

**SCHOOL OF PUBLIC HEALTH  
COLLEGE OF HEALTH SCIENCES  
UNIVERSITY OF GHANA, LEGON**

**SOCIO – CULTURAL FACTORS AFFECTING ANTENATAL CARE USE IN  
THE GA EAST MUNICIPALITY**

The watermark is a large, light blue shield-shaped crest. The top half contains three golden wheat stalks. The bottom half contains a golden cross with ornate, swirling flourishes. The text 'BY' is centered over the wheat stalks.

**BY**

**KINGSLEY ANIM ODURO  
(10269423)**

**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF  
GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENT  
FOR THE AWARD OF MASTER OF SCIENCE IN APPLIED HEALTH  
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## DECLARATION

I, **Kingsley Anim Oduro** hereby declare that apart from the references to others people's work which have been duly acknowledged, this work is a result of my independent work. I further declare that no part of this study has been submitted for any degree award.

.....  
**KINGSLEY ANIM ODURO**  
(STUDENT)

.....  
DATE

.....  
**DR. EMMANUEL ASAMPONG**  
(ACADEMIC SUPERVISOR)

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DATE

INTEGRI PROCEDAMUS

## DEDICATION

This work is dedicated to my wife Gladys Abena Pokua, my children; Irene, Rhoda, Michael and Mildred whose tremendous support and encouragement has brought me this far.



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## ABSTRACT

**Introduction:** Evidence indicates that antenatal care coverage in Ghana is high and encouraging, however gap still exists in the continued use of public health facilities. Many pregnant women seek care from other different sources apart from the formal public health facility.

This study sought to examine the knowledge of antenatal care use, to examine the socio – cultural factors that affected the use of Public Health antenatal care services, and also to determine alternative antenatal care practices being undertaken by pregnant women in the Ga East Municipality.

**Methods:** A qualitative study of 25 in depth interviews were conducted at Abokobi, Aporman and Dome within the Ga East Municipality. This included twenty (20) pregnant women, accessing antenatal care at a Public Health facility. Three Traditional Birth Attendants two trained and one unskilled, and two (2) professionals (Midwives) from a Public Health facility took part in the study. Interviews and discussions were audio – taped and transcribed and coded into larger themes and categories.

**Results:** Findings showed that pregnant women in the Ga East Municipality have knowledge of antenatal care services and use them. However, due to perceived threats and beliefs which are given socio-cultural interpretations, the women are driven to seek multiple sources of care. These simultaneous use of biomedical care, traditional birth attendants, herbalist, and spiritualist, affects continued use of antenatal care services from public health facilities.

**Conclusions:** Antenatal care should be packaged to provide psychosocial support that helps women deal with pregnancy-related fear that makes them seek alternative sources to using the conventional public health facility.

## LIST OF ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Antenatal care
APA:	American psychology Association
GHS	Ghana health services
GSS	Ghana statistical service
HBM:	Health belief Model
HIV:	Human immunodeficiency virus
MDG	Millennium development goal
MOH:	Ministry of Health
SMPG:	Safe motherhood programme of Ghana
STDS:	Sexually Transmitted Disease
STIS:	Sexually Transmitted Infections
TBA:	Traditional birth attendance
UDHS:	Uganda demographic health survey
UNICEF:	United Nations Children's Fund
WHO:	World Health Organisation
MMR:	Maternal mortality ratio
GoG:	Government of Ghana
GDHS:	Ghana demographic health survey

CHPS: Community based health planning services

JHS: Junior High School

SHS: Senior High School



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## CHAPTER ONE

### 1.0 INTRODUCTION

#### 1.1 Background

Globally, there has been a remarkable drop in Maternal Mortality Ratio (MMR) by 45% since 1990. (Guyer, Freedman, Strobino & Sondic, 200). Despite this recent decline, Sub-Saharan Africa still has the highest maternal mortality ratio MMR in the world, even though strategies and interventions that highlight the importance of maternal health care (Hogan et al. 2010; WHO 2012). In 2013, an estimated 289,000 women died worldwide, down from 523,000 in 1990. But 800 women a day are still dying from complications in pregnancy and childbirth globally- equivalent to 33 an hour. Sub-Saharan Africa has 99% of all maternity related deaths (UNFPA, 2013)

The United Nation Millennium Development Goals (MDG 5) on maternal health targets to reduce the number of women dying during pregnancy and childbirth by three-quarters between 1990 and 2015, and one of the strategies that is being used to meet this target is to focus, strengthen and promote the continued use of Public Health antenatal care services.

Progress towards achieving Millennium Development Goal 5 has been slow in some resource-limited countries. (Falconer. 2012). At the onset of the Millennium, maternal mortality ratio for sub-Saharan Africa was estimated to be nearly 50 times higher than what was reported by industrialized developed countries (Ronsmans, et al. 2007).

Regrettably, trends show evidence of little maternal health improvement in sub-Saharan Africa over the last decade (United Nations: The Millennium Development Goals Report 2011).

In developing countries, pregnancy and childbirth continue to account for most maternal deaths. (Ronsmans et al. 2007), these death outcomes, are mainly attributed to pregnancy

related complications such as haemorrhage, sepsis, and hypertensive complications. (United Nations; 2012). These conditions are seen as outcomes of economic, educational, and socio-cultural factors (Howson, et al. 1996). Where there are adequate facilities and appropriate interventions, it is estimated that 90% of such maternal deaths could be avoided.

Antenatal care refers to the interventions that are aimed to control maternal and infant mortality. It is a planned programme of medical management of pregnant women directed towards making pregnancy and labour safe and satisfying experience. (MOH, 2006). Antenatal care is also concerned mainly with early detection, diagnosis, prevention, and treatment of general medical and pregnancy related disorders.

The provision of such special care of women during pregnancy through the public health services is affected by the relatively low development in modern obstetrics, antenatal care has evolved over a period of a century with the trend changing from an in - patient to an out – patient form of care that takes place today. (WHO &UNICEF, 2001).

Antenatal care has become an important pillar in the safe motherhood program as it aims at improving the outcome of pregnancy for both the mother and the fetus. Antenatal care also provides a very important opportunity for discussion between a pregnant woman and the health care provider about health behaviour during pregnancy, and recognizing complications that may arise, during pregnancy, delivery and postnatal, it also help with a delivery plan that will meet the need of the individual pregnant woman.

Evidence of accessing antenatal care has been shown by various authors to improve maternal health, thereby reducing maternal and infant morbidity and mortality.(Lassi, Salam & Bhutta, 2014)

Accessing antenatal services provide opportunities for health education, health promotion and social support at both the individual and community level (Sugathan et al. 2007). Accessing antenatal care is important in bringing women into contact with the public health care system where issues relating to pregnancy and complications are addressed to reduce maternal and child mortality.

This contact of the pregnant woman with the public health facility, facilitates women in accessing health care for future health needs including postnatal care. It is important for early diagnosis and prompt treatment of complications for pregnancy, and other illnesses that could arise during pregnancy, such as sexually transmitted diseases (STDs), malaria, helminth infections among others.

Promoting healthy behaviours and increasing knowledge about pregnancy and pregnancy related complications among women, families and communities are essential to the health and well – being of pregnant women (Nuwaha, et al 2000). The immediate cause of pregnancy related complications, ill – health and death are inadequate care of the mother during pregnancy and delivery. More detailed factors, including woman’s poor health and inadequate nutrition may also affect the pregnant mother and the fetus. (National Institute for Health and Clinical Excellence, 2008).

The health of the pregnant woman improves through effective antenatal care increases a mother’s chance of giving birth to a healthy baby. Whereas any woman can develop complications during pregnancy and delivery, many of such complications can be prevented or treated before they become life threatening emergencies which can be managed appropriately by trained and equipped health care providers.

Although every mother looks forward to having a healthy baby after nine long months of pregnancy, it’s not usually the case in some rural areas. Some rural women do not

seriously consider continued use of antenatal care services due to some socio– cultural factors yet continue antenatal care use is a prerequisite for safe motherhood.

In order to understand why some pregnant women in the rural settings do not seek continued use of antenatal care services, there is the need to examine some socio – cultural factors and alternatives to antenatal care services being undertaken in early phases of the pregnancy.

This study sought to examine the socio-cultural factors that affect antenatal care use in the Ga East,

## **1.2 Problem statement**

In Ghana high rates of maternal mortality remain a public health concern as the 2007 Ghana Maternal Health Survey report estimates a maternal mortality ratio of 580 deaths per 100,000 live births (GSS/GHS, 2007). Due to the high maternal deaths, the Minister of Health declared maternal mortality as a “national emergency” during the 2008 Ghana Annual Health Summit (MoH / GoG, 2011).

In developing countries, including Ghana, complications of pregnancy and childbirth are the leading causes of deaths among women of reproductive age (WHO 2012; Rosato et al. 2006). Most of these maternal deaths and injuries are caused by biological processes, not from the disease, which can be prevented and have been largely eradicated in the developed world. Maternal mortality has remained high in Ghana despite the efforts that has been made over the past years. The Ghana Demographic Health Survey (GDHS) of 2009 found that, the proportion of the women who do not attend antenatal care account for the high maternal mortality rate, irrespective of the effort made by the government of Ghana and the Ministry of Health.

Lack of continued use of antenatal care, continue to expose mothers and infants to the highest risk of deaths which could be prevented.

In 2005, there were 4,669 new-born deaths, representing 88% of total infant death (5,291) (safe motherhood Ghana report, 2006), country wide there were 11,063 in 2005 and 11,387 still deaths in 2006, (safe motherhood Ghana report, 2006).

Though the maternal mortality rate decreased the total deaths increased from 912 in 2005 to 957 in 2006 to 148 (15.5%) been adolescents, maternal death notified in January 2006, there were 471 deaths notified out of 957 maternal deaths. Maternal death notification (Ghana safe motherhood program report, 2006) stated that 70.1% of death occurred in the rural areas while the urban recorded 29.9% indicating that much maternal death occurs in the rural setting as compared to the urban areas.

This makes it prudent to assess the socio - cultural factors that affect women from assessing continued public health antenatal care use. Hence the aims of this study in the Ga East Municipality.



### **1.3 Theoretical Framework**

For the purpose of this study the health belief model (HBM) has been adopted and used to explain the health seeking behaviour of pregnant women in the Ga East Municipality in accessing antenatal care services.

The Health Belief Model (Rosenstock, 1966) is a psychological model that attempts to explain and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals. The health belief system is based on the understanding that a person will take a health - related action, if that person feels that a negative health condition can be avoided, have a positive expectation that by taking a recommended action she will avoid a negative health condition, and believe that he/she can successfully take a recommended health action.

The HBM is spelled out in terms of four constructs representing the perceived threat and net benefits: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. Perceived susceptibility is the extent to which individuals believe they are likely to suffer from a particular ailment, discomfort or disease that is an individual assessment of their risk of getting the condition. Perceived severity deals with an individual's perception of how serious it might be for them both medically and socially that is an individual assessment of the seriousness of the condition, and its potential consequences. Perceived barriers deal with impediment to or the likely cost of change in health behaviours that is an individual assessment of the influences that discourage adoption of the promoted behaviour and the Perceived benefits of engaging in a particular health related behaviour which deal with an individual assessment of the positive consequences of adopting the behaviour.

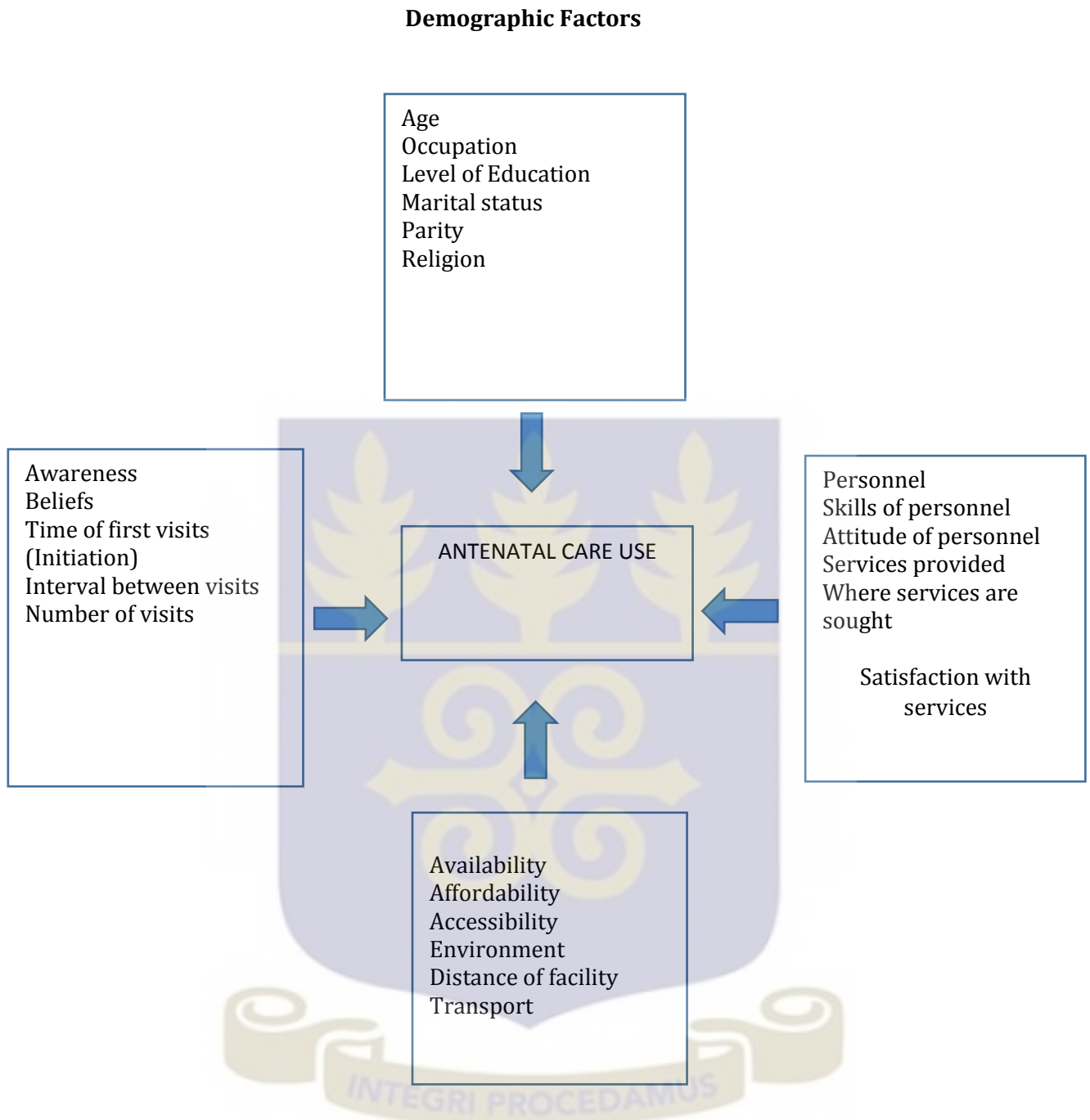


Figure 1: Conceptual Framework of health seeking behaviour of the pregnant women

Source: Adapted from the Health belief model (Becker, 1974).

#### **1.4 Justification**

Maternal and child mortality is high in Sub – Sahara Africa, especially where most of the of the diseases or sicknesses which are pregnancy related are preventable when pregnant women report at the antenatal clinics and are screened, pregnancy related abnormalities will be detected and dealt with thereby reducing the chances of the mother losing her life and that of the baby and will intend bring down the maternal mortality ratio to the barest minimum.

However, in rural settings it is reported that most pregnant women do not seek antenatal care services at all or do so very late in the pregnancy (Kenneth et.al 2013). Evidence highlights the belief that other alternative sources of antenatal are practiced among some women in rural settings. The maternal mortality rate (MMR) is the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes). The MMR includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, for a specified year.

Ghana even though has made strides in reducing MMR from 580 in 1990 to 350 2012, (WHO, 2012) However, the maternal mortality ratio is still on the high side as compared to countries such as Estonia that has an MMR of 2, Greece 3, Sweden 4, Japan 5, USA 21, Tunisia 56 and Libya 58. Looking at the figures there is the need to investigate further into antenatal care usage in Ghana as it is hovering around 350 per 100.000 births.

Studies have shown that there are number of factors that hinder the women from assessing antenatal care. These factors ranges from accessibility of the facilities, economic factors, socio – cultural factors and practices, in some cultures women are excluded from some sensitive family discourse, such as family planning, family size. Access and use of

maternal health facilities, which is usually hinged on cultural beliefs and values designed and sustained by men in order to maintain their domination and suppression of women (Isiugo- Abanihe, 2003; Moore, Helzner, 1996; Sen et al., 1994).

This research sought to investigate some of the socio – cultural factors that affects pregnant women’s continued use of public health facilities in the Ga East Municipality.

### **1.5 Research Questions**

1. Are women in the Ga East, Municipality aware of antenatal care services?
2. What is the knowledge of women about the benefits of seeking antenatal care services early?
3. What are the socio – cultural factors preventing women from assessing antenatal care in the Ga East Municipality?
4. What alternative antenatal care practices are available to women in the Ga East Municipality?

### **1.6 Objectives of the study**

#### **1.6.1 General objective**

Public health facility for antenatal care exist and yet high maternal and child mortality rate continues to be high in Ghana and the general objective is to determine the socio – cultural factors that affect women assessing to antenatal care in the Ga East Municipality

#### **1.6.2 Specific objectives**

- To establish the knowledge of women about the benefits of seeking antenatal care services early.
- To identify the socio–cultural factors affecting women who seek antenatal services in the Ga East Municipality

- To determine alternative antenatal care practices being used by women in the Ga East Municipality

### **1.7 Organisation of chapters**

This dissertation is organized under six chapters. The First chapter, which is the introductory chapter, contains the background to the study, the statement of the research problem, the research questions and objectives, the justification for conducting this study, the conceptual framework within which the study is situated and the organization of the chapters. This is followed by Chapter two, which presents a review of relevant literature on the issue under investigation.

The research methods used in this study are explained in chapter three. The information on the study area, the study population, sample size and sampling techniques and procedures and methods of data handling and analysis are also presented in the chapter. Chapter Four is where the research findings are presented. The discussion of findings is the focus of chapter Five and the conclusion, summary, and recommendations are presented in chapter six.



## CHAPTER TWO

### 2.0 LITERATURE REVIEW

#### 2.1 Antenatal care

Antenatal care refers to the regular medical and nursing care recommended for women during pregnancy. Furthermore, it is a type of preventive care with the goal of providing regular check-ups that allow doctors or midwives to detect early abnormalities and complications in the pregnancy or potential health problems that may arise in a pregnant woman and treat (WHO 2005).

Pregnancy is a crucial time to promote health behaviors, prevent stillbirths and avoid some major causes of illness among new born. Essential interventions during the pregnancy period are provided through antenatal clinics, some of services provided at the antenatal clinics include TT immunization, identification and management of STIs, including HIV and syphilis, malaria prevention through treatment, identification and management of pregnancy complications such as anemia, nutrition, counseling, preparedness and counseling on maternal and newborn danger signs.

The usual recommendation nowadays is for early booking (first antenatal visit) to take place in early pregnancy, prior to 14 weeks. The World Health Organization (WHO) recommends that pregnant women in developing countries should seek ANC within the first 4 months i.e. 16 weeks of pregnancy. A WHO Technical working Group recommended a minimum of four antenatal visits for a woman with a normal pregnancy (Lancet, 2001). Minimum of 4 visits should be made as follows, First visit- early (0-16 weeks) in the first trimester after missing two periods, second visit-(16 to 28 )weeks, third visit- between (28 to 36 weeks and fourth visit- after 36 weeks.

However, some women may require more than four visits, especially those who develop complications (Lancet, 2001). Although progress has been made globally in terms of increasing access and use of antenatal visit, the proportion of women who are obtaining the recommended minimum of four visits is too low especially in Sub-Saharan Africa.

The challenge to most Sub-Saharan African countries is to formulate application of the WHO ANC model within country needs and resources and identify the best approaches to deliver effective and sustainable ANC. This requires countries to respond to certain key questions: How to re-organize services to ensure delivery of a comprehensive, integrated package and assessing the contribution of the package to improve the quality of care and components that require strengthening over time.

The person best able to offer ANC services is the person with midwifery skills who is part of and lives in the community she or he serves. However, in developing countries like Uganda which have a shortage of well-trained health care personnel, ANC care is often provided by less qualified staff such as auxiliary nurse/midwives, village midwives, health visitors and Traditional Birth Attendants (TBAs) whose background may be conditioned by strong cultural and traditional norms which may impede the effectiveness of their services. These persons have at least frequently provided the backbone of maternity services at the periphery. For the fulfillment of complete set of tasks required to manage normal pregnancies and births, their skills need to be improved through education, training and supervision by well-trained midwives.

The World Health Organization (WHO), estimates that there are 5.1 million deaths among newborn that is before the baby is one month old. Almost 3.4 million of these occur during the first week of life, while 4.3 million fetal deaths are estimated to take place before or during delivery. These 7.6 million prenatal deaths are largely consequences of poorly

managed pregnancies and deliveries or the result of inadequate care of neonate during the first critical hours of life.

Every year over 200 million women become pregnant. It is estimated that more than 50 million women each year develop pregnancy-related complications, which require medical attention (Murray. 1997). For close to 600,000 women pregnancy-related complications are fatal (WHO, 1996). Nearly all maternal deaths occur in developing countries. And among the most vulnerable and disadvantaged population groups.

The current global estimates, show that in the developing world approximately 65% of pregnant women receive at least one antenatal care visit. 40% of deliveries take place in health facilities and slightly more than half of all deliveries are assisted by skilled personnel. This contrasts sharply with developed countries where practically every woman receives regular care during pregnancy, delivery and the postpartum period. By the end of 20th century, it was estimated that every year an estimated 45 million pregnant women were still receiving no antenatal care, more than 75 million births take place at home and 60 million women giving birth with only a traditional birth attendant or a family member present; in many cases the mother is alone (Glasier, Gulmezoglu, Schmid & Moreno 2006)

Africa has the lowest rate of 63% delivers in health facilities and just over 40% with a skilled attendant at delivery (Villar. 1997). The antenatal care rate in East Africa was reported to be less than 40% of deliveries with a skilled care provider present and or in a health facility.

In less developed countries 35% of pregnant women receive no antenatal care at all during pregnancy (Uganda results from the 2002 survey), 70% and 90% of women receiving antenatal care return for a second visit. The proportion of women continuing care for 4 visits or more is, however remarkably low. Data on the timing of the first antenatal visit

reveal care usually starts sometime in the first 5 or 6 months. The greatest disparities between the global assessment and Uganda are found in rural and urban access to services (56 versus 49) and newborn care (72 versus 68) (Centenary, 2010)

## **2.2 Socio – cultural factors influencing antenatal care services**

A good deal of literature, have identified a number of barriers faced by women in seeking professional health care, particularly for maternal services (Park, 2005). The perception of a normal versus a complicated delivery, for instance, appears to influence where women will look to deliver, regardless of other barriers at any time (Park et.al. 2005). While the study shows that many women do not seek care because childbirth is seen as a woman's struggle to endure, there is also recognition within communities that pregnancy contains risks beyond a woman's control, which may indicate some scope to seek care (Parkhurst & Ssengooba, 2005)

In Ghana, lack of resources and skilled staff to improve quality and delivery of maternity services, despite good policies and concerted efforts, have hindered utilization of those services by women or a reduction in the high ratio of maternal deaths (Bantebya, 2003). There has not been an increase in the utilization of emergency obstetric services at health facilities nor a corresponding significant reduction in maternal deaths. The proportion of women delivering in health units remains low and there is a gap between the numbers attending antenatal services and those delivering at health facilities (EQUINET, 2007).

Antenatal care is an opportunity to promote the use of skilled attendance at delivery and healthy behaviors such as breastfeeding, early postnatal care, and postpartum family planning for limiting or spacing births. However, studies have shown that there are many who miss the opportunities for care, because of client- and health system-related factors.

Mothers and children may face risks because of limited or late-term ANC visits, low-quality care during visits due to poor provider training, infrastructure and administrative weakness at facilities (Armar, 2006).

The individual's use of the health facility is also influenced by the characteristics of the community in which the person lives, indicating a need to look beyond the individual factors when examining health seeking behaviors (Stephenson, 2002). First, consumers lack human capital-education to promote their own and their families' health (Tim, 2004). Education may provide consumers with a basis for evaluating whether they or a dependent require treatment inside or outside the home. Thus, rural areas like Kisoro in Uganda, which has high rates of illiteracy have been characterized by less antenatal care visits by pregnant women and mothers.

Education provides the consumer with the basis for evaluating whether they require treatment. While it is sometimes suggested that individuals are unable to assimilate information on treatment options, this assumption is challenged by Leonard's recent work in Tanzania (Leonard, 2002).

These studies suggest that, far from being passive consumers, patients actively seek out not only the best-known provider but the best facility for a particular illness. Thus, Perceptions of quality do, in fact, accord quite well with technical evaluations.

Studies in many countries have also shown that barriers such as distance may be surmountable, as evidenced in cases where individuals bypass local services to reach ones of higher quality or when Distance is given as a reason for non-use, despite health facilities being available.

There is much evidence to suggest that distance to facilities imposes a considerable cost on individuals and that this may reduce demand. In some studies that was carried out, in Bangladesh it was reviewed that, transport as a proportion of total patient costs, a study carried out in Bangladesh suggested that, transport to health facilities was the second most expensive item for patients after medicines (CIET Canada, 2000). Making the pregnant women not attending regular antenatal clinics due to the cost involved.

Two types of barrier are critical: physical and financial. In poor countries, the density of health infrastructures equipped and staffed with competent, available and committed personnel is low (Koblinsky et al, 2006). For women this often means they are too far to walk and they prefer to deliver at home rather than embarking on a long and difficult journey to under-equipped health centers or poorly staffed district hospitals. When women or the family decision-makers decide to attend an appropriate health service, the next obstacle is money. In many settings, patients have to pay out-of-pocket for everything, including a tip for the personnel, and this may result in delays, which can sometimes be fatal, and in catastrophic expenditure for the household (Borghi, 2008).

The UDHS 2007 findings indicate disparities in utilization of health services, with rich, urban and more educated people more likely to use health services than the poor less educated rural residents. This trend was attributed to better economic and physical access to services among the former, but also to attitudes influenced by religion, culture and limited understanding of disease causation among the latter. The reason why the poor do not make more use of public services is driven by both supply and demand factors (Ensor, 2004).

Cultural and socioeconomic factors such as the low status of the female in society, limited decision making powers, social immaturity and financial limitations might contribute to

poor utilization of ANC services, resulting in an increased incidence of pregnancy and obstetric complications. Bouwer et al added that religious beliefs in certain societies may pose barriers to the utilization of ANC services. Bouwer et al recommended that health workers should understand variations in family composition, social class, health beliefs and behaviors and be able to bridge the gaps between the beliefs and behaviors. In a number of South Asian societies the mother-in-law dominates decisions on childbirth and care related to pregnancy, particularly in the early stages of marriage.

In these circumstances, whether a woman is delivered at home by a family member, by a traditional birth attendant (TBA), or at a health facility, much depends on the beliefs of the mother-in-law. At the community level the TBA is also vital in influencing demand. One study in Rajasthan found that more than 90 percent of women that did not obtain referral care were advised against it by the TBAs (Hitesh, 1996).

Many cultural, religious, or social factors may impede the demand for health care. In communities where women are not expected to mix freely, particularly with men, utilization of health services from static facilities may be impeded. Cultural conventions about proper treatment of health issues may also inhibit access. Ndyomugenyi reports that, the women of the Alur tribe of Uganda may be thought weak if they receive help during delivery. A similar finding is reported for the Bariba tribe in Benin. There is also evidence that women often accept illness with genital-urinary symptoms as part of life and may be embarrassed to seek medical care. A study, in Bolivia, found that women were put off by well-ventilated delivery rooms when their own understanding required warm conditions for the delivery to progress.

Cultural norms, restrictions, can prevent women from seeking health care outside the home for themselves and their children. This barrier is often raised still further when men

provide services, and has been offered as one reason why Asian women living in Western countries often make little use of health services. Another example of culture as a barrier to using health services is the perception and the unacceptability of modern contraception among men in parts of many rural areas of Uganda including Kisoro.

Shaffer in his study suggests that cultural issues relating to language and staff insensitivity are important and deter some women from accessing antenatal care early and regularly (Shaffer, 2002). Conventional systems of antenatal care have changed little over the years and tend to be task focused and culturally homogenous. Easily overlooked details, like the gender of the consulting doctor, can make a big difference to women's perceptions of antenatal services. In a study of Islamic women living in Australia (Tsianakas, 2002), found that the prospect of being given an ultrasound by a male doctor, rather than a female, caused them to cancel antenatal appointments. Hispanic women living in the US failed to return for antenatal appointments because they felt staff were too harsh or simply unwilling to answer their questions (Tandon, 2005).

These kinds of cultural oversights may be viewed as disrespectful by women from various ethnic groups and generate feelings of frustration and further marginalization.

Financial barriers may also interact with other demand barriers. One study in Kazakhstan, for example, found that the education of the household head or the care-seeker was an important determinant of the willingness to travel long distances to obtain treatment. A review by WHO found that the direct costs of maternal health care range between one and five percent of total annual household expenditures, rising to between five and 34% if the woman suffers a maternal complication (WHO, 2006). At the national level, the WHO estimates totals of \$95 million and \$85 million are lost each year by Ethiopia and Uganda respectively due to poor maternal health. Globally, \$15 billion is estimated to be lost every

year due to reduced productivity related to the death of mothers and neonates. Country estimates range from \$1.50 per person per year in Ethiopia to almost \$5 in Senegal.

Lack of access to quality care is the main obstacle to reduce maternal mortality in low and middle income countries. The average of skilled attendance at delivery to all developing countries was 42% in 1990, rising to 52% in 2000. However, the average for Sub-Saharan Africa was 40% in 1990, rising to just 43% in 2000. Some countries, like Ethiopia, have rates as low as 10%.

A second problem is that the available resources are not allocated to the most effective interventions, and are geographically concentrated in large cities, and do not reach the poor. Despite the WHO *Alma Ata Declaration*, the bulk of public health expenditure continues to be absorbed by hospital based care delivered at some distance from poor rural populations. Shifting the balance of resources further toward primary care would not necessarily have the desired impact on the level and distribution of population health. However, there are major deficiencies in the quality of primary care delivered in many developing countries.

### **2.3 Intervention measures to the factors affecting the utilization of Antenatal care services among women**

A large body of evidence confirms that many people in the developing world go without health care from which they could benefit greatly. The poor in developing countries are even less likely than the better off to receive effective health care (O'Donnell, 2007). Concern for the level and distribution of health services in the developing world demands that measures be taken to redress both facts.

In the health sector, there are a number of policies with implications for maternity service provision. To expand the platform for health care services, the private sector is envisaged to play an important role in the implementation of the national health policy and a public-private partnership policy has been drafted to set the modalities of the collaboration (Freddie, 2004). In Uganda, more specific health sector interventions focusing on health education and information campaigns have been formulated. Providing information on the types of diseases that can be self-medicated and those that require medical information may raise the demand for care. It is likely and evidenced by the interventions discussed that these will often have to be accompanied by ways of getting patients to health services.

Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks and preventable death. Yet cost-effective interventions exist to stop these unnecessary inequalities. To achieve the greatest health gains at the least cost, national and donor investment strategies have given considerable emphasis to health interventions for women, particularly during their reproductive years. There has been much progress in improving women's health; however, some challenges remain and new ones keep emerging.

Investment in pregnancy and safe delivery programs is a cost-effective way to meet the basic health needs of women in developing countries. Prevention of unwanted or ill-timed pregnancies is also essential to improving women's health and giving them more control over their lives. Safe motherhood interventions can strengthen the performance of the overall health system. The effectiveness of maternal health services is often hampered by organizational and institutional constraints. Improving access to good-quality maternal health care remains a challenge in many countries because it requires a functioning primary health care system in the community and a referral system to a health facility

capable of providing emergency obstetric care. Safe motherhood interventions designed to integrate various levels of the health sector can thus bring about improvements that more broadly affect the health system.

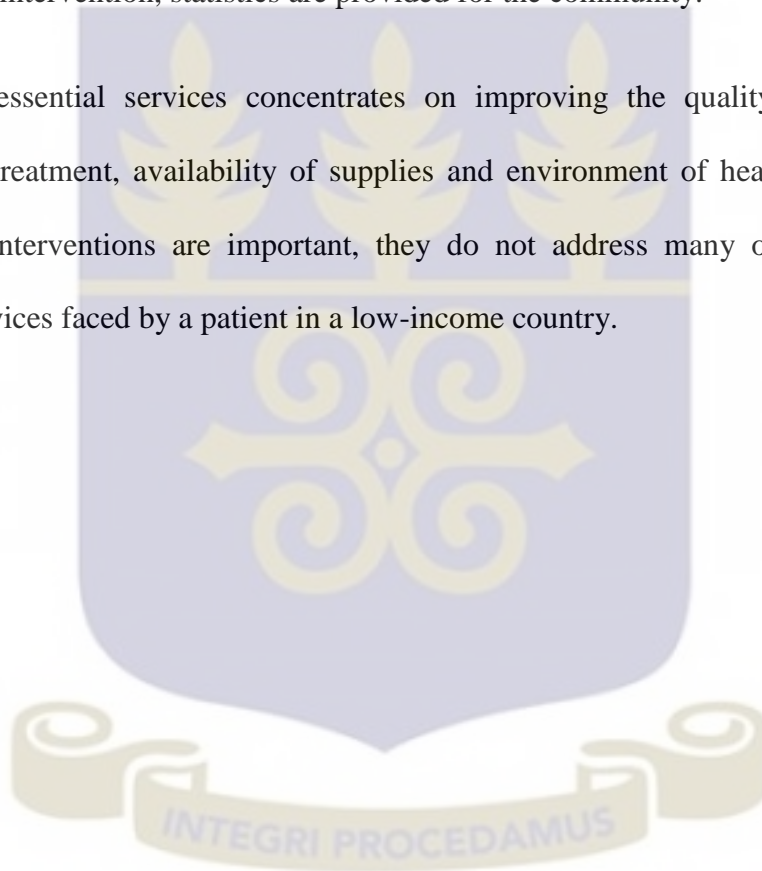
Interventions to improve women's educational attainments are potentially wide reaching and mostly outside the traditional scope of the health sector. Apart from improving the general standard of, and access to, education, targeting schemes for raising female enrollments have been developed to include financial and nonfinancial incentives to families, scholarship schemes, and the promotion of all-girl schools (to overcome cultural constraints that prevent girls from mixing with boys). Schemes to empower women may be helpful in breaking down historical barriers to seeking care. Services that are sensitive to prevailing cultural conventions, without compromising medical standards, may also have an impact on the demand for services. However, such schemes have favored mainly the urban population with less impact to the rural poor like those in Kisoro. Most of the interventions incorporating community education appear to show some evidence of an increase in the use of facilities, particularly by women with complicated deliveries. However, some of these studies allege only a general increase in uptake of services, but do not attempt to quantify the change or attribute it to the intervention.

Other studies provide —harder's evidence of change in behavior. Education and information campaigns in Nigeria, Sierra Leone, and Ghana all led to significant reported increases in attendance at normal and complicated deliveries as a result of the intervention (Nwokoby, 1997). The community campaign in Kebbi State, Nigeria was reported to have a significant positive impact on awareness of obstetric complications but no impact on referrals. Similarly, a campaign to target men and women to overcome cultural resistance to referred labor showed little increase in referrals. In the latter case it is argued

that inflation and other economic factors began a general decline in facility-based delivery that the intervention halted but did not reverse.

However, in Ghana, health information improved women's knowledge of the need for antenatal care, complications, and post-delivery care and increased the use of services (Gennaro, 2001), Postpartum care went up from 26 percent to 72 percent while the use of clinic or district hospital for delivery went up from a combined 29 percent to 59 percent. Pre- and post-intervention, statistics are provided for the community.

Delivery of essential services concentrates on improving the quality of staff skills, protocols of treatment, availability of supplies and environment of health facilities. Yet while these interventions are important, they do not address many of the barriers to accessing services faced by a patient in a low-income country.



## CHAPTER THREE

### 3.0 METHODOLOGY

#### 3.1 Study type

This is an exploratory study employing qualitative research approach. This was employed to explore and understand the knowledge of antenatal care of the women within the Ga East, Municipality

#### 3.2 The Study Area

The study was conducted in the Ga East, Municipality of the Greater Accra region. The municipality shares boundaries to the south with Accra Metropolis, to the West with Ga West, to the north with Akuapim South District and to the east by La Nkwantanang Municipality. The municipality has four sub-districts namely; Tiafa, Dome, Haatso and Abokobi as its capital. It has a population of 165,274 with two public and fifteen private health facilities. It also operates community health programs (CHPS) in 38 demarcated zones and 17 functional zones. Public service and trading are dominant occupations with, a sizeable proportion of the labour force in the municipality is unemployed reflecting a high poverty level in the municipality.

Two of the four sub –districts Abokobi and Dome were purposively selected as sites for data collection. Abokobi was selected because it's a rural setting and developing into an urban area, though the capital of the municipality.

### **3.3 The study population**

The study population lived in the Ga East, Municipality, and included pregnant mothers, who were attending antenatal care at an Abokobi health facility, mothers who also used the services of Traditional Birth Attendants, Traditional Birth Attendants who live in the community and provide services, and health professionals (midwives) at the Abokobi Health facility.

### **3.4 Recruitment of study participants**

Participants were purposefully recruited for this study. These were women in the reproductive age group who were pregnant or had given birth within three weeks to twelve months as at the time of the study. The researcher first paid several visits to the facility where the pregnant women go for antenatal care services.

### **3.5 Sample and sampling techniques**

A total of twenty (20) mothers (participants) were enrolled into the study. After interviewing this number of people, it was realized that no new narratives were coming up, an indication that saturation point had been reached hence the interview was stopped. In addition, five (5) key informants also took part in the study and these included two (2) Midwives from Abokobi health facility, and three (3) Traditional Birth Attendants, (2) at Dome Railway crossing and (1) at Aporman all in the Ga East Municipality.

### **3.6 Characteristics of the study participants**

The ages of these pregnant women varied between 15 and 38 years. Most of the women were unemployed whilst few were engaged in diverse occupations such as selling (pettey

trading). Three (3) of the women were married and living together with husbands, 5 were living with partners at the time of the study and the rest living on their own.

### **3.7 Data collection technique**

In - depth interviews were used in collecting data from respondents. This method was chosen to ensure that as much detailed information as possible was obtained from the respondents. An interview guide which was based on the research questions and objectives of the study was designed to guide data collection. The researcher and two trained field assistants undertook the interview sessions from 18<sup>th</sup> May to 3<sup>rd</sup> June, 2015. The interview was conducted in Akan, English and Ewe depending on which language a particular respondent was more comfortable with. With the consent of respondent, the interview sessions were captured on a recorder to guarantee that no information was lost. In addition to the recorded interviews, the researcher and the assistants took notes.

In-depth interviews are very effective in getting diverse information from individuals it offers one to dig deep and customise the questions in line with the participants' on the go although within the constraints of a framework. One – on – one in depth, also offers the opportunity to have an uninterrupted interview as compared to focal group discussion where others could jump in to disrupt the one on the floor.

However, there are disadvantages that exist in in-depth interview like the challenges in training interviewers. In order to make the person feel comfortable and interested about the topic they saying, interviewers must use effective interview techniques like body language and friendly speaking. It is difficult to train out a well interviewers since rather than knowledge, experience can bring an absolutely advantages to their career, generalizations about the results are usually not able to be made due to the small samples

### **3.8 Data Management and Analysis**

All data from the in-depth interviews (IDIs) were audiotaped using a digital audio recorder and complimented with written interview field notes. Both audiotaped data and written interview notes were transcribed into Microsoft word for windows. All transcripts were entered into Nvivo 10, a qualitative analysis software package. And content analysis on the qualitative data based on emerging themes and sub-themes in line with the study objectives. The content analysis was also employed to compare and contrast the views of participants. Descriptive narratives supported by illustrative quotes were used to present the results. In selected cases the original words or phrases in the local language was left in the transcripts.

### **3.9 Ethical considerations**

Ghana health service Ethics Committee approved the protocol for the study. All the participants gave either a written or verbal consent, expressing their willingness to participate in the study. Respondents who gave written consent were asked to append their signature or thumbprint on an informed consent form as an indicator of their consent to be part of the study. In efforts to maintain confidentiality, codes were used to identify research respondents.

Participation in this study was entirely voluntary and participants had the option to participate or to discontinue their participation without any adverse consequence. Participants were given sufficient information about the study to enable them to decide whether to take part or not.

There were no risks of participating in this study. The study did not anticipate any major cost for participants except the participants' time spent during in-depth interview. Field

notes and electronic data have been stored in a locked file cabinet and access was limited to the PI and the Supervisors of the study.

### **3.10 Pre – test**

A pre-test of the study was carried out at Danfa a suburb of Accra in the La Nkwantanang Municipality to finalize the wording of the questionnaire such as a culturally acceptable way of asking about the other alternative practices being undertaken by the women as a source of antenatal care. Danfa has similar demographic features to where the research was conducted.



## CHAPTER FOUR

### 4.0 RESULTS

#### 4.1 Introduction

This chapter presents the analysis and findings of the study. The chapter is organised by sessions in accordance with the research questions and objectives, and these are the knowledge of antenatal care use, importance of the antenatal care use, alternative practices undertaken by the women,

#### 4.2 Socio-demographic characteristics of the participants

A total of 25 participants were involved in this study as shown in table 4.1. This consisted of 20 pregnant mothers, 3 Traditional Birth Attendants and 2 health workers. The breakdown of the ethnic groups are as follows; Ga 8, Akan 6, Hausa 2, Ewe 1 and other 2. Most of the participants were above twenty one (21) years of and seven (7) were below the age of twenty (20). The health workers interviewed were female midwives with the Abokobi Health facility.

Almost all the participants were Christians and all had some level of education except one who had no formal education. Meanwhile most of the participants were unemployed with few engaged in petty trading.

Three (3) of the participants were married traditionally, five were living with partners but not legally married and the rest were living on their own or with family. The health workers were married and living with their families. Two of the traditional birth attendants at Dome are widows and one at Aporman is married and living with her family. They have all practiced traditional birth attendants for three decades.

**Table 4.1: Socio-demographic characteristics**

Characteristic of IDIs participants	Number of participants	Percentage
<b>Ethnic background</b>		
Ga	8	40.0
Akan	6	30.0
Hausa	2	10.0
Ewe	2	10.0
Others	2	10.0
<b>Age</b>		
20 years and below	7	35.0
21 – 40 years	13	65.0
<b>Religion</b>		
Christian	18	90.0
Muslim	2	10.0
<b>Level of education</b>		
No formal education	1	5.0
JHS	18	90.0
SHS	1	5.0
<b>Occupation</b>		
Unemployed	11	55.0
Trading	6	30.0
Artisan	3	15.0
<b>Marital status</b>		
Single	17	85.0
Married	3	15.0

**Source: 2015**

#### 4.3 Knowledge of antenatal care use

Many women view pregnancy as a mystery that is clothed with anxiety and a lot of uncertainty and therefore every step is taken in their view to protect the mother and the child till the baby is delivered and this was confirmed by both mothers attending antenatal care at a facility. When asked about their knowledge about antenatal this is what some had to say, the various quotations below goes to support their knowledge about antenatal care.

*It's the name given to the place where they take care of pregnant women at the hospital (Pregnant woman, Abokobi Health facility).*

*If a woman you've taken seed you come to the Dr to see you or nurse to look at your health, that of the child, how you take your drugs and your nutrition, sometimes you're not taking good nutrition, it could affect your blood level so they will give you drugs and tell you what to eat in order to improve on your blood level (Participant attending antenatal care at an Abokobi health facility')*

*Sometimes you're not feeling well and you go to the hospital to find out and the nurse will tell you you're pregnant so they will give you a date and tell you that you will be coming for antenatal (A pregnant woman attending antenatal clinic at Abokobi Health Facility).*

*Antenatal care as I know is that when you are pregnant, you go and they attend to you concerning your health and that of the baby in your tummy' (Pregnant mother, Abokobi)*

*Is part of the hospital that they attend to pregnant women, once you are pregnant and you go to the hospital the nurses will tell you that you have come to antenatal clinic and they will give you a date for your next visit'(Pregnant mother, Abokobi)*

However, when midwives were asked to share their knowledge about antenatal care this is what they had to say,

*Okay health workers attending to pregnant women as soon as they are pregnant till they deliver (A midwife at Abokobi Health facility)*

*.Antenatal care is an individualized client centered given to the pregnant women from the time of conception till their delivery, we take care of like when they come we do test take their vital science we do physical examination (Another midwife at the Abokobi Health Facility)*

The Traditional Birth attendants, when interviewed on the knowledge of antenatal care services, also had something to say about it. The following are quotes from two Traditional Birth Attendants on their knowledge of antenatal

*Antenatal care is the unit that has been set aside to take care of pregnant women in the hospital and as a woman once you take seed you need to go and see them' (TBA participant, Akporman)*

*Antenatal is where women who are pregnant go for treatment to check their bp (blood pressure) at the hospital and also to see if the baby is lying in the correct position (Untrained TBA, Dome)*

*Antenatal care is a place at the hospital where if you are a woman and you are pregnant, you go so they take care of the pregnancy and you the mother (A pregnant woman TBA client, Dome)*

#### **4.4 Importance of antenatal care to the pregnant women**

Participants were also able to state the benefits of antenatal care practices to both mother and baby. This suggests that the pregnant mothers, Traditional Birth Attendants and health workers had a fair knowledge about the importance of antenatal use, as seen in the narratives below.

*For me, going to antenatal check-up is very important to me because you cannot tell if your child is lying well in your tummy or not, so when you go they will check and tell you the child is lying at its proper place (A pregnant woman ANC client Abokobi)*

*Am told the child could develop some complications while growing in the tummy so if I don't go for check-ups to know if everything is okay, I could lose my baby and carrying pregnancy is not easy if you have to lose you baby so for me I don't miss my appointment time (A pregnant woman ANC client, Abokobi)*

*It offers you to know a lot of things like your nutrition, what you should eat so your baby will be healthy, you will know if your blood level is ok or not (Pregnant mother, Abokobi)*

*Oh, if you go for antenatal check-ups you will be taught a number of things that will help you and the unborn child to be healthy, sometimes they can advise you on what to do if your work is such that it can cause a problem to the baby you will be advised ( pregnant woman, Abokobi)*

*You get to know if your child is doing well, also your blood group and if your blood level is low you will be told and given medication so for me antenatal care is good (A pregnant woman attending ANC at Abokobi)*

*They will check your Bp (blood pressure) your weight and if you have too much blood they will let you know and how to control it, (A pregnant woman attending TBA at Akporman)*

*It helps us to know if our baby is healthy and also lie in a safe position, there was a time when I was pregnant with my first child and I thought all was well, but when I came for antenatal care I was told my child was not lying in the correct position so they corrected it if I had stayed home wouldn't have known and who knows may have lost my baby boy (A mother who has delivered Four months ago and was visiting the ANC at Abokobi).*

The following narratives are what two health professionals (midwives) at Abokobi health facility also said about the importance of antenatal care.

*It helps to detect early section of any abnormality in a pregnant woman, such as severe anaemia, malaria in pregnancy, pregnancy induced hypertension. It can also promote good condition throughout the pregnancy for both mother and baby, the growth of the foetus. We do palpate them we take our standard height may be foetus is not growing well and then we take steps to normalise it. (Midwife, Abokobi health facility)*

*we prepare the pregnant woman physically and emotionally towards child birth we are also able to detect any disease and then we also monitor the growth of the baby the foetus so that the woman will have a safe delivery any deviation from normal too are refer to for immediate attention' (Midwife, Abokobi health facility)*

#### **4.5 Alternative practices undertaken by the pregnant women**

Most of the women when asked about if they engage in alternative practices to the public health facility they said yes, they do apart from the antenatal care and this includes visiting Traditional Birth Attendants and also seeking spiritual protection for the pregnancy and that spiritual threat were of much concern to them during pregnancy. The women perceived to be vulnerable to spiritual attacks that can lead to the destruction of their pregnancy. A number of the participants perceive this spiritual susceptibility as a credible traditional belief. They believe spiritual attacks manifest first in the supernatural and then in the physical. Consequently, miscarriage and other maternal complications can be physical manifestations of such spiritual attacks. A disease condition locally referred to as “asram,” was severally perceived as a physical manifestation of evil spiritual attacks on a pregnant woman. This threats that has socio – cultural beliefs drives them to seek other sources of antenatal care. The participants mention some of the alternative sources as

Traditional Birth Attendants, herbalists, and spiritualist. The following narratives below were given to support their claims.

*For me I believe spiritual forces exists and they cause this illness called “asram”. it is about evil eyes and it causes this disease, some people transfer the disease to the child in the womb or when you eat outside or another person sees the food that you are eating they can do that.” (Pregnant woman, Abokobi).*

*‘I lost my first child, though I was regular at Antenatal and gave birth there, but three weeks after giving birth my baby died and was told by an old lady in the house that it was ‘asram’ that killed my baby and that as for ‘asram’ the Doctors cannot detect it so if you’re pregnant and only rely on the hospital you may lose your baby so since then, eh I decided that though I will go to the hospital, will sought a man of God who is spiritual and can see things to be praying for me to protect my baby (Pregnant woman, Abokobi)*

*When I missed my menses and I went to the hospital, I did a test and was told I was pregnant after a while my tummy was not showing so a friend told me that evil forces could cause my tummy not showing so was asked to see a Traditional Birth Attendant at Akporman who said “Atari” meaning the baby was attached to a part aside where it should be and is the work of the devil’ (Pregnant woman TBA client, Dome)*

Some of the participants interviewed believed that if you take seed in the initial stages of the pregnancies you don’t have to let people know or broadcast it because someone who doesn’t like you hears that you’re pregnant can attack you spiritually to destroy the pregnancy even if you’ve not wronged the person. Also going out in the night alone after 6 pm as some of the spirits may be returning from where ever they went to. Below is a quotation from a participant.

*My grandmother who was a herbalist, but sees things in the spiritual realm too told me one day that some people when you tell them you're pregnant at the early stages of the pregnancy and they have evil eyes and bad intentions about you they can destroy the pregnancy so when am pregnant, I shouldn't tell anybody, so my first child I stayed home didn't even go to the hospital till when the pregnancy was about six months before going to the hospital so was taking some herbs she showed me how to prepare it before she died (Pregnant woman, Abokobi)*

*When am pregnant, I don't go out in the night, I am told when go out in the night, you might meet sprits returning and could attack you and destroy the baby in your womb, ..... "I have a spiritual father, he's very powerful, so when my time is almost due will go to stay there till am about delivering and some of the Traditional Birth Attendants are good, some also sees things in the spirit so when you're pregnant and relay only on the hospital am afraid it's not enough, for them they don't see anything oooo, they only scan and give you medicine (Pregnant mother, Abokobi)*

This claim of spiritual attacks, is a traditional belief, which have been expressed by some of the women who patronise the services of the public health facility as well as traditional Birth Attendants. Few of the women interviewed who uses the public health facilities debunk this assertion of meeting evil spirits when you go out in the night alone though believe evil spirits exists. This is what a participant said.

*some of this traditional beliefs are not practical, I have two kids and carrying my third child and I go out to sell and comes home late sometimes after 9.00pm and never encountered any of the things that some people claim and sometimes go to see my pastor for prayers in the night too'(Pregnant woman, Abokobi)*

#### **4.6 Care seeking behaviour**

From the study it has come to light that most of the women who took part in the study receive pregnancy related care from multiple sources based on how one sees or access

threats to the pregnancy. The majority of the participants utilizes both public health facilities as well as non-public health facilities such as Traditional Birth Attendance, spiritualist/ prayer camps, herbalist, and is due to the fact that they want total security and guarantee for their pregnancies and their babies. In fact, all the women interviewed have attended antenatal clinic for safety reasons and the fact that all the Traditional Birth Attendants both trained and non-trained do refer them to Antenatal clinics, while they also do their bid.

‘....As for me, this is my third pregnancy, but will always prefer to give birth at the hospital because sometimes there are complications and you will be referred to a bigger hospital for help if you give birth at the Traditional Birth Attendants Place and there are complications, before they look for a car and send you, you may die on the way so as for delivery I prefer the hospital’ (*Pregnant mother, Abokobi*)

‘.....If you’re giving birth at the TBA and you start bleeding plenty and you need blood, she can’t give you blood and even where will she get the blood you will die, I like their care and attention they provide but when it comes to delivery I prefer the hospital’ (*Pregnant mother, Abokobi*)

#### **4.7 Challenges faced by the pregnant women at the public health facility**

Some participants highlighted some negative attitude of some of the nurses when you go for antenatal services and especially to delivers, you will be in pain seriously and you call them, they won’t mind you, and if they come, the way they talk to you is so painful and if not the fact that you want your life like you will get up and insult them.

*My first born was delivered at legion hospital it was so painful, I went into labour for two days couldn’t sleep was crying and when at a point I felt my baby was coming and I called the nurse she didn’t mind me for several times and when eventually she came she came and shouted at me. ‘maame are you the only person who has come here to deliver and you are making noise and shouting as if someone is killing you make noise again and you will see (Pregnant mother, Abokobi)*

*I delivered my first child at a Traditional Birth Attendants place at Kukurantumi, couple of years ago but that woman is dead now, may her soul rest in peace. The way this woman will talk to you, massage you and pamper you, you won't even feel the pain in delivery, but my second child, I had at the hospital hmm the way the nurse treated me when I called her that the baby was coming and I could feel it and it was so painful, she told me that the baby is not ready to come now and that I should keep quiet, and that do I see the other women crying or making noise and that when you have a little pain then you're making noise and disturbing and when I was enjoying with my husband did I make that noise so I should shut up*  
**(Pregnant woman, Abokobi)**

#### **4.8 Psychosocial support**

All the Pregnant women interviewed, were of the view that when you are pregnant, you need to be pampered so you can have a sound mind to deliver. For them any day any time they're pregnant they will seek for the services of Traditional Birth Attendants sometimes the way they talk to you alone makes you happy. When they see that something is not right with the pregnancy, how they will break the news to you, you won't panic as compared to what you get at the hospital. This a narrative of a pregnant woman.

*When I visited antenatal one day and the nurse saw me she said 'maame look at your stomach don't you see that your stomach has shifted and you won't come to the hospital, you stay home eat and sleep. You come to the hospital when you like and something happens to your baby, then you begin to blame us', I felt so bad, so in the evening I went to see a Traditional Birth Attendant at Akporman and she was so nice and said 'Atari' meaning the baby was not at her normal position she massaged my tummy and the baby moved to its normal position*  
**(Pregnant woman, Abokobi)**

*When I was pregnant at the age of sixteen and I went to the hospital the nurse treated me badly she insulted me that small girl and you're pregnant, you don't know anything about pregnancy, even look at your breast so small 'Akora boni' meaning (bad girl) I regretted going to the hospital*  
**(Pregnant woman, Abokobi)**

#### 4.8.1 Accessibility of TBAs

Some of the women who do attend public health facility and also patronizes the services of the Traditional birth attendants talk about the issue of accessibility of the Traditional birth attendants that they are easily accessible any time you need their services they are there to render it, sometimes you can call them on the phone that you're not feeling well and they will come home and see you meanwhile with the hospital if something is happening to you after normal working hours you cannot go because they will tell you the Doctor has closed so go and come the next day, this is what some had to say,

*As for Auntie, (that's how they call the TBA) she lives with us and her house is not far and anytime you can go to her even in the night anytime, even sometimes when you're feeling weak and you send for her she will come and attend to you' (a mother who had delivered 7 weeks ago TBA client, Dome)*

*As for the TBAs they are like our mothers, we live with them so they understand us they will tell you anytime you need me, come and knock at my door even if it's midnight, I will open you and even sometimes she will pay you visit at home so for me it makes me very comfortable (pregnant woman, Abokobi)*

On the contrary, a pregnant woman who patronize a public health facility didn't agreed to that fully with the assertion that if you know you have to see your doctor you make the effort to go there during working hours and that some delay to do what they think is important to them and think the doctor should wait for them this is what she had to say.

*Some people when it's time for them to go for antenatal they will delay and want to go and sell to make money and go in the afternoon when the Doctor have closed and will turn round to complain, but when it's time to vote, or she has to travel they will get up early and prepare (Pregnant woman ANC client, Abokobi)*

#### 4.9 Increasing the usage of antenatal care

On the way forward in increasing continues use of the public health facility, almost all pregnant women had issues that they wanted addressed, these range from the attitudes of health care providers, problems with the laboratory facilities. Respondents said once these issues are addressed they will be fine and this what some had to say

*Some of the nurses don't regard us as human beings and when you come here for antenatal they talk to you anyhow you ask questions and they get angry. Especially if you are in a queue and your name is mentioned and you don't hear and she has to mention your name again she will insult you in the presence of everyone, it is very embarrassing (Pregnant woman ANC client Abokobi)*

*When it's time for you to deliver and you come to the facility and you are in pain, no one will listen to you even when you call the nurse then she gets angry. If you cannot contain the pain and you have to shout small then trouble they will insult you and say 'why are you the only person given birth' as if they don't know what one goes through when given birth they will shout at you and sometimes will come and slap your buttocks (Pregnant woman, ANC client at Abokobi)*

##### 4.9.1 Laboratory services

All the women interviewed had serious issues with the laboratory service and complained that they don't come early and when they do the test for you and give you time or date to come for it you will go and after waiting for a long time then they will tell you that it's not ready. Most often, they will tell you that there is no light though they have generator they will tell you it is turned on for only emergency cases. Where the Doctor requires the results immediately, you will be asked to go to Madina to have your lab done, this what many said;

*Sometimes you come early morning because you have appointment to see the Doctor and you are asked to go to the lab in the morning before you are seen and you will be told no light so you have to go to Madina and sometimes you have done your lab you've done already, they will tell you is not ready and you cannot see your Doctor so you have to go back **(pregnant woman, ANC client Abokobi)***

*Here at Abokobi I don't know the problem with the lab people or their machine, most of the things they will tell you our machine can't do it so go to Madina.**(Pregnant woman, ANC client Abokobi)***

On the contrary, the health workers (midwives) on the way forward as to what can be done to increase uptake of the service looked at it from a different perspective and raised three major issues that if addressed will help increase the number of pregnant women assessing the facility, and the following narratives captured their views

*There should be a lot of education in the community to raise the awareness level of the perception on antenatal services care through the durbars and the media. Also some of the attitudes of our own colleagues, nurses towards the clients must change sometimes we don't talk to them well' '...That is why we lose them to the TBAs they live in the community with them and the way they handle them, they pamper them thanks to God that now we collaborate with the TBAs so they make referrals to us **(Midwife, Abokobi)***

*The health service here talked about the introduction of pregnancy school, but it hasn't taken off yet it will also help a lot'. '...Male involvement is also very important because the women are not empowered in this rural area so the women depend on the men financially and so if the man knows the importance of the antenatal care he will readily give them money to come **(Midwife, Abokobi)***

## CHAPTER FIVE

### 5.0 DISCUSSIONS

#### 5.1 Introduction

The key findings of this study is discussed in details according to the objectives which include the awareness and knowledge of antenatal care services, socio-cultural factors affecting antenatal care use and alternative care practices being undertaken by pregnant women within the Ga East Municipality.

#### 5.2 Awareness and knowledge of antenatal seeking antenatal services

Antenatal care is a common practice among pregnant women in the Ga East Municipality. The findings of the study revealed that all the mothers who participated in the study acknowledged the use of antenatal care.

The level of knowledge of mothers about the antenatal care services, could be attributed to their educational status. Since the demographic characteristics of the mothers showed that most of them had some level of education. Hence educational could be linked to the mother's level of exposure and access to information on antenatal cares services that are given at the facility.

In some studies, knowledge of antenatal was identified as a major structural variable that could influence greatly the decision on whether to utilize antenatal care services. The pregnant women knew that they had to at least visit the antenatal clinics four times from time of taking seed till they deliver.

This goes in sharp contrast to the study conducted by Singh and Khare (2001). In Zimbabwe which stated that majority of Zimbabwe's pregnant women had an average of one visit before delivery and an initial antenatal care visit was made during the second and third trimester. However, knowledge about the benefits of the antenatal care services as

narrated by the pregnant women included the following: knowing baby's condition, safe delivering, food education, prevention of diseases, and detection of infections and obtaining drugs. Lack of knowledge about ANC and delivery were major barriers to seeking health care among pregnant women in Uganda. These high number of pregnant women accessing antenatal care is similar to those from an evaluation of antenatal care attendance in developing countries (WHO. 2003). However, there was high attendance of antenatal visits by the women in Ga East Municipality.

### **5.3 Alternative to public health antenatal practices**

Most of the women interviewed were categorical in their narratives that they do utilize other alternative care in addition to the public health facility. This is because of certain fears that they anticipate and believe that the facility may not have solutions to them, and the fact that they need psychosocial support. The attitude of some health workers also drives them to such places such as herbalist, traditional birth attendants and spiritualist.

Women expressed fear of, possible loss of baby, labor pains, and other maternal complications. Although previous studies found women exhibiting similar fears about their baby's wellbeing, childbirth, and hospitalization (Mrisho et.al 2004; Saisto et.al, 2003; Stathan et al, 2003), this study indicates that fear may be increased by the wide range of socio-cultural beliefs about threats associated with early disclosure, and witchcraft. These beliefs not only thrive within rural settings, but also lead to actions that may disrupt continued use of facility-based maternity care; a behavior identified amongst the women who utilize only public health facility and those who use the TBAs as well. It was observed that antenatal clients expressed similar cultural beliefs and fears, and therefore combined the use of facility-based services and alternative services during pregnancy, but usually deliver at the health facility. On the contrary, TBA clients (women who patronize

the services of TBAs as well as public health facilities) who expressed similar cultural beliefs and fears, combined the use of facility-based services and alternative services, but delivered with the help of the TBA. The disruptive role of socio-cultural perceptions in the use of public health facility services among pregnant women has been identified in other contexts (Bazzano et.al 2008, Geissler et.al; 1999).

In rural Zimbabwe, it is believed that disclosure of pregnancy in its early stages makes the woman and the pregnancy more vulnerable to witchcraft and because of that the pregnant women delay and avoid attending public health facilities as compare to the increase use of other forms of care (Mathole et.al 2004). Also, researchers found a high cultural value attached to home births or outside the public health facility due to the psychosocial services that are provided by the traditional birth attendants here in Ghana (Gyeke, 2013). Some Tanzanian women have the belief that long labour may be caused by extramarital affairs during pregnancy, therefore, some avoid delivery at the health facility due to fear of being exposed (Mrisho et.al, 2004).

Evidence suggests an overwhelming belief in religio-cultural dimension of threats to the pregnancy. This view does not only suggests crucial relationship between the physical and spiritual, but also the need to seek both medical and spiritual therapies (Sakey. 2002). Women severally explained maternity complications as manifestations of spiritual attacks leading to the use of faith healing as a health delivery option (Sakey. 2002). Consequently, most pregnant women, including regular antenatal clinic clients and TBA clients claim they seek spiritual support from diverse sources to help address these perceived dangers. In Ghana, African syncretic and Pentecostal churches provide a faith healing and create avenue where pregnant women can express faith in a Superior Power that can alleviate their health problems (Addai, 2000). Some of these healing requires specific actions,

which might not encourage the use of health facilities (Mathole et.al, 2004, Sakey. B 2000). However, actions undertaken relate not only to socio-cultural influences, but also experiences of pregnancy complications. Pregnant woman are likely to implore the help of a faith healer when orthodox medicine is unable to address her condition. In Zimbabwe faith healers are believed to have powers that enable them to offer some kind of protection for the women and their pregnancies from harm, consequently making them play a major role in the care of pregnant women during the early stages of the pregnancy (Mathole et.al 2004. A study in Ghana also suggests significance of religion on use of maternal health services (Addai 2000).

#### **5.4 Psychosocial support**

Findings suggest pregnant women's need for psychosocial and emotional support also influence the ways they use available maternity care services. Unlike conventional antenatal care users, the women who also uses the services of the Traditional Birth Attendants consistently compared public health facility services with alternative services and often made choices considering previous unpleasant experiences with health workers attitudes as well as their emotional needs. Even though, public health facilities exist in rural setting, some women prefer the TBA's services, because of how their psychosocial needs would be addressed. In situations where fear becomes inevitable, a TBA's ability to provide strong psychological and emotional support during and following delivery becomes a better option (Howson et al, 1996, Hunt et.al, 2002, Shiferaw et al, 2013). Some pregnant women's expressed scepticism about public health facility-based care and this was also represented in other studies (Bazzano et al 2008, Shiferaw et al 2013).

Studies in rural communities suggest women's preference for the TBAs provision of psychosocial support, and culturally sensitive services, in addition to being caring,

accessible, available and trustworthy (Pfeiffer et al 2013, Shiferaw et al 2013). These experiences are different from reports of health care workers' negative attitudes and insensitivity, and women's lack of confidence in healthcare staff, which discourages use of public health facilities (Paula, et al, 2001, Simkhada, et al 2008). Utilization may be based on expressed need and health delivery options perceived by the pregnant woman as better for addressing her psychosocial needs.

The health-seeking behaviour of pregnant women suggests concurrent use of facility based care and alternative forms of care, including herbalists, spiritualists/prayer camps and TBAs. The faith healers focus on the spiritual, while the public health facilities attend to the physical. Also, some pregnant women use a range of herbal therapies provided by TBAs, herbalists and Spiritualists. However, observations indicate slight differences in reasons for use of herbal medicines, for instance, most of the TBA clients used herbal medicines regardless of the condition of their pregnancy, expressing the belief that it strengthens the baby.

Although, pluralistic care-seeking behaviour has been previously identified among pregnant women (Howson et.al, 1996, Igboanugo et.al, 2012), it is important to note that this study also confirms the high patronage of public health antenatal services within rural settings. Reports from developing countries show high utilization of antenatal clinic services, often determined by socio-demographic, structural, cost, contexts, as well as cultural factors (Akazili et.al 2011, Simkhada et.al 2008, Cicekloglu et.al 2005)

In Ghana, the Maternal Health Survey shows 96% of pregnant women received antenatal care from a skilled provider. However, this percentage decreases dramatically for skilled assistance at delivery and postnatal care following delivery (55%) (GSS/GHS, 2007).

The situation was worse in the Northern part of the country where a recent study detected as high as 71% home deliveries (Akazili et al 2011). Also a recent study in Ethiopia found as high as 71% of women received antenatal care from a health professional, yet only 16% of deliveries were assisted by health professionals (Pfeiffer et al, 2013). High antenatal care use and low skilled attendant at delivery could partially be explained by observed patterns in the concurrent use of multiple sources of care.

Decisions may be deferred to the TBA because she is seen as an authority on traditional pregnancy-related practices (Howson, 1996). This is similar to findings from a study conducted in rural Ghana, which indicates older female relatives and traditional birth attendants along with the woman's husband, decide if and when the laboring woman should seek care (Bazzano et al 2008). This situation grants the pregnant woman limited control over decisions made regarding the use of facility-based care. Some studies suggest that some women attended antenatal clinics just to acquire an antenatal attendance card needed to ensure care in case of complications (Mrisho et al 2009)

Regardless, skilled obstetric care during delivery has been identified as one of the most important ways to address maternal mortality, and in sub-Saharan Africa, this is often achieved by encouraging deliveries in health care facilities (Harvey et al 2007, Graham et.al 2001). Estimates show that use of skilled obstetric care at delivery could reduce maternal mortality by 13–33% globally (Graham et.al 2001).

## CHAPTER SIX

### CONCLUSION AND RECOMMENDATIONS

#### 6.1 Conclusions

Socio-cultural beliefs and observations concerning threats of pregnancy, determines how pregnant women seek available pregnancy related health care services. Perceived spiritual threats which commonly results in expressed pregnancy-related fear among pregnant women and their use of conventional healthcare, together with alternative psychosocial, spiritual and herbal therapies. Even though facility-based care has great advantage over other forms of care, care-seeking patterns indicate that psychological needs and attitudes of health workers may disrupt continued use of health facility care throughout the pregnancy-delivery process.

#### 6.2 Recommendations

- Improvement of all-inclusive maternity care model that encourages continued use of the facility based care starting from pre-pregnancy through pregnancy, delivery, and beyond. Services provided must address the psychological needs of pregnant women, by encouraging healthcare professionals to interact, Identify, and provide for those who require psychological / emotional counselling.
- Some forms of rewards should be given to serve as motivation for the alternative care providers who refer pregnant women to facility-based care visits. This may offer a unique opportunity for strengthening collaboration between conventional and unconventional care providers. In this regard, a unique referral system that offers recognition and or a reward to alternative care providers who refer pregnant women to facility-based care, must be developed.

- Public health Facility based offers important opportunities to encourage women to deliver with a skilled attendant despite gaps that exist in a health facility. Therefore, efforts should be made programmatically to emphasize the need for skilled birth attendance in addition to accessing antenatal care.



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## APPENDICES

### APPENDIX 1: INFORMED CONSENT

School of Public Health

College of Health Sciences

University of Ghana.

Dear Respondent

You are being invited to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please ask the researcher if there is anything that is not clear or if you need more information

I am a student at University of Ghana doing a MSc. Degree in Applied Health Social Science. I intend to carry a study as one of the programme requirements. The main purpose of the study is to identify socio – cultural factors affecting antenatal care use among pregnant women in the Ga East Municipality.

The results of this study will hopefully improve the uptake of antenatal services among pregnant women and thereby help to reduce the burden of maternal morbidity and mortality. I have attached a questionnaire which asks you to respond to a series of statements and questions.

The items in the questionnaire focus on your knowledge as regards to antenatal care use. The items also seek to identify some social- cultural factors that influence the use of antenatal care. Finally the questionnaire includes statements that help to establish your attitude towards antenatal care.

I want to stress that your participation in this study is voluntary and all efforts to protect your identity and keep the information confidential will be taken. There is no risk connected to the study.

Refusal to participate will not affect your work or care you shall seek at any of the health facilities in any way. Should you have any questions about the research or any related matters, please contact the researcher on **0233365017** or [anim.oduro@me.com](mailto:anim.oduro@me.com)

Your participation will be greatly appreciated.

Yours Faithfully,

Kingsley Anim Oduro

**Principal Investigator**

The Academic supervisor can be reached on **0244278453**



## CONSENT FORM

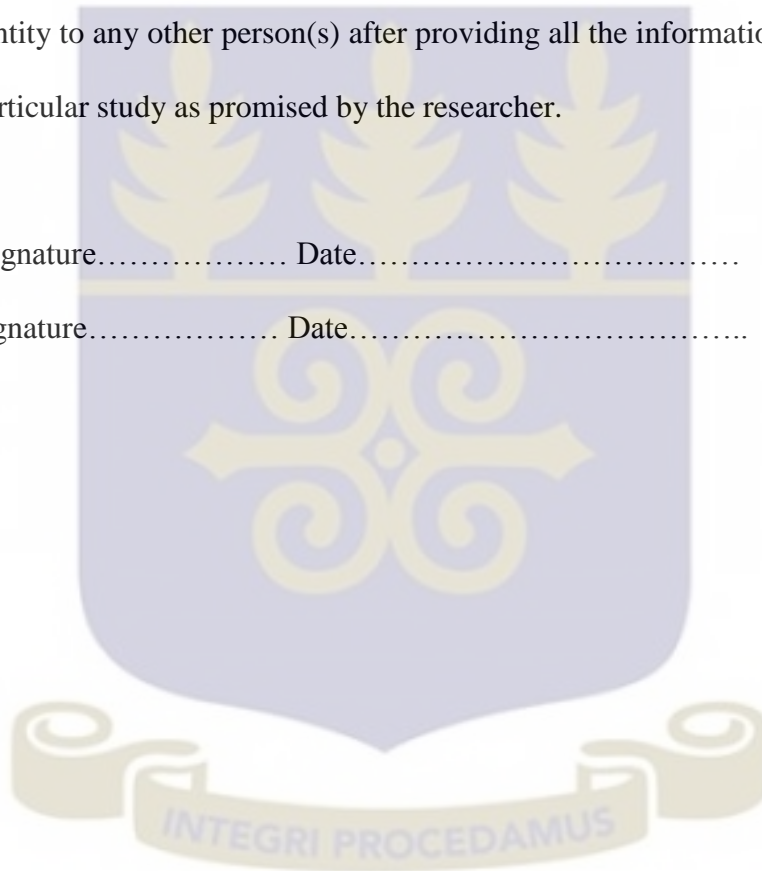
### PARTICIPANT

I..... Have been thoroughly briefed on the entire methodology and significant of the ongoing study, which is being conducted by Kingsley Anim Oduro. On my own free will, I hereby consent to be part of the study, based on my understanding of what the study entails.

I am doing this on condition that under no circumstances should my references be made to my actual identity to any other person(s) after providing all the information requested from me for this particular study as promised by the researcher.

Respondent signature..... Date.....

Researcher signature..... Date.....



**APPENDIX 2: INTERVIEW GUIDE**

**SOCIO – CULTURAL FACTORS AFFECTING ANTENATAL CARE USE IN  
THE GA EAST MUNICIPALITY**

Questionnaire No. :.....

Date.....

Village.....

Name of interviewer.....

Name of health facility.....

**INSTRUCTIONS**

- (a) Explain the purpose of the interview to the mother,
- (b) Ask for consent before proceeding with the interview
- (c) Make sure all questions are answered
- (d) Tick as appropriate

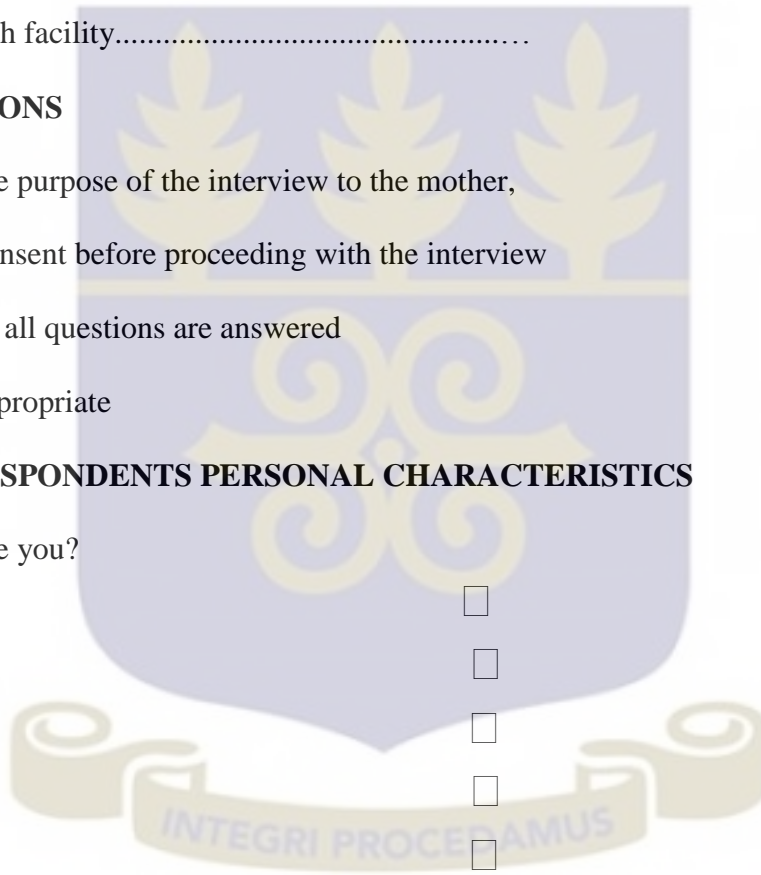
**PART A: RESPONDENTS PERSONAL CHARACTERISTICS**

1. How old are you?

- (a) 11-15
- (b) 16-20
- (c) 21-25
- (d) 26-30
- (e) 31-35
- (f) 36-40
- (g) 41-45

2. What is your marital status?

- (a) Married
- (b) Single
- (c) Divorced
- (d) Widowed



- (e) Separated
3. What is your tribe or ethnic group?
- (a) Akan
- (b) Ga
- (c) Ewe
- (d) Hausa
- (f) Others (Specify).....

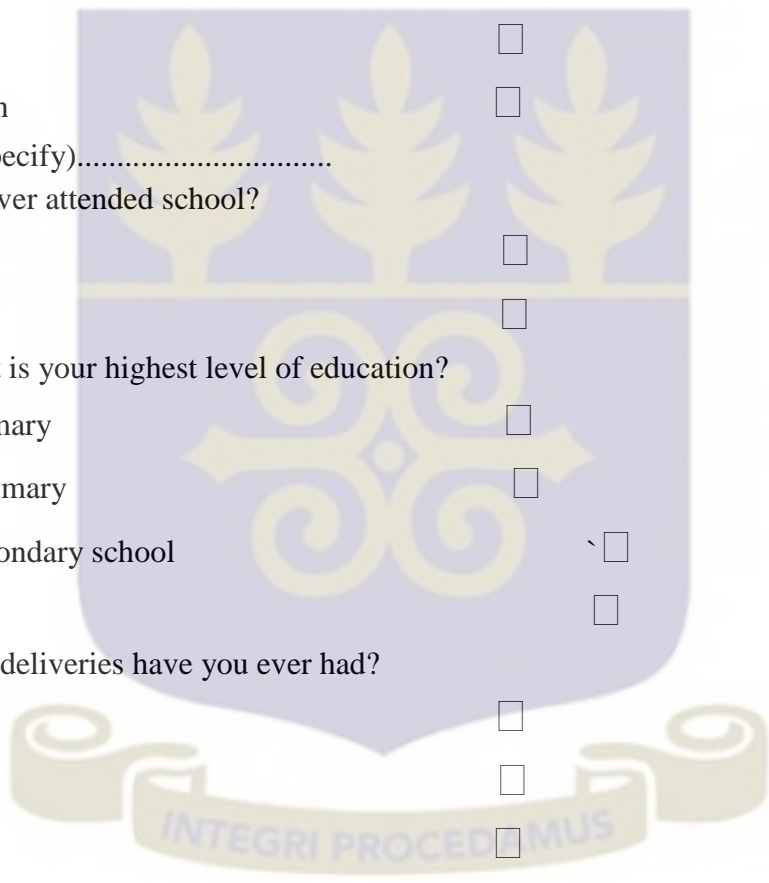
4. What is your religion or denomination?
- (a) Christian
- (b) Muslim
- (c) No religion
- (d) Others (Specify).....

5. Have you ever attended school?
- (a) Yes
- (b) No

6. If yes, what is your highest level of education?
- (a) Junior primary
- (b) Senior, Primary
- (c) Senior secondary school
- (d) Tertiary

9. How many deliveries have you ever had?
- (a) None
- (b) One
- (c) Two
- (d) Three
- (e) Four
- (f) More than four

10. How many children are alive?
- (a) None
- (b) One
- (c) Two
- (d) Three



(e) Four

(f) More than four

11. What do you know about antenatal care?

.....  
.....

12. How did you get to know about antenatal care? .....

13. What do they do? .....

14. What are the importance of antenatal care to you? .....

.....  
.....

15. Why do people not attend antenatal care? .....

.....  
.....

17. Apart from using antenatal care services what other methods or services does people use when pregnant? .....

.....  
.....

18. Why do they use that? .....

19. How is the decision made before accessing antenatal care?

20. What do you think can be done to increase the rate at which people seek antenatal care? .....

Thank you for participating in the research