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Socio-cultural Barriers to Accessibility and Utilization of Maternal and Newborn Healthcare Services in Ghana after User-fee Abolition

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Abstract - The government of Ghana is implementing a new maternal healthcare policy that provides free maternity care in all public and mission healthcare facilities. Despite the implementation of the policy, Ghana continues to register strikingly high maternal mortality rates and low levels of skilled maternal healthcare services accessibility and utilization. Based on focus group discussions and key informant interviews with 185 expectant and lactating mothers, and 20 healthcare providers in six communities in Ghana, we explore socio-cultural factors that inhibit women’s access and use of skilled maternal and newborn healthcare services in Ghana despite these services being provided free. We found that cultural preferences for home births, social expectations regarding women’s conduct during pregnancy and childbirth, women’s religious beliefs and practices including faith healing and observance of religious dictums, cultural norms and traditions including rituals around pregnancy, negative conceptions of health-facility birth, the legitimacy of a pregnancy, and women’s relative lack of power and freedom to make decisions, were the most important socio-cultural factors that affected access and service utilization. Our findings suggest that women’s decision to seek skilled maternity care services depends not only on whether these services are readily available in close proximity and at an affordable price, but importantly on the cultural perception and acceptability of the service and a woman’s self-efficacy to negotiate societal norms and discursive practices that regulate behaviour during pregnancy and childbirth.

Keywords - Maternal and Newborn Health, User-Fee Abolition, Socio-Cultural Barriers, Thematic Network Analysis, Self-Efficacy, Ghana

1. Introduction

Evidence suggests that access to appropriate healthcare, especially skilled attendance at birth and timely referrals to emergency obstetric care services, is strongly associated with substantial reductions in mortality and morbidity for both mother and newborn over home births (Starrs, 2006; Ronsmans & Graham, 2006; Essendi et al., 2010; Abor et al., 2011). However, in many countries of sub-Saharan Africa including Ghana, few women use health facilities for birth (Abor et al., 2011). The high prevalence of maternal illness, near misses, maternal and neonatal deaths, and other potentially devastating acute obstetric complications women suffer in the region has generally been linked to their poor access to skilled maternal and newborn healthcare services (Ronsmans & Graham, 2006; Campbell & Graham, 2006). While in high-income countries coverage of skilled birthing services is almost universal, in Africa only 47% of women give birth with a skilled care provider (Ronsmans & Graham, 2006).

Like many countries in Africa, Ghana is one country in which for the majority of women, the experience of pregnancy and childbirth can still in fact be equivalent to a death sentence, characterized by fear, anxiety, anguish and pain. In 2012, the WHO estimated that Ghana’s maternal mortality ratio (MMR) was 350 maternal deaths per 100,000 live births (WHO, 2012). Maternal mortality, which accounts for 14% of all female deaths, is the second largest cause of female deaths in Ghana (Abor et al., 2011). Recent survey data also suggest that only 55% of women receive skilled assistance during delivery or postnatal care following delivery (Ghana Statistical Services et al., 2009). The survey also suggests that more than 45% of births still occur at home without any form of skilled care (Ghana Statistical Services et al., 2009).

To address the barriers to access and increase the proportion of women who seek skilled antenatal, delivery and postnatal care in a health facility, the Ghana’s government made a political decision in 2003 to reduce financial barriers
to access through the introduction of a free maternal healthcare policy (Witter et al., 2007). The policy currently provides free materninity care in all public and mission healthcare facilities to women, and the objective is to reduce financial barriers to access and improve access and use of skilled delivery services (Penfold et al., 2007). Against this background, it is striking, as Johnson and colleagues observed, that Ghana continues to register high MMR (Johnson et al., 2009). While a number of studies have suggested that the implementation of the policy of free maternity care in Ghana has significantly eliminated financial barriers to access (Penfold et al., 2007; Bosu et al., 2007; Dzakpasu et al., 2012), Ghana continues to register strikingly high MMR as well as low levels of skilled maternal healthcare services accessibility and utilization. One recent World Bank study indicated that Ghana was off track to achieving the maternal and child health-related Millennium Development Goals (i.e. MDG 4 and 5) targets despite implementing the free maternity care policy (Schieber et al., 2012). The same study further showed that among countries with similar levels of income and health expenditure, Ghana performed worse than average with respect to neonatal, infant, under-five, and maternal mortality.

The stall in Ghana’s progress towards improving maternal and newborn health and the gaps in the continued use of maternity services from a skilled provider clearly suggest an urgent need for further research to understand the factors other than money that might be inhibiting access (Dako-Gyeke et al., 2013). The purpose of this paper is to explore socio-cultural factors that inhibit women’s access and use of skilled maternal and newborn healthcare services in Ghana despite these services being provided free. We believe an understanding of the remaining barriers other than money and supply side factors in the context of Ghana’s free maternal healthcare policy could form an important first step towards the establishment of comprehensive policies for the reduction of maternal and neonatal mortality.

2. Subjects and Methods

2.1. Research design

The data reported in this paper are part of a larger, original study that we conducted to examine the effects of Ghana’s free maternal healthcare policy on women’s maternity care seeking experience, equity of access, and barriers to accessibility and utilization of maternal and newborn healthcare services. The design of this larger study was mixed, involving analysis of a nationally representative retrospective household survey data alongside qualitative exploration using data generated from focus group discussions (FGDs), key informant interviews (KII$s) and structured field observations. In this paper, we focus on reporting findings from the qualitative component of the study, which explored how socio-cultural beliefs and practices affect the choices that individual child-bearing women make or not make in relation to access and use of skilled maternal and newborn healthcare services.

2.2. Study context

We conducted empirical research in Ghana between November 2011 and June 2012 in a total of 6 purposively sampled communities, namely Kuntanase, Abono and Piase in the Bosomtwe District of the Ashanti region, and Sankpala, Mpha and Tidrope in the Central Gonja District of the Northern region. We chose the six communities not only to capture a divide between a relatively destitute northern Ghana and a relatively prosperous southern Ghana, but also to provide a diversity of social and health situations that are largely representative of the country. Although our six study communities showed variable levels of performance on maternal and newborn health indicators, access to antenatal, delivery, post-delivery and newborn care services in all these communities were below the national averages.

We chose Ghana for this research not only because of the country’s poor maternal and neonatal health, but also because maternal, neonatal and infant health has attracted a lot of policy attention including the implementation of the free maternal healthcare policy since 2003 (Witter et al., 2007). We also chose Ghana because it presents an interesting case study. Ghana is one of only a handful of countries in Africa to actively started implementing both universal maternity care and health insurance policies at the national level. Because of this, Ghana is often seen as ‘an example of global good practice’ (WHO, 2010; Schieber et al., 2012). The economic and political conditions in Ghana also make the country an interesting case study. Ghana is situated within the predominantly economically marginalized and politically unstable region of West Africa, but forms an exception. It is relatively politically stable, with vibrant civil society activism and media pluralism. A rebasing of its economy in November 2010 moved the country into the category of lower-middle-income countries (Schieber et al., 2012). Ghana also recently started producing oil in commercial quantities. Despite all these developments, maternal, neonatal and infant mortality ratios have remained persistently high.

2.3. Research participants

Participants comprised women who were pregnant at the time of this research or had given birth between January 2011 and May 2012, and healthcare providers. The ages of these women varied between 20 and 45 years. The majority of the women had no formal education. A few of the women were unemployed while most were engaged in diverse occupations such as farming, trading, hairdressing, dressmaking, and teaching. Several of the women were also married or living with a partner. Majority of the women had between 1 and 3 children.

The healthcare providers we interviewed included health professionals (doctors, nurses, midwives, healthcare managers, and health policy-makers or implementers) from health facilities in the study communities, district and regional health directorates, and Ghana Health Service at the national level. We interviewed these diverse actors at multiple levels because we wanted to explore multiple perspectives on the research.
topic.

2.4. Sampling and recruitment

We used purposive sampling to select all research participants under the ‘healthcare providers’ category. This was a judgmental selection of participants based on our evaluation of the relevance of their roles to, or knowledge of, the research topic. In total, we interviewed 20 healthcare providers.

We however used simple random sampling to select the women. We acknowledge that the emphasis of qualitative research is not always on generalization hence randomization might not be a necessary requirement. However, we used simple random sampling because we wanted to assure justice by using a fair and transparent sampling procedure, which will ensure that every pregnant and lactating mother in the study communities had a fair chance of taking part in the research. Indeed, the idea of chance - which was embedded in our sampling procedures - helped to eliminate questions about why one woman was included and another excluded from the study.

Four main steps were followed to recruit participants. First, we enlisted all pregnant and lactating mothers in each of the study communities using a five-item short questionnaire, which asked whether a woman was pregnant at the time or had given birth since January 2011, the name of the woman, age and house number/name. Second, after the listing was completed, we randomly selected the required number of women from the pool of enumerated names in each study community. We predetermined the required number of participants at 5% of the total enumerated population of pregnant and lactating mothers of each study community, and this took into account the time and resources at our disposal. This generated a total of 185 women. Third, the randomly selected women were further randomly allocated to either focus group or key informant interview. Finally, we took the randomly selected names to the various communities, explained the research purpose, and how they were selected, and then invited each of the selected women to participate in the study. Where any of the randomly selected women was not available or declined to participate in the study – and there were only 2 of such cases – we repeated the selection process to get a replacement.

2.5. Data collection

To reproduce women’s experiences of seeking maternity care in a normal peer-group interpersonal exchange, we used focus group discussions (FGDs) and key informant interviews (KIIs). In all, 6 focus group discussions – one in each of the study communities and involving a total of 104 women - were completed. Groups consisted of 17 - 24 participants. This difference was mainly due to differences in the sizes of the enumerated populations. We held all focus groups in the study communities. Discussions in the focus groups lasted 1.30 to 2 hours, and ended when a point of saturation was reached i.e. when no new issues seemed to arise. All discussions were held in the local dialects – Twi in Kuntanase, Abono and Piase; Dagbani in Sankpala and Tidrope; and Gonja in Mphaa. We did this because the literacy [written or spoken English] rates are low among the study participants. Because our knowledge of the interview language was limited, we engaged one female research assistant from each community to facilitate the discussions.

To complement our focus groups, we conducted KIIs. Our choice of this data collection technique was informed by two main factors. First, it is often argued that people may not necessarily tell the truth in any objective sense when it comes to sensitive issues such as health and disease within a group context (Oppermann, 2000). For this reason, some have suggested the need for a mixed data collection technique in the social aspects of disease and health research (Lise & Samuelsen, 2004). We therefore triangulated our FGDs by conducting KIIs. Second, we used KIIs because it was simply impossible to organize FGDs with healthcare providers. This created special recruitment problems – problems that we appropriately overcome by conducting individual interviews. A major advantage of this method was that it addressed sensitive issues such as personal experiences of childbirth and barriers to accessibility to, and utilization of maternity care services.

In total, we completed 81 and 20 KIIs with women and healthcare providers respectively. Interviews lasted 10 to 15 minutes. We conducted all interviews with women in Twi, Dagbani, and Gonja, while interviews with healthcare providers were held in English.

2.6. Instruments

An open-ended thematic topic guide constituted our research instrument. We designed the instrument to ensure that similar themes were covered in each discussion or interview. The instrument however had built-in flexibility that allowed us probe more on any pertinent but unexpected issues that arose during the interview process. The instruments focused primarily on exploring women’s experiences of seeking or not seeking maternity care services, women’s interaction with maternal and newborn healthcare services, and the barriers to, and enablers of, access, and how access could be promoted. To ensure that the instrument was reliable, we engaged in a continuous review of the questions. This helped us to reframe questions, clarify and use more appropriate or easily understandable concepts as the research progressed. We audio-recorded all discussions and interviews alongside hand-written field notes.

2.7. Ethics

We obtained ethical clearance from the University of Oxford Social Sciences and Humanities Inter-divisional Research Ethics Committee (Ref No.: SSD/CUREC1/11-051), and the Ghana Health Service Ethical Review Committee (Protocol ID NO: GHS-ERC 18/11/11). In addition, we obtained informed written and verbal consent from all research participants.
2.8. Analysis
We analysed our qualitative data using the Attride-Stirling’s thematic network analysis framework (Attride-Stirling, 2001). This involved several steps. Following the completion of interviews, the first author and three other language specialists - Twi, Dagbani and Gonja - transcribed all audio-recorded interviews. All the authors then reviewed all transcripts and interview notes for overall understanding and comprehension of meaning. This first step was completed with a separate summary of each transcript outlining the key points participants made. Second, we exported the interview transcripts into NVivo 9 qualitative data analysis software, where the data was both deductively and inductively coded. We continued coding the data until theoretical saturation was reached (i.e. when no new concepts emerged from successive coding of data). Third, we applied the completed code structure to develop and report themes. Themes simply represented some level of patterned response or meaning within the data set (Boyatzis, 1998). Finally, all the themes identified were collated into a thematic chart to reflect basic themes, organizing themes, and global themes (Table 1). We then went through the data segments related to each basic theme to ensure that the thematic chart reflected the data. Where necessary, we made refinements. In all, we identified 22 codes, which were grouped into 12 basic themes, and further clustered into 4 organizing themes, and 2 global themes (Table 1). These constitute the structure of our findings section. Where appropriate, we used verbatim quotations from interview transcripts to illustrate relevant themes. In few instances too, qualitative responses are aggregated and presented in a quantitative fashion to facilitate easy understanding.

3. Results
Once pregnant, Ghanaian women can theoretically make use of prenatal, antenatal, delivery and postpartum care services in a wide range of locations - from the home with family members, friends and traditional birth attendants (TBAs) to rural clinics and ultra-modern hospitals with nurses, midwives, doctors and specialized obstetrical-surgeons. Focus groups and key informant interviews with women and healthcare providers revealed that most women do want professional assistance in a health facility setting during pregnancy, childbirth, and immediately after childbirth if their needs are met. This is not only because of the special value of childbirth to men and women in Ghana, but also because of the fear that a woman might die in the process of giving birth. Thus it is the combination of the need to procreate, the joy and fulfillment that childbirth comes with, and the fear that a woman might die during childbirth that sometimes warrant care-seeking. Despite this, our discussions and interviews with women and healthcare providers revealed that in practice, several socio-cultural factors significantly influenced women’s decisions regarding whether to seek care, place of birth, birth position, and even how the mother may or may not behave during this period. Our research participants’ accounts in this regard converged on a number of specific common themes, which we explore in detail below.

3.1. Intra-familial decision-making, women’s autonomy and access
One socio-cultural factor that was reported to profoundly limit women’s access to and use of skilled maternity care services relates to women’s autonomy in relation to decision-making and physical mobility within the family set-up. The majority of statements women made in our focus groups and interviews indicated that women were unable to access or utilize skilled maternal or newborn care services because they lacked the independence to make decisions even in situations where they felt they needed care. Several women reported that although they were often expected to nurture their pregnancies and successfully give birth to healthy normal babies, the power to make decisions regarding how and when to seek pregnancy and birthing care was mostly not entirely theirs. Accordingly, such powers are dispersed among a complex network of actors, with husbands and mothers-in-law being seen to have the greatest share of authority as final arbiters.

The problem is that as a pregnant woman, I can’t just get up on my own and say I’m going to hospital to check my pregnancy. I have to consult my husband because he is the one taking care of me and he is the one who made me pregnant. So even if I don’t feel fine and my man says no I can’t go to the hospital, there’s nothing I can do. That is why some of us don’t go to hospital to check our pregnancy (Pregnant Woman, FGD, Tidrope).
Table 1. Thematic Network Analysis Framework (from codes to global themes)

<table>
<thead>
<tr>
<th>Codes</th>
<th>Basic Themes</th>
<th>Organizing Themes</th>
<th>Global Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>-There is joy in pregnancy &amp; Childbirth -Women feel accomplished in giving birth safely. -Giving birth safely absolves a woman from blame. -Getting pregnant and giving birth is normal for every woman. -Women are naturally made to get pregnant and to give birth without asking for assistance.</td>
<td>1. Pregnancy &amp; childbirth are normal fulfilling biological functions women have to perform</td>
<td>Pregnancy &amp; childbirth is role fulfillment, self actualization and empowerment</td>
<td>Women’s experiences of pregnancy &amp; childbirth</td>
</tr>
<tr>
<td>-A woman can die while pregnant or giving birth -Pregnancy and childbirth is an anxious phase of a woman’s life -Pregnancy makes women highly dependent on others</td>
<td>2. Pregnancy &amp; Childbirth is dangerous – you either die or live</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-A pregnant woman needs care, love and empathy to be able to deliver safely</td>
<td>3. Care during pregnancy is important for safe delivery</td>
<td>Women want skilled attendance at birth</td>
<td></td>
</tr>
<tr>
<td>-Women should go to hospital when pregnant -It is good to deliver in a hospital -Midwives can help to deliver women safely</td>
<td>4. Hospital delivery is good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Older women don’t want to be treated by younger nurses/nurses -Hospital birth means questionable moral character -Assisted birth is a sign of physical weakness -Unwed expectant mothers fear being recognized -Muslim women don’t want to be attended to by men -Husbands are major decision makers -Mother-in-laws are influential -Homebirth preserves tradition -First time mothers need to observe certain rituals -God’s medicine is the best</td>
<td>5. Age hierarchy conflicts between elderly mothers and young nurses/nurses limit access</td>
<td>Socio-cultural constraints</td>
<td>Barriers to access and service use</td>
</tr>
<tr>
<td></td>
<td>6. Rituals, cultural prescriptions and proscription during pregnancy &amp; childbirth limit equal access</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Religious beliefs &amp; practices, especially beliefs in divine healing, hinder equal access</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Women’s lack of decision-making power in the family and household limit access.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Cultural preferences for home births undermine skill care seeking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Negative social and cultural conceptions of health-facility birth make women want to avoid giving birth in health facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. The legitimacy of a pregnancy – unwed women who get pregnant are stigmatized and this limit such women’s ability to access care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Gender conflicts prevent access</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Another participant said:

Sometimes it is not our fault that we don’t deliver our babies in the hospital... When I was pregnant I didn’t go to hospital until it was 8 months. I wanted to go but my mother-in-law didn’t agree. When it was time for me to give birth too, she said I should deliver at home. I was thinking of delivering at the hospital, but she and my husband were not in favour; so I had no option. I didn’t want any problems (Lactating Mother, KII, Sankpala).

In this regard, Table 2 summarizes a count of statements women made in relation to the principal decision-maker(s) or final arbiter(s) in episodes where a woman was unable to access or use skilled ANC, delivery and post-delivery care during her last pregnancy. In nearly half (49.2%) of the cases, the final arbiter was the husband. In the second highest (16.2%) number of cases, mothers-in-law made the final...
decision regarding non-access, while in 12.4% of the cases husband plus mother-in-law were the final decision makers. Strikingly, only in 5.4% of the cases were women themselves the final decision-makers.

### Table 2. Final decision-makers in skilled care services accessibility and utilization

<table>
<thead>
<tr>
<th>The last time you were unable to access or use skilled antenatal or delivery or post-delivery care services, who in your household, family, or community made the final decision?</th>
<th>Frequency of Statement</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>10</td>
<td>5.4</td>
</tr>
<tr>
<td>Husband</td>
<td>88</td>
<td>49.2</td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>29</td>
<td>16.2</td>
</tr>
<tr>
<td>Mother</td>
<td>14</td>
<td>8.1</td>
</tr>
<tr>
<td>Self + husband</td>
<td>5</td>
<td>2.7</td>
</tr>
<tr>
<td>Self + mother-in-law</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Self + Mother</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Husband + mother-in-law</td>
<td>22</td>
<td>12.4</td>
</tr>
<tr>
<td>Husband + mother</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Mother-in-law + mother</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Self + husband + mother in law</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>179</td>
<td>100</td>
</tr>
</tbody>
</table>

A few women however reported their experiences, which indicated defiance or at least the potential for defiance in situations where they faced medical emergencies but their husband, male partner or mother-in-law had decided against using health facility services.

*When I was first pregnant, I was not going for antenatal care...my mother-in-law didn’t want me to go; she always said I was ok. But inside me I felt like I should go. So one day I told my mother-in-law that I must go to see the midwife whether she likes it or not, and I went* (Lactating Mother, FGD, Abono).

While a few women reported that they defied the decision and wishes of their partner and/or mother-in-law outright, others said that they found an influential person in the community or a bosom relative or friend of their spouse’ to plead on their [women] behalf.

A substantial number of the healthcare providers interviewed for this research also mentioned women’s lack of autonomy and control over decisions concerning the use of skilled pregnancy or delivery care services as a major challenge to improving maternal and newborn health.

*You see part of the reason why the women are not coming [to hospital] is because they depend on other people like their husbands to make that decision* (Female Healthcare Provider, KII, Kuntanase).

One midwife also said:

*One of the biggest reasons why women don’t come to deliver in health facilities is that many of them are powerless. This is particularly so with childbirth where husbands, mothers-in-law, traditional birth attendants and other family or community members are part of the decision-making process* (Female Healthcare Provider, KII, Sankpala).

### 3.2. Religion and access to skilled care

Our focus discussions and interviews with lactating mothers, pregnant women, nurses, midwives and healthcare managers in the Bosomtwe and Central Gonja districts of Ghana also revealed that religious beliefs constituted an important cultural barrier to access and use of skilled care services. Our discussions with women and healthcare providers revealed that the effects of religious beliefs on maternal and newborn healthcare services accessibility and utilization in Ghana operated via the concept of faith healing, the doctrine of maintaining the sanctity of the female body in Islam, as well as the social support networks provided by religious groupings.

*I haven’t gone for check-up yet because I believe the best medicine comes from the creator [God]. As a believer [Christian] I know strongly that there is no medicine that heals better than God’s. That is why I pray, and my church members, we all pray to God to protect my baby in the womb from all evil and infirmity; and when it is time for me to give birth, I pray that God will grant me safe delivery without any problems. For me, I believe everything depends on God and my faith...I can go to hospital thousand times, but if God wishes my pregnancy or delivery not to be successful, no medical doctor can help me* (Pregnant Woman, KII, Kuntanase).

In the communities where this research was undertaken, women reported that faith healing was widely practiced among believers of virtually all the religious denominations. However, the first element that we found to have had profound material bearing on maternal healthcare accessibility and utilization was the beliefs and proselytization of various syncretic Christian religious sects belonging to the Zionist and Pentecostalist denominations. In all our focus group discussions with women as well as interviews with healthcare...
providers in the Bosomtwe district, it was widely acknowledged that these Pentecostal and Zionist churches have been growing in Ghana both in terms of the establishment of new branches and in the number of new converts (most of whom are women). Examples included the Apostolic Revelation Society, Jehovah Witness, and Kyiribentua. Mention was particularly made of the proliferation of Zionist prayer and healing camps - places where faith healing was mostly practiced. Indeed, not only did we observe the presence of these churches in different parts of Ghana during the course of our research, but also several of these prayer and healing centres were noted - usually at very obscure locations on the outskirts of towns and villages. However, because congregants of these religious sects are usually apprehensive of topics relating to medicine, the pregnant woman quoted above was the only participant of a Zionist orientation who accepted to take part in this research. Nevertheless, several focus group discussants in Abono and Kuntanase mentioned women they personally knew who would not access or use any form of orthodox medical care during pregnancy, labour or after delivery by virtue of their membership of one Zionist congregation or the other.

You know, there are some of the women, no matter how sick they are, they will never take any ‘wherefo duro’ [western medicine] because their faith forbids them from taking medicine or going to a hospital. So for such women, when they are pregnant, they never go for antenatal care let alone think about going to hospital to give birth (Lactating Mother, FGD, Kuntanase).

One discussant agreed:

What my sister is saying is true. I live close to one woman…she is like that... she goes to one church call ‘Kyiribentua’, and in that church, they don’t believe in hospital medicine...even people who are rich and have been to school...all of them don’t use hospital medicine. So any time she is pregnant, she doesn’t go to hospital (Pregnant Woman, FGD, Kuntanase).

Interestingly, some participants reported that women from other mainstream religious denominations including Catholics and followers of Africanist traditional religion were increasingly patronizing the prayer and healing services of these Zionist religious sects. According to this account, most of these women initially go to these prayer and healing camps for the purposes of finding solutions to problems related to infertility. However, once conception takes place and a pregnancy emerges, such women feel indebted to these prayer and healing centres and are therefore compelled to obey and live by their dictates and teachings, including upholding a fervent belief in faith healing while rejecting orthodox medicine.

But it is not only the beliefs and practices of Zionists Christians in Ghana that negatively limited women decisions regarding accessibility to, and utilization of maternity care services. In the predominantly Muslim-dominated district of Central Gonja where this research was also conducted, certain Islamic religious beliefs and practices were found to also limit women’s ability to access and use maternal and newborn care services at health facilities. But unlike some of the Zionists who were reported to completely reject western medicine, we did not encounter any Muslim women with such views. Nonetheless, several personal and interpersonal narratives from women in Mphaa, Sankpala and Tidrope indicated that the Islamic religious faith significantly and negatively impacted women’s access to maternity care services mainly through what participants approximated as “the doctrine of maintaining the sanctity of the female body in Islam”. Basically, the doctrine enjoins Muslim women, especially those who have entered into properly constituted marriages or unions in accordance with Islamic practice, to preserve their physical body away from the prying eye of the public, particularly from the opposite sex with whom they bear no intimate relationship. This is achieved through such putative material practices as proper dressing.

The reason why we don’t go to the hospital sometimes is that, if you go there they will see your body...your private parts. You know we are Muslims, and it is not proper for people...the men in particular, to see us naked just like that. It is not proper Muslim behaviour. We are supposed to dress well and cover our bodies. If you are married, the only male who should see your nakedness is your husband. But as you know, some of these hospitals have men in the place where women go to check their pregnancies or even in the rooms where we are suppose to give birth (Pregnant Woman, FGD, Mphaa).

One discussant concurred:

That is the problem for us Muslim women. Sometimes, some pregnant women want to go and check their pregnancy or even give birth at the clinic, but they fear that maybe a male nurse, midwife or doctor will be there or will be made to perform operation [CS] on them. Because Allah...does not like us to leave our bodies open just anyhow, we feel it is not proper for the doctor to see us naked. Even our husbands would not be happy if that happens (Lactating Mother, FGD, Mphaa).

In this way, some Muslim women found it simply sacrilegious and unacceptable to either undress before a total stranger like a nurse or midwife or allow a male doctor to examine their bodies during antenatal clinics or delivery.

3.3. Hospital delivery, moral judgement, and access to skilled care

Interviews with women also revealed that although the Ghana government’s position is that all birth must now take place in a healthcare institution under the supervision of trained health personnel, in some communities, a woman who delivers at a health facility is seen as lacking in self-sufficiency and moral character. One participant explained:
They will say you are weak or irresponsible if you go to the hospital to deliver your baby. That is why some women do not go to hospital to deliver (Lactating Mother, KII, Piase).

Accordingly, the cultural ideal of unassisted labour, including non-health facility delivery, reflects a belief that a woman is typically created competent and self-sufficient enough to give birth unaided or with limited medical support. A common theme that ran through most of the discussions here was that pregnancy is a condition that prepares a woman for a ‘‘battle’’ – the battle of childbirth. And there is enormous expectation for every woman to win this battle. How a woman wins this battle is significant in determining her social status in the community. According to this account a ‘‘proper woman’’ should never lose the battle of childbirth; for if she does, it is symptomatic of personal failure. But a woman who delivers by herself is seen as a valiant warrior and is highly respected.

It was a really great feeling. It was not easy...it was very difficult, but I felt so great after the final push that made the baby slide out. I felt like a hero when I saw my baby because I did it myself without the help of anybody (Lactating Mother, FGD, Kuntanase).

Another mother related:

Me...I have concluded that any woman who can give birth by herself is not a wimp, because if you can give birth you can do anything. After I had my baby, I felt great. I felt like me too I am capable of succeeding in bringing forth a new life all by myself (Lactating Mother, KII, Piase).

A woman who delivers via the assistance of a medical doctor or by caesarean section was however viewed as failed and weak. It is in this context that some women believed a deliberate movement into a health facility for the purposes of giving birth was an admission of a woman being unable to perform a natural duty and therefore being obliged to rely on medical interventions. Although most participants admitted that sometimes, medical intervention remained the only way to bring about safer birth, the desire to avoid being socially stigmatized as weak helped quell the need for seeking care during pregnancy and labour. Also, the belief that pregnancy and birthing was test of resilience, endurance and tolerance of pain provided the necessary context within which women’s decisions and options for seeking care modulate.

In addition, once a woman delivers at a health facility, it was not only her physical competence that was questioned, but also her moral character.

I believe another reason why we [women] feel reluctant to go and give birth at the health centre is because our husbands and family members will say we have something to hide. You see, here if you go into difficult labour, people believe that you have done something wrong...something like having an extramarital affair. So this is the time they expect you to confess all your sins...therefore if you go to the hospital and the nurses help you deliver, you will have problems with your family (Pregnant Woman, FGD, Mpha).

Several women gave graphic accounts of how in the event of a woman going into a difficult labour, traditional birth attendants, mothers-in-law and husbands often spend considerable amount of time waiting to resolve fidelity issues while the lives of both mother and the unborn baby deteriorate. Indeed, our interview with one of the midwives at the Buipe Rural clinic corroborated the experiences women related above. In one instance for example, a midwife tells of a pregnant woman from a polygynous union who went into a difficult labour and was brought into the clinic by her (the pregnant woman’s) mother. Three days after the woman delivered, her husband visited the clinic. However, instead of the usual joy that fathers express when their wives deliver safely, the man became furious upon seeing his wife. As if that was not enough, the man demanded to take his wife home. But as soon as the couple left the premises of the clinic, the man told the wife that he was sending her back to her parents. The reason: the man told the wife that none of his first two wives has ever given birth at hospital or health facility, and that the woman was not only weak but also she was irresponsible for conniving with her mother to go and deliver at the clinic so as to bring him debt. According to the midwife, but for the intervention of community elders, the District Director of Health Services and she (the midwife) herself, the couple would have been divorced.

Consequently, although most participants admitted that moral judgment and stigma became detrimental to their bodily health and health-seeking behaviour, they told of the fact that unassisted birth not only earned them respect but also made their marriages stable. Thus women’s feeling of empowerment and self-worth came not from the availability of new birthing options and their ability to access or utilize them, but from a desire to maintain stable familial relationships and from a lifestyle seen by others as morally responsible.

3.4. Pre-marital pregnancy, legitimacy of the unborn child and access

Within the socio-cultural milieu of the communities in which this research was conducted, pregnancy, childbirth and parenthood are valued and fulfilling roles. And women who experience these at the right time and in an accepted manner and within a supportive healthcare, family and social network system regard them as positive experiences, which enhance their self-esteem and self-actualization.

The best thing about being pregnant is that you become the centre of attention for everyone around you. That is a really good feeling...you don’t think so? Look, in the family, in society, at work, in the market and even at the clinic, everyone is very careful with you (Pregnant Woman, KII, Tidrope).

But for a woman to experience this phenomenon at a time and in a manner deemed wrong is the very antithesis of the joy, fulfilment and self-actualization that these roles may confer.
Premarital and extramarital pregnancy is one such example. Among the different ethnic and cultural groupings as well as religious traditions in the six research communities, premarital and extramarital pregnancy is generally abhorred.

In most of the communities we serve...a woman who gets pregnant outside or before a legitimately constituted marriage is not only likely to face rejection and ridiculing from her family and the wider society, but also her opportunities for seeking proper medical care during pregnancy, labour and post-labour may be heavily restricted. So sometimes it’s not the fault of the women; the social pressures are inescapable (Female Healthcare Provider, KII, Tamale).

Indeed, several of the statements the women made in response to the question of why they failed to access care suggested that several women were unable to access or use skilled birthing services at one point during their last pregnancy due to the fact that their pregnancies were considered illegitimate. This participant explained:

I gave birth at home. I didn’t go to hospital. Why? I was very ashamed. You see I’m not married, and in this community once you are not married and you become pregnant, people will say you are immoral. Some will even insult you and call your unborn baby bastard. So it is very shameful if anybody ever discovers that you are not married yet you have gotten pregnant. I wanted to avoid all the shame, gossip and ridicule. That is why I kept everything to myself and didn’t go to see the midwife (Lactating Mother, KII, Abono).

Another participant said:

The problem is that it’s not that I didn’t want to go for antenatal or even deliver my baby at the hospital. The issue is that I’m married and we had one child. But my husband travelled to Libya for two years now. I was lonely and I thought I needed to have a bit of company. Everything was done secretly. Unfortunately, I got pregnant and I didn’t want to abort the pregnancy. But at the same time I didn’t want anybody to know. I am a Christian, and you know...I was afraid that if my family and church people get to know I was finished! I was so afraid my father would ban me from coming near him. I was also afraid that people, especially my church members, would gossip about me and say that I have been committing adultery. Because of all these things I never wanted anybody to know. I basically went into hiding as well as wearing clothes that made it hard for people to know that I was pregnant...So you see if I went to the hospital to see the nurse about my pregnancy, then people would have seen me and everything would have gone wild (Lactating Mother, KII, Phase).

The situation was often exacerbated if the pregnant woman was an adolescent. Several women reported that adolescent pregnancies were particularly problematic because such young girls do not usually want people to know about their pregnancy. Health workers were also reported to regularly abuse or ridicule teenagers and unwed mothers. Indeed, on all the occasions that women spoke of the illegitimacy of their pregnancy as a barrier to skilled care access during interviews, we were particularly struck by how women focused on what others would think, say and do when they learn of their pregnancy. Women were especially concerned about the stories and gossip that would be told of, and circulated about, them and the way these would be full of negative judgments. In an effort to minimize shame and ridicule as well as maintain their dignity, such women felt that they needed to keep secret their so-called illegitimate pregnancy by not accessing and using skilled care while faithfully enduring what some characterized as “quiet suffering”.

3.5. Primiparas, pregnancy rituals, and access to skilled care

Our focus group discussions and interviews with women in the Bosomtwe and Central Gonja districts of Ghana also revealed that cultural beliefs and rites of passage around first-time pregnancy limited the ability of primiparas (first-time mothers) to access and use maternal and newborn healthcare services within health facility settings. A significant number of the statements women made in relation to the reasons why they did not access care pointed to restrictions imposed by certain pregnancy rituals. One such cultural ritual was the practice of Trigibu among the Gonjas and Dagombas – the two main ethnic groups of the Central Gonja district. Basically, Trigibu describes the practice whereby after the first and second trimesters or first six months of pregnancy, primiparas are formally and openly declared pregnant. One woman gave an account of Trigibu thus:

Trigibu...it is our tradition...our culture that our forebears handed down to us. It usually involves series of elaborate ritual preparations that culminate in a communal ceremony during which a sister-in-law (where the primigravida is married) or an elderly woman (where the pregnant woman is not married) jokingly and publicly slaps the pregnant woman and openly declares that from today, you [pregnant woman] shall be called pregnant. After this open declaration, food and drinks are shared (Pregnant Woman, FGD, Sankpala).

Fundamentally, Trigibu is grounded in the Dagomba’s and Gonja’s belief that exposing one’s pregnancy during the early stages makes them vulnerable to attack by evil spirits, witchcraft and jealous community members. It is the idea of vulnerability of mother and unborn child during pregnancy and the need to protect mother and foetus that provide context for proscribing, instituting and enacting myriad of rituals and behavioural codes for expectant women. Consequently, under the dictates of Trigibu, a primigravida is culturally prohibited from making her pregnancy public during the first and second trimesters. Rather, she is expected to carry and nurture her pregnancy in secrecy until after such a time that the family is able to organize and perform Trigibu.
In addition, during this period, primiparas are expected not to travel out of the home for relatively long distances including visiting a healthcare centre. This travel restriction is meant to prevent a situation whereby a ‘‘stranger’’ would incidentally address the primigravida as a pregnant woman prior to the performance of Trigibu. Benign as this cultural ritual might seem, the majority of the women we interviewed were unanimous in their responses that it does serve three purposes: to protect mother and foetus during this period of vulnerability, ensure safe delivery, and enhance the delivery of normal healthy children. Our engagement with women and healthcare providers especially in Mpha, Sankpala, Tidrope and Buipe however revealed that Trigibu did impose significant limitations on women’s ability to access and use skilled birthing services in a number of ways. The need for secrecy and the limitations imposed on travel by the non-performance of Trigibu meant that primiparas usually avoided getting prenatal check-ups, at least during the first six months of pregnancy. Similarly, the need to protect oneself socially through compliance with the dictates of Trigibu as well as the resources required to perform Trigibu overwhelmingly outweighed the need to protect oneself biologically. One participant illustrated:

*Trigibu is our tradition. It is good, because it helps protect our unborn babies and us from evil. It is just that sometimes it is not too good. When I was pregnant, I wanted to go and see our nurse early, but I did not go to see the nurse during the first five months because my husband was not ready for the family to perform Trigibu. It was only after the first six months when Trigibu was performed and both the secrecy of pregnancy and travel ban were lifted that I was able to openly declare my pregnancy as well as go to the nurse to check my pregnancy (Lactating Mother, FGD, Tidrope).*

Another woman interjected:

*I agree... Trigibu... it is the tradition here. It is good, but you see it is not always easy to organize and perform Trigibu because you need money. So sometimes for some pregnant women, Trigibu is done very late or it is not done at all. In that case such women cannot go to hospital even when they are sick (Lactating Mother, FGD, Tidrope).*

For fear of receiving reprisals from healthcare providers for either seeking care late due to late or non-performance of Trigibu, participants reported how several pregnant women often reneged on seeking skilled care but resorted to other home-based self-medication including giving birth at home with the assistance of traditional birth attendants and family members. Data from our interviews further revealed that once a primigravida failed to attend antenatal care or deliver at the health facility due to delayed or total non-performance of Trigibu, but all the same went on to have a safe home birth, such women often tended to access and use less of skilled care services in future pregnancies.

*Are you asking why I didn’t go to give birth at the hospital? I didn’t go because when I was pregnant with my first son, I didn’t go to hospital for check-up or delivery. I gave birth at home and my delivery was ok and my boy too was fine... For my first son, I didn’t go to the nurse to deliver because I was unable to go for check-up at that time because by the time my family performed the necessary ceremonies [referring to Trigibu], it was too late. I feared that if I went to the nurses, they would be asking me too many questions. That is why I decided to give birth at home. But for this one [referring to her three-month old baby], because I didn’t have problems with my first delivery, I imagined that this one too would be the same. I thought it was not really necessary to go and see any nurse (Lactating Mother, KII, Sankpala).*

### 4. Discussion

This study examined how socio-cultural factors inhibit women’s access to and use of skilled maternal and newborn healthcare services in Ghana. Our findings reveal the complex interplay of several socio-cultural factors in undermining women’s ability and willingness to access and use maternal and newborn healthcare services despite these services being provided free. The effect of these factors on women’s ability to access needed care were often exacerbated by healthcare providers’ lack of knowledge or insensitivity to women’s religious and cultural practices, and the provision of limited health information or information that lacked the cultural and religious specificity to meet the needs of women.

Our findings suggest that the inability of some women to access and use maternal and newborn healthcare services could be related to differences in socio-cultural beliefs and practices. For example, in Sankpala, Tidrope and Mpha, cultural practices such as Trigibu made it difficult for first-time mothers to access and use skilled care services because of the need to maintain secrecy about their pregnancy until such rites of passage were performed. In other instances, cultural beliefs, that viewed pregnancy and childbirth as a test of endurance and tolerance of physical pain, limited women’s ability to access and use birthing services. Similarly, the belief that a woman who gave birth in a health facility was ‘‘not woman enough’’ or had a questionable character was found to discourage a significant number of women from giving birth in health facilities. In other cases, the shame and public ridicule associated with pre-marital or extramarital pregnancy made it difficult for some women to seek skilled maternity care services in a health facility. Indeed, many international studies have identified some of these cultural beliefs and practices as key reasons for which women do not seek maternity care services in a timely manner. For example, due to cultural beliefs and practices relating to first-time pregnancies, primiparas are one sub-population known to be less likely to seek skilled antenatal, delivery and postpartum care at a health facility (Yanagisawa, Oum & Wakai, 2006). Similar to our findings above, once a first time mother has had a successful non-skilled maternity care experience, it has been found that it is five to seven times more difficult to convince...
her to use skilled care services in future pregnancies (Yanagisawa, Oum & Wakai, 2006). Griffiths & Stephenson (2001) and Stephenson et al. (2006) also found that home birth and non-use of health facility birthing services carry a higher prestige in local communities in India and Africa respectively. One study in Ghana also found that the ability to deliver at home successfully was associated with strength as well as good moral character (Bazzano et al., 2008). Similarly, Kyomuhendo (2003) reported from Uganda that while pregnancy and childbirth are perceived as dangerous events, a woman who delivers by herself is highly respected hence women often opt for unassisted home delivery. In Bangladesh, results of an anthropological study showed that blame was placed on women who needed to ask for assistance or have delivery in a health facility, as they were believed to have done something wrong to cause the difficulties, which lead to the problems requiring assistance (Afsana & Rashid, 2009).

In Tanzania, Mrisho et al. (2007) also showed that beliefs that obstructed labour was due to infidelity hinder skilled care seeking, while Mathole & Shamu (2009) found that shame associated with the pregnant state deterred visiting the clinic. The above suggests that our findings might not be peculiar to Ghana.

While it is undoubtedly clear that cultural factors are playing an important role in undermining women’s ability to access maternal health care in Ghana, it is important not to unduly ascribe a deterministic power to them. This is critical because culture itself is dynamic, and as demonstrated by some aspects of our findings in this paper the processes by which culture exerts its influence on access are sometimes ambiguous and malleable. For example, some women who became pregnant in a manner deemed culturally unacceptable defied all public ridicule and sought care in a health facility. Likewise women were found to be constantly shifting between traditional home-based maternity care and modern maternity care services during one pregnancy to the other depending on outcome and experience. Often, the shifts from traditional forms of maternity care to more modern forms of care were neither unidirectional nor do they just result from increasing enlightenment and complete attitudinal change towards a particular system of care. Rather, these shifts were sometimes precipitated by the nature of the pregnancy (whether ‘legitimate’ or ‘illegitimate’), and the immediate circumstances under which labour started. The above suggests that use and non-use seem to be in constant flux, dictated to by both cultural conditioning and pragmatic or practical weighing of alternatives rather than irrational attachment to culture or tradition. Such an eclectic pattern of service accessibility and utilization calls into question explanations of healthcare services utilization as a consistent choice of individuals or communities. Such shifts also dull any attempt to see culture as mounting an insurmountable barrier to access. Therefore, instead of considering women’s decisions regarding access to and use of skilled birthing services to be determined by cultural beliefs and practices, it is perhaps more helpful to consider women’s choices and preferences as being influenced by variety of cultural factors over which they have varying degrees of discretion and control. That way, what is required understands of how cultural barriers to access evolve and change over time and how these changes women’s ability and willingness to access and use maternal healthcare services provided in health facilities.

That cultural beliefs and practices negatively affected women’s ability to access maternity care services in Ghana has two broad policy implications. First, it suggests that much as it is important to recognize and criticize the limits imposed by local health systems barriers, pregnancy and childbirth management in our study communities must also be understood as a cultural artefact within which decisions regarding access to and use of maternity care services are influenced not just by skilled care services availability, physical accessibility or costs (affordability), but also by socio-cultural beliefs and directives that influence how childbirth care services are perceived and used. Second, it shows that for some women the decision to access maternal health services in a health facility is not always based on the availability, affordability, and efficacy of these services. Rather, basing decisions on factors such as the avoidance of shame or waiting for Trigibu to be performed can be a legitimate and logical way of trying to minimize different kinds of threats. As some of these cultural beliefs and practices are highly context specific, it is important that information, education and communication interventions aiming to influence skilled care seeking behaviours among women should move beyond one-size-fit-all templates to focus on addressing the specificity of these socio-cultural beliefs and concerns of different communities that directly or indirectly negatively impinge access and use of skilled care. Changing, modifying and accommodating some of these cultural beliefs should also involve health education campaigns that communicate the importance of women delivering their babies with a relatively well-resourced skilled health professional in attendance, as well as challenge negative socio-cultural beliefs and practices which constrain women’s ability to access and use skilled delivery services.

Our findings also suggest that in many instances husbands, mothers-in-law, and traditional birth attendants were the major decision-makers, especially when an obstetric emergency set in. In several cases as reported above, the power-play between women, their husbands and mothers-in-law has often resulted in women either not accessing needed care or reporting to a health facility only when complications have set in. Such unbalanced power relationships between women and husbands or mothers-in-law at the household level and the effect on access demonstrate how access can be undermined by women’s lack of decision-making autonomy even if such services are free and easily accessible. That many women lacked the independence to decide whether to access and use services in the Bosomtwi and Central Gonja districts of Ghana, however, needs to be understood within two broad contexts, namely gender inequity, and the culture of communal decision-making. In relation to the first context, many
of the accounts provided by women and healthcare providers showed that a patriarchal ideology, coupled with low levels of female education and high levels of economic marginalization among women particularly in rural Ghana, has created a social, economic and political environment in which women are chronically dependent on men. Although many of our research participants acknowledged that this situation was fast changing especially in urban societies and among the younger generation, they said a combination of machismo, the culture of female submissiveness and women’s economic dependence on men still created an unequal power relationship in both public and private spheres. In this unequal power relationship, women often ceded their autonomy and decision-making power to men, including decisions concerning access and use of maternal health services. That gender inequity and economic marginalization have inhibited women’s ability to autonomously make decisions about access and use of birthing services suggest that efforts to improve women’s economic status and promote gender equity among Ghanaian women may have potential benefits for increased and equitable access. Of course, this is neither suggesting that women’s enjoyment of equal decision-making rights at the family or household level will necessarily result in increased access, nor is it suggesting that non-egalitarian gender ideologies necessarily correlate with worse maternal healthcare access for women.

The second context is that many aspects of life in the communities in which this study took place are organized around the family, household and the community. Within this frame, people tended to be interdependent, and decision-making on matters of importance such as seeking healthcare for a sick person tends to be communal in nature. It is this sense of interdependence and communal decision-making that seem to explain why women lose their autonomous decision-making power to other family members. For example, in the event that a decision has to be made on whether to deliver in a health facility, women’s accounts suggested that consultations usually start with a woman and her husband or the father of the unborn child. From there, and depending on the outcome and situation of the pregnancy, mothers-in-law may then be involved. Other persons such as traditional birth attendants, brothers, sisters, and other people in the community may also be invited to help with the decision-making. In rural settings such as Tidrope, women reported that even a person alien to the community might be invited to help with decision-making if such a person is deemed to have some knowledge in pregnancy and childbirth or commanded some respect and authority in some other unrelated fields. Our findings here would therefore indicate that policy-makers should look to engage with a wider network of decision-makers to promote access and skilled attendance rather than focus solely on individually oriented education campaigns.

Religious beliefs and practices are another set of cultural factors identified in this study as having significant influences on accessibility and utilization of maternal and newborn health services. For example, women professing traditional/spiritualist and Islamic religious faiths were reported to access and use less of health facility delivery services compared with Christians. That differences in religious beliefs and practices influenced accessibility to, and utilization of maternity care services in Ghana is not entirely novel. Previous studies in Ghana found that Roman Catholic congregants were more likely to use antenatal care services, take all two doses of Tetanus Toxoid vaccine, choose a health facility as a place of delivery, and use postnatal care services as compared to other religious groups (Addai, 2000: Gyimah, Takyi & Addai, 2006; Abor et al., 2011). Elsewhere in Zimbabwe, one study also found that women belonging to some Pentecostal Christian religious groups including John Morange Apostolic, Christ Church, and Mugodhi were more likely to refrain from use of antenatal care (van den Heuvel et al., 1999). What is novel though is that the qualitative methods employed in our study shed more light on the relationship between religion and access in two important ways that previous studies have not done namely, the mechanism by which the relationship is effected, and the ambiguities embedded in the relationship.

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In relation to the first issue, our findings suggest that the explanations for why women of certain religious groups are more likely to use maternity care services in a health facility than others might be sought in differential orientations to theological teaching, different life-styles, and pragmatic orientations. For example, our qualitative data revealed how among certain charismatic Christian sects including the Apostolic Revelation Society and Kyiribentua, beliefs in faith or divine healing encouraged negative attitudes towards orthodox medicine more generally and hospital-based maternity care in particular. Similarly, the religious beliefs and practices
of some women who professed Islam were found to equally influence willingness to access and use maternal health services in health facility settings in ways that were largely negative. For instance, although Muslim women in the Central Gonja district did not in principle object to receiving skilled care in a health facility, their ability to access care was often conditioned by a religious obligation to maintain bodily sanctity through modest dressing and the avoidance of unlawful bodily exposure or contact with certain people including male caregivers. In several instances, this requirement made it difficult for some Muslim women to access care due to women’s fear that such a prerequisite was unlikely to be met in a health facility setting. These findings support previous studies of the maternity care needs and barriers to maternity care access among Muslim women in England (Ali, 2004), New Zealand (De Souza, 2006) as well as among Indo-Canadian and Vietnamese-Canadian Muslim women (Spitzer, 2005). This again suggests that some of these religious barriers to skilled maternity care are not unique to women in Ghana. It also means that Ghana could learn from other countries that have successfully found ways to address this unique maternity care need of different religious groups such as Muslim women.

The second significant issue that our findings highlight is the fact that sometimes religious affiliation per se does not limit access and that the relationship can be more ambiguous and complex than most epidemiological surveys determine. For example, our discussions and interviews with women in Bosomtwe district revealed that women who were confronted with infertility problems often tapped into different solution regimes, some of which involved the blending and re-blending of religious identity, beliefs and practices. In this process of shifting religious identity, the relationship between religion and access to care was often manipulated and blurred, so that it was not exactly clear whether it was the nature of the problem and solution a woman faced that determined access to skilled care or religious affiliation per se. This challenges any assumption that asserts religious beliefs and practices as static, such that membership of a particular religious community would always automatically mean access or non-access. In this regard, it would be important to see the effect of religion on access and use of maternal health services as being mediated by series of intermediary variables, some of which are based on pragmatic reasoning and action.

Put together, our findings in this paper clearly suggest that the benefits to be had from any maternal healthcare policies could be enhanced and made more useful to women if such policies are attentive to the circumstances of women. They also highlight the important point that effective progress towards increasing the proportion of women who are assisted by skilled health professionals during pregnancy, delivery and post-delivery in Ghana would require healthcare providers to acknowledge not only the limitations imposed by health system barriers, but also socio-cultural factors as well such as Triguba, and then devise public health strategies to redress them.

Our findings and recommendations in this paper should however be read against the backdrop of certain limitations. The qualitative research reported in this paper was conducted in only six communities. While focusing on a small number of communities enabled us to gain a more in-depth understanding, we recognize that in a country of more than 24 million people with multiple ethnic, tribal, and religious groupings, it is hard, if not impossible, to say anything about phenomena such as pregnancy, childbirth or the factors that limit access and use of skilled birthing services that would hold true all the time and for the different regions, districts, communities and peoples of Ghana. In other words, we recognize the limitation of generalizing our findings to other parts of the country or outside Ghana, as they may not be representative of what is prevalent in the entire population.

5. Conclusion

The study we report in this paper contributes to understandings of how socio-cultural factors can undermine women’s ability or willingness to access and use maternity care services in contexts like Ghana where services are provided free at the point of delivery. Our findings clearly suggest that childbirth in Ghana is uncomfortably situated at the junction of biology and cultural politics. Like death and disease, childbirth is a natural biological event, so that in bearing a child, a woman performs an important biological function of procreating and reproducing the human species. Yet, the biological act of childbirth is everywhere socially marked and accomplished in and significantly shaped by socio-cultural politics. In this cultural politics, the biological act of childbirth becomes a diffuse social entity constructed in discursive practices and shaped and reshaped by cultural, social and political influences that all determine women’s access and use of birthing care services. Therefore, whether a pregnant woman goes for antenatal check-up at the health facility or utilize skilled delivery and postpartum care services depends not only on whether these services are readily available in close proximity and at an affordable price, but importantly on both the cultural acceptability of the service and a woman’s agency or ability to negotiate these societal norms, cultural proscriptions, religious dictums and discursive practices that govern and regulate decisions and behaviour during pregnancy, labour or immediately thereafter. There is therefore the need for moving beyond free maternity care in Ghana to engaging with the culturally specific maternity care needs of women as well as addressing the unique cultural constraints of women, and other social determinants of maternal health including re-dressing women’s relative powerlessness in decision-making.

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