sub-District was chosen as an urban zone whilst Gnani sub-District represented rural communities.

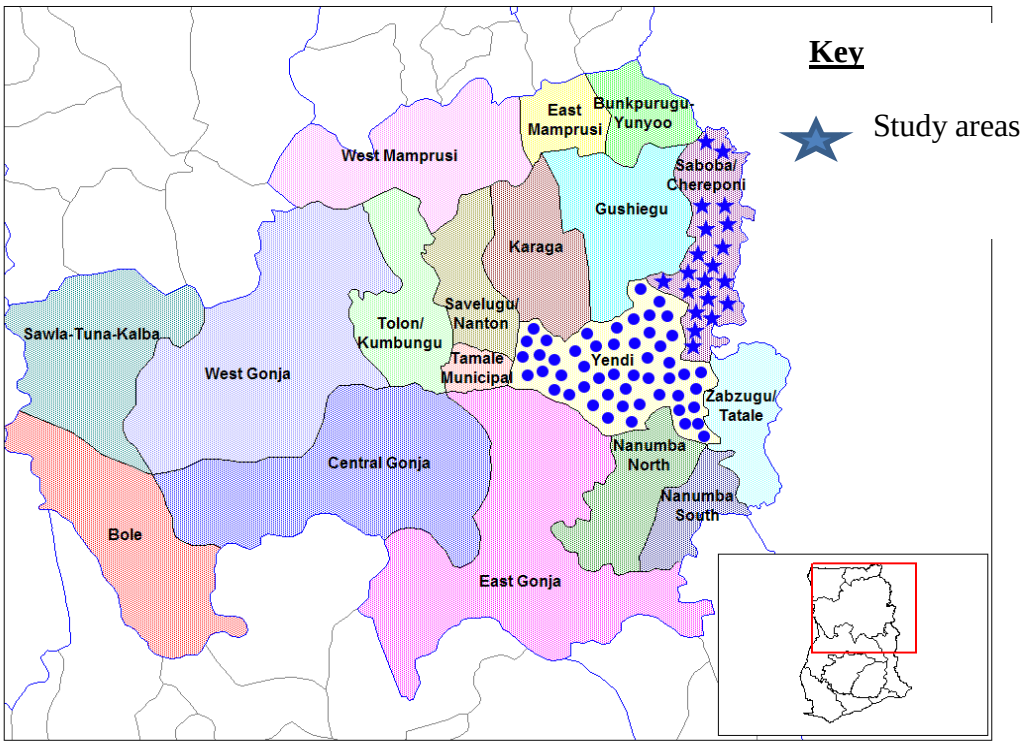

Figure 2.4: Map of Northern Region of Ghana showing the study districts

Source: World Maps 2014.

As a deprived district without a referral health facility and stationed medical doctor, the Chereponi District (Figure 2.4 above), which is a typically rural of over 85% without a tared road (GSS, 2014c) was chosen with the interest of knowing how women receive care in maternity, especially under serious obstetric complications. Aside, even though there are other ethnic groups, the district is dominated by Chorkosis (who are Akans and distinctive amongst the ethnic groups

in the region), to help study how people of different ethnic backgrounds behave towards care seeking in maternity. Selected communities in this district were the Chereponi town and Wenchiki community.

2.5 Conclusions

This chapter presented the profile of Ghana and a brief discussion of the Northern Region, the Yendi Municipality and Chereponi District which are the study sites. The various safe motherhood interventions in Ghana have also been discussed.

Given the statistics of health facilities and the human resource base of the Ghana Health Service vis-a-vis the population of the country, it is obvious that a heavy pressure is mounted on healthcare providers and the facilities. Equally, clients will also suffer stress for delays and long time waiting. These conditions together with other factors are sources of demotivation to both the care-giver and the care-seeker. The worse of it is that, the health personnel and facilities are not evenly distributed across the country. Disparities exist between rural and urban communities, and amongst regions and districts. For example, four out of the only five teaching hospitals in the country are located in the southern sector, with only one for the northern regions.

The youthful nature of Ghana's population means that greater percentage of people are within the sexually active category, which suggests high fertility rate especially in rural areas and amongst the illiterates who might not subscribe to modern methods of birth control. This calls for urgent attention to maternal healthcare in the country. Though successive governments have been committed in instituting measures to improve maternal and child health, some institutional and socio-cultural conditions in the community and facility environments have hampered the success of those measures creating a standstill development. A closer look at the maternal healthcare policy in the population policy indicates sound implementation strategies. However, even though some progress is made, a lot is left to be fulfilled. Analysis of the implementation challenges

points to attitudes of professionals and lack of political will to deal with culture and the demands of clients to encourage service utilisation.

Chapter 3 presents literature review of previous studies, theories and models on maternal healthcare services utilisation. It also presents critical review of previous studies and theories/models as well as the conceptual framework for the study.

CHAPTER 3

LITERATURE REVIEW

3.1 Introduction

Since the mid-1980s research has persistently shown that maternal healthcare services utilisation is a function of both the socio-cultural environment of the care-seeker and the organisational or institutional structures of the care-giver. In recent times, utilisation of maternal healthcare services is viewed from the perspectives of demand and supply (ICRW, 2010). This implies that the care-seeker needs adequate knowledge about pregnancy signs/symptoms and service quality to improve utilisation through regular, timely care-seeking and choosing the best quality from the available services. On the other hand, the care-giver needs to know about the care-seeker's background to meet their demands by suppling quality healthcare services. Thus, the cultural and social organisation of the individual's family, community and the state institutions at large define the option to make in terms of choice of healthcare services (Babalola & Fatusi, 2009; ICRW, 2010; Abel & Frohlich, 2012).

This chapter critically reviews the literature on maternal healthcare and is organised in sections. Section 3.2 presents discussion on previous studies on maternal healthcare, whilst Section 3.3 discusses theories and models of healthcare services utilisation. The conceptual framework for the study is discussed Section 3.4 before the conclusion of the chapter.

3.2 Previous Studies

This section reviews empirical literature on socio-cultural dimensions of maternal healthcare under four main sub-headings. These are gender and maternal healthcare; culture and indigenous birthing practices; socio-economic and demographic determinants; and organisational and institutional conditions. A critical summary of the existing studies is also presented at the end of this section.

3.2.1 Gender and Maternal Healthcare

Gender may be described as socially or culturally constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women. This socially or culturally constructed difference between men and women varies from place to place and time to time. Gender is a central organising principle of societies, and often governs the processes of reproduction (Food & Agriculture Organisation (FAO), 2007). Analyses of gender differences often show a disadvantaged and weaker position of women and girls in all aspects in society (Epstein, 2007; FAO, 2007; ICRW, 2010). The society uses gender as a medium through which low status and discrimination are created which in turn results in inequalities in societies and poor health seeking behaviour for women (Nwokocha, 2007).

The principle of gender roles that regulates the existing social relations between males and females is not only against human rights, but also one of the chief hindrances to human development (UNDP, 2004). In sub-Saharan Africa, some women are subjected to repeated childbearing at short intervals to satisfy their husbands' quest for large family size or sex preference (Magadi & Curtis, 2003). In Ghana, the respect women have for their culture (Nukunya, 2003) subjects them to victimisation of traditional gender norms (Tsikata, 2007).

Empowerment is essential to women's health because it enables women to articulate their health needs and concerns, access health services without delays and seek accountability from service providers (ICRW, 2010; Hagman, 2013; UNFPA & ICRW, 2014). In most developing countries, women's socio-economic status is significantly low to enable them contribute meaningfully to family discourse. Consequently, men take sole decisions that affect members of their families (Nwokocha, 2007). Based on traditional gender roles, women rely on advice from their husbands and parents to take decision on the type of health facility to use (Grieco & Turner, 2005; Mrisho et al., 2007). In Ghana, the power to make decisions in the family rests in the hands of

male family members who usually control resources and the spiritual matters of the family (Nukunya, 2003; Tsikata, 2007). The inability of women to make decisions places male family members and community members in decision-making roles, who often make poor decisions about healthcare during pregnancy and child birth, partly because they do not understand the dangers involved (WHO, 2001).

The contributions of both men and women are required for positive maternal outcomes (Kabakyenga, Ostergren, Turyukira & Pettersson, 2012; Story et al., 2012; Mangeni et al., 2013). If men are better educated on the danger signs of pregnancy and childbirth they could play a life-saving role (ICRW, 2014) by avoiding harmful cultural practices like early marriages through which young women are being forced to marry older men rendering them vulnerable to maternal complications and mortality (UNDP, 2007; WHO, 2013). A positive maternal outcome is a function of joint commitment on the part of the women and their spouses in the areas of decision-making, household roles and general duties (Davis, Luchters & Holmes, 2011; Mitchell, 2012; Story et al., 2012; Mangeni et al., 2013; ICRW, 2014).

3.2.2 Culture and Indigenous Birthing Practices

Reproduction is a life-changing event that is influenced by the physiological as well as the cultural orientation of spouses (Nilsson & Lundgren, 2007). In Lao People's Democratic Republic, cultural traditions and medicinal plants have significant roles during pregnancy, birth and postpartum care in many rural areas (Lamxay, de Boer & Bjork, 2011). In spite of the improvement in access to modern healthcare system, cultural affinity continues to be an important reason for the patronage of the services of TBAs (Sparks, 1990; Maimbolwa et al., 2003; Oshonwoh, Nwakwuo & Ekiyor, 2014). Hence, cultural competence and psychological support are necessary qualities of care-giver to the woman during delivery, which is a source of positive maternal outcome (Sparks,

1990; Asefzadeh, Taherkhani & Ghodosian, 2014). It is necessary that the healthcare system recognises TBAs and purposefully make use of their rich experiences and knowledge during maternity (Sparks, 1990; AbouZahr, 2007). Recognition of TBAs will empower them to play active mediating role between their communities and health facilities for rapid intervention especially during emergency.

Rituals are normally associated with traditional birthing practices (Asefzadeh et al., 2014; Oshonwoh et al., 2014). The maternity period is a crucial period in women's life and is regulated with a collection of knowledge and experiences of the women, husbands, mothers-in-law, mothers and other relatives (Maimbolwa et al., 2003; Nyanzi, 2008). In sub-Saharan Africa, most pregnant women attend ANC at least once, but only a few of them deliver at the hospitals (Kinney et al., 2010). This is because some pregnant women use health facilities to ascertain that their pregnancies are free of complications and turn to home care (Neema, 1994; Sychareun et al., 2012).

The TBAs perform consultative functions in the various communities by examining pregnant women, offer advice and refer them to medical facilities when deemed necessary (Maimbolwa et al., 2003; Nyanzi, 2008). However, delivery supervision differs from community to community due to cultural variations. In Gambia (Nyanzi, 2008) and Ecuador (Soguel, 2009), husbands, mothers and close relatives of the woman normally supervise deliveries. However, in Zambia, aunts and husbands are preferred whilst mothers-in-law are not permitted to witness childbirth (Maimbolwa et al., 2003). In Sudan, in the event of prolonged labour and retention of the placenta, the parturient is subjected to blowing into an empty bottle to facilitate delivery (Asefzadeh et al., 2014), whilst other societies subject women under such circumstances to confession of sins (Senah, 2003; Maimbolwa et al., 2003; Fronczak et al., 2007).

Post-delivery practices also vary from culture to culture. For example, in Sudan, the mother and the newborn are confined and surrounded by a woolen rope and a knife hanged over their heads to protect the baby from evil spirits, and painful breast after birth is treated by rubbing husband's

shoe on the breast of the woman (Asefzadeh et al., 2014).

During parturition, pregnant women are examined by the TBAs to find out whether the foetus is positioned well through vaginal examinations to check cervical dilation (Maimbolwa et al., 2003). The TBAs also give traditional medicine to women to relieve pain during labour, treat abnormal discharges, and to enhance expulsion by helping the woman to push during labour (Senah, 2003; Maimbolwa et al., 2003; Nyanzi, 2008; Soguel, 2009; Sarkodie & Abubakari, 2014).

The traditional vertical system of delivery position is perceived as safer, easy and natural unlike the painful artificial horizontal birthing in hospitals (Soguel, 2009; Burns, 2010; Indraccolo et al., 2010; Mensah et al., 2014). According to Burns, during delivery the body does not need technology but tranquility because it has been naturally conditioned to perform birthing function. In Ecuador, the horizontal birthing system applied in the hospitals is described by the indigenous people as deadly and illogical (Soguel, 2009). Giving birth in a calm environment without medical and technological manipulation is a rewarding and fulfilling experience (Indraccolo et al., 2010).

Medical conditions during pregnancy have spiritual explanations in the traditional setting (Maimbolwa et al., 2003; O'Driscoll et al., 2011; Asefzadeh et al., 2014; Oshonwoh et al., 2014). Therefore, rituals are performed when the woman is in labour, after birth, and weeks later (Maimbolwa et al., 2003; Fronzak, Arifeen, Moran, Caulfield & Baqui, 2007; O'Driscoll, Payne, Cromartey, St Pierre-Hansen & Terry, 2011; Sychareun et al., 2012). Many traditional people believe in superstition, ancestors and witchcraft which influence them to consult spiritualists when women develop complications during pregnancy (UNDP, 2007). In Ghana, herbal concoctions are used as remedies to induce labour and some of these herbs can be toxic. Substances like *mansugo or akpeteshie* (local gin) are normally given to women in labour in order to induce labour and to aid in speedy delivery, whilst *Kalutgotim*, a local herbal preparation often of oxytocic derivation is administered in obstructed labour. This herb enhances labour contractions without a corresponding dilation of the uterus thereby, causing rupture in most women (Senah, 2003). Obstructed labour and

retention of the placenta are associated with beliefs and practices from culture to culture. Across cultures, these conditions are linked to witchcraft, evil spirits, violation of taboos and marital infidelity (Senah, 2003; Maimbolwa et al., 2003; Fronczak et al., 2007). Under such conditions women are subjected multiple vaginal examinations, injection and ingestion of herbal medicines to facilitate delivery (Fronczak et al., 2007). In Bangladesh, most births are assisted by women with some practical experience with little formal training, who usually do multiple vaginal examinations and use injectable oxytocic medications to augment the birth canal (Fronczak et al., 2007).

During obstructed labour women are made to confess extra marital affairs and traditional medicine is given to them so that labour will progress (Senah, 2003; Maimbolwa et al., 2003; Fronczak et al., 2007). When application of herbal medicines after confession fails, the TBAs use a number of techniques to facilitate delivery of the baby or placenta including inserting fingers to remove the baby or placenta (Maimbolwa et al., 2003; Fronczak et al., 2007). This practice may expose the mother, baby and the TBAs to infections especially where sterilised gloves are not used. This may partly explain the incidence of puerperal and neonatal sepses in mothers and babies respectively in developing countries.

The traditional birth setting is evidenced by careful rituals in disposing off the placenta (Maimbolwa et al., 2003; Sychareun et al., 2012). Across cultures, the placenta is buried in a designated place in the house or village following spiritual rules to protect the baby and the mother (Maimbolwa et al., 2003; Sychareun et al., 2012; Asefzadeh et al., 2014).

In Ecuador, the traditional birthing is normally supervised by the TBAs and a spiritualist locally known as *yatchak* with concocting teas and washing waters and ingestion of special infusions. Herbs are used to clean and numb the vaginal area during birth to enhance muscular activity. The *yatchak* (literally translated as he who knows) oversees the spiritual dimension of the birthing process and ensures that it follows ancestral cosmic laws (Soguel, 2009).

To fully understand the attitudes of women towards the utilisation of maternal healthcare

services requires a thorough knowledge of the traditional institutions on how pregnancy is handled in the society. Any scientific idea is always seen as imposition on society and will not yield the desired results where the culture of the people is not taken into consideration (AbouZahr, 2007). In Ghana, cultural as well as religious beliefs play a role in the type of care women receive during the pregnancy-postpartum period. As a result, herbalists, TBAs and pastors or prophets are all engaged in the traditional system of maternal healthcare (UNDP, 2007).

3.2.3 Social, Economic and Demographic Determinants

Maternal healthcare services utilisation is complex and determined by multiple factors from the socio-cultural environment including the organisational structures of the community and the healthcare system. It is common in both past and present studies that women differ in behaviour towards healthcare services utilisation and these differences are normally traced to their background (UNDP, 2007; GSS, 2008, 2009; Abor & Abekah-Nkrumah, 2013; Amoateng, Kalule-Sabiti & Ngake, 2014). For example, mother's age could be used as a proxy for the women's accumulated knowledge of healthcare services, which may have a positive influence on the use of healthcare services (GSS, 2015). However, as a result of modernisation and the new educational policies in recent years, younger women in Ghana are well informed about the need and availability of modern healthcare services and place more value upon modern medicine (Bougangue & Kumi-Kyereme, 2015).

Women from large families tend to underutilise healthcare services because of too many demands on their resources including time (Abor & Abekah-Nkrumah, 2013). For instance, in Ecuador some women do not seek institutional delivery because they want to be with their children and take care of them (Soguel, 2009). Again, income, educational levels, and the involvement of spouses in maternal healthcare contribute greatly to the use of healthcare services by women (GSS, 2008, 2009; ICRW, 2014). Women's involvement in gainful employment is also an important

factor positively affecting the use of quality medical care to treat complications (ICRW, 2014). Women's economic empowerment leads to political empowerment, where they play a role in decision-making discourse on issues concerning their health and that of other family members. This is because when a woman is empowered economically she can also contribute financially in running the home, and therefore, her consent will be needed in decision-making in the household. In Ghana, women's wealth or that of their spouses is positively and significantly associated with choosing health facility for delivery (GSS, 2008, 2009). A woman's level of education has a significant impact on the use of maternal healthcare services (GSS, 2015). Therefore, improving educational opportunity for women may have a large impact on improving the use of such services (McAlister & Baskett, 2006; Hagman, 2013; WHO, 2013; ICRW, 2014). Educated women are more aware of health problems, know more about the availability of healthcare services, and use this information more effectively to maintain or achieve good health status (GSS, 2008, 2009; USAID & CRS, 2012; Hagman, 2013; Esena & Sappor, 2013). In areas where literacy rates are high, social networks may provide women with access to contacts and information on safe motherhood and reduce uncertainty about formal health systems (Abor, 2014). At the individual level, low maternal education, the low status of women, and personal barriers remain important hindrances to improvement of maternal healthcare services use (Gage, 2007). This calls for the need for programmes to educate women on issues concerning appropriate healthcare seeking in maternity (Ononokpono & Odimegwu, 2014). Women of higher parity are less likely to deliver in health facilities because of experiences, and that more children mean fewer resources for medical bills (Galaa & Daare, 2008; Ononokpono & Odimegwu, 2014).

Place of residence is another variable that may affect the utilisation of maternal healthcare services. In most developing countries like Ghana (Bawah, 2008; GSS, 2012), urban dwellers are relatively closer to healthcare facilities than their rural counterparts. Physical proximity of healthcare services plays an important role in utilisation of these services (Grieco & Turner, 2005;

Cannavan, 2008). There is no equity in the distribution of healthcare services between the north and south of Ghana (Bawah, 2008; GSS, 2012, 2015). Most rural based illiterates and poor women in Ghana perceive supervised delivery as an option only for pregnant women who experience deadly complications (Galaa & Daare, 2008).

Religion is another influential variable in maternal healthcare services utilisation. In Ghana, members of Christ Apostolic Faith Church neglect medical care in maternity based on the belief that God is the creator and is capable of healing people of their ailment. They also do not attend ANC to avoid blood transfusion (UNDP, 2007).

Ethnicity influences utilisation of maternal healthcare services because different ethnic groups may exhibit different cultures, values and belief systems which invariably, may affect behaviour, perception and use of healthcare services. In Ghana, due to beliefs in child confinement for protection and the perception that PNC is for weaker women and those who develope complications, the Ewes, Guans and Mole-Dagbani ethnic groups are less likely to utilise PNC services compared to the Akans, whilst Gurma women are less likely to deliver in health facilities (Abor, 2014). A study in Nigeria shows that women in communities with diverse ethnic groups have a lower likelihood of using facility-based delivery services (Ononokpono & Odimegwu, 2014). As society becomes more diverse and complex, improving healthcare services utilisation requires consideration of influence of heterogeneity on individual's health seeking behaviour (Rebhan, 2008).

Data from Bangladesh, India, Pakistan, Kenya, Nigeria, and Tanzania show that more than half of the births in these countries were delivered outside a health facility (Nai-Peng & Siow-li, 2013). Analyses of these data further show that institutional delivery was closely associated with educational level, family wealth, place of residence, and women’s media exposure status. Higher parity and younger women were less likely to use a health facility for delivery and within each country, the poorer, less educated and rural women had higher unmet need for maternal

healthcare services. Service related factors including accessibility and socio-cultural factors also posed as barriers to institutional delivery (Nai-Peng & Siow-li, 2013).

3.2.4 Organisational and Institutional Conditions

In some cases, pregnant women and their spouses may have the resources, knowledge about pregnancy-related complications, and willing to seek professional care during maternity, however, the quest for clinical care may be demotivated by conditions such as distance and transportation problems, material and human factors within health facilities such as lack/inadequacy of drugs/blood, lack of equipment amongst others (AbouZahr, 2007; GSS, 2008, 2009; Turkson, 2009; Esena & Sappor, 2013). In recent times, the collection of informal fees from women in the facilities (Baru, 2013; Banchani & Tenkorang, 2014) is a source of demotivation for clinical services utilisation. Thus, when the provision of care is at odds with local contextual beliefs and experiences, it is likely to be ignored especially when utilisation results in loss of resources, poor service delivery due to resource constraints or when the women experience covert or overt abuse in care settings (Finlayson, Dietrich, Neufeld, Roback & Martin, 2013). A study in Tanzania discovered that lack of confidentiality and rude behaviour in health workers become major challenges to healthcare service utilisation (Pfeiffer & Mwaipopo, 2013). The problem of home delivery will not be solved by focusing merely on improving the formal healthcare system in the form of provision of facilities, equipment and professionals. As discussed earlier on, practices of community members cannot simply change only by facility access. There is the need for frequent in-service training for professionals on handling of women in maternity, focusing on how to motivate women within the facility. The experiences of women in their previous pregnancies either motivate them or discourage them to continue seeking care from the facility (Kumbani, Bjune, Chirwa, Malataand & Odland, 2013; Oleyinka, Osaji, Alade & Egbuniwe, 2014).

Distance to the facility coupled with the cost of transportation is a major factor especially in

rural communities where people walk several kilometres before accessing a facility. The situation worsens during the rainy season when all the access roads which are mostly untarred are not motorable and associated with high transport fares. Many researchers (Grieco & Turner, 2005; Cannavan, 2008; Pfeiffer & Mwaipopo, 2013; Worku, Yalewand & Afework, 2013; Oleyinka et al., 2014) have concluded with recommendations for improvement in transportation system for safe motherhood to be realised. Pfeiffer and Mwaipopo (2013) observed that some women in Tanzania were not patronising the formal healthcare facilities for delivery because the health facilities were located very far away from their communities. Though the Ghana Government has been committed to building roads and providing ambulatory services, some of these roads are not tarred and not serviceable during the rainy season. As a result, private transport owners charge exorbitant fares when women are in critical obstetric conditions. The introduction of the CHPS compounds as a national policy in Ghana was to increase the utilisation of healthcare facilities. However, referral services are not effective due to lack of ambulances at facilities (Turkson, 2009).

Shortage of qualified health workers is a major challenge for accessing essential healthcare in Africa, which suffers more than 24% of global burden of disease, and yet, has only 3% of the world's health workers (Kinney et al., 2010). In Ghana, implementation challenges discovered by Banchani and Tenkorang (2014) were inadequate in-service training, limited knowledge of health policies by midwives amongst others. In-service training is important for professionals to be introduced to modern ways of health delivery and to refresh their minds of what they learned in the colleges. It also forms a source of cultural orientation to health workers in areas where they work. The most cited barrier in developing countries relating to the delays within health facilities in existing literature is inadequate training/skills or mixed, which account for 86% (Howson et al., 2013). Delays in the decision to seek care may be due to the fact that, many health facilities are under-resourced and unable to cope effectively with serious obstetric complications (Combs Thorsen et al., 2012). The health system in Ghana is challenged with infrequent or irregular

supply of drugs and equipment and understaffing (Esena & Sappor, 2013; Oiyemholan et al., 2013; Banchani & Tenkorang, 2014). To ensure effective health delivery, the health system has to put in place concrete and practicable measures on both the demand and supply sides to enhance effective and quality healthcare delivery (Nai-Peng & Siow-li, 2010).

3.2.5 Critical Summary

In the preceding sections, empirical studies on utilisation of maternal healthcare services has been reviewed and categorised into four sub-themes; gender factors, culture and tradition, social, demographic and economic factors, and organisational or institutional conditions.

The major factors in these themes are embedded in the theories and models of healthcare services utilisation. These theories recognise social, cultural and political structures, which affect the individual at the agency level in the use of healthcare services. The four main themes influence a woman's utilisation of healthcare services in the various stages of maternity as they are inter-connected and interact to influence health services use.

The review of the literature concluded on cultural environment, family and community networks and accessibility to services as important determinants of maternal healthcare service use with gender playing key role at all levels. Maternal healthcare services utilisation which forms the central theme across the literature is composed of ANC, skilled delivery (SD) and PNC. However, these stages have been treated and discussed individually in the literature. As indicated in Figure 2.3 on page 53, they are not isolated stages but inter-connected like a system to impact women's health in maternity. Therefore, these inter-connected stages of maternal healthcare system need to be understood holistically. The literature presents a limited discussion to the individual stages of the maternal healthcare system. Premised on the fact that each stage impacts other(s) and the total health of the woman, her foetus or her child (Nwokocha, 2007), ANC and PNC must equally be treated with urgency as important stages in maternity like the delivery stage. Again, normal

check-ups for screening or any uncomfortable conditions in these stages should be considered as serious issues. This is not adequately addressed in the literature.

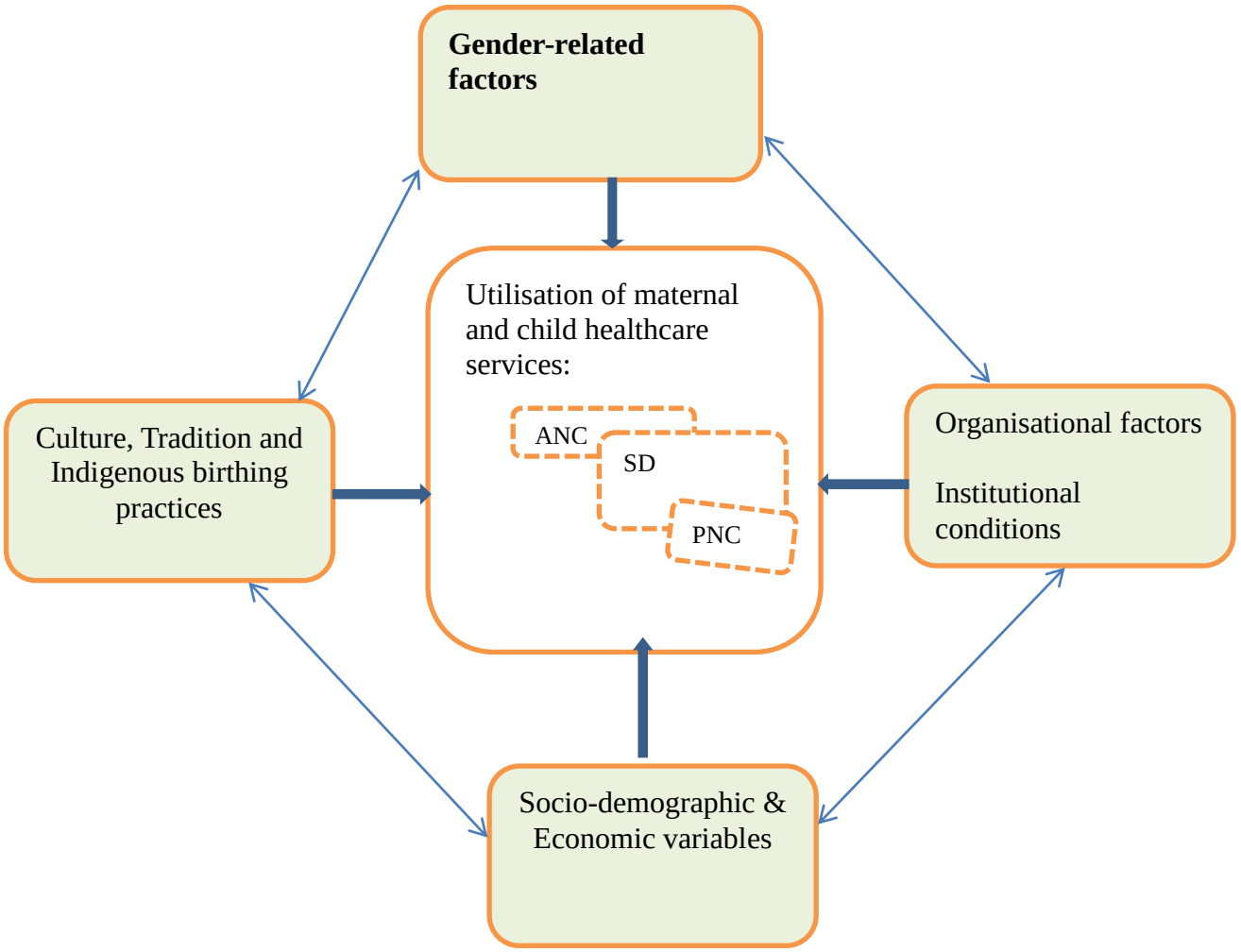

Figure 2.5: Thematic Illustration of Maternal Healthcare Services Utilisation

The focus of maternal healthcare is centred around emergency obstetric care or delivery, thereby, overlooking other equally important medical conditions like sexually transmitted infections (STIs) screening and treatment, which can also harm both the mother and child. Screening and treatment of infectious and parasitic diseases or other health conditions cannot be neglected in maternal healthcare because they have cumulative effects on the final outcome. Though, the safe

motherhood interventions in Ghana recognise the three stages, delivery of care at the implementation level is more skewed towards skilled delivery - i.e, relaxed towards ANC and PNC. However, the outcome of delivery could be linked to the type of care given to women during pregnancy, which also has implications for postnatal maternal and child health.

The use of traditional medicine has been extensively researched and discussed with more attention focused on the TBAs, the majority of whom are women. Hence, they overlook the activities of the male traditional practitioners (herbalist, sooth sayers, priests etc). It is usually men who control the spiritual affairs within the family and the community (Nukunya, 2003). The activities of the TBAs often reflect the culture of the society (Nyanzi, 2008), but cultural preservation of every society is enforced by men. Again, though the literature recognises gender issues, the practices of the TBAs are not linked to gender. The existing literature assumes that the TBAs prepare the herbs and administer on their own, free from male influence. However, mostly TBAs are women whose powers may be customarily limited to men especially in patriarchal society. The TBAs mostly give assistance to women at delivery and the issue of who initiates or contracts the services of TBAs is not adequately addressed in the available literature.

The next section turns to a critical review of the theories and models of healthcare services utilisation.

3.3 Theories and Models of Healthcare Services Utilisation

The theoretical and conceptual issues discussed relating to healthcare services utilisation include review of Andersen's health behaviour model (1995), the structure and agency theory (Giddens, 1984; Germov, 2014), the gender empowerment framework (ICRW, 2010), and the three delays model (Thaddeus & Maine, 1994). Further, there is a brief critical summary of the reviewed theories and models. In addition, the conceptual framework for the study is discussed.

3.3.1 Andersen's Model

The most widely used model in healthcare research is the Andersen's Model (Rebhan, 2008; Babitch et al., 2012). This model discovers and measures conditions that either facilitate or impede utilisation of healthcare services (Andersen, 1995; Andersen & Newman, 2005; Porteous et al., 2015). An individual's access to and use of healthcare services is considered to be a function of three characteristics; predisposing factors, enabling factors and need factors (Andersen, 1995; Porteous et al., 2015).

The predisposing factors comprises the socio-cultural characteristics of individuals that exist prior to their illness such as the social structure including education, occupation, ethnicity, social networks, social interactions, and culture, and the health beliefs, attitudes, values, and knowledge that people have concerning and towards the health care system as well as demographic factors like age and gender. However, the enabling factors refer to the logistical aspects of obtaining care at the personal/family level such as the means and know-how to access health services, income, health insurance, a regular source of care, travel, extent and quality of social relationships. It also involves the community in terms of available health personnel and facilities, waiting time as well as genetic and psychological characteristics of the individual.

The need factors are the most immediate cause of health service use, from functional and health problems that generate the need for health care services. Perceived need will better help to understand care-seeking and adherence to a medical regimen, whilst evaluated need will be more closely related to the kind and amount of treatment that will be provided after a patient has presented to a medical care provider (Andersen, 1995; Andersen & Newman, 2005). Thus, perceived need explains how people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether they judge their problems to be of sufficient importance and magnitude to seek professional help (Andersen, 1995; Rebhan, 2008) whilst evaluated need represents professional judgment about

people's health status and their need for medical care.

This model recognises biological/genetic factors, worldviews and health beliefs of people and alternative system of healthcare. In addition, the model views utilisation of health care services from economic, epidemiological and sociological points of view (Rebhan, 2008). Moreover, it has been subjected to peer scrutiny and review, and proven to be the most applicable and extensively used model in health services utilisation in different environments and continuously gaining more grounds in health research in both developing and developed worlds (Rebhan, 2008; Babitch et al., 2012). Further, the model attaches importance to individual differences, quality care, consumers' satisfaction and provides opportunity for evaluation/assessment of the healthcare system. However, despite its wide acceptance and usage, this model is more inclined to quantitative studies and has been used mostly in secondary data analysis (Babitch et al., 2012), with the tendency of discovering and measuring determinants of healthcare services utilisation. As a result, its application is limited in the present study which is purely qualitative.

3.3.2 The Structure and Agency Theory

There is a standing debate over the extent to which human behaviours are determined by social structure (Germov, 2014; Raffiee & Mirzaee, 2014). Structure may be described as the recurring patterns of social interaction through which people are related to each other (Germov, 2014). In contrast, agency is defined as the ability of people, either as individuals or groups to influence their own lives in the society. An agent is an individual who takes action to effect changes, and whose behavioural outcomes can be evaluated in terms of his or her own values and goals (Sen, 2001). Whilst agency may be referred to as choices made within social structures in a society, structures are about differences in power that empower individuals and classes differently (Abel & Frohlich, 2012). This means that people within the same environment may have different opportunities within given social structures. Thus, structure is the arrangements within a given

society which influence the choices and opportunities available to individuals. Agency however, is the capacity of persons to act by making their own free choices. The structure-agency debate is an issue of socialisation against autonomy in determining whether an individual acts as a free agent or in a manner dictated by social order (Abel & Frohlich, 2012; Raffiee & Mirzaee, 2014).

The debate over the primacy of structure and agency in influencing the behaviours and the conditions of individuals in society has generated arguments from three different philosophical viewpoints (Abel & Frohlich, 2012; Germov, 2014; Raffiee & Mirzaee, 2014). Whilst some social theorists like Karl Marx believe that it is the social structures that shape humans by causing people to behave in a particular manner, others like Weber & Popper are of the view that it is the agency that is responsible for human behaviour. Placed at the centre of these two groups is another group of philosophers such as Giddens & Germov who theorise that there is interaction between structure and agency, and that both structure and agency are capable of influencing human behaviour.

In spite of the controversies, most sociological theories can be located in the category that emphasise complementarity of both philosophies. The UNDP (2011), ICRW (2010, 2014) and the WHO Commission on Social Determinants of Health recognise the interaction between social structure and agency. Germov (2014) maintains that there is no conclusion to the debate on structure and agency, but it is helpful to recognise that humans influence society and are at the same time influenced by society. Germov argues that although in countless ways our actions and thoughts are shaped by our social environment, humans have the capacity to think and act to change the society into which they are born.

Within the same society people with equal capabilities will not necessarily produce equal outcomes because of different preferences and values. However, those outcomes occur because of differences in people's choices rather than their constraints on their abilities to exercise their choices. Inequalities in status are not just when the social systems disadvantage specific groups of

people because of gender, race or birthplace (UNDP, 2011).

McLaren, McIntyre, and Kirkpatricks (2009) argue that not all interventions influence social inequalities in health in the same way. Influence depends on whether the strategy is structured or agentic as structured strategy targets the conditions in which behaviour occur and agentic, the behaviour change amongst individuals. Germov (2014) also maintains that structure and agency are not propositions in the form of a choice between constraints and freedom, but are part of the interdependent processes of social life. According to him, social structure should not be perceived as negative and only serving to constrain human freedom because in many ways structure enables individuals to live, by providing healthcare, welfare, education and work.

Frohlich and Potvin (2008) contend that one of the most important contribution to sociology is structuration theory, which is based on the idea that both structure and agency give rise to people's behaviour. On issues of vulnerability, they argue that some groups are vulnerable with regard to their agency, their position with regard to their social structure and their social practices. Therefore, it is only by focusing on all these that one would be able to reduce social inequalities in health. According to McLaren et al. (2009) participatory strategies may ultimately be agentic if structured conditions are not addressed. However, Frohlich and Potvin (2008) maintain that participation is a means by which resources are redistributed; with a deliberate intention of providing how the dominant structures of society can be bypassed and the voices that seldom listened to be heard. This agrees with the argument that participatory planning is a public health intervention that aims to correct resource imbalance (ICRW, 2010; UNDP, 2011).

3.3.2.1 Structuration and Health Inequalities

Global attention on health inequalities began to be more serious in the mid1980s after the publication of thought provoking articles by Rosenfield and Maine (1985), Harrison (1985), and WHO (1986) to alert the world on the state of women's health during pregnancy and childbirth.

Since then reduction of health inequalities has remained central as evidenced by the first Safe Motherhood Conference in Nairobi, Kenya in 1987, the 1994 Cairo Conference, the fouth world conference on women in Beijing, the 2000 World Summit and the 2014 World Women's Conference in Paris. Both structural conditions and individual agency were identified by these conferences as influential to health inequality for women in reproduction.

In the quest towards the reduction of inequalities in health, enabling individuals to act in favour of their health remains a concern in health promotion programmes. Knowledge about the role of the social structure in human behaviours helps to understand patterns of social structure and how they influence health (Abel & Frohlich, 2012). From the Marxian philosophy, it could be stated that structure causes inequality in society as the social structures cause inequality in distribution of resources and opportunities in different dimensions of the society including inequality in access to healthcare services (UNFPA & ICRW, 2014). Inequalities in access to health information and services are partly associated with high mortalities amongst pregnant women in especially developing countries. Consistent with GSS (2008, 2015), Kinney et al. (2010) observe that in sub-Saharan Africa, there is equity gap in coverage, access to health services and quality of health delivery system amongst various segments of the population or different classes of people.

Medical sociologists have also dealt with the structure-agency debate on health inequalities. In recent times, there is unanimous recognition, that concerns regarding the production and reproduction of health inequalities must consider both the social structure and individual agency (Abel & Frohlich, 2012). For instance, whilst the ICRW (2014) calls for structural changes in the provision of education, economic and social opportunities to improve women's access to maternal healthcare services, the centre also calls for adoption of practical strategies at the individual level to facilitate safe motherhood.

Abel and Frohlich (2012) argue that a major contribution of Weber's work to a critical

understanding of life style is the acknowledgment that people's choices are constrained by the material resources and normative rules of the community or the status group to which they belong. Weber's analysis has been criticised as being deficient in explaining the nature of differences in social patterns in healthy life styles (Abel & Frohlich, 2012). To address this insufficiency, Bourdieu (1984) proposes a strong connection between the possession of different forms of capital and the choices individuals have to make. Bourdieu argues that the unequal distribution of structurally-based capital resources is a basic system of inequality in societies which is a product and a major process of social reproduction of power and privilege.

Bourdieu (1984) recognises three main forms of capitals (social, economic & cultural) which are inextricably linked and interact to contribute to reproduction of social inequalities and power distribution in society. It is argued that none of the three forms of capital alone can fully explain the reproduction of social inequalities alone as it takes the interaction between the three to permit for social inequalities to endure over time (Abel & Frohlich, 2012).

Based on the understanding of the structure-agency processes, alternative approaches to health promotion should be focused on promoting "structurally transformative agency". An example is community structures that allow for citizens' participation and increased autonomy in community health matters (Abel & Frohlich, 2012).

In recognising the importance of the structure and agency interaction, the health researchers now call for removal of factors at the structural level which create inequalities and develope or strengthen the agency level through empowerment to ensure effective utilisation of maternal healthcare services (CSDH, 2010; ICRW, 2010; UNDP, 2011; Germov, 2014; UNFPA & ICRW, 2014). At the structural level, there is unequal governmental allocation and distribution of resources such as medical facilities and personnel; creating inequalities between different groups within the society e.g, rural-urban, between regions, the poor and rich and men and women (UNDP, 2011; Baru, 2013; ICRW, 2014; Germov, 2014). According to the UNDP (2013), whilst

both males and female face health disparities, girls and women continue to experience a majority of health disparities. This comes from the fact that patriarchal cultural ideologies and practices have structured society in a way whereby women are vulnerable to abuse and mistreatment, which makes them prone to illnesses and early deaths. Though women have longer life expectancy, they are restricted from receiving many opportunities, such as education and paid labour that can help them improve their accessibility to better healthcare resources (ICRW, 2010; UNDP, 2011).

The capability approach (Sen, 1993, 1999) has been suggested as being potentially important for understanding of inequalities in health and for public health action towards reducing social inequalities (CSDH, 2008; Marmot, 2010; Ruger, 2010). According to Robeyns (2005), the core of the capability approach is its focus on what people are effectively able to do or what they are based on their capabilities. The perspective for collective action for a change allows for linking the capability approach to the current sociological discourse on the role of agency and in particular, to the concept of structurally transformative agency (Abel & Frohlich, 2012).

In applying the capability approach to explain health inequalities, Nussbaum (2005) admitted that feminism is multi-faceted. Whilst recognising the need for a universal approach to battle injustices against women, she argues that it is imperialistic to make universal claims about fundamental human principles. Nussbaum's point of argument clearly illustrates the line between the respect for and preservation of a culture, and the conflicting agenda it has in emancipating women from patriarchal structures. Basically, Nussbaum seeks to make fundamental human right universal for both men and women so that they both benefit the good of the structures. By identifying the crucial elements of a "good" human life, her proposition tries to neutralise the debate between respecting culture and the imperialist nature of applying universal principles. Whilst acknowledging cultural preservation, Nussbaum calls for a breakdown of structures that create inequalities in access to healthcare information and services between men and women.

3.3.3 Gender Empowerment Framework

This framework was developed by ICRW (2010) for measuring the determinants and barriers to maternal healthcare services utilisation. The model functions on the assertion that a mix of economic, socio-cultural and gender-related factors shape women's health-seeking behaviour, their demand for maternal healthcare services, and their ability to access such services. The framework measures the experiences of women by explaining how structure and agency interact to influence maternal healthcare (ICRW, 2010). Whilst considering poverty as a key determinant of maternal mortality and morbidity, the model perceives poverty as a consequence of gender inequality, which is located in social structures and operates at the individual and collective levels through discriminatory socio-cultural ideological norms. The model also considers effective use of maternal healthcare services as a consequence of the forces of demand and supply of healthcare services.

On the demand side, these strategies range from the removal of user fees to the provision of conditional or unconditional cash transfers. On the supply side, delivery of services is shaped by financial, physical and human resources to provide sustained, high-quality, accessible and affordable care (ICRW, 2010). Figure 3.1 on page 65 shows at its base the kinds of broad strategies needed to increase utilisation by enabling women to overcome barriers posed by poverty and gender inequality both of which are consequences of the social structure.

From the supply side, strategies designed to increase utilisation include performance-based incentives for providers and contracting private organisations to provide maternal healthcare services. Strategies that empower women to become active healthcare consumers are also needed but are much less common. They include education, employment, social networks and increased mobility. They are shown at the intersection of poverty and gender inequality because they simultaneously help women to overcome both the poverty and gender inequality barriers to healthcare utilisation (ICRW, 2010). For the individual woman, poverty and gender inequality are

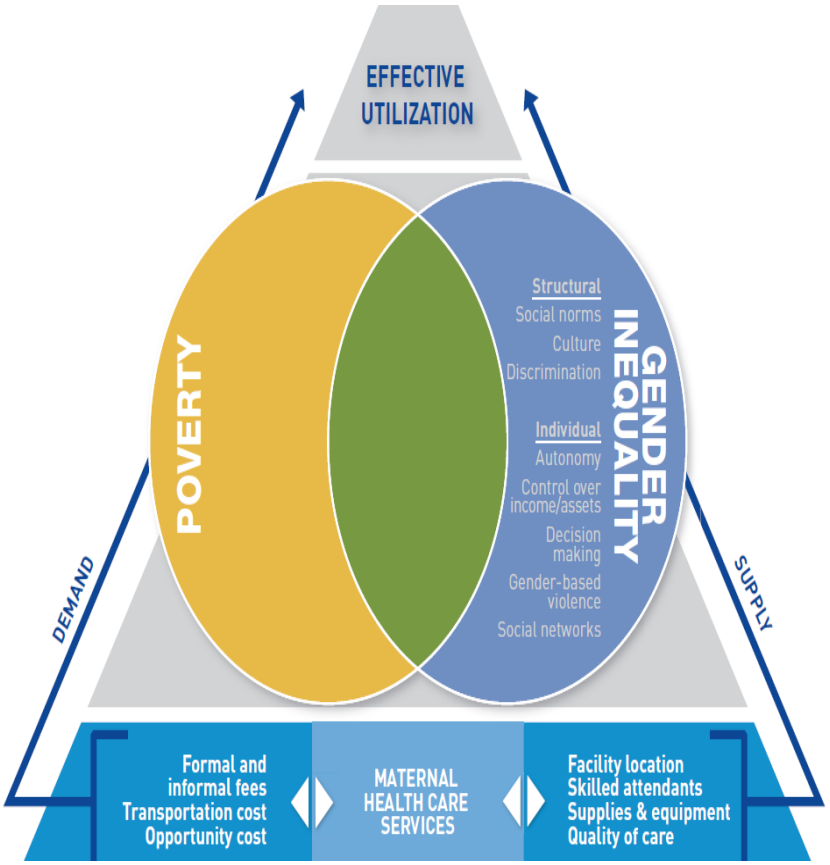

Figure 3.1: Empowerment Framework

Source: ICRW, 2010 pp.6

key factors affecting demand for healthcare services. These variables form the centre of the factors that influence effective utilisation, both because of their importance and because they act as barriers or filters that mediate an individual woman's ability to translate demand into effective utilisation. Many of the factors affecting women's individual agency play out at the household and community levels and are, in turn, socially reinforced. Together, they influence a woman's empowerment or disempowerment, and her ability to effectively use maternal healthcare services (ICRW, 2010; UNDP, 2011; Germov, 2014).

The circles in Figure 3.1 overlap because poverty is closely interlinked with gender inequality. However, gender inequality can affect women's demand for services at all socio-economic levels. Two sets of factors contribute to gender inequality:

i. Institutional or structural factors such as culture, social norms and discrimination that, in turn affect women's individual ability to act on their own behalf (agency) and

ii. The factors that affect individual autonomy, ability to make decisions (e.g., to seek care, engage in social interactions, move freely outside the home, etc.), control over vital resources (e.g., income and assets, time, etc.), and gender-based violence (Farmer, 2006; ICRW, 2010; Dayal, 2013).

3.3.4 The Three Delays Model

This model identifies and explains how socio-cultural conditions mediate to influence maternal healthcare services utilisation (Thaddeus & Maine, 1990, 1994; Combs Thorsen et al., 2012). Speedy intervention is essential in the management of obstetric emergencies (UNDP, 2007; GSS, 2015). The position of this model is that, the ability of the healthcare system to effect rapid intervention is usually mediated by socio-cultural factors (Thaddeus & Maine, 1990, 1994; Waiswa, Kallander, Peterson, Tomson & Pariyo, 2010; Combs Thorsen et al, 2012). Thaddeus and Maine, the proponents of this model, identify three delays namely; the delay to seek care (Delay 1), the delay to reach proper medical services (Delay 2), and the delay in accessing quality care at the facility (Delay 3).

The delay to seek care is normally referred to as delay one. Timely reception of care especially in emergencies by the woman lies in the woman's ability or her care-giver's ability to recognise a medical condition, or its severity for intervention. This also depends on whether the medical resources are in the position or ready to offer timely care. Thaddeus and Maine (1990, 1994) maintain that the inability of the woman or the care-giver to quickly recognise a potentially severe medical condition will result in delays in taking appropriate decision or seeking appropriate care, which in turn results in delays in professional intervention. The model holds that when the woman or her care-giver after appreciating that the condition needs care perceives available

facilities to be in the position of providing quality care, they will go for medical care. However, where the care quality cannot be guaranteed by the woman or the care-giver, reception of care may delay.

Taking a quick action at this level depends on the decision by the woman or her care-giver, which is informed by their knowledge about the condition, their perception of the severity of the condition, and their beliefs around pregnancy and childbirth. For instance, it is a norm that pains at the onset of labour must be borne with stoicism until the foetus is ready for expulsion. In some instances, pregnant women regard small amount of blood discharge as normal (Senah, 2003). In Bolivia, women of the Aymara and Quechua indigenous groups see bleeding as a normal cleansing process, and this may lead to a protracted excessive bleeding (WHO, 2001). This non-recognition of EoCs (emergency obstetric conditions) resulting from worldviews and cultural beliefs can be fatal. In traditional communities, over reliance on husbands and family heads for money and decision-making may end the woman who needs medical care in home care, either to conform to societal norms or for fear of poor quality care from the professionals.

The delay to reach proper medical services is delay two. This delay often occurs after the need to seek professional care or an emergency situation is appreciated and the decision to seek care has been reached, but the action to move is delayed or hindered by difficulty in transportation such as poor roads or in some areas no road network for cars to use, lack of means of transport, and the cost of transportation, which is compounded by long distance to the facility.

Delay three is the delay in accessing quality care at the facility. This delay is associated with the delays in obtaining care within the health facility after the woman has finally located the facility. These delays are normally due to inadequacy or lack of facilities, equipment (blood banks, laparotomy set, autoclaves) and professionals (obstetricians, gynaecologists, anaesthetists, midwives) as well as difficulties in obtaining medical supplies or regular supply of electricity and

water. Within the health facilities, women who have been referred from other facilities or the traditional practitioners are subjected to long waiting periods. Sometimes, the private maternity homes, the district and regional hospitals may delay intervention due to some problems peculiar to them.

The midwives may lack the skills required in the use of special life-saving instruments and other modern obstetric techniques. The professionals may also delay referrals especially in private facilities for financial reasons hoping for spontaneous delivery (Senah, 2003). The problem is compounded by lack of ambulances and other necessary medical equipment and supplies to handle obstetric emergencies. The facility-based delays take the form of delay in providing appropriate care at the initial facility, delays in transferring women to other facilities for specialist care, and delays in providing appropriate care within the facility to which the woman is referred (Thaddeus & Maine, 1994).

3.3.5 Critical Review of the Theories and Models

Whilst the theories and models provide detailed information for understanding the complexities of healthcare services utilisation and inequalities, they have some limitations. The structuration theory does not adequately address culture and its influence on humans, especially women towards healthcare services utilisation. However, "to understand how social practices are sustained over time, researchers need to study the particular setting in which they take place, rather than ignoring or seeking to control this setting" (Jones & Karsten, 2008, p.135). Healthcare system structures should be examined in "culture-specific context". This is because there is no unitary meaning for constraint in social analysis since "a variety of different types of constraint may enable or restrict individuals in a particular setting" (Jones & Karsten, 2008, p.135).

It is argued that all human beings are knowledgeable agents (Giddens, 1984; Jones & Karsten,

2008). However, individuals vary in their levels of knowledge, experiences and reasoning capabilities as well as in values and orientation. Much as individual differences are not adequately addressed, the structuration theory also overlooks cultural factors (Wafa & Jamel, 2013), but cultural behavioural codes are very influential especially in maternal healthcare services utilisation. Structure and agency philosophy tends to centre more on the individual, however, according to Wafa and Jamel (2013), the power of the individual is limited and all transformation requires a number of individuals to act together. Women may be knowledgeable about pregnancy and related complications as well as the need to attend hospital but based on their cultural beliefs they may choose to seek spiritual healing or traditional herbal care. Aside, the ability of the knowledgeable and conscious individuals to act and influence social structures depends of the level of empowerment of the individual. It is worth saying that not all women and people from all backgrounds can have opportunities and capabilities to occupy spaces within structures and effect changes by making free choices. Thus, the free choices to make as stated in the structuration theory are not "freely free". Only the "empowered' will have capabilities in the form of power, resources or voices to influence structures in society and choose alternative healthcare services other than what is prescribed by the social setting.

The gender empowerment framework contains the three central components of health utilisation theories and models - that is, culture, social networks and accessibility (Rebhan, 2008). Also, it contains variables such as informal fees, demand and supply factors, and difficulties in acquisition and supply of drugs which are emerging and showing significant importance in recent healthcare services utilisation research. Although relevant for the study, the model fails to indicate the interaction between structure and agency, thereby, treating them as separate entities. If effective utilisation of maternal healthcare services is a function of demand and supply, and supply is on the side of structure whilst demand on agency/individual side, then there should be interaction between structure and agency as the dualism theory holds (ICRW, 2010; Baru, 2013;

Germov, 2014). In addition, the biological/genetic factors of the individual are not considered in the model. Women are different in physiology, response to health conditions and in reasoning. Implying that with equal opportunities to resources women will still behave differently towards healthcare. Again, the model does not include epidemiological issues, thus, centred on only structural inequalities, poverty and maternal healthcare. Furthermore, the framework places emphasis on economic factors, and can best determine the function of its variables through measurement of those variables, which is more inclined to quantitative research.

Originally, the delays model was designed for emergency obstetric care (EoC) and has been commonly used to explain why delays occur in accessing EoC. The original model does not adequately address issues regarding ANC and PNC because the model assumes that delays are linked especially to delivery or EoC, which are usually the outcome of the direct causes of maternal deaths. It does not take into account that in the absence of obstetric complications a woman might be carrying a medical condition which may not be known and may delay in seeking ANC or PNC. Moreover, the direct causes of maternal mortality such as anaemia, hypertension, and HIV and AIDS amongst others are not regarded as emergencies (Combs Thorsen et al., 2012). However, these conditions also require timely and appropriate management during the maternity period if the woman and her foetus/baby are to have good health because obstetric conditions are products of these medical conditions. For instance, timely ANC screening allows for detection of HIV and AIDS for prevention of mother to child transmission.

For comprehensive data analysis, the model needs to consider all the three stages (ANC, Skilled Delivery and PNC) of maternity as equally important without limiting care seeking to only emergency obstetric care (EoC) and delivery. That is maternal healthcare needs to be considered as a system with ANC, skilled delivery and PNC as individual parts which are inter-connected. Therefore, the model should function by linking up these three stages, which form individual parts of maternal healthcare system. This is not well addressed in the previous

model and existing studies have treated the stages separately. The rationale is that, analysing each stage of the pregnancy-postpartum processes as separate entities will only produce findings related to these stages as individual parts.

Table 3.1: Critical Summary

Theory/Model	Key Themes	Critique
Structure and Agency (Giddens, 1984; Germov, 2014)	Both structure and agency shape human behaviour Everybody is regarded as knowledgeable and agents of change Individualistic Empowerment is key to reducing inequality	Does not adequately address cultural influences on behaviour towards health services utilisation. Healthcare system structures should be examined in culture-specific context Does not consider individual differences. People differ in knowledge, experience, reasoning capability as well as in personal and cultural values. Socio-cultural behavioural codes are more influential than agentic values. Empowerment alone may not reduce inequality. Both empowerment and cultural emancipation required.
The Gender Empowerment Framework (ICRW, 2010)	Measures determinants and barriers to maternal healthcare services utilisation Regards maternal healthcare services utilisation as a function of demand and supply Explains how structure and agency influence maternal health care Poverty is considered a key determinant of maternal mortality and morbidity and a consequence of gender inequality Gender inequality is located in socio-cultural ideological norms	Does not clearly indicate interaction between structure and agency, thereby presenting them as separate entities. Forces of demand and supply not completely explained as they are not directly linked to structure and agency Does not consider individual differences. Women differ in physiology, response to medical conditions, reasoning and culture Places strong emphasis on economic factors Considers poverty as an outcome of gender inequality which is not universally applicable because both husband and wife could be poor.
The Delays Model (Thaddeus & Maine, 1994; Combs Thorsen et al., 2012)	Identifies and explains socio-cultural conditions that mediate to delay or deny women's access to maternal healthcare services	Centred on EoCs which are the end points of direct causes of maternal mortality Direct causes of maternal mortality and morbidity not considered as emergency. These conditions also require timely interventions Inter-connectedness of ANC, delivery and PNC not emphasised

However, a different response will be generated when their inter-connectedness is emphasised (Nwokocha, 2007). By considering maternal healthcare as a system, any pregnancy-related condition in the pregnancy-postpartum continuum is treated as important, and equally requiring timely intervention by health professionals. Thus, maternal healthcare is perceived as a system, with the individual stages forming parts of the whole - implying, that in analysis, poor ANC affects delivery and the health of the woman after delivery. Evaluating maternal healthcare in totality requires a complete analysis of all the stages as a system. This critical review is summarised in Table 3.1.

3.4 Conceptual Framework

This study is guided by the structure and agency (SA) theory inclined to Giddens' dualism philosophy (1984) and the three delays model. As indicated earlier on, the SA theory has been widely used in different disciplines in the social sciences to explain how social, cultural and political structures constrain the individual at the agency level or influence their behaviour, and in turn being shaped by human actions. In recent times, in recognition of the influence of social and structural injustices especially towards minority groups in society, the SA theory is being used as a suitable framework to explain constraints and health inequalities (UNDP, 2011; Baru, 2013; ICRW, 2014; Germov, 2014). Apart from adopting the homogeneous sampling technique of the purposive sampling to select only women, the use of the delays model in previous studies concentrated heavily on emergency obstetric complications, neglecting the direct causes of maternal mortality and other medical conditions which produce the emergency complications. Again, the inter-connectedness of ANC, delivery and PNC are not emphasised in the previous studies. Given that previous studies which centred more on quantitative methods overlooked maternal healthcare as a holistic issue and at the neglect of the role of men, traditional practitioners such as herbalists, spiritualists as well as the techniques employed by the TBAs in

the traditional medical care, it becomes necessary for this study to find answers to the research question; What, if any, socio-cultural structures and conditions associated with pregnancy and childbirth determine utilisation of maternal healthcare services in the Northern Region of Ghana? Answering this question calls for a comprehensive qualitative data from the key actors in maternity care such as women and their spouses, traditional practitioners including TBAs and the healthcare professionals for a balanced discussion. To direct this study to its focus requires a suitable theoretical model that identifies how socio-cultural contexts including the structure of the society and social relationships create social stratification and assign individuals to different social positions and roles. This therefore, informed the choice of the SA theory and the delays model as the conceptual framework for this study. The limitations of the SA theory in healthcare research mentioned in Table 3.1 are taken care of by the delays model which is a culturally sensitive model.

The two models are compatible as they both recognise the interaction between structure and agency. The SA theory provides a conducive platform for analysing the distribution of access roads, healthcare facilities, equipment, drugs and health personnel. It is able to analyse inequalities in access to health services amongst different segments of the population. The delays model is able to analyse socio-cultural structures within households and at community level to discover their influences on maternal healthcare services utilisation. Combining the two makes it possible to analyse gender issues such as decision-making and access to healthcare services. In this framework, women are placed at the agency level, and socio-cultural and organisational/institutional structures as well as environmental conditions at the structural level.

The delays model is useful in categorising the contributing factors that hinder maternal healthcare services utilisation and establish where improvements could best be made during maternity for promotion of maternal healthcare (Combs Thorsen et al., 2012). Again, it recognises the three phases of delays in analysis by linking them up and showing their inter-relatedness, and provides

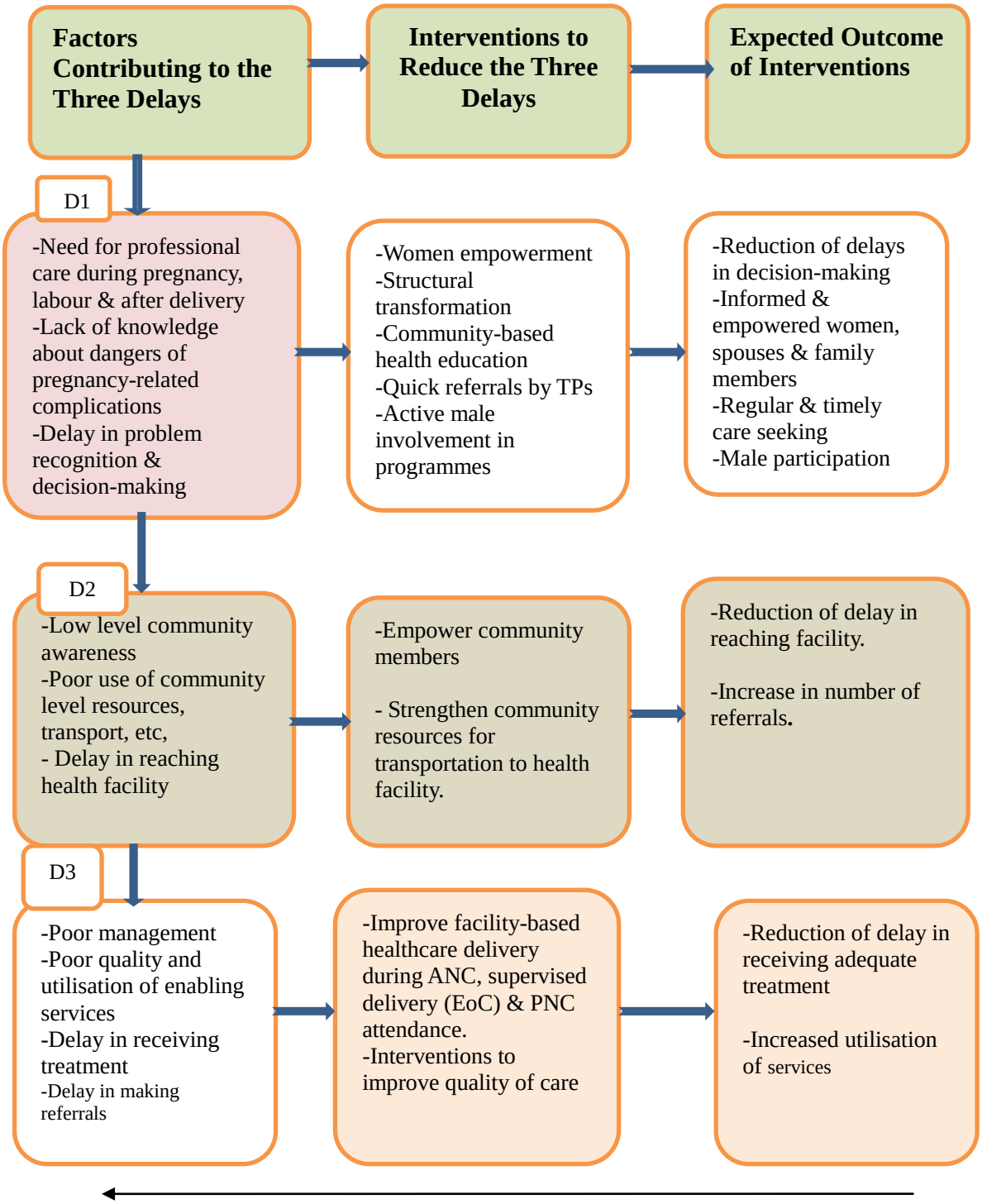

Figure 3.2: The Delays Model

Source: A Modified Version of Thaddeus and Maine (1994)

feedback for improvement in the form of recommendations in analysis. The model is useful for discovering and gaining knowledge about the barriers between the onset of obstetric complication

and its outcome, and establish the point at which optimisation of healthcare delivery is needed (Combs Thorsen et al., 2012). D1, D2 and D3 as indicated in the model refer to delay one, delay two and delay three respectively. The model helped to ascertain the mediating barriers to timely and regular care during ANC and PNC and suggest ways for improvement.

The limitations in the original delays model discussed above have been addressed to make it capable of modeling women's healthcare from ANC, through delivery to PNC and to be able to analyse the status of women's health in each of these stages. It will further link the stages up to establish a complete state of women's health in maternity as a whole. The short arrows show how the various phases of delays are inter-connected, whilst the outer arrow shows that the outcome of interventions can influence the phases of delays in the various stages and inform interventions through recommendations for improvement.

3.5 Conclusions

This chapter discussed the previous studies and theoretical/conceptual issues in healthcare services utilisation. It is noted that most of these studies overlooked the various stages of pregnancy-postpartum as continuum and instead viewed them as individual and independent stages. The inter-connectedness between the stages have not been considered in most studies which are heavily skewed towards emergencies and delivery. Critical summary of the literature highlighted that maternal healthcare services utilisation is influenced through key factors such as culture, social networks and access which are embedded in social, cultural and political structures. These structures in turn affect the women at the agency (individual) level, creating inequalities and poor healthcare services utilisation.

The chapter also presented the structure-agency theory and the delays model as the framework for the study based on the principle of complementarity and ability to model the study to its focus. The blend of the two seeks to analyse structures within households, communities and

in facilities that determine women's utilisation of healthcare services during pregnancy and childbirth. The combination of the two models in this study considers maternal healthcare as a system of inter-connected parts. Therefore, the results generated from the study will not be related to the individual stages but the outcome of care seeking or provision in all the stages.

The next following Chapter 4 discusses the methods and techniques adopted in data collection, the research participants and how the data were managed and analysed.

CHAPTER 4

METHODOLOGY

4.1 Introduction

This chapter discusses the components of the research design adopted for this study. The formulation of the research design considered the issues raised in the problem statement, the research questions and the research objectives for the study. Section 4.2 presents the qualitative research design for the study under which justification of qualitative method (Section 4.2.1) for the study and culturally appropriate approach (Section 4.2.2) are discussed, whilst Section 4.3 discusses the research participants and sampling procedures as well as the socio-demographic characteristics of the participants. The sample size for the study is presented in Section 4.4 whilst the research instruments and the rationale for using the instruments are discussed in Section 4.5.

A pilot study was conducted before the main data collection. The outcome of this study is discussed in Section 4.6. Section 4.7 presents the training of a field rapporteur whilst Section 4.8 discusses pre-field activities carried out. Ethical and political considerations are discussed in section 4.9. Further, Section 4.10 discusses trustworthiness and dependability and how they were ensured in the study. The organisation of field work and challenges encountered during data collection are discussed in Sections 4.11 and 4.12 respectively. In addition, data management and anlysis comprising translation, transcription as well as coding of the field data are discussed in Section 4.13, whilst the chapter conclusions are presented in Section 4.14.

4.2. Qualitative Research Method

This study was purely qualitative guided by the naturalistic or interpretivists' philosophy of reality. The naturalistic or interpretivists' epistemology holds that reality is subjective and can be found in the minds of people through interaction (Lietz & Zayas, 2010). Qualitative research design was preferred as opposed to the quantitive design because this study was exploratory in

nature which required the research to seek and explain reality in its natural setting. The philosophical logic behind the qualitative epistemology is to understand and explain or interpret patterns of social relationships rather than determining causality of dependent and independent variables for generalisation as in quantitative designs. In the social sciences particularly, qualitative designs are characterised with the philosophical underpinnings of phenomenology, based on detailed description of people's experiences of events in their socio-cultural set up. Qualitative research uses a naturalistic approach that seeks to understand phenomena in *context-specific settings* such as "real world" setting, where the researcher does not attempt to manipulate the phenomenon of interest (Patton, 2002; Denzin & Lincoln, 2008; Lietz & Zayas, 2010).

4.2.1 Justification of Qualitative Design for the Study

The choice of the qualitative data collection method was motivated by the rationale that the issues under investigation were too subtle and complicated to be adequately explored by using standard survey techniques (Patton, 2002). It is argued that research should be grounded in the worldviews and cultures of the local people (Ling, 2004, 2007; Smith, 2012). Moreover, the choice of the naturalistic epistemology was also necessitated by the rationale that it is uniquely suited to address issues or questions that might be difficult and sometimes impossible for researchers to investigate under more structured and less flexible design (Babbie, 2004, 2010). Matters relating to decision-making, ethnicity, cultural or traditional beliefs can best be investigated using a qualitative methodology (Ling, 2004).

Further, different perceptions of human nature influence the choice of different research approach, and local knowledge may be uncovered through the development of a research paradigm grounded in the local cultures (Ling, 2004, 2007) to naturally unfold issues of interest (Babbie, 2010). Qualitative research tends to be interpretive and seeks to understand a

phenomenon in its context in greater depth (Denzin & Lincoln, 2008; Lietz & Zayas, 2010). It seeks to explain the nature of social practices, relationships, and beliefs along with the meaning of human experiences from the participants' points of view (Silverman, 2010; Lietz & Zayas, 2010).

Ling (2004) contends that failing to recognise that ways of knowing and research methodology are culture-bound has serious consequence such as marginalisation and exclusion of culturally diverse interpretations of reality and human experiences. Women are marginalised in African society (Nwokocha, 2007) and therefore, qualitative methodology will be very useful at gaining meaning and information from marginalised groups in society. Thus, the use of probes by the researcher during interaction is capable of eliciting responses from "silent voices" which would not have been reached with the positivist approach. The design and the investigation processes both empower the individual participants to share their views, make their voices heard and minimise power relations that often exist between researchers and participants.

The qualitative research design is flexible and this defining characteristic of the research design enables the researcher to direct the discussions to other areas even though the focus of the investigation may be known in order to raise concerns which may be useful to the study. Another important factor which influenced the choice of the qualitative design was the feature of researcher-participant relationship. The researcher is the tool by which data are gathered. This is an important function of the researcher-participant relationship in qualitative research as it influences research outcomes. This relationship is at the centre of in-depth interviews (IDIs) and focus group discussions (FGDs), which were the techniques of data collection in this study. Investigating issues on ethnicity, gender, religion and belief systems requires building a strong rapport between the researcher and the participants to unveil contextual issues. Eisner (1991) contends that, a good qualitative study can help us understand a situation that would otherwise be difficult to interpret or confusing. Adding that, the quality concept in qualitative study has a

purpose of generating understanding.

Culture is expressed and shown in our worldviews, the way we interact and communicate with people around us, the way we engage with nature, our perception of human nature, our concept of knowledge and our beliefs about what can and cannot be known. Thus, research methodology as a way of knowing is inextricably linked to culture (Ling, 2004). The positivist approach where the researcher has to distant himself/herself from the data collection process is however, limited in the focus of this study. Patton (2002) supports the researchers' deep involvement into the research as the research instrument. He maintains that the real worlds are subject to change, and therefore, a qualitative researcher should be present during the changes to record an event after and before the change occurs.

A typical motivating quality of the qualitative design is its ability to provide plausibility of interpretations. In qualitative research, the investigator does not acquire the information and knowledge in a vacuum, but rather in a context and, in this way, the research findings are a product of various situational factors, making the interpretation of findings in qualitative investigation more credible (Patton, 2002; Silverman, 2010).

This study requires a comprehensive data on traditional birthing practices, intra-household decision-making towards healthcare services utilisation and the influence of socio-cultural factors on the choice of facilities by pregnant women. Babbie (2010) contends that qualitative research generates a comprehensive perspective of phenomena to investigators, arguing that, by going directly to the social phenomenon under study, and observing as completely as possible, the researcher can develop a deeper and full understanding of the phenomenon. Qualitative researchers may recognise several nuances of attitudes and behaviours that might escape researchers using other methods. Qualitative research is especially appropriate to the study of those attitudes and behaviours best understood within the natural setting (Babbie, 2010).

Delving into sensitive issues in research calls for excellent skills on the part of the

investigator to create a very encouraging and conducive environment for the interaction. Matters relating child death, miscarriages and still births require the presence of the researcher to create a friendly and comforting situation to enable the participants respond well without any shock, fear, intimidation or embarrassment. The researcher's presence is also needed to explain to the participants their allowance to opt out or choose not to respond to some issues when considered embarrassing or when they find it uncomfortable to do so.

Further, due to linguistic and conceptual in-equivalence of words and terms (Ling, 2004), direct interaction between the researcher and participants is a necessary requirement to explain issues well in order to generate expected responses, for a high context cultures (Ling, 2004) like those of the people in the Northern Region of Ghana need non-verbal communication in some instances to better understand certain terms.

Above all, based on the rationale that about 65% of women who had home delivery in the region had no formal education (GSS, 2012), the choice of qualitative design is appropriate for issues to be explained to the level of participants for understanding and for generating relevant responses.

4.2.2 Culturally Appropriate Approach

The study adopted a culturally appropriate methodology in the data collection because different perceptions of human nature influence the adoption of different research orientation (Ling, 2004, 2007; Karwalajtjs et al., 2010; Smith, 2012). In a study of indigenous communities in Sarawak, Malaysia, Ling (2004, 2007) argues that, a culturally appropriate approach be adopted in an indigenous environment to investigate issues pertaining to peoples culture, tradition and behaviours.

This methodology was characterised by building of networks and warm relationship in the study communities, which allowed for identification of dialectical differences and preferences. In

addition, through this culturally competent (Price-Robertson & McDonald, 2011) interaction with the community members, the perceptions of the communities towards research was established, and appropriate approaches were adopted. In the data collection, talking was mixed with gestures and signs to properly convey meaning. Besides, the study was planned to ensure that the execution of the data collection exercise would not coincide with the customs of the local communities such as funerals, festivals and naming ceremonies. In view of this, Saturdays and Sundays which were normally used for funerals and naming ceremonies respectively in these traditional areas were not considered for data collection.

The population of Ghana is composed of diverse people in ethnicity, social class and cultural origins, including people from neighbouring La cote d'Ivoire, Togo and Burkina Faso (GSS, 2015). There is the need for adjustment of research methodology when working with migrant communities (Lu & Gatua, 2014). Aside, inter-ethnic marriages, which is typical of Ghanaian communities also import cultures from traditional areas into other traditional communities, thereby, influencing the cultures of those communities and individuals as well. Therefore, as maintain by Karwalajtjs et al. (2010), a research guide developed for working with only Dagombas and Chorkosis, who form the majority in the respective districts for the study may not work well with these populations, which may pose challenges to the research. Moreover, accessing and gaining trust of potential participants in a cross-cultural community as well as understanding language and cultural differences is a challenge (Karwalajtjs et al., 2010). For example, in the research, some traditional practitioners were reluctant to be participants for fear of being arrested for practising without licenses because they were unfamiliar with the kind of research. Lu and Gatua (2014) confirming the observation of Ojeda, Flores, Meza and Morales (2011) mentioned that for previous experiences of being exploited, or deceived for research purposes, concerns about language fluency, or for fear of being reported, individuals may not agree to be participants.

As a male, the researcher was subjected to cross-gender and cross-cultural research ethical guidelines. In Ghana, seeking verbal permission or consent of community leaders such as chiefs, assembly members and household heads is a crucial customary requirement (Tindana, Kass & Akweongo, 2006; Andoh, 2009). In reaching married women for research participation, the consent of their husbands or household heads is a necessary requirement especially in patriarchal setting like the northern Ghana (Tindana et al., 2006). Therefore, the research began with seeking the consent of both community leaders and husbands of participants. The participants were offered a choice of gender of interviewer to ensure that cultural and gender sensitivity protocols were respected (Marin et al., 2015). Again, the husbands of the participants and parents or guardians of minors were given the opportunity to be present with their partners and children respectively during the interview sessions. However, none of them expressed interest to do so. They expressed that they only needed to be informed about it. One of the husbands, who is also an assemblyman, said:

> *"We don't need to be with our wives during interviews. We only try to make sure we protect our wives and children from bad people. But in your case, we have been informed and the chief and all the household heads are aware. Aside you have been with us for some time now. Sitting in the interviews demonstrates lack of trust for our wives and you. It is not necessary to be with our wives because they don't need husbands for the answers you seek."*

The interview sessions were held in the participants' homes. However, where a request was made for a more conducive venue the researcher followed the demand. In the villages, the researcher was often accompanied by community facilitators, who assisted in reaching the participants for the interviews. They were also used to explain the purpose of the study to participants and to introduce the researcher to the individual participants.

Further, qualitative interviews are usually recorded and then transcribed for data analysis. However, this common procedure may not work for people who are not familiar with scientific research (Rubin & Rubin, 2005; Lu & Gatua, 2014). This was an issue raised by some participants who wanted their responses written during the data collection because recording was

perceived as threatening. In a similar study, Adu-Gyamfi (2015) observes that in Ghana, tape recording and signing of informed consent forms are perceived to have a legal bindings or implications on the participants. Some participants preferred verbal consent and written responses. This category of participants was given verbal informed consent and their responses in the interviews were written in books. This implies that using tape recorders and consent forms in some settings in Ghana may not generate candid responses. Ghana is becoming increasingly diverse (GSS, 2015) and as such, cultures are mixing and influencing one another. With this increasing cultural heterogeneity, healthcare utilisation behaviour is likely shifting. Addressing the needs and values of this shifting population requires an understanding of their culturally linked healthcare utilisation determinants (Rebhan, 2008). Therefore, unless qualitative research is carried out in a culturally sensitive manner, there could be many threats to the trustworthiness of the research (Suh, Kagan & Strumpf, 2009). Thus, to avoid poor execution and insensitive research approaches, which can result in questionable and possibly misleading findings (Ojeda et al., 2011), this study adopted a culturally appropriate methodology.

4.3 Research Participants and Sampling Procedures

4.3.1 Research Participants

The participants for the study were categorised as A (women within the age range of 15-49 years who have ever been pregnant in the two years preceding the time of data collection); B (men whose wives fall within category A) and C (traditional practitioners). These categories of participants were selected because they are the main actors in maternal healthcare as explained in Chapters 1 and 3 and therefore, must be included because both methodological and data triangulation helps to establish credibility (Silverman, 2010; Lietz & Zayas, 2010). In addition, to avoid one-sided data, the health professionals were interviewed to seek their views on conditions that facilitate or inhibit utilisation of maternal healthcare services. This was to ensure that both

the service provider and the clients were interviewed to get a balanced data.

4.3.2 Sampling Procedures

Sampling procedure is an essential aspect of research because the research participants and the data they provide are to contribute to better understanding of issues under investigation as well as the theoretical framework (Tongco, 2007). Therefore, choosing a sampling technique should involve sound judgment about the participants for the research.

Purposive sampling is symbolised in most qualitative studies but the method is not sufficiently accounted for in most studies (Tongco, 2007). In this study, the research participants were selected using a maximum variation or heterogeneous purposive sampling method. The rationale was to provide as much insight as possible into the experiences of women within and outside healthcare facilities during the pregnancy-postpartum period. By this, the main actors in maternal healthcare such as women, their spouses, traditional practitioners and healthcare professionals were sampled for the research. Thus, the various categories of participants were purposively chosen to provide information on management and treatment of pregnancy-related complications and delivery. According to Lietz and Zayas (2010), the use of purposive sampling technique is distinctive in qualitative study in seeking a specific group of participants who have experienced the issue being studied.

The snowball sampling was used to reach the various categories of the participants after which non-proportional quota sampling technique was used to reach representation of participants based on background characteristics such as age, ethnicity, level of education, occupation and residence. This was to create a room for analysis of interesting background characteristics on issues under investigation, because both data triangulation and analysis triangulation produce findings that are trustworthy and dependable (Silverman, 2010; Lietz & Zayas, 2010).

The researcher targeted three midwifery officers from each district comprising one municipal/district midwifery officer and the midwives in the charge of the selected sub-districts. However, in the Yendi Municipality the municipal midwife and the Yendi sub-district midwifery officer refused to participate in the interview for fear of blackmail by journalists despite the issuance of introduction letter. As a result, the study interviewed Gnani sub-district midwife. In the Chereponi District, the community health officer in charge of Wenchiki sub-district and the Chereponi District Midwifery Officer as well as the district health administrator were selected and interviewed.

The husbands were reached through the chiefs, assembly members and their household/family heads. The respective wives of the sampled men were reached for participation in the research through their husbands as demanded by the custom. By the Ghanaian custom this is a way of seeking the consent of the husbands. After prior notice to the chiefs and opinion leaders in the various communities, the researcher was introduced to the leadership of the traditional practitioners comprising traditional birth attendants, spiritualists and herbalists. Together with the assembly members, the leaders of these groups led the researcher to reach their members in the various locations for participation.

In selecting participants for the focus group discussions (FGDs) extra care was taken to ensure relative homogeneity (FHI & USAID, 2011), such that participants with similar characteristics such as ethnicity, education, location and age were interviewed together. The composition of an FGD is essential because variations in background may hinder some participants from speaking candidly (Patton, 2002; Amedahe, 2006).

The participants were put into three special groupings based on common characteristics (Table 4.1, pp. 91). For instance, the teenagers share common physiological and psychological characteristics. Theoretically, 20-34 age range is considered as ideal for pregnancy and childbirth, as women in these ages are physiologically and psychologically matured for child bearing. Aside,

unlike the teenagers and those aged 35 years and above, they stand less risks of complications related to pregnancy and childbirth (GSS, 2009). Finally, just like the other age groupings, they share common characteristics which will motivate them to discuss issues at length in FGDs. Women aged 35 years and above stand the risks of pregnancy related complications as a result of their ages and multi-parity. These issues were considered especially in the conduct of FGDs. Most of the husbands and wives fall within the ages of 35-49 years. All the traditional practitioners (TPs) interviewed fall within the age range of 50 years and above.

4.3.3 Socio-Demographic Data

It is essential to consider the socio-demographic data when studying maternal healthcare because the background of the individual has a significant impact on their health (GSS, 2008, 2009, 2015). In this study, background variables of interest were level of education, age, location, religion, occupation and ethnicity. These are discussed in Chapters 5 and 6 respectively.

4.3.3.1 Age Distribution of Participants

Apart from the TBAs and the health professionals, only women in their reproductive ages (15-49) were selected for the study (Table 4.1).

Table 4.1: Distribution of Participants by Age

	15-19	20-34	35-49	50+
Husbands	1	7	22	10
Women	2	21	32	-
Professionals	-	-	2	1
TBAs	-	-	-	21
Spiritualists	-	-	-	21

Source: Fieldwork, 2016

4.3.3.2 Distribution of Participants by Educational Level

As shown in Table 4.2, 15 of the husbands interviewed had no formal education. Most women (21) had no formal education. Twelve (12) of them had certificate/diploma, whilst only 4 had tertiary education. The highest level of education for the TBAs and the spiritualists was middle school.

Table 4.2: Distribution of participants by level of education

	No formal education	JHS/Middle School	Secondary School	Certificate/ Diploma	Tertiary
Husbands	15	7	9	4	5
Women	21	10	8	12	4
Professionals	-	-	-	1	2
TBAs	17	4	-	-	-
Spiritualists	15	6	-	-	-

Source: Fieldwork, 2016

4.3.3.3 Distribution of Participants by Occupation

The occupation of the women and their spouses was considered in the data collection. The data were gathered mainly from those in the service industry such as teachers, agric officers,

Table 4.3: Distribution of Participants by Occupation

	Service industry	Trading	Farming
Husbands	9	9	22
Women	17	15	23

Source: Fieldwork, 2016

paramedical health workers, nurses, those in the security forces like the police, fire service and immigration. Aside, data were taken from women and men who were traders like businessmen and women, or those in vocational jobs like dressmakers, beauticians and drivers amongst others. Most of the participants (both males and females) were farmers (Table 4.3).

4.4 Sample Size

According to Ramli (2011) depending on the topic of interest, approximately ten to fifteen key participants constitute a desired sample size for a qualitative research. In a similar argument, Silverman (2010) re-emphasising the views of Marshall (1996); and Guest, Bunce and Johnson (2006) maintains that a qualitative inquiry sample tends to be small as it is not meant for generalisation, and that qualitative research is much more concerned about generating understanding about some aspects of human experience for a particular group of people. The study was focused on understanding the experiences of women in maternity in particular traditional settings, which may not be applicable in other settings due to cultural and locational variations. It is not meant for generalisation and therefore, did not require a large sample size (Silverman, 2010).

Two main ethnic groups in the Northern Region of Ghana comprising the Mole-Dagbani (Dagombas) and Akan (Chorkosis) were studied in the Yendi Municipality and Chereponi District respectively. Using the administrative structure of Ghana Health Service, four sub-districts were purposively sampled in the study areas. These include Yendi and Gnani sub-Districts in Yendi Municipality, and Wenchiki and Chereponi sub-Districts in Chereponi District. There was the need to analyse rural and urban influences in healthcare services utilisation. The Yendi and Chereponi sub-Districts were purposively selected based on the rationale that they are the administrative capitals and urban communities whilst Gnani and Wenchiki sub-Districts form the remotest sub-districts in the Yendi Municipality and Chereponi District respectively. They were

sampled for data from rural areas.

Based on data or thematic saturation, the study conducted 30 IDIs and 15 FGDs. Research indicates that it is nearly impossible for a researcher to know when they have reached saturation point unless they are analysing the data as it is collected (O'Reilly & Parker, 2013). As indicated, earlier, the data collection considered immediate expansion of field notes and transcription within 24 hours after data collection, which was followed by thematic analysis of the data. The analysis of the data reached a stage where the same themes were recurring, and no new insights were arising from additional sources of data. The research realised that there was enough data to ensure that the research questions were answered. According to O'Reilly and Parker (2013), when the amount of variation in the data is levelling off, and new perspectives and explanations are no longer coming from the data, the research is approaching saturation. It is worth mentioning that, it is unnecessary and unethical to recruit further participants to a study and not make full use of the data they provide (Mason, 2010; Francis et al., 2010; O'Reilly & Parker, 2013). The sample helped the research to appropriately perform in-depth analysis of the data, comprehensive data treatment and inter-coder agreement, which may be difficult with larger samples, especially, due to financial constraint and the fact that it is time consuming.

Table 4.4: Distribution of Participants by Location

	RURAL	URBAN	TOTAL
IDIs	15	15	30
FGDs	7	8	15

Source: Fieldwork, 2016

Table 4.4 above shows the distribution of participants between rural and urban communities. In all 30 IDIs and 15 FGDs were conducted. Depending on the plan of the study and what the

research intends to achieve, either IDI or FGD could be conducted first (Freitas, Oliveira, Jenkins & Popjoy, 1998). This research planned to use focus groups in the initial stages to guide the construction of the topics of the individual interviews and to provide a base/guide for selecting participants for more detailed interviews. In each sampled community, the study conducted IDIs after FGD sessions. This step was taken to validate the data generated from the FGDs by probing deeply into issues that were not well explained in group interviews. The IDI exercise provided privacy to clarify issues that were not explained well in group discussions.

Table 4.5 (pp. 96) shows distribution of various categories of research participants. Nine (9) of the FGDs were conducted in the Yendi Municipality, out which 5 sessions were held in Nayilifong CHPS (urban) in Yendi sub-District and 4 of the interviews were conducted in Kamshegu CHPS (rural) in Gnani sub-District. These comprise 2 FGDs each for women in rural and urban centres, 2 FGDs for husbands in rural communities and one (1) FGD for husbands in urban community. The rest are one (1) FGD each for TBAs and spiritualists respectively that were conducted in rural communities. Six (6) FGDs were conducted in the Chereponi District, out of which 3 each were conducted in rural and urban communities respectively. Two (2) of these FGDs were conducted in rural areas for women, whilst one (1) FGD was conducted for women in urban area. Again, one (1) FGD was conducted for rural husbands, whilst one each was conducted for TBAs and spiritualists in the urban areas. Out the 30 IDIs, 15 were held in Yendi Municipality, comprising 9 and 6 each for rural and urban areas respectively. These include one (1) health professional, 2 women, 2 husbands, 2 TBAs and 2 spiritualists from the rural areas. In the urban areas, 2 women, 2 husbands, one (1) TBA and one (1) spiritualist were interviewed. Fifteen (15) IDIs comprising 10 from rural areas and 5 from the urban areas were conducted in the Chereponi District. These include 3 health professionals, 2 women, two (2) husbands, one (1) TBA and one (1) spiritualist from the urban area, whilst IDIs in rural areas comprise two (2) woman, two husbands (2), one (1) TBA and one (1) spiritualist.

Table 4.5: Distribution of Participants by Districts

	IDIs	**FGDs**
YENDI MUNICIPALITY	15	9
Health professionals	1	-
Women	4	4
Husbands	4	3
TBAs	3	1
Spiritualists	3	1
CHEREPONI DISTRICT	15	6
Health professionals	3	-
Women	4	3
Husbands	4	1
TBAs	2	1
Spiritualists	2	1
Total	30	15

Source: Fieldwork, 2016

4.5 Research Instruments and Rationale

The naturalistic philosophy holds that reality is subjective and it is in the minds of people (Babbie, 2010). This reality can only be known through a warm interaction between the researcher and the participants. High context cultures as noted by Ling (2004) which is typical of Africa (Hall, 1976), are more accustomed to non-verbal cues and messages and rely on shared experience and context. Therefore, this study needs instruments that will bring the researcher and the participants together in interaction for a better understanding of issues and terminologies

related to the investigation through non-verbal communication where appropriate.

The major instruments for the study were individual or in-depth interview (IDI) guide (Appendix II) and focus group discussion (FGD) guide (Appendix III). The IDI and FGD guides were made up of open-ended questions with more probing questions to generate detailed information about issues under investigation. Based on the research questions and objectives of the study both instruments were put into sections in addition to a section on socio-demographic data.

The use of IDIs and FGDs for investigation in this study was necessitated by the need to understand why some communities, families and pregnant women exhibit certain behaviours that affect pregnancy outcomes. Also, inner motivations and emotional responses of people to certain socio-cultural features cannot be established without an in-depth exploratory approach (Nwokocha, 2007). Even though FGD and IDI are both interviews, the use of the IDI is to provide privacy and confidentiality to participants so as to allow them to express themselves freely (FHI & USAID, 2011). In IDIs, participants are more confident, more relaxed and are motivated to express their deepest thoughts about research issues (Milena, Dainora & Alin, 2008). Moreover, the IDI was used to validate the results of the FGD (Patton, 2002; Lietz & Zayas, 2010). The FGDs were used to provide the discussants with the opportunity of explaining certain cultural beliefs, norms, values and practices about pregnancy and childbirth (Nwokocha, 2007). FGD provides wider meanings by generating relevant and comprehensive data on social and cultural norms, the prevalence of these norms, and people's opinions about their own values (FHI & USAID, 2011). Furthermore, the diverse nature of the population of the study communities signifies cultural diversities, which calls for face to face interactions with non-verbal cues (Ling, 2007; Solomon, 2011) for better understanding of terms and expressions.

The use of the interview guide is capable of generating interesting issues which the interviewer could freely explore, probe and ask questions for explanation and clarity. The

interview guide is useful in conducting group interviews since it keeps the interactions focused but makes room for individual views and experiences to come up in the course of the interview (Patton, 2002).

Besides, detailed analysis of social and personal data from IDIs goes into delicate issues more deeply and sensitively than other instruments (Nwokocha, 2007). According to Shafritz and Roberts (1994), FGD is a socially appropriate means for gathering data because the participants are usually keen to discuss issues that are very delicate openly. Therefore, the selection of participants for group discussions was carefully done and guided by the background factors (Basch, 1987; Shafritz & Roberts, 1994; Patton, 2002).

As a moderator and instrument, the researcher created an enabling environment which aroused the interest of the participants to share their views through the use of probes, transitional questions and facilitating interaction amongst participants. By this, the researcher remained reflexive, neutral (Patton, 2002) and focused on issues under study. The FGDs were also characterised by lively discussions as participants were encouraged by alternating the "difficult" questions with very easy and interesting ones. Also, the responses provided were not judged, and all contributions made were treated with utmost respect, with the view that there is no wrong or right answer.

Using their ages, the women were categorised into three main groups for the FGDs i.e., 15-19, 20-34 and 35- 49. This was to create age homogeneity during the FGDs to some extent, facilitate group discussions and simplify analysis since the respondents were of similar backgrounds and experiences. All things being equal, women from the ages of 15 to 19 and those aged 35 and above are prone to complications during pregnancy and childbirth whilst 20 years to 34 years are recommended for pregnancy and childbirth (ICRW, 2007; GSS, 2008, 2009).

According to Singer and Baer (2007), in societies that look to tradition as a guide to the present, aging may be followed by a gain in social stature. According to the 2010 population and

housing census of Ghana, about 65, 826 people in the Northern Region do not belong to any religion and 395,756 people are members of Traditional Religion. These categories of people adhere to tradition. Therefore, age segregation is justifiably applicable here if the young ones are to express themselves freely. Similarly, the social roles expected of younger and older persons in a community may define the social interaction between them differently (Ling, 2004). Therefore, the various age groups should be separated to encourage the younger ones to express their views without fear of being accused of anything by the older ones. Similarly, spouses of the target women were divided into three separate groups based on their ages (15-19, 20-35, 36 and above) just as their female counterparts to ensure homogeneity and its associated merits in FGDs. Aside, participants were also grouped according to their localities and ethnicities in order to hold detailed discussions on issues concerning participants from different places of residence and ethnic backgrounds. Interviewing participants from the same places of residence in the FGDs will allow the researcher to analyse access factors such as nature of roads and distance to the facility. It was also to make it easy in the analysis to examine urban and rural influences.

The Northern Region is prone to ethnic conflicts. Since 1994 the region has not enjoyed stable peace. Ethnic segregation for FDGs was a necessary security measure. Moreover, since different ethnicities have different cultures, separating participants according to their ethnic backgrounds was a motivation in itself for participants to comfortably express their views on cultural issues because, even though sometimes shared (Ling, 2007), culture is paradoxical and relative at the same time. The segregation was also to give room to the "minority" groups to express their views freely and avoid the issue of cultural ethnocentrism in mixed group discussions. Mixing the various participants from diverse backgrounds will also generate misunderstanding on some cultural issues amongst participants from different ethnic backgrounds which would take much time. This explains that cultural or ethnic segregation was to enable cultural factors to flow freely in the course of the interaction. For instance, it avoids the problems

associated with dialectical differences (Patton, 2002; Ling, 2004) and ensures smoothness of interaction because of minimised linguistic and conceptual barriers.

The spiritualists and herbalists were separated from the TBAs because the spiritualists were mainly men likewise, the TBAs were females. They were particularly interviewed on the traditional birthing practices and associated beliefs, and their views on the modern healthcare system.

4.6 Pilot Study

A logical way of testing whether questions produce different answers is to pre-test questions before the main research starts (Teijlingen, Rennie, Hundley & Graham, 2001; Amedahe, 2006; Silverman, 2010). A pilot study is required because every side of research design needs clarification, and many features of the design cannot be determined without a prior exploratory research (Teijlingen et al., 2001; Thabane et al., 2010; Leon, Davis & Kraemer, 2011). Regardless of its research benefits, most studies ignore pilot studies (Teijlingen et al., 2001; Thabane et al., 2010). Before the actual research, the FGD and IDI guides were tested in a pilot study conducted in Savelugu and Sangbana in the same region. The communities were chosen for the pilot study because they have similar characteristics as the sampled communities for the research (Amedahe, 2006), in terms of ethnic, religious and locational factors. The pilot study conducted 2 IDIs each for women, their spouses and traditional practitioners and 2 IDIs for health professionals. In addition, one FGD each was conducted for women and their spouses, and the traditional practitioners in each community. The rationale was to check for the possibility of inconsistencies, correct possible mistakes, and identify the language needs of the prospective participants. Before the pilot study, formal consent was sought from the communities for the pilot study and those sampled for the research. This made it possible for the researcher to identify likely issues that needed to address to ensure smooth and successful data collection exercise.

To discover potentially neglected aspects of the study design, and to ensure the appropriateness of the interview questions, the participants in the pilot study were asked to share their thoughts after the interview sessions. This was done to identify and guide necessary modifications to the research design (Leon et al., 2011). Consequently, the pilot study resulted in some changes in the study design. For instance, the study intended for more focus group interviews for the traditional practitioners, but as a result of the pilot study, a modification decision was made to conduct more individual interviews and fewer focus group sessions for them. This decision was necessitated by the fact that most participants were not willing to express their views freely in the group discussions. Those interviewed individually discussed issues at length. The researcher discovered that members did not want to disclose some information about their practices in groups for others to copy them. Therefore, they kept them secret and only disclosed when interviewed individually.

To fulfil cross-gender research ethical principles, the study intended to use females (non-relatives) or male/female siblings of the female participants to sit in the individual interviews to avoid suspicions of all forms. However, this method did not work because the participants were neither willing nor comfortable to freely share ideas deeply in the presence of fellow women or their siblings. One of the participants in an individual interview noted:

> "*... Me I am not comfortable with the woman. There are some things I cannot say when fellow woman is with you. I can assure you that if you keep doing this work with the woman, you may not get what you need for your study. Because women don't trust women. When you tell a woman something she will carry it to other people."* (Female participant, Sangbana).

These views were shared by almost all the women in the pilot study. Similarly, using relatives of the participants was perceived as indirectly reporting their husbands to their families. As a result, the women opposed to that. They rather preferred only the male researcher interviewing them. In the individual interviews a number of participants shared these views by the first participant as a response to a request for a relative to sit in the interview:

> *"It is not allowed by the custom to share some marital issues with my relatives. Unless there is a serious problem requiring solution by family members from both spouses. Even that, I need to first report to my husbands parents, uncles or brothers. If that fails then I can report to my family members. Please, can I be interviewed alone? I cannot share anything with you whilst I have my sister with me because it is a way of reporting my husband to her. she may not respect my husband and this could result in divorce."* (Female participant, Savelugu)

Notwithstanding that, several participants agreed to be interviewed with their sisters or any female sitting in. This called for comparison of two different categories of datasets from those interviewed alone and those whose sisters sat in the individual interviews or those who allowed females other than their siblings to sit in their interviews. In comparing datasets it then became necessary to consider interviewing without anybody sitting in because those interviewed by the researcher alone, irrespective of the researcher's gender, were more detailed and the women were more comfortable in providing information. Therefore, the interview sessions were conducted solely by the researcher. The use of the information centres in the various communities by the community leaders also facilitated this method since the entire community were aware of the purpose of the research and the researchers' presence in the community. Further, having spent some time with the communities the issue of "suspicion" was not a concern.

The pilot study also led to clarification of the conceptual framework for the study. In analysing the data from the pilot study, it was established that the women who used the health facilities delayed in professional care seeking within the maternity period, because some cultural beliefs and practices mediated to cause the delays. It was also realised that the same socio-cultural conditions held some women to the traditional practitioners in their respective communities, and they never sought professional care. Besides, some women attempted seeking care from professionals but gave birth on their ways to the facility, while some were delayed in the facilities by the professionals. The preliminary findings appeared to confirm the applicability of the three delays model (Thaddeus & Maine, 1994; Waiswa et al., 2010; Combs Thorsen et al., 2012) and the theoretical foundations of the structuration theory which guided the interview

processes as the conceptual framework.

4.7 Training of a Rapporteur

Even though the research was solely conducted by the researcher, during the FGDs especially, the researcher could not perfectly do everything alone. In this case, somebody was trained on data collection and ethics of research to be a rapporteur by taking notes as the researcher moderated. This way, an individual very comfortable with the local culture and fluent in the local languages as well as English Language was selected and given ethical training regarding the ethnic groups concerned and generally on data collection.

4.8 Pre-field Activities

Before the actual data collection, the investigator conducted reconnaissance surveys in the selected communities in order to identify the likely issues that would be needed to address to ensure smooth and successful data collection exercise. Two of these surveys were conducted in each selected community. This was in addition, to familiarise the researcher with the culture, language needs and the general picture of the sampled communities so that advance preparation could be made for data collection. It was during these visits that the investigator ethically sought formal consent from the community gate-keepers for the data collection.

4.9 Ethical and Political Considerations

According to La-France and Crazy-Bull (2009), ethical issues are important aspects for studying indigenous populations. Prior to conducting the study, ethical approval was obtained from the Faculty of Social Sciences Postgraduate Research Proposal Defence Committee and an introductory letter obtained from UNIMAS Graduate School (See Appendices). At the beginning of data collection permission was sought from community leaders such as municipal/district

assemblies, assembly members in local areas, chiefs, opinion leaders and the Ghana Police Service. The purpose of the research was explained to them and formal letters (Appendix I) seeking their consent were given to them to sign or thumbprint to indicate approval.

In Ghana, to engage married women in any activity requires permission from the husbands or parents of the husbands. This cultural ethical factor was observed in accessing participants for the interviews. Where a minor was involved or a woman was not in marriage but falls within the sample frame, the parents or brothers were contacted for consent as demanded by the Ghanaian custom. Consistent with the culture of Ghana, Patton (1990) observed that in many cultures it is a breach of etiquette for an unknown man to ask to meet alone with a woman. The spouses of the women were given the opportunity to be present during the interview session. However, none of them expressed interest in joining their spouses for the interview.

According to Babbie (2004, 2010), a major tenet of social research is that participation must be voluntary. To conform to this research norm, individual participants were given informed consent forms to read and sign or be read to them for thumb printing to signify understanding of the purpose of the research and the possible risks involved, as well as an agreement to participate voluntarily in the interview.

Basically, social research should not cause harm to the people being studied, regardless of whether they volunteer for the study (Babbie, 2010). In line with this, steps were taken by the researcher to ensure that information that would embarrass the participants or endanger their homes, lives, friendships and jobs was not released to anybody. Babbie (2010), contends that research participants can be harmed in a psychological way as some probing questions can be destructive to a weak self-esteem. The study attached particular importance to the psychological and emotional well-being of the participants and looked for subtlest dangers (Patton, 2002) and guarded against them in the interviewing process and afterwards.

During data analysis and discussions, ethical issues were considered in the use of

words/terminologies and phrases to describe people, cultures or an ethnic group. According to the American Psychological Association (2012) this should be considered in order not to marginalise or underrate any group or individuals in the society. Shortcomings of the study were made known to readers and all the negative findings related to the analyses were as well reported.

The clearest concern in the protection of the participants' interests and well-being is the protection of their identity (Babbie, 2010). Anonymity and confidentiality were also given consideration and observed as principles of research to make participants comfortable and eliminate fears in providing important information. Assurance of anonymity and confidentiality enables participants to establish trust in the researcher and provide relevant information (La-France & Crazy-Bull, 2009).

To ascertain anonymity in the study, the researcher tried to refrain from recording or using names in the exercise. Rather, identification numbers were used for easy access to the participants when the need arose to contact them for further information. Also, in booking appointment for interviewing participants in the first time, only telephone numbers were taken to contact them.

To ensure confidentiality, a password system was developed to deny people other than the researcher access to the tape recordings to ensure that people do not get the information from the field. Also, since the researcher had access to the identities of the participants, he subjected himself to training in the ethical responsibilities of the various ethnic groups and applied them before, during and after the data collection. Before the data collection, the investigator sought training on the ethics of the Mole-Dagbani, and the Chorkosis, who form the major ethnic groups in the selected areas.

Babbie (2010) observes that the most fundamental technique of ensuring confidentiality is to remove identifying information as soon as it is no longer necessary. To deny people access to the information, the investigator made sure that after booking appointment with participants for interviews and contacting those needed for further information, all identifying information were

removed from the interview booklet.

4.10 Trustworthiness and Dependability

The use of the terms validity (trustworthiness) and reliability (dependability) has generated concern amongst methodologists. There have been debates between the positivists and the naturalists, and amongst some of the naturalists themselves. Golafshani (2003) notes that reliability is a concept to evaluate quality in quantitative study with a purpose of explaining. But in qualitative research, the concept "quality" has the purpose of generating understanding (Stenbacka, 2001). According to Stenbacka, the difference in purposes of evaluating quality in qualitative and quantitative research is one of the reasons why the concept "reliability" is not relevant in qualitative research because it is misleading in qualitative study. It is further argued, that if reliability is used in a qualitative research as a criterion, then the consequence is rather that the study is "no good" (Stenbacka, 2001).

From another perspective, Patton (2002) states that, validity and reliability are two factors that any qualitative researcher should be concerned about whilst designing a study, analysing results and judging the quality of the study. Healy and Perry (2000) assert that the quality of a research in a particular paradigm should be viewed by the terms of that paradigm. Lincoln and Guba (1985), maintain that whilst reliability and validity are necessary criteria for quality in quantitative studies, the terms credibility, neutrality, or conformability, consistency or dependability and applicability or transferrability should be the necessary criteria for quality in qualitative research. To Lincoln and Guba, the term "dependability" be used in qualitative research for reliability, with inquiry audit as one measure of enhancing dependability. In the same vein, Seale (1999) endorses the concept of dependability with the concept of consistency or reliability in qualitative research. This study adopts trustworthiness and dependability for validity and reliability respectively.

4.10.1 Ensuring Trustworthiness and Dependability

In order to reduce researcher's bias to improve quality of the findings of the study and to make the research outcome more dependable, different ways have been suggested by qualitative methodologists. For example, it is argued that inquiry audit should be used to ensure dependability of a qualitative inquiry (Lincoln & Guba, 1985), and that inquiry audit can be used to examine both the process and the product of the research for consistency (Hoepfl, 1997).

According to Campbell (1996), data consistency will be achieved when the steps of the research are verified through examination of such items as raw data, data reduction product and the product process notes. However, in the views of Lincoln and Guba (1985), since there cannot be validity without reliability, a demonstration of validity is enough to establish reliability. In support of this view, Patton (2002) with regards to the researcher's ability and skill in any qualitative inquiry also states that reliability is a consequence of validity in a study.

Guba and Lincoln (1985) argue that, ensuring credibility is one of the most important factors in establishing trustworthiness. To make sure that the research findings are in agreement with the reality, the researcher adopted the following measures:

As explained in the ethics section of this work, the research developed an early familiarity with the cultures of the various ethnic groups to which the participants belong. Thus, before the first data collection dialogues took place, the researcher got himself acquainted with the cultures of the prospective participants through consultation of appropriate documents like written and audio-visual materials and preliminary visits to the study communities. To build trust between the researcher and the researched, Lincoln and Guba (1985), suggest that prolonged engagement should be established between the researcher and the participants so that the researcher can gain an understanding of the participants.

The study used both methodological and data triangulation. Combining different research methods enables the limitations of the individual methods to be taken care by others (Guba &

Lincoln, 2005). In this study, the methodological shortcomings of FGD were taken care of by the individual interviews. Individual interviews have been observed as having the ability of validating the results of FGD in health research (Shafritz & Roberts, 1994). Aside, supporting data were obtained from documents to provide a background to and help explain the attitudes and behaviour of the participants, as well as to verify particular details that participants have supplied. Again, the researcher ensured sincerity in the participants' responses by making sure that anybody approached was given the opportunity to refuse to participate in the interview. This was to ensure that the data collection sessions involved only those who were genuinely ready to take part. As ethics of research requires, from the beginning of each interview and FGD session, the researched were encouraged to be frank. The participants were told that there were no right or wrong answers to the questions that would be asked. In the course of the interviewing and discussions the investigator assumed an independent status to enable participants contribute ideas and talk about their experiences without fear of losing fame or respect to the investigator and other participants (during FGDs). The researcher also asked the participants to exercise their rights by withdrawing from the interviews or the discussions at any point without explaining to the investigator and fellow participants (during FGDs).

Another technique adopted by the study was the use of iterative questioning during interviewing to uncover deliberate lies. This was employed by using probes to generate detailed data, with the researcher returning to matters previously raised by the participants through rephrased questions. Where contradictions came up, falsehoods were detected and the suspected data discarded.

The research was subjected to scrutiny by colleagues, peers and academics especially, during presentations at the various stages of the research. The fresh perspectives that such individuals brought allowed them to frequently challenge the assumptions made by the investigator whose closeness to the study frequently inhibits his ability to view it with real detachment. To this end,

the contributions given enabled the investigator to refine the methods adopted, develop greater explanations of the research design and strengthen the arguments based on the contributions made.

One important thing that was not left out in the research is reflexivity. In qualitative inquiry, meanings attached to social phenomena are produced through interaction, and are culturally constructed (Ling, 2004, 2007; Smith, 2012). Therefore, the gender, class, ethnic background and age amongst other variables of the researched vis-a-vis the researcher's background can have impact on the data outcome. A researcher's own sex, age, level of education, ethnic background amongst other demographic characteristics may influence the researcher-researched relationship. As a male researcher, this was considered not only in cross-gender interviews, but also in interviewing the men. A conducive environment was created for both women and men to freely discuss issues without being influenced by the researcher's background. The researcher was also mindful of his age and level of education in dealing with the various participants. The interview process was subjected to self-searching by examining any preconceived ideas about issues and about the researched, and how these could affect research decisions especially, the selection and wording of questions, interpretations and findings as well. The entire process of investigation was based on reflexivity, free from self-fulfilling prophecy (Madon et al., 2011) of the researcher. The study ensured that the production of knowledge reflected the joint actions of the researcher and the participants. Finlay (2002), explains that self-examination, inter-subjective reflection, mutual collaboration amongst others, ensure trustworthiness, transparency and accountability of research.

Above all, member checks were used by the researcher in the study by embarking on checks to ensure accuracy of the data on the spot, in the course or at the end of data collection dialogues. The participants were asked to read the transcripts from their contributions or listen to the tape recordings of their voices to check whether their words matched what they actually intended. Where there were differences between the written reports or the recorded messages and what the

participants actually intended to say, it was noted and changes were made. These steps were followed in order to ensure that the work possesses the important features of a qualitative data such as credibility, confirmability, transferability to make the work trustworthy which will consequently result in dependability.

4.11 Fieldwork

The field work which began on 30th of May 2015 and ended on the 30th January, 2016, was conducted over a period of 8 months. The researcher solely conducted all the IDIs and moderated the FGDs whilst a rapporteur helped in making notes during the FGD sessions. This was to ensure uniformity and consistency in the questioning, responses and interpretations of the IDI and FGD guides.

4.12 Field Challenges and how they were Overcome

During the data collection, some challenges were encountered in the study communities. One of such problems is the weather due to climate change. Part of the data collection period coincided with the rainy season which made movement very difficult. Due to the seasonality of rainfall in the study areas which permits farmers to farm only once a year, it was a busy period for farmers to spend time on interviews, because it was the planting season and delaying in planting may lead to crop failure. Staying in the community in the period, the researcher noticed that most farmers were not going to their farms on market days. Therefore, arrangements for interview appointments were fixed on market days and late in the evenings after they have returned from their farms.

Another challenge was reluctance on the part of the people to be participants especially the traditional practitioners, who operate without permit for fear of being reported for arrest. Some also entertained the fear that the recordings may be used against them in future and opted for

writing instead of voice recording. This delayed the interviewing process especially in the FGDs. However, the researcher's stay in the communities and interacting with the members, involving key members of the communities in the organisation of the interview sessions, and the use of the community information centres by the assembly members motivated the potential participants to take part and some accepted the use of tape recorders.

Some of the health professionals were not willing to provide data from their institutions for fear of blackmail following the recent activities of investigative journalists in the country. In connection with this, in the Yendi Municipality, the health professionals suggested choosing study sites for the study. But this was not considered by the researcher on the grounds that they may go to the various communities to meet potential participants and guide them on how to respond to questions. The researcher dealt with the communities through the gate-keepers before consulting health professionals.

Further, the study found that the traditional practitioners were not responding candidly in FGDs like in interviews. This called for reducing the number of FGDs and increasing IDIs for this category of participants.

As a male researcher, in an attempt to follow cross-gender research guidelines, females of similar background as the participants were initially employed to be with the researcher during the interview sessions to avoid suspicions of all kinds. However, the technique could not generate data effectively as the participants did not express themselves candidly and some refused to talk because of the presence of a fellow woman. The participants opted for one-on-one interview with the researcher. The females were later dropped and the data were collected solely by the researcher.

4.13 Data Management and Analysis

The study was programmed to allow for expansion of field notes and transcription of recorded data to be done the following day after each interview session. Immediate expansion of field notes, transcription and analysis is recommended (Patton, 2002; Silverman, 2010; FHI & USAID, 2011) for qualitative inquiry as the issues are fresh in the mind of the researcher. This also served as a guide for subsequent data collection as the initial analysis suggested change of questioning in some cases. It also helped the researcher to contact participants with ease in case of loss of important information or for clarity as the researcher was still in the study communities.

4.13.1 Transcription and Translation

Both the in-depth interviews and focus group discussions were conducted in English Language and the respective local dialects (Dagbani & Chokosis) of the participants (for those who did not understand English Language). The data collected comprised written text, visual data from interesting phenomena and tape-recorded audio data. The first step in the analysis began with putting the recorded data into written form in the respective languages in which the recordings were made. Those in local dialects were then translated into English Language for analysis. This process was carried out with ethical conscience to avoid distortion of information and to ensure that the identity of the participant was not connected with the data to ensure anonymity. To produce a dependable and trustworthy data for the analysis, verbatim transcription and translation were done and non-verbal cues were noted and included.

4.13.2 Coding and Analysis

The data were analysed based on the judgment of the outcome of coding with the Atlas.ti.v.7 software and manual coding by the researcher. The ATLAS.ti.v.7 is a qualitative data analysis software designed to organise, manage, and analyse textual, visual and audio/video data. The

purpose of this software was to uncover, and systematically, analyse complex phenomena that were hiding in unstructured data (Centre for Family Demographic Research (CFDR), 2012). The software provides tools that allow the user to locate, code, and annotate findings in primary data material (Lewins & Silver, 2007). It helps the researcher to weigh and evaluate their importance and to visualise complex relationships between the findings. The choice of this software was informed by the rationale that it has wide usage because of its flexibility and is applicability in the study. Aside, the software is capable of consolidating large volumes of documents and keep track of all notes, annotations, codes and memos in all fields that require close study and analysis of primary material consisting of texts, images, audio etc. In addition, it provides analytic and visualisation tools which are designed to open new interpretative views on the material (Friese, 2011). To ensure credibility and to make sure that no vital data were left out, manual coding exercise was carried out, which was compared with the outcome of the Atlas.ti.v7 software.

Thematic analysis was used for analysing the data. The data which were recorded with a tape recorder during the FGDs and IDIs sessions were played and listened to repeatedly in order to get familiar with the data. There were comparisons of words, emphasis of participants, comments, consistency of comments, and the specificity of responses in follow-up probes. Similar thoughts experienced across the participants were identified, coded and grouped together. Out of each group of similar thoughts, a unifying concept or underlying theme was derived. Key points, phrases, and illustrations were also identified to back up the findings. Finally, emerging themes that are similar were grouped together to come up with major themes through a consultative process amongst authors. Samples of the analysis are summarised in pages below.

4.13.3 Worldviews and Health Beliefs around Pregnancy and Childbirth

The category 'behavioural codes' classifies the norms, values or taboos that women in the study communities are supposed to observe during the maternity period.

Table 4.6: Worldviews and Health Beliefs around Pregnancy and Childbirth

Code	Sub-category	Category	Theme
Prohibition from:extra-marital sex, late night and hot afternoon movements Instant protection for babies after birth, Burial of placenta by biological father/male siblings	Non-Food Taboos	Behavioural codes during maternity	Worldviews and health beliefs around pregnancy and childbirth
Prohibition from: Eating eggs/duck eggs Eating the meat of dead animals Eating the meat of pregnant animals Eating food prepared with shea butter	Food Taboos		

Source: Fieldwork, 2016

These behavioural codes are in two major forms. These are non-food taboos and food taboos (Table 4.6). For instance, in all communities, pregnant women were not supposed to eat eggs (food taboo) or go out late in the night (non-food taboo) to avoid giving birth to thieves/children without hair and abnormal babies respectively. The theme worldviews and health beliefs around pregnancy and childbirth addressed behavioural codes which took the form of food taboos and non-food taboos, which are coded and further discussed in detail in Chapter 5.

4.13.4 Decision-Making for Care Seeking

In this study, different people within the family, be it nuclear or extended, were involved in the decision-making process. This implies that in the compound houses especially decision-making on care seeking does not rest only on the woman or the husband but includes other members of the family such as senior male siblings of the woman's husband, his father, uncles or grandfathers (further explained in Chapters 5 & 6). The decision-making processes

informed the nature of decision reached which were sub-categorised into 'decision types', and these were further grouped to form the category 'actors'.

Table 4.7: Decision-Making for Care Seeking

Code	**Sub-Category**	**Category**	**Theme**
Decision-making process	Type of decision	Actors of decision-making	Decision-making for care seeking
Decision made is by only woman; subject to approval by husband or family	Individual and Tentative	Woman/wife	
Sole decision-making, decisions reached are final and implemented	Individual, Independent and final	Husband	
Sole decisions by family head Family head & other male members of the family Decisions are final Delayed decisions	Individual or Joint, solely male decisions	Family	
Both husband and wife decides but husband dominates, finalises the decision, and implements	Joint but male-dominated	Husband and Wife	

Source: Fieldwork, 2016

The various actors in the decision-making process took different types of decisions (Table 4.7). For example, women who need care were observed as one of the actors of decision-making who make individual decisions especially in the absence of their husbands or family heads but these decisions were tentative' - subject to approval by the either the husbands or family heads. These are summarised in Table 4.7 and further explained at length in Chapter 6.

4.13.5 The Role of Traditional Birth Attendants in Maternity

The role of TBAs as a theme was coded under the heading 'specific role', which was sub-headed as 'forms of role', which fall under 'stages in maternity' as the main heading. Basically,

in the various stages of pregnancy and childbirth, the role of the TBAs were classified as medical or spiritual. These are summarised in tabular form (Table 4.8), and elaborated and discussed in Chapters 5 and 6.

Table 4.8: The Role of TBAs in Maternity

Code	Sub-Category	Category	Theme
Specific Role	Form of Role	Stage in Maternity	The role of TBAs in maternity
Foetal examination Examine women's -health Make referrals Guide women to use medicines Assist women to syringe Give treatment Provide counselling Serves as liaisons	Medical Role	Prenatal Stage	
Assist in spiritual bathing of the pregnant woman Performs any other role assigned by spiritualist or husband	Spiritual Role		
Prepare room for delivery Prepare women for delivery Assist at delivery Administer medicines Insert hands into birth canal to remove baby or placenta Make referrals Give psychological support	Medical Role	Delivery Stage	
Assist husbands/spiritualists to perform spiritual roles Instructed to subject parturient to confession in prolong labour/placental delay	Spiritual Role		
Cutting and treating umbilical cord Bath both baby and mother Perform fundal massage Give treatment to heal wounds Treat bleeding Make referrals Educate mother on personal hygiene Prescribes food for woman	Medical Role	Postnatal Stage	
Assist men to give spiritual protection to baby	Spiritual Role		

Source: Fieldwork, 2016

4.14 Conclusions

This chapter presented the design, data collection methods and procedures employed in the study. The use of a culturally appropriate approach, pilot study and the necessary changes made in initial design were also discussed. The challenges experienced in the field and how they were dealt with were also presented. It also discussed how the data were managed and analysed and presented samples of how coding was done.

The combination of IDI and FGD in the study was equally useful in revealing issues as each of the instruments took care of the weaknesses of the other. As the FGDs generated debates over issues to bring out interesting responses amongst participants, the IDI was able to illicit information that participants were not in the position to give in group interviews.

Cultural consideration in data collection is a rewarding strategy in indigenous research. The adoption of a culturally appropriate approach in this study symbolised appreciation of people's culture, accepting them and accommodating them. The presence of the researcher in the communities and following the cultural ethics of the people eliminated fear and created good rapport between the researcher and the participants which is a precondition for candid responses. Sticking rigidly to laid down research procedures without being mindful of the culture of a people is a step to generating false responses from research participants. Assessing the needs of indigenous communities in research should be a priority in qualitative studies. Getting exposed to the culture and environment helped the research to overcome challenges encountered in the communities.

Spending some time with research communities enabled the research to be exposed to cultural and ethical principles including cross-gender issues. This guided the research to adopt the appropriate ways of reaching the prospective participants for the study. This study revealed that cross-gender research needs consideration of the cultural setting of the participants rather than documented principles that might not be applicable to some cultures. That is, ways of reaching

participants or candid data and dealing with research is culture-specific and do not necessarily follow a universal path. Therefore, studies in indigenous communities that do not incorporate cultural demands is likely to end in an inaccurate data or shallow results.

The following Chapter 5 presents results and discussions of analysed data on worldviews, health beliefs and indigenous birthing practices.

CHAPTER 5

WORLDVIEWS, HEALTH BELIEFS AND INDIGENOUS BIRTHING PRACTICES

5.1 Introduction

Worldviews and health beliefs are important components of culture that inform indigenous healthcare practices and people's attitudes towards healthcare (Baer & Nichols, 1998; WHO, 2001; Maimbolwa et al., 2003; UNDP, 2007; UNFPA, 2016). Human reproduction is a function of both biology and culture of the individuals involved (Nilsson & Lundgren, 2007). Therefore, under the influence of cultural behavioural codes, pregnant women seek care from traditional practitioners (Senah, 2003; Obasi, 2013; Sarkodie & Abubakari, 2014; Rutaremwa et al., 2015).

This chapter is organised into two main sections. The first section (5.2) presents and discusses results on worldviews and health beliefs around maternity, and how the services of traditional practitioners (TP) impact clinical care. In this section, discussions are based on data which answer the first research question "what values, norms, beliefs and perceptions inform pregnancy and childbirth practices". To answer this question which addresses the first objective of this study, an empirical qualitative data on worldviews, and health beliefs around pregnancy and childbirth were collected from TPs, husbands and wives. The data collection also considered the linkages between these worldviews and health beliefs and the utilisation of maternal healthcare services in the selected communities.

Section 5.3 deals with traditional practitioners (TPs) and indigenous birthing practices. This section highlights and discusses the role played by the TPs such as herbalists, spiritualists and traditional birth attendants (TBAs) who are the main actors in the traditional medical practice. This section answers the research question: "How is maternal healthcare provided or received in the traditional setting"? Answers to this question address the second objective of this study.

5.2 Worldviews and Health Beliefs around Maternity

Worldviews and health beliefs are the attitudes, values, and knowledge about health and healthcare services held by individuals and their families that might influence their subsequent perceptions of need and use of healthcare services (Andersen, 1995). In this section, interview transcripts and field notes generated from husbands, wives and traditional practitioners in FGDs and IDIs are used to discuss the worldviews and health beliefs around pregnancy and childbirth, and how they influence utilisation of clinical services in the selected communities. The discussion also includes the impact of the TPs activities on maternal, foetal and neonatal health.

The data generated a number of issues from husbands, their partners as well as the TPs regarding taboos that expectant and nursing mothers were expected to observe during the period of maternity and the ethical values behind these beliefs and practices. These comprised dietary taboos and non-food taboos. Dietary taboos are behavioural codes which forbid women from eating some kinds of food during the pregnancy-postpartum period. In this study, the dietary taboos observed during pregnancy were; prohibition from eating the meat of pregnant animals of all kinds, dead animals of all kinds (i.e those not slaughtered), eggs (amongst Dagombas) or duck eggs (amongst Chorkosis) and shea butter or its related food. The non-food taboos are prohibitions that are not related to food which expectant and nursing mothers or their spouses were expected to observe. The non-food taboos discovered in the study were prohibition from; extra marital sexual intercourse for spouses, premarital pregnancy and late night and hot afternoon movements for pregnant women. Aside, they had to give protection for babies immediately after birth and the burial of placenta must be done in the baby's father's house by the biological father or his paternal male relatives.

The main values behind these behavioural codes were to: save the lives of women and their babies; declare the spouses innocent or guilty of extra marital sex; show submissiveness to spouses, family heads, elders and to build trust for marriage sustenance; establish the paternity of

the unborn baby if the pregnancy was a product of extra marital sexual intercourse or in the case of premarital pregnancy when the man responsible is not known; seek ancestral protection and avoid punishment or misfortunes from disobedience; and show commitment and faithfulness to the ancestral gods. Violation of any of the taboos from the two categories required rituals or sacrifices to purity the spouses and the babies or else, the family may be cursed, the baby or the spouse involved may suffer misfortunes or die.

This research discovered that conforming to the traditional norms of birthing resulted in dualism of care seeking from the clinical and home care sources. This was the outcome of dual-beliefs systems practiced by the participants. Both the Muslims and Christians adhered to the Traditional African Religious principles which form the foundation of the Ghanaian culture (Nukunya, 2003). Using the services of the traditional practitioners led to poor clinical attendance in the form of low ANC visits, poor timing and neglect of ANC, Skilled Delivery and PNC. Also, the quest for privacy for ritual performance and observance food taboos promoted home care at the neglect of intensive clinical care during the pregnancy-postpartum care.

5.2.1 Dietary Taboos

The husbands, wives and the TPs were asked to mention some of the food taboos that expectant women were supposed to observe. The commonest and most frequently observed tabooed foods identified across the datasets were; the meat of dead or pregnant animals, food prepared with shea butter and eggs (amongst Dagombas) or duck eggs (amongst Chorkosis). The primary reason for instituting and observing food prohibitions (bindiri chiaha amongst Dagombas) during pregnancy was to ensure the delivery of normal and healthy babies as well as to avoid punishment from the ancestral world in the form of abnormalities in children such as deformities and mental retardation, curses or death. This was the response of an herbalists:

"Eating dead or pregnant animals will make the baby die in stomach or the woman die.

Sometimes pregnancy will spoil. If mother eat eggs she will born thief baby and the baby will give her troubles." (67 years, Herbalist, MSLC, Christian).

Whilst the consumption of dead and pregnant animals in pregnancy was believed to be the cause of premature birth, miscarriage, still birth or maternal death, the consumption of eggs (amongst the Dagombas of the Mole-Dagbani ethnic group) or duck eggs (amongst Chorkosis of the Akan ethnic group) in pregnancy was believed to be the cause of giving birth to thieves. Shea butter was said to be a facilitating ingredient to the development of abnormality in foetuses or babies.

The views of men including the TPs appeared to be resilient in normalising food taboos as compared to their female counterparts. Interestingly, some of the husbands with higher level of education ensured that their spouses observed food taboos in their most recent pregnancies. In an IDI with a husband, he said:

"There is one thing I used to remember my old Daddy after his death. As a man and the family head I have to ensure that my wife followed the norms to free her from any spiritual punishment. My father showed me a number of women who suffered permanent injuries and disabilities because they disobeyed the tradition. Personally, I was very strict on my wife till she delivered. In fact, she observed the food taboos perfectly." (42 years old man, social worker, bachelor degree, Muslim).

Though some TBAs and some mothers were in support of the observance of some of the food taboos, the taboos appear to be losing their values amongst the women with formal education. All the women interviewed had knowledge about food taboos and their implications but those with secondary education and above were less concerned about the taboos in their last pregnancies. In both FGDs and IDIs, some women identified some food taboos as rather harmful to their health and that of their unborn babies. This was expressed in FGD by an immigration officer and supported by her colleagues:

"...I don't have food taboos in my dictionary unless I am advised by the doctor that a particular type of food is not good for me. My husband always talks about it but I don't have the time to be too selective in eating because I am pregnant. What about our counterparts in the south? Don't they also have ancestors and gods? Food taboo remains a thing of the past to me." (34 years, Bachelor degree, Christian).

According to both the husbands and their spouses, pregnant women were subjected to vegetarian

diet in the third trimester to reduce the fats in the body to enhance rapid delivery when they were due for delivery. Together with other food taboos, the pregnant woman was limited in her choice of food. They had to also stick to vegetarian diet because they could not trust the source of food or meat sold on the market or in restaurants as to whether it was prepared from shea butter, pregnant animals or dead animals which were all forbidden. This is the experience of a participant in her last pregnancy in FGD which was similar to other women's views:

> *"Over here, in pregnancy we have some foods that we are not supposed to eat. In my case I stopped attending programmes to avoid eating out. I stayed away from all sorts of meat because my husband was too strict on me. I had to rely on vegetables and beans became my only source of protein. Anyway, I did not suffer to deliver. By the time the TBA came to the house to assist I had already delivered."* (39 years old, trader, JSS, Muslim).

Observance of food taboos created limited choices of food for the pregnant women. This situation renders women susceptible to food related health conditions like anaemia which is one of the top four leading causes of maternal mortality in Ghana (GSS, 2009, 2015). In fact, according to the 2015 report by the Ghana Statistical Service and collaborators, this region is leading in incidences of anaemia in babies in the country. Women are required to eat nutritious and balanced diet during pregnancy because the foetus depends on the food the pregnant woman eats to develop and grow. Having a limited choice of food can affect the diet and health of a pregnant woman and the unborn baby (Wahid & Fathi, 1987; Arzoaquoi et al., 2015). This is more serious in the dry season in Ghana when vegetables and other important food ingredients become very scarce and expensive especially, in the study region. Another participant, 31 years old female teacher said:

> *"Pregnancy is associated with feelings for different varieties of food. I ate what I felt for and what is good for me and my unborn baby. The question is who cooks? My husband never visited the kitchen throughout my pregnancy so how would he discover what I cook for myself? ..., me I never followed any of those taboos unless what the doctor asked me not to do. If I don't eat good food and die my husband will marry another woman. We are already two."* (Bachelor Degree, Muslim).

This is a woman who is conscientious and empowered by education and career. She is economically empowered and resourced with the requisite knowledge to ensure good health

through healthy lifestyles. Education is a weapon for fighting and reducing socio-cultural poverty in society because educated women are able to articulate their health needs and concerns confidently (Obasi, 2013; Harvey, 2014; Ukegbu et al., 2014; UNFPA & ICRW, 2014). Women who were totally economically dependent on their husbands demanded money from them before getting what they wanted. This surrendered them to total control by their husbands because the husbands only gave money when they considered the purpose necessary. Educated and empowered women had knowledge about nutrition and could acquire nutritious food without the husbands' support.

Some women ignored skilled delivery to avoid eating forbidden foods in health facilities and the associated punishment from the spiritual world. This is because seeking clinical services for ANC or delivery may require detention for intensive care. Suggesting that, the woman will be fed by the facility. This makes some families decide for the parturients to remain home and deliver or seek healthcare from the TPs because they could not determine the kind of food that would be given to them and they had no control over the clinical staff. This was evident in the views of the TPs, husbands and women who expressed their experiences in the FGDs. However, this generated arguments amongst the men. Whilst some argued that they could prepare food at home and carry to their wives at the hospital, others considered it as difficult to break the protocols in the hospital every day to send food. Aside, they said it was not easy to meet the visiting hours in the facility, and that, would also affect productivity on their farms and in their businesses. Furthermore, they complained that whether a woman ate from the facility or not she was made to pay for the food. This is what a participant expressed in FGD:

> *"... Already the professionals do not want us to observe the taboos. If you tell them that they should not give your wife a particular type of food that is what they will give. I cannot carry food every day to the hospital. Look at the way they will even ask you; what do you want? Why coming at this time? I have to go to farm too. So, the best way is to keep her at home and our mothers will help her deliver safely. Apart from that I know women; they are like children; they will eat the hospital food and put you the man in trouble."* (43 years old man, farmer, MSLC, Muslim).

Whilst acknowledging the need for food taboos, other men disagreed with their colleagues with the view that it was allowed to send food to the facility for those on admission, and that, it was up to the family to make sure they met the visiting hours. A participant noted:

> *"Let us all know one thing. I don't defy the need to observe our food taboos but I think the hospitals allow family members to send food to relatives on admission. They only make sure you meet the visiting hours in order not to interrupt their work. We all have work to do but pregnancy and childbirth are equally important. Why do we work? To feed our wives and children so we have to be committed to the process of giving birth as well."* (32 years old man, lab technician, diploma, Muslim).

5.2.2 Non-Food Taboos

Beside food prohibitions, the participants were asked to identify behavioural codes that women or their spouses were supposed to observe during the pregnancy-postpartum period. The main prohibitions identified by the participants were confession by parturient during delivery for extra marital sex or to establish the biological father of the unborn baby during delivery for premarital pregnancies and movement restrictions. The men were also to abstain from extra marital sex when their wives were pregnant unless the extra sexual partner was a former girlfriend or a co-wife. They were also to give protection to babies immediately they were born using concoctions, and ensure that they buried the placenta at the backyard of their houses by themselves or their male siblings. These are further explained below.

5.2.2.1 Unacceptable Sexual Relationships

The participants were of the view that unacceptable sexual relationship was the cause of obstructed/prolonged labour and retention of the placenta as well as maternal and infant mortalities, which consequently results in home delivery for ritual purification. The study discovered extra marital sexual intercourse and premarital sexual relationship as culturally unacceptable, which women and men ought to avoid. Across the datasets from all settings, extra marital sex dominated as a taboo amongst the participants. Marital infidelity on the part of both

partners has a serious repercussion on the pregnant woman and the unborn baby. It was believed that extra marital affairs could bring curses to the woman in the form of labour dystocia (obstructed labour) or prolonged labour and retention of the placenta during delivery.

According to the TPs, the situation is worsened when the said pregnancy was an outcome of marital infidelity. Death was identified as the most serious form of punishment meted out to such women from the ancestral world. In the event of obstructed labour or retention of the placenta arising from the presumed extra marital affairs, the woman was subjected to confession and rituals to purify her to enhance release of the baby or the placenta by the ancestral spirits.

However, the TPs added that women could suffer obstructed labour when their parents were not in support of the relationship and they went ahead to marry - implying, that the parents could pronounce curses on the woman in question. In that case, if the parents were dead the family would have to pour libation to the ancestors of the house to apologise to free the woman whilst she remains in labour. Where the said parent was alive, an apology would be rendered on behalf of the woman for reversal of the curse to enhance expulsion of the baby or the placenta.

In the IDIs, the husbands and the TPs mentioned that the men were not expected to establish new sexual partners at the time their pregnant spouses were not medically fit for sex unless the said partners were old girlfriends or co-wives. Any man who violated this norm was not allowed to set eyes on his newly born baby, lest the child would die unless he confessed for purification through rituals or sacrifices.

Women including teenagers who got pregnant through premarital sexual relationships were made to undergo the same process to enable the family to establish the paternity of the baby. It was believed that at the mention of the baby's biological father's name, the baby would rapidly expel. Thus, because premarital sex is prohibited, young girls found it difficult to mention their boyfriends' names and the boys also denied responsibilities. Therefore, this was the only way to establish truth regarding paternity of the baby.

Whilst the husbands limited their explanations on prolonged labour and retention of the placenta to extra marital sex and curses from parents, in the IDIs the spiritualists added that sometimes women experience such complications due to machination by witches which is a spiritual battle from enemies. They further explained that it could occur as a form of punishment to either of the spouses for their wrong doings against the gods of the land or ancestors within the family.

The views of the TPs and the women established that the weight of these prohibitions was heavily carried by the women. The TPs mentioned that even though some of the complications were caused by men, women became the objects of the burden because of their physiology. The TPs noted that, when men violated the taboos they kept them secret and quickly reported to the spiritualists for purification rituals. Some of the women noted that they were made to undergo rituals when they had not committed any sins. The issue of extra marital relationship being the cause of prolonged labour and retention of the placenta (walisiyuu amongst Dagombas) cuts across the different ethnic groups in the study site.

In this study, the men, TPs and women aged 40-49 years who had either basic or no formal education showed a very strong commitment to these beliefs as most of them were in support of the taboos and insisted on continuous observance. This practice has the tendency of being sustained in these communities for some time as the mothers pass on the tradition to their daughters. These women who had been subjected to societal or institutional oppression through male supremacy had internalised these oppressions on the grounds of cultural and religious or moral conformity. Two teenagers who got pregnant through premarital sexual intercourse were made to deliver at home for the families to establish paternity of the babies. This partly explains why some interventions put in place to encourage health services utilisation do not succeed in some cases. A woman shared her views in IDI on this issue. She said:

"...today marriages are not sustainable because the young ones who have been to school feel

the taboos are not necessary. So, they do things that are not to be done by married women and invite curses to themselves and bad luck to their husbands. This "chilhili" (taboo) is good to keep women holy. People who don't observe this taboo end up breaking up with their partners because they end up flirting with all the men around." (46-year old woman, farmer, Muslim).

A closer look at the data shows that teenagers and women aged 35 years and above, had higher risks of developing or aggravating any existing complications or even dying especially during delivery. This is because the teenagers are vulnerable and susceptible to complications during pregnancy and delivery because their reproductive system might not be developed or matured for childbirth (GSS, 2008). As the teenagers may experience obstructed labour due to early pregnancy and foeto-pelvic disproportion, those aged 35 years and above may also develop complications due to age and multiparity (Senah, 2003; GSS, 2008, 2009). The age, parity, pre-existing conditions and the present state of a woman's health are factors suggesting the likelihood that they will need health services (Andersen, 1995; Rebhan, 2008). It is expected that the teenage expectant mothers, women with multiple parities and those aged 35 years and above will make timely and frequent use of clinical services. Women with multiple parities are expected to have had enough of education and counseling on pregnancy and childbirth which would be translated into positive behaviour towards modern healthcare services. Rather, this research found that the choices and utilisation of healthcare services were significantly driven by the cultural/religious beliefs and practices of the women and either the women or their families did not have perceived need for clinical services.

As indicated earlier on, it was through the older women (some of whom were mothers to the teenage mothers) who have internalised these oppressive practices that the husbands/family heads were able to enforce the confession. This was the experience of a teenage mother during delivery as she shares with the researcher in IDI:

"I started feeling pains around 7pm. When I told my mother she called my uncle. I thought they were organising for hospital but they called one old lady to come and help me deliver. I was in serious pain for more than three hours. So they asked me to confess so that I can

deliver fast. I told them I didn't have anything to confess but they didn't mind me and insisted. My father was not around when I was going to deliver. It was my mom and my uncle who insisted that I confessed. I did not have anybody in mind apart from my boyfriend I told them about. So I mentioned his name and after some time I delivered." (Teenage Mother, 18 years, dropout, Muslim).

Mothers of some teenage mothers who happened to be participants also noted that some of the young girls felt shy to mention those responsible for their pregnancies, especially, where the parents did not know their fiancees, and therefore, confession was the best alternative to establish the paternity of their babies. One of the mothers had this to share in FGD:

"Some of the girls they ear locked. When they pregnant they hide it so the father and mother will try to know them boys but they do not tell so when it reach birth day they will confess for the mother and father to know their man. When my daughter is pregnant she do not tell anybody who pregnant her so my husband tell me to force her to confess if she is going to born and she mention the boy name." (48 years old, farmer, primary school, Muslim).

Whilst some spouses felt that this taboo regulates women's sexual behaviour in the society, others protested for change. The young and formally educated women felt it is a disgraceful and embarrassing norm to observe. Some of them who observed the taboo claimed they did so out of duress - under the influence of their family heads and the labour pain. A 23-year old woman who is a social worker shares her experiences in IDI:

"Hmm... I don't even know how to put it. You see, because of the nature of my work my husband did not trust me. So, I am a victim of this taboo as I was made to deliver at home so that I could confess but I knew I was not having any extra marital affairs. I spent less than 30 minutes in labour. The placenta followed the baby like mother and child and all my enemies were in shame. This is a kind of embarrassment and punishment to women. Whoever kicks against it is taken for being unfaithful to the husband and the tradition continues." (Bachelor degree, Muslim).

The male participants who had contrasting views felt that the taboo was good to keep marriages, arguing that there was sanity in the community compared to other areas in the southern part of the country where the taboo was not observed. Below are the views of a male participant in IDI:

"... Any woman who do not like to born home and say the truth is just like "ashawo" (prostitute). And every man can chop her. If we stop this law many women will die because they will not say true in delivery and die. But if they say true, we go do this thing ooh.... what we call it ahh !!sh ... ritual yes, to make her free not die." (51 years old man, farmer and herbalist, MSLC, Muslim).

The husbands felt the taboo sets moral standards for them and makes their wives faithful and committed to them in marriage.

5.2.2.1.1 Influence of Compound Housing and Extended Family Systems

The compound housing system was observed to have influence on decision-making towards women's utilisation of healthcare services. The study discovered that enforcement of home delivery, confession and the associated rituals was facilitated by the traditional compound housing system (Figure 5.1) which was the commonest in the study region. This system allows spouses and members of the extended family to live under the same roof.

Figure 5.1: Compound House

Source: Fieldwork, 2016

Comparison of data from the women established that unlike spouses who stayed separately, couples who stayed in the compound houses were usually the objects of cultural beliefs and practices. This housing system is structured hierarchically, with the young couples at the bottom

who depend on the family heads at the top for any action. In such a situation, even the husband has no total control over issues in the marriage when the senior brothers, parents, uncles and grandfathers are around. This study observed culture and social networks having strong influence on women's access to the health services. In some instances, transport-related factors were not the cause of women's inability to access health facilities. The women's attitudes towards health seeking were strongly influenced by the socio-cultural structures within the households and the community. Therefore, irrespective of the level of education or knowledge of the spouses in the compound houses, they had to obey their parents and uncles. In FGD one woman said:

> *"..., it is a problem. I and my husband stay with his parents and uncles on the same compound. Everything my husband will inform the father and uncles and they dictate to him what he should do. To the extent that when I decided to go for scan to check whether my time was due he had to tell the uncle who is older than his father and the uncle suggested that we should rather go and consult a spiritualist because he can even give us the day of delivery and it will not fail. So, my husband obeyed him and did so. When I was due for delivery, my sister who is a nurse asked me to come to her hospital for supervised delivery but I was made to have home delivery."* (29 years old woman, Fire Officer, bachelor degree, Muslim).

In FGD a 28 years old Christian female teacher in support of her colleagues' condemnation described this practice as "barbaric, disgraceful, embarrassing and an infringement on women's human and reproductive rights". To some women, the men delayed them unduly just to avoid facility-based delivery when they informed them of labour symptoms. In FGD a woman who had been refused institutional delivery on two occasions through intentional delays by the family had this to share:

> *"When they don't want you to go to hospital for delivery they will not tell you the woman. They will be delaying you and be arranging for the herbalists and TBAs. They will be holding meetings and before you realise you are about to deliver and then they tell you it is risky to go to the hospital because the baby can come out any moment. In my first pregnancy, this is what they did. In my last pregnancy, too the same thing."* (29 years, trader, SHS, Muslim).

Spouses with strong ties with members of the extended family but stayed separately had different experiences. Decision for care seeking was either jointly taken by the couples or individually taken by the husbands and was influenced by the knowledge of the couples. In response to a

colleague participant's views above, a police woman staying in barracks with the husband alone had this to share:

> *"I will not dispute what my co-participant is saying and I can feel what she went through because I had a similar experience in my last pregnancy when I was staying with my husband's parents in a compound house. Sir, I can assure you that everyone in these communities is strongly attached to the extended family system and the relationship is always intimate. My husband's parents have no hand in our decisions on childbirth because we do not stay with them anymore, we don't share with them anything relating to pregnancy. But once a while we meet to discuss issues of family interest. Of course, they are more experienced than us so if we need guidance we fall on them. Over here my husband is the head of this family and we take our own decisions"* (30 years old, Diploma, Muslim).

In support of the women's views, some men had divergent views from their colleagues in the FGDs. Three of the four men who opposed to the practice of confession in labour were career men who were not living with their parents under common roof. The fourth person was a university student. They argued that extra marital sexual intercourse and childbirth had no scientific link. One of the participants had this to say:

> "*... Some of the innocent women who die during delivery in these areas have this old-fashioned taboo to blame. Extra marital sex and obstructed labour or retention of placenta in delivery have no scientific link for they just punish our women for nothing. It is just that one cannot overrule one's father's decision when staying with them that is why sometimes some guys succumb. Why are the men not forced to confess like women?"* (37year old man, Agric Extension Officer, Muslim).

Interference of the the elderly members within the compound houses was a key obstacle to some couples. Because overruling father's decisions was regarded as a disrespectful act which could attract curses to the son in question. Below are the views of a man who stayed with parents in the compound house and later moved out to stay with the wife:

> *"Hmm... The moment the old men see that you are not in favour of their decisions they get angry at you and some may even pronounce curses in extreme cases. You and I know that by our tradition, curses from parents are not good to be associated with, hence, most young guys will put knowledge and education aside to listen to the elderly people. The best way out of this is to stay with your wife alone just as we have relocated. Now we determine what to be done and not my father."* (34 years old man, social worker, bachelor degree, Christian).

Some of the young and formally educated couples practised the tradition for avoidance of curses from their parents/family heads which they believe do not fail. Similarly, Arzoaquoi et al. (2015)

observed amongst the Krobo ethnic group in Ghana, that women observe some behavioural codes in pregnancy as a way of showing respect to the elders and ancestors.

5.2.2.2 Restrictions on Movement

Pregnant women were not allowed to move outside their houses late in the night, not even staying outside the rooms in the house. They were not allowed to go into the bush in hot afternoons. These were to avoid any encounter with "alizini" (dwarfs) amongst the Dagombas or spirit bird (owl) amongst the Chorkosis that could attack the woman and cause abnormality in the unborn baby. This taboo generated diverse views from the various participants in the study. Some of the husbands insisted that their wives observed the taboo whilst others opposed. For example, a husband in Yendi community shared this in FGD with colleagues:

> *"I came to meet it so as a man I cannot allow curses to affect my children when I can prevent it. I made sure my wife did not move out late in the night and in hot afternoons till she delivered. Why can't human beings follow some basic life principles and be free? We want to be like those in the west but we are blacks with our own culture."* (45 years old man, farmer, MSLC, Muslim)

Others explained that the taboo was no more necessary because pregnant women could travel and return at any time. Some also visit their farms and may return in the afternoons through the bush. More than half of the participants (husbands) in the group reacted against the statement made by their colleague above. One of them said:

> *"Tradition be what? People whose wife go out night time in southern Ghana they die or they sick or their childs die? What about when the woman travel and keep late and coming home? Or she go to farm and come hot afternoon? So, we must forget about this old tradition and make the women feel free to deliver baby for us. Me I will not be support of that old village law."* (48 years old man, farmer, no formal education, Muslim).

In-depth interactions and further probes with the women revealed that most women who had home delivery experienced it in the night. Some urbanites, women in communities with CHPS compounds and those in villages without facilities behaved similarly towards facility-based delivery. Some women explained that they spontaneously experienced the signs of labour late in

the night and there was no means of transport to access the facility. Others said they did not have the need for clinical care because they were healthy. One participant shared this with the researcher in IDI:

> *"Oh! This is not my first time. I normally deliver in the house in the night because I don't have any problem. You know it is not good to be going out in the night in pregnancy or as a parturient. If there is no problem with you better deliver at home. When you are going to hospital many people will be looking at you but in home delivery they will not know but only to hear that you have given birth."* (38 years old woman, farmer, JHS, Muslim).

Women who felt they were strong and healthy at the onset of labour delivered at home in the night. A woman in Yendi town who stays near to the municipal hospital had this to share in IDI:

> *"Hmm... OK. I don't know how to begin but I have to explain. If you ask I will tell you. My house is just by the health centre and I don't need a vehicle to visit the facility. I did not go to the health centre to deliver because I was waiting for my husband to come before. So, when he came he told me it was late and so he sent for a spiritualist and one old woman who has been assisting women in delivery and they told me to exercise patience. I waited in pain till the man gave some herbal derivation to drink. Afterwards I was left with the old lady till the baby expelled."* (38 years, trader, Junior Secondary School leaver, Muslim).

As discussed earlier on, this had nothing to do with means of transport and distance but the need to avoid facility-based delivery late in the night. Because it was forbidden to go outside late in the night - she must remain indoors. In support of this tradition, one man in IDI said:

> "*It is the will of the ancestors that a woman delivers in the night at home because that is the time the ancestors are awake and can protect the baby and the mother from our enemies. The house is the dwelling place for the ancestors and they will not be happy seeing a parturient leaving their vicinity for the hospital to deliver. Definitely, that woman will get attack on her way to the hospital or within the hospital."* (51 years, farmer, no formal education, Muslim).

Contrary to previous studies, this study discovered that as women, the TBAs had limited power to influence in treating or choosing a type of treatment for women. They primarily assisted at delivery after the family had reached a decision. The study found that the choice of home birth in the night was initiated by the family heads and the TPs as an act of protection for the parturients and their unborn babies from ancestral spirits. According to the TPs and the husbands, the TBAs only took instructions from them and acted accordingly. In both FGDs and IDIs the TBAs

explained that they only gave herbs when the men asked them to do so for their work was not to treat pregnancy complications but assist at delivery. This is what a 70-year old TBA shared in IDI:

> *"..., we do not plan for or initiate home delivery late in the night for our daughters in this community. We are also women, we know what women go through in pregnancy. We are not even in support because it could be risky. Usually, it is the husbands or the elderly men in the husbands' families who decide whether women should have home delivery or not given the time the woman is about to give birth. We only assist them to have safe delivery. We don't administer herbs on our own unless the husband or family head gives herbs to us and instructs us to do so."* (Woman, farmer and also TBA, no formal education, Muslim).

The men were very firm in justifying home delivery, which some women described as an "old-fashioned tradition". Two male participants in FGDs explained the reasons for home delivery in the night. A 57-year old spiritualist and husband in a rural community had this to share in FGD:

> *"This world!! So, Ghanaians now want to be like white men! The family heads or husbands do not just get up and take decisions. Whatever we do is in the interest of our wives and the unborn babies. If our spiritual research tell us to allow the woman deliver in the hospital we follow. However, if we foresee danger in hospital delivery we insist on home delivery to be on the safer side."* (MSLC, African Traditional Religion).

In a similar setting, another participant noted:

> "I *don't deny tradition and I will not be the first man in my family and this community to challenge the status quo and invite curses to myself and my descendants. I have witnessed instances where some husbands tried to send their wives to the hospital for delivery late in the night and the women never returned to this community. What happened? They died in the process. Personally, I will not see death and chase it because I want to be labelled a modern man."* (45 years old man, farmer in urban community, MSLC, Muslim).

In contrast, some of the men felt that it was oppressive to subject women to home delivery in fulfilment of a tradition which could negatively impact their health and that of the unborn babies. They argued that, it was a sort of punishment meted out to women who did not deserve it. In the FGDs, some men described the act as "wicked and careless" on the part of husbands. This is what one man said about late night detention for delivery:

> *"I bet you all reasons they give you say they cannot take them wives to hospital night time is not true. They hide truth from you. They don't go hospital for delivery in night time because*

> *it is a taboo. They say the woman will meet spirit and born sick baby. Me, two times I carry my woman go hospital night for deliver and she born healthy and beauty babies. Where dey the alizini ?(where is the dwarf)? Allah dey and is Allah who protected us always."* (Driver, 35 years, JSS, Muslim).

The establishment of the CHPS compounds was an attempt to extend healthcare facilities to the door steps of rural women primarily, to improve access for the achievement of the MDGs 4 and 5 (GSS, 2008). This is an intervention adopted to reduce the risks of transport and distance factors as well as financial constraints, and to actively involve the communities especially the men in maternal healthcare.

Even though some communities were provided with facilities and professionals, they did not make good use of the healthcare services because the services were not acceptable by their culture, which rendered those services inaccessible to the women. Failure to consider the strength of cultural beliefs in traditional communities will not yield the desired results of healthcare programmes. Behind poverty, which is the end point factor captured in most studies, there are socio-cultural issues that are normally neglected. The healthcare providers and implementers tend to neglect the fact that, health beliefs are well grounded in some communities, and therefore, inform their behaviour towards healthcare. However, these beliefs are losing grounds in some urban communities with the advent of Christianity/Islam and modernisation as the cities grow to be more of cosmopolitan. However, the Yendi Municipality as the traditional seat of the Dagbon people (Dagombas), has strong adherence to the culture in both urban and rural communities. Although some of them tried to hide their true religious practices to avoid the stigma attached, they were more inclined to the principles of the traditional religion.

Issues related to dualism of belief systems and the implications for maternal healthcare are discussed partly in the following sections of this chapter and in Chapter 6.

5.2.2.3 Protection of Babies

To protect babies from the machination of witches and enemies, they were given herbal concoctions immediately after birth. Amongst the Konkomba and the Bimoba ethnic groups, "gbaligi" and "mortonn" respectively were prepared from herbs, mixed with shea butter and given to the baby immediately after delivery. Similarly, the Dagombas and Chorkosis also administered "datari" and "ayiri" respectively.

This belief was also associated with baby confinement where babies were kept indoors for at least one week - after naming ceremony before they were exposed to the public or sought PNC. According to the husbands and the spiritualists, institutional delivery creates an uncomfortable environment for the families to give protection to their babies. In IDI a spiritualist shared his views with the researcher:

> *"The hospital environment is not good for us to perform rituals or give the protection to our babies, it needs privacy. Some people see us as devils because of our beliefs so we can't do certain things in public. Even the time given us in the hospital may not be enough for us to do those things. Certain things are best done in some places."* (73 years, spiritualist, no formal education, African Traditional Religion).

A woman who was treated by an herbalist to get pregnant shared her experiences in IDI:

> *"I suffered several times before getting pregnant. So Baba* (herbalist) asked my husband to keep me in his house till delivery because he needed to perform some rituals as soon as I delivered. So, I stayed there and gave birth and he performed those rituals before my mother in law came for me the following day."* (34 years old, trader, Muslim).

Some women who sought treatment from spiritualists before getting pregnant were supposed to give birth in their custody for some rituals to be performed immediately after they gave birth. This affected use of facility-based delivery and PNC services.

5.2.2.4 Burial of Placenta

The burial of placenta was also found at the centre of discussions especially, amongst the male participants. No other person apart from the biological father of the baby or his male

siblings had the authority to bury the placenta and it must be buried at the backyard of the father's house. The placenta was believed to have the tendency of communicating with the baby and if exposed, bad people could use it to send curses to the baby to cause abnormalities or death.

Utmost importance was attached to the burial of the placenta. By cultural demands, burial of the placenta was not possible within the health facility. This called for the placenta to be carried home from the facility for burial after institutional delivery. Some men who attempted to carry the placenta home after facility-based delivery reported to have been embarrassed by some health personnel and other clients within the facility. In FGD this is the experience of one of the few caring husbands who were chaperones:

> *"When my wife is to deliver and go to hospital I try to bring the the... the...Oh what they call it ah! Ah!! Ahh!!! oh !oh!!Shh... the placenta yes. The way the nurse eye me and other peoples in hospital look at me some way. Them disgrace me big one. I won't go to that place and carry it again. Lala! lala!! If my wife want to born again she go born in the house. The old woman will deliver her good."* (36 years, farmer, JSS, Muslim).

Humiliating husbands in the health facility is an act of not appreciating their presence and discouraging them in playing the role of accompanying spouses to facilities. Any behaviour towards people from different religious divides which carries a stigma is inappropriate and a violation against their religious rights as provided in the 1992 Republican Constitution of Ghana. Though the formulation of the maternal healthcare policies recognises the culture of people, the policies lack comprehensive care at the implementation level. Understanding people's culture and accommodating it is a positive step towards improving healthcare delivery (Baer & Nichols, 1998; Rebhan, 2008) and healthcare providers are expected to be culturally sensitive in health service delivery.

5.2.3 Ethical Values and Implications for Clinical Care

The primary rationale for the observance of the two categories of taboos (dietary and non-food taboos) was to ensure safe delivery of normal babies. Data from the men and the

traditional practitioners show that there are some specific ethical values behind the observance of the prohibitions during the maternity period. They noted that the observance of the taboos saves the lives of women and their babies as well as declaring spouses innocent or guilty of any sinful act. Besides, it is a way of showing submissiveness to spouses, elders and to build trust in marriage. Again, the behavioural codes were to establish the paternity of the unborn baby, show commitment, faithfulness or obedience to the ancestral gods, and to seek their protection or avoid misfortunes.

The indigenous birthing practices and the associated behavioural codes were observed to have some implications for utilisation of clinical services. The study found out whether there were instances when the worldviews and health beliefs around pregnancy and childbirth conflicted with reception of professional care, and what participants did in such cases. Supported with evidences shown in earlier discussions, indigenous birthing practices adversely affected utilisation of clinical services which had implications for maternal and child health in the areas of drug intake, clinical attendance and the choice of care source in several ways:

Firstly, one major outcome of traditional birthing practices was dualism of care which adversely affected clinical attendance and drug use. This practice, where women received care from both professionals and traditional practitioners (TPs) originated from the dual beliefs or dual faith systems practiced in the communities. That is, adherence to the beliefs in Traditional Religion which forms the foundation of the Ghanaian culture in addition to either Islamic or Christian principles. Some women used clinically prescribed drugs alongside traditional herbal medicines. In some cases, self-prescribed drugs were used alongside herbal concoctions.

Secondly, as a corollary of the above, the use of TPs' services led to poor maternal clinical attendance in the form of low ANC attendance, poor timing and neglect of ANC, skilled delivery (SD) and PNC. Timing for clinical care was interrupted by the services of the TPs, thereby, delaying or denying women's access to clinical services. Only women with evaluated need made

effective use of medical services during this period. Even where the women had perceived need for professional care and were not empowered enough, they were held to traditional gender expectations on decision-making and their husbands chose alternative system of care for them.

Thirdly, preference for home delivery was discovered in the study relating to the quest for privacy for rituals and sacrifices. Data from both the husbands and the TPs who normally enforced the traditional laws showed that the stages of labour were associated with rituals and sacrifices but the clinical environment was not conducive for performing such rituals. For example, the application of herbal concoctions during prolonged labour or retention of placenta and the burial of the placenta were identified as impossible in facility-based delivery.

Fourthly, the need to observe food taboos caused women and their families to neglect intensive clinical care. The women either stayed at home for TBAs' services or with the herbalists/spiritualists or received traditional care when they were supposed to receive intensive care from health professionals. This was due to the fear of being given forbidden foods while on admission in the health facility since they had no control over what they ate in the hospital.

5.2.4 Commentary

The indigenous birthing practices and the associated prohibitions were driven by the cultural and religious beliefs of the people. The study revealed systems of oppression at the household and community levels that relate to societal, cultural, religious and moral values. These systems empowered men who used their supremacy advantage over their spouses to hold them to traditional gender expectations. The power that is given to men by the culture facilitated women's oppression and the internalisation of oppressive codes by the women themselves which adversely impacted the use of healthcare services.

The observance of prohibitions subjected some pregnant women to purely vegetarian diet and the services of the TPs. This has serious implications for the health of the woman or her

foetus. For instance, though some food taboos may help check foeto-pelvic disproportion (Senah, 2003), which usually results in labour dystocia and consequently prolonged labour, they may worsen the anaemic status of the pregnant women and affect the growth and development of the foetuses (Senah, 2003; Zepro, 2015; Arzoaquoi et al., 2015; Ugwa, 2016; Maliwich-Nyirenda & Maliwich, 2016). The food taboos created limited choices of food for the pregnant women, which can affect the diet and health of the expectant mother and the foetus (Wahid & Fathi, 1987; Arzoaquoi et al., 2015). Expectant and lactating mothers are supposed to eat nutritious and balanced diet because the foetus/baby depends on what the mother eats for growth and development. Both the Andersen and Newman's health behaviour model and the three delays model emphasise the power of cultural beliefs in influencing healthcare services utilisation. The society has created structures in form of walls - making it difficult for women at the agency level to break. This creates inequality in access to healthcare between men and women to the disadvantage of women. The study observed that in most cases, duality of structure and agency was not functioning because the structural forces were domineering over the agency. However, few empowered women were able to stand against dominant norms. This sustains the call for female education for empowerment to position well to make informed changes in the structural systems for equity to take place for improved access to healthcare services.

The prohibitions were not just isolated norms, but located in cultural structures and being enforced by men at familial and the communal levels. Some women were confined in the custody of TPs. Presupposing that, they may live with life threatening conditions which may not be known since the TPs could not detect with traditional techniques. Aside, some of these women did not get the opportunity for early screening and treatment of pregnancy-related conditions like anaemia, pre-eclampsia amongst others. Anaemia is one of the leading causes of maternal deaths in Ghana and a common condition suffered by pregnant women and new born babies in the study setting (GSS, 2015). This may be attributed to poor dieting amongst other factors during the

pregnancy-postpartum period (GSS, 2008, 2009, 2015).

The study observed that location of health facilities was not a major concern for skilled care. Some women staying closer to facilities neglected clinical care neither for economic nor transport-related factors. They did not have perceived need (Andersen & Newman, 2005) to seek clinical care either because they judged themselves strong and healthy or it was in fulfillment of the traditional birthing culture. This is a confirmation that, cultural and social norms restrict women's mobility and care seeking (Hagman, 2013; Sarkodie & Abubakari, 2014; Munguambe et al., 2016).

Apart from the risks in combining the clinical drugs with herbal medicines, the herbal products were not tested in laboratory to ascertain the chemical composition, efficacy, dosage and expiry dates. Neither were the herbal concoctions subjected to clinical trials. This could be dangerous to both the woman and her foetus as the herbs may contain harmful toxic substances that have adverse impact on maternal and child health (Sarkodie & Abubakari, 2014). Whilst the beliefs in African Traditional Religion (ATR) were a source of power to men to influence their wives, it was a source of fear to women to succumb to the practices to avoid any misfortunes arising from disobedience. Resorting to TPs for treatment or delivery did not only interrupt clinical drug intake, but also resulted in lower number of clinical visits and delays in care seeking especially, in critical phases in the three stages of maternity.

Some women neglected clinical services in their critical stages. Meanwhile, it is required of women to seek professional care during these phases regularly and timely (WHO, 2013; GSS, 2015). This is because the totality of a woman's health in the pregnancy-postpartum continuum functions as a system comprising ANC, SD and PNC (Nwokocha, 2007). Some women especially, in Yendi Municipality with history of safe delivery delivered at home with the assistance of TBAs or relatives and did not seek PNC until after one week. These women and their husbands perceived institutional delivery and PNC as options for the weaker and unhealthy women. The

women who had perceived need for clinical care were influenced by their predisposing factors (Andersen, 1995; Porteous, Wyke, Hanaford & Bond, 2015). This confirms the observation that the Mole-Dagbani women are less likely to seek PNC services from professionals (Galaa & Daare, 2008; Abor et al., 2011).

Safe-motherhood interventions should be focused on breaking cultural structures that inhibit access to healthcare through key personalities at the household and community levels. The quest to conform to the worldviews and health beliefs around pregnancy and childbirth necessitated home care that was characterised by purification rituals. For fear of being fed with forbidden foods because they had no control over food prepared in facilities, women ignored facility-based intensive care. However, this received counter arguments from some husbands with formal education who had knowledge about gender norms to resist dominant traditional societal gender role expectations. They argued that food was allowed to be sent to the facilities for women on admission. There were also few illiterate husbands who were not in favour of these practices but were influenced by the hierarchical structures within compound houses and could not avoid these practices.

Most of the formally educated women were less concerned about the taboos especially, in their most recent pregnancies. Those staying outside compound houses were able to express their health needs and concerns, and timely accessed clinical services. Thus, they were able to translate knowledge into behaviour to ensure good health (Obasi, 2013; Harvey, 2014; Ukegbu et al., 2014; UNFPA & ICRW, 2014) because they stayed alone with their partners and were free from interference. Women who were totally dependent on their husbands for their needs were under total control of their husbands and the husbands only provided when they considered necessary. This observation sustains the argument for women's empowerment as a necessary condition for positive maternal outcomes.

This study noticed that men were behind the activities of the TBAs. The TBAs were mainly

women who acted on instructions from men such as family heads and spiritualists who provided the herbal concoctions. Perceiving assistance at delivery as women's space, the men practised birthing culture using the TBAs by directing them on how to apply the herbal concoctions in the three stages of maternity when the need arose. For instance, in the event of obstructed labour or retention of the placenta, the TBAs were provided with "datari" (amongst Dagombas) or "ayiribiri" (amongst Chorkosis) to administer for the release of the baby or placenta respectively. In most cases, the TBAs activities did not reflect their desires nor knowledge and experiences, but the culture and patriarchal preferences of the men.

Amongst the women detained for home care were those with higher risks such as teenagers, mothers with multi-parities and those aged 35 years and above. Detaining these categories of women in labour for rituals may lead to serious complications or death as the traditional medical setting is limited in detecting, managing or treating some obstetric complications. This is typically signifying cultural influence on reproduction which may interact with biological or genetic conditions of the woman and negatively impact her health. The neglect of medical services by some women was not necessarily for the sake of their health, but for avoiding misfortunes or curses in their babies or future generation from the spiritual world. This concurs with previous findings that Ghanaian women succumb to traditional beliefs and practices as an act of respect for their culture (Nukunya, 2003; Arzoaquoi et al., 2015).

Poverty and lack of healthcare facilities have been the reasons most researchers assigned to poor utilisation and the high rates of maternal deaths in Ghana. Behind poverty, which is the end point factor, there are socio-cultural issues which are normally neglected. Poverty could be economic, social, intellectual, psychological or cultural. Neglecting the fact that, health beliefs are well grounded in some communities and inform their behaviour towards healthcare is a step towards failing healthcare programmes. This is a source of worry to the Ghana Health Service and other stakeholders because many women with serious obstetric conditions suffer permanent

injuries, deformities and deaths in this region (GSS, 2012). The traditional beliefs around pregnancy and childbirth were part of institutional systems located in cultural structures at various levels of human community. The delays observed in this study could be described as "systemic structural delays". These systems were oppressive with male supremacy and characterised with tough walls against empowerment of women. As a result, some women especially, the elderly and illiterates had to internalise and normalise these oppressive systems for conformity. Section 5.3 presents results and discussions on the role of traditional practitioners in indigenous maternity care.

5.3 The Role of Traditional Practitioners in Indigenous Care.

This section discusses the role of traditional practitioners in indigenous birthing practices. Indigenous birthing practices may be described as the processes and methods involved in the provision of maternal healthcare outside the modern healthcare facilities. The data for discussion in this section were sought from TPs. This section answers the research question: "How is maternal healthcare provided or received in the traditional setting?" Answers to this question address the second objective of this study. To answer this research question, the research subjected the participants to interviewing on how they provided care in the various stages of maternity in the traditional setting. The data showed that the TPs performed both medical and spiritual roles in the three stages of maternity. The medical role took the form of diagnosis, preparation, prescription and administration of herbal concoctions to treat pregnancy related complications and assistance at birth whilst the spiritual role involved spiritual research for identification and solution of problems, and performance of purification rituals or sacrifices. In this study, both the spiritualists and the herbalists performed the same roles (medical and spiritual) and both terms have been used interchangeably. The results obtained from the data analysis are stated and discussed in the following pages from Section 5.3.1 5.4.

5.3.1 Prenatal Period

The prenatal period is the time between conception and birth. This period is generally divided into three stages: the germinal stage; the embryonic stage; and the foetal stage, which lasts from two months after conception until birth (GSS, 2004, 2008).

The main actors in the traditional medical care were the TBAs and the spiritualists with the husbands/family heads serving as liaisons between the expectant women who needed care and the practitioners who were the service providers. The practitioners exhibited high level of knowledge about signs of pregnancy. For example, a TBA noted:

> *"Signs of pregnancy depends on the individuals e.g, some women vomit but others don't. Some lose appetite, experience dizziness, and sleeping always. But breast enlargement and increase in stomach size is common to all. Stoppage of menses is also common but some can have their menses while pregnant up to some time."* (69 years old, MSLC, Christian).

The practitioners worked in collaboration with one another to offer the best of services to the expectant mothers and their families. For example, the TBAs worked with the spiritualists and they referred cases beyond their control to their superiors or healthcare professionals.

5.3.1.1 The Role of Traditional Birth Attendants in Prenatal Period

The TBAs constituted key stakeholders in traditional healthcare system who worked individually or with the spiritualists. The medical role of the TBAs involved examining women, their foetuses and suggesting to their husbands to seek medical care where necessary. They took verbal reports from the women, placed their hands on the stomach and at the lower abdomen of the women to determine the position as well as state of health of the foetuses in the womb. They also guided women on the intake of the medicines provided by both professionals and the spiritualists. The most predominant form of treatment provided during pregnancy was ingestion and injection of herbal mixtures into the expectant mother. The herbal mixtures were made up of extracts from plants such as the leaves, barks, roots grinded and mixed with ingredients such as ginger, pepper, garlic and water, which is used to cleanse the reproductive system, treat infections

or relief the expectant mothers of constipation. Apart from the fetish priest amongst them, the TBAs were not supposed to give treatment to the expectant mothers. They only did that when the husbands of the women in question appealed to them to help administer some medicines which they considered as feminine gender role.

The TBAs acted as liaisons between the professionals and the communities by referring women to the professionals especially, in the event of life-threatening conditions such as bleeding or prolonged labour. Again, as explained in Section 5.2, they acted on instructions from the men who determined the kind of treatment for their pregnant spouses based on advice from the spiritualists. A 73-year old TBA shared her experience in IDI with the researcher. She said:

> *"I cannot prescribe herbs or drugs for pregnant women. Even if I know medicines, I must explain to the husbands how it works and convince them before some of them agree. It is difficult because sometimes I give suggestions and they don't agree. After applying the medicine they bring a different one forcing me to apply to the same woman at the same time. The medicines I give to the women to take be it herbal of drugs from chemical shops are supplied by their husbands. He will bring the medicine and ask me to give to the wife. The men feel a woman should be catered for by a woman and because it is pregnancy and not any ordinary sickness they prefer we the TBAs to other women to take care of the woman but mostly they won't allow us to do what we feel is right."* (TBA, no formal education, Muslim).

The TBAs could only give treatment based on the initiation and support of the men. In some cases, being driven by their beliefs around pregnancy, the men refused to send their spouses to hospital when the TBAs suggested to them. They rather preferred home care as they had different explanations and curative measures for the conditions. One of the TBAs in Yendi shared this in IDI:

> *"It is not that we the TBAs don't want our clients to go for professional care. As I talk to you I don't have a second eye to see spirits. So, if the men insist on home care with their own reasons which are usually not disclosed to we the women, what can I do. I know I am not a doctor but having given birth nine times and worked as a TBA for 31 years I can examine pregnant women and ask them questions on how they feel and see what is going on. From this end I have to advise that the woman be taken to the hospital if I realise it could be dangerous or give first aid and monitor and see. But the idea of consulting professionals do not work in many instances since the husbands come in with alternative medicines from the spiritualists."* (TBA, 81 years, no formal education, Muslim).

The views by a husband below confirm the statements above:

> *"Ooh! you know as men we have certain things we cannot share with women. Some of the women are under spiritual battle and we need to protect them with herbs so we consult people who have second eyes to tell us what to do. You see them beautiful like that some of them have been married spiritually and nothing in the hospital can solve that problem. Some of these things if you neglect your wife may die in the hospital. In some cases, we insist on home care because we had seen the cause and the way out. If you joke with spirits you will die before your destined date of death"* (41 years old, driver, MSLC, Muslim).

Spiritual marriage emerged in other interviews and group discussions with husbands and TPs. They believed that evil spirits could marry some women which could generate spiritual battle when the woman gets pregnant. Because in spiritual realm if the woman delivers a normal live baby, the spiritual marriage will be broken. Hence, the spiritual husbands work hard to either terminate the pregnancy or maintain the relationship or kill the baby and the mother.

Interaction with the TBAs showed that the bond between the TBAs as liaisons between communities and the health facilities was not strong and characterised with frequent conflicts over the role of the TBAs, especially, the untrained ones. The already fragile bond was weakened or broken by socio-cultural structures enforced by the men. The societal structures in the communities had negative impact on the health seeking behaviour of women. The continuous neglect of professional care gradually broke down the bond of the relationship and created a wall between the TBAs and professionals. The TBAs had been identified in most research as the cause of poor clinical attendance by women in maternity. Most TBAs considered liaising with the professionals as their duty but this role could not be effectively executed because the men had to agree before a referral was made or the spiritualists declared the expectant mother free of attack before she could seek clinical care. In IDI, a TBA said:

> *"Yes, we suggest to the husbands to send their wives to hospital but they will tell you that they are waiting for some days. Some will tell you after one week or a month and we have no control. We normally give the herbs to their wives on their behalf. So, I have realised that when they give herbal medicines to use for one week and the time does not elapse, they will not pay heed to hospital care."* (57 years old, TBA, MSLC, Muslim).

The few trained TBAs were able to identify danger signs during pregnancy. They had knowledge about source of appropriate care but access to the services of the professionals was often blocked

or delayed by the men, usually the heads of the families who spent part of the emergency periods with spiritualists thereby, delaying timely intervention. But for the influence of men, the TBAs role of connecting pregnant women to the health facilities would have improved ANC attendance considerably in terms of number of visits and timing. As discussed previously, some women did not attend ANC until after four months because they had to hide the pregnancy for fear of spiritual attack. It is worth repeating that, failing to seek early care denies women the opportunity of evaluated need (Andersen, 2005), hence, fatal health conditions in pregnancy could not be detected and managed or treated by the spiritualists and TBAs. In IDI, a TBA in Yendi said:

> *"Hmm... I remember they brought one lady to me who had swollen feet and complained of pains in the chest. In trying to find out I realised she had been in that condition for more than one week. The husband told me they first took her to a herbalist for one week. So, after that period they were advised to seek professional care. When I led them to the hospital it was realised that her blood pressure had gone too high and they had to admit her."* (69 years old, TBA, MSLC, Muslim).

The research discovered that the spiritual role of the TBAs depended on the instruction given by the husbands or spiritualists. Any ritual or sacrifice that required the hand of a woman was performed by the TBAs. For instance, they were involved in performing spiritual baths initiated and instructed by the spiritualists. They also performed any other feminine spiritual role assigned them by the husbands, family heads or spiritualists.

> *"I don't have eyes to see things. I only do what the husbands or the spiritualists ask me to do. Sometimes they give me some herbal mixtures to bath the pregnant women. I also assist the spiritualists and the husbands to perform rituals during pregnancy to solve spiritual problems."* (TBA, 58 years, no formal education, Christian).

5.3.1.2 The Role of Spiritualists in Prenatal Period

The spiritualists also formed essential healthcare providers in indigenous birthing**.** In the prenatal stages, the medical role played by the spiritualists or herbalists comprised diagnosis, preparation, prescription of herbal medicines and administration of the herbal concoctions. They were involved in treating complications such as bleeding, abdominal pains, nausea and other

pregnancy-related conditions in the prenatal stage. In addition, they made referrals to either their superiors or healthcare professionals where the situation was beyond their control. In FGD, a participant said:

> *"We make herbal medicine and treat womens when they carry babies and sick. We can treat bleeding, nausea and vomiting, pains in waist or abdomen etc. Yes, so if I cannot cure the problem I ask the man to take the woman to another person who know how to cure better. I also can ask the woman to go for hospital because some problems are hospital problems."* (Herbalist, 65 years, MSLC, Christian).

In the prenatal stage, the spiritualists conducted spiritual research, monitored the health of the woman and her foetus and performed rituals and sacrifices for purification and pardon for sustenance of the pregnancy or safe delivery of healthy and normal babies. This role made them superiors over the family heads/husbands and the TBAs in traditional medical care as they took directions from the spiritualists.

According to the spiritualists, they identified sins committed by the couples or their families which could result in pregnancy wastage, miscarriage, still birth or abnormality in babies and pacified the gods and ancestors to avert the situation. This involved spiritual betting with the promise of honouring the objects of worship with live animals such as fowls, guinea fowls, dogs, rams and cows etc., depending on the taste or request made by the spirit. They gave instructions to the husbands and heads of families to perform the sacrifices in some cases. They continued to monitor the pregnancy till delivery. When a condition required close monitoring, the women were kept in custody of the herbalists who used their special TBAs to treat them. In the camps, the women were subjected to some food and movement prohibitions to ensure that they and their unborn babies were protected.

Any instructions from the spiritualists to the family heads that required assistance of women were redirected to the TBAs to perform the role. The TBAs who were structurally positioned at the bottom, probably because of their gender, performed a role directed by the spiritualists at the topmost position and enforced by the husbands who mediate between the TBAs and spiritualists.

This is a statement made by a TBA working with an herbalist in a local shrine:

> *"I work with an herbalist in this shrine as a TBA. I don't do anything without the consent of the herbalist. I prepare food for the pregnant women. I make sure they don't eat foods like eggs, some meat and shea butter because they taboo that. But when the herbalist give me meat to give them I do. He alone knows why they are asked not eat that. I only know that it will help them stay strong and have safe delivery of normal children."* (59 years old woman, MSLC, African Traditional Religion).

The spiritualists and the herbalists explained that whatever they did was for the good of the expectant mother, the unborn baby and the entire family. This is what one herbalist told the researcher in IDI:

> *"We see things before we act. We don't enjoy when women eat some kinds of food but we enjoy when they have safe delivery of normal babies. The taboos women observe are meant to keep them healthy and protect them from evil hands. If you deny and joke with it you will see the results for yourself. The men know."* (72 years old man, herbalist and priest, no education, African Traditional Religion).

Sometimes based on the findings and directives of the spiritualists, women were restricted to eat certain foods during this period. As discussed in Section 5.2, observing the food prohibitions may deny expectant mothers and their foetuses essential nutrients such as iron and protein.

The research found that, the preparation and use of herbal medicines were not tried in laboratory and clinical settings respectively. Therefore, the chemical composition of the herbs was not known, and there was no scientific measurement in the prescription and dosage of such herbs. These concoctions may be overdosed or react with other chemicals in the body, especially in the case of dualism in health services usage, which was typical of the participants' behaviour in this study. This can be harmful to the health of both the woman and her foetus (Sarkodie & Abubakari, 2014).

5.3.2 Intra-Partum Period

The process of labour and birth is divided into three stages (GSS, 2004, 2008, 2015). The first stage comprises early labour stage and active labour stage whilst the second stage is the

"pushing" stage which begins when the parturient is fully dilated and ends with the birth of the baby. The third stage begins right after the birth of the baby and ends with the delivery of the placenta. Each phase is characterised by different emotions and physical challenges (Ghana Health Service, 2008). Even though the earlier stages were equally handled with care, the TPs considered the pushing and the third stages as most critical as most maternal deaths according to the spiritualists occurred during delivery or shortly after delivery. An herbalist noted:

> *"The target of every evil spirit is the delivery period. So every man must be extra vigilant during this crucial stage in order not to lose his wife or child."* (63 years old man, herbalist & driver, MSLC, Muslim).

5.3.2.1 The Role of Traditional Birth Attendants in Intra-Partum Period

Assistance at delivery formed the central role of the traditional birth attendants. To the TBAs, the delivery stage constituted the most important and sensitive stage where they used their experiences and knowledge to assist their fellow women to deliver safely. Assistance at delivery was done by making the parturient assume vertical postures (preferably kneeling) in labour to facilitate rapid delivery. Most TBAs explained that kneeling was safer for the baby than squatting with inexperienced mothers because the squatting posture may harm the baby's head or neck in spontaneous delivery where crowning occurs shortly and not being noticed by the TBAs. In IDI, a TBA said:

> *"The women kneel down and bend small while they push. The kneeling is better than squatting especially for women who have not given birth before. Inexperienced women may not have patience when squatting and could harm the baby when it is coming out and we don't notice it early. We normally rely on the men to give any treatment but when they are not ready with the medicines and we realise the baby is about to come out we proceed to help the woman without the husband's consent."* (62 years, no formal education, African Traditional Religion).

The traditional theatre (birthing room) was swept with a broom and old and soft garments were spread on the floor especially, at the outlet of the birth canal during crowning so that the baby would not be injured when it was born. The TBAs also stood by the parturient closer to the outlet

of the birth canal to receive the baby upon expulsion. At the same time, emotional and psychological support were given to the parturient as a way of sharing the labour pain with them and motivating them to endure pain and push until the baby was born.

Where the parturient was required to be given ingestion or injection of herbal concoctions, the TBAs performed that role following the directives of the husbands or spiritualists. In the event of prolonged labour, the parturient was made to confess of her wrong doings especially, marital infidelity. In FGD, a TBA explained:

> *"Normally childbirth is witnessed by women. So, when the men go for the medicines they give to we the women to give to the parturients. When our husbands see that the delivery is delaying because the woman has had extra marital sex, they ask us to give the herbs to them to drink after confession. The gmanchey (concoction used in obstructed/prolonged labour and for retention of placenta) will help the woman to deliver fast when she confesses. But what the woman say is always the secret of women and we don't tell people. If we tell people there will be divorce."* (70 years, no formal education, Muslim).

They also helped the spiritualists to administer any herbs meant for facilitating rapid delivery. Where the complication in labour had to do with the physiology of the woman, the TBAs referred the parturient to hospitals for professional care. However, when the family heads insisted on home delivery, the TBAs employed their traditional methods of assisting at delivery such as applying "gmanchey" for the parturient to drink. This herbal concoction serves as lubricant in the reproductive tract which facilitates rapid delivery and the release of placenta. When that failed, they skilfully pressed the tummy to enhance the release of the baby or placenta. When this could not work they inserted their hands into the vagina to carefully pull out the baby or the placenta from the womb. The study discovered that the TBAs did not use sterilised materials in assisting at birth. A trained TBA in one of the villages explained in IDI how they assisted at delivery. She said:

> *"Hmm... We have complained for years but they don't mind us. We don't have gloves. We use bare hands to help women to deliver. We insert the bare fingers into the vagina to pull out the baby or placenta when they delay. Same thing is done when cutting the cord. Meanwhile when the professionals came to talk to us some years back they told us to refrain from that behaviour yet they won't provide the necessary materials for birthing. Apart from washing*

our hands in water with soap we don't do anything to protect ourselves or the women and the babies." (59 years, MSLC, Muslim).

The vaginal examinations, insertion of hands in removing the baby or placenta from the womb as well as the cleaning, bathing, clamping and cutting of the cord were performed without using gloves but bare hands. The cord was cut as soon as the baby was born, tied with thread and dressed with shea butter mixed with herbs. In most cases, the rooms were not disinfected before delivery especially, where the signs and symptoms labour did not show early for preparation. The third stage of labour was managed using *akpeteshie* herb-mixed (herbal concoction with local gin), a warm towel and shea butter for fundal massaging.

The TBAs played a very significant role by giving consolation, psychosocial support and demonstrating empathy at birth which are beneficial to the woman and her baby (Sparks, 1990; Asefzadeh et al., 2014; Oshonwoh et al., 2014). However, the use of herbal mixtures including *akpeteshie* herb-mixed during obstructed labour could be harmful to the parturients and the babies (Senah, 2003; Sarkodie & Abubakari, 2014). Amongst the Chorkosis, in the event of prolonged labour or placenta retention, *ayiribiri* (herbal preparation) was administered to avert the condition. *Ayiribiri* is mixed with water in a calabash and given to the woman to drink to facilitate the expulsion of the baby or placenta. In Chereponi, a TBA in IDI said:

"When a woman is in difficulty in labour we give her ayiribiri to drink. The husband will bring the ayiribiri and give to us to give to the woman. Normally, the men do not witness delivery. The herbs help the woman to deliver fast. We also apply it when the placenta delays." (62 years, no formal education, African Traditional Religion).

The use of concoctions in traditional birthing has been highlighted in some African studies such as Maimbolwa et al. (2003) in Zambia, Senah (2003), Arzoaquoi et al. (2015) and Sarkodie and Abubakari (2014) in Ghana. According to Maimbolwa and collaborators, the TBAs in Zambia relied on traditional beliefs and witchcraft to explain the misfortunes connected to obstructed/prolonged labour and delay in placenta expulsion and the parturient is expected to confess her alleged 'bad' behaviour. Research indicates that even when obstructed labour does not

result in maternal death, it leads to prolonged labour, or even, permanent ill health in the majority of cases. For instance, the prolonged pressure on the bladder during obstructed labour could cause severe damage to the lower genital tract resulting in a false passage between the bladder and the vagina, and the woman suffers incontinence of urine and sometimes of faeces (Senah, 2003; Maghuyop-Butalid, Mayo & Polangi, 2015; UNFPA, 2016). Though the chemical components of some herbs may be good for delivery (Senah, 2003) others can be sufficient enough to cause death (Senah, 2003; Maghuyop-Butalid et al., 2015), especially, when the parturient is made to overdose on them.

According to Saravan, Turrel, Johnson and Fraser (2010), in developing countries, many women still prefer the services of TBAs to the professionals, because they are always available and share common cultural beliefs. Aside, the spirituality attached to childbirth drives women and their families to give preference to home delivery (Maimbolwa et al., 2003; Fronzak et al., 2007; O'Driscoll et al., 2011). The psychological support provided by the TBAs which was lacking or inadequate in facility-based care, was a source of motivation for home care in the study. However, the TBAs were not in the best position to handle obstetric complications because they are less likely to recognise most maternal complications (Bailey, Szaszdi, Glover & Rev Panam, 2002) and give appropriate treatment.

There were no evidences of elements of sterilisation and disinfection in the birthing process. Thus, bare hands were used in all traditional obstetric activities including vaginal examinations. Healthcare providers must wear sterile gloves in order to avoid the risk of contamination with the patient’s blood and other fluids (WHO, 2009), especially in the advent of HIV and AIDS, and hepatitis B. By these practices, the parturients and their babies were exposed to infections because there was no protection against micro-organisms which may come from the TBAs. Aside, the TBAs could also be infected in the process of offering assistance at birth. According to the WHO (2014), puerperal infections are the sixth-leading cause of deaths amongst new mothers.

Similar to the observations of Maghuyop-Butalid et al. (2015), the TBAs did not consider cord pulsation in the clamping and cutting of the cord. Clamping and cutting of the cord at least within 1-3 minutes is recommended for improvement of the iron status of the infant (WHO, 2012).

In spite of the shortfalls discussed above, the TBAs played an important role in linking up women to the health institutions for emergency care. Aside, they provided comfort and psychological support to their clients which remain the hallmark of traditional medical practice. Most of the women commended the TPs especially the TBA for their care which motivated them to seek their services. According to Burns (2011), the physiology of a woman has been prepared to get pregnant and deliver naturally. Burns argues that, during delivery the body does not need technology but tranquility because it has been conditioned to perform that function. Similarly, Indraccolo et al. (2010) argues that birthing in a calm environment without medical and technological manipulation is a rewarding and fulfilling experience. This makes the TBAs continue to be doulas in the traditional medical practice.

As stated earlier on, the major task performed by TBAs in traditional birthing is assistance at delivery. However, due to traditional gender roles, they were made to perform some spiritual roles such as assisting in ritual performance, application of spiritually-oriented concoctions or any other spiritual role considered as women's space.

5.3.2.2 The Role of Spiritualists in Intra-Partum Period

The medical role of the spiritualists during the intra-partum period was mainly centred on examination of the parturients, preparation and prescription of herbal mixtures. They also guided husbands and TBAs on how to apply the herbal medicines to ensure safety. It should be noted here that in most cases, the spiritual role was performed alongside the medical role. For example, the diagnosis and preparation of the concoctions were performed spiritually and medically concurrently.

During the delivery stage, the spiritualists played the role of overseeing the delivery process by spiritually monitoring and giving instructions to the husbands/family heads and the TBAs on how to administer the concoctions or perform rituals and sacrifices to pave way for safe delivery. A spiritualist noted:

> *"Young man, God is using some of us in these communities to save the lives of our mothers during the pregnancy-postpartum period. Some of the incidences of maternal and infant deaths recorded in the clinics are not the making of God nor the professionals. The moment a woman gets pregnant some evil spirits begin to fight her. You see, this beautiful women you find in town, some of them are spiritually married and their husbands will continue to fight them when they are pregnant for their physical husbands. So, we try to work out in the spiritual realm to fight them and offer sacrifices to ancestral spirits and gods to intervene and save the woman and her baby. We prepare a special herbal medicine to husbands to administer during prolonged labour. The herbs help the women to give birth fast. When the woman is guilty of an offence we pacify the spirits to pardon her after she confesses."* (67 years, spiritualist, MSLC, African Traditional Religion).

However, in complex or difficult situations, the spiritualists were directly involved in the performance of rituals or sacrifices to the ancestral spirits and the gods. They also played the role of going into the spiritual realm to mediate between the spouses and the spirits and demand favour from the spirits by betting on offering sacrifices of animals to the spirits should the parturient deliver safely of a normal baby. In IDI, a spiritualist said:

> *"We guide the men to do the right thing during delivery. Sometimes when women are in difficulty in labour we go into betting with the spirits promising them sacrifices of animals of different kinds depending on the taste or demands of the said spirits so that the woman will deliver peacefully and have a normal baby."* (67 years, MSLC, African Traditional Religion).

In the event of complications like prolonged labour and retention of placenta, the spiritualists pronounced very powerful and authoritative words commanding evil spirits to release the parturient, her baby or the placenta. This was normally applied when all attempts have failed and the life of the woman was in danger. A spiritualist had this to share in IDI:

> *"Personally, when I see that a particular spirit or any devil having to do with any complication I will first give warning for the release of the woman. If they remain stubborn, I will then prepare and start commanding them with a very powerful word. I call their names with authority, and they will free her to deliver or release the placenta."* (59 years, MSLC, Muslim).

The application of *gmanchey* or similar ones like *ayiribiri* and *datari* in obstructed/prolonged labour was associated with delays. Below is the experience of a parturient who was delayed in the hands of TPs:

> *"Hmm... I was in labour pain for hours. I was suffering but I had to wait for them to prepare and give the herbs to me. For about six hours the pain became severe... They used all the herbs. I was still suffering, they sent for the herbalist and still it couldn't work. Then the TBA appealed to them to carry me to the hospital. On the way to the hospital I delivered."* (33 Years Old, Trader, SSS, Muslim).

With strong attachment to the health beliefs and cultural practices, they did not consider some complications as medical problems and this delayed women's access to health facilities for timely intervention. Before they considered professional care, the parturient might have suffered several degrees of complications. A parturient that was denied timely access to professional care by the husband and a spiritualist had this to share:

> *"... They called TBA and one spiritualists to come and help me deliver. For several hours I was suffering. The TBA tried to convince them to carry me to the hospital but the man assured them I will soon be okay. I was lucky to have the hospital just at the back of my house. I nearly lost my life before they rushed me to the hospital. I lost the baby and developed serious complications because the doctor said it would have been a success with caeserean session if I had come earlier."* (19 years, JHS, Muslim).

5.3.3 Postnatal Period

A postpartum period or postnatal period is the period beginning immediately after the birth of a child and extending for about six weeks (Ghana Health Service, 2008). According to the participants, this is the time the newly born baby was formally welcomed into the family and the mother was honoured with new clothing and special diets. In FGD, a participant shared her post-delivery experiences and the colleagues expressed similar views. She said:

> *"After delivery, my husband then came to my room the following day and asked me to mention the type of dresses I will need and the quantity. He was so much enthused to have a male child for the first time. He slaughtered fowls, guinea fowls and a ram for me before the naming ceremony. On the day of naming ceremony, may goats and rams lost their lives to my joy."* (43 years old, graduate teacher, Muslim).

The participants noted that successful delivery cements the relationship between the spouses, and

between the woman and her husband's family. As a patriarchal society, the bond of love between spouses especially, was even stronger when the newly born was a boy because the father considered the baby boy as his successor who remains in the family even after marriage. This is the experience of a young woman with her father-in-law after first delivery in marriage. In IDI she said:

> *"I remember when I gave birth my father-in-law told me that 'you're welcomed into this family and I know you're going to give me more of this in future'. He was very happy to have a male grandchild from our marriage."* (28 Years old, trader, SSS, Muslim).

It was at this stage that women who had been subjected to maltreatments and insults because of their inability to give birth wiped the tears on their faces and counted themselves as "human beings" within their families and the entire community. This signifies how children are very important in traditional Ghanaian society especially in marriages.

5.3.3.1 The Role of Traditional Birth Attendants in Postnatal Period

After supervising and achieving a successful parturition, the TBAs then employed the local methods of treating the newly born baby and her mother. This involved the use of materials such as toilet soaps and warm water for bathing the mother and her baby. The birthing room was washed with water and soap after delivery. Perfumes or powders were then sprayed or sprinkled in the room. In IDI, a TBA described how they worked in postnatal stage. She said:

> *"After delivery, we cut the cord using blade and a thread is used to tie it. Then a herbal preparation mixed with shea butter is applied to the cord. The baby is bathed with warm water and toilet soap after that we apply powder to the neck, armpit and genital area. After bathing the baby, we use old clothes to mob the floor with water and soap. After that, we normally use powder or perfume on the floor."* (59 years, TBA, MSLC, Christian).

After bathing they applied powder on the baby, especially around the neck, armpit and the genitals. The mother was bathed with warm water after hot water had been applied on her around the lower abdomen. Fundal massage was applied as the woman assumed dorsal recumbent position on a mat. By this, a piece of soft cloth or towel was dipped into hot water to make it hot,

and then, the water in the material partially squeezed out so that it could contain some amount of the hotness. The hot material was then put on the lower abdomen and pressed for some time as woman laid down. The TBA continues by saying:

> *"We normally bath the mother with hot water, soap and sponge. Before bathing, she is made to lay down on her back so that we use hot water and towel with shea butter to massage her in lower abdominal area. She will lay down and we put the towel into hot water and apply to the abdominal area after we have applied the shea butter to avoid burns. We do this every morning and evening before bathing. This will heal her wounds and check bleeding. She also uses powder and shea butter as body cream. Because she is breastfeeding the shea butter is harmless to the baby."* (59 years, TBA, MSLC, Christian).

This was done repeatedly every morning and evening before the woman bathed until after some time when the TBAs were satisfied. The practice was meant to heal the wounds in the womb and the reproductive tract, and control bleeding. In order not to burn the skin, shea butter was applied to the body (around the lower abdomen) before the hot towel was applied. Local herbs were then prepared and mixed with *akpeteshie* (local gin) for the woman to be drinking routinely till she was fully recovered. This was also to help heal the wounds, give appetite, bring out the blood clots in the system and control excessive bleeding. Below is the explanation given by a TBA in FGD which the colleague discussants confirmed:

> *"We give them special herbs mixed with 'akpeteshie' so that the reproductive system will be cleansed. All clotted and stagnant blood in the system will be melted and passed out. It also controls excessive bleeding after birth and heal the wounds in the body. Aside the woman gets appetite to eat food."* (70 years, TBA, no formal education, Muslim).

The intake of alcohol could have adverse implications on the babies' health. Although the processes involved in the reduction of sleep in babies remain unexplained, research shows that short-term exposure to small amount of alcohol in breast milk produces distinctive changes in the infant's sleep-wake patterning (Mennela & Gerrish, 1998). Infants tend to sleep fast, but for shorter duration normally, within 3.5 hours after the consumption of breast milk flavored with alcohol (Mennella & Beauchamp, 1991).

According to the TBAs, after bathing, the husbands were advised to send their wives for

postnatal check-up. Women were guided by the TBAs to take drugs given them from the hospital during PNC visits. The TBAs also assisted in treating the women and the babies especially when they failed to seek PNC. In FGD a TBA explained circumstances under which they gave treatment to women after delivery. This was confirmed by others in the group and raised in other group discussions. She noted:

> *"Usually after bathing the baby and the mother we ask the family to take them to hospital for check-up. Some of them listen to us but others do not because most families want their women to attend hospital after the naming ceremony - i.e., after the 8th day. In that case we are forced to assist in giving treatment when their husbands request or bring herbs or any drug for use."* (70 years, TBA, no formal education, Muslim).

Upon request made by the husbands, the TBAs prescribed drugs for treating pregnant women. The husbands may also bring some herbs from the herbalists and ask them to give to the women and their babies.

A piece of cloth was normally tied around the lower abdomen of the woman meant to squeeze out the stagnant blood in the womb and to control protruding of the belly. This was practiced until she stopped bleeding or she was fully recovered.

In home delivery, the baby lacks the opportunity of receiving vitamin K (clotting factor), especially where PNC is delayed or denied as observed in this study. This increases the susceptibility of the new-born to bleeding disorders (Maghuyop-Butalid et al., 2015), because vitamin K prophylaxis is safe and prevents haemorrhagic diseases of the new-born (GSS, 2015; Maghuyop-Butalid et al., 2015).

The application of fundal massage, local gin (akpeteshie) and a piece of cloth as a third stage labour management method is not in compliance with the recommendations of the WHO. To prevent postpartum haemorrhage, it is recommended that active management of third stage labour (AMTSL) should involve injection of oxytocin to the mother after delivery, and performance of controlled cord traction (CCT) i.e., pulling on the umbilical cord while applying counter pressure to help deliver the placenta, and massaging the uterine fundus after placental delivery (WHO,

2012).

Nonetheless, the TBAs were very instrumental to the welfare of the women. After treating them in pregnancy and providing emotional support and assistance at delivery, they further spent some time with the nursing mothers to guide them on dieting and hygiene to avoid infections. They also assisted in the preparation of food for the lactating mothers and bathing the baby in the convalescent period, normally between one and three months until the woman was fully recovered. Just like Burns (2010) and Indraccolo et al. (2010) observed, this care and love demonstrated by the TBAs are normally given at the time women need most comfort. This remains an indelible memory in them and motivates them to seek the services of TBAs next time.

It should be noted that the TBAs had no specific spiritual role within their capacity in this period. They only relied on the space provided by the husbands/family heads and spiritualists based on what they deemed as a woman's space.

5.3.3.2 The Role of Spiritualists in Postnatal Period

Just like the delivery stage, the medical role of the spiritualists in the postnatal stage involved preparation and prescription of medicines for the lactating mothers and their babies. Spiritually, they were involved in assisting the husbands and family heads to perform rituals and offer sacrifices to the ancestors and gods for wiping their tears. They also found out whether the sacrifices offered the gods were accepted by the spirits or not. In a group session, all the participants agreed with these procedures as narrated by their colleague. The 69 years old sooth sayer said:

> *"When we prescribe or perform sacrifices during pregnancy and delivery, we try to find out whether those rituals have appropriately done and accepted by the spirits or not. Where it requires that we do it again, we do. Sometimes the husbands may not follow the right procedures and the ancestors will reject the offer. In that case we find out and re-perform or redirect them to do because failing to do the right thing can bring curses to the spouses and their baby in future. The child can grow to become a thief, drunkard or a very poor and useless person."* (MSLC, Muslim).

If the sacrifices were not accepted by the spirits, the spiritualists would ask them to re-perform the rituals because failing to accept the offer by the gods meant they were not happy with the offer or they did not follow the right procedures. Aside, they also played any spiritual role assigned them by the family heads such as determining the destiny of the baby, finding out which profession would be better for the baby in future and any dietary prohibitions that the child would observe. In IDI, another spiritualist explained his role after delivery. He said:

> *"We try to find out which of the family members has reincarnated and that can inform the life span and taboos for that child to observe. We can also find out the job that can help the child succeed in life so that the parents will prepare them for that job."* (65 years, sooth sayer, MSLC, Muslim).

The spiritualists' activities contributed to delays in PNC because they directed husbands on how long to confine the baby and the mother and when the sacrifices should be performed to thank the gods. Assigning spiritualists to protect the baby required rituals and application of herbs for bathing and drinking which delayed PNC. For example, in IDI an herbalist said:

> *"We believe that when children are born spirits will still attack them so we monitor them after birth. The minimum number of days for bathing herbs is three or four days but mostly babies are made to bath for one week before they are formally out-doored on the eighth day."* (78 years, no formal education, African Traditional Religion).

This indicates that a woman and her baby could only seek PNC after three days - i.e., after the critical period and miss opportunity of being screened or treatment.

5.3.4 Commentary

The TPs' activities delayed the parturients in seeking medical care during obstructed/prolonged labour and retention of placenta. This is risky for maternal and neonatal health. Obstructed labour can result in prolonged labour and severe damage to the lower genital tract causing a false passage between the bladder and the vagina, and the woman suffers incontinence of urine and sometimes of faeces (Senah, 2003; Maghuyop-Butalid, Mayo & Polangi, 2015; UNFPA, 2016). Again, though the chemical components of some herbs used in

traditional birthing may be good for women in pregnancy (Lisha & Nisser, 2015), or delivery (Senah, 2003), others cause death (Senah, 2003; Maghuyop-Butalid et al., 2015) when pregnant women overdose on them (Kee, Hayes & McCuistion, 2014). Obstructed/prolonged labour and retention of placenta are life-threatening complications that require the expertise of midwives and obstetricians. It is harmful to handle such conditions under home care because the TPs cannot perform amniocentesis to determine the foetal state of health and position with the use of only bare hands on the tummy and multiple vaginal examinations in labour as observed in the study.

None of the spiritualists had a license to operate as an herbal drug producer. Neither were the TBAs except four of them who were registered or trained. Again, their herbal products were not subjected to any laboratory investigations or clinical trials to ascertain efficacy, safety, dosage, the chemical composition and expiry date amongst others. This implies that the expectant and nursing mothers or their foetuses and babies may overdose on these substances or use substances that may be harmful to them. The observed practice of applying herbal concoctions to newly born babies immediately after birth was equally dangerous to the baby's health (Aasland, Borchgrevik & Fugeli, 1997; Marcus & Snodgrass, 2005). The age of the baby may subject it to vulnerability as a result of the strength of the chemicals in these concoctions. Aside, these concoctions may also be contaminated and cause ill-health to the baby. This is because there is a positive association between the use of herbal products in pregnancy and foetal ill-health (Gibson & Powrie, 2001; Nordeng & Havnen, 2004).

Using *akpeteshie herb-mixed* (local gin mixed with herbs) during lactation is hazardous to babies because they feed on what their mothers eat. Studies show that no amount of alcohol in breast milk is safe for a baby to drink, and exposure to small amount of alcohol in breast milk causes disturbances in the sleeping behaviours of infants (Mennela & Gerrish, 1998). There were no evidences of measuring and regulating alcohol intake for expectant and nursing mothers in the study. This means the mothers may take more than necessary, which will be absorbed into the

bloodstream and into the breast milk for the foetus or baby to feed on respectively. This exposes the baby to higher risks of consequences of alcohol consumption because of its age and size of body organs (Mennella & Beauchamp, 1991).

The TPs handled some pregnancies and related complications at home. But they were not in the best position to handle obstetric complications because they are less likely to recognise most maternal complications (Bailey, Szaszdi, Glover & Rev Panam, 2002). For instance, they cannot perform amniocentesis to establish the state of the foetus health. Again, they cannot determine the level of blood in the woman's body and ascertain whether she needs blood or not. Even if detected, they cannot perform blood transfusion. Additionally, the chemical components, efficacy and safety of the *mossi* (herbal beverage) administered in pregnancy as blood supplement is unknown and its impact on the woman, her foetus or baby remains a research gap and a subject matter for scientific inquiry. The Northern Region is leading in anaemic cases especially in newborns in Ghana (GSS, 2015). Though malaria, malnutrition and genetic conditions are possible factors, over reliance on the use of *mossi* as blood supplement in pregnancy could contribute to this situation. TPs cannot detect some health conditions and manage or give treatment. For instance, they cannot detect HIV and AIDS and prevent mother to child transmission which is an important intervention in maternal and child healthcare (GSS, 2008, 2009, 2015).

The birthing environment was not hygienic enough. There were no evidences of use of gloves or sterilisers, and *dettol antiseptic* was used in rare occasions. The commonest substance used to control infections was soap and water which in some emergency situations were neglected. Using bare hands in multiple vaginal examinations, clamping and cutting of the umbilical cord and the stoical removal of baby or placenta from the womb is subject to infections (Fronczak et al., 2007; GSS, 2008) because there was no protection from micro-organisms. This has been observed to have heavily contributed to maternal morbidity and mortality (Fronczak et

al., 2007; WHO, 2014). Hence, puerperal sepsis, a likely outcome of this practice is the sixth-leading cause of deaths amongst new mothers (WHO, 2014). Healthcare providers must wear sterile gloves in order to avoid the risk of contamination with the patient's blood and other fluids (WHO, 2009), especially, in the advent of HIV and AIDS and hepatitis B amongst others. The TBAs could also be infected with the said diseases in the process of offering assistance at birth to an infected parturient.

It was observed that the TBAs did not consider cord pulsation in the clamping and cutting of the cord. Clamping and cutting of the cord at least within 1-3 minutes for improvement of the iron status of the infant is recommended (WHO, 2012). Delayed cord clamping enhances baby's weight and haemoglobin level which is capable of sustaining the baby for about 3-6 months (American Pregnancy Association, 2016) and improves maternal and infant health and nutrition outcomes (WHO, 2012).

Most of the babies delivered at home were denied the opportunity of receiving vitamin K because they either delayed postnatal care (PNC) attendance for ritual confinement or did not attend PNC at all. This increases the susceptibility of the new-borns to bleeding disorders, because vitamin K prophylaxis is safe and prevents bleeding-related diseases in new-borns (Maghuyop-Butalid et al., 2015).

Fundal massaging with a hot towel on the abdomen, the use of *akpeteshie herb-mixed* (local gin mixed with herbs) and a piece of cloth tied around the tummy as management of third stage labour defies WHO recommendations. Active management of third stage labour should involve injection of oxytocin to the mother after delivery and performance of controlled cord traction in order to control postpartum haemorrhage (WHO, 2012).

Even though they played a lifesaving role where health professionals were absent, the activities of the TPs were not only harmful due to the substances and techniques employed, but also reduced the number of clinical visits, delayed or denied ANC, SD and PNC. This partially

explains the region's highest number of amaemia cases in babies (GSS, 2015), maternal deaths and home deliveries in the country for two consecutive years (GSS, 2011, 2012).

5.4 Conclusions

This chapter discussed the worldviews and health beliefs around pregnancy and childbirth, highlighting the ethical values behind them, and how they impacted utilisation of clinical services during the three stages of maternity. The role of traditional practitioners in indigenous birthing practices and the implications for maternal and child health were also discussed.

The study discovered a dual-faith system practised by the participants in all communities which led to dualism in healthcare, where expectant and new mothers received care from both health professionals and the traditional practitioners. Irregular and low clinical visits as well as delays were associated with this system of care.

This study also discovered systems of oppression inherent in the worldviews and health beliefs which operated in economic, moral and religious or cultural values, and enforced by husbands and family heads or traditional practitioners who used male supremacy to hold the women to the traditional expectations of maternity care. There were traces of institutional oppression especially, at the household levels in the various communities which led to marginalisation of women who had to succumb to the dictates of culture through men's voices. This led to the situation whereby over time, especially the illiterate and elderly women internalised the culturally oppressive codes and normalised their practices by influencing colleagues and young women to observe those codes in the pregnancy-postpartum period.

Using the delays model and the structure and agency theory in concert, the research discovered that the exercise of the institutional systems and the oppressive codes were facilitated by traditional compound housing system which typically put members of the households into structural hierarchies according to ages and gender. Thus, factors that regulated women's health

seeking behaviour were not isolated but located in structured systems in hierarchies. Therefore, young couples had to comply with grandfathers, uncles and senior brothers who shared common roof with them. Together with the African Traditional Religious principles which formed the foundation of the culture of the people, this research discovered delays in accessing clinical services which were systemic, structured and described in this study as *systemic-structural delays*. This was associated with the traditional gender role expectations in maternity, rituals and sacrifices which formed the major features of traditional birthing processes and had adverse impact on the woman at the agency level.

These notwithstanding, the women with secondary education and above who were gainfully employed were able to overcome these cultural dictates to put up positive attitudes towards clinical care. Equally, most husbands with high educational background were able to stand against dominant societal gender expectations which were likely to have adverse impact on maternal health. Some spouses had to move out of the traditional compound houses to stay separately in order to avoid succumbing to harmful beliefs and practices in pregnancy.

The worldviews and health beliefs reflected in the role of the traditional practitioners in indigenous birthing practices which were characterised by the use of herbal concoctions and spiritual forces to treat or manage pregnancy-related complications. Traditional leaders as well as religious leaders from Christianity, Islam and the African Traditional Religion should be actively involved in rural maternal healthcare programmes. Gender responsive approaches should be adopted by using husbands, traditional practitioners including the TBAs in healthcare programmes for promoting clinical services utilisation. The Ghana Health Service should work in collaboration with Food and Drugs Authority to encourage and monitor drugs produced by the herbalists and spiritualists. Aside, the TBAs need to be trained and provided with sterilisers and gloves to assist deliveries in emergency situations where health professionals are not available. The TPs should be assisted to have access to laboratory testing and clinical trials of their herbal

products to ensure safety, efficacy and licensing. There is an urgent need for the Ghana Health Service to identify the traditional practitioners for health screening and certification. Also, education on the need to detach spiritual matters from health conditions is essential to promote maternal and child health.

The TBAs interests in institutional delivery were subdued by the spiritualists' activities through the husbands and family heads. In fact, the TBAs could best be described as doulas in the traditional medical practice, and their contribution remains paramount regardless of the deficiencies in their methods of treatment and delivery. However, both TBAs and the women who needed care were at the receiving end, not based on their demands, but the desires of the men and the patriarchal society.

The next chapter discusses gender roles and decision-making towards healthcare seeking at the household level. It also examines both the care-seeker and care-giver perspectives on the conditions that promote or inhibit effective utilisation of clinical services in maternity.

CHAPTER 6

DECISION-MAKING AND UTILISATION OF MATERNAL HEALTHCARE SERVICES

6.1 Introduction

Decision-making, especially between spouses has been observed in most studies as a central phenomenon in utilisation of maternal healthcare services (McAlister & Baskett, 2006; Hagman, 2013; UNFPA & ICRW, 2014). It has been established that the type of decisions taken and the timing of reaching a decision by individual women, spouses or families to a large extent, have impact adversely and positively on utilisation of maternal healthcare services, which invariably, affect the outcome of care seeking (Senah, 2003; Comb Thorsen et al., 2012). As evident in the literature, these decisions are rooted in the background of the actors.

This chapter focuses on two main themes in two sections. Section 6.2 is on gender and decision-making towards care seeking, whilst Section 6.3 deals with the provision and reception of maternal healthcare services by discussing the views of both the care-seekers and the care-givers on conditions that promote or inhibit clinical services utilisation. Conclusions drawn from the discussions in Sections 6.2 and 6.3 are presented at the end of the chapter.

6.2 Gender and Decision-Making Towards Healthcare Seeking

Gender may be described as the characteristics that a society or culture delineates as masculine or feminine. It refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women. Gender roles have an impact on the health of the individual especially women because they govern the processes of reproduction and healthcare (FAO, 2007; ICRW, 2010; UNDP & ICRW, 2014).

This section discusses gender and intra-household decision-making towards the choice of

maternal healthcare services in the study area. It further discusses the role played by husbands to promote women's health especially, at the household level during the pregnancy-postpartum period. Because the role of husbands/family heads in decision-making is very instrumental in promoting maternal health (Hagman, 2013; UNDP & ICRW, 2014).

Using the views of husbands and wives who were at the centre of intra-household decision-making, this study finds answers to the research question: "How does spousal decision-making inform the choice and practice of maternal healthcare"? This section addresses the third objective of the study.

6.2.1 Masculine and Feminine Roles

Responses generated from the study showed that male-centred decision-making was perceived as a *customary mandate* by both husbands and wives. It was discovered that the men were mandated by the custom to make sole decisions for their families but they may involve their wives.

> *"As women, we only suggest to our husbands and they decide to take or not. It is the men who decide for us. Hmm...women's decisions are always considered as children's decisions. We only take decisions from them. That is why if your husband is not around you find it difficult to do things."* (35 years, mother, trader, SSS Christian).

To understand the issues well, the researcher first sought information on gender roles. Traditionally, there were some tasks that have been assigned to women and some assigned to men. Both sides of the participants unanimously established that there are roles that men played within marriages. Both partners noted that they could not perform some roles because of their genders. Even when the women were involved in the decision-making process, it was finally concluded by the men who were either the husbands or the family heads. That is, decisions taken jointly between spouses were solely finalised by men.

> *"Yes, by the custom it is the men who take decisions. Oh!! Even the bible mandates us to be the heads. You may involve your partner but you have to take the final decision and make*

sure the decision protect your wife, the children and yourself. In my absence, my wife may seek help from my bothers in this house to reach a decision." (43 years, husband, farmer, SSS, driver, Muslim).

This study observed differences in status regarding decision-making between husbands and wives. Women were unable to make personal decisions about healthcare as they relied on husbands and their relatives. There is the need for modification and elimination of gender roles that deny women equal opportunities in access to healthcare services. This is necessary because inequalities in access to healthcare is a major impediment of maternal healthcare (Nussbaum, 2005; WHO, 2007; Nwokocha, 2007). Even under critical obstetric conditions women depended on their husbands who did not feel the symptoms of the complications to determine the severity of the condition and decide on care seeking for them. It is women who experience the symptoms of pregnancy or related complications and the severity, yet, they did not have the mandate to express their perceived need. The men were non-professionals who under the influence of health beliefs delayed in making informed decisions and led to the use of traditional medicine as the first choice leading to further delays.

"Hmm... I suffered for one week before the herbalist allowed me to go to hospital. I was bleeding but they gave me some herbs to bath, drink and syringe. For 6 days, I could not rest...very painful in waist. So, when i went to the clinic it was too late and lost the baby." (29 years, mother, trader, JHS, Christian).

Perceived need better predicts care seeking and adherence to medical regimen (Andersen & Newman, 2005). However, the women's perceived need for care seeking was being influenced by the men, some of whom did not even have knowledge about pregnancy-related complications. This is a husband's response to question on pregnancy signs in IDI:

"I can't tell whether a woman is pregnant or not until the belly enlarges or she tells me. Some people say the breasts also enlarge but some women have big breasts already. It is difficult. Apart from the belly I told you, I don't have any idea about pregnancy signs. Some women have big stomachs. In that case I can't know whether they are pregnant or not. I think it's the weight of the baby that is why some woman may have waist pain. But when they syringe it helps them... even bleeding." (45 years, JSS, Christian).

As discussed in Chapter 5, taking decisions in a typical northern compound house involves a lot

of actors such as husbands, fathers, bothers, uncles and sometimes grandparents and this caused delays. This sustains the argument that the provision of maternal healthcare services and professionals with the entire necessary infrastructure alone cannot make health services accessible to the women (UNFP & ICRW, 2014).

The expected impact of the CHPS compound system is not felt here probably, because the men were not directly involved in the programmes as originally planned and therefore, driven by their health beliefs to mediate the path to clinical healthcare with cultural practices. Responses from the participants indicate that the Ghana Health Service have not been meeting the community members to educate them on how to improve maternal health in the various CHPS zones. Engaging men in maternal healthcare programmes in communities will make them appreciate the need for change of some harmful gender roles and cultural practices. Involving men in maternal healthcare has the potential of improving women's health (Kululanga, Sundby, Malata, & Chirwa, 2012; Hagman, 2013; Mangeni et al., 2013) because if the men accept the available maternal health programmes, they can then make it accessible to the women (UNFPA & ICRW, 2014).

It should be noted, that culture does not only shape treatment of illness but also illness recognition, perception of severity and confidence in the efficacy of specific treatment for specific illnesses (Rebhan, 2008). Modernising or modifying cultural practices, which normally mediate between health facilities and women is an act of removing structural barriers to provide some autonomy to the woman at the agency level. This way, the men will be in the position to facilitate speedy intervention, which will consequently, result in increased utilisation of maternal healthcare services through ANC, SD and PNC, which are the expected outcomes of the maternal healthcare policies and the conceptual framework for this study.

Even though there were traces of some men performing "women's roles" such as cooking, washing and fetching of water, it was explained that those men were not bound by the tradition or

by marriage to perform those duties. They did so because they wanted to help their spouses. This is what one female participant shared with colleagues and the researcher in FGD:

> *"To avoid role ambiguity, the society has assigned different roles to men and women. Anyway, they are not taboos and can be ignored but it is an issue of conformity in the society."* (38 years old teacher, bachelor degree, Muslim).

Both the male and female participants identified roles such as cooking, washing, cleaning/sweeping, fetching of water, gathering firewood, shopping for cooking and carrying food stuffs from the farm as women's spaces. On the farm, the women were expected to assist their husbands in sowing/planting and harvesting. Decision-making, payment of bills of all kinds (medical, rent, water/electricity, and school fees), taking care of farm animals and weeding were cited as masculine roles.

The women in the study communities were not in good position to realise better maternal outcomes for it is argued that women are likely to have better outcomes when their husbands directly get involved in ANC visits, and supporting their wives during pregnancy, delivery and post-delivery periods (UN, 2005; Kabakyenga et al., 2012; Story et al., 2012; Mangeni et al., 2013). Apart from paying for healthcare cost which was considered as men's space, and in rare cases following spouses to the clinics, most husbands did not show concern in activities regarded as feminine roles during pregnancy. This could have negative impact on their wives' health services utilisation because men who show concern in pregnancy have their wives more likely to utilise reproductive health services (UN, 2005; Kululanga et al., 2012).

6.2.2 Decision-Making Towards Care Seeking

Decision-making between spouses was investigated to ascertain whether decisions on healthcare were solely taken by husbands, wives, other family members or jointly taken. The study discovered that husbands and family heads dominated in decision-making towards the choice of maternal healthcare services. In FGD, this statement made by a husband was supported

by colleagues and repeated in similar settings in the research. He said:

> *"Normally they inform us when they are not feeling well... Some of the conditions faced by women in pregnancy need to be investigated from the spiritual realm before we take decisions. We know it is good to quickly go to the hospital but you may lose either your wife or the baby in the hospital if you don't decide and act wisely. I plan with my father and senior brother. Women should not be part of issues relating spirits. Your wife may suggest to you but you have to take the best decision in her interest."* (54 years, husband, MSLC Muslim).

The data showed that intra-household decisions on care seeking throughout the maternity period were dominated by the husbands. Care seeking was influenced by male dominant decisions either between spouses or amongst the members of the extended families (in compound houses). Most decisions were husband-centred upon consultation with family heads or spiritualists.

It was discovered that structures such as cultural beliefs and traditional discriminatory gender norms affected women's individual ability to act on their own behalf. The customary mandate that strongly drove the men to make decisions on women’s care seeking was discriminatory and a violation against women's reproductive rights (Republic of Ghana, 1992; AU, 2006). It made the women unable to freely take and implement decisions concerning their own health.

The provision and implementation of the CHPS compounds in the study communities neglected the influence of power imbalances between men and women in influencing the use of maternal healthcare facilities. Similar to this study, a study on male dominance and maternal healthcare in Nigeria establishes that cultural and social norms restrict women's mobility and prevent them from seeking healthcare (Nwokocha, 2007). This study discovered that gender inequality in decision-making within the household was regulated by socio-cultural norms and manifested in power differences between husbands and wives.

Entrusting decision-making in the hands of only men within the family denied women timely and speedy access to healthcare services. This is because decisions taken by the men were located in structures, culture-driven and associated with delays in recognising the problem, decision-making on the source of care and in making referrals from the spiritualists.

6.2.2.1 Women's Involvement in Decision-Making

The women were asked to mention how they were involved in the decision-making process towards healthcare. It was revealed that the women lacked total freedom in taking independent decisions as they had to seek approval from the men. However, a good number of the participants indicated that they had joint decisions, with very few women mentioning that they made independent decisions towards healthcare. Further probing with those who had independent decisions proved that they had to seek permission and approval from their spouses or family heads before they could seek care. All the women in FGD subscribed to these comments made by their colleague:

> *"I need permission from my husband but if he should refuse I will still go for check up because it is my health. If he refuses to pay I can pay for myself. Yes. For peaceful coexistence, the tradition is that if your husband is not around you seek permission from the brothers or parents. If those people are not around you can inform his paternal uncle or best friend."* (26 years old, policewoman, SHS, Muslim).

On the same issue, the husbands held to the view that, it was their duty mandated by their custom to always protect their wives and children. Therefore, irrespective of where a woman is going, there is always the need for her to seek permission from the husband.

> *"Culturally, husbands are the decision-makers. If for any reason a woman wants to go to the hospital, culture demands seeking permission from the husband or family head. These are followed to protect the women."* (Husband, 48 years, O' level, Christian).

However, some of the husbands disagreed with their colleagues, arguing that, it is always important for the couple to know the movement and whereabouts of each other, but seeking medical care should not be connected to seeking permission. Adding that, it should be just giving information to the husband that she is going for check-up without requiring any approval.

> *"I think issues concerning medical care should not be taken for granted especially, in pregnancy. Yes, it is good to be informed so that the husband will know where the wife is but it should not be a must to seek approval from the husband."* (Husband, 52years, MSLC, Muslim).

Women were asked to state the action they would take if their husbands refused to allow them to

seek medical care. The women who had internalised and normalised the traditional gender roles said if their husbands refused to grant them permission to seek care they would remain at home because by the tradition, a woman must not question a man on certain issues. The statement that "a married woman is supposed to be submissive and sober to the husband because in marriage, the husband plays fatherly role whilst wife plays the role of a daughter" made by one woman was unanimously agreed. One female participant commented on this in the IDI:

> *"The men are not expected to tell we the women everything. Some might not approve permission to visit the hospital because they have seen a danger ahead or being cautioned by spiritual fathers to do so but they cannot inform you the woman. You see, women are not part of that game. So, our husbands can only tell us don't go and that's all."* (45 years, MSLC, Muslim).

As discussed in Chapter 5, the traditional gender role has been internalised by some women who considered them as normal giving men the supremacy backed by spiritual beliefs to control them with the oppressive cultural norms. These discriminatory acts against women rendered women minors within the household and the community. This is a form of social inequality created through gender roles that deny women in contributing to decision-making on matters concerning their own health.

The mandate given men as sole decision-makers is a gender role in itself and a source of gender inequality. The men's power to control women was embedded in beliefs in superstitious and ancestral spirits. Because Ghanaian women have respect for their culture (Nukunya, 2003; Arzoaquoi et al., 2015), most women had to succumb to what the family or society had for them without questioning the implications. In a similar setting, a male participant in support of his colleagues' contributions in the FGD added this:

> *"A woman has no right to question a man about certain things especially, relating to spiritual matters. Any woman who tries to find things about spiritual issues is always a witch. So, wives are not to be allowed to consult spiritual fathers for anything. That is why we don't involve them in consultations and we don't discuss the outcomes with them."* (48 years, farmer, MSLC, Muslim).

The women with contrasting views felt that they carry the pregnancy and remain the objects of all

the associated complications and consequences. Therefore, if they were denied the opportunity to seek care they would ignore whoever was in control and seek care because it is about their lives.

> *"... I will break the law and go for care because I feel the pain and I will be person who will die. He may even get a replacement of me on my funeral day..."* (34 years, SSS dressmaker, Christian).

The Ghana Statistical Service and collaborators (2004, 2008, 2009) have persistently mentioned financial constraints as one of the major determinants of healthcare services utilisation in Ghana. The data from this study did not support this observation. Financial issues did not come out in the interviews as major issues, probably, the NHIS is taking care of this problem. However, two women who were denied ANC visits by their spouses explained that even though covered by NHIS, their spouses could not raise money to take care of extra expenses in facilities.

6.2.3 Gender, Health Beliefs and Decision-Making

The decision-making process was male-dominated, culture-centred and spiritually driven based on masculine and feminine roles, health beliefs and the supremacy given men by the society. Women were marginalised in decision-making and treated as minors as most of them only followed decisions made by husbands and family heads. This discrimination and inequality in decision-making at the disadvantage of women influenced their health-seeking behaviours such as demand and ability to access and utilise healthcare services. The male dominance was embedded in systemic hierarchical structures within the household especially, in compound houses. The decisions taken at the household level took the following forms:

i. Inter-household joint decisions involving men from different households within the compound houses which were finalised by the family heads;
ii. Intra-household joint decisions involving spouses only and finalised by the husbands;
iii. Individual tentative decisions made by women;
iv. Individual final decisions made by either a husband alone or a family head alone.

The study found that though non-family members, the traditional practitioners were important stakeholders and actors in decision-making at the household level. Mostly, men's choices of care type, location and timing for seeking care for women in the pregnancy-postpartum period were dependent on the outcome of their consultation with the spiritualists. The dual-faithed and male-dominant decisions influenced maternal clinical attendance in the following ways: Firstly, decisions were delayed for initial ANC visits. Some pregnant women were delayed seeking ANC at the initial stages with the intension of hiding their pregnancies from the evil public eye. They believed that in its early stages, pregnancy should be hidden to avoid spiritual attacks. Therefore, early ANC attendance draws people's attention to pregnancy and exposes pregnant women to people who cause misfortune to the life of the woman or her foetus. This is what a sooth sayer (spiritualist) and father to a newly born baby said:

> *"We normally advise women to hide pregnancy in the early stages because this is the time the devil normally attacks women to spoil their pregnancies for them. That is why we make some women don't go to hospital because other people will see them and they will get problems. Sometimes the nurses will make all those in the hospital see that somebody is pregnant and it is bad."* (58 years, spiritualist, MSLC, African Traditional Religion).

Women who exposed their pregnancies in early stages were considered as leading indecent lives. Pregnancy was only to be known to the spouses and their parents in the early stages. This supports Arhin's view (2001) that it is culturally immodest to show early signs of pregnancy in Ghana. Most husbands confided in TPs and assigned them the responsibility of treating their wives in early pregnancy. The men mentioned that if a woman was not sick and people set eyes on her at the hospital they concluded that she was pregnant unless the woman was a nursing mother or an old lady who could not give birth anymore. This did not only affect the timing of ANC attendance, but also the number of visits. Most of the female participants and their husbands indicated that they made first ANC attendance in 4 months and above, when the belly begins to protrude and they could not hide anymore. A young woman shares her experiences in pregnancy in IDI:

> *"I go to doctor two months and then I born baby. My husbands say I for no make people see me rough rough so I don't go out. One day my husband mother say I go to doctor and I go. So am in the house and two months time I born in the house."* (21 years, primary sch., farmer, Muslim).

Pregnancy wastage or miscarriages are commonly experienced by women in the first trimester of their pregnancies (GSS, 2008). Complications experienced by women at this critical phase of pregnancy were attributed to the machinations of the devil or enemies. The participants did not consider the fact that the stage is critical and the delicate foetus still undergoes through stages of development and that pre-existing medical conditions could cause a miscarriage.

Secondly, the dual faith-based decisions neglected clinical counselling and screening and resorted to spiritual consultation and herbal treatment. This deprived some women of important health information. For example, further probes showed that most of the women who did not use clinical services and those with low attendances did not know that they had to make 4 visits with at least once in each trimester (for pregnant women without serious complications). Most of the women experienced miscarriages in their first trimesters or early in their second trimesters. A woman shares her experiences during pregnancy with the researcher in IDI:

> *Oh! Hmm... the pregnancy spoil when I get about four months. I go antenatal care three days time then I get the miscarriage. Before I go to hospital I feel pains in my waist side for some days and I tell my mother in law but she tell me that it will be o.k. But some day it become serious then I cry and my husband take me to doctor. After three days, the baby come out and die."* (Trader, 29 years, JHS, Muslim).

The few women who made ANC attendance within the first trimester were women with serious obstetric complications who had evaluated need (Andersen & Newman, 2005), and those who had attained higher levels of education and were staying outside compound houses with their spouses.

Thirdly, the first ANC visit was used as a means of verification for further decision-making. The first antenatal check-up was meant to confirm the women's perceived status of pregnancy and later turn to herbal care. Most of the men had inadequate knowledge about pregnancy signs and either depended on their spouses or medical screening. As a result, they used clinical

screening results to verify their wives' pregnancy status, which then informed their care seeking decisions.

Most of the husbands said the first action to take upon realising that their wives were pregnant was to let their wives go for medical check up to confirm their perceived status. Some other men began giving them herbal treatment or buying drugs from chemical shops without professional prescription to treat them so that they could carry the pregnancy to term. Interaction with the women showed that their husbands asked them to first confirm with medical doctors through laboratory investigations to be sure that they were pregnant, establish the age of the pregnancy and afterwards, turned to herbal treatment. This category of women did not use ANC services after screening or considered it later around 6 months and above when they were preparing for delivery.

As a tropical country, Ghana is still battling with malaria which is a precondition for anaemia in pregnancy. The blood level of pregnant women needs regular monitoring in the hospital through laboratory tests. When women confirm their pregnancy status on the first ANC visits and turn to herbal treatment as observed in the study, their blood levels cannot be determined later in pregnancy. This becomes very risky for those who are anaemic because in the event of haemorrhage such women stand the risk of losing their lives.

Fourthly, the decisions taken encouraged the use of TPs' services, which resulted in lower and irregular ANC visits. The data showed lower number of ANC visits between 0-5 with most of the women making one or two visits. It was observed that the number of ANC visits was higher amongst the women who initiated ANC early and those who had attained SHS and above in education compared with their counterparts. Similar to GSS (2008) and Hagman (2013) the study found positive correlation between female education and maternal clinical attendance. Whilst women who made early clinical visits were motivated by their evaluated needs (Andersen & Newman, 2005), those with higher formal education used their knowledge about health

information and adopted health promoting attitudes. The average number of ANC visits was about 2; and some of the women never visited the health facilities again after they had been confirmed pregnant through laboratory tests. This is what a man shared in IDI:

> *"... Having established that she was pregnant after the first medical check-up, I bought some minerals for her to be drinking so that she could increase her blood level to avoid blood shortage in her body. She did not go for treatment again."* (39 years, JHS, farmer, Muslim).

In IDIs with the women in the same community one nursing mother noted:

> *"My husband used to buy medicines for me. Sometimes he prepares herbs for me. When I got pregnant and tested positive, my husband prepared "mossi" (a local beverage prepared from herbs) for me so that I could get enough blood. I used to drink mossi at least twice everyday till delivery." (*36 years old trader, JHS, Christian).

As indicated in Chapter 5, the practice of dual faith systems led to dual decisions and dualism of care. Some husbands had to consult spiritualists to find a lasting solution to persistent miscarriages/still births experienced by their partners. As the TPs took care of the spiritual issues and tackled with herbs and concoctions, the professionals used laboratory investigations and drugs to handle the physiological conditions. In two separate FGDs in rural communities all the male participants had similar responses to the question on whether their wives used traditional medicine alongside hospital drugs. This was what one participant shared in FGD which came up in another FGD and had full support from colleagues in both sessions:

> *"Several times we treat the complications like bleeding and abdominal pains with herbs. Sometimes too we combine the herbs with drugs from the hospital to manage complications* (43 years man, farmer, no formal education, Christian).

> *"We ask them to go for medical check-up and when it is confirmed that it is pregnancy we use herbal medicine in addition to the hospital drugs to treat them."* (25 years old man, trader, SHS, Muslim).

It was expected that a secondary school graduate would behave differently towards societal norms, but it appeared they behaved to the demands of the tradition partly, because they were not on their own as they shared compounds with parents and uncles or they were ignorant about the risks involved in excessive use of traditional medicine. In FGDs with career women, they

admitted knowing about the availability of TPs and testifying that they had treated some woman in the community. However, six out of ten of them said they had been educated on the need to seek professional care only and so, they did not patronise the services of the TPs in their most recent pregnancies. The six participants unanimously endorsed this comments made by their colleague:

> *"There are many traditional practitioners in this community who treat pregnant women and nursing mothers but I did not use their services in my last pregnancy. I was advised to seek medical care for better health for myself and unborn baby."* (34 years old woman, teacher, bachelor degree, Muslim).

They admitted having knowledge of how harmful it could be to combine drugs because the professionals educated them on the dangers of some herbs and the effects of using herbs alongside clinical drugs. The study establishes that these career women were not staying in compound houses with their extended family members. They were people who had migrated from their traditional communities to work in other areas. In that case, either decisions were jointly taken or the husbands took the decisions. In contrast, the career women who happened to be in their traditional community argued that they were not assertive enough to resist the demands made by their husbands' parents since they stayed in the same houses. They explained that they did not call for herbal medicine but the family members provided them and asked them to use. A 30-year old police officer had this to share:

> *"Hmm...actually, it is not easy. Sometimes we are made to do things unwillingly but a woman has no mouth to complain in a family house. My brother, I used both herbs and drugs from the hospital because I had no option. In my previous pregnancy I used only hospital drugs and the pregnancy terminated in the seventh month. I actually refused herbs but this time my marriage was at stake and I had to combine. Thank God I had a successful delivery this time."* (SHS graduate, Christian).

As mentioned earlier on, experience, knowledge and level of education were translated into positive attitudes for spouses who stayed outside the family compound houses. Some of the women had the health information to translate into health promotion behaviour but the socio-cultural setting did not allow them to derive full benefits of their level of education,

knowledge and experiences. Though they had equitable gender attitudes and high level of awareness on laws related to reproductive health and human rights (UNFPA & ICRW, 2014), they could not put them into practice.

Fifthly, based on their beliefs and faith system, home delivery was the first choice for most births which were assisted by TBAs. Delivery care is the next important stage in the period of maternity. In fact, it is the stage that is normally associated with maternal mortality or development of serious complications (GSS, 2008). Some of the participants sincerely confirmed the responses of their partners that their wives had home deliveries in last pregnancies with assistance from TBAs. Neither educational level of participants nor residential status showed any influence on place of delivery. In IDI, a female participant in Yendi with five children noted:

> *"To be frank with you I have not given birth in hospital before. I think that is one thing Allah has blessed me with. I only use herbs and am okay. Some people spend a lot of money in the hospital but they end up in operation before they deliver. Some don't even get children."* (41 years old woman, SHS, Muslim).

The women mentioned that most deliveries, miscarriages and stillbirths occurred at home and the associated complications were handled by the TPs. Apart from the beliefs, some families resorted to traditional care because of recognition, trust and the satisfaction they derive from the TPs. The inadequate knowledge of the husbands about pregnancy-related complications together with the dual fath beliefs system also informed the dual care seeking behaviour. This confirms the observation that inability of men to judge the severity of health conditions and their implications leads to multiple care seeking (Killewo et al., 2006).

The women received warm treatment with satisfaction from the TBAs who were much involved in pain control and interaction with the parturients during delivery. Both men and women mentioned that many women in both previous and present pregnancies delivered at home. In individual interviews, these were the experiences of women in home delivery and miscarriage respectively:

"... Oh yes, I have five times home delivery experience. I normally have short time labour - about five minutes and delivery follows. I was assisted by the TBAs. I did not have any serious medical condition that required that I go to the hospital for delivery. Safe delivery I always say is the gift of God because in the face of doctors and all the machines women still die in the hospital." (39 years old woman, trader, JHS, Christian).

"Yes, I had a miscarriage in last pregnancy. I was treated at home by the help of herbalists. Oh!! that was not the first time. They have been treating me." (43 years, farmer, no formal education, Muslim).

Similar to Galaa and Daare (2008), facility-based delivery and postnatal care was for women with serious obstetric conditions who needed special care. The men were also asked to mention where their spouses gave birth in their last pregnancy. These were the responses generated from IDI and FGD respectively:

"Oh! my wife has had several home deliveries. Even in the most recent pregnancy she delivered at home. She was assisted by the community TBAs. There was no problem. No complications recorded. After delivery, she was very healthy and strong so there was no need to even go to the hospital ..." (53 years, farmer, no formal education, African Traditional Religion).

As discussed in Chapter 5, observance of taboos was a decision for positive maternal outcome and safe delivery was perceived as an outcome of perfect observation of taboos.

"Oh! yes, all the deliveries my wife experienced happened at home and were assisted by TBAs. She never had any complication after delivery because I made sure she observed all taboos related to pregnancy especially food taboos and she was always given herbs to keep her strong and healthy..." (34years old, social worker, SHS, Muslim).

These findings partly explain the high home deliveries and maternal mortalities in the region (GSS, 2012). The various maternal healthcare interventions put in place by successive governments such as NHIS, CHPS amongst others could not impact supervised delivery as expected. This supports the argument that not all population interventions influence social inequalities in health (McLaren et al., 2009). Needs assessment is required to identify the needs of the communities so that specific interventions could be introduced to make maternal healthcare more acceptable and accessible.

Just like ANC, timing for PNC attendance was very poor. None of the women who had home

delivery was able to meet the requirement of PNC attendance within 48 hours after delivery. The earliest recorded was three days by one participant with the most of them seeking PNC after 7 days when the naming ceremony had been celebrated. Some of the participants waited till about three weeks after delivery before seeking care. In IDI, a man shared the experiences of his wife with the researcher:

> *"... Yes, my wife delivered at home in her last pregnancy just like the previous ones. She was assisted at birth by Mama who treated her with the herbs I brought from Baba Yaru. The herbs healed her so she did not attend PNC at all. She did not fall sick and the baby was also very strong."* (56years old farmer, MSLC, Muslim).

Others did not seek PNC at all because either they did not experience any complications and considered it unnecessary or their complications were treated with herbal medicine. This is what one woman experienced in her last pregnancy after premature birth:

> *"Hmm.. Yes, I had a premature birth and the child did not survive. A certain woman in this community treated me with herbal medicine that my husband brought from a herbalist. Even though I attended ANC before the incidence, I did not go to hospital afterwards. I did so to avoid embarrassment from the public. People would be asking about the whereabout of the baby and I would be sad. I just kept myself indoors."* (32 years old woman, farmer JHS, Muslim).

Unlike the clinical system where premature babies are put in incubators, the TPs used thicker garments to wrap premature babies and asked women to carry them to hospital. Some of the women who bled profusely after delivery were sent to herbalists for treatment. This was the experience of a woman who delivered at home:

> *"I bled after delivery but herbs were used to treat me for a week before I went for PNC at the hospital. I did not take any form of modern treatment for one week. Normally it is not allowed to take a newly born baby to hospital until at least after one week."* (43 years, trader, JHS, Muslim).

Others, were given self-prescribed medicines by their husbands from chemist shops and TPs. The confinement of women for one week after delivery was motivated by the need to give protection to the lactating mothers and their babies. The newly born babies were not supposed to be seen outside the mother's bedroom until they attained seven days, then on the eighth day, the naming

ceremony was performed. On that eighth day, outsiders could see the baby since it had undergone spiritual fortification. Though critical phase, the postnatal period was often neglected by the women. Apart from postpartum haemorrhage, the practice of waiting for at least one week before seeking PNC subject women and their babies to puerperal and neonatal infections respectively.

In the FGDs, both the men and women mentioned that the TPs were readily available and more concerned about them. Aside, the TBAs hardly delayed them in performing their tasks. In some of the CHPS zones the participants questioned the efficiency and qualification of some of the health professionals. They claimed that, delivering in the CHPS compounds was like doing it under the supervision of the TBAs. Adding that, the TBAs were even more experienced than those community health officers (CHOs) who did not have any equipment to assist at delivery.

6.2.4 Husbands' Contribution in Maternal Healthcare

The study observed that the men performed political, economic and spiritual roles in addition to assisting in household tasks. As discussed earlier on, the political function took the form of decision-making. Apart from that, economic role (payment of medical bills) emerged as the primary role that almost every husband played during the maternity period. Both the husbands and wives were asked to mention the roles men played during the pregnancy-postpartum period. Most of the wives noted that their husbands provided money for settling medical bills, buying herbal medicines, paying for the services of the TPs and transport cost. In both FGDs and IDIs all the men mentioned payment of medical bills as a primary responsibility that they were committed to in their spouses' last pregnancies. The men noted that it was one role that they could not compromise. None of the men interviewed admitted having failed to settle medical bills because it was a disgrace to any man who failed/defaulted in settling medical bills. However, some women had contrasting views mentioning that their husbands did not care about settling medical bills. They claimed that, not even transport fares were given to them by their husbands.

Interaction with some of the husbands revealed that, they considered all costs apart from transportation as covered by health insurance. Therefore, they did not see the logic in giving extra monies to their spouses. Some women had to go to their farms or bush with their pregnancies to gather firewood, carry several kilometres to the market centres to be sold to settle medical bills. A number of women agreed with these views shared by their colleagues in FGDs:

> *"The only role my husband played in my pregnancy and childbirth was to impregnate me and allow nature to take its own course. He never assisted me in any way. He did not provide money for treating the pregnancy, no emotional or psychological support and never bothered to assist in performing any task at home. It may sound harsh but he is well described as a liability. Under serious conditions he would expect me to still perform normal duties such as cooking, washing and sweeping."* (29 years old trader JHS Muslim).

> *"When I was pregnant and after delivery my husband did not provide any form of assistance. Even he did not care about payment of bills that most men are committed to. It is a disappointment and a shameful behaviour."* (48 years, farmer, MSLC, Muslim).

Some of the men accompanied their wives to the clinics for treatment by carrying them in their cars or on motor bikes and bicycles to the health centres for treatment. Some women agreed with these views as shared by some participants in FGDs:

> "*My husband assisted me by carrying me on his motor bike to hospital and took care of the medical bills..."* (31 years old woman, trader, JHS, Muslim).

> *"... Oh yes, I remember when she was going for the first check-up I carried her on my bicycle to the clinic..."* (38 years man, Trader, JHS, Christian).

It was observed that motor bikes and bicycles were the most common means of transport in the area (Figure 6.1). It was impossible to link up to some farming communities with cars because there were no access roads apart from footpaths. At least every household had either one motor bike or bicycle. Though they were useful to the people, the motor bikes and bicycles are not the best means for pregnant women, especially in the first and third trimesters when women are susceptible to miscarriages and premature births respectively, particularly on the uneven and gully-eroded roads in the areas. Applying some of the roads and footpaths indicated that they were not smooth, as they were undulating and characterised by pot holes and gullies (Figure 6.2).

Figure 6.1: Major Transport Means in a Village Compound House

Source: Fieldwork, 2016

This would not give the pregnant woman smooth journey and could have a serious effect on her pregnancy. For instance, a woman experiencing haemorrhage or abdominal pains is likely to worsen her condition on a motor bike, or even worse on a bicycle through a rough road. Again, this situation is even worse for a parturient and the unborn baby. Aside from paying medical bills and accompanying their wives to the hospitals, the other issue which emerged in the interactions was the role the husbands played in household chores to assist their wives at the time they were not supposed to perform certain tasks because of their conditions. According to most women, their spouses never assisted in performing any household chores. In both IDIs and FGDs almost all the women agreed with these shared views from their colleagues:

> *"The role my husband played during the maternity period was to pay for the cost involved in treatment at the hospital... For household chores, he was not involved. I performed every household task alone."* (29 years woman, trader, SHS, Muslim).

> *"These our men? The only role they play is to bear the medical bills... any other work is*

regarded as a woman's job. I wish my husband is always by me during delivery to see how women suffer." (40 years old woman, trader, SSS, Christian).

Figure 6.2: Transport network in the study area

Source: Fieldwork, 2016

However, one female participant indicated that her husband had been very helpful to her in pregnancy. She stated that the husband assisted her in fetching water, cooking, cleaning and washing. A teacher in one of the communities shared this with the researcher:

> *"My husband does a lot to assist me during pregnancy and after delivery. He assists me in washing, cooking in addition to payment of bills. Even though we both earn salary he takes care of all payments himself."* (34 years old woman, bachelor degree, Muslim).

Most of the husbands admitted that they did not assist their spouses in performing household chores. They argued that those tasks were not part of their responsibilities. Across the datasets, the men in polygamous marriages unanimously explained that it was because of those tasks that they married at least two wives so that the other wife could help when the need arose. Meanwhile,

some of the wives in polygamous relationships expressed fear in getting closer to their rivals as they perceived each other as enemies. They explained that they could not receive medical care because their rivals who were their seniors in marriage ill-advised their husbands not to send them to hospital. Some of them said they had been subjected to maltreatment by their rivals. Most of the wives did not like the use of rivals to assist in running the home because they were already not in good terms with each other. Therefore, they wondered how somebody who is not in good terms with another could generously and wholeheartedly support. The women rather preferred either mothers or sisters of their husbands to help them during this period. This is the experience of a young lady in polygamous marriage in IDI:

> *"My rival does not like me since the day my husband brought me to this house. She fights me unnecessarily every day. I treat her like my mother but she doesn't like me. When I was arranging to attend hospital she told our husband to forget about it and give me herbs. When she was pregnant last time, I did every work in the house but I fear to ask her to help now. Just last week she beat me and I bled but our husband did not do anything to her."* (20 years old, trader, JHS, Muslim).

Women who were in marriage before their husbands added new wives also accused the young girls for agreeing to marry their husbands. They noticed that they had a lot to do and therefore, could not stay in the house to take care of pregnant young girls who wanted to take their husbands from them. Some of them explained that even getting closer to their rivals would result in problems because in the event of any complications they would be prime suspects. They rather suggested that their husbands should bring their female relatives to take care of their young wives. In IDI, a woman who is the first wife in polygamous marriage had this to share:

> *"I didn't ask my husband to go in for a second wife. I cannot do extra work in the house because my husband is married to a young girl. He can help himself... hehehe!! My children need my attention. Our husband knows I won't do it and I will not do that is why I didn't get married to a man with a wife."* (45 years old, trader, O'level, Muslim).

The men noted that even though it is not their role, it was not a taboo to perform those tasks but they were also engaged in their farms to produce food for the family. Below were the responses from some husbands in FGDs on the role they played in the household to help their pregnant

spouses:

> *"... For washing and other household chores I did not do. They were rather taken care of by our mother."* (38 years old man, Trader, SSS, Christian).
> *"I played the role of buying drugs and paying her medical bills. For cooking, washing and cleaning I did not take part in them because those are things for the women." (*36 years old teacher, diploma, Muslim).

> *"I think I helped her small for example, I paid for the cost of treatment and sometimes I washed my personal clothings but not that of the wife. If a man is found washing for the wife in this community it will be a history."* (42 years old man, first degree, policeman, Muslim).

The data did not show any difference in background variables amongst the men on performance of household chores. Unlike observations in existing literature, the background variables of the participants did not make any differences in their actions and perceptions about the performance of household chores. Though the level of education of men influences their involvement in household chores (UNFPA & ICRW, 2014), in this study, most men with high level of education acknowledged the need to assist women in pregnancy but considered that best done by female family members. The only difference was that these men assigned female relatives to assist their spouses unlike the case of their counterparts where the pregnant women were made to do the work themselves. In Yendi, in-depth interviews with some men who were graduates of university working in different agencies like Ghana Education Service, Ghana Health Service and the Ghana Police Service established that the men were not in support of the idea of married men doing washing, cooking and cleaning. One of them remarked:

> *"For how long has the custom changed for men to be cooking, sweeping, washing and fetching water? I think we should be careful! This is haram in the sight of our ancestors. At a point, these women will demand that we allow them to be chiefs of these areas. I personally will prefer that my sister comes to stay with me to do that or any other female relative."* (37 years old man, laboratory technician, Muslim).

Maternal healthcare does not end in the health facility or with the traditional practitioners, but extends to the home as well. Conditions in the home can either make a woman healthy or unhealthy. For instance, women with clinical history of haemorrhage, abdominal pains or hypertensive disorders are normally cautioned to avoid lifting heavy objects like water in buckets

to keep them healthy and help sustain the pregnancy. Therefore, they need help other people especially their spouses to observe these health principles. Just like any other African countries, in traditional patriarchal Ghanaian society, the need for husbands to be concerned about women's health is relevant for promoting maternal healthcare. It was observed that some of the husbands were concerned about drug intake and therefore, monitored their spouses to take drugs given to them in the hospital. In the IDIs a woman shared this with researcher:

> *"... My husband provided milk, eggs and mossi to help build my blood. He also monitors the intake of the drugs given me at the hospitals."* (25 years old woman, student, diploma, Christian).

Some of the husbands mentioned that they monitored their wives to take drugs that were given to them in the hospital to make sure that they avoided taking the drugs at wrong times or overdosing on them. Others noted that they monitored the use of the herbs given to their spouses by the traditional practitioners to ensure that they followed the right procedures. All the male participants in both FGDs agreed with these views shared by their colleague:

> *"I make sure my wife is take the hospital medicine. When I give her herbs from the Baba place (spiritual father/herbalist) too I watching her to take it. I show her how to do because when I does not show and she do wrong, the medicine will spoil. So, she have to follow the way correct every time to get healthy and the baby too healthy. So, when the medicine spoil too Baba will collect another money to treated her again."* (46 years old man, Farmer, MSLC, ATR member).

It was observed that the use of herbs goes with some procedures, the violation of which may render the herbs ineffective. To avoid this, the husbands normally demonstrated the drug use for the wives to observe before they were made to use. Where spiritual issues were attached, missing any step in administering the herbs rendered the whole thing useless and the medicine had to be re-prepared.

6.2.5 Commentary

The study revealed differences in status between spouses within households which manifested in both intra-household and inter-household decisions-making, and the status of decisions taken by wives and husbands. Whilst husbands took individual and final decisions, wives could only take tentative decisions subject to approval by men. The decision-making process which considered women as minors was characterised by marginalisation and oppression of women which was not only discriminatory, but also a precondition for inequalities and disparities in access to healthcare. These are major impediments to improvement of maternal health (Nussbaum, 2005; Nwokocha, 2007; WHO, 2007).

Women who felt symptoms of various pregnancy-related conditions did not have the mandate to make decisions about their own experiences but had to report to men, most of whom did not have adequate knowledge about pregnancy signs and their implications on women's health. This system of decision-making was observed to be connected to the cultural mandatory role given men to take sole decisions which was regarded as an act of protection for women. This unequal distribution of opportunities (ICRW, 2010; Abel & Frohlich, 2012) and power in decision-making observed between husbands and wives led to delayed and inappropriate decisions towards care seeking. The men determined the severity of the women's conditions and decided on the type of care they needed upon going through the family protocols and spiritual consultations. In line with the observations of Jammeh et al. (2011) and Qureshi et al. (2016), these processes of decision-making denied women speedy clinical intervention. Many women in African countries have always been delayed in receiving medical care due to lack of knowledge about the severity of the conditions and the associated dangers, and inability of the men to make quick and informed decisions (Somé, Sombé & Meda, 2013; Ganle et al., 2015; Manguambe et al., 2016). These findings sustain the conclusions that the patriarchal Ghanaian society entrust the power to make decisions in the hands of male members of the family (Nukunya, 2003; Tsikata,

2007). This symbolises gender inequality in decision-making process within the household which is critical and a neglected issue in maternal healthcare programmes (ICRW, 2010).

Though both men and women in the region suffer disparities regarding distribution of health facilities and personnel (Bawah, 2008; GHS, 2010; GSS, 2015), the study discovered that disparities for women were further widened by the male-dominant philosophies and practices connected to healthcare decisions and accessibility. This supports the statement by the UNDP (2013) that patriarchal ideologies and practices have been structured to make women vulnerable to illness and deaths. As argued by Nussbaum (2005), there is an urgent need for elimination of cultural practices that deny women equal access and opportunities to healthcare in these communities to improve women's health in maternity.

Marginalisation of women as observed in the decision-making towards care seeking is a precondition for subjecting women to maternal morbidities and mortalities. This is because decision-making is a key component of care seeking (Thaddeus & Maine,1994) and appropriate and timely decisions lead to positive maternal outcomes. Therefore, neglecting women's minds and voices in determination of the severity of their obstetric conditions and the choice of care or timing of care seeking may amount to adverse implications for the health of both the expectant mother and her unborn baby. It is women who experience the symptoms of the conditions and can best tell the severity of such complications. Using health beliefs and masculine role to determine women's state of health, type of care needed and the time for care seeking as observed in the study deprived women of expressing their perceived need and knowing their evaluated needs. This is an act of genderism which is in contradiction with human rights and women's reproductive rights (Republic of Ghana, 1992).

As mentioned repeatedly in this study, the practice of dual faith system with the African Traditional Religion at the centre impacted the decisions-making process which contributed to poor care seeking behaviour. This manifested in the use of services of TPs as the first choice of

care, irregular use of clinical facilities, poor timing and lower number of clinical visits. At the same time, the women were made to use clinical services alongside herbal treatment. The source of care was chosen by the men, driven by socio-cultural and gender related factors upon spiritual consultations. In line with UNDP (2007),) Rebhan (2008) and UNFPA (2016), the study found that the culture of the communities was a barrier to maternal healthcare services utilisation as it influenced the women's knowledge and beliefs about maternal complications as well as their attitudes towards the treatment of such conditions. The need to protect newly born babies resulted in child confinement for at least one week which deprived mothers and babies of timely PNC. Again, early signs of pregnancy and the onset of labour were borne with stoicism in secrete in order not to attract evil eyes from the public. As discussed in Chapter 5, this practice which confirms the observation of Arhin (2001) exposes expectant mothers and their pregnancies or babies to health risks.

The first ANC was for verification for further decision-making. This period is very crucial in maternity because risk factors are normally screened for during this period for treatment and counselling (GSS, 2008, 2009; WHO, UNICEF, UNFPA & World Bank, 2013, 2014). As a tropical country, Ghana is still battling with malaria which is a precondition for anaemia in pregnancy. The blood level of pregnant women needs regular monitoring in the hospital through laboratory tests to save the woman's life. Aside, the unborn baby needs regular clinical monitoring to ensure that is in good state. When women confirm their pregnancy status on the first ANC visits and turn to herbal treatment, their blood levels cannot be determined later in pregnancy. This becomes very risky for those who are anaemic because in the event of haemorrhage such women stand the risk of losing their lives. As indicated in previous chapter, the 2015 report by Ghana Statistical Service shows that anaemia is one of the top leading causes of maternal deaths in the country with the study region leading in anaemia cases in babies. A related study in a similar setting (Munguambe et al., 2016) noticed that ANC attendance was for

registration with the facility to avoid maltreatment during delivery in future. In some cases, the use of TPs was not related to beliefs but the comfort the women and their families derive from them, and the inadequate knowledge about pregnancy-related complications on the part of the men to make informed decisions towards care seeking. This also calls for health professionals to strengthen their care to women in maternity by accommodating cultural differences when they visit the facility.

In spite of the extended family influence in the compound houses, most formally educated women showed positive attitudes towards clinical care seeking. This maintains the positive correlation between female education and maternal clinical attendance (GSS, 2008; Hagman, 2013). Most of these formally educated women were well informed about pregnancy-related complications, nutrition and the need for frequent clinical care. Some were able to stand against food taboos which they felt could lead to deficiency of important nutrients. This confirms that literacy skills enable women to perceive and retain health information and adopt health promoting behaviour (Preston, 1989; Magadi & Curtis, 2003).

Involving men in maternal healthcare has the potential of improving women's health (Kululanga, Sundby, Malata, & Chirwa, 2012; Hagman, 2013; Mangeni et al., 2013). Traditional masculine and feminine roles and the beliefs systems of the participants also affected the involvement of husbands in maternal healthcare at the household level. Even though they provided funds for settlement of bills and supervised drug intake with a few of them accompanying their wives to the facilities, most husbands did not perform the feminine roles in person at the household levels to assist their spouses who were not fit to play such roles. Whilst those in polygamous marriages used co-wives to perform such duties, the men in monogamous marriages used female relatives. However, both the pregnant women and the non-pregnant rivals preferred female relatives of their husbands for such roles. Some other men did not assign the feminine gender roles to female relatives and co-wives but left them to their pregnant wives to

perform irrespective of their conditions. This has adverse impact on the health of the woman especially, those with obstetric complications that do not require them to perform some household chores.

Following wives to the facility was observed to expose men to conditions in the facilities which helped them to appreciate the conditions to make healthcare more accessible to their partners. For example, after misunderstandings between spouses over payment made in the health facilities, some of the men who followed their wives to the facilities found that apart from the insurance cover, some unofficial monies were collected in the facilities. This maintained the trust they had for their wives and motivated them to take care of extra expenses. Again, visiting the facilities exposes men to education on maternal healthcare which helps them accept the available maternal health programmes and make them more accessible to the women as well as increase their commitment in assisting their spouses at the household level.

This section discussed masculine and feminine roles in decision-making for maternal healthcare. The section also examined how the faith systems of the communities informed decisions towards care seeking as well as the role played by husbands in maternity. The next Section (6.3) discusses conditions that influence effective utilisation of maternal healthcare services within health facilities from the perspectives of both care-seekers and care-givers.

6.3 Provision and Reception of Maternal Healthcare Services

This section presents results and discussions on the organisational or institutional factors which influence effective provision of maternal healthcare services in the selected area. This section seeks to find answers to the research question, "What are the institutional/organisational factors that influence effective provision and reception of maternal healthcare services?" This is the fourth and final research question for the study which addresses the fourth objective. Essentially, the formulation of this objective was rationalised by the quest to generate a balanced

data for a deeper understanding of health services provision by looking at both demand (client) and supply (care-giver) sides for a balanced discussion of issues. The demand side relates to the views of the pregnant women and their families are the clients, whilst the supply side deals with the service providers who are the health professionals (ICRW, 2010). Secondary information was sourced from the Ghana News Agency, Ghana Statistical Service, Ghana Health Service, the Yendi Municipal and Chereponi District Assemblies. In addition, primary data were generated using individual interviews of health personnel. From the data, the factors identified were analysed under the domains of inadequate staffing, financial constraint, inadequacy of equipment and facilities, lack of professionalism, lack of transportation means and network, and poor clinical attendance as discussed below.

6.3.1 Inadequate Staffing

The health facilities in the study area did not have enough health personnel to handle pregnant women in addition to other clients. Data from Yendi Municipal Assembly showed that the municipal hospital which served as a referral centre to the whole municipality, the Chereponi as well as the Saboba Districts, had only four medical doctors including one specialist who was also the medical superintendent. In her half-year performance report, the municipal director of health service noted:

> *"The Yendi Municipal Hospital is critically lacking in professionals such as midwives, nurses and doctors, making work at the hospital difficult."* (Ghana News Agency, August 17, 2014).

The Chereponi District Hospital had only one non-resident medical doctor who was also the superintendent, with two medical assistants who were national service personnel. In addition, the hospital had only two registered nurses, two qualified midwives, sixteen community health nurses, one laboratory technician and a driver (Chereponi District Hospital, 2015). A midwife explained how the inadequacy of staff affected the provision of healthcare. She said:

> *"As a young district, we face a lot of difficulties. We have only one medical doctor who is not even resident. He is the superintendent of this hospital as well. My brother, you can judge for yourself; we are only two midwives responsible for all the pregnant women in the whole district. You can imagine, all the pregnant women and other patients with different medical conditions compete over the few staff."* (Midwife, Chereponi).

Information from Human Resource Division of the Ghana Health Service showed that the health professionals have been refusing postings to the health facilities in the region because of its deprived nature. In an interview, a midwife noted:

> *"Because of high doctor/nurse - patient ratio, the women spend several hours in the facility. Sometimes some of them do not get access to the doctor. The work load on the only one lab technician makes him unable to finish working on all samples to be presented to the doctor or the medical assistants. So the woman cannot see the doctor without lab test in some instances."* (Midwife, Chereponi).

The study discovered inadequate staffing and congestion in health facilities as sources of demotivation to women in using health facilities. These were reported in recent related studies in Ghana (Oiyemhonlan et al., 2013; Banchani & Tenkorang, 2014). Considering the population (117,780) of the Yendi Municipality in addition to the two neighbouring districts, a heavy pressure was mounted on the professionals to deal with the heavy congestion in the facilities of clients with different ailments. This negatively affected the provision of services as most women spent longer hours within the facility before accessing the midwife or doctor.

6.3.2 Financial Constraints

Another inhibition identified from the data was financial restraint. The health facilities in the area lacked adequate funds to run the business of healthcare. In an address during the 2014 half-year performance, the Yendi Municipal health director noted:

> *"There are also the problems of inadequate funds to run the health centre, delays in the reimbursement of the National Health Insurance Scheme (NHIS) claims. In addition, difficult procedures involved in procurement delay the acquisition of medical supplies for smooth running of the facility."* (Ghana News Agency, August 17, 2014).

In Chereponi, the hospital administration noted:

> *"We just had upgrading of this facility to the status of district hospital. You hear a big name but we lack a lot of things here. One big problem is about how to get the health insurance claims. It is also very difficult these days because of the procurement law to get medical supplies. In fact, it takes a long time and this delays procurement. As a result, we run short of medical supplies including drugs."* (Hospital Administrator, Chereponi).

They identified issues such as delays in reimbursement of the NHIS claims, the bureaucratic and difficult procedures involved in procurement. These delayed the provision of clinical supplies to run the facilities effectively, which in turn, created artificial shortages. From the demand side, payment of illegal fees was mentioned by some participants as a financial problem hindering reception of maternal healthcare services.

With the introduction of National Health Insurance Scheme and the strengthening of the procurement laws, financial difficulties as a barrier is shifting from client side to the facility side. This has been highlighted in other studies (ICRW, 2010; Baru, 2013; Banchani & Tenkorang, 2014). In this study, except in few instances, the participants did not mention financial restraint as a major problem which prevented them from seeking care. Instead, the care-givers complained about the difficulties involved in procurement and reimbursement of the NHIS claims to enable them to secure their medical supplies. Procurement difficulties are amongst the most cited healthcare barriers accounting for 65% in developing countries in recent times (Martin et al., 2013). According to the participants, because the health insurance does not create any room for the professionals to directly collect monies, they had informally introduced collection of monies at certain points within the facilities, which were not documented nor supported with payment receipts. Some women mentioned that the collection of these monies generated misunderstandings between them and their husbands when they failed to render account with evidence of payment. A woman had this to share:

> *"My husband has insured me with NHIS but anytime I go to the hospital the workers will ask me to pay money and they don't give receipts. The last time I went to hospital I had a problem with my husband on return because I paid some monies and could not produce receipts. Because of the insurance cover he was not convinced that I paid money in the hospital. They will collect money at every joint but they won't give you any paper as*

evidence. The problem is that some women use the pregnancy and delivery period to cheat their husbands. When you ask for the purpose of the money they get angry and offended. I think they should always give receipts for every pesewa collected to avoid confusion between spouses, because after that day my husband did not give money to go for check up again. Anytime I asked he told me insurance is there but you cannot access proper healthcare when you rely on insurance alone with this health workers." (37 years, trader, SSS, Muslim).

Some husbands also explained that they had insured their spouses and babies, and did not understand the cause for the extra fees which had no receipts to show. Some men were of the view that their spouses capitalised on the hospital attendance to spend their monies, and that explained their inability to show receipts. A man who followed his wife to the hospital shared his experience in FGD. He noted:

"I nearly fought my wife when she told me she made some payments and could not produce receipts. When I followed to the clinic the next time, they asked her to pay some money and she called me to come and pay. After paying I requested receipt and they told me they don't have receipt for that. It became a tug of war because I insisted on receipt and this attracted attention. Many women told me they suffer the same condition and their husbands are suspecting them and fighting them. Some of the workers get into the job for money not for saving lives." (48 years, policeman, Muslim).

As discussed in the previous section, when husbands accompanied their wives to the facilities, they were exposed to conditions within the healthcare system and got to understand how their spouses spent the monies they gave to them.

The collection of unofficial fees from the women without issuance of payment receipts was perceived as unfaithfulness on the part of the women by their husbands and sponsors and discouraged them to continue financing their wives. This is because the women could not produce receipts as evidence to their spouses in rendering accounts to them. The participants complained that they spent extra monies for laboratory tests which were covered by the insurance policy. During delivery, some monies were collected from the families of the parturients before delivery or the woman herself after delivery. Studies have shown that the removal of fee paying in accessing health services by women in maternity has resulted in the medical system charging informal fees and asking women to undergo laboratory test outside the public facilities (Baru,

2013). Similarly, in the Tamale Metro, Banchani and Tenkorang (2014) discovered collection of illegal fees as one major deterrent of health service use. It is worth noting, that Ghana is still on the path to achieving the Sustainable Development Goal 3, and many families in the informal sector are yet to understand or develop trust in the NHIS policy to register. Therefore, subjecting policy holders of this good intervention to payment of illegal fees as noted in the study is a source of distrust and demotivation and a precondition for failure of the NHIS policy, poor utilisation of the facilities, poor maternal healthcare and failure to achieve the Sustainable Development Goals on maternal and child health.

6.3.3 Inadequacy of Equipment and Facilities

As a corollary of the above point, it was difficult to repair or replace the old and worn out medical equipment when they run down. According to the Chereponi District Assembly, some medical equipment were lacking in the health facility which in turn affected the delivery of healthcare to the women. A midwife in the hospital noted:

> *"We lack so many equipment for proper provision of healthcare. We need more equipment in addition to the few we have. For instance, the hospital has only one weighing machine, one incubator, one suction machine and only one oxygen cylinder. You can imagine! How many children will get the opportunity for weighing, or using an incubator in case of premature birth? Clearly, mothers are expected to spend many hours in the facility just for weighing of their babies."* (Midwife, Chereponi).

Anytime someone was using each of these equipment, it was impossible for another person to use. Existing literature (Esena & Sappor, 2013; Oiyemhonlan et al., 2013; Banchani & Tenkorang, 2014) shows that the healthcare system in Ghana is challenged with infrequent or irregular supply of drugs and equipment, understaffing and congestion in the facilities. In the two assemblies, the CHPS compounds did not have sterilisers to assist them at delivery and every used material needed to be sent to the municipal or the district hospital for sterilisation making it impossible for any other person to use at the time. A community health officer in a CHPS compound said:

> *"We don't have sterilisers in this compound. After using any material which requires sterilisation, we send to the district hospital. So sometimes they bring women for delivery and sterilised gloves are not ready, and other necessary equipment have not been sterilised or they have not brought them from the district hospital. This way, we become handicapped. You can see how it is risky to assist delivery without these materials."* (CHO, CHPS Compound, Yendi Municipality).

In the absence of the sterilisers, the CHOs worked like the TBAs - i.e, in emergency situation, without sterilised gloves they had to assist at delivery. Another pressing issue mentioned by the professionals and the clients was the fact that the health facilities were not enough and the existing ones lacked space to accommodate their clients to an appreciable level of comfort. This created congestion and delays in the facilities and some women travelled long distances to access healthcare. The Director of Ghana Health Service explained that:

> *"The Municipal can boast of just one hospital, only seven CHPS zones, with four compounds, out of the twenty-two demarcated CHPS zones, implying that a larger proportion of the population traveled more than eight kilometres to access healthcare which is not acceptable per the health policy of the country."* (Ghana News Agency, August 17, 2014).

It was pathetic to discover that the maternity ward in the Chereponi District Hospital which served as a referral centre to the CHPS compounds in the district was shared by both men and women. In an interview, a health professional said:

> *"Hmm! It will surprise you that in this facility, the maternity ward is dual purpose. Both men and women use the ward. It is very congested and there is absolutely no privacy. Some women sleep on the floors. Currently, there are only three beds in the maternity ward."* (Midwife, Chereponi).

There was no privacy especially for the women. Aside, due to lack of space and beds, most women admitted were found sleeping on mats on the floors of the *dual purpose or unisex maternity ward*. Further, staff accommodation emerged as a condition which hindered the effective rendering of services by the health professionals. Most of the workers were not staying around the health facilities. Some of them were staying outside the communities with the facilities. In an interview with Ghana News Agency (GNA), the Yendi Municipal Coordinating Director said:

> *"We are aware of the challenges like accommodation, CHPS compounds, Transportation, water and sanitation, which the assembly has been trying, in collaboration with the Municipal Health Directorate to solve."* (17th August 2014).

In the Chereponi District the professionals explained the problems they had with staff accommodation. The Government Hospital administrator said:

> *"Most of the workers stay far from this facility because of lack of accommodation. It is always better to have health professionals staying around the facility to avoid any problems associated with transportation and to ensure that any time their services are needed they can easily avail themselves for duty. We need more of staff accommodation for the workers."* (Administrator, Chereponi Hospital).

Health professionals are supposed to stay near the facility to be able to attend to duty on time and respond to a call for emergency when the need arises. The provision of decent accommodation is an incentive and a source of motivation to the health workers for effective provision of services.

The participants noted that congestion and delays within the facility, coupled with intense heat was a source of demotivation to use the health facilities. Intense heat is typical of the tropical continental climatic zone which covers the whole Northern Region. Some women explained that even the seats for women to use in the facilities were not enough to absorb women. It was common to find women with their babies on the back or shoulders standing and waiting for their turn to see the doctor. Some of the husbands mentioned that they could not take their wives to the health facilities and wait till they were treated because of congestion and the long period of waiting. However, the clinical staff explained that as part of the strategies to promote male involvement in maternal healthcare, women who attend maternal clinic with their partners were given priority to see the professionals irrespective of the time they reported to the facility.

Apart from the long waiting period and heat, they could not get chairs because some women and other patients around were standing and waiting for others to be served before they got access to the seats.

6.3.4 Lack of Professionalism

The participants were aware of the fact that the available facilities did not have enough spaces to give them comfort or adequate staff to promptly attend to them, but their major concern was lack of professionalism exhibited by some nurses and midwives who put up dehumanising attitudes towards clients. To some participants, the medical doctors were more humble, duty-conscious and cultured compared with the other professionals within the facilities. Some women could not receive skilled delivery or attend PNC just to avoid insults and shouting from some nurses either for failing to attend ANC in a particular facility, not attending ANC at all in the prenatal stage or not delivered in health facilities and reported for PNC. According to some women their experiences in emergency situations for delivery even put them off institutional delivery. During emergencies, instead of timely attending to patients, they rather wasted time and asked women in pain why they did not seek care previously. During delivery or PNC, they requested non-existent folders (documents containing clinical history) from women who never attended ANC and failure to produce the folders was a source of insults and undue delays to such women. Below are the experiences of a husband in a health facility within the Yendi Municipality. In FGD he said:

> *"I had a painful experience when my wife was going to deliver in the clinic for the first time. She attended ANC in a different facility before we migrated to this community. Because the labour was felt very early at dawn, I could not remember to carry her folder. So when we got to the hospital, the baby was about to come out. But the nurses on duty wasted time asking for folders, clinical ID cards and other things which could not instantly assist the woman in any way. Because that was her first time to get pregnant, she rather tried preventing the baby from coming out till the nurses come around and unfortunately, we lost the baby. In her second pregnancy, she delivered at home and went to the hospital for PNC on the second day. In my presence, the way the nurses humiliated her for delivering at home, it was a bad experience I had. But the same people are making noise all over that women should visit the hospital after birth. Until that day I did not know that the campaign on hospital delivery is rather to enable the nurses insult women!"* (45 years, trader, SSS, Christian).

In IDI, a woman expressed her joy in home delivery by saying:

> *"I can frankly and comfortably describe home delivery as very good because the TBAs give you strong emotional support and the family members around sympathise and empathise*

with you and share the pain with you, unlike the shouting and insults in the hospital." (34 years, trader, JHS, Muslim).

Some women said even within the facility they did not receive care from nurses and midwives. They noted that under emergency situations when they shouted for assistance from nurses and the midwives, they were ignored. In the IDIs, one woman asked:

> *"... Now, please, Sir, tell me which is better. To give birth at home with the assistance of the TBAs and giving birth in the health facility without assistance after long period of waiting on the floor."* (40 years, trader, SSS, Muslim).

These undue delays and negative attitudes towards pregnant women within the facility are sources of demotivation and challenges to clinical service use (Comb Thorsen et al., 2012; Esena & Sappor, 2013). This was the major cause of failure of the maternal exemption policy in Ghana (Biritwum, 2006). In Yendi, client side delays in decision for care seeking in some cases were linked to inability on the part of professionals to effectively cope with serious obstetric complications either for lack of expertise or due to the small number of professionals in relation to many clients.

Mothers who could not communicate in English could not access vital health information. After taking scan they could not determine the expected date for delivery, and for fear of intimidation, they would not ask from the professionals. The professionals failed to provide them with information about their health and educate them as part of their responsibilities. The situation was worse in cases where both spouses were illiterates. A related study in the Central Region of Ghana (Turkson, 2009) established that health professionals in rural communities were not telling women their health problems and how to manage them. Consequently, women who had no information about their health either travelled to distant places for quality healthcare or resorted to traditional care. Similarly, some local health facilities were underutilised because the care-givers could not meet the expectations of the women and their families. Studies in Africa (Esena & Sappor, 2013; Kumbani et al., 2013; Pfeiffer & Mwaipopo, 2013) especially, have

observed dehumanising behaviour of care-givers as a major challenge to utilisation of maternal healthcare services. To avoid maltreatment from clinical care-givers, some participants in the study registered with the health facilities during the prenatal stages not for regular attendance, but as a guard against emergencies to avoid insults for not bearing clinical identification cards. Interaction with the women discovered that they did not have knowledge of the use of clinical ID cards and folders. They mentioned that those documents contain their names and addresses. Unlike the literates, none of the illiterates had information about the relationship between the 'often demanded' documents and their clinical history. Health information should not be given on assumption but based on needs assessment of the audience. From the same sources of information, the literate mothers and their illiterate counterparts had different understanding about the importance of clinical ID cards and folders. Normally healthcare professionals study the clinical background of patients where necessary before commencing treatment. Where the client is not informed, it will be counted as undue delay.

However, the women with secondary education and above were able to seek information and interact with the professionals. Aside, they could read the scan to know the expected date of delivery or seek explanation from professionals and prepare for delivery. In confirmation of Preston (1989), Hagman (2013), UNFPA and ICRW (2013), the study observed that literate women had an advantage over their illiterate counterparts in accessing health information.

6.3.5 Transportation Means and Network

The study area had serious problems regarding the road network and the means of transport. The 90km road which was the main road linking the two major health facilities in the study area was untarred with gullies and pot holes. As a result, it took more than three hour-drive to get to

Yendi from Chereponi instead of one hour and thirty minutes. This was the road used for transferring emergency cases from the Chereponi Government Hospital to the Yendi Municipal Hospital when referrals were made. Proper care calls for good transport system with good roads and ambulatory services for referrals.

The situation in Chereponi was worse. Not a single road in the district was tared including roads within the district capital. In the rainy season, some communities in the district were cut off completely from communities with health facilities due to seasonal flooding. This made healthcare inaccessible to women. For instance, the Bunbrunga community was completely cut off from the Chereponi community during rainy season.

> *"You can see for yourself... Even the main road in the district capital is not tarred. You can imagine what is happening in the hinterland and I know you have visited some of the places and seen the nature of the road network. Our main referral road is very bad but we have no option than to apply it. In the rainy season, most roads are not applicable and the women resort to home care for all pregnancy related cases. Hence, the high infant and maternal deaths in this area."* (District Health Administrator, Chereponi).

In view of this, most women resorted to both trained and untrained TBAs for delivery. Besides, the district lacked a referral hospital and depended on the Yendi Municipal Hospital for referral services which in itself was not well positioned for such services. As a young district, the Chereponi District Hospital lacked means of transport. The only few old and weak motor bikes available were very expensive to maintain due to their ages and degrees of damages.

In the Yendi Municipality, the assembly noted:

> *"The Yendi Municipal road network consists of only 57km of first class roads, 246km second class roads and 183km of feeder roads. The rest were footpaths liking up some farming communities. Apart from the first-class roads, the rest of the roads are marked by pot holes and gullies and the feeder roads are waterlogged especially in rainy season thereby, making them impossible to apply"* (GNA, 2014).

According to the municipal assembly, this situation made some women patronised home care for delivery. However, the participants did not mention the road network as a major concern in the interviews and group discussions. The major concern about transportation was the means of

transport. Probably, the poor road network had affected the transport system in the area since there were no public transport in some areas by observation and experience. The services of the national ambulance system were non-existent in the rural areas and ineffective in the urban communities. Paradoxically, even communities situated few kilometres away from Yendi on first class roads had problem with means of transport. This could be attributed to the sparse nature of the population in these areas which might not attract transport business. The most accessible means were motor bikes and bicycles. Commercial cars were irregular and unreliable on the roads. Due to that, some people traveled to nearby communities on foot or using motor bikes and bicycles.

6.3.6 Poor Clinical Attendance

The Chereponi Hospital complained of irregular and untimely clinical attendance by women during the pregnancy postpartum period. Some women registered poor timing for ANC whilst others recorded lower number of ANC visits. Skilled delivery care attendance was very poor and the few attendances made came very late to the facility.

> *"Clinical attendance by women in the pregnancy-postpartum period is very poor. For instance, out of 7,918 of ANC visits registered in 2014, only 1,055 women had supervised deliveries and 1,031 women sought PNC within the critical period (48 hours after delivery). The rest of the women resorted to home care. Most women just come to the hospital for ANC maybe once. The number of ANC visits and the timing of attendance in the various stages are very poor."* (Administrator, Chereponi Hospital).

Some women avoided clinical care during delivery for fear of caeserean session. However, this was not mentioned by the women and their husbands, rather, it was identified by the care-givers. Aside, some of the CHPS compounds did not have nurses to assist the women. In Chereponi, a midwife remarked:

> *"The beliefs in superstition is influencing some of the women in the way they use the health facilities during pregnancy, delivery and the postnatal stages. For example, it is common for women to suspend PNC till after seven days of delivery when the naming ceremony has been celebrated. Aside, they believe in giving some herbs to the baby especially, for protection*

just after delivery. This partly explains the choice for home delivery for the women." (Midwife, Chereponi, Hospital).

According to the Midwifery Unit, the beliefs in superstition and overreliance on herbal medicine accounted for the poor utilisation of clinical services.

As highlighted previously, the care-seekers' data showed that the poor clinical attendance by the women was mainly informed by the worldviews and health beliefs around pregnancy and childbirth. The need to observe taboos or perform rituals for protecting the woman and her baby was a major hindrance for the reception of modern healthcare services. The provision of clinical services was observed to be parallel to the cultural practices of traditional care and that partly informed the poor attendance. This is because healthcare provision that is theoretically and contextually at odds with local contextual beliefs and experiences is likely to be underused (Finlayson et al., 2013).

6.3.7 Commentary

Factors identified in the study as determinants of provision and reception clinical services at the institutions were analysed under the domains of inadequate staffing, financial constraint, inadequacy of equipment and facilities, lack of professionalism, transportation means and network, and poor clinical attendance. Though these factors have been captured in other studies, they were considered in this study on the grounds that healthcare resources are not equitably distributed in Ghana (Bawah, 2008; GSS, 2008, 2009, 2015). As a result, the intensity of these conditions on maternal healthcare services utilisation may differ from place to place. Aside, this objective was to generate a balanced data from both the clients and care-givers for deeper understanding of the complexities of maternal healthcare services utilisation for even discussion of issues.

One important theme that emerged in the data was inadequate staffing of healthcare

professionals in the area. This coupled with congestion in health facilities demotivated women in using the facilities. Recent studies (Oiyemhonlan et al., 2013; Banchani & Tenkorang, 2014) in Ghana have observed similar conditions as impediments to maternal healthcare.

Across the datasets, financial constraint which used to be a major concern in healthcare access was gradually becoming an issue of the care-givers. In rare cases did the clients complain about financial barriers. The barriers identified by the women and their husbands were not much related to affordability but rather symbolises cheating by care-givers in the form of collecting unofficial monies from expectant mothers for services covered by health insurance policy. Therefore, some women neglected seeking clinical services to avoid being cheated by the healthcare providers. From the care-giver perspective, the emphasis was on the delays in reimbursement of insurance claims by the insurance authority and bureaucracy in procurement procedures which together created lack of funds and artificial shortages of medical supplies including drugs. Recent studies in developing countries indicate that the introduction of health insurance with free maternity care has resulted in the collection of unofficial fees in health institutions (ICRW, 2010; Baru, 2013; Banchani & Tenkorang, 2014). Procurement difficulties have been counted amongst the most cited healthcare barriers accounting for 65% in developing countries (Martin et al., 2013). This calls for re-examination of the procurement law for the healthcare system to remove and reduce the associated barriers and delays respectively.

Lack of professionalism on the part of healthcare providers caused some women to seek clinical care and never returned. Others only registered with the facilities to avoid insults, shouting and undue delays from care-givers during emergencies. Thus, facility-caused delays were sources of demotivation to service use in the study areas. This was a source of measure or feedback to the clients for further decisions towards healthcare as some of them mentioned that they would rather remain with the traditional practitioners for care. This partly caused the use of the services of the TPs during maternity. Apart from causing delayed decisions, some of the

women who were not treated fairly in previous pregnancies did not use the facilities in their recent pregnancies. This sustains the argument that patient side delays in the decision to seek care may be due to inability on the part of professionals to effectively cope with serious obstetric complications (Comb Thorsen et al., 2012; Martin et al., 2013).

The illiterate women complained of not being informed on their health after clinical screening. The healthcare providers failed to give them information on the expected date for delivery and about the health problems they carried to the facilities. They could not question the professionals because they could not speak English. The literates had the ability to seek information about their health even when it was not provided. These attitudes of professionals observed in the study has the tendency of causing women to travel to distant places for quality healthcare or resort to traditional care and rendering the local facilities underutilised (Turkson, 2009). The low maternal literacy and low status of women as noticed in the previous section, were important impediments to improved maternal healthcare.

The system of transportation in the area was very poor. Though the road network was bad and some communities totally cut off from health facilities in rainy seasons, the concern of the participants was more centred on means of transport. The major means were motor bikes and bicycles. Even communities on first class roads lacked cars to travel to places with health facilities. Apart from the bad roads, the sparse population in the area did not attract private transport investors. The national ambulance system which has been instituted to promote safe motherhood was not functioning well. Therefore, traveling in pregnancy under serious obstetric conditions was a very stressful experience and for that reason some women resorted to the TPs. As indicated in the literature (Turkson, 2009; Esena & Sappor, 2013; Pfeiffer & Mwaippo, 2013; Worku et al., 2013), the transport problems did not only delay clinical attendance, but also motivated the women to use TPs services. According Andersen and Newman (2005), though the care seeker may have the perceived need to seek professional care, if the transport system is not

favourable, they may resort to traditional care. This is the cause of delay 2 in the delays model delay 2 where the decision the decision to seek professional care has been reached but the transport network or means becomes a hindrance to the facility (Thaddeus & Maine, 1994).

The beliefs systems of the communities as discussed earlier on was also identified by the women and care-givers as a major barrier causing poor clinical attendance. A related study (Sarkodie & Abubakari, 2014), observed traditional beliefs and superstition as responsible for delayed clinical attendance by pregnant women in the East Gonja District of Northern Region of Ghana.

The research shows that ANC coverage in the region was relatively high, but the full package of four visits were lacking - implying that most women missed screening, counselling and treatment during pregnancy. Thus, contact point of one ANC visit as noticed in this study was not effective to improve women's health.

The provision of quality services especially within health facilities is a key motivation to increase demand for clinical services. Where the provision of quality care is compromised with push factors such as payment of unapproved fees, negative attitudes of care-givers amongst others as noticed in this study, demand for services will fall and the health of the client remains a challenge. Andersen and Newman (2005) agree with Thaddeus and Maine (1990, 1994) that when clients have both perceived and evaluated need but the facility conditions including the attitudes of professionals are not friendly to the clients, they may not use the facility services. Moreover, the environmental and political factors such as roads, the ambulance system etc be improved to facilitate the client's demand for healthcare services. All these factors need to function well for quality healthcare to occur.

6.4 Conclusions

As noticed throughout the discussions, issues relating choice of maternal healthcare services were not based on what women felt or experienced but the culture, gender norms and religious beliefs of the people about pregnancy and childbirth. By the custom of the communities, men were required to make sole decisions for their families. Thus, sole decision-making by men was an outcome of enforcement of traditional gender roles. This resulted in male-dominated decisions in choosing healthcare services for women. These decisions were informed by their worldviews and health beliefs around maternity which in turn rendered the women incapable of making free and informed decisions about their own health.

The decision-making process was structured in layers within the household with women in the lower layer taking instructions from their husbands at the middle layer who took decisions through spiritual consultations with the spiritualists in the top layer. These layers were held together in social coherence at both household and communal levels and the women who were supposed to fight against the discriminatory practices that marginalised them rather internalised and normalised them because of power imbalances which allowed the men to exert their supreme powers on them.

Decisions made by the dual-faithed people resulted in dual decisions which placed clinical care as a second option, thereby, interrupting the reception of clinical services. It was also associated with combination of drugs from both traditional and clinical sources which exposed women and their unborn babies to health risks.

Though some husbands were involved in household chores as a way of assisting their spouses to perform their feminine duties, apart from providing funds for cost of treatment, monitoring drug intake and in few instances accompanying spouses to health facilities, most of the husbands were not directly involved in household chores. Some did not even use their female relatives or co-wives to perform such feminine roles. However, the trend appeared to be changing

amongst the formally educated couples, particularly where the wives were career women and staying outside compound houses where decisions were solely taken by spouses.

In spite of the interventions like NHIS, establishment of CHPS compounds and the extension of pre-existing health facilities, quality service was lacking in the study communities. Quality service provision requires the availability of people with appropriate skills and the essential equipment and drugs. But these were major constraints identified by both the clients and service providers in both Yendi Municipality and Chereponi District.

From the supply side, amongst other factors, the major constraints to health services use were difficulties in procurement and reimbursement of NHIS claims, and inadequate facilities. The difficulties in procurement and reimbursement of NHIS claims were major setbacks to acquisition of medical supplies which caused delays and artificial shortages of supplies. Another essential demotivation was the belief in superstition connected to pregnancy and childbirth. This together with other conditions mentioned above caused delays in providing quality care in the facility.

On the demand side, the participants mentioned collection of illegal fees, dehumanising attitudes of professionals, congestion and delays within the facilities as key constraints to services use. It was also observed that after several hours of delays at home on decision-making and access problems, the women were further delayed for hours within the facilities even under emergency obstetric conditions. A typical traditional society like the study area needs motivation from the professionals to persuade them, after pondering over choosing from the available services and finally settled on the hospital. Failure to satisfy the health needs of women within the facility confirms the perceptions they had about the medical system, and is a necessary condition for neglecting medical facilities.

The use of health facilities was influenced by the socio-cultural environment of the women evidenced by the data, which greatly delayed service usage by delaying in recognising the problem and the decision to seek appropriate care. Critical analyses of the data from both demand

and supply sides reveals that the women faced the consequences of the three delays - especially delays one (household level delays) and three (within the facilities). Even though the study is not about neonatal deaths, the findings here are consistent with Waiswa et al. (2010) that irrespective of poor transport system, most delays in care seeking occurred at the household level and within the facility.

Improving maternal healthcare should be targeting strengthening both institutional and community programmes. The community-based programmes should be indigenised and actively involve traditional leaders, traditional practitioners, family heads and religious leaders and the health professionals to influence intra-household decision-making towards care seeking. This will remove the socio-cultural healthcare access challenges faced by the women and promote inclusion of women in decision-making which is a step towards improved maternal health. The CHPS compounds should be equipped to resource the community health workers to work better.

Whilst monitoring health facilities on collection of unapproved fees, the Ghana Health Service should work with the National Health Insurance Authority as well as the Procurement Board to reduce the delays associated with monetary transactions in facilities. Above all, the National Ambulance System as well as the Metro Mass Transit buses should extend their services to make it more accessible to rural communities to be accessible to pregnant women. Further, there is the need for education on the need to detach spirituality from health conditions to promote quick access to clinical services. This should be done through public health education programmes by the Ghana Health Service with household heads, husbands, traditional and religious leaders as targets.

This chapter has focused on decision-making towards utilisation of maternal healthcare services. It has discussed two major topics; first, gender and decision-making towards healthcare seeking, and second, the institutional conditions that informed the provision and reception of maternal healthcare services. The next is the conclusion chapter which draws together the major

themes and issues emerged from the study as well as presenting the contribution of this thesis to knowledge, and recommendations for maternal healthcare practice and future research.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

This study explored maternal healthcare from the socio-cultural perspectives by examining the social and cultural conditions within households, communities and the health facilities that influence utilisation of maternal healthcare services. The study focused on how worldviews and health beliefs around maternity as well as how household decision-making determines healthcare services utilisation.

Using a qualitative design, this study adopted culturally appropriate approaches to answer the research question: What, if any, socio-cultural structures and conditions associated with pregnancy and childbirth influence utilisation of maternal healthcare services in the Northern Region of Ghana? Guided by the structure and agency theory and the three delays model, this study explored the experiences of women and their spouses in the three inter-connected stages of maternity. The study also included herbalists, spiritualists as well as healthcare professionals. The findings provided insights for the researcher to analyse the stages of maternal healthcare system comprising the prenatal, intra-partum and postnatal stages.

It is worth mentioning here that, though the Andersen's Health Behaviour Model was only reviewed and not used as the conceptual model, the discussion on women's behaviour towards maternal healthcare in Chapters 5 and 6 used Andersen's concepts such as evaluated need, perceived need and predisposing factors to describe women's healthcare seeking behaviour. In this conclusion chapter, the key findings of the study, the contribution of this research to new knowledge, and the implications of the findings for healthcare practices, education and policy development as well as recommendations for policy consideration are highlighted. Recommendations for future research are also presented before the conclusion of the thesis.

7.2 Key Findings

The worldviews and health beliefs around maternity took the form of dietary and behavioural taboos which adversely impacted utilisation of maternal healthcare services. These behavioural codes were spiritually inclined and the observance of these norms was a means of maintaining traditional values and beliefs such as protecting the lives of women and their babies from evil forces and showing reverence to family, community and the spiritual world to avoid misfortunes or death.

The study also discovered dual faithism which manifested in the blend of traditional religion with either Christianity or Islam that led to dualism of care and over-reliance on traditional medicine and home delivery. The dual care seeking attitudes which emphasised the need to observe traditional patriarchal norms and practices resulted in poor clinical attendances for prenatal, intra-partum and postpartum care.

The ideology and arrangement of the traditional compound housing and the extended family systems influenced the order of care seeking within households which formed the basic unit of decision-making through structured patriarchal systems based on worldviews and health beliefs. The barriers to care seeking were not isolated but systemic and structured within the households in hierarchical layers. Women were observed to be minors, recipients and objects of the actions of men. Whilst the traditional religious health beliefs served as sources of power to the men, it rendered women powerless and subjected them to threats to succumb to the voices and plans of the men. As a result, the women internalised and normalised the observance of prohibitions associated with pregnancy and childbirth with home delivery as a priority and a testing ground for women's sexual life in marriage. The findings of this current study concurred with other studies which observed and explained why more than half of births in developing countries of Asia and Africa are delivered outside health facilities (Nai-Peng & Siow-li, 2013).

In terms of the role of the traditional practitioners, they took the form of medical and spiritual

involving diagnosis, preparation and prescription of herbal medicines and administration of such products or sometimes in combination with pharmaceutical drugs from chemist shops. An important observation was that both roles were not separate activities but carried out concurrently. This sustains the observation that medical conditions during pregnancy have spiritual explanations in traditional setting (Maimbolwa et al., 2003; UNDP, 2007; O'Driscoll et al., 2011; Asefzadeh et al., 2014; Oshonwoh et al., 2014; UNFPA, 2016). Consistent with previous research (Senah, 2003; Fronzak et al., 2007; Nyanzi, 2008; Soguel, 2009; Sychareun et al., 2012; Sarkodie & Abubakari, 2014), the various stages of indigenous maternity care were associated with the use of herbal products, rituals and sacrifices. Parallel with existing literature that puts the TBAs at the centre of traditional care, this study observed both the spiritual and medical roles of the TBAs as conditioned and limited by the traditional gender roles. Their primary role was assisting at delivery, which is a traditional gender space and they only gave treatment upon instructions from male members of the family or spiritualists. Consistent with existing studies (Sparks, 1990; Maimbolwa et al., 2003; Oshonwoh et al., 2014), cultural bond had great impact on maternal healthcare services utilisation. The foremost reasons for seeking the services of TPs particularly the TBAs were their cultural competence and the psychological support women derive from them. Although necessary, they were lacking in facility-based care especially during delivery.

Decision-making towards healthcare was based on masculine and feminine roles, health beliefs and cultural norms of the households. Similar to existing studies (Epstein, 2007; FAO, 2007; Nwokocha, 2007; ICRW, 2010, 2014), this study found that women had low status and occupied a weaker position within households and the larger society. Just as Nwokocha observed, the society used gender as a means to create low status and discrimination against women which facilitated inequalities and poor health seeking behaviour for women. The decision-making process was male-dominated with strong male supremacy which facilitated discrimination, oppression and marginalisation against women. Similar to the observation of Gage (2007), at the

individual level, the low status of women remains an important hindrance to maternal healthcare services utilisation. Whilst male-dominance in decision-making was regarded as a cultural mandate and an act of protection for women, women could only make tentative decisions about their own health subject to men's approval. This sustains the observation that adherence to and respect for culture subject women to victimisation of traditional gender norms (Tsikata, 2007; Arzoaquoi et al., 2015) because decision-making power is in the hands of men who control resources and spiritual matters (Nukunya, 2003). A neglect in the traditional setting was the fact that a positive maternal outcome is a function of joint commitment of men and women in all aspects of maternal healthcare including decision-making (Davis et al., 2011; Kabakyenga et al., 2012; Mitchell, 2012; Story et al., 2012; Mangeni et al., 2013; ICRW, 2014).

The utilisation of maternal healthcare services was examined from both the care-giver and the care-seeker sides to identify and understand the forces of demand and supply (ICRW, 2010; UNDP, 2011) aspects of clinical services and the impact of the structural organisation of health institutions. Delays in payment of health insurance claims by the NHIS Authority and bureaucracy in procurement were major concerns of service providers. Inadequacy of equipment/facilities and staff as well as poor clinical attendance due to superstition had a heavy impact on effective delivery of clinical services. There cannot be quality obstetric care when health facilities are under-resourced or challenged with irregular supply of drugs and equipment. Lack or inadequacy of medical supplies causes delays within facilities and make professionals unable to cope effectively with serious obstetric complications (Combs Thorsen et al., 2012). Just like in other developing countries (ICRW, 2010; Baru, 2013), the implementation of national health insurance policy was challenged with infrequent medical supplies due to delays in disbursement of insurance claims by the insurance authority and the rigid procurement procedures. Irrespective of the expertise of health workers, it is practically impossible to achieve positive outcome without medical supplies because they are necessary and crucial complements

of health delivery system. In principle, under a critical condition, no rational being will seek the services of a facility after previous experience of drug shortage in the facility and the stress involved in searching for drugs in private shops.

The care-seekers identified collection of illegal fees at various points within facilities as a major demotivation for utilisation of clinical services. In recent times, as developing countries adopt health insurance system to reduce financial burden and the associated delays, the collection of informal fees from women in the facilities emerges as an obstacle to clinical services (ICRW, 2010; Baru, 2013; Banchani & Tenkorang, 2014). This attitude is a recipe for ignoring facility-based care because it is at odds (Finlayson, et al., 2013) with the expectations of the clients and the principles governing the health insurance policy. Effective health delivery calls for putting in place concrete and practicable measures on both the demand and supply sides to enhance effective and quality healthcare delivery (Nai-Peng & Siow-li, 2010).

Another issue that raised concerns by the women and spouses was lack of professionalism exhibited by the care-givers. Any abusive behaviour put up by professionals towards clients either covertly or overtly is a source of demotivation for future use of the facility (Finlayson et al., 2013). This is because the experiences of women in their previous pregnancies either motivate them or discourage them to continue seeking care from the facility (AbouZahr, 2007; Kumbani et al., 2013; Pfeiffer & Mwaipopo, 2013; Oleyinkaet al., 2014).

In terms of roads and transport, the care-givers were much concerned about both means and network but the care-seekers in all rural communities including those with first class roads identified means of transport as a major concern. In all, there was a gap of transportation and communication between the remote communities, the CHPS compounds and the referral facilities due to poor road network and lack of means of transport. For many years transportation has been a common barrier of healthcare access in developing countries. Several studies on maternity (Grieco & Turner, 2005; Cannavan, 2008; Nai-Peng & Siow-li, 2013; Pfeiffer & Mwaipopo, 2013;

Worku et al., 2013; Oleyinka et al., 2014) have concluded with recommendations for improvement in transportation system. Though the CHPS system has considerably bridged the transportation gap between remote communities and CHPS compounds, effective referral services for specialist care within and between the districts were hampered by poor road network and lack of means of transport. Transport is a crucial component of healthcare system. Hence, improvement of health infrastructure and development of human resources must go alongside improvement of transportation system to attract both care-seekers and care-givers.

To sum up, this study observes cultural beliefs and practices, lower status/position of women, abuse of power by healthcare professionals and administrators as well as incomprehensive formulation and implementation of maternal healthcare policies as major impediments to maternal healthcare. Again, poor facility and road infrastructure also accounted for the poor delivery and utilisation of clinical services.

7.3 Conclusions to the Key Findings

From conception to the post delivery period, three main categories of factors from the socio-cultural environment influence maternal healthcare services utilisation: the family/household structures and conditions comprising gender, cultural norms and beliefs, background of couples and housing system; institutional structures and conditions such as the traditional institutions, the health institutions and the political institutions; and community resources and environmental factors such as leadership ideologies, the transportation system, and the availability or location of health facilities and personnel.

The management and treatment of obstetric complications, the delivery process and the post-delivery practices were guided by the worldviews and health beliefs of the communities. Despite the comprehensive strategies designed in the population policy to deal with the traditional institutions as stakeholders and partners in promoting maternal health, acceptance of

modern healthcare services remains a challenge at the household level. Though the CHPS compounds have relatively bridged the disparity gap between rural and urban communities by making healthcare closer to rural women, the implementation strategies of this good intervention were not comprehensively followed. The lack of materials like sterilised gloves for delivery assistance in the CHPS compounds put some women off the facilities. Because they perceive the role of the community health workers just like that of the TBAs. The responsibility of the Ghana Health Service (GHS) personnel to occasionally meet the TBAs and the communities were not well carried out. This is a key strategic activity under the CHPS programme to involve community members especially, men in maternal healthcare. Though some CHPS compounds were committed to women's health, the top structures of GHS were not functioning as desired. Occasionally meeting TPs and men as well as their spouses is a positive step towards the removal of cultural barriers associated with maternal healthcare and a means of male involvement.

Decision-making is an important ingredient in healthcare services utilisation. However, this has not received adequate attention in the implementation of maternal healthcare policies which are usually skewed towards provision of facilities, professionals and transportation system. In all the communities, the study discovered male-dominance in decision-making as an act of protection and a cultural mandate. Traditionally, women had no space in decision-making, not even about their own health. This male supremacy which marginalises women who experience the symptoms and severity of pregnancy-related conditions, positions men to make decisions for women regarding the timing for care-seeking and type of care to receive. Most of these men apart from the TPs, did not have enough knowledge about pregnancy and childbirth. This subjected women to receiving care from TPs instead of clinical professionals. Apart from the traditional gender roles, the men's decisions for the women's care-seeking was informed by dual-faithism which in most cases, led to dualism of care involving the use of herbal and clinical medicines concurrently. The three dominant religions - Traditional, Christian and Islamic were all sources of

gender discrimination in decision-making as well as alternative care. The male-dominant decisions were facilitated by the traditional compound housing system that has members of external families housed under common roof - different households under one roof. The household was the basic unit of decision-making. However, in inter-household decision-making which was typical of the study area, each household within the compound house was represented by a man and decisions finalised by the family heads. Joint decisions taken at intra-household level involved only the spouses and were finalised by husbands. Exclusion of women in decision-making concerning their health is a precondition for wrong decisions on timing for care-seeking and the type of care required because most of the men who took decisions did not have adequate knowledge about pregnancy and related complications. They could not also determine the severity of women's complications to make informed decisions. Since women are the objects of both decisions and obstetric conditions, and are the only people at the household level who can feel and judge the extent of severity of their conditions, patriarchal gender norms should give way to women's autonomy in making decisions about their own health. This is because a wrong decision taken leads to wrongful choice of care and negative maternal outcomes. It is an act of oppression to treat women who are partners in marriage as minority by making them seek approval from male family members before seeking care even in the absence of their husbands. Another issue connected to the household decision-making was the consultation of spiritualists by the family heads or husbands before reaching a final decision based on dual-faithed beliefs. This was also a source of delays as well as a means of denying women access to healthcare services. This sustains the argument presented earlier on that the Christian, Islamic and the ATR are sources of gender discrimination and alternative healthcare. However, few relatively empowered women were able to take decisions on their own and acted for positive health outcomes. This was possible because they did not need financial guarantee from their spouses before implementing their decisions. The ability of these few women to make informed

decisions was also due to the fact that they had attained an appreciable level of education with adequate knowledge about reproductive health. Aside, they were married to men who were even higher than them in terms of education and understood their actions. The level of education and exposure of these men helped them to stand dominant against traditional gender norms.

Maternal healthcare in the traditional setting was governed by indigenous knowledge and cosmic order based on their beliefs through dietary and behavioural taboos around human reproduction. Care-giving in the pregnancy-postpartum continuum was characterised by the use of herbal medicines alongside rituals and sacrifices. Maternity care was entrusted into the hands of TPs who diagnosed the women, prepared, prescribed and administered medicines. Treatment and management of pregnancy and related conditions were associated with injection and ingestion of herbal concoctions into the women. These concoctions were not subjected to laboratory investigation and clinical trials but according to the clients and the TPs, they were effective. In spite of the poor hygienic conditions observed, the inappropriate methods adopted in care-giving which exposed women to health risks, the TPs services were very helpful especially, to the communities without facilities and motorable roads. Women relied fully on the TBAs especially for delivery in rainy seasons when some communities were completely cut off from clinical services by floods. The policy of training traditional midwives is a good intervention in itself but lacks comprehensive implementation and sustenance. Most of the TBAs interviewed were untrained and had no access to professional guidance on assistance, whilst the few trained ones also complained of lack of materials for assistance at delivery.

Just like the households, the health institutions were composed of structured systems that hindered effective delivery and utilisation of healthcare services. Though few women with high education mentioned that they were treated well in the facilities in their last clinical attendances, most of the women had issues with non-satisfactory behaviours from the service providers which was a major push factor. The clients enjoyed receiving care from professionals who applied the

common humanity principle in care-giving. Enduring the pains associated with pregnancy and childbirth requires sympathy, empathy and encouragement from care-givers. When this is compromised, care-seekers look for alternative care sources and this leaves an indelible memory as a demotivation for future facility-based care. In some cases, the unprofessional behaviour was exhibited towards men who accompanied spouses to the facilities. The act of collecting unauthorised monies from clients was not only an act of cheating and abuse of office, but also generated misunderstandings between spouses when women failed to produce official receipts in rendering accounts to their husbands. This attitude defies the purpose of the establishment of national health insurance scheme. Aside, it is a potential ingredient for causing people to lose trust in health professionals and the NHIS Authority. The success of health policies depends largely on how the healthcare professionals and administrators handle the implementation of such policies.

The professionals neglected cultural attachment in dealing with clients who were adherent to cultural methods of birthing. Some men were ridiculed by professionals for carrying placenta from facilities for home burial. Cultural tolerance is required for professionals to understand the culture of the people and help them modify the harmful parts to improve women's health in maternity. Healthcare providers need intensive in-service training on culture of the people they deal with because culture is relative. The provision of healthcare services appeared to be parallel to the cultural norms of indigenous people and this served as a push factor within facilities. However, with modification of culture and integration of health promoting cultural practices into the modern healthcare system, utilisation would increase for improved maternal health to be realised. Understanding the cultural beliefs and practices of a people is a step towards improving access to care because this forms the basis of health education and development of strategies to influence clinical services' acceptance and utilisation.

The national health insurance appears to be losing its major merit of reducing delays related

to finances at the implementation level. The referral facilities complained of delays in disbursement of claims by the insurance authority and bureaucracy in procurement, which in most instances, led to artificial shortages of medical supplies. These are potential factors to push professionals in making insured clients buy drugs outside facilities or pay for services covered by the insurance policy within the facilities since clients would need them at the time. Aside, they will have to secure the drugs and necessary materials needed for the said services for others to benefit. Matters relating to healthcare must be treated with urgency. Measures need to be instituted to fast track the payment of insurance claims to health facilities for effective delivery of services. The procurement management need to put measures in place to remove structures that delay the process especially, in dealing with health institutions to ensure prompt and regular supply of drugs and other medical materials needed to run the business of health delivery.

7.4 Contribution to Knowledge

Both empirically and theoretically, this study has contributed to the body of knowledge on utilisation of maternal healthcare services by filling the existing research gaps, adding to existing literature and introducing a new conceptual model (Figure 7.1, pp. 247) and a proposition of a theory on maternal healthcare services utilisation which are both discussed in the next page.

Firstly, the study provides insights into the role played by the various categories of traditional practitioners and the power imbalances between the TBAs and their male counterparts in the traditional medical practice. The present study fills the gap in the literature of the gender aspect of the traditional medical practice that limits the power of the TBAs to the instructions of men and the spiritualists who indirectly use the TBAs to practice indigenous birthing culture. This research discovered strong gender forces behind the role of TBAs. That is, their role was traditionally gendered and facilitated by men for the purpose of fulfilling their cultural demands. Whilst previous studies have featured mainly the TBAs in home birthing (Senah, 2003; GSS,

2008, 2009, 2015), in this study, it was observed that the TBAs were just acting on instructions of the husbands/family heads and the spiritualists.

Secondly, one important observation made in the existing literature was analysing the various stages of maternity without emphasising their inter-connectedness. Though the study was not directly guided by the systems approach, the research attached equal importance to the inter-relationship of the stages of maternity by considering ANC, delivery and PNC as inter-connected parts of maternal healthcare system. Also, the blend of the structure and agency theory and the delays model identified systems and structures especially, within households that hampered women's clinical services utilisation at the agency level throughout the maternal stages. Moreover, rather than the extended family system as reported in previous studies (Senah, 2003; GSS, 2008) the hierarchical structures in compound houses facilitated the observance of prohibitions around pregnancy and childbirth that obstructed women's utilisation of healthcare services.

Thirdly, the study also provided illuminating findings related to the establishment of health insurance in developing countries and the associated challenges such as power abuse in the healthcare system by healthcare providers and administrators, and lack of professionalism on the part of healthcare providers in handling obstetric or gynaecological conditions especially in emergencies.

Fourthly, in the light of the findings, this study developed the systemic structural model (Figure 7.1, pp. 248) for viewing maternal healthcare services utilisation. The model explains that, the ability of a woman (agency) to effectively utilise maternal healthcare services is hampered by collective socio-cultural systems in hierarchical structures within the family, the traditional, health and the political institutions that hold women to the norms of the systems. This model views maternal healthcare as a system of inter-connected stages of antenatal care, delivery care (DC) and postnatal care. The overlap of the circles in the diagramme between ANC, DC and PNC

demonstrates that they are inextricably linked and equal attention is required in all the stages to ensure positive maternal outcomes. Suggesting that, analysing one stage will not produce the actual health status of women in maternity but only the individual stage but a different response is generated when it is analysed as a system (Nwokocha, 2007). The model considers both direct and indirect causes of maternal mortality and morbidity as equally important conditions that should be given necessary attention in each of the stages.

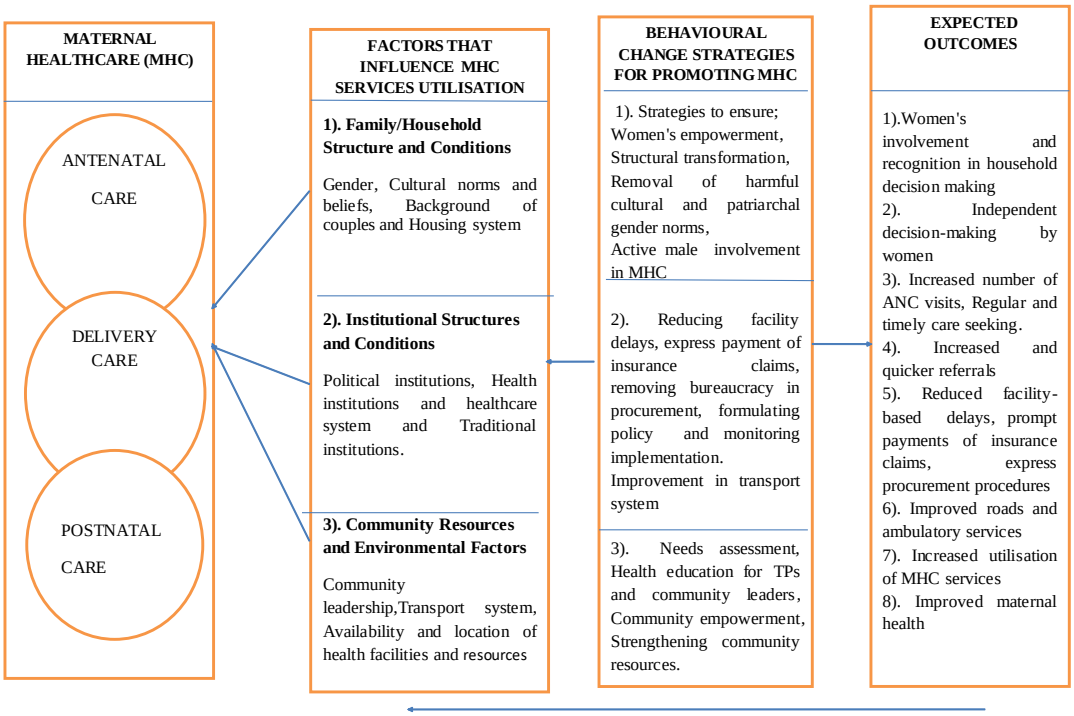

Figure 7.1: Systemic Structural Model for Viewing Maternal Healthcare Services Utilisation

According to this model, three main categories of factors influence maternal healthcare services utilisation: the family/household structures and conditions comprising gender, cultural norms and beliefs, background of couples and housing system; institutional structures and conditions such as the traditional institutions, the health institutions and the political institutions; and community

resources and environmental factors such as leadership ideologies, the transportation system, and availability and location of health facilities and personnel. The model also presents strategies to produce behaviour changes to promote maternal healthcare at the familial, communal and institutional levels. Aside, expected outcomes of the interactions between the factors that influence maternal healthcare in the three stages are provided for assessment for achieving equilibrium. The arrows between these factors and the strategies for maternal healthcare promotion and between the strategies and expected outcomes signify interaction. The long arrow beneath the diagramme symbolises feedback for equilibrium.

Sixthly, more importantly, the study argues that given the power imbalances between men and women and the supremacy of structural forces over agency, the provision of health infrastructure and personnel without structurally transformative strategies at present time might not meet the desired outcome so far as these conditions remain functional. However, with time and with increased access to secondary education and above, especially, for women, women's empowerment will take its course with cultural modification or modernisation, and traditional norms and beliefs will give way to modern and scientific methods of healthcare. This will result in access to health information, healthcare and positive maternal outcomes. A critical look at the maternal healthcare policies indicates that they are sound and comprehensive, but there is more to implementation. There is collision between policies and implementation practices particularly with regards to NHIS, CHPS, the national ambulance services, road infrastructure and health facilities as well as professional conduct and the safe motherhood protocol. Where the policies consider cultural, structural and gender responsive strategies, they are not properly followed in implementation. Both NHIS and CHPS are excellent promising healthcare policies well designed to promote maternal healthcare. However, they lack all-inclusive approaches in implementation as indicated in the strategies. For example, contrary to the policy, there is neglect of culturally sensitive and gender responsive strategies in the implementation of CHPS programme. Also, the

safe motherhood protocol is not observed in the healthcare system, both between and within healthcare facilities for referrals and care for clients respectively.

Maternity care is prone to crises in religious institutions (African Traditional Religion (ATR), Christianity & Islam) due to genderism. Religion is not only a potential source of perpetual discrimination, marginalisation and oppression against women, but also a source of alternative care and male supremacy that denies women the freedom for independent and informed decision-making towards care-seeking. In all, the most instrumental empowering tool for improving women's access to healthcare is education with its complements such as employment and cultural modernisation which reflects in contribution towards family discourse and detachment from external families in compound houses which removes family structures that inhibit women's involvement in decisions and promote quicker and well informed decisions. Further, education provides women with information on reproductive healthcare which is translated into positive attitudes towards healthcare and consequently, positive maternal outcomes. One question worth answering is "is it only female education that matters in promoting maternal health"? Reproduction is a function of sexual activities between men and women. Therefore, promotion of female education should be "carefully" used as women specific approach. Equally, education of men is crucial for understanding of health issues, breaking traditional gender walls, modifying culture and actively involving in roles regarded as feminine space especially during pregnancy. This study maintains that, whilst the exercise of the Free Compulsory Universal Basic Education (FCUBE) Programme and girl-child education are necessary, basic education requires additional exposure to educative programmes on maternal healthcare either through the media or community programmes to make women more knowledgeable and assertive to harmful traditions to their health. Ideally, secondary education and above is better for women to put up positive attitudes towards maternal healthcare.

7.5 Implications for Healthcare Practices, Education, Policy Development and Recommendations

The outcome of this study has implications for healthcare practices, education as well as policy development. As a result, some recommendations have been made to relevant organisations, agencies and individual stakeholders for improvement of maternal and neonatal health in the study communities and in similar settings.

Firstly, since the TPs work in collaboration, educating them together would improve their practices and access to clinical care through prompt referrals. Regular provision of educative programmes for the TPs on the implications of their practices for maternal, foetal and neonatal health as well as the need for clinical care will help them detach beliefs from healthcare. Aside, through these programmes a warm rapport would be established between the TPs and health professionals. If the healthcare system could accept the TPs activities, train them to handle basic health issues and timely effect referrals in deprived communities, it would produce better maternal outcomes.

Secondly, the traditional medicines used by the TPs were not subjected to laboratory investigations and clinical trials. Following this, the study recommends to relevant organisations and agencies like the WHO, international NGOs, the Ghana Standards Authority and the Ghana Health Service (GHS) to collaborate to educate the TPs, community leaders and women as well as their spouses on the dangers involved in using non-certified drugs. The traditional practitioners should be given the opportunity to access laboratories at minimal cost with the standards authority. This would ensure that the herbal medicines given to women or babies are wholesome and meet the standards of WHO.

Thirdly, to deal with the power imbalances between men and women observed in the study, it is recommended that alternative approaches be adopted by relevant organisations and agencies to

maternal healthcare by focusing on structurally transformative agency (Abel & Frohlich, 2012) strategies such as establishing policies that will allow for active male participation in maternal healthcare. Even though the CHPS policy recognises this, the gender responsiveness aspect is not comprehensively implemented. Active male participation would make men understand the predicaments and concerns of women and consider the need to give women autonomy over their own health. This would in turn give women opportunity for making independent and informed decisions by promptly seeking healthcare from professionals. Since men remain the perpetuators of the cultural beliefs and practices with supremacy, their involvement will gradually breakdown the walls of culture that mediate to delay or deny women access to professional care which will subsequently empower women. To this end, modernisation of healthcare will take it roots as the women would be empowered to be active agents of change. This would remove gender inequalities and strengthen the women for effective utilisation of health services because men will become active partners of modern maternal healthcare.

Fourthly, subjecting NHIS policy holders to payment of illegal fees or payment for services covered by the insurance policy will not sustain the policy that is introduced to reduce financial burden and increase utilisation. Many people in the informal sector, mostly, the rural inhabitants are yet to understand and be part of this policy. Therefore, this practice as observed in the study will not encourage people to enrol on the programme. There should be an established monitoring unit to work in collaboration with the clients in the various health facilities to promptly deal with complaints and suggestions. Any structures related to the difficulties and bureaucratic procedures involved in reimbursement of insurance claims and procurement should be removed or reconsidered to avoid delays and artificial shortages of medical supplies.

Fifthly, the study also recommends to the WHO, NGOs, the GHS and their international and local partners to redesign the health promotion programmes towards strengthening both facility-based and community-based health promotion programmes. At the community levels,

efforts be made to educate community members including men and adolescents on maternal complications to help them recognise problems and make timely decisions towards care-seeking. This is necessary because under severe obstetric pain, women may not be in the right position to make informed decisions. Inevitably, people around them make decisions for them. Therefore, they must have adequate knowledge about pregnancy, childbirth and healthcare to make informed decisions for the women. To improve upon the poor clinical attendance observed in the study, people should be educated on the dangers involved in dualism of care and the need for timely and regular clinical attendance. Interventions should be strategically directed to home care and facility-based care rather than only concentrating on facility-based clients and service providers.

Sixthly, though some of the TBAs had adequate knowledge about pregnancy and childbirth, they were limited in their abilities to make referrals because of their gender. Their efforts and suggestions for referrals were subject to approval by the husbands and family heads, who were also reliant on spiritualists or herbalists. Aside, the relationship between the TBAs and professionals was not cordial. Some of the women and the TBAs themselves reported having received hash words from some professionals for resorting to TBA care or for giving care and making referrals later respectively. Irrespective of their background and the deficiencies in their activities, the TBAs' effort in rural healthcare should be recognised, appreciated and accorded the desired respect by men and health professionals. Measures should be put in place to establish warm relationship between the TBAs who function as liaisons and the professionals to promote timely referrals especially, in rural communities. Strategies to allow TBAs perform their roles free from the interference of husbands and spiritualists should be put in place with the commitment of community leaders through community healthcare promotion programmes.

Seventhly, due to cultural diversity, this study recommends the provision of culturally sensitive training programme for the health professionals in collaboration with the municipal and district assemblies in the region and other settings of similar characteristics to acquaint them with

the cultures of the various communities. This will help the professionals understand, appreciate and accommodate the cultures, and in turn, position them to contain any culturally influenced behaviours put up by clients within the facilities. Understanding the culture of people is a necessary precondition for changing them for improved healthcare.

Eighthly, the poor transportation system in the form of poor roads and lack of transport means coupled with uneven distribution of facilities and health professionals means that women would continue to seek the services of the TPs. To avoid the delays associated with transport, the municipal and district assemblies should work in collaboration with the GHS and the National Ambulance Service to improve upon the ambulatory system in the areas. The introduction of the National Ambulatory System was a step to facilitating quick referrals as an intervention towards improving maternal healthcare. Making ambulances available together with the tele-communication network will facilitate quick referrals and timely professional intervention. The road network should also be improved by the Ministry of Roads and Highways through the Department of Feeder Roads in the municipal and district assemblies. The Transport Ministry should also dedicate some of the public transport buses to deprived communities for easy access.

Ninthly, the health facilities especially, the CHPS compounds need to be resourced with qualified personnel and equipment. Apart from qualified midwives, the most of CHPS compounds lacked basic materials like sterilisers and gloves to assist at delivery. These conditions did not motivate women to use the facilities in the CHPS compounds. Resourcing the CHPS compounds with human and material resources will put the facilities in the best position to handle cases effectively at their level. To increase utilisation of maternal healthcare services, it is important to bring the TBAs closer to the community health officers in the CHPS compounds to boost the confidence and trust of the community members in clinical services.

Tenthly, the delivery process by the TBAs was observed to be liable to exposing women and their babies as well as the TBAs to infections. There is the need to strengthen the TBAs training

programme and resource them with gloves and sterilisers to be used during delivery in the absence of professionals. Voluntary counselling and screening services on infections be carried out by GHS and their international as well as local partners for the TBAs to know their statuses before they are allowed to offer their services.

Eleventhly, given the inter-connectedness of education, employment and empowerment, this study considers education as the most powerful tool for improvement of maternal healthcare. Education has the tendency of exposing women and their spouses to health information, making them able to stand against dominant gender norms at both familial and communal levels and take informed decisions. Since reproduction is a function of sexual activities between men and women, promotion of female education should be "carefully" used as women specific approach. Equally, education of men is crucial for understanding of health issues, breaking traditional gender walls, modifying culture and actively involving in roles regarded as feminine space especially during pregnancy. Though the girl-child education programme under FCUBE is in force, the compulsory aspect of the programme is not enforced. Currently, there is no application of any legal instrument to compel parents to send their daughters of school going age to school and the issue of who goes to school and at what age remains the choice of parents. There is the need for application of legal instruments to enforce the FCUBE and girl-child education programmes as well as intensification of reproductive health education particularly at the basic education level where most girls end their education.

Finally, given the impact of the structural systems on maternal healthcare, the study recommends the adoption of gender responsive and gender mainstreaming policies and programmes by the stakeholders like WHO, GHS and relevant agencies and NGOs in the provision of maternal healthcare with active engagement of men. Approaches of these policies should be culturally sensitive and structurally transformative on the woman at the agency level to empower women for autonomy in all spheres of life for an improved healthcare system.

7.6 Limitations of the Study

Maternal healthcare encompasses the healthcare dimensions of family planning, preconception, prenatal, delivery and postnatal care (WHO, 2013). Due to time factor and resource constraints, the study was limited to the prenatal-puerperal period. Moreover, the study mainly concentrated on two major ethnic groups - the Dagombas and the Chorkosis in the Northern Region using qualitative methods which makes the findings non-generalisable. Further, special population like women with disabilities who constitute an important segment of the population were not covered in this study to discover the challenges they faced during pregnancy and childbirth.

7.7 Recommendations for Future Research

The observation made in this thesis necessitates recommendations for future studies in two key areas. These are, first, the methods of research, and second, the topical areas that need to be further examined. This research has shown that a qualitative research design is able to yield insightful data to understanding topics related to socio-cultural dimensions of health care and human behaviour. Whilst not negating the strengths of quantitative methods in high coverage and determination of causality for generalisation, this thesis recommends that where quantitative techniques are employed in health services utilisation research, particularly in indigenous communities, they should be complemented with in-depth qualitative interviews with FGDs and IDIs.

The thesis further recommends that studies in indigenous communities should not follow a uniform approach, instead, the methods need to be adapted to the local cultural way of interaction and communication. Culturally sensitive research builds strong rapport between the researcher and the research participants, in addition to elimination of fears and suspicions by the latter. Apart

from motivation of participants to provide candid responses, culturally sensitive research would also enable the research to observe cultural and ethical principles peculiar to the study setting including cross-gender ethics, which are necessary conditions for reflexivity in data collection and analysis. Following the above-mentioned limitations, the following topical areas are suggested for further research:

i. This study recommends a further study on indigenous family planning practices including abortion and the use of modern family planning services in the various CHPS zones.
ii. A study should be conducted on spousal preparations towards childbearing in the pre-conception period.
iii. There is the need to research into knowledge, perception and treatment of postpartum depression and anxiety amongst the traditional communities.
iv. The study further recommends future studies on beliefs and perception about caesarean section and its patronage by local communities.
v. A similar study is recommended for the Guans and Gurma ethnic groups in the region to present a complete picture of maternal health situation in the region.
vi. The maternal healthcare situation of the women with disabilities should also be studied.

7.8 Conclusions

This study focused on the social and cultural contexts on how the structure of the society and social relationships create social classes and assign men and women to different positions, which exposes women to damaging health conditions during pregnancy and childbirth. Apart from the familial and communal levels, the study also considered the delivery and utilisation of maternal healthcare services from the clients, healthcare professionals and the traditional practitioners to reach sound and balanced conclusions.

Based on these conclusions, the study developed a model as a framework for viewing

maternal healthcare services utilisation. This model uniquely emphasises the inter-connectedness of the stages of maternity as well as the importance of the role of the key actors in maternal healthcare. The dominant role of men in the activities of women and the TBAs including the methods, materials and substances used in maternity care in traditional practice which were hitherto not emphasised have been extensively discussed in the present study.

In addition, the model recognises the forces of socio-cultural determinants of maternal healthcare access and how that impact the health of women during maternity as a disadvantaged group in society. This study did not limit the issue of power to only domination, but also related it to the relevant existing policies and legal structures as well as the role of the state in the policy formulation and implementation. Based on the conclusions drawn from the findings and the existing maternal healthcare policy analyses, this thesis suggests adoption of gender responsive and mainstreaming policies and programmes as well as a culturally competent and structurally transformative agency strategies to empower women at the household and community levels in all spheres of life through active engagement of men.

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APPENDICES

Appendix I

Informed Consent for Participants

Topic: Socio-Cultural Dimensions of Maternal Healthcare in Ghana

Dear Sir/Madam,

I am a Ghanaian student of the above-mentioned institution conducting a research on socio-cultural dimensions of maternal healthcare in Ghana. This study mainly intends to explore the experiences of women during the pregnancy-postpartum period by looking at how socio-cultural factors within the household, community and the health institutions influence maternal healthcare services delivery and utilisation in the Northern Region of Ghana.

Please, be informed that this is purely an academic exercise and shall be solely used for academic purposes. I hereby assure you that information provided would be treated as confidential and your identity as a participant would be covered. You are at liberty to stop being interviewed at any point in time or ask any questions about this research.

I would be very grateful if you could help this research with your views and ideas on the topic. Thank you.

Date..... Sign/thumbprint.....

Appendix II

Interview Guide

Section A: Socio-demographic background of participants

Please, could you share with me a little bit about yourself?

1). Marital status:.....

2). Ethnicity:.....

3). Religious denomination:.....

4). Place of birth:.....

5). Age:.....

6). Place of residence:.....

7). Occupation:.....

8). Level of education attained:.....

10). Hometown:.....

11). Nationality:.....

12). Traditional area:.....

13). Number of children:.....

14). Number of wives.....

15). Place of interview.....

16). Date of interview.....

Part 1: Interview Guide for Women

Section B: Experiences of women during the pregnancy-postpartum period.

- How many times have you been pregnant?
- How many children do you have?
- How do you get to know that you are pregnant? (probe for signs of pregnancy)
- Did you experience any complications in your last pregnancy? If yes, what measures did you take to manage them? (find out the nature of complications, whether complications were

reported to professionals or treated with alternative medicine and why).

- What role did your husband play in managing the complication? (probe for involvement of spouse in the action taken).
- Have you ever experienced miscarriage/still birth/premature delivery? If yes, how many times? At what stage in pregnancy did that happen? (probe for clinical attendance/alternative care before and after).
- Do you have traditional birth attendants/herbalists/spiritualists who give treatment to pregnant women in this community or in a nearby community? If yes, did you use their services in your last pregnancy? If no why? Probe further
- In your last pregnancy did you seek medical care? if yes, at what stage? (probe for timing and number of visits)
- Have you experienced home delivery before? If yes, why didn't you give birth in a health facility? Who assisted you at delivery? Are there other women in this community who have had home deliveries?
- How would you describe your experiences in home delivery?
- Have you ever given birth in a health facility? If yes, can you share your experiences with me?
- Did you seek treatment after home delivery? If yes, **when and where**? If no, why and how did you treat yourself?

Section C: Gender and decision-making towards utilisation of maternal healthcare services

- In seeking care in your last pregnancy how did you choose a place for ANC, delivery and PNC? (probe for personal/joint/husband/other family members).
- Did you always need permission from your spouse before seeking care? If yes, what happens

if he refuses?

- Do you need approval of your husband before choosing **where** and **when** to seek care? If yes, in the absence of your husband what do you do? (probe for who decides e.g father or mother of husband/self)
- Have you ever experienced an instance where your husband prevented you/disagreed with you from/in seeking health care? If yes, what was the reason? Did he prescribe a different source of care for you? If yes/no, what did you do? (probe for type of prescribed source of care).
- Are you allowed to make your own decision about your health during pregnancy and childbirth? If no, would you prefer that women be allowed to make their own choice of care? If yes, why?
- What role does your husband play during your pregnancy and childbirth? (probe, helping in household chores, payment of bills, accompanying her to clinic?
- Who are normally allowed to witness/assist women during childbirth in this community? Whom do you prefer to witness/assist your delivery and why?

Section D: Worldviews and health beliefs around pregnancy and childbirth

- In this community do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the worldviews and health beliefs? (probe for beliefs around, pregnancy, delivery, and post-delivery & the implications in each case)
- Do you have prescribed food for pregnant women? If yes, what type of food are pregnant women allowed/not allowed to eat? (probe for food taboos and implications). In your last pregnancy, did you observe these taboos?
- What is your opinion on these worldviews and health believes?

Section E: Perception and reception of maternal health care services

- Are there instances when the worldviews and beliefs conflict with professional care during pregnancy and child birth? If yes, what is normally done in such instances? (probe)
- Have you ever experienced any complications during, pregnancy, delivery or after delivery? If yes, how did you manage it? (probe - in clinic or by TBA/herbalist)
  (probe for reasons in either case)
- Why do you think some women do not use health facilities during pregnancy, delivery and post-delivery period?
- Do have problems in using the available health care facilities in this community? If yes, what problems do you face during pregnancy and childbirth? (probe for both, structural and individual hindrances to utilisation of facilities).

Thank You

Part 2: Interview Guide for Men

Section B: Knowledge about pregnancy

- How many years have you been in marriage?
- How many wives do you have?
- How many pregnancies have you experienced with your wife/wives?
- How many children do you have?
- Please, how are you able to know that your wife is pregnant? (probe for knowledge of pregnancy signs)

Section C: Gender and household decision-making towards care seeking

- Having established that your wife is pregnant what did you do or do you normally do? (Probe further for care seeking and the type of care).

- What role did you/do you play during pregnancy, delivery and postnatal periods? (probe decision on choice of care, assistance e.g., accompanying wife to clinic, payment of bills, etc.).
- In your wife's last pregnancy did she seek ANC? If yes, how was the decision reached ? (probe for whether it was a joint decision, woman's decision or taken by the husband and why). What was the age of pregnancy at the time of seeking care?
- Has your wife ever given birth at home? If yes, who assisted in delivery? Did she experience any complication(s) during/after delivery? (probe for experience of complications, and assistance offered, PNC).
- Are there TBAs/herbalists/spiritualists in this community who treat women during pregnancy or assist during delivery? If yes, do women in the community patronise their services? If yes, has your wife ever utilised their services? (probe for reasons for choice).

Section D: Worldviews and health beliefs around pregnancy and childbirth

- In this community do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the worldviews and health beliefs? (probe for beliefs around, pregnancy, delivery, and post-delivery & the implications in each case).
- Do you have prescribed food for pregnant women? If yes, what food are pregnant women allowed/not allowed to eat? (probe for food taboos and implications). In your last pregnancy, did you observe these taboos?
- What is your opinion on these worldviews and health believes?

Section E: Perception and reception of maternal health care services

- Are there instances when the worldviews and beliefs conflict with professional care during pregnancy and child birth? If yes, what is normally done in such instances? (probe).

- Have you ever experienced any complications during, pregnancy, delivery or after delivery? If yes, how did you manage it? (probe - in clinic or by TBA/herbalist) (probe for reasons in either case).
- Why do you think some women do not use health facilities during pregnancy, delivery and post-delivery period?
- Do have problems in using the available health care facilities in this community? If yes, what problems do you face during pregnancy and childbirth? (probe for structural and individual hindrances to utilisation of facilities)

Thank You

Part 3: Interview Guide for Traditional Practitioners

Section B: Knowledge, experience and role in maternity

- For how long have you been practising?
- How many women have you treated in pregnancy or assisted them at delivery?
- Please, how are you able to know that a woman is pregnant? (probe for knowledge of pregnancy signs)
- Please, how do you get to know of a complication during pregnancy, delivery and post-delivery periods? (probe for knowledge of signs/symptoms of pregnancy-related complications).
- Are you a trained practitioner? (probe for screening, certification and registration of practitioners and their herbal medicines).

Section C: Traditional practitioners' role in ANC, delivery and PNC

- What role do you play to help women during the prenatal-puerperal period? (probe for role in ANC, delivery and PNC e.g, preparation towards birth, support during delivery and treatment

after birth). Further probe for handling complications during pregnancy, delivery and post-delivery stages.

- Have you ever made a referral of a case to health professionals? If yes, under what condition did you do that? (probe for instances during pregnancy, delivery and after delivery). For how long was the woman in your custody before the referral was made?
- What is the nature of relationship between you and health professionals? (probe for whether they cooperate with them or not). Do you hold meetings with them on maternal health issues? (probe for assistance from the Ghana Health Services)
- In your opinion, do you think the traditional system of delivery is in conflict with the modern system? If yes, how?
- Would you say that some women/families may decide not to use facility-based services during pregnancy and childbirth to fulfil their traditions? If yes, what are the reasons? (probe for reasons or circumstances).

Section D: Worldviews and health beliefs around pregnancy and childbirth

- In this community do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the worldviews and health beliefs? (probe for beliefs around, pregnancy, delivery, and post-delivery & the implications in each case)
- Do you have prescribed food for pregnant women? If yes, what type of food are pregnant women allowed/not allowed to eat? (probe for food taboos and implications). In your last pregnancy, did you observe these taboos?
- What is your opinion on these worldviews and health believes? (probe for support or dislike and why).

Part 4: Interview Guide for Healthcare Professionals

Section B: Institutional and organisational challenges to healthcare delivery

- How is the patronage of maternal healthcare facilities? (probe ANC, delivery and PNC attendance).
- What do you think are the reasons why some women deliver at home? Are there TBAs/herbalists/spiritualists in this community who treat women during pregnancy or assist during delivery? If yes, do women in the community patronise their services? (probe for collaboration with traditional practitioners).
- Do you have challenges with the communities regarding utilisation of maternal health care services? If yes, could you share with me?
- What institutional/organisational or professional factors do you think facilitate/inhibit effective provision and utilisation of maternal health care services? (Probe further)

Thank You

Appendix III

Focus Group Discussion Guide

Topic: Socio-Cultural Dimensions of Maternal Healthcare in Ghana

Section A: Socio-demographic data

Respondent	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Age												
Marital status												
Sex												
Level of education												
Occupation												
Ethnicity												
Religion												
Number of children												
Number of wives												
Hometown												
Place of birth												
Residence												
Traditional area												
Place of interview												
Date for interview												
Time of interview												

Part 1: Focus Group Discussion Guide for Women

Section B: Experiences of women during the pregnancy-postpartum period.

- How many times have you been pregnant?
- How many children do you have?
- How do you get to know that you are pregnant? (probe for knowledge about signs and

symptoms of pregnancy)

- Did you experience any complications in your last pregnancy? If yes, what measures did you take to manage them? (find out the nature of complications, whether complications were reported to professionals or treated with alternative medicine and why; probe further for knowledge about pregnancy-related complications).
- What role did your husband play in managing the complication? (probe for involvement of spouses in the action taken).
- Have you ever experienced miscarriage/still birth/premature delivery? If yes, how many times? At what stage in pregnancy did that happen? (probe for clinical attendance/alternative care before and after; further probe for knowledge about critical periods).
- Do you have traditional birth attendants/herbalists/spiritualists who give treatment to pregnant women in this community or in a nearby community? If yes, did you use their services in your last pregnancy? If no, why? Probe further
- In your last pregnancy did you seek medical care? If yes, at what stage? (probe for timing and number of visits). If no, why?
- Have you experienced home delivery before? If yes, why didn't you give birth in a health facility? Who assisted you at delivery? Are there other women in this community who have had home deliveries?
- How would you describe your experiences in home delivery?
- Have you ever given birth in a health facility? If yes, can you share your experiences with me?
- Did you seek treatment after home delivery? If yes, **when and where**? If no, why and how did you treat yourself and the baby?

Section C: Gender and decision-making towards utilisation of maternal healthcare

services

- In seeking care in your last pregnancy how did you choose a place for ANC, delivery and PNC? (probe for actors of decision-making and type of decisions e.g., personal/joint/husband).
- Did you always need permission from your spouse before seeking care? If yes, what happens if he refuses? (probe for conditions informing action).
- Do you need approval of your husband before choosing **where** and **when** to seek care? If yes, in the absence of your husband what do you do? (probe for who decides e.g father or mother of husband/self).
- Have you ever experienced an instance where your husband prevented you/disagreed with you from/in seeking healthcare? If yes, what was the reason? Did he prescribe a different source of care for you? If yes/no, what did you do? (probe for type of prescribed source of care and reasons behind).
- Are you allowed to make your own decision about your health during pregnancy and childbirth? If no, would you prefer that women be allowed to make their own choice of care? If yes, why?
- What role does your husband play during your pregnancy and childbirth? (probe, helping in household chores, payment of bills, accompanying her to clinic? Further probe traditional gender roles (women's space/men's space).
- Who are normally allowed to witness/assist women during childbirth in this community? Whom do you prefer to witness/assist your delivery and why?

Section D: Worldviews and health beliefs around pregnancy and childbirth

- In this community do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the worldviews and health beliefs? (probe for beliefs around,

pregnancy, delivery, and post-delivery & the implications in each case). Did you observe them?

- Do you have prescribed food for pregnant women? If yes, what type food are pregnant women allowed/not allowed to eat? (probe for food taboos and implications). In your last pregnancy, did you observe these taboos?
- What is your opinion on these worldviews and health believes?

Section E: Perception and reception of maternal health care services

- Are there instances when the worldviews and beliefs conflict with professional care during pregnancy and child birth? If yes, what is normally done in such instances? (probe)
- Have you ever experienced any complications during, pregnancy, delivery or after delivery? If yes, how did you manage it? (probe - in clinic or by TBA/herbalist)
  (probe for reasons in either case)
- Why do you think some women do not use health facilities during pregnancy, delivery and post-delivery stages? (probe for household/community and facility-based barriers).
- Do you have problems in using the available healthcare facilities in this community? If yes, what problems do you face during pregnancy and childbirth? (probe for both, structural and individual hindrances to utilisation of facilities).

Thank You

PART 2: Focus Group Discussion Guide for Men

Section B: Knowledge about pregnancy

- How many years have you been in marriage?
- How many wives do you have?
- How many pregnancies have you experienced with your wife/wives?

- How many children do you have?
- Please, how are you able to know that your wife is pregnant? (probe for knowledge of pregnancy signs).
- Could you identify some complications women experience during pregnancy? Did your experience any of such conditions in her last pregnancy? If yes, how did you handle it (probe for source and timing of care).

Section C: Gender and household decision-making towards care seeking

- Having established that your wife was pregnant what did you do or do you normally do? (Probe further for care seeking and the type of care as well as timing).
- As a husband, what role did you/do you play during pregnancy, delivery and postnatal periods? (probe decision on choice of care, assistance e.g., accompanying wife to clinic, payment of bills, etc.). Probe further for gender roles.
- In your wife's last pregnancy did she seek ANC? If yes, how was the decision reached? (probe for whether it was a joint decision, woman's decision or taken by the husband and why). What was the age of pregnancy at the time of seeking care?
- Has your wife ever given birth at home? If yes, who assisted at delivery? Did she experience any complication(s) during/after delivery? (probe for experience of complications, and assistance offered, PNC and why home delivery).
- Are there TBAs/herbalists/spiritualists in this community who treat women during pregnancy or assist during delivery? If yes, do women in the community patronise their services? If yes, has your wife ever utilised their services? (probe for reasons for choice).

Section D: Worldviews and health beliefs around pregnancy and childbirth

- In this community do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the worldviews and health beliefs? (probe for beliefs around, pregnancy, delivery, and post-delivery & the implications in each case).
- Do you have prescribed food for pregnant women? If yes, what food are pregnant women allowed/not allowed to eat? (probe for food taboos and implications). In your last pregnancy, did you observe these taboos?
- What is your opinion on these worldviews and health believes?

Section E: Perception and reception of maternal health care services

- Are there instances when the worldviews and beliefs conflict with professional care during pregnancy and child birth? If yes, what is normally done in such instances? (probe).
- Have you ever experienced any complications during, pregnancy, delivery or after delivery? If yes, how did you manage it? (probe - in clinic or by TBA/herbalist) (probe for reasons in either case).
- Why do you think some women do not use health facilities during pregnancy, delivery and post-delivery period?
- Do you have problems in using the available health care facilities in this community? If yes, what problems do you face during pregnancy and childbirth? (probe for both, structural and individual hindrances to utilisation of facilities)

Thank You

Part 3: Focus Group Discussion Guide for Traditional Practitioners

Section B: Knowledge, experience and role in maternity

- For how long have you been practising?
- How many pregnant women have you handled or assisted at delivery?

- Please, how are you able to know that a woman is pregnant? (probe for knowledge of pregnancy signs/symptoms).
- Please, how do you get to know of a complication during pregnancy, delivery and post-delivery periods? (probe for knowledge of signs/symptoms of pregnancy-related complications).
- Are you a trained practitioner? (probe for screening, certification and registration of practitioners and their herbal medicines).

Section C: Traditional practitioners' role in ANC, delivery and PNC

- What role do you play to help women during the prenatal-puerperal period? (probe for role in ANC, delivery and PNC e.g, preparation towards birth, support during delivery and treatment after birth). Further probe for handling complications during pregnancy, delivery and post-delivery stages.
- Have you ever made a referral of a case to health professionals? If yes, under what condition did you do that? (probe for instances during pregnancy, delivery and after delivery). For how long was the woman in your custody before the referral was made?
- What is the nature of relationship between you and health professionals? (probe for whether they cooperate with them or not). Do you hold meetings with them on maternal health issues? (probe for assistance from the Ghana Health Service).
- In your opinion, do you think the traditional system of delivery is in conflict with the modern system? If yes, how?
- Would you say that some women/families may decide not to use facility-based services during pregnancy and childbirth to fulfil their traditions? If yes, what may be the reasons? (probe for reasons or circumstances).

Section D: Worldviews and health beliefs around pregnancy and childbirth

- In this community do you have beliefs, taboos, norms around pregnancy and childbirth? If yes, what are some of the worldviews and health beliefs? (probe for beliefs around, pregnancy, delivery, and post-delivery & the implications in each case).
- Do you have prescribed food for pregnant women? If yes, what type of food are pregnant women allowed/not allowed to eat? (probe for food taboos and implications).
- Do you enforce the observance of these prohibitions? If yes/no, why?
- Are there instances when the worldviews and beliefs conflict with professional care during pregnancy and child birth? If yes, what is normally done in such instances? (probe).
- What is your opinion on these worldviews and health believes? (probe for support or dislike and why).

Thank You